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A Community Ready for the Future? A Social Marketing Study of Meals on Wheels Services in Ireland



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Declaration

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Philosophy, is entirely my own work and has not been taken from the work of others and to the extent that such work has been cited and acknowledged within the text of my work.

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Abstract

This research, undertaken in the Irish Meals on Wheels (MOW) community, seeks to address the challenges associated with MOW stakeholders' behaviours through the application of a community social marketing model: the Community Readiness Model (CRM). Building on an increasing recognition of the value of community-led approaches, this research examines behaviour change from the perspective of a community, rather than the traditional focus on the individual, encompassing the environment in which behaviours occur.

The application of the CRM in this research facilitates a systematic process of assessing and understanding the behaviours of key stakeholders involved in MOW services in Ireland, shaped by consultation with older people at different stages of MOW service use (current, former and potential MOW users). Through adapting this multi-perspective approach, this research moves beyond individual behaviour change to examine multi-level change and social implications. Furthermore, this research contributes empirical support to the discussion of broadening the scope of social marketing theory to encompass social and environmental factors.

Contributions to practice are shaped by insights into barriers and benefits, and levels of community readiness identified in this research. The application of the CRM as a means of assessing and monitoring gradual changes allows the development of greater control within the management structure of MOW. From a policy perspective, this research contributes to the body of knowledge that will guide efforts to continue to support older people to live in their own homes. The adaptation and testing of the CRM in the Irish context benefits not just the older population, but also acts as a guide for social change for other key areas of community life in Ireland requiring change such as health, social justice, transport, and energy sustainability.

Peer Reviewed Conference Presentations

FitzGerald, C., Domegan, C. and Scharf, T. (2013) The Ebb and Flow of a Community Behaviour Tool; The Community Readiness Model, 12th International Congress on Public and Non Profit Marketing, Gran Canaria, Spain. (Awarded Best Paper).

FitzGerald, C., Domegan, C. and Scharf, T. (2013) The Future of Meals on Wheels: A practice-led study, Annual Irish Academy of Management Conference, Waterford Institute of Technology, Ireland.

FitzGerald, C., Domegan, C. and Scharf, T. (2013) Towards a new future: A Social Marking Approach to Meals on Wheels, Irish Gerontological Society Doctoral Colloquium , Dublin, Ireland.

FitzGerald, C., Domegan, C. and Scharf, T. (2013) Are you ready for community behaviour change? Irish Ergonomics Society Annual Conference, National University of Ireland Galway, Ireland.

FitzGerald, C., Domegan, C. and Scharf, T. (2012) Towards a new future? A Study of Meals on Wheels. Overall OF Best Poster at Synergy Event, National University of Ireland Galway, Ireland.

FitzGerald, C., Domegan, C. and Scharf, T. (2012) From Meals on Wheels to a Community Meals Service: A Collaborative Community Study with COPE Galway, Well Being Conference, National University of Ireland Galway, Ireland.

FitzGerald, C., Domegan, C. and Scharf, T. (2012) A Recipe for Change: The Community Readiness Model, European Social Marketing Conference, Lisbon, Portugal.

FitzGerald, C., Domegan, C. and Scharf, T. (2011) Round Table Discussions, Annual Social Marketing Conference, National University of Ireland Galway, Ireland.

Chapter One: Introduction

1.1 Introduction

Social marketing is a framework that draws from several traditional scientific disciplines, such as psychology, sociology, anthropology and communications theory, with the aim of understanding not only how to alter individual behaviour, but also how to link this to a broader focus on bringing about societal change (Kotler and Zaltman, 1971). In recent years, the broadened era of marketing has been further extended, as is evident in the social marketing literature (Fry, 2014; Lefebvre, 2012; Wymer, 2011; Szmigin et al., 2011). This advancement sees social marketing efforts moving from an individual focus, to encompass systems, infrastructure and societal norms (Brennan et al., 2014). In this respect, social marketing has been described as “the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society” (Andreasen, 1995, p. 7).

Conceptually, marketing is entrenched in exchange theory, where exchange and benefits for consumers is a central focus, with the concept of exchange restricted to economic exchange in return for a tangible product (Chapman Walsh, 1993). Comprised of a combination of socio-cultural and economic cultural thoughts, marketing in the traditional sense intends to bridge a gap between the needs of individuals and the needs and abilities of producers. This broadened notion of marketing proposed that marketing should incorporate the public sector in satisfying society’s needs, by adapting marketing principles to encompass all aspects of individuals’ needs, no longer focusing solely on commercial consumer products (Kotler and Levy, 1969). The further extension of the broadened era of social marketing sees social marketing efforts moving from an individual focus to

encompass systems, infrastructure and societal norms (Brennan et al., 2014; Wilkie and Moore, 2003). This transition from the traditional view of social marketing moves beyond the individual to examine broader social issues that impact on both behaviour and behaviour change.

In addressing this transition, there is an evident need to recognise a broader perspective to acknowledge behaviour change at the community level (Kelly et al., 2013; Andreasen, 2010), focusing on behaviour change through the use of contemporary social behavioural ecological focuses and theory. Community social marketing aims to understand the complexities of changes from group, organisational and environmental perspectives. This broadened perspective locates social marketing programmes or interventions as embedded within the macro-level social policy environment and impacting on micro-level choices.

By nature, communities are fluid, ebbing and flowing, adapting and growing, ever changing. This fluidity presents significant challenges to community behaviour change programmes. Indeed, different understandings of the term community also represent a challenge in relation to such programmes. A community can be defined in a variety of ways; at a macro-level, a community can encompass geographical, cultural and interest dimensions; at a micro-level, the focus may be on specific groupings within larger communities (Selem, 2011). A community can exist where residents experience their society and culture. It may correspond to a professional society or group, a community of interest, or a community of place, with the latter referring to a group of people who share specific geographic and social contexts for activities (Edwards et al., 2000). Against this broad background and in order to best understand the complexities of communities from a behavioural change perspective, social marketing offers effective approaches to examine, strategise and mobilise behaviour change in communities. The diversity of communities, in terms of geography, culture and

population composition, inherently excludes a *one-size-fits-all* approach to community social marketing interventions (Edwards et al., 2000).

In introducing this thesis, this chapter begins by providing an overview of the study's research background. Following this, the research problem and research purpose are outlined. Relevant research gaps are identified and the research question is presented. The chapter ends with the study's contribution to scholarship and an overview of the thesis structure.

1.2 Research Background

A distinctive feature of social marketing is that it brings knowledge from the commercial arena and applies it to solving a broad range of social and health problems (Stead et al., 2007). This feature has a client-centred ethos at its core, where clients perceived needs, values and preferences are at the centre of specific behaviour-modification strategies (Burroughs et al., 2006). Social marketing aims to develop satisfying exchanges and create a combined strategy, centred on the marketing mix, competitive analysis, audience segmentation, use of formative research to make strategic decisions and on-going monitoring and evaluation (Hastings, 2007; Grier and Bryant, 2005). Social marketing approaches can be applied not only to the behaviour of individuals, but also to the behaviour of professionals, organisations and policy makers. Having established the area of social marketing as the field of study, the focus now turns to examining the role that behaviour plays in social marketing.

Social marketing approaches tend to address and overcome what are perceived as being unhealthy behaviours, such as smoking and obesity, by modifying unhealthy behaviours in ways that create healthy behaviours. Such behaviour modifications have been successfully achieved through the application of social marketing approaches through awareness and educational campaigns. Such

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social marketing efforts focused on modifying individual attitudes that reinforce unhealthy behaviours, as well as providing alternatives to replace unhealthy behaviours with healthy behaviours (Wymer, 2011). Social marketing applications have proven successful in addressing a variety of social issues, including substance abuse, disease prevention, nutrition, recycling, sustainability and transportation (Lefebvre, 2011; Wymer et al., 2011; McKenzie Mohr, 2000; Bryant, 2000).

Several challenges impact on social marketing efforts, presenting significant barriers to effective programmes. Such challenges include the short life span of social marketing programmes, segmentation barriers and addressing complex issues, coupled with a tough economic climate to establish and maintain sustainable social marketing efforts (Bartholomew et al., 2011; McKenzie Mohr, 2000). While these challenges reinforce the importance of working with communities to provide sustained support for social marketing efforts (Slater et al., 2000), they also indicate the need to further examine additional lesser-researched barriers, such as the assessment of levels of community readiness. Community readiness relates to the degree to which a community is willing and prepared to take action on an issue (Oetting et al., 1995). Measuring community readiness levels acts as a tool to assess readiness levels and develop community-specific, stage-appropriate strategies. Matching an intervention to a community's level of readiness is paramount to the success of an intervention in order to ensure intervention efforts are challenging enough to mobilise community behaviour, but not so much so that community members are unable to respond to the efforts (Plested et al., 2006).

In the domain of social marketing, recognition is growing of the value of community-led approaches in overcoming the challenges associated with traditional social marketing programmes (Bryant et al., 2007). Such community-led approaches see community social marketing programmes dominating the

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literature (Stead, 2012; Bryant et al., 2007; Plested et al., 2006; McKenzie Mohr, 2000). Community social marketing facilitates an understanding of how the behaviours of community stakeholders can act as benefits or barriers to change. Such a collaborative and community-centred approach enhances the synergy between programmes and communities, where community resources and relationships are strengthened and sustained. Bringing about effective community behaviour change requires the development and management of transformational partnerships with local stakeholders to ensure that communities are actively involved in addressing local issues and in ensuring community needs, barriers and motivators are accurately understood (Sprague Martinez et al., 2012; Jones and Wells, 2007).

This thesis recognises this growing value of community-led approaches, which are a product of their interactions as opposed to the sum of their parts. Chapter Two discusses the role of social theory in social marketing efforts, particularly the different community social marketing models that dominate the literature: Community Based Prevention Marketing (Bryant et al., 2007), Community Based Social Marketing (McKenzie Mohr, 2000), Community Led Social Marketing (Stead et al., 2012) and the Community Readiness Model (Plested et al., 1999). This review of social theories responds to a need to take into account broader social issues that impact both on behaviour and behaviour change; where awareness is on the interaction of individuals in the social environment in which behaviour takes place (Fry, 2014; Lefebvre, 2012; Wymer, 2011; Szmigin et al., 2011). Since communities greatly influence and shape individuals' behaviours, a combination of social marketing and complementary approaches such as community mobilisation to address community-level issues is recommended (Kelly et al., 2013; Andreasen, 2010).

One such approach is the Community Readiness Model (CRM). The CRM integrates community culture, resources and levels of readiness to address

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community issues and guide the complex process of community change (Jumper Thurman et al., 2003). The CRM provides a tool for social marketers to develop a comprehensive understanding of the community and social contexts in which behaviour takes place. The CRM has proven effective in addressing behavioural change in a variety of health-related issues, such as sexual health, heart health, mental health and nutrition (Kelly et al., 2003). Previous applications of the CRM provided key insights into community beliefs and norms, identifying community members' perceptions of important local issues, while providing policy makers with a measurement tool to assist in planning, implementation and evaluation of community based intervention programmes (Scherer et al., 2001). While behaviour change at the individual and community level can be challenging, community behavioural change related to health issues is particularly complex for social marketing efforts. This difficulty of behaviour change in health issues is multi-faceted and is due to the links between community and cultural norms (Grier and Bryant, 2005).

In this study, the Meals on Wheels (MOW) community is utilised as a community context that warrants community behavioural change related to health issues. MOW provides nutritional support for older people by delivering either a hot or chilled meal to their home. In Ireland, MOW services are currently going through a transitional period, moving away from its historical charity origins towards approaches characterised by public-private partnerships of varying kinds in different communities. MOW services are also tasked with meeting the needs of a growing and diverse client base. The older population aged 60 and over in Ireland is projected to grow from 532,000 in 2011 to over 1.4 million by 2046, with the number of older people living in their own homes predicted to double by 2021 (CSO, 2013). Such demographic change is likely to increase demand for MOW services. It is in the light of these transient complex social issues and community setting that this research is conducted. In order to ensure that MOW services are ready to meet the needs of a growing and increasingly diverse older

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population, it is essential that the perceptions and experiences of the older population are examined and understood.

Due to the state of transition in MOW services, MOW communities in Ireland are currently moving to different variations of a MOW community model, ranging from public private partnerships to commercially based MOW services. This evolution is taking place within the social policy context which has already been decided and which MOW services have to implement. In recognition of the social policy decisions that have been made, MOW services are now faced with the need to work with users, clients and community stakeholders to shape, deliver and manage MOW services in response to this positioning of social policy. Within Irish MOW services, different MOW communities are at different levels of readiness to change, necessitating a community model which can capture and manage the varied characteristics of different MOW communities, such as regional, identity and geographical. In light of these transitions, MOW presents a complex social issue, involving a variety of different stakeholders.

Many definitions of MOW exist (Wilson and Dennison, 2011; Krondl et al., 2008; Keller et al., 2006; Moran, 2004; Krassie et al., 2000), with most focussing on the nutritional aspects of MOW. Such definitions tend to overlook the social role of MOW. The role of MOW in providing a source of social support to older people lacks adequate research and has been neglected in the literature. A research gap is evident in the literature; while research to date has focused on nutritional aspects of MOW; further research is required to examine MOW from a broader perspective, which this study aims to address. In recent years, the term MOW has seen variations, with some organisations adopting different terms for the meals service, such as *Delivered Meals*, *Community Catering* and *Food Service* (Meals Victoria, 2009; Home And Community Care, 2004). Such descriptions represent a visible move away from the traditional, and increasingly stigmatised, charity model of MOW provision. Although some variations exist, overall the

dominant and most recognisable name for the service is *Meals on Wheels* (MOW). For the purpose of this study, MOW is used as a term that encompasses both nutritional and social support elements of a meals service for older adults. In relation to MOW services, the definition used throughout this thesis refers to a service as “an act or performance that benefits the client by bringing about a desired change in or on behalf of the recipient” (Lovelock and Wright, 2001, p. 66). For the purpose of this thesis, the *MOW service* refers to the traditional charity model, while *MOW services* refers to a more recent concept encompassing a public private partnership approach.

This thesis sets out with the contention that community social marketing approaches have the capacity to examine effectively this multi-stakeholder collaborative exchange process. Community social marketing efforts provide effective frameworks to adapt for application in MOW. Previous applications of the CRM have been shown to be effective in addressing a variety of health issues. This suggests that the utilisation of the model can be an effective tool to examine the MOW community from a behavioural perspective. In the area of social marketing, there is a growing consensus around the important role of including both locality and community. Increasing awareness and interest surrounds this focus, which community social marketing brings about among both practitioners and researchers (Farmer et al., 2002; Middlestadt et al., 1997; Israel et al., 1994). In recognition of the need to work with communities and localities, this study, particularly the shaping of the central research question, involved a community research partner. The community research partner for this study was a well-established local organisation with significant MOW expertise and experience that provides social services in the community; one such role of the organisation is the provision of MOW. The community research partner assisted in co-creating the central research question, as well as acting as a key champion in accessing participants for Stage One of the research process.

1.3 Research Problem

National and international research into MOW has heavily focused on nutritional aspects of MOW (Lirette et al., 2007; Lee and Frongillo, 2001). In this respect, MOW research has typically lacked focus in exploring a wider, contextualised view of MOW, concentrating instead primarily on nutritional issues at a micro-level. Consequently, a gap exists in examining MOW from not just the micro-level, but looking beyond this into the environment of MOW to incorporate the meso-level of MOW. Informed by current thinking in social marketing research, the inclusion of a multi-level perspective in this study extends current approaches; bridging a gap in MOW research by incorporating the perspectives of current, former and potential MOW users as well as those of relevant community stakeholders.

A key feature of a more contextualised account of MOW arises from the growing awareness in research of the social policy challenges posed by the progressive ageing of Ireland's population (Connell and Pringle, 2005). Set within the context of a reorientation of social policy towards an individualisation of risks that were once shared collectively by society as a whole, this thesis also explores the ways in which a changing social policy context impacts upon the lives of older people. The ideology of policy changes towards a more individualised approach to MOW has not yet been reflected in practice; with the provision of MOW yet to mirror the proposed change to a fully individualised and personalised service. A successful transition to this new approach is dependent on the collaboration of MOW stakeholders and users by understanding how community stakeholders' behaviours can act as benefits or barriers to change across different subsystems such as health and welfare from a meso-level perspective. This study seeks to address the challenges associated with stakeholders' behaviours, through the application of the CRM in assessing behavioural change social contexts and measuring behavioural change required in MOW. By exploring the systems that

surround MOW services in Ireland this research assesses the levels of behaviour change required for the MOW system to develop, resulting in the creation of community-specific strategies underpinned by the CRM (Plested, 1999). As well as measuring readiness levels, this study provides evidence that can inform policy and practice change around the experiences and perceptions of older people and MOW.

In light of changes at the policy level, coupled with a challenging economic climate, which has seen funding cutbacks in the provision of community-based supports, the application of the CRM to the MOW community is warranted as a measure to assess community readiness in the environment where behaviour change occurs. Such community consultation is essential to ensure that MOW are shaped by both users and stakeholders. The application of the CRM to this area provides a systematic approach to measure attitudes, efforts, knowledge and resources within the MOW community, which are key to assessing the community's readiness to change to a more personalised approach. The application of the CRM to the MOW community ensures that community-based programmes are successfully implemented and community needs are met; an essential component in the social marketing planning process (Selem, 2011).

1.4 Research Purpose and Research Question

The purpose of this research is to explore the key stakeholder behavioural changes required in the MOW community. The key behaviours are explored by examining MOW from several different perspectives or levels within the systems that surround MOW in Ireland and its evolving client base. Social marketing efforts focus on examining a diversity of perspectives by adopting a multi-level approach; a concept this study adheres to through involving multi-level perspectives from the MOW community to capture a deeper understanding of MOW (Dagger and O'Brien, 2010). This approach is complementary to this study

where it facilitates the understanding of target audiences at different stages of MOW service use to ensure that the experiences of users as well as community stakeholders are accurately captured, to assist with effective segmentation and targeting of social marketing approaches (Zainuddin, 2013).

Cognisant of the changing social policy environment, particularly MOW services and in recognition of adopting a comprehensive view of MOW services and its users and stakeholders, the research question to be pursued in this thesis is presented as follows:

“What key stakeholder behavioural changes are required to facilitate Meals on Wheels services to support a growing and diverse older Irish population?”

To assist in answering the research question, the following research objectives are considered:

Research Objective 1: To establish the role of social policy in MOW services in Ireland.

Research Objective 2: To determine how MOW services are perceived by the older population of current, former and potential MOW users in Ireland.

Research Objective 3: To establish what community social marketing efforts exist relevant to MOW services.

Research Objective 4: To adapt and test a community social marketing model suitable for wider application to different MOW services in Ireland.

Research Objective 5: To establish the levels of readiness to change of key stakeholders involved in MOW services.

1.5 Research Approach

The research approach, as presented in Table 1.1, was developed to respond to the study's research question. The approach provides an account of the methodology used to respond to the identified gaps and research objectives. A more detailed account of this process is provided in Chapter Three.

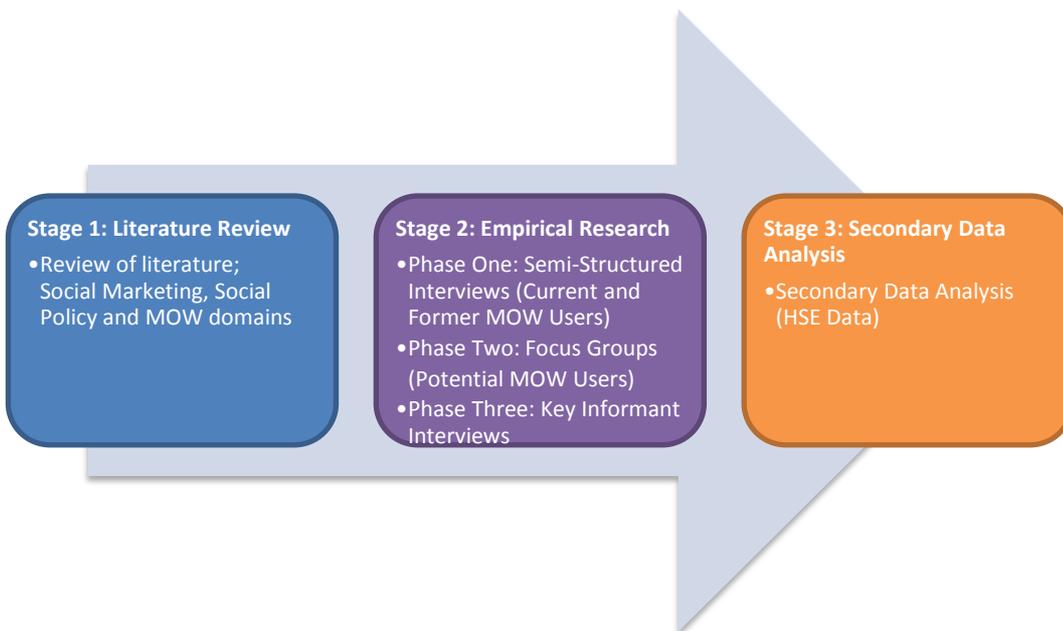
Table 1.1: Research Gaps

Research Gaps	Research Objectives	Method	Analysis
Lack of literature on community social marketing applications to behavioural ecological issues; MOW	To establish what community social marketing efforts exist relevant to MOW services	Literature review	Critical Literature Review
Lack of mapping of social policy origins and developments on MOW in Ireland	To establish the role of social policy in MOW service in Ireland	Literature review	Critical Literature Review
Limited research on MOW use and experiences from a micro-level / downstream, with current and former users	To establish how MOW services are perceived by the older population of current and former MOW users	Qualitative semi-structured interviews	Thematic analysis, Analytic memos
Limited research on MOW use and experiences from a micro-level, with potential users	To establish how MOW services are perceived by the older population of potential MOW users	Focus groups	Thematic analysis, Analytic memos
Limited application of the CRM in multi-stakeholder community organisations such as MOW community	To adapt and test a community social marketing model suitable for wider application to different MOW services in Ireland To establish levels of readiness to change of key stakeholders involved in MOW services	Key informant interviews	Anchored rating scales, Thematic analysis, Analytic memos

1.6 Research Methodology

Responding to the central research question and the study's research objectives involved a three-stage process, underpinned by a qualitative approach. The research conducted is informed by the constructionism ontological position, which best responds to the central research question by adopting a multi-perspective approach. The epistemological approach of this research perceives reality as a co-construct shared between the researcher and research participants, while shaped by experiences of the individual (Creswell, 2012, p. 36). The process of the inductive research design of this study is outlined in Figure 1.1.

Figure 1.1: Research Process



Stage One is comprised of a literature review addressing three central bodies of knowledge relating to the fields of social policy for older people, social marketing and MOW. A critical review of community social marketing literature was conducted to explore and identify potential frameworks for use in this study. In order to contextualise the development of MOW services in Ireland, a review of

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Irish social policy, with a particular focus on ageing policy was undertaken. This element of the review charts the origins and changes at policy level, indicating where MOW services have come from and where MOW services are today.

Stage Two is an empirical stage, consisting of three phases of fieldwork: semi-structured interviews, focus groups and key informant interviews. A detailed account of each method is provided in Chapter Three.

Stage Three entails of a secondary data analysis of HSE data. The HSE (Health Service Executive) provides public health and social care services in Ireland. These data consisted of responses to a questionnaire distributed by the HSE to MOW providers. Elements of the HSE questionnaire relevant to this study were analysed to contextualise the empirical research undertaken, and to incorporate additional depth and context to this study's findings. A more detailed account of this approach is provided in the secondary data analysis section in Chapter Three. The chosen research methods ensured that a broad array of perspectives would be accessed to ensure results were broadly representative of the micro and meso-levels of the MOW community.

1.7 Research Contributions

This study seeks to make a contribution to research knowledge in four key areas; theoretical, methodological, policy and practice.

Theoretical contributions: This study is theoretically significant to the social marketing domain, whereby it extends current knowledge in the area of community social marketing. Knowledge is extended through an extensive application of the CRM to not alone assess levels of readiness of key stakeholders, but also through the multi-level approach used where experiences and perceptions of the target audience are captured at different stages of MOW

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service use. This provides a tangible contribution to knowledge, with this study moving beyond other community social marketing approaches that focus on the analysis of community actors to identify the benefits and barriers to change. This study responds to the need for social marketing efforts to encompass societal changes by examining the behavioural ecological environment and infrastructure of the MOW community. By extending knowledge, this study also contributes to discussions around broadening the social marketing theory scope beyond the individual (French, 2009), which sees the inclusion of the social and environment as factors warranting investigation. This exploratory research looked at behaviour change and the implementation of behaviour change as a collaborative experience between citizens and stakeholders (Wymer, 2011) as opposed to one sole activity.

This research contributes to the recognition of behaviour change as a process rather than an event, addressing the broader perspective on behaviour change within the environment in which it takes place, which this research contributes to. A social ecological framework is incorporated throughout, using a broader focus for social marketing that, going beyond the individual to the wider picture, consists of factors such as environment, policy, structural environments and social norms which impact on social outcomes (Gordon, 2013; Andreasen, 2002; Wells, 1997; Goldberg, 1995). This signalling to look beyond the individual to the environment where the behaviour takes place is captured in the research objectives and methods used in this study, which assume a down-stream (MOW users) and mid-stream (MOW stakeholders) approach, utilising the CRM to move beyond behaviour change. Furthermore, the application of the CRM ensures that communities were *worked with* as opposed to *worked on*, allowing for social marketing to fulfil the goal of client orientation. The application of the CRM to the MOW community outlines how this is achieved through the scaling-out of the co-creations of value from the individual to the community level identification of barriers and benefits to MOW services. This leads to the whole

process of behaviour change in the MOW community being understood by viewing it from *all* the perspectives simultaneously. This is achieved through consultation with community members (current, former and potential MOW users and key stakeholders) who represent the different aspects of MOW services.

Methodological contributions: The addition of supplementary methods to further shape and expand the CRM equips the study with more than a macro focus, incorporating micro and meso-level perspectives. The use of additional methods to shape the CRM is the first time the CRM has been applied with such an approach to ensure the study consisted of a co-creative approach. Semi-structured interviews and focus groups were incorporated into the shaping of the CRM questions in recognition of the multi-level perspectives required to best respond to the study's central research question. This study illustrates a greater level of depth in both the methods used prior to the application of the CRM, as well as in the additional level of analysis used in the CRM key informant interviews. In order to increase the rigour of the CRM, this study developed and tested a systematic approach to the identification and mapping of key informants. This systematic approach to identifying and mapping key informants resulted from a review of dominant approaches utilised in stakeholder literature. This approach was developed in response to a potential limitation of the CRM identified in relation to the lack of a systematic approach to accurately capture and map the different stakeholders involved in a community, to ensure the key informants selected most accurately represented the community.

Furthermore, the development of an introductory script to the CRM process as an additional step in the CRM approach is introduced and tested for the first time in this study. This measure adds rigour to the CRM process, drawing on literature from focus group methodologies to best meet the needs of participants, ensuring that those taking part in the CRM fully understand the

process and what is expected of them. The addition of this step allows for a more transparent application of the CRM, building greater rapport and buy in with key informants from the community. As the CRM was developed in the US, with the vast majority of previous applications also conducted in the US (Kostadinov et al., 2015), this research required the cultural adaptation of the CRM for the Irish context for the first time. This was achieved by culturally adapting elements such as terminology, phrasing, and flow, and applying the CRM to address a complex community setting. More specifically, this study tests the CRM in a new domain through examining behaviour change from the broader perspective to incorporate a societal change focus. Through the adaptation and testing of the CRM for a new issue and a new country, findings of this study can support the application of the CRM to different MOW providers in other areas across Ireland that are facing the same social, environmental or behavioural issues.

Contributions to Practice: As the study tests the application of the CRM in a new domain, cultural modifications and pilot testing were necessary for the Irish context. The resultant modified tool for measuring community readiness can be applied nationally as a metric for gauging progress. Utilising the CRM assessment identifies dimensions of readiness in the MOW system that requires management attention to meet the needs of a growing older population. In responding to the central research question, this study acknowledges not alone the nutritional and social roles of MOW, but also the lifestyle and monitoring roles of MOW, which to date has not been investigated sufficiently. Due to the disproportionate research focusing on the nutritional aspect rather than the social role of MOW, this study contributes to the social MOW body of knowledge through incorporating this area into the research methods. Furthermore, the application of the CRM to this study goes beyond previous MOW studies, providing multi-level perspectives contributing to societal issues.

Contributions to Policy: The adaptation and testing of the CRM in the Irish context is of potential benefit not only to older members of the community, but also represents a guide for mobilisation to other key areas of community life in Ireland requiring change; health, social justice, transport and energy sustainability, through its community engagement and co-creation approach to increase community capacity making. This study equips Irish community projects with a tool to implement similar strategies in a long-term societal change approach. The application of the CRM to the social policy of ageing literature is of particular relevance to policy makers by offering insights into MOW community readiness levels. The findings commit to providing guidelines, strategy and best practice approaches for future utilisations of the CRM as a tool to ensure resources are utilised effectively in communities that help shape the co-creation of strategies.

Based on how research may be considered to have shown originality, this study is expected to contribute to knowledge achieved in several ways (Philips and Pugh, 2000; Francis; 1976). To summarise the contributions discussed, it is expected that this study contribute to knowledge through:

1. The first application of the CRM to the area of MOW.
2. The examination of the behavioural ecological environment and infrastructure of the MOW community.
3. The utilisation of cross-disciplinary approaches to synthesise a community specific guide for MOW key stakeholders.
4. The provision of multi-level perspectives in relation to MOW services for policy makers and practitioners.
5. The cultural adaptation and testing of the CRM for the first time in Ireland.
6. Testing the CRM for further application to different MOW variations of public private partnerships developing in different communities across Ireland facing similar social, behavioural or ecological issues.

7. The development and testing of additional steps in the CRM process to increase rigour.
8. The application of supplementary methods and analysis to expand the application of the CRM for the first time.

1.8 Chapter Overview

Chapter One introduces the research study. The research background, research question and objectives of the study have been outlined, along with a description of the overall structure of the thesis.

Chapter Two explores the social marketing literature, with a focus on the dominant community social marketing approaches. Particular regard is given to community social marketing approaches. Chapter Two sets the scene for the background of the research question, exploring community social marketing efforts in a bid to respond to MOW in Ireland which is going through transition. A review of MOW literature and Irish social policy for older people assists in contextualising the study's research question.

Chapter Three describes the methodology associated with the fieldwork component of the study. The research process is described. The research design is detailed, comprising of the study design, sampling approach, data collection procedure, data analysis and ethical issues.

Chapter Four presents the main findings of the research study, responding to the study's central research question and the objectives outlined previously.

Chapter Five reviews the study's key findings in the context of existing knowledge (presented in Chapter Two). This discussion draws on results obtained from the study's mixed-methods approach, interpreting these in light

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of relevant academic literature. The limitations of this study are also addressed. The chapter concludes with the researcher's own interpretation of the study's central contribution and provides recommendations for future research.

Chapter Two: A Social Marketing Approach to Meals on Wheels

2.1 Introduction

This Chapter introduces literature from three key areas to inform this study: social marketing, social policy and Meals on Wheels (MOW). The literature review begins with an exploration of the origins of social marketing, detailing in which transitions in social marketing led to community social marketing approaches. This Chapter critiques the dominant community social marketing models to identify the community social marketing framework used in this study. The review of literature then moves to situate the MOW community as the context to which the community social marketing framework will be applied. MOW in Ireland is positioned within its social policy context and a case is made for applying the social marketing framework to this particular community. To commence this Chapter, a review of the social marketing literature is outlined in the following section.

2.2 Social Marketing

The concept of social marketing is based on the view that techniques from commercial business, which have proved successful, can be employed to enhance social issues. Several definitions of social marketing exist, with one of the most widely acknowledged describing it as “the design, implementation, and control of programs seeking to increase the acceptability of a social idea or practice in a target group(s)” (Kotler, 1975, p. 5). This definition emphasises that social marketing is more than merely social advertising and social communication.

Social marketing possesses a conceptual framework, which focuses on creating satisfying exchanges and creating a combined strategy. This process of achieving satisfying exchanges is centred on the marketing mix, competitive analysis, audience segmentation, use of formative research to make strategic decisions and on-going monitoring and evaluation (Hastings, 2007; Grier and Bryant, 2005). A key component of social marketing is its client-centred style, giving clients perceived needs, value, and preferences precedence over the selection and promotion of a specific behaviour modification strategy (Burroughs et al., 2006). A unique trait of social marketing is how it goes beyond applying educational or communication approaches to issues, focusing instead on behaviour change (Donovan, 2011). This behavioural focus involves the creation of exchanges that foster behaviour change with target audiences (Madill et al., 2014). As a result, social marketing efforts have successfully been applied to address social issues; influencing social behaviours to benefit both target audiences and wider society (Madhill et al., 2014; Kelly et al., 2013; Jumper-Thurman et al., 2003; Slater et al., 2000).

In relation to service use such as MOW, social marketing efforts provide an approach to explore and understand why clients engage in positive social behaviours through the use of services (Zainuddin, 2013). This understanding of service use, particularly in the field of health service use, illustrates the realisation of meeting social marketing aims of bringing about pro-social behaviours, which benefit both the individual and society (Andreasen, 1994). Social marketing efforts focus on examining not just insights from one perspective, instead they adopt a multi-level approach; a concept this study adheres to through involving multi-level perspectives from the MOW community to capture a deeper understanding of MOW (Dagger and O'Brien, 2010). This multi-level approach complements this study, assisting in understanding and capturing target audiences at different stages of MOW service use. The significant contribution this study offers is how this study moves beyond other

community social marketing approaches which focus on analysing some community actors to identify barriers and benefits to behaviour change. This study is distinctive in that it extends the behavioural ecological and environment aspect through the application of the CRM. Having introduced the key social marketing concepts relevant to this study, the following section examines the role that behaviour change plays in social marketing efforts.

2.2.1 Social Marketing and Behaviour Change

Social marketing addresses social challenges that require social effort in order to bring about behaviour change. Behaviour change is seen at the core of social marketing efforts (French, 2011; Smith, 2006; Andreasen, 1995), coupled with key additional concepts including citizen-centric planning, value co-creation, audience segmentation, formative research and the marketing mix (Lefebvre, 2012; French, 2011). The citizen-centred focus of social marketing has recently been extended to move beyond an individual behaviour change focus to other levels (Cairns and Rundle-Thiele, 2014; Luca and Suggs, 2013). While many social marketing efforts focus on the individual, a more recent transition within social marketing, sees an extended view being adopted incorporating additional factors such as ecological determinants. The recent extension of the traditional view of social marketing, which goes beyond perceiving behaviour at the level of the individual, is further investigated in this study, as outlined in Chapter One. This is achieved in this study, which takes into account broader social issues that impact both on behaviour and behaviour change; where awareness is centred on the interaction of individuals in the social environment where behaviour takes place (Fry, 2014; Lefebvre, 2012; Wymer, 2011; Szmigin et al., 2011).

Streams of Behaviour Change

Social marketing acts as a tool for systematic planning, using approaches from the commercial sector as well as experiences from public and not-for-profit sectors to achieve and maintain positive behaviours (French, 2011). The concept of down-stream is used to describe the focus of social marketing efforts. *Down-stream* social marketing involves voluntary behaviour change at the individual level. At the opposite end of the continuum, there is *up-stream* social marketing efforts, involving not only policy makers and regulation bodies (Hoek and Jones, 2011), but also recognising broader contributors such as social, ecological, legal, political and other factors that influence individual behaviour (Kelly et al., 2013; Niblett, 2005).

Although the central aim of social marketing is to bring about behaviour change, with a recent focus on recognising social change, the focus is typically placed on individual level behaviour change, or, as it is often referred to, *down-stream* social marketing. There is growing recognition that for social marketing approaches to be most effective in bringing about successful behaviour change, attention must be placed not only on the down-stream factors that affect behaviour, but also on *mid-stream* factors (Andreasen, 2006). Such recognition of the influence of mid-stream social marketing efforts influence on individual behaviour change necessitates social marketing research to examine and understand such factors in order to address social issues and bring about effective and sustainable change. Against this background, social marketing efforts focusing on the community level assist in accurately capturing a more diverse understanding of mid-stream factors associated with MOW communities.

Social marketing literature highlights the need for greater collaboration between mid-stream and down-stream approaches to address if an integration gap exists, with the need for greater collaboration required (Gordan, 2011; Wymer, 2011).

Where social marketing efforts fail to consider the social ecological framework that surrounds the individual, efforts of behaviour change are less effective (Wymer, 2011). The social ecological framework represents a need for a broader focus for social marketing, going further than the individual to the wider picture, which consists of issues such as environment, policy, structural environments and social norms which impact on social outcomes (Gordon, 2013; Andreasen, 2002; Wells, 1997; Goldberg, 1995). This signalling to look beyond the individual and to the environment where the behaviour takes place is captured in the research objectives and methods used in this study, which assumes a downstream (MOW users) and mid-stream (MOW stakeholders) approach, utilising the CRM to move beyond behaviour change.

With the role of behaviour streams or levels in social marketing outlined, the next section looks again at behaviour, this time from the perspective of the dominant models of behaviour used in social marketing efforts. The purpose of this next section is to provide the rationale for the selection of the theoretical framework used in this study: the CRM.

2.3 Community Social Marketing

Communities vary greatly, regarding their interest and willingness to try new strategies, as established by both researchers and practitioners (Jumper-Thurman, 2001; Bukoski and Amsel, 1994). Behaviour change at any level is difficult, and if there is no community investment, then change will not occur (Thurman et al., 2003). The need for conducting community assessment prior to implementing community-based programmes is well recognised, with best practices for implementing community-based programmes identifying the need for community readiness towards programmes (Stith et al., 2006). Communities are central to shaping individuals, as described by Bracht “communities can shape individuals behaviour both symbolically and tangibly, transmitting values

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and norms” (Bracht, 1999, p. 20). As systems of exchange and influence, communities establish opportunities for people to behave in some ways and not behave in others. Therefore, in order to ensure community-based programmes are successfully implemented and meet community needs, the assessment of community readiness is regarded as an essential component in the social marketing planning process, although the assessment of community readiness is not always done in community social marketing efforts (Kelly et al., 2003).

Community social marketing developed from social marketing, psychology and social science disciplines. Community social marketing addresses the aforementioned transition in social marketing, moving beyond individual behaviour change to utilising a strong understanding of target audiences’ motivations for engaging or not engaging in certain behaviours (McKenzie-Mohr et al., 2012). The importance of understanding communities in relation to behaviour change is identified in the social marketing literature, with readiness recognised as the *precursor* to implementing change (Chilenshi et al., 2007; Armenakis et al., 1993). Others have also highlighted the powerful role understanding community readiness has on the level of success for community programmes and strategies (Minkler et al., 2009; Kakeduda et al., 2008; Stith et al., 2006; Thurman et al., 2003). It is essential to understand the community if research is to inform and shape policy and programmes. In order to do this, the community must be explored and understood in relation to determining community readiness in an attempt to engage in efforts to bring about change.

Despite the barriers of working with communities to better understand and shape social marketing efforts, barriers to this approach must not be overlooked. In response to an area of social marketing that warrants further investigation, barriers such as the short life span of efforts, the importance of working *with* communities as opposed to *on* communities is reinforced in order to provide sustained supports which are perceived to be a priority in social marketing

efforts (Slater et al., 2000). Community social marketing approaches can assist in developing efforts that are sustainable through this collaborative approach of working with communities. Previous work with communities has proven effective in developing strategies to address health disparities by providing public health practitioners, policy makers, researchers and community organisers with data from the community to inform the development of evidence-based disparities (Kakeduda et al., 2008; Minkler et al., 2008).

Community-led approaches directly involve working with the community in both the development and implementation of social marketing efforts (Bryant et al., 2007; Bryant et al., 2000). Benefits of community-led approaches include increasing the cultural relevance of interventions, strengthening community capacity and minimising the overall cost (Stead et al., 2013; Bryant et al., 2007). In order for community programmes to be successful, collaboration and cooperation among community members is needed. When programmes include local people, they are more likely to be effective and sustainable in addressing local issues and settling local norms (Edwards et al., 2000). Ascertaining when a community is ready to change is vital to establish, as a lack of community readiness increases the likelihood of unsuccessful programme implementation. Cognisant of these challenges and opportunities, the following section outlines the dominant community social marketing models used in social marketing efforts.

2.3.1 Dominant Community Social Marketing Models

This section provides a critical discussion of the dominant community social marketing models. An overview of each model is provided in Table 2.1, following which, each model is critically reviewed in relation to suitability for application in this study. Four dominant community social marketing models were identified from the social marketing literature that predominantly features in the health

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and environment domains of social marketing. The origins of the dominant community social marketing models range from the US, Canada and Europe.

Table 2.1: Dominant Community Social Marketing Models

	Community Based Social Marketing (McKenzie-Mohr, 2000)	Community Based Prevention Marketing (Bryant et al., 2007)	Community Led Social Marketing (Stead, 2012)	Community Readiness Model (Plested et al., 2006)
Description:	Focuses on the barriers and benefits of behavioural change	Community directed framework where academics work with community partners for preventative interventions	Based on the concept that the consumer is the most important participant in the change process	A model of community change used to assess readiness levels of a community to address local issues
Key features:	Identification and removal of barriers, strengthening incentives to behaviour change	Preventative research, Community learning, Community based participatory research	Audience insight, Consumer solution generation	Readiness assessment, Systematic assessment of readiness, Community investment and involvement
Previous applications:	Environmental issues; Recycling, Pollution, Water, Energy, Transportation, Agriculture and conservation	Tobacco and alcohol use. Physical activity, Obesity, Head and eye trauma	Health inequality issues	Health issues; Obesity, Alcohol use, Substance abuse, Domestic and sexual violence, HIV / AIDS

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Having outlined the dominant community social marketing models in the above table, the next section will examine each model with relevance to this study.

Community Based Social Marketing (CBSM)

Community Based Social Marketing (CBSM) draws on research from the social sciences, which determines that behaviour change is most effectively achieved through initiatives delivered at community level. CBSM focuses on removing barriers to a specific activity and increasing incentives surrounding positive behaviours (Mc Kenzie-Mohr, 2007). CBSM is targeted at interventions at the meso level, or mid-stream social marketing, which sees CBSM applied to a community as opposed to an individual. To date, CBSM has been primarily utilised for pro-environmental issues, with more recent applications of the model demonstrating a transition of CBSM to address health issues (Athey et al., 2012). CBSM has been applied successfully in changing a variety of environmentally responsible behaviours, such as energy conservation, recycling and use of public transport (Tabanico and Schultz, 2007). Previous applications of CBSM is largely in the area of environmental issues rather than the area of health, which is the main focus of this study and the central research question. To best respond to the central research question of this study, the preferred community social marketing model would display previous applications relating to complex health and social issues, as opposed to environmental applications, with a focus on social change rather than behaviour change alone.

Community Based Prevention Marketing (CBPM)

CBPM is a community driven social change model, which applies social marketing techniques and community organisation principles to design or modify interventions. CBPM focuses on interventions to promote health and prevent

disease (Bryant, 2008). A distinguishing feature of CBPM is the capacity to lend itself to an internal solution (Brennan et al., 2014).

Policy is at the core of CBPM planning process, a focus that recently has seen the development of an extended framework CBPM for Policy Development (Bryant et al., 2014). This recognition of policy from the outset represented a variance for application to this study, where in the context for this study, shifts had already occurred from a policy perspective. The proven success of CBPM, particularly in the area of public health, presented potential advantages for application to this study. As the focus of CBPM lies in preventative research, application of CBPM was not identified as the most appropriate CSM approach to respond to the scope of the research question. Rather than providing a behavioural assessment of the community, as required to respond to the central research question, CBPM focuses on designing, implementing and evaluating health interventions, which were outside the remit of this study. From a review of previous CBPM applications (Bryant et al., 2010; Monaghan et al., 2008; Burroughs et al., 2006), CBPM lends itself to more geographic communities, rather than the CRM which acknowledges the diversity and flexibility in community applications, encompassing geographic communities, but also organisational, structural and cultural communities. The CRM allows for strategic implementation and management of processes, an attribute that differs from CBPM, which aims to design, implement and evaluate interventions (Bryant et al., 2008). The application of CBPM in addressing MOW is, therefore, deemed to be outside the remit of this study. However the potential future application of CBPM is warranted to further investigate in the MOW from a systems approach.

Community Led Social Marketing (CLSM)

Community Led Social Marketing (CLSM) is an emerging approach that draws upon community participation and community development. This approach

focuses on an asset-based process in examining issues in the community, gaining insight from theories of diffusion, engagement and social marketing approaches (Smith and Henry, 2009). CLSM is centred on the client as the key participant in the process of behaviour change, where their role and contribution to the change process is on-going. As well as focusing on involving communities for insight and consultation, CLSM utilises methods to ensure communities are in charge on generating solutions to community issues. Key features of this approach include a sense of shared ownership with communities and researchers, where communities are supported to bring about change (Smith and Henry, 2009). Previous applications of the CLSM approach have focused on nutrition and physical activity issues (Stead et al., 2013), sexual health (Plant et al., 2010) and cancer screening (Smith and Henry, 2009). As this approach is still in the early stages of application to social marketing efforts, and due to the strong community development ethos as opposed to psychology, this approach was deemed unsuitable in assisting to answer this study's central research question. The lack of sufficient psychology ethos for social marketing efforts limits programme contributions in relation to the effective and sustainable behaviour change.

The Community Readiness Model (CRM)

The Community Readiness Model (CRM) is a strategic theory-based model, used to assess and build community capacity to tackle social issues (Kelly et al., 2003). The CRM presents a model to gauge community readiness, providing a systematic method for assessing developmental readiness at community level and instrumental in bringing about effective behavioural and societal change. Providing a systematic way of assessing developmental readiness at community level, the CRM incorporates involvement and investment with communities, making it a culturally sustainable approach (Kelly et al., 2003). Based on the fundamental principle that community change should be in the hands of the

community (Thurman et al., 2003) the CRM recognises that each community is unique and has its own set of strengths and problem areas. This focus of the CRM allows the community's influence and knowledge to assume a central role in application of the model, allowing researchers to meet communities where they are and on their own terms (Kakeduda et al., 2008).

From an organisational level, the CRM acknowledges organisational and institutional norms that frame the community change required. From the perspective of policy level, the CRM locates policy at an organisational level, focusing on leadership and current resources, allowing for monitoring of incremental changes within the community, with the potential to reassess and revise strategies to ensure behaviour change is accurately measured and mobilised. The CRM is particularly beneficial when policy knows what to do, which in the case for Irish social policy for older people. Irish policy for older people aims to support older people to live in their own homes. However difficulties and complexities exists in relation to how to make the policy work. An example relevant to this aspect of the model can be seen in MOW providers' food delivery system whereby internal processes and policy can hinder the adaptation to changes and challenges with organisational policies. The underpinnings of the CRM lend its application as a community model, with its relevance not solely focused on the area of social marketing, but also to other areas of health and social issues.

2.3.2 Selection of Community Social Marketing Model for This Study

Having critically reviewed and discussed the four dominant community social marketing models, the Community Readiness Model (CRM) was identified as the most suitable in responding to the central research question of this study.

One of the key criteria in the selection of the community social marketing model to respond to the central research question was the issue of social change. While

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CBSM acknowledges the ecological aspect of behaviour change by incorporating the analysis of barriers and benefits, it primarily manages to direct these ecological factors through the 4 P's (Product, price, place and promotion). This factor lends to CBSM to focus on behaviour change, with the issue of social change currently outside the remit of CBSM. CBPM efforts act as a community directed social change and marketing process, using social marketing strategies to design, implement and evaluate health promotion and disease prevention programmes or policies (Bryant et al., 2000). While the CRM allows for social change, rather than solely behaviour change focus, as offered by CBPM, the context for applying CBPM to the MOW community in response to the central research question didn't present the most appropriate framework for this particular study.

While the CBPM recognises the need for integrated interventions at individual, environmental and organisation levels (Green and Raeburn, 1990), the CRM also focuses on these three areas, with additional focus on the community level, which was significant to the selection of the CRM in this study. CRM incorporates community readiness theory, which defines communities not alone as geographical or organisation structures, but also as a community of place or interest (Thurman et al., 2003). With both CBPM and the CRM providing different approaches to sustainability, the approach adhered to in the CRM was most relevant to this study which examined MOW; a voluntary organisation, where the CRM offers a more cost effective approach to sustainability within the community in question. The CRM identifies and works with existing community resources, ensuring that the application was financially sustainable in the community. The involvement of community partners as part of the CBPM approach is further expanded on in the CRM, which adopts a greater focus on an ecological framework. This approach ensures that a broad and multi-level approach is adhered to in community involvement. This element of the CRM approach was further strengthened in this study through the systematic

selection of community stakeholders, with broader community members included in the shaping of the CRM application through semi-structured interviews and focus groups.

The CRM presented the strongest case in answering the central research question for this study for several reasons. The CRM moves beyond individual behaviour change to community behaviour change; recognising the environment where behaviour changes takes place. Examining different levels, as opposed to the traditional social marketing focus on one level, the CRM sees both mid-stream and down-stream levels incorporated into the research process. Previous applications of the CRM in complex health issues such as alcohol use (Kelly and Stanley, 2013), nutrition (Kelly et al., 2003), substance use (Slater et al., 2000), sexual health and mental health awareness (Edwards et al., 2000), illustrate that the model has been successful when applied to similar areas as that required for this study. A diverse range of cultures have applied the CRM, illustrating the cultural transferability of the model, which works within each specific community culture to develop strategies and actions that are right for each community. As well as integrating community culture, the CRM also integrates existing community resources to more effectively address community issues, focusing on the use of local resources rather than relying on external resources (Plested et al., 2006).

A unique aspect of the model is that the CRM allows for social marketers to develop a deep understanding of complex social issues by identifying dimensions and stages of readiness at the community level in a sustainable and culturally relevant process. For the context of applying the CRM to the MOW community, previous applications of the CRM have provided guidance for community members towards a more focused and manageable approach, which particularly resonates with the management and organisational processes of MOW provision. These attributes of the CRM recognise that individual behaviour

change takes place within a community of some type and that without support for the community; individual behaviour change is more difficult to bring about (Ogilvie et al., 2008) particularly in the area of MOW. For the context of this study, the CRM is the most relevant model to apply in best responding to the central research question of this study by providing a systematic way of assessing developmental readiness at the community level (Kelly et al., 2003), particularly as MOW services represent a complex social issue. With MOW services in Ireland developing in a fragmented manner, due to the organic development of the service, the application of the CRM is appropriate to capture levels of readiness in this disjointed service.

These traits of the CRM presented the strongest argument for this community social marketing model to be applied in answering the central research question of this study. Having outlined the dominant models of community social marketing and the rationale for selecting the CRM, the following section examines the relationship between the CRM and social marketing.

2.4 The Community Readiness Model and Social Marketing

The CRM complements social marketing research by providing a framework to assess social contexts where individual behaviour change occurs (Kelly et al., 2003). Behavioural change in health areas is difficult, with interconnected issues linked with community and cultural norms. Such complexity lends to an approach which incorporates community influences and utilisation of community resources to address such complex issues (Kelly et al., 2003).

Communities greatly influence and shape individuals' behaviours. This was seen, for example, in research conducted regarding drug use and young people, where it was found that the drug-taking behaviour was learned from community-level sources; peers, families and schools (Oetting et al., 1998). Therefore, in order to

address community level behaviour change, Andreasen (2010) suggests the combination of social marketing and complementary approaches such as community mobilisation to address community level issues (Kelly et al., 2003). Furthermore, such approaches also demonstrate the importance of including a broad range of individuals from a community in order to gain perspectives from each segment of the community, as opposed to just one group, which the application of the CRM assists with. This “broad based coalition” (Kelly et al., 2003, p. 418) is also essential in facilitating the networking of local leaders and in ensuring that local resources are utilised effectively and efficiently. Such an approach is particularly important in this study in considering what change is needed across a community providing and using services such as MOW where changes in multiple behaviours are desirable.

This study contributes to the transformational potential of social marketing, exploring the MOW community as a social interaction between the different members within the dynamic market system that is MOW. By taking the view that, in the context of MOW, behaviour change is a socially entwined practice between individuals who are an active component in the behaviour change process, the purpose of this study is to apply the CRM to investigate and explain transitions in the MOW community.

The CRM offers unique advantages as a theory-based model, in that it possesses the ability to classify communities by dimensions and stages of readiness, with the overall aim of mobilising communities to the next stage of readiness. Such contributions of the model are recognised in the social marketing domain as having the potential to improve effectiveness of social marketing efforts by increasing the suitability and subsequent effectiveness of strategies resulting in both successful and sustainable behaviour change outcomes. Kelly et al. (2003) identify the CRM as a community mobilisation approach that merits further investigation due to the model’s capability of enhancing social marketing efforts.

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The use of CRM as a mobilisation approach has direct implications for the wider community, where the community is targeted as opposed to the individual, with such action at community level linked to an increase in effectiveness of individual level interventions (Kelly et al., 2003). The CRM is recognised for its “unique contribution in providing a systematic means of assessing developmental readiness at the community level” (Kelly et al., 2003, p. 414). Due to influential factors such as community norms and values, which may act as barriers to the adoption of the desired behaviour, it is essential to examine the issue of community mobilisation. This is achieved in this study with the application of the CRM to a new community for the first time.

Depending on the level at which barriers to individual behavioural change exist (individual, community and societal), the combination of social marketing with complementary approaches is required (Andreasen, 2002). Kelly et al. (2003) recognised that combining the CRM with traditional social marketing practice highlights the strengths of the CRM relative to other community based social marketing approaches such as CBPM (Bryant et al., 1999), in working with communities on social marketing programmes. Such community based social marketing approaches highlight the importance of community involvement and empowerment, ensuring that cultural needs are taken into consideration and in turn leading to sustainable behaviour change programmes. Andreasen (1995) identified the capacity of the CRM to enhance several key elements of social marketing; individual behaviour change, audience research, segmentation and consideration of the 4 P's. The CRM assists with the conceptualisation of community needs, costs and channels of information based on information from the overall stage of readiness or scores by dimension.

Similarly, community readiness provides a tool to evaluate readiness for interventions, to assess audience and community needs and to guide strategy development. The CRM acts as a tool for evaluation, adding value to the design

of prevention efforts, due to its usefulness in facilitating the evaluation of impacts on higher order aggregates than individuals (Flay and Cook, 1989). The CRM works effectively with social marketing efforts by providing a framework for assessing the social contexts where behavioural change takes place and for measuring changes in readiness related to community-wide efforts. Such insights gained from the CRM provide guidance for the co-creation of program planning and message design. Given that social marketing focuses on the client driven ethos, audience research and segmentation become central elements in developing social marketing programmes. The CRM assessment enhances traditional methods of formative research, such as focus groups with target audience members, by illustrating how community-level factors or norms can act as barriers to desired health behaviour change. Furthermore, the application of the CRM to MOW services allows for reflection on the context as well as the audience.

2.5 The Community Readiness Model

The term *community readiness* is evident in the literature since the mid-1990s (Chilenski, 2007; Carmack, 1965; Burgess et al., 1955), where it was used primarily to describe the ecological context and organisational system where the implementation of community change efforts takes place (Chilenski et al., 2007; Boyd and Angeique, 2002; Cummings and Worley, 2001; Brofenbrenner and Morris, 1997; Foster-Fishman and Keys, 1997). This recognition of the broader picture, rather than focusing on the individual, is central to this study, where the individual is located in their immediate environment without assuming individual agency.

The Community Readiness Model (CRM) presents a framework for recognising that communities are at different stages of readiness in relation to implementing issue-specific programmes and initiatives (Kakefuda et al., 2008; Borrayo, 2007;

Findholt, 2007; Oetting et al., 2001; Plested et al., 2007; Edwards et al., 2000). The CRM can be described as a map and a repair kit, which shows a community where they are and what they need to do to get moving again (Oetting et al., 2001). Thurman et al. (2003) describe the CRM as a practical tool that can be used by communities to focus their efforts towards a desired goal, making the most of the community resources and reducing the risk of failure, creating an approach to community behaviour change which is both sustainable and motivating.

2.5.1 The Community Readiness Model: Theoretical Origins

Literature relating to readiness theory identifies three typologies of readiness: individual, group and community readiness (Miller, 1990), as outlined in Figure 2.1.

Figure 2.1: Typologies of Readiness



Source: Adapted from Edwards et al., 2000; Rogers, 1975; Warren, 1978.

Having outlined the dominant Typologies of Readiness in Figure 2.1, the different types of readiness are now discussed.

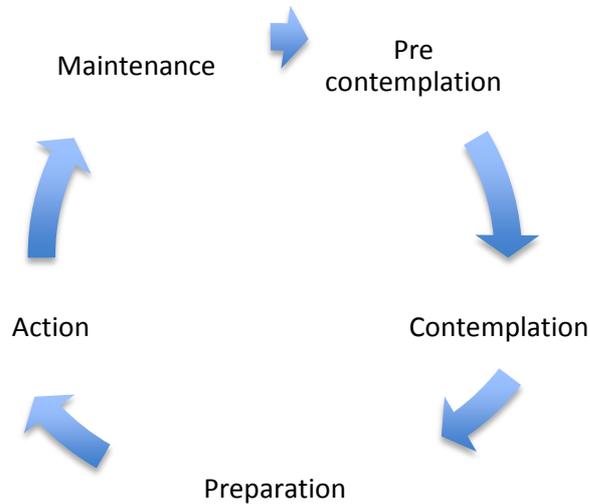
Individual Readiness

Individual readiness considers an individual's psychological needs, representing a deviation between what is expected and what is reality. Individual readiness can be defined as:

“An individual's sense of dissatisfaction resulting from perceived discrepancy between what is and what should be, with the subsequent motivation to seek information, to learn and to adopt new behaviours aimed at alleviating this discrepancy” (Thurman, 2001, p. 135).

Since the 1980s, Prochaska and DiClemente have been involved in work on individual psychological readiness, concentrating on readiness for change and providing a model for personal readiness; the Transtheoretical Model (Stages of Change Model). The Transtheoretical Model illustrates readiness as playing a vital role in the development of an intervention at an individual level (Prochaska and DiClemente, 1983) and has a strong history of applications to health related social marketing efforts (Andreasen, 1995). The Transtheoretical Model identifies five stages of personal readiness; pre-contemplation, contemplation, preparation, recognition of the problem, action and final maintenance stage, as shown in Figure 2.2.

Figure 2.2: The Transtheoretical Model.



Source: Prochaska and DiClemente, 1983.

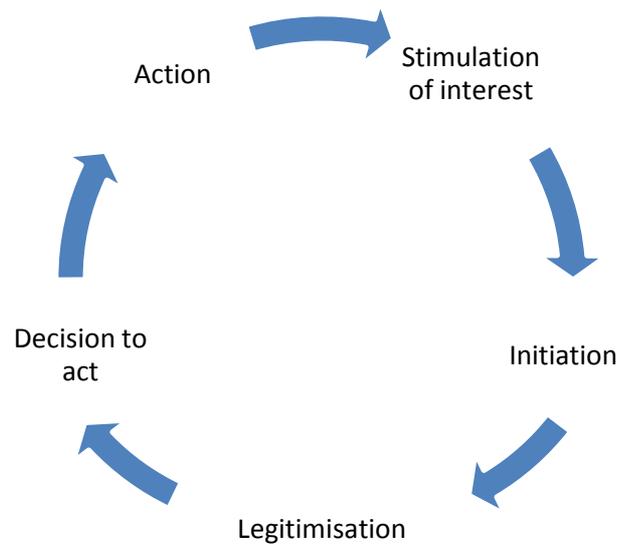
The Transtheoretical model played a significant role in the development of the Community Readiness Model (Edwards et al., 2000). While the Transtheoretical model addresses readiness, it only does so at an individual level, making it unsuitable for adequately understanding group or community readiness. Additionally, the Transtheoretical model focuses on one level of readiness, where community readiness has multi-levels. Prior to the development of the CRM, a gap existed in the behaviour-change literature regarding a standard method for describing and assessing community readiness (Jumper-Thurman, 2001).

Group Readiness

Group readiness is similar to individual readiness, in that it also refers to psychological needs, however it differs in that the decision-making process in a group can change the process of problem identification, creating solutions and acting on the solutions. Warren's Social Action Process (Warren, 1978) was

significant to the creation of the CRM, which focuses on the process of group readiness involved in a social action approach. The stages in Warren's Social Action Process, outlined in Figure 2.3, refer to the need for stimulation of interest, initiation, legitimisation, the decision to act and implementation to bring about group change (Jumper-Thurman et al., 2001). The Social Action Process identifies stages on the community level that pave the way for collective action to be undertaken, focusing on group readiness as opposed to the readiness of an individual (Warren, 1978). Warren's approach contributed significantly to the development of the CRM through its involvement of group characteristics, of which the decision-making process and leadership is central (Edwards et al., 2000).

Figure 2.3: Social Action Process



Source: Warren, 1978.

Community Readiness

Community readiness can be defined as “the relative level of acceptance of a programme, action or other form of decision-making activity that is locality-based” (Donnermeyer et al., 1997, p. 68). Change at the community level is

difficult due to the complexity of interrelated community factors, such as sustaining citizen participation and empowerment (Florin and Wandersman, 1990) and maintaining long-term funding (Steckler and Goodman, 1989). Resources also differ significantly in each community, as do strengths, challenges and political climates (Thurman et al., 2003). The different levels of readiness at community level indicate what level of readiness the community is at and what is needed to mobilise the community. As described earlier, other models used in social marketing approaches to assist in understanding community change include the Transtheoretical Model of Change (Prochaska, 1992), Theory of Reasoned Action (Fishbein and Ajzen, 1975) and the Theory of Planned Behaviour (Ajzen, 1985). While community readiness is similar in some ways to group readiness, it is differentiated by the variety of members within a community (Miller, 1990).

2.5.2 The Development of the Community Readiness Model

The CRM was developed at the Tri Ethnic Centre at Colorado State University in an attempt to assist communities to become more successful in addressing issues of substance misuse and HIV/AIDs prevention (Oetting et al., 1995). The CRM was developed in response to a social marketing study, which examined substance use among middle school adolescents and found that results varied from community to community. The varied levels of change evident in different communities appeared to be linked to communities' attitudes towards change, prompting the need for a new process to guide communities through the complex process of behaviour change (Kelly and Stanley, 2013). These findings, together with a seminal paper regarding community readiness for prevention, which highlighted that the initiation of a social marketing programme would not be successful unless a community was ready for change, proved key to developing a theoretical model of community readiness (Thurman et al., 2000).

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The development of the CRM commenced with focus group work at Colorado State University, where community readiness levels and stages were defined. At this stage it was identified that an individual's readiness alone would not provide a strong enough framework for the theory. The CRM origins are rooted in psychological readiness literature, extending the Transtheoretical Model of Behaviour Change (Prochaska and DiClemente, 1982) and social action work in the area of community development (Warren, 1978). With additional input from Donnermeyer, a rural sociologist in Colorado State University, further theoretical perspectives were gained from the field of community development and rural sociology. These were the combination of input from the additional theoretical fields contributed to the creation of a hierarchy of stages of community readiness, stage descriptions and dimensions where communities were thought to differ in readiness (Oetting et al., 2001).

Having reviewed the theoretical origins of the CRM and established the different types of readiness, the focus now turns to the key concepts of the CRM.

2.6 The Community Readiness Model: Key Concepts

This section examines the key concepts associated with the CRM. It starts by clarifying the definitions associated with the CRM and moves on to detail the principles of the model, with relevance to this study's central research question. This is followed by an overview on insights into how the CRM is applied.

Community Readiness Model Definitions

To clarify the terminology used around the CRM, some key definitions are examined. *Community readiness* has been defined as "the relative level of acceptance of a program, action or other form of decision-making activity that is locality based" (Donnermeyer et al., 1997, p. 68). The term *community* in the

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CRM can refer to “where residents experience their society and cultures” (Edwards et al., 2000, p. 292). However *community* as a term can be defined in a variety of ways; at macro-level on a geographic, cultural and interest based, or at a micro-level on specific groupings within larger communities (Selem, 2011). Edwards et al. (2000) define community as representing a community of place; a group of people sharing specific geographic and social contexts for activities. This latter definition is consistent with other definitions of community in the community-based literature, which acknowledges the role of structures, mechanisms, norms and roles in the definition of a community (Kelly et al., 2003; Edwards et al., 2000).

In the CRM, the definition of community depends on the problem or issue identified. Communities as defined by both geographical location and organisational structures have implemented the CRM. Therefore, community readiness theory applies to either a community of place or a community of interest, depending on the issue’s definition (Thurman et al., 2003). In the case of this study, the community in question is the MOW community, which defines the community for this study as a community of interest as opposed to an area or a geographic place. The MOW community refers to the different members of a MOW organisation; current MOW users, former MOW users, the wider older population, MOW providers and MOW stakeholders.

The concept of community readiness revolves around the idea that starting a new programme is only appropriate when the community is ready. In order for community interventions or programmes to be successful, a community must be consistent with their awareness of the problem and their readiness for change (Plested et al., 1997). This is done by, firstly, assessing how ready a community is, or to assess community readiness. Secondly, the community must be brought to a stage where programme conduction is feasible; techniques need to be developed to move communities to higher levels of readiness.

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The CRM is based on four underlying principles (Edwards et al., 2000, p. 296). The first assumes that communities are at different stages of readiness for dealing with a specific problem. The second offers that the stage of readiness can be accurately assessed. The third refers to the need for communities to be able to progress through a series of stages to develop, implement, maintain and improve effective programmes. The fourth principle relates to the critical process of identifying the stage of readiness in order for interventions to move communities to the next stage.

The CRM identifies particular characteristics as being related to different levels of problem awareness and readiness for change (Plested et al., 1997). The model can be utilised as either a research or an evaluation tool to assess change. In relation to the use of the CRM for research, the model allows researchers to match a community to its specific stage of readiness, an important feature given the fluidity and diverse types of communities. From an evaluation perspective, the CRM is valuable in gaining information from evaluations that traditional methods may not capture due to its effectiveness in providing insights into changes within the community, such as community norms, leadership issues or policy issues (Kelly et al., 2003). The CRM can also be used as a community diagnostic tool, which identifies the level at which to intervene and at what level interventions are appropriate relative to each stage of readiness, achieved through applying and scoring the CRM (Vernon and Jumper-Thurman, 2002).

The CRM defines nine stages of readiness for six dimensions, which are discussed in the next section. The original CRM dimensions and stages were developed using the critical incident technique, with the aim of gaining understanding into the complex process of community change. The critical incident technique is a qualitative research approach that provides a guide for collecting and analysing information. It can be described as:

“A set of procedures for collecting direct observations of human behaviour in such a way as to facilitate their potential usefulness in solving practical problems and developing broad psychological principles” (Flanagan, 1954, p. 327).

The critical incident technique outlines procedures for collecting observed incidents that have special significance and meet systematically defined criteria. In the development of the CRM, experts in community work developed several critical events through an iterative process in which the stages and dimensions were identified and refined (Edwards et al., 2000). This process, which is outlined in greater detail in Chapter Three, resulted in the development of six behaviourally anchored rating scales for use in ascertaining a community’s stage of readiness on each dimension (Edwards et al., 2000).

This section provided rationale and insight into the terminology and concepts associated with the CRM. The next section expands on these initial concepts to detail the dimensions involved in the model.

2.6.1 The Community Readiness Model: Dimensions

The CRM consists of a set of dimensions and stages used in the assessment of community readiness. To illustrate the purpose of each dimension in the CRM process, the dimensions of the CRM are outlined in Figure 2.4. The six dimensions of the CRM encompass the larger construct for the CRM; existing efforts, community knowledge of the efforts, leadership, community climate, community knowledge of issues and resources (Kelly et al., 2013). All six dimensions require consideration to gain an accurate understanding of the community (Thurman et al., 2003).

Figure 2.4: CRM Dimensions



Source: Adapted from Kelly et al., 2003.

The dimensions of readiness are key factors that influence a community's preparedness to act on an issue. Each dimension is measured in the CRM and is useful for diagnosing community needs and for developing strategies to meet community needs (Plested et al., 2006). The dimensions of readiness provide information on what is needed in the community to bring about mobilisation. An example of this is the dimension of leadership, which if scored lower than the efforts dimension, would indicate that the community needs to focus work on its leadership in order to create a stronger systematic mobilisation (Thurman et al., 2003). With the CRM dimensions having been described, the stages of the model are now reviewed.

2.6.2 The Community Readiness Model: Stages

The different stages of the CRM are similar to information processing models used by marketing practitioners which propose that individuals move through sequential steps towards action (Kelly et al., 2003). This approach of information processing theory is subject to discussion, particularly in relation to the basic unit

of analysis used, with the issue of seeing the role of the individual in the decision making process as lacking in empirical validation (Hult et al., 2004; Parkinson and Reily, 1979). The advantages of using this approach lies in simplifying inquiry into the decision process. The Transtheoretical Model, on which the CRM is based, highlights the series of different processes occurring at each stage as well as the need to use strategies which are suitable to each stage for optimum results (Kelly et al., 2003). In the CRM, each stage of readiness is a qualitative description, based on information about a specific dimension (Jumper-Thurman et al., 2001). The CRM identifies nine stages of readiness as described in Figure 2.5.

Figure 2.5: CRM Stages of Readiness

<i>Stage</i>	
1	Community Tolerance; suggests that the behaviour is normative and accepted
2	Denial; involves the belief that the problem does not exist or that change is impossible
3	Vague Awareness; involves recognition of the problem, but no motivation for action
4	Preplanning; indicates recognition of a problem and agreement that something needs to be done
5	Preparation; involves action planning
6	Initiation; involves implementation of a program
7	Institutionalisation; indicates one or two programs are operating and are stable
8	Confirmation and Expansion; Involves recognition of limitations and attempts to improve existing programs
9	Professionalisation; marked by training and effective evaluation

Source: Plested et al., 1997.

The different levels of community readiness and the strategies for each level aim to address issues within the community in order to mobilise the community. The CRM provides an approach, which acknowledges that social marketing efforts are not solely focused on promotion and social advertising, but address targeted community relevant issues comprised of a community-based, multi-component

community approach. The CRM advocates working with communities to assess and mobilise behaviour at community levels. This collaborative nature of the CRM contrasts with traditional social marketing efforts where there is an overemphasis on promotion and advertising (Stead and Hastings, 1997).

The identified roles of both the dimensions and the stages provide insight into the purpose of each in the application of the CRM, highlighting the collaborative community focus entrenched in the CRM. This resonates with the central research question of this study. With both the dimensions and the stages of the CRM discussed, the focus now turns to applying the CRM to assess community readiness.

2.6.3. Development of the Community Readiness Model Anchor Statements

The initial development of the CRM anchor statements saw several revisions, where issues in the development of a community readiness scale were identified in the development of the required forty-five anchor statements. The descriptive statements attempted to describe typical behaviours that communities may face at different stages of readiness (Oetting et al., 2001). This process of expert ranking saw experts, psychologists and sociologists who had comprehensive experience working in a diversity of community settings, rank a large amount of possible anchor statements along a scale that signified the nine stages of the community readiness scale (Oetting et al., 2001). Each potential anchor statement was rated by experts, either between a stage or at a stage of readiness. Based on this, an average was calculated to match up anchored statements with a specific stage of community readiness. Any anchored statements that had averages that were half way between two stages were deemed ineligible, as were statements that had a standard deviation that was greater than the space between two stages.

This process of expert ranking was carried out a number of times until 45 anchor statements were developed. Appendix A lists the anchor statements used to measure readiness. The 45 anchor statements developed were subjected to validity and reliability tests during two pre-tests with prevention programme practitioners. These pre-tests comprised of measuring community readiness with key informant interviews, with scores assigned for the readiness stage of each of the five dimensions of readiness developed based on the comparison of answers provided by the key informants (Donnermeyer et al., 1997). This process resulted in the development of an initial set of interview questions, which were reviewed, by a number of the same experts used to develop the anchor rating statements. These interview questions, once developed, were piloted in 20 different communities to validate relevant responses for measuring community readiness in each of the five dimension of readiness. A list of these interview questions is provided in Appendix B. When the CRM had been revised and agreement was reached from experts involved, a modified Delphi method was utilised to ground the anchors for each category, which allowed for a greater level of predictive accuracy than other methods that consist of several experts (Oetting et al., 2001; Oetting et al., 1995).

2.7 Assessing Community Readiness

The CRM is applied to assess community readiness through a series of questions discussed with key informants with the aim of increasing community readiness. These two key concepts will now be examined in greater detail to ascertain a greater understanding of the application of the model.

2.7.1 Key Informants

An accurate depiction of the community requires a framework to bring together different community perspectives to create an account representing different

segments and perspectives of the community (Jumper-Thurman et al., 2001). However, due to the complexity and ever-changing nature of communities, it is improbable that one organisation or one person could accurately represent an entire community. Similarly, due to the three different types of readiness that exist as previously discussed, and considering that community members' participation in local issues is limited (Donnermeyer et al., 1997), the role of systematically selected stakeholders in the community is crucial when assessing community readiness. In order to assess community readiness to address a specific issue, key informant interviews are utilised to obtain information from members of the community who are knowledgeable about the issues (Plested et al., 1998). This key informant interview method is most appropriate, considering that in the community, the planning, funding and implementation of programmes is carried out by community leaders, making the community leaders the most likely to know what is going on in their community (Jumper-Thurman et al., 2001). The method of key informants is a technique adopted from community psychology, used to obtain accurate accounts about what is going on in a community (Oetting et al., 2001; Aponte, 1978; Hagedorn et al., 1976; Warheit et al., 1976).

2.7.2 Increasing Community Readiness

Based on the level of readiness of the community, strategies that reflect the readiness level are offered to guide the community in bringing about increased community readiness, which assists in mobilising the community to achieve the desired behaviour change. Each stage of readiness has a proposed strategy, which corresponds with the community's level of readiness. Such readiness-based strategies can be facilitated by a community readiness workshop for stakeholders and local leaders, where, in a programme, community members discuss and plan the issues, benefits and barriers in the community (Kelly et al.,

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2003). Table 2.2 outlines the strategies that are relevant to each stage of community readiness.

This section discussed the key concepts of the CRM, including the dimensions and stages. Additionally the application of the CRM has been conceptualised for this study. The next section looks at previous applications of the CRM.

Table 2.2: Community Readiness Strategies

Community Readiness Stage	Goal	Strategy
1. No awareness	Raise awareness of the issue	One to one visits with community leaders and members Visit existing and established small groups to inform them of the issue Make one to one phone calls to friends and potential supporters.
2. Denial	Raise awareness that the problem or issue exists in the community	Continue one to one visits with community leaders and members Discuss descriptive local incidents related to the issue Approach and engage local education / health outreach programmes to assist in the effort Begin to point out media articles that describe local critical incidents Prepare and submit articles for church bulletins, local newsletters, newsletters Present information to community groups.
3. Vague awareness	Raise awareness that the community can do something	Present information at local community events and to unrelated community groups Post flyers, posters and billboards Conduct informal local surveys / interviews with community people by phone or in person Publish newspaper editorials and articles with general information related to locality.
4. Preplanning	Raise awareness with concrete ideas to combat the issue	Introduce information about the issue through presentations and media Visit and develop support from community leaders in the cause Review existing efforts in community to determine who benefits and the degree of success Conduct local focus groups to discuss issues and develop strategies Increase media exposure through radio and public service announcements.

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<p>5. Preparation</p>	<p>Gather existing information to help plan strategies</p>	<p>Conduct community surveys Sponsor community events to initiate effort Present in depth local statistics Determine and publicise the costs of the problem to the community Conduct public forums to develop strategies Utilise key leaders and influential people to speak to groups and local media.</p>
<p>6. Initiation</p>	<p>Provide community specific information</p>	<p>Conduct in service training for professionals and para-professionals Plan publicity efforts associated with start-up of program or activity Attend meetings to provide updates on progress of the effort Conduct consumer interviews to identify service gaps and improves existing services Begin library or internet search for resources and or funding.</p>
<p>7. Stabilisation</p>	<p>Stabilise efforts / programme</p>	<p>Plan community events to maintain support for the issues Conduct training for community professionals Conduct training for community members Introduce programme evaluation through training and newspaper article Conduct quarterly meetings to review progress and modify strategies Hold special recognition events for local supporters or volunteers Prepare and submit newspaper articles detailing progress and future plans Begin networking between service providers and community systems.</p>

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<p>8. Confirmation / Expansion</p>	<p>Expand and enhance service</p>	<p>Formalise the networking Prepare a Community Risk Assessment Profile Publish a localised Programme Services Directory. Maintain a comprehensive database Develop a local speakers bureau Begin to initiate policy change through support of local city officials Conduct media outreach on specific data and trends related to the issues.</p>
<p>9. High level of community ownership</p>	<p>Maintain momentum and continue growth Develop community specific strategies</p>	<p>Engage local business community and solicit financial support Diversify funding resources Continue more advance training of professionals and para-professionals Continue reassessment of issue and progress made Utilise external evaluation and use feedback for program modification Track outcome data for use with future grant requests Continue progress reports for benefit of community leaders and local sponsorship.</p>

Source: Adapted from Edwards et al., 2000.

2.8 The Community Readiness Model: Previous Applications

The flexible nature of the CRM has led to the application of the model in a variety of areas. Although the CRM was initially developed to address substance use issues (Edwards et al., 2000), it has since seen broader applications in assessing readiness for a variety of issues. Applications of the CRM have focused on three areas: health issues, social issues and environmental issues (Ogilvie et al., 2008). Application to health issues include addressing issues such as provision of health services (Oetting et al., 2001), obesity (Findholt, 2007), drug use (Plested et al., 1999), alcohol use (Jumper-Thurman et al., 2000), heart disease (Plested et al., 1998), brain injury (Kakefuda et al., 2008) and HIV prevention (Thurman et al., 2007). Applications of the model with an environmental focus addressed issues such as water and air quality, sustainability, recycling issues and contamination issues (Thurman et al., 2003; Edwards et al., 2000). From a social perspective, the CRM has been used to address intimate partner violence (Brackley et al., 2003), homelessness (Plested et al., 1998), cultural competency (Vernon et al., 2002) and suicide prevention (Edwards et al., 2000).

Previous applications of the CRM have identified both strengths and limitations of the model. Applications of the CRM to address substance use issues found that the model is effective in customising interventions and activities specific to a variety of community settings. It was also found that the application of the model assisted in raising awareness with community members of community issues (Ogilvie et al., 2008; Vernon and Jumper-Thurman, 2002). Further applications of the model in relation to alcohol use found that the model identified additional findings into multi-level insights, looking beyond the initial community issues. The CRM was found to be successful at providing guidance and understanding of complex issues such as student drinking and drug use (Kelly and Stanley, 2013; Plested et al., 1999). In addition to providing the community with an assessment of the different stages of readiness, the model

has also been effective as a training device for local leaders as a systematic and sustainable tool for social change (Plested et al., 1999). Application of the model to health and social service organisations in developing areas (Scherer et al., 2001) as well as to examine intimate partner violence (Brackley et al., 2003) found the CRM to be effective in identifying community issues within minority groups.

Limitations of the previous applications of the CRM identified a lack of research into the comparative criticality of the dimensions of the CRM for assessing community readiness. This potential limitation could be overcome by increasing the scope of the application of the model in a variety of research areas such as public health, social marketing and community development. It was also found that the interview questions that were linked to the six dimensions of readiness didn't gain sufficient breadth (Kelly and Stanley, 2013; Plested et al., 1999). For the purpose of this study, this issue was addressed through additional analysis to capture greater detail from the key informant interviews.

The CRM demonstrates a capability to access otherwise unidentified insights of true community members (Scherer et al., 2001) as well as identifying health disparities (Kakefuola et al., 2008). Further application of the CRM was acknowledged in relation to the cultural appropriateness of defining community issues, which would benefit from wider application of the CRM in culturally diverse communities (McCoy et al., 2007). When applied to explore issues relating to breast cancer, the CRM proved valuable for formulating intervention strategies, with communities identified which warrant further exploration relating to the model itself. This area that warrants further investigation related to the potential of the CRM to overlook additional factors that contribute to cultural under-representation that extend beyond the six dimensions assess, such as socio economic factors or broader determinants. The potential over reliance on key informants in the CRM was also identified (Lawsin et al., 2007),

something which a more systematic process of identification of key informants assists in addressing, as developed and utilised in the application of the CRM to the MOW community in this study. Other potential limitations of the CRM have been identified in the application of the model to obesity issues, where (Sliwa et al., 2011) found that due to the fluid nature of communities, the CRM offers a once off view of change and readiness in communities. This issue could be addressed through evaluation of the CRM at several time points to provide a more encompassing view of the community (Sliwa et al., 2011). Although the previous applications discussed illustrate the effectiveness of the CRM, further application of the model is warranted in more diverse communities to overcome the limitations identified, which makes the models application for the first time in the Irish context of particular relevance.

The innovative capabilities of the CRM, as well as assessing community levels of readiness and providing insights into community beliefs and norms, have led to the model having been identified as a complementary approach to social marketing efforts (Kelly et al., 2003; Slater et al., 2000). Such innovative capabilities include the models recognition of the role of community involvement and empowerment as well as lifestyle behaviours that require targeting through understanding community influences and using community resources, an aspect that traditional social marketing efforts lacks (Edwards et al., 2000; Donnermeyer et al., 1997; Oetting et al., 1995). Furthermore, the key concepts of the CRM, as discussed earlier, equip the model with the capability of enhancing social marketing efforts through its systematic process of assessing readiness at the community level. This enables social marketers to use the CRM to guide the development of programmes and initiatives as well as the implementation and evaluation of interventions (Kelly et al., 2003). Furthermore, the CRM's community-centred approach reflects social marketing's client-driven approach (Andreasen, 2002, p. 7), adding to traditional formative research

approaches by highlighting how community-level factors or norms may act as barriers to specific behaviour change (Kelly et al., 2003).

With the social marketing theoretical framework for this study having been outlined, the next section details the community where this study applies the CRM; Meals on Wheels.

2.9 Meals on Wheels

This section provides an overview of Meals on Wheels (MOW) in Ireland, which is the domain of application of the CRM. Firstly, in order to situate the development of MOW, the social policy background of MOW is discussed to demonstrate how the origins of MOW are reflected in MOW services. Following this, specific focus is given to an overview of MOW in Ireland, specifically the changes and challenges faced by MOW. Through the account of events outlined in this section, the case is made for the need to investigate MOW services through application of the CRM, where changes to policy have begun to be reflected in practice and requires organisational implementation.

MOW plays a central role in supporting older people to age in place. Ageing in place refers to the maintenance of care and support in the home and community as opposed to institutional care (Winterton et al., 2012). The main function of MOW is to provide meals to older people, thereby supporting older adults' normative preference to age in place (O'Dwyer and Timonen, 2008). MOW have been shown to be vital in maintaining a sense of independence in later life. Through MOW, older people are not only supported to live in their own homes, but are also assisted when dealing with challenges of ageing such as isolation and loneliness (Age Action Ireland, 2009). In relation to this study, MOW provides a suitable community context in which the CRM is applied.

This section details the changes and challenges faced by MOW services, setting the scene for issues faced by the MOW community that merit further investigation. The role of social policy for older people in Ireland, with a particular focus on the development of community-based services such as MOW is now outlined.

2.9.1 Social Policy for Older People in Ireland

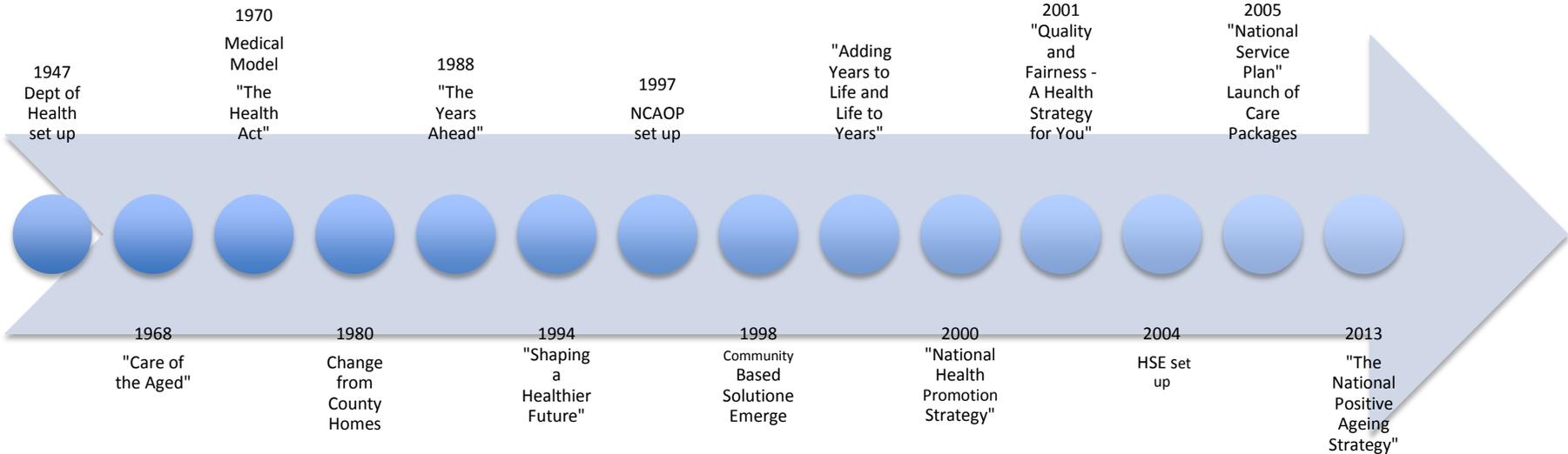
MOW can be located within the development of social policy, specifically social policy for older people in Ireland. MOW services and its historical origins are shaped by the social policy for older people. With MOW in Ireland forming part of community based services within the area of national policy for older people, this section outlines relevant policies and events that have affected MOW.

Origins

A longstanding history and a close connection exist in Ireland between ageing and social policy with care requirements and preferences of older people differ considerably (Kennedy and Quin, 2008; Garavan et al., 2001). Since the 1960s, policy documents have recommended that older people, where possible, should be enabled and supported to live in their own homes (Kennedy and Quin, 2008). This strategic policy goal is, however, contradicted by the actual development of social policy for older people in Ireland. As outlined in Figure 2.6, provision for older people in Ireland originated with a focus on institutional care for the extremely destitute. Formal care for older people historically took place in institutional settings and was subject to means testing. By contrast, there has been limited development of the community-based services that are typically required to support people to age in place.

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Figure 2.6: Timeline of Social Policy for Older People in Ireland



The Care of the Aged Report (Department of Health, 1968) was the first government policy which specifically addressed the care of older people. Published by an interdepartmental committee, this report sought to reform the system of care for older people with the primary recommendation to develop policy to support older people to live in their own home. *The Care of the Aged Report* stressed the importance of the availability of suitable community care to ensure older people had the option to remain living in their own homes. The report also demonstrated support for acknowledging the preferences of older people living in their own homes, although often the opposite is portrayed (Considine and Dukelow, 1999). The report introduced the policy theme, which remains central to policy today of the promotion of the independence of older people, maintaining older people in their own homes for as long as appropriate, prolonging their time in the community and avoiding institutionalisation. The report also recommended that services for older people should be extended, beyond the focus of poor individuals. The report recognised the difficulties associated with old age and ageing, as well as the need for a mixed economy of welfare through the involvement of a host of bodies. New proposals were put forward for community-based services. The inclusion of elements of care, such as occupational health and physiotherapy, were recognised as a means to increase the standard of care services at a variety of levels. The introduction of geriatric assessment units within hospitals for those who required institutional care was also proposed.

The Care of the Aged Report also set out to transfer responsibilities for services for older people from the local authorities to a national system consisting of eight health boards under the direction of the Department of Health. This move highlighted a shift away from the traditional view that state social support imposed on the family and voluntary sector (Conroy, 1999). A particular focus of the report was on the role of the voluntary sector with regard to domiciliary care. Although the report was influential in many ways, it also portrayed older

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people and ageing in a negative light, referring to older people who required care as a significant problem for society (Kennedy and Quin, 2008). For the context of this study, this was a period of importance, as the availability of MOW increased in the 1960s following the introduction of Social Service Councils as advised in the *Care of the Aged* report (Garavan et al., 2001)

Continuing the shift initiated by *The Care of the Aged Report*, moving away from the traditional model of support based on institutional provision the *Health Act* (ISB, 1970) made way for the medical model becoming institutionalised for social services. *The Health Act* contributed to the operation of voluntary bodies in offering assistance to organisations that provide similar or supplementary services to those being provided by the health authority (Department of Health, 1953). Although some changes had occurred, it became apparent that the development of social policy in Ireland had overlooked a stage, which was to develop an inclusive coordination of social policies, resources, rights, entitlements and system of redistribution. However instead, social policy moved straight through into the mainstream of national policy making (Conroy, 1999). This shortfall is still an issue to date, where policy in Ireland is shaped more by political and economic considerations as opposed to concern about demographic change (NPAS, 2013).

Of particular interest to this study was the transition moving towards community-based solutions in the 1990s. The 1990s saw a change in the role of non-governmental organisations, with organisations utilised as an instrument of service provision, positioning such groups within the remit of planning and developing despite receiving little funding. Although the Irish economy strengthened towards the end of the 1990s, the development of the Irish welfare state did not prosper as expected, instead developing into a mixed economy of welfare. This sees voluntary organisations, family, friends and neighbours as the main source of frontline care in personal social services (Mayo,

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1994). This can be seen in the provision of social services to older people, whereby the family, the private sector, the voluntary sector and the state are all involved in the provision of services (Considine and Dukelow, 1999).

The Years Ahead: A Policy for the Elderly (1988) echoed the 1968 *The Care of the Aged Report* by questioning the level of services available to assist older people to remain living in their own homes, stating that a broader and more specific range of services was necessary. *The Years Ahead Report* (Department of Health, 1988) became the basis of official policy for older people in Ireland (Quin et al., 1999). It emphasised the role of both the family and the voluntary sector in providing such support for older people. This policy highlighted the need for older people to remain living in their home for as long as possible, ensuring the preservation of independence and dignity. The report also outlined the importance of community-based services for enabling older people to live in their own homes for as long as possible, recommending the development of community and institutional based medical services for older people as well as focusing on improving housing for older people. *The Years Ahead Report* went on to become the cornerstone of government policy in Ireland (Kennedy and Quin, 2008). Although the *Years Ahead Report* showed a turning point with the recommendation of supports for older people living at home, a review of the report found that few recommendations had been implemented, with such support remaining informal and unstructured (Ruddle et al., 1997). Issues surrounding time and resource limitations led to the home focus of the policy being somewhat lost, with services continuing to be centre-based rather than home-based.

The strategy *Shaping a Healthier Future* (Department of Health, 1994) proposed a comprehensive health strategy, which focused primarily on reshaping health services. *Shaping a Healthier Future* highlighted the importance of promoting community care for older people (Department of Health, 1994). The Strategy

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focused on the role of GPs, Public Health Nurses and Home Helps in supporting older people who live in their own homes. The matter of the importance of supporting older people to live in their own homes was entrenched in the strategy, stating that the strategy worked to “ensure that not less than 90% of those over 75 years of age continue to live at home” (Department of Health, 1994, p. 67).

The *Home Care Package Scheme* introduced in 2001 and subsequently extended in 2007 entailed provision of home care for older people, based on the specific needs of the individual, ranging from home helps, physiotherapists and home care assistants. Although substantial investment has been made into the scheme, issues surround entitlement elements of the scheme. Above all, older people do not necessarily have an automatic right to be eligible for the service. *The Home Care Package Scheme* remains to be established as a national scheme founded in law.

Although several policies have laid out aims to support older people living at home, the area of home care is the least developed aspect of care of older people currently in Ireland due to the limited nature of social care services. It has been suggested that the Irish state over-relies on the support from the family in caring for and maintaining older people in their home (Convery, 2001). In relation to MOW, as is similar in other such community care services, due to the organic and unstructured manner with which the service was established and developed, the service has evolved in a fragmented and ad hoc manner with gaps in provision based on the geographic location, with duplication of services in some areas and no services in others (Garavan et al., 2001).

From the key policy documents relating to older people outlined, it is clear that more recent policy strategies represent a shift away from institutional provision to the development of community-based schemes that support people to age in

place. This shift incorporates the role of MOW, which is discussed in detail in the coming section, but which predominantly acts as a means of supporting older people to live in their own homes.

One particular challenge is the disparity between the ideology and the practice surrounding policy for older people and MOW, which takes place within the context of National Policy for Older People. A gap in policy exists in relation to the need for a National Food and Nutrition Policy for older people (Timonen and O'Dwyer, 2008; FSAI, 2000). A recent emergence saw private sector organisations offering home-care support, which not-for-profit or public sector organisations have not been able or allowed to supply. This new home-care packages or cash-for-care policy approach indicates the influential nature of public financing in shifting the perception of providers (Doyle and Timonen, 2007). As well as the introduction of home care packages, other changes in this area of policy in recent years have seen the move towards a more individualised approach to service provision, with the ethos of supporting older people to live in their own home still advocated by policy. However, the ideology of policy is not yet reflected in practice, with the provision of MOW yet to mirror the proposed changes to a more individualised and personalised service. The policy changes failed to consult or seek insights from the MOW community, particularly with MOW users. Changes at policy level, coupled with a challenging economic climate, have seen funding cutbacks in the provision of community based supports such as Home Helps, further reiterates the need for this area to be assessed.

As well as policy transition, further challenges faced in the provision of MOW can be seen in the responsibilities for the service. As the State has no legal power over obligations for MOW to be provided, the predominant providers of MOW are not for profit / voluntary organisations who are part funded by the Health Service Executive (HSE) (Doyle and Timonen, 2007). The HSE provides some

financial support to MOW through grant funding, working in partnership with statutory, non-statutory and community groups to provide meals services (Timonen and O' Dwyer, 2008). This presents challenges in relation to the assumed responsibility of stakeholders in MOW, as well as a lack of clarity in relation to the current and future direction of MOW. This lack of policy direction for MOW is further reflected in the provision of MOW, where the fragmented nature of MOW service provision mirrors the ad hoc and organic origins of the social policy which shaped MOW.

In light of the challenges at policy level, the application of the CRM is warranted as a measure to assess community readiness in the environment where behaviour change occurs. Such community consultation is essential to ensure that MOW is shaped by users and stakeholders. The application of the CRM to this area provides a systematic approach to measure attitudes, efforts, knowledge and resources within the MOW community, which are key to assessing community readiness to change to a more personalised approach of service provision. The application of the CRM to the MOW community ensures that community-based programmes are successfully implemented and community needs are met, an essential component in the social marketing planning process (Selem, 2011). Having set the context of MOW from a policy perspective, the next section sees some policy issues reflected in MOW.

2.10 Overview of Meals on Wheels

Through examining the systems surrounding MOW, this study identifies and investigates levels of behaviour change required to develop to a more client-orientated approach, creating community specific interventions underpinned by the CRM. The primary focus is on the Irish context, but international efforts are also outlined where relevant to the Irish situation.

2.10.1 The Role of Meals on Wheels

The primary role of MOW is to support the nutritional needs of older people and to assist older people to live in their own home for as long as possible (Wilson and Dennison, 2011; Krassie et al., 2000). Community-dwelling older people who receive MOW have shown improved nutritional status; compared to if they were not in receipt of MOW (Keller, 2006; Millen et al., 2002; Shoviv and Geoghegan, 1997). However, although the importance of a secure and consistent source of nutrition for the older population is evident, research in this area presents some contradictory findings, warranting further rigorous investigations into the nutritional value of MOW (Krassie et al., 2000; Stevens et al., 1992; Pargeter et al., 1986; Stuckey et al., 1984). A lack of systematic nutritional evaluations of MOW services is emphasised in the literature, indicating a deficit of nutritional requirements (Kronvall et al., 2008).

Although MOW has been shown to provide social interaction for people at risk of social isolation (Winterton et al., 2012; Henry, 2006; Grant and Jewell, 2004; Locher et al., 1998), little research has been conducted into the social role of MOW (Share, 2005). In recent years, growing recognition has been placed on the social aspect of MOW, where as well as providing nutrition, MOW can also provide social contact (Winterton et al., 2013; Locher et al., 1997). As well as providing social contact, MOW also contributes to assisting older people to remain living in their own homes (Administration on Aging, 2004).

The monitoring role of MOW, though an important attribute, seldom features in the literature. Monitoring the wellbeing of meal recipients has enormous potential for helping to ensure that older people can remain living at home and facilitate a cost-effective tool for health authorities. The lack of a monitoring process has been identified as a shortcoming of current MOW services in Ireland (Timonen and O' Dwyer, 2008). However, it is advised that MOW services do not

over rely on the monitoring role of the service, which could result in a sense of false security and an inadequate substitute for a more robust approach to monitored care (Cicely Northcote Trust, 1988).

2.10.2 Previous Irish Meals on Wheels Research

To date, limited research has been undertaken on MOW in Ireland, with a scarcity of studies focusing on the social aspects of MOW (Edward et al., 2002). The first comprehensive analysis conducted on MOW in Ireland was the National Council on Ageing and Older People (NCAOP) report *The Role and Future Development of the Meals on Wheels service for Older People in Ireland* (O'Dwyer and Timonen, 2008). For the first time in Ireland, research focused on accumulating baseline data on the existing operation of MOW to facilitate the development of recommendations for the future development of MOW. The report found that although MOW was a key service for many community-dwelling older people as well as those with disabilities, several improvements were needed in the organisation of services to ensure that they were efficient, effective and of high standard. The report was the first in Ireland to quantify the number of MOW users, establishing that between 10,000 and 12,000 older people were using MOW at that time (O' Dwyer and Timonen, 2008). Local community and charitable groups provided the majority of MOW, receiving some financial support from the State (O' Dwyer et al., 2009). In such organisations, volunteers comprised almost 90% of the workforce (O' Dwyer and Timonen, 2008). The study showed that the majority of MOW organisations charged clients for their meals, with more than 90 per cent of organisations doing so.

This study takes the findings and the recommendations from the NCAOP report, acknowledging the key contribution the report has made to MOW research in Ireland, and draws upon its findings and recommendations. Due to the forecast demographic changes to the older population and the challenges outlined that

are faced by MOW, the need to investigate the behaviours of key MOW stakeholders is required. Such an examination is needed to ensure the MOW community is aware and ready to bring about changes needed to equip MOW to meet the needs of an increasing older population as well as the diversification of client needs. As seen in a previous study (Hutchin, 2006), MOW stakeholders were found to be resistant to service change in relation to managerial and safety practices as well as new approaches to meeting increased demand for MOW services. This resistance to change was found to be primarily due to a lack of government funding, with other issues such as lack of sufficient training on health and safety for staff and volunteers as well as increased pressure from the HSE to increase MOW service provision. This positions the CRM as an especially relevant approach to capture readiness levels. The need to have a stronger client-centred approach to MOW was outlined as a recommendation from the NCAOP study, which is incorporated into this study through consultation with older people through interviews and focus groups.

Having detailed the social policy origins of MOW in Ireland and provided an overview of service provision, the role of MOW and previous MOW research in Ireland, the next section examines the changes and challenges faced by MOW services in Ireland.

2.11 Meals on Wheels: Changes and Challenges

According to the literature, MOW faces significant challenges in the coming years; a growing user base, social and economic challenges, all while attempting to provide a key service to older people in need of home care (Stoddart et al., 2002). This section provides an account of the changes and challenges in the area of MOW, or as is referred to in this study: the MOW community. The MOW community refers to current MOW users, former MOW users, the wider older population, MOW providers and MOW stakeholders. The changes and challenges

will be identified such as demographic changes, service transition and issues surrounding volunteers and food safety. The result of this critical review makes the case for MOW as a suitable choice of community to base this research on and provides insight into the MOW context in Ireland.

2.11.1 Changing Demographic Context

MOW is tasked with meeting the needs of a growing and diverse client base, with the older population in Ireland set to increase significantly in the coming years, growing from 532,000 in 2011 to over 1.4 million by 2046 (CSO, 2013). This increase is likely to see the number of older people living in their own homes doubling by 2021. Such demographic changes bring challenges to services such as MOW, which will see increased demand for efforts to support ageing in place.

Furthermore, a growing number of older people implies a greater degree of diversity within the older population and amongst potential MOW users. Such diversity incorporates features such as age itself (with more people reaching advanced old age), socio-economic status, ethnic and cultural identity, and health status. In order to meet the demands of future MOW users, it must be recognised that the preferences of older people are also likely to become more diverse over time, with regards to cultural and taste preferences.

To date, the Irish health system has not seen significant increases in the older population. Furthermore, the lack of focus on interpreting the world of older people as subjects is a challenge facing policy makers in Ireland. The issue of older people being treated as subjects is a factor which needs to be addressed, as it is a recurrent theme in the literature, with an evident need for MOW development to more accurately understand and work with older people (O' Loughlin, 2005; Quin et al., 1999 and Hazan, 1994). The involvement of different

segments of the older population in this study recognises these issues and bridges this gap by working with older people to gain a more accurate insight into their experiences with MOW through the application of the CRM.

2.11.2 Meals on Wheels Service Transitions

With the origins of MOW rooted in the involvement of local charities, some negative connotations from this nature of development still exist, with the approach used seen by some as handouts from charities (Costigan et al., 1999). This stigma towards using MOW has been argued in the Irish context with different accounts of the level of prevalence of this stigma in the current service (O'Hanlon et al., 2005; Garavan et al., 2001). Attempts to overcome the stigma have been made, particularly through bringing in a charge for meals to distance the service from the traditional charitable service. However, although this has been shown to lessen the feeling of embarrassment for users (Timonen and O'Dwyer, 2008), there remains a need for a sense of discretion and flexibility in the service for older people who are not able to meet this financial arrangement. Current MOW challenges include inconsistencies and diversity in MOW provision across the country, stemming from the role of voluntary providers responding to particular needs in their local areas. In recent years, such diversity has become more apparent due to the lack of more formal and structured services, policies and supports and has led to challenges to maintaining an organised and high quality service. Faced with the increasing older population this strained area is likely to come under even greater pressure.

A further change is currently taking place between the non-profit sector, the state and the MOW market, as seen in international MOW organisations (Winterton et al., 2013). Amongst other challenges presented by this transition is the reduction of government support for community services such as MOW, with

the option of outsourcing meals seen as a more attractive and efficient approach (Bowlby and Lyods, 2011; Office for the Community Sector, 2009).

In light of these changes and challenges, the MOW community provides a valuable community for the application of the CRM. By utilising MOW as a community where the CRM is applied, this study seeks to provide insights and understanding into what key stakeholder behaviour change is required to support changes in MOW shaped by the older Irish population.

Role of Volunteers

Traditionally, MOW has been a volunteer-run service due to its charity-based nature where volunteers assisted in meals preparation and meal delivery. However, the recent decline in numbers of volunteers in Ireland presents a significant challenge to MOW, particularly as the older population continues to grow (Timonen and O' Dwyer, 2010). This drop in number of volunteers has also been seen internationally, with MOW organisations adopting innovative approaches to MOW provision to manage the effect of low numbers of volunteers. Many MOW services continue to use volunteers in some capacity, whereby food preparation is conducted by volunteers while supported with paid staff (Winterton, et al., 2012; Campus Kitchens Project, 2010; Santropol Roulant, 2010; Shields and Cook, 1997). Responding to the challenge of low volunteer numbers, an increase can be seen internationally in the number of MOW models comprising of a mix of commercial meal providers, paid staff and volunteers. An example of this public-private partnership can be seen in the UK, where the Suffolk County Service sources its meals from a private company *Apetito*. The meals are then delivered by a combination of volunteers and paid drivers, depending on whether the meals are hot or chilled. Similarly, MOW services in Canada utilise a combination of paid workers and volunteers to prepare and deliver meals (Winterton et al., 2012; Meals on Wheels of Winnipeg, 2009).

Food Safety

An additional challenge faced by MOW providers is food safety and regulation. In Ireland, all MOW providers are required to follow the Hazard Analysis and Critical Control Point (HACCP) guidelines, as outlined by the Food Safety Authority of Ireland Act 1998 (FSA, 2000). This issue is particularly challenging for MOW provision in Ireland. Due to the ad hoc approach to MOW, significant variation exists in the different methods of meal preparation. Food preparation varies from organisations that employ qualified chefs to prepare meals to a neighbour preparing a meal for someone in the locality. Additionally, many organisations may not have sufficient resources to ensure nutritional consideration is given to meals provided, especially in smaller organisations. Such difficulties have previously been identified where MOW providers had difficulty complying with food safety and hygiene regulations (Hutchin, 2006). In light of the increased older population, issues such as food safety and hygiene coupled with low levels of volunteerism present significant challenges to the future of MOW in Ireland.

2.11.3 Client Centred Approach

A key finding from the NCAOP report stated the need for MOW services to adopt a client-centred approach; with MOW users having regular input into the service, through use of an anonymous feedback system (Timonen and O'Dwyer, 2008). Traditionally, MOW comprised of the home delivery of a hot meal. In recent years, national and international MOW providers are moving to provide chilled rather than hot meals. This move towards chilled meals provides greater flexibility around preparation and delivery times for MOW providers. The chilled option of MOW provision is popular amongst providers as it facilitates a reduction in meal delivery frequency (Krester et al., 2003). This option is also common where providers have difficulty recruiting or retaining volunteers to

adequately run a service. While chilled meals may make more sense from the providers' perspective, the MOW clients' perspective must be incorporated into this approach, with MOW clients' personal preferences central to the provision of either chilled or hot meals.

However, this new approach presents challenges for MOW users, where it is crucial for client consultation around changes such as the meal temperature. Limited research has been carried out on this topic, with what little reference being made indicating that this approach is not necessarily the preferred choice of older people (Powys, 2007). The provision of both hot and chilled meals is a viable approach, having been found to facilitate both flexibility and choice for clients as well as adhering to social support and monitoring the well-being and safety of older people in their own homes, while financially presenting a cost-effective model (Walsall Council, 2005). This example illustrates the need for a more client-centred approach to MOW, where regular and on-going consultations are undertaken with MOW users and the wider older population to ensure people's needs are being met. This leads to the issue of MOW knowledge, where a greater focus needs to be on the social perspective of the user, in order to cater for each client's specific nutritional and social needs (Winterton et al., 2013).

2.11.4 Knowledge Deficit

An international study that audited MOW identified a lack of knowledge of MOW amongst people aged over 55 years (CMDHB, 2007). A similar study found that a lack of knowledge of MOW was a key factor for older people who had not used MOW (Wilson and Dennison, 2011). Furthermore, lack of knowledge of MOW amongst health professionals is prevalent, with findings from the literature indicating that health professionals lacked basic MOW information (Wilson and Dennison, 2011). This issue around a lack of information is problematic in

ensuring older people, particularly those most vulnerable, are provided with adequate and up to date information on an important service that not only provides nutritional and social support, but is also capable of monitoring their wellbeing. Such a lack of knowledge from health professionals' perspectives also negatively impacts on the likelihood of referral of eligible older people to MOW. In one Irish study, Public Health Nurses (PHNs) reported that they did not perceive their role in supporting MOW as important. This contradicts the same report's finding that most people referred on to MOW were referred by PHNs (Timonen and O' Dwyer, 2008).

Similarly, the need for a more coordinated approach between health professionals involved in MOW, primarily GPs, PHNs and social workers is required, with a previous study flagging a lack of open communication, collaboration and information sharing between MOW stakeholders (McGivern, 2006). Issues concerning inadequate information about MOW are apparent amongst both older people and health professionals. This in itself has negative implications for the current and future MOW and warrants further investigation. The application of the CRM with key MOW stakeholders can provide insights into knowledge and MOW efforts for each stakeholder and for the overall MOW community and can provide evidence-informed recommendations for improving such issues.

Although previous reports have emphasised the need for a greater focus on user responsiveness, the need still remains for closer consultation with the target groups and users (Quin et al., 1999; Department of Health, 1994). A lack of collaboration in services regarding interdepartmental and local level coordination was identified as a barrier to community based services, such as MOW (NESF, 2005). Others have also highlighted the lack of "joined-up thinking" regarding the different components of the community based services, claiming that instead of working together in complementary manner, formal and informal

care providers continue to work detached and opposite each other (Considine and Dukelow, 1999). These barriers to knowledge and knowledge sharing in MOW stem from social policy and are reflected in the dis-jointed and diverse nature of MOW provision in Ireland to date. This issue requires a collaborative approach to investigate the MOW community, as achieved through the application of the CRM, which will be outlined in greater detail in Chapter Three.

2.12 Summary

This Chapter introduced literature from social marketing, social policy and MOW contexts. Having established the CRM as the theoretical framework used to answer the central research question of this study, an overview of the MOW community, changes and challenges were detailed. The MOW community allows for contributions to social marketing research by the application of the CRM to this setting. This Chapter assisted in answering the central research question by addressing two of the research objectives of this study. Firstly, through examining the social marketing literature and identifying the dominant community social marketing models, relevant social marketing approaches were identified and critically reviewed in relation to their suitability for application in this study. Secondly, the social policy developments of MOW in Ireland were documented; where issues in the development of the service were shown to mirror the challenges currently faced by MOW.

From the changes and challenges experienced in MOW, it is evident that the CRM accurately meets the needs required in answering the research question of this study. The CRM, as discussed in this Chapter, presents a model to gauge community readiness, which is instrumental in bringing about effective behavioural and societal change. The relevance of the model in understanding complex issues with multi-stakeholders closely adheres to the MOW challenges

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identified. Chapter Three outlines the qualitative methodology used to address the central research question.

Chapter Three: Research Methodology

3.1 Introduction

This chapter provides an outline of the methodology used in this study to answer the research question: *'What key stakeholder behavioural changes are required to facilitate Meals on Wheels services to support a growing and diverse older Irish population?'* This chapter begins by outlining the philosophical and epistemological stance of the researcher. An account of the study's strategies of enquiries, procedures and rationale for the sampling process and protocols for conducting interviews and focus groups are then outlined, followed by the exploration of ethical considerations relating to the study. This chapter also provides an overview of the data analysis approach used in the study.

3.2 Philosophical, Ontological and Epistemological Considerations

Bryman (2004) identifies epistemological considerations as concerning the question of what is, or should be, regarded as acceptable knowledge in a discipline. The knowledge claim of research provides the philosophical context in which the research is grounded and framed. Stating a knowledge claim means that researchers start a project with certain assumptions about how they will learn and what they will learn during their inquiry (Creswell, 2003).

Philosophical assumptions are involved in the development of deciding on the choice of research approach. For each assumption the researcher must select a stance, which has practical implications for the design and the conduction of research, as outlined in epistemological and ontological assumptions (Creswell, 2009).

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Research designs are the plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis (Creswell, 2003). Accordingly, the research design of this study begins with a reiteration of the research question: *‘What key stakeholder behavioural changes are required to facilitate Meals on Wheels services to support a growing and diverse older Irish population?’* Qualitative research focuses on identifying a small number of people that will provide in-depth information about each person, as opposed to selecting a large number of people. The research conducted in this study is informed by the constructionism ontological position. Bryman (2012) defines constructionism as:

“Asserts that social phenomena and their meanings are continually being accomplished by the social actors, implying that social phenomena and categories are not only produced through social interaction but that they are in a constant state of revision, where knowledge of the social world is seen as indeterminate” (Bryman, 2012, p. 33).

From the perspective of constructionism, concepts and theories are constructed by researchers from stories developed from the research participants in an attempt for participants to both explain and rationalise their experiences (Corbin and Strauss, 2008). The underpinnings of this position assume that factors such as organisation and culture are not pre-given, and are seen instead to oppose social actors as outward realities that they have no role in forming (Bryman, 2004).

The constructionism approach responds to the study’s central research question, which focuses on the behaviours of the MOW community through a combination of semi-structured interviews and focus groups. Through assuming this approach, the meaning of events may not be apparent, but are fashioned from the participants in this study (Silverman, 2005). This research paradigm assists in

responding to the study's research question, which incorporates several of the paradigm's key assumptions (Crotty, 1998; Creswell, 2003). This stance implies that "social properties are outcomes of the interactions between individuals, rather than phenomena out there and separate from those involved in its construction" (Bryman, 2012, p. 380). The constructionism notion resonates with this research examining the behavioural changes in the MOW community through multiple perspectives, which is reflective of the methods and analysis used in this study (Golafshani, 2003; Lantz and Booth, 1998). With the ontological position of this study adopting a constructionism approach, the epistemological approach sees reality as being co-constructed between the researcher and those involved in the research, shaped by experiences of the individual (Creswell, 2012, p. 36). Having outlined the ontological nature of this study, the next section focuses on the strategies of inquiry.

3.3 Strategies of Inquiry

Strategies of inquiry provide researchers with specific guidance contributing to the overall research approach (Creswell, 2003). At a fundamental level, the theoretical stance of a research methodology can be classified in two broad strategies; quantitative and qualitative methods (Patton, 1988). By nature, qualitative research involves an interpretive, naturalistic view of the world, concerned with understanding or interpreting phenomena (Lewis and Richie, 2003). Inductive research designs are widely used in qualitative research, with the aim of utilising the data to shape broad themes into a generalised model or theory (Creswell, 2002). This study utilises an inductive analytic approach, which has a qualitative orientation (Guest et al., 2013).

This study's research question lends itself to qualitative research methods, as a qualitative approach is most effective in understanding a particular social situation, event, role, group or interaction (Locke et al., 2000). In the next

section, the rationale for the selection of the methodological approach will be outlined.

3.4 Credibility in Qualitative Research

In qualitative research, credibility of findings does not carry the same connotations that it does in quantitative research (Creswell, 2003). The issues of validity in qualitative research examines if findings are accurate from the view of the researcher, the participant or the reader (Creswell and Miller, 2000). Although terms relating to reliability and validity are more commonly found in quantitative approaches, qualitative methods must ensure a strong level of credibility, with terms such as credibility, transferability and trustworthiness used in the qualitative context (Golafshani, 2003).

In order to ensure credibility of data, descriptive measures must be documented for the entire process to enhance the trustworthiness of the data. Lincoln and Guba (1985) describe the key criteria for rigour in qualitative research as outlined in Table 3.1. With regards to this study, credibility was encompassed into the methods by use of multiple interviews, representing individuals with different perspectives and insights into the issue, achieving data triangulation. Furthermore, member checks were utilised from the outset and throughout the research process, where the community research partner provided on-going consultation in relation to the approach of the research. The issue of transferability was addressed through the inclusion of rich qualitative descriptions in the study, from which other researchers could decide if the results of the study were applicable elsewhere. Through accurate record keeping which detailed the different processes and procedures utilised throughout the study dependability was achieved. Confirmability in the study was comprised of research reflexivity, whereby the researcher systematically reflected on the role of the researcher and how this shapes the study, representing an

Chapter Three: Research Methodology

acknowledgment of biases, values and interests (Creswell, 2003). A summary is provided in Table 3.1 which provides an account of how different approaches were utilised in this study to ensure credibility throughout the research process.

Table 3.1: Process of Ensuring Qualitative Credibility

Measurement	Strategy	Example in this research
Credibility (Guba and Lincoln, 1994)	Researchers’ reflection on experiences during the study (Koch, 2006). Reporting clearly the participants’ perspectives in the study.	Reflective diary. Observation sheet. Face sheet. Identification sheet. Seating plan. Summary sheet
Applicability (Ryan-Nicholls, 2009; Koch, 2006)	Use of triangulation in data sources and using data collection procedures to confirm findings. Detailed reporting of the context in which the study was carried out.	Different levels of MOW population. Ecological approach for KII. Field documents (Pre, During, Post).
Auditability (Koch, 2006)	Justification of participant selection criteria, and how these participants were accessed. Describing and justifying data collection, data analysis and the interpretation process. Keeping all personal memos, data-display charts showing coding instructions, categorical data assignments and particular data component linkages.	Strategic selection criteria for each phase based on research questions. KII stakeholder theory adapted resulting in systematic process of identification.
Rigour (Creswell, 2003)	Triangulation. Rich descriptions of study procedures. Reporting possible sources of bias.	Three qualitative phases show broad view of service. Potential bias documented from outset in a reflective diary.
Validity (Denzin and Lincoln, 2005)	Internal validity of schedules.	Internal validity was addressed by pre piloting and piloting interview schedules and focus groups guides and KI script.
Reliability (Denzin and Lincoln, 2005)	Inter-rater reliability.	Inter-rater reliability was added to the CRM scoring, ensuring increased reliability and rigour.

Source: Ryan-Nicholls, 2009; Koch, 2006; Denzin and Lincoln, 2005; Creswell, 2003; Guba and Lincoln, 1994.

3.4.1 Triangulation

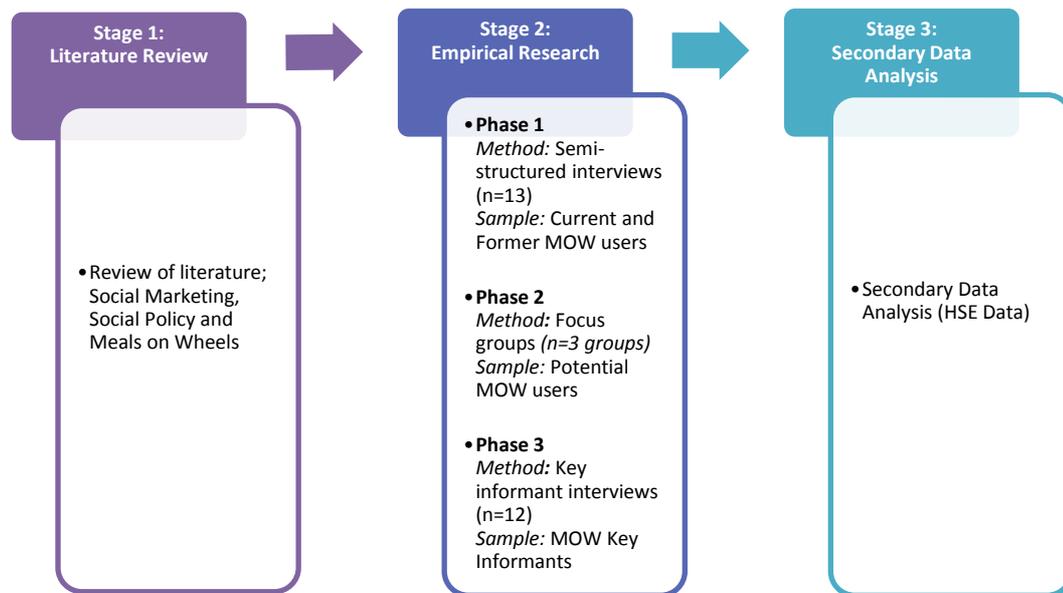
Triangulation refers to using several types of methods or data, which lead to a stronger study due to the combination of methods (Patton, 2002). The goal of triangulation in research is to test for consistency in order to demonstrate that different sources of data unearth similar findings. For studies that do not use triangulation for whatever reason, such as financial or time constraints, and instead rely on one method alone there is an increased risk of errors stemming from the method used (Patton, 2002). Denzin (1978, p. 28) describes the value of triangulation as “no single method ever adequately solves the problem of rival causal factors” expressing that each method discloses different aspects of empirical reality, necessitating the use of multiple methods of observations. While inconsistencies in triangulation may become evident, Patton (2002) argues that such inconsistencies are important in their own right, allowing for a deeper insight into the inquiry approach and the research topic.

Triangulation methods can be categorised as relating to data, theory and methodological methods (Patton, 2002). Data triangulation refers to the use of several different sources of data. Investigator triangulation is when different researchers participate in a study. Theory triangulation consists of using several perspectives to construct a data set (Brewer and Hunter, 1989). Lastly, methodological triangulation refers to the application of multiple different methods to study a single issue. The use of multiple methods equips answering the research question with “an arsenal of methods that have no overlapping weaknesses in addition to their complementary strengths” (Brewer and Hunter, 1989, p. 17). Triangulation can be achieved through using a combination of methods, such as combining interviews and observations as well as using a mixture of samples (Patton, 2002). The use of methodological triangulation and data triangulation is employed in the study to increase the validity and achieve rigorous findings.

3.5 Methods, Rationale and Design

This study's research question adopts a qualitative approach to explore the relationship between the members of the MOW community. In order to better understand both the nature and practice of relationships between community members and community organisations, qualitative techniques of data gathering through semi-structured interviews, key informant interviews and focus groups are applied. As the figure below illustrates, there are three phases in the methods design, each of which are outlined below.

Figure 3.1: Methods Design



3.5.1 Phase One: Meals on Wheels Users Past and Present

Phase One of this research focused on understanding users' experiences with MOW, allowing for a deeper understanding of the current MOW target audience. Semi-structured interviews were used in this phase in order to gain insight into MOW from the perspective of both current and former MOW users, living in

both urban and rural geographic areas. Including the perspectives of MOW users in both urban and rural areas allowed for greater insight into the barriers and benefits of MOW use. The MOW community was segmented into current MOW users (n=11) who live in both urban and rural areas, as well as former MOW users (n=2). This segmentation process ensured that multi perspectives were provided, with a particular focus on the individual or micro-level focus.

3.5.2 Phase Two: Potential Meals on Wheels Users

The aim of Phase Two was to explore perceptions of MOW from older people who had not previously used MOW. Phase Two consisted of focus groups (n=3) conducted with people aged 65 and over of the community, who have not used MOW and are therefore seen as potential MOW users. Groups were selected from both urban (n= 2) and rural (n= 1) dwelling areas. The aim of the focus groups was to gain insight into how MOW are perceived by potential users, and to identify the perceived benefits and barriers to future use of MOW. The addition of focus groups prior to the application of the CRM assists in providing contextual information, which offers informative intervention design tools (Kesten et al., 2015). The role of focus groups in Phase Two was to encourage a range of responses, which provide a greater understanding of the perceptions of participants on the research issues (Hennick, 2007). This approach was used to explore in depth and understand perceptions that can influence behaviours, providing older people who had not used MOW with the opportunity to describe their perceptions of MOW and attitudes towards potentially using the service. Focus groups were identified as an effective method to assist in responding to the research question through obtaining an understanding of older people who had no previous experience with MOW. This phase adheres with social marketing's client centred approach, by determining the target group's perceptions of key issues as well as their preferences and attitudes before the CRM was applied in Phase Three.

3.5.3 Phase Three: Meals on Wheels Key Informant Interviews

Phase Three focused on the key stakeholders involved in the provision of MOW. Through application of the Community Readiness Model (CRM), participants (n=12) were systematically selected using the Key Informant Selection plan developed for this research. As outlined in greater detail in Chapter Two, the Community Readiness Model (CRM) moves beyond individual behaviour change to community behaviour change, which recognised the environment where behaviour change takes place. The CRM examines perspectives of stakeholders from different levels within the MOW community, as opposed to the traditional social marketing focus on one individual level, which see both up-stream and mid-stream levels incorporated into the research process. The CRM was applied in the third phase, where a community assessment was conducted to establish the level of readiness for the key stakeholders in the MOW community.

Through the preparatory element of the CRM prior to the application of the model, a potential limitation of the CRM was found in the method for identifying suitable participants that represent the community. While the CRM provided general information on who to include as a key informant, for this study further rigour was added to the selection process, which resulted in the criteria and the selection plan adopting a more systematic approach to identifying and including all relevant stakeholders for the study. The key informant interviews, which were used to score community readiness, act as a tool for formative research and as a complementary approach to social marketing. As well as assessing community levels or readiness, the CRM key informant interviews provide insights into community beliefs and norms, resulting in the CRM to being identified as a parallel approach to apply to social marketing efforts (Kelly et al., 2003; Slater et al., 2000). The CRM recognises the role of community involvement and empowerment as well as lifestyle behaviours that require targeting through understanding community influences and using community

resources, an aspect that traditional social marketing efforts lack (Edwards et al., 2000; Donnermeyer et al., 1997; Oetting et al., 1995). The use of semi-structured interviews and focus groups with different stages of MOW users complemented the CRM by shaping the key informant interviews and providing additional information and rigour to the study. This allowed for a multi-perspectives approach, allowing for greater insight into similarities and disparities between the different components of the MOW community.

3.6 Sampling Strategies

The primary sampling strategy used in this study was purposive sampling. Purposive sampling is conducted when the researcher identifies specific criteria for individuals to meet for inclusion in the sample. This criterion includes individuals who can contribute relevant data. Purposive sampling, as defined by Creswell and Plano Clark (2007) means that researchers deliberately select participants who have experience with the key concept being explored. Purposive sampling does not necessitate the random selection of participants. Clear identification of inclusion and exclusion criteria are used to assist with the strategic approach of purposive sampling procedures (Bryman, 2012). Purposive sampling strategies involve the selection of units with direct reference to the research question that is asked (Bryman, 2008).

The purposive sampling approach resonates with the research question of this study as well as drawing from the lack of an alternative sampling frames and the qualitative nature of the study, to respond to the diverse perspectives of MOW. The lack of a sampling frame with the MOW community indicated that a purposive approach to sampling was the most effective way to sample. The sampling strategy utilised for all three phases of the fieldwork was purposive. The criteria involved in the sampling strategies are outlined in the following section.

3.6.1 Phase One Sampling Method: Semi-Structured Interviews

The sampling process of Phase One consisted of the sampling of two different populations; urban and rural current MOW users. For this study, a current user was defined as “an individual who is currently (2012) availing of home delivered MOW in Galway city or county”. The MOW urban site was identified as the primary site for recruiting MOW users who were currently using MOW and living in an urban area.

Developing the sampling frame for the MOW urban site users required meeting the needs of MOW providers’ policies and procedures for accessing client information and ensuring confidentiality. It was initially anticipated that the researcher would have direct access to client information; however this approach wasn’t feasible due to issues relating to data access and protection policies¹. Insight into one of the MOW urban sites list of current MOW users was achieved following obtaining Garda Clearance, reviewing the MOW provider’s policies and procedure documents and adherence to of the MOW providers Code of Practice and Confidentially statement forms. Direct access to the contact details and information of MOW users for this MOW provider was not possible, with only MOW staff members’ granted access to user information.

Following consultation with the urban MOW provider, the following process was adhered to in order to select the urban current MOW sample:

- Development of inclusion / exclusion criteria for participants
- Identification of a key champion in the MOW urban site for the study and criteria process
- Briefing with the key champion with inclusion and exclusion criteria
- Each individual on the client list was numbered numerically

¹ Greater detail on ethical considerations relating to accessing data is outlined in Chapter Three

- This list was anonymised and the researcher randomly selected the sample through simple random sampling.

The sampling process for Phase One consisted of purposive and random sampling. This process involved the development of inclusion and exclusion criteria, as outlined in Section 3.8. Following the development of inclusion and exclusion criteria, the next step in this process was the identification of a key champion in the urban and rural sites. The role of the key champions in this study was to assess all current MOW users and to screen each user using the inclusion and exclusion criteria, resulting in a list of MOW users that met the criteria. This element of the process involved briefing each of the key champions on the inclusion and exclusion criteria, with rationale for the criteria explained to ensure that each key informant was clear on the criteria. The key champions compiled a list of all current MOW users who met the study criteria requirements. Subsequently, current users who met the criteria were randomly selected to take part in the study. To ensure sampling error was minimised, the key champion numbered each potential participant. This list of numbered clients was then anonymised and provided to the researcher. The researcher then conducted simple random sampling to select the sample. Having randomly selected the sample, the key champion made initial contact with the selected individuals by phone, using a standardised guide. A study information leaflet developed and piloted by the researcher, is presented in Appendix C. The standardised information on the study was to ensure that the key champion did not induce response error.

The sampling process for the MOW rural site followed a similar approach to that outlined earlier with the urban MOW site, involving the identification of a key champion and screening of MOW users using inclusion and exclusion criteria. As the rural site was located in a Gaeltacht area; an area where Irish is the first

language spoken, additional language criteria was required as the researcher was conducting interviews in English only.

3.6.2 Phase Two: Focus Groups Sampling Method

This phase consisted of focus groups with older people who had not previously used MOW. The sampling process for this phase began with the mapping of community groups and organisations in Galway city and county that were attended by people aged 65 and over. The geographical boundaries of the research were determined by CSO data, presented in Appendix D (CSO, 2013). Once established, a gatekeeper in each of the 12 organisations was identified and contacted. Initial contact was made by phone, where an overview of the study was provided to the gatekeeper including the criteria for the focus groups participants. This initial phone contact was followed up by posting out information about the study. Follow up calls were made to provide an opportunity to answer any questions about the study, as well as to offer an invitation to the gatekeeper for the group to participate in the research. The gatekeeper then provided the group with information sheets and consent forms for the research. The gatekeeper contacted the researcher if the group was interested in taking part, where a time and location was arranged to facilitate each focus group. Following the process outlined, ten groups were contacted and invited to participate in the research. However due to the focus groups being held during the summer, the majority of community groups did not hold meetings during the summer months, which was a potential limitation for recruitment and representativeness, although the target number of focus groups for this project was achieved with the three groups.

3.6.3 Phase Three: Key Informant Interviews Sampling Method

Sampling approaches for the key informant interviews also adopted a purposive approach (Donnermeyer et al., 1997). This sampling process was utilised primarily due to a lack of a sampling frame. In order to develop a sampling approach for the key informant interviews, the CRM literature was reviewed for guidance and insight from previous applications of this process. However, it was identified that a gap in the literature existed in relation to this crucial part of the CRM process. In light of this, a systematic process for the identification of key informants was developed, which is outlined in Table 3.2. To overcome a lack of clarity and guidance in the CRM process of identifying key informants, stakeholder theory literature was critically reviewed to assist in establishing a more comprehensive and transparent approach to identifying key informants (Schwalbe, 2010; Marr, 2008). The terms key informant and key stakeholders possess similar traits, with the majority of relevant literature existing most commonly using the term key stakeholder. While the literature may have used the term key stakeholder, for the purpose of application of the CRM this was adapted to include reference to key informants. Table 3.2 combines two key stakeholder approaches as outlined by Schwalbe (2010) and Marr (2008), resulting in a more robust process than the original CRM process. This approach was adhered to in this study, making the identification process more systematic, resulting in a more robust list of key informants.

Table 3.2: Steps in Identification of CRM Key Stakeholders

Step	Task	Action
1	Identify all stakeholders	Brainstorming session with the community in question
2	Create a stakeholder register	Create a document that contains details of stakeholders identified
3	Identify key stakeholders	Identify key stakeholders based on KII criteria
4	Identify process stakeholders	Stakeholders contributions (Inputs and outputs) are examined
5	Identify a narrow list of key stakeholders	Identify a narrow list of key stakeholders, based on the KII criteria
6	Key stakeholders mapping	Mapping of key stakeholders geographically

Source: Adapted from Schwalbe, 2010; Marr, 2008.

The combined approach outlined in Table 3.2, used to identify key stakeholders in the MOW community, was developed for this study. Through following a series of actions, this approach ensures the systematic identification, mapping and selection of key stakeholders to be involved in conducting key informant interviews in the application of the CRM.

3.7 Sample Criteria

The inclusion and exclusion criteria for each phase of the research are discussed in the following sections.

3.7.1 Phase One: Semi-Structured Interviews Sample Criteria

Inclusion Criteria for Semi-structured Interviews

- Age: 65+

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- Gender: Male and Female
- Cognitive level: Competent individuals; do not have severe cognitive impairment
- Geographic location: Galway – urban and rural areas
- Community dwelling
- Connection to MOW: Current and former clients
- Referral route: Self and external referrals.

Exclusion Criteria for Semi-structured Interviews

- Age: Less than 65 years of age
- Cognitive impairment
- Recent difficult life events.

Rationale for inclusion and exclusion criteria

Age: The age criteria for this study was set at sixty- five and over, reflecting the public sector retirement age and state pension at the time in Ireland (Citizens Information, 2012). Although MOW are provided to children and younger adults with a disability, due to time constraints and in light of the overall research question, for the purpose of this study they were not included in the sample. However, extending the study to include younger people in the future would be a viable study, with the literature highlighting the growing younger client base of MOW (HACC, 2004).

Gender: Male and Female. In order to ensure a diverse range of data was obtained, both males and females were included in the study. In including both genders a greater diversity and representation of the overall population of MOW stakeholders is provided (Timonen and O' Dwyer, 2008).

Cognitive level: For the purpose of this study, only cognitively competent individuals, who did not present with severe cognitive impairments, either from

medical or medication reasons were included in the study. This was to ensure that only individuals who were sufficiently cognitively competent and who could provide informed consent participated in the study. All participants provided informed consent. Individuals' level of competence was assessed primarily by the gatekeeper and also by the researcher, based on judgements of competence and previous health issues rather than medical judgements, to ensure suitability to participate.

Living arrangements: For the purpose of this study, individuals must have been living at home and not in a residential setting. This is to ensure a community focus. Individuals living in nursing homes, residential homes or other residential care settings were not included in this study, as the research questions refers to MOW delivered to older people in their own home as opposed to meals served in residential settings. This criterion is supported by previous literature, which identified that most MOW recipients live in their own homes or on their own (Krasie et al., 2000; Stevens et al., 1992; De Graaf et al., 1990).

Geographic location: In order to establish the geographic boundaries of the study, individuals must live in Galway urban and Galway rural areas. The geographic boundaries for what consists of urban and rural areas in Galway were identified from information from the CSO, presented in Appendix D.

Connection to Meals on Wheels: In order to represent the different stages of use in the MOW community, the community was segmented into three target audiences; current users, former users and potential users. Having input and understanding from the different levels of the community provides data triangulation, with different perspectives of the issue achieved. For Phase One, current and former user's perspectives and experiences were explored through use of in depth interviews. To date, literature in the area of MOW has lacked a client focus, which is why in this study, the MOW clients are a central part of the

research process, with their views shaping the Key Informant Interview conducted with MOW key stakeholders.

Current Meals on Wheels Users: Individuals who use MOW providers in urban and rural Galway are included. There is no minimum duration of using MOW for participants, to ensure that broad views of clients' experiences are included. Again, the urban and rural inclusion will provide different insights into MOW and experiences in different parts of the city and county. Using a mixture of MOW providers will also provide varied data for the study.

Former Meals on Wheels Users: The experience of individuals who have chosen to no longer avail of MOW lacks adequate research. In an Irish study, former MOW clients proved difficult to recruit (Timonen and O' Dwyer, 2008). In order to provide information into former clients experience and potential recommendation for the future of MOW, as well as identification of benefits and barriers with MOW, the inclusion of former MOW clients is essential. In light of the previously documented challenges in recruiting former MOW clients, the inclusion criteria for this study includes individuals from MOW providers, in rural or urban Galway, with no restrictions on duration of receipt of MOW.

Meal Type: Individuals who receive or have received either chilled or hot meals from MOW providers are included in the study.

Recent Difficult Life Events: Issues brought to MOW providers' attention that are difficult or traumatic for the client, making them particularly vulnerable. Difficult life events may include recent loss of spouse or a recent health diagnosis.

3.7.2 Phase Two: Focus Groups Sample Criteria

Inclusion Criteria for Focus Groups

- Age: 65+

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- Competent individuals: Do not have severe cognitive impairment
- Connection to MOW: Potential clients (have not previously used MOW).

Exclusion Criteria for Focus Groups:

- Age: Less than 65 years of age
- Cognitive impairment
- MOW connection: If they have previously used MOW.

The same rationale applies for focus group sample characteristics as for the semi-structured interview sample characteristics, with the exception that focus group participants have not previously used MOW.

3.7.3 Phase 3: Key Informant Interviews Sample Criteria

The sampling process and sample characteristics for the key informant interviews was a more complex process than the previous two phases. In order to identify the key informants for the community assessment, several steps were taken. Firstly, the CRM literature was examined to determine what the term key informant meant. Secondly, a systematic approach for identifying key stakeholders was developed, based on information drawn from Schwalbe (2010) and Marr (2008). Thirdly, stakeholder literature was reviewed to identify and map the different types of stakeholders and stakeholder groups used in the CRM process.

3.8 Key Informants

3.8.1 Defining Key Informants

Based on the CRM literature, there are apparent contradictions surrounding the definition of key informant criteria, with definitions varying to include *leaders*

(Plested et al., 1998) with others stating that key informants are *not necessarily a leader* (Oetting, 2001). This lack of clarity and consistency surrounding the definitions of key informants associated with the CRM signifies a need for a consistent and more rigorous approach in ensuring accuracy in identifying key informants. This gap in the literature was addressed through the development of a structured and defined step in the CRM process for identifying key informants. Further to this, in order to develop a conceptual definition of the term *key informant*, a summary of the dominant terms in the CRM literature is provided at the end of this section.

When considering who would be a suitable key informant, Oetting et al. (2001) suggest keeping the following question in mind, *who would know what is going on in this area?* Key informants should be people who represent different segments of the community. Key informants should be selected from members of the community who know about the problem being examined, existing prevention programmes aimed at the problem, and various segments of community leadership (Plested et al., 1998). They should be leaders or working in the community on a day-to-day basis (Plested et al., 1998).

A key informant is a person who is likely to know about the problem or issues of concern, not necessarily a leader or decision maker. Depending on the problem, different key informants can be used, but they are all going to be people who are involved in community affairs and who know what is going on (Edwards et al., 2000). Key informants should be selected from community members who know about the issue being examined (Jumper Thurman et al., 2001). Jumper Thurman et al. (2001) discuss how key informants should be in touch with various segments of the community leadership, and would be leaders or professionals working in the community on a daily basis (Jumper Thurman et al., 2001). From this context, a key informant is seen as simply a person who knows the community, who knows about the problem or issue and who can provide specific

data about what is happening in that community (Oetting, 2001). In a cross border study in the US and Mexico, the definition was adapted to the issues being examined, resulting in the following key informant definition *“individuals in the target community who possess specific interest in community development and well-being, and enough familiarity with the community that they could provide specific information on community dynamics”* (Scherer et al., 2001 p. 23). The following definition of a key informant was developed and used in this study to best respond to the study’s central research question: *Someone who is involved with the MOW community and who can provide information about what is happening in the MOW community.*

3.8.2 Mapping Key Informants

Literature on stakeholder and key stakeholder theory was reviewed to assist in the systematic identification of potential stakeholders to be included in the list of potential key informants. Schwalbe (2010) defines stakeholders as people involved in and affected by project activities, including project sponsor, project teams, support staff, clients, users, suppliers and competition. Marr (2008, p. 31) defines a stakeholder as *“a person, group of people, or institution that has an investment, share or interest in an organisation and who may significantly influence the success of this organisation”*. A systematic approach for identifying key stakeholders was developed based on information drawn from Schwalbe (2010) and Marr (2008). In reviewing literature relating to stakeholder groups, a particularly useful article by Hult et al., (2011) was identified whereby an extensive review of 58 marketing articles was conducted, resulting in the identification of the six primary stakeholder groups (Hult, 2011), customers, suppliers, employees, shareholders, regulators and the local community. Based on the stakeholder literature (Hult et al., 2011) Table 3.3 was developed, to ensure that the process of identifying and selecting key informants was done in a systematic and rigorous manner.

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The process of identifying and selecting key informants as outlined in Table 3.3 focused on assisting the selection of potential participants to take part in the key informant interviews. Due to the composition of the MOW service, it was not possible for the key informant participants from each of the stakeholder groups identified by Hult (2011) to take part in the key informant interviews. This was largely due to the content of the key informant interview, with the focus of the questions not relevant to some of the stakeholder groups, such as suppliers and regulators. The customer stakeholder group was represented through Phase One and Phase Two of the research, through interview and focus groups with current, former and potential MOW users.

Table 3.3: Primary Stakeholders and Key Elements

Stakeholder	Key elements
Customers	Customer relationships essential Need for long term commitments to nurture relationships Customers must be understood in order to provide a sustainable and relevant service Customer focus.
Suppliers	Strong relationships Collaborative culture Good communication.
Employees	Central to building customer commitment Customer needs knowledge.
Shareholders	Customer satisfaction Loyalty Strong relationships Sustainability.
Regulators	Close coordination Responsive.
Local Community	Support Trust.

Source: Adapted from Hult et al., 2011.

3.8.3 Key Informant Terminology

The criteria for inclusion and exclusion for key informants is broken down into the following areas:

Meals on Wheels community: Community can be defined in a number of ways such as geographic areas and spatial characteristic with social relationships. A community can also be defined as a community of interest (Turman et al., 2003) or an organisation (Edwards et al., 2011). For this study, a definition was adopted for the purpose of responding appropriately to the research question, whereby for the context of this study the term *community* refers to a community of

interest, which is the MOW community. The MOW community refers to the different members of a MOW organisation, MOW providers and MOW stakeholders. The MOW user perspectives were captured in Phases One and Two, with the findings used to shape the selection of KI's. Though MOW is often referred to in the literature as a *service*, this study explores beyond the MOW service, to examine the community where the service takes place and the community members associated with MOW.

Involved with: Working, either on a paid or voluntary basis in the MOW community. Both directly and indirectly involved with the MOW community. Directly; MOW provider, MOW delivery driver. Indirectly; Funding agent, referral agent.

Represents different segments of the Meals on Wheels community: An ecological approach was adopted to ensure that stakeholders from a variety of different areas from the community were interviewed, to get an accurate and broad perspective of MOW. The MOW community was divided into two levels, micro and meso-level (Bronfenbrenner, 1979) and applied to the Primary Stakeholder and Key Elements (Table 3.3).

Someone who is a key stakeholder in the Meals on Wheels community: For the purpose of this study the approach was taken to only include key leaders or stakeholders in the community, as outlined in Table 3.4.

Key stakeholder: Key stakeholders were identified through reviewing stakeholder theory literature and adhering to guidelines and a strategic process of identification outlined by Schwalbe (2010) and Marr (2008). While a stakeholder can be defined as “a person, group of people, or institution that has an investment, share or interest in an organisation and who may significantly influence the success of this organisation” (Marr, 2008, p. 31), this definition

differs in relation to key stakeholders. In addition, a *key stakeholder* can be defined as an “Individual who has direct influence over the area of interest, or who will be directly affected by it, and who can influence stakeholders, employees, vendors and even customers” (Silverstein et al., 2009, p. 69). The process for sampling comprised of inclusion and exclusion criteria for each phase details the measures taken to ensure transparency and transferability.

Table 3.4: List of Identified MOW Key Stakeholders

Stakeholder	Title
Public Health Nurse	Director PHN / Assistant Director PHN
Home Care Package Coordinator	Home Care Package Coordinator
Community Social Work Service with Older People	Social Worker with Older People Services
GP	General Practitioner
Department of Health	Assistant National Director for Older Persons
HSE	Home Help Coordinator
Community Development Officer	Community Development Officer
Manager Older People Services	Manager Older People Services
Urban MOW Provider	MOW Business Development Manager
Rural MOW Provider	MOW Manager
Urban MOW Driver	MOW Urban Driver
Rural MOW Driver	MOW Rural Driver

3.9 Sample Size

A sampling unit refers to the element or set of elements considered for selection as part of a sample such as an individual, an organisation or a geographical area (Bowling, 2002). The following outlines the units of analysis for each phase:

- Phase One Unit: MOW Current / Former user
- Phase Two Unit: Potential MOW user
- Phase Three Unit: Key stakeholder / Key informant

The geographical boundaries where the research was conducted were identified based on the CSO data, including both urban and rural areas.

Phase One: Semi-structured Interviews Sample Size

A sample of 7 current urban MOW users, 4 current rural MOW users and 2 former MOW users were recruited. A sample of 10 current MOW users was aspired for. A small sample was sought to provide detailed insight into several users, as this element of the research focused on understanding users' experiences with MOW. It was anticipated that recruiting former MOW users would be difficult, as was found in previous MOW research (Timonen and O'Dwyer, 2008).

Phase Two: Focus Groups Sample Size

Phase Two consisted of three focus groups. Kreuger (1994) recommends that the number of participants comprising of a focus group be between five and eight participants. The sample size recruited for each of the three focus groups comprised of n=7, n=4 and n=6 participants. While it was endeavoured to reach a number of five or more participants per group, one focus group held was comprised of 4 participants, due to 3 participants who had agreed to take part not being able to attend due to personal circumstances. The aim of having small groups, such as those utilised in this research was to gain understanding into people's perceptions and experiences, which is best accomplished with smaller groups (Stewart et al., 2007).

Phase Three: Key Informant Interviews Sample Size

CRM literature states that reliable information can be obtained from four to six key informants (Jumper-Thurman et al., 2001, Donnermeyer et al., 1997). However, more interviews can also be conducted, with previous studies having been conducted with 10 to 15 individuals in order to include all relevant stakeholders (Thurman et al., 2003). A sample size of 12 key informants was recruited, which encompasses the meso and micro-levels of the MOW community as applied to this study. Micro-level refers to the individual level, meso refers to community level (House et al., 1995). The micro-level was captured by the previous phases of research outlined, comprising of interviews and focus groups with older people. Key informants interviews capture the meso-level, with members represented in the key informant interviews such as MOW providers, MOW funders, GP's and PHN's. This approach to micro and meso-level ensures multiple perspectives were captured, proving a more holistic view of MOW to most appropriately respond to the research question of this study.

3.10 Fieldwork Procedure

This section provides an overview of the fieldwork procedure for each of the three phases of fieldwork consisting of the development of the data collection methods, piloting and application. Prior to the application of each phase, each data collection tool was subjected to a pilot phase.

3.10.1 Phase One: Past and Present MOW Users

The semi-structured interview schedule used during semi-structured interviews with current MOW users was developed to respond to the central research question. Through combining key issues that emerged following a review of

relevant literature in the MOW area, the literature review and research objective lead to the following topic of interest identified to explore further in the fieldwork:

- Service awareness and perceptions
- Access to service
- Experience with service
- Future of the service.

The interviews adopted a semi-structured interview approach to uncover and describe participant's attitudes and perspectives on MOW. A focus was put on MOW users past and present experiences of MOW, as the literature states that these time frames provided a richer ground for data as opposed to attempting to create future forecast (Patton, 2002). The interview schedule explores the future of MOW through the inclusion of questions relating to future recommendations.

The approach outlined by Rubin and Rubin (1995) was adhered to in the development of interview questions. This approach identifies three types of qualitative questions; main questions, probes and follow up questions. Main questions are developed prior to the interview, and are composed on the key questions relating to the topic. These are used to initiate and guide the interview and depending on the course of the interview may be changed if needed. Patton (2002) refers to the different types of questions in the development of qualitative interviewing, which were adhered to in the creation of the interview schedule.

Prior to the semi-structured interviews being conducted, the schedule was pre-piloted (n=5) and piloted (n=1) with older people who used MOW to check the validity of the interview questions, and to ensure that the information documents were easily understood and provided adequate information. The pre-pilot phase was conducted before the pilot phase to ensure that the following

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documents were ready for the pilot stage; Study information leaflet (Appendix C), Consent form (Appendix E), Interview guide for current (Appendix F) and former MOW users (Appendix G) and the phone schedule for recruiting participants (Appendix H). In adhering with the empirical research, the pre-pilot of the documents involved with Phase One was conducted in the West of Ireland. The site for the pre-pilot was selected outside of the empirical research site in order to minimise contamination of research communities (Singh Maini, 2000). The sample was selected based on the criteria for empirical research, which included; aged 65 years or above, not living in residential care, current meals on wheels users, cognitively competent to participate. Due to difficulties in recruiting pre-pilot participants who were former MOW users, the current MOW users also reviewed the interview schedule for the former users' interview.

The site and the sample for pre-piloting stage one were selected through working with a gatekeeper. The gatekeeper selected was a contact of the researcher from previous work as a Research Assistant. Contact was initially made by phone, informing the gatekeeper about the study and the pre-pilot phase. Information on the study was posted to the gatekeeper, who then agreed to participate. Criteria for suitable participants for the pre-pilot were discussed with the gatekeeper, who with this information selected six suitable MOW users. Each participant was informed about the study and invited to take part in the pre-pilot, which was explained also. Each participant was provided with a Study Information Leaflet for his or her keeping. Five out of the six suitable participants agreed to take part in the pre-pilot, with one individual unable to attend due to a hospital appointment. The pre-piloting was conducted at a local community centre, where local older people take part in social activities once a week, run by the HSE.

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The following three areas were assessed regarding the interview guides questions in the pre-test as outlined by Fowler (Fowler, 2002; Fowler, 1995) in conducting pre-tests:

- Is it easy to read as worded?
- Do respondents understand the question in a consistent way?
- Can the question be accurately answered?

As a result of the pre-test, some changes were made to the research instrument, the interview schedule for current MOW users. The Study Information Leaflet was clarified in relation to the role of the participant. Following the piloting of the interview schedule, changes were made to terminology, where “barriers and benefits” was changed to “satisfied and dissatisfied” following feedback from participants. The flow of the questions warranted further probing and explanation, which led to the addition of probes to further explain the answers given and the reason behind answers at a deeper level.

Following the pre-pilot and pilot phases, the semi-structured interviews with current MOW users (n=11) were held in the homes of MOW users across Galway city and county during the month of February 2013 (Appendix I).

3.10.2 Phase Two: Potential Users

In developing the content of the questions, Krueger’s (1997) process of “types of focus group questions” was used as a framework to model the composition of the group’s questions. An unstructured interview format was selected for the study, and was utilised in developing questions for the focus groups due to its aim of obtaining true meanings from individuals along with exploring the complexities of their attitudes, behaviours and experiences (Bowling, 1999). The method of unstructured interviews was utilised due to the flexibility allowed,

providing participants with the opportunity to discuss their own personal experiences (Bowling, 2009).

The focus group schedule was piloted at the same service as Phase One. The focus group pilot was held at a different date and with different participants used in the Phase One pilot. Pilot participants attended a day centre once a week, and had no previous experience with MOW.

The focus group discussions were held during April 2013 in Galway city and county. Two focus groups were held in local Community Centres and one was held in a Day Centre.

3.10.3 Phase Three: CRM Key Informant Interviews

The CRM key informant interview questions (Oetting et al., 1995) were modified for application in the Irish context. The modified questions were pre-piloted with a CRM expert involved with the CRM development and application. An overview of the modifications is outlined below:

Modification to the CRM key informant questions for application to MOW

- Some terminology and the general flow of questions in the original CRM key informant questions presented challenges for application to MOW. These challenges were identified as terminology, phrasing, use of language and questions structure. E.g. Prompts were added to explore “Who do these efforts serve?” Prompts: Who are these aimed at? For example, individuals of a certain age or with particular types of need
- An individual involved with the development and previous applications of the CRM was involved in guiding the restructuring and adaptation of the questions. The opening question of the CRM question, which used words

such as “concern”, which for the context of the study, were felt would cause confusion for participants in response to such a question

- It was identified that no specific guidelines were developed in relation to the introduction of the CRM readiness assessment interview. Having previously conducted semi-structured interviews and focus groups in the earlier phases of fieldwork the researcher noted the essential role of grounding the research in establishing a strong rapport and understanding of the interview process with participants. In light of this, an additional phase was added to the CRM process to include the “Preparation of Introductory Script” presented in Appendix J
- While the aim of the CRM is to score the responses and ascertain levels of community readiness, some questions structure lacked depth and probing, to sufficiently explore areas such as awareness of barriers as well as actions responses
 - Therefore, the CRM questions were further adapted to incorporate a deeper level of probing, while still maintaining the central CRM questions necessary for scoring
 - The addition of further probe questions allowed for greater follow up and probe response, to provide more than just the CRM scores to report on and helping the interview to flow like a conversation
- Questions in the original CRM, which asked participants to rate an issue (e.g. question 7), a need to increase clarity and help the participants be more succinct was identified. For example, question 15 was preceded by asking the participant to identify leaders; which then will help shape his/her responses to what follows rather than relying on an abstract idea of leadership
- Some confusion was identified where Dimension C ended and D commenced. In light of this and to ensure greater clarity for participants and responses, a lead in line was included to focus the participant on the next issue to be discussed, and to separate the questions “Next, we are

going to talk about community climate, about what is the general attitude of the community toward MOW”

- The term “community” which was defined as part of the CRM, was outlined in the introduction, to clarify that it was the MOW community, as opposed to a geographic community. In light of this, the terminology of the original CRM was modified in terms of the use of the word “community” in some questions to avoid confusion and help stakeholders understand clearly the questions.

Following the CRM pre-pilot, the revised CRM key informant questions were piloted with a MOW stakeholder (n=1). This pilot also included an introductory script, developed for the application of the CRM to the MOW community. The introductory script (Appendix J) was developed following the focus groups conducted at Phase Two of the fieldwork to shape the CRM identification of key informants’ process. A potential limitation to the CRM was identified, whereby the current literature on the CRM and its application do not provide guidelines on the preparation of an introductory script to ensure that the key informants clearly understand the issues and the community. Following the pilot, clarification was made in relation to MOW and the term “issue” used in the CRM key informant questions. The addition of lead in lines and probes assisted in the conversational flow of the key informant interview. The key informant (n=12) interviews were held in the work place of each key informant, in Galway and also around the country. The key informant interviews took place over June, July and August 2013.

Having outlined the fieldwork procedures, the next sections examine the Secondary Data Analysis Phase.

3.11 Secondary Data Analysis Phase

The secondary data analysis phase was incorporated to provide an overall context for the MOW service in Ireland. Secondary analysis was undertaken of a questionnaire-based survey conducted by the HSE (Health Service Executive; providers of public health services in Ireland). The questionnaire (Appendix K), developed by Timonen and O' Dwyer (2008), was disseminated by the HSE in 2010 to services that provided either MOW or centre-based meals and were in receipt of HSE funding. From the questionnaire administered relevant questions to responding to this study's central research question were identified. The remaining questions were not of immediate relevance to this research project, relating to such issues as staff training programmes, catchment areas and centre based meals, which are outside the remit of this study. Seventy questionnaires were completed, with fifteen of these relating to provision of centre-based meals; in these cases, questions that related to MOW were not completed. This left fifty-five completed questionnaires relating to MOW, which will be discussed in the next Chapter in relation to relevant questions for the context of this study.

3.12 Ethical Considerations

Ethical considerations for this study were initially addressed through the development of *Protocols for Dealing with Distressed Participants* (Appendix L), which comprised of documents such as summary sheets, semi-structured interview observations, face sheet information, during and post interview assessments. In order to gain access for suitable sites in which to conduct the research, permission was sought to collect data. Gatekeepers were required to gain access and information on suitable people to approach who met the criteria for participants.

The ethical considerations of this study encompass both the steps taken to address potential ethical issues as well as the values of an ethical procedure. As is the nature of qualitative research, ethical issues must be considered throughout the entire research process, with a particular focus on the stages of data planning and data collection. Due to the nature of qualitative research, records such as quotes and narratives may pose a risk to identify a particular person who has participated in a research project. Due to such potential issues, qualitative researchers undertake a number of approaches to protect the identity of research participants, principally through the anonymisation of transcripts (Gibbs, 2006).

Ethical approval was obtained for the study from the NUI Galway Research Ethics Committee in July 2012. This ethical clearance was sought to protect the participants of the study through assessing and minimising the risk for participants. Ethical approval was also sought to protect the researcher while conducting the research. In addition to obtaining ethical approval from an academic perspective, the researcher received on Procedure for Disclosures, which led to the researcher developing a protocol in the event that sensitive information was disclosed during the course of the fieldwork (Appendix M).

Ethical risks in relation to the researcher were identified from the nature of the different elements of the methods used, particularly Phase One where the researcher visited the homes of current and former MOW users to conduct semi-structured interviews. Efforts were put in place to ensure this was done as safely as possible, with the researcher phoning a member of the supervisory team to check in and out of each interview.

Through the development, pre-piloting and piloting of clear and comprehensive information leaflets (Appendices C, N, O and P) and consent forms (Appendix E), along with detailed explanation of the research process including confidentiality issues, participants were made fully aware of the purpose of the research and how the information would be used to ensure the research was conducted in an honest and open manner, to maintain a sense of autonomy. As previously mentioned Garda Vetting was sought due to the nature of the fieldwork, which involved working with older people. Prior to the commencement of fieldwork, the researcher followed the Garda Vetting Procedure and received Garda Vetting clearance.

Having established the methodology and the methods utilised, the next section details an overview of qualitative data analysis approaches, following which the analysis process utilised is detailed, incorporating steps such as transcribing and analytical strategies.

3.13 Different Approaches to Qualitative Data Analysis

It has been argued that qualitative analysis does not possess the same clear-cut rules that are found in quantitative analysis (Spencer et al., 2003), instead qualitative data analysis largely depend on the researcher's epistemological stance as well as the study's central research question. Some qualitative analysis approaches focus on words and conversations, such as linguistic traditionalists,

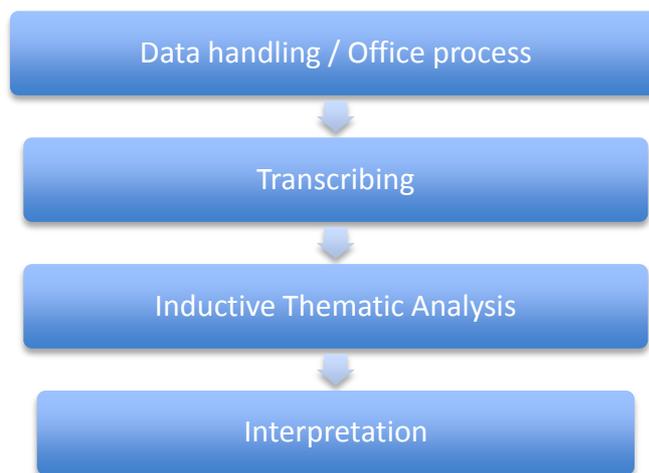
which consist of analysis techniques such as formal narrative analysis, discourse analysis or linguistic analysis (Glense, 2011). Other approaches use thematic analysis in order to see the text as a window into human experiences, whereby data is coded and separated to allow for further analysis and description (Glense, 2011).

It is this thematic approach that forms the basis of the analysis for this study. A range of methods of qualitative data analysis are resonant; building theory from data with a social process emphasis seen in grounded theory approaches to a focus on the patterns on language associated with the social production of reality associated with discourse analysis (Schutt, 2011; Coyle, 2006; Silverman, 2005). Inductive thematic analysis; a form of thematic analysis was selected over other such approaches such due to its flexible nature, where this approach best responds to the study's research question. Several variations of thematic analysis approaches exist such as inductive, theoretical, and experiential and construct thematic analysis (Braun and Clarke, 2013). Inductive thematic analysis can be defined as "a rigorous, yet inductive, set of procedures" used to explore themes "in a way that is transparent and credible" (Guest et al., 2012, p. 15). In inductive thematic analysis the "method draws from a broad range of several theoretical and methodological perspectives, but in the end, its primary concern is with presenting the stories and experiences voiced by study participants as accurately and comprehensively as possible" (Guest et al., 2012, p. 13). Thematic analysis can be classified into an examination of commonalities and differences within the data. A commonality refers to any feature that two or more cases have in common, e.g. characteristics, experiences or opinions. These similarities, or what is common in the data, may then be subjected to further analysis, resulting in the identification of potential subdivision within the data set.

The focus of inductive thematic analysis centres on generating analysis from a bottom up approach, where the data is used to shape findings, rather than

adhering to an existing theory. The analysis process approach is now outlined, as presented in Figure 3.2.

Figure 3.2: Analysis Process Approach



Source: Gibbs, 2006; Flick, 2006; Mason, 2002; Coffey and Atinkson, 1996.

3.13.1 Data Handling of Qualitative Analysis

Literature on qualitative data analysis recognises that the process involves both data handling and interpretation (Gibbs, 2006; Flick, 2006; Mason, 2002; Coffey and Atinkson, 1996). To discuss the data analysis process used in the study, the first step, having collected the data sets, was to address the process of *sorting, retrieving and handling of* data, which is known as the *office process* (Gibbs, 2006), with a view to ascertaining how this process can lead to the development of analytic ideas and concepts (Richie and Lewis, 2003). Office processes assist with handling the voluminous amounts of qualitative data, which can be generated, ranging from interview transcripts, field notes or visual data. NVivo, computer software to assist with the management of qualitative data was utilised to assist with analysis process approach, to assist in the management and organisation of data.

3.13.2 Transcribing

In qualitative research interview recording, observations and field notes are often transcribed to assist with data analysis (Gibbs, 2006). For this study, the researcher transcribed all data. As transcribing is time-consuming the fieldwork was scheduled, where possible, to allow sufficient time between each interview or focus group for the researcher to transcribe each session. This approach helped to minimise an accumulation of data requiring transcribing and assisted in working with the data in a time effective manner.

The objective of transcribing is to ensure that it captures and accurately represents aspects of interviews and focus groups (Mishler, 1991). Ensuring the facilitator of the research completes the transcription process allows for continuity and familiarisation with the data and the analysis process, allowing the researcher to become extremely familiar with the data and its content.

Strategy for transcribing

Differing arguments are put forward in the literature relating to the value of transcribing either partial or full amounts of interviews or focus groups. For this study each interview and focus groups session was fully transcribed. Both verbal and non-verbal actions were transcribed. Pseudo names were used for the transcribing process. An assistant moderator assisted in facilitating each focus group discussion by completing a seating plan to ensure each participant's responses were documented correctly. Furthermore, at the beginning of each focus group, following the moderator's guidance, each applicant gave their name as well as some other ice breaker information, which again helped to ensure the response were accurate and documented accordingly. The pseudonyms were used to ensure participants' identities were kept confidential.

For this study, the transcribing approach used did not tidy up the participant's speech, e.g. grammatical errors. This decision was to help maintain the naturally occurring conversation and response of participants while maintaining a true sense of participants' responses to accurately reflect the discussion and the participant interaction from each group. Following the transcribing of each interview and focus group, the recording was listened back to again to check the transcribing against the original recording. This process of checking against the original recording was particularly useful where the setting was noisy; one interview in particular caused difficulties, where an unassuming heater made it extremely difficult to transcribe.

3.13.3 Metadata

In the area of qualitative data analysis, analytic tools are used to help distance the researcher from the literature and personal experiences that may limit the researcher's ability to recognise new insights or possibilities in the data (Corbin and Strauss, 2008). Additional documentation was completed pre, post and during each research phase to assist in contextualising each phase of the fieldwork, allowing a deeper level of understanding in the analysis process. The documentation provided the analysis phase with greater rigour due to the contextual information provided. The documents are included in Appendix Q. These cover documenting information such as participant observations, face sheets and post interview reflexivity.

3.13.4 Constant Comparisons Method

During the coding process a constant comparative approach (Glaser and Strauss, 1967) was applied, making comparison at each level of the analytic process to establish analytic distinctions. This approach, which examined what is common in the data, also assisted in the identification of anything that might be missing

from the data, for instance if previous research had found certain issues that were not evident with a similar sample. This method of cross checking the data to examine what, if anything is missing. This helps to prevent concepts from data being lost through the application of the constant comparison method alone. This step in the thematic analysis process is advantageous as a pre-cursor to coding, as coding can often come with distractions related to the physical process of coding as opposed to the thought processing and meaning interpretation of the data (Yin, 2011).

The analysis process draws on the idea of analysis in a grounded theory approach, specifically the constant comparative approach (Corbin and Strauss, 2008). The constant comparison method was initially supported as part of the grounded theory approach (Glaser and Strauss, 1967), which later was argued to be central to the wider picture of qualitative data analysis (Barbour, 2008). Although this comparison approach is closely linked to comparative analysis, it merely overlaps with the aims of thematic analysis (Harding, 2013). The constant comparison method compares one incident with another to categorise data that is deemed not difficult to understand (Glaser and Strauss, 1967).

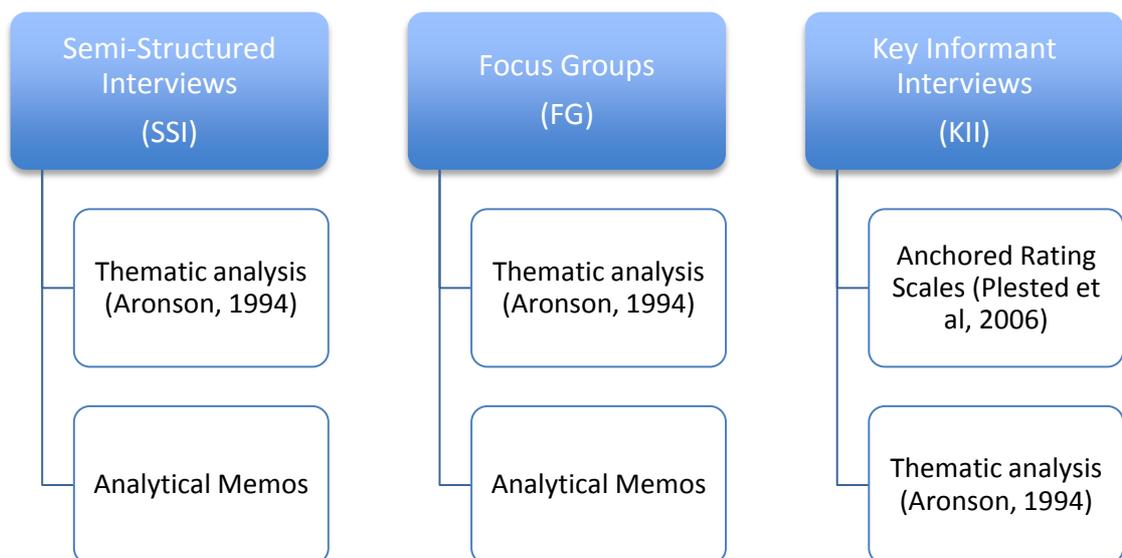
Throughout the data analysis process, each incident the researcher identifies is compared with other incidents in the data to facilitate the researcher in distinguishing one theme from another. Charmaz (2006) gives an account of this central qualitative role as “at first you compare data with data to find similarities and differences, comparing interview statements and incidents within the same interview and compare statements and incidents in different interviews” (Charmaz, 2006, p. 54). Using the constant comparative method to identify findings also mirrors the broader aims of thematic analysis whereby commonality, differences and relationships are examined (Gibson and Brown, 2009).

In the application of the constant comparative method for this research project a list was compiled of data similarities and differences, which was amended when further cases were added to the analysis. From this list broad differences and common factors were noted with research findings identified once all cases were included in the analysis (Harding, 2013).

3.14 Qualitative Data Analysis Process

This section will detail the qualitative data analysis process adhered to, and will be detailed for each of the three phases of fieldwork as outlined in Figure 3.3.

Figure 3.3: Data Analysis Process



3.14.1 Thematic Analysis Process

Thematic analysis examines differences in the data set as well as examining relationships (Gibson and Brown, 2009). Inductive thematic analysis consists of reading through textual data, identifying themes, coding the themes, and interpreting the structure and content of the themes (Guest et al., 2013). Prior to the commencement of the analysis process, the following process was followed, as outlined in Figure 3.3, to prepare and manage the data effectively, the first step of which was the data handling process.

Coding

Gibbs (2006) defines coding as how the data you are analysing is defined, involving the identification of one or more passages of text or other data items that show the same theoretical or descriptive idea of the code. Coding is an approach to arranging text into categories to develop a framework of thematic ideas. Charmaz (2003) describes coding as the process of defining what the data is about, through creating codes by defining what is seen in the data. Codes emerge as the data is read, re-read and scrutinised, guiding the researcher to interact with the data and ask specific questions of the data. It is important to acknowledge that coding is more than merely rephrasing and identifying concepts in data. Instead the process of coding involves working with additional data analysis techniques such as asking questions of the data and comparing the data, which leads to the development of concepts representative of the data and in turn developing these concepts in relation to their properties and dimensions (Corbin and Strauss, 2008).

The process of coding links the collection of data and the development of theories. In the coding process, there are two phases; the open phase, where each line of the data is named, followed by a focused phase that uses the most

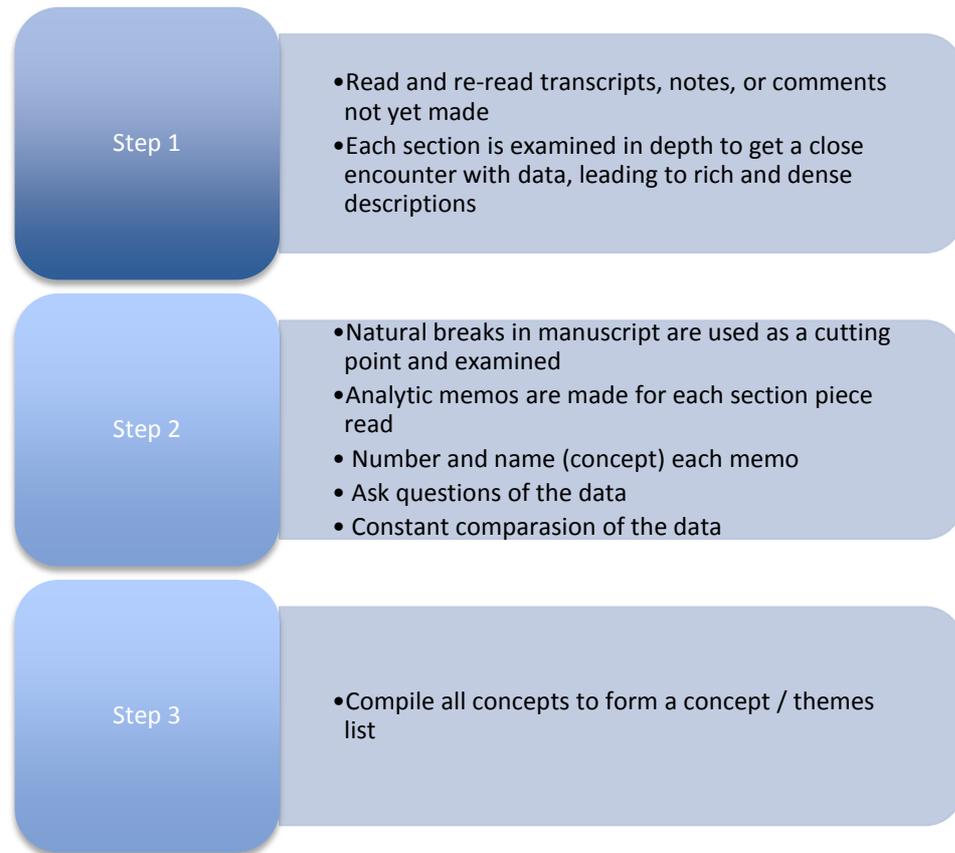
significant or most frequent initial codes to help arrange and organise the data. Through this approach to coding, two forms of analysis are facilitated; the ability to recover all coded data with the same label and combine passages that are examples of the same phenomenon or idea. Furthermore it allows for analytic questions, such as relationships between codes and comparisons (Gibbs, 2006).

In this study, to assist with the coding process a codebook (Appendix R) was developed which documented code definitions, the thought process behind each code, how each code was selected and how the code would be used. From the early stages of the coding process, developing and adding to a codebook helped to apply codes in a way that was systematic, consistent and reflective. The development of the codebook followed the format recommended by Gibbs (Gibbs, 2006) where each code was given a name or a label and the date when the coding was done was recorded with any additional notes about the code, for example its correlation to other codes.

3.14.2 Analysis of Semi-Structured Interviews

The process of open coding or first cycle coding was utilised for the analysis of the semi-structured interviews, as well as for the focus groups analysis. The open coding process is outlined in Figure 3.4.

Figure 3.4: Open Coding Process



In the data analysis process analytical memos act as a guide and as such are unpolished. Analytical memos provide a means of collecting useful information on the researcher's initial thoughts and interpretations of the data, assisting in gaining clarification for the data analysis process. Analytic memos adhere to the interpretive nature of qualitative data analysis, acting as a way to document and reflect on the researchers coding process, coding choices and the emergence of patterns, categories, sub categories, themes and concepts in the data (Saldana, 2009). The development and management of analytic memos is largely dependent on the researcher. Options available include using qualitative data management computer software such as NVivo to add memos and the use of colour coded cards (Corbin and Strauss, 2008). While some researchers code and categorise analytic memos, for the purpose of this study, analytic memos were used for guidance and reflection only, and for this reason the memos themselves were not coded and categorised.

Second Cycle Coding: Focused Coding

Once the open coding process was completed, the analysis process moved to a deeper level beyond the descriptive phase to focus coding. Focused coding reorganises and reanalyses the data from the first cycle codes. Focused coding assisted in moving analysis in two directions; establishing the content and form of analysis and clarification of the relationship between the categories (Charmaz, 2003). Focused coding uses meta codes to capture the connections and develop a more analytical than descriptive approach. Focused coding is designed to reduce and focus the number of codes that are created through the initial detailed process of “intensive seeing”. Focused codes often end in “ing”, due to their capabilities in capturing processes.

3.14.3 Analysis of Focus Groups

Morgan (1997) states that focus group interviews can be utilised as either a self-contained research method, or utilised in conjunction with other methods. The level and depth of analysis of data from either type is largely dependent on the time and rigour of the analysis. In the context of this study, the use of focus groups was not the preliminary method. Focus groups were used in this study to assist in the shaping and contextualising of other phases. Due to the complementary use of focus groups in this study, the data analysis did not require conduction at a deeper level (Morgan, 1997).

Bowling (2009) states that in order to analyse and present qualitative data, the researcher must be familiar with taking field notes, audio recordings and transcriptions. In order to ensure this was achieved, Krueger and Casey’s (2000) *Transcription Based Analysis* method was used to analyse the data, as they state that this method uses complete transcripts as a foundation for analysis. The approach outlined in Figure 3.4 was also adhered to for the analysis of focus

group data. As well as the process of analysis outlined earlier, further procedures specific to focus group analysis were adhered to such as the development of seating plans, debriefing and note taking with the moderator and the assistant moderator immediately after each focus group (Krueger, 1998). Similar steps were followed as used in Phase One analysis, such as data cleaning and preparation and transcription (Hennick, 2007).

3.14.4 Analysis of Key Informant Interviews

The analysis of the key informant interviews (KII) adopted a different approach to Phases One and Two. In accordance with the CRM literature, the KII's were scored using an anchored rating scale (Plested et al., 1998). On completion of each KII, each interview was transcribed, with one copy used for the researcher to score independently, and another copy given to a second reviewer to score, to allow for a systematic scoring approach to reduce bias and to increase rigour. Before an account is provided of the process adhered to for the CRM scoring process, a brief explanation of anchored rating scales and expert raters used to score the CRM which forms part of the validation process of the CRM will be provided (Kelly et al., 2003).

In the context of the CRM an anchored rating technique was used for the development of descriptions for each of the nine stages of readiness (Smith and Kendall, 1963). Anchored rating scales have proven effective in a variety of applications (Oetting et al., 2001; DickensHamilton, 1990; on et al., 1977). Use of anchored rating scales are particularly effective when it is necessary to compare behaviours where several parties are involved, whom possess a variety of different behaviours (Oetting et al., 2001). The process of anchored rating uses experts to develop statements, which describe the different stages in a specific process (Donnermeyer et al., 1997). Typically anchored rating scales are developed from the result of a number of experts in a specific area creating

initial descriptions that are then reviewed by an independent group of experts who make any necessary adjustments. The consensus reached by the experts on critical incident descriptions becomes the basis for conducting a reliable assessment or evaluation (Oetting et al., 1995).

3.14.5 CRM MOW Scoring Process

Having discussed the anchored statement process of the CRM in Chapter Two, the CRM scoring process will be now be outlined. The process for scoring consisted of firstly each interview being read in its entirety to gain a sense of familiarity with each interview. Following this, each of the six dimensions was designated a different colour to highlight each dimension. Each dimension was then re-read to reacquaint the scorer with the key concepts of each dimension refer to transcript is then re-read. Once the dimension was re-read, each transcript was read through and statements that referred to aspects of each dimension were highlighted. Following this, the anchored rating statement of the CRM (Appendix A) were compared to the highlighted statement for each dimension with a view to examining if the community exceeds each anchored rating statement. If the community did not exceed the anchored rating statement the scorer moved on to the next statement and examined if the statement had been exceeded. This process of examining if statements were exceeded was continued until the scorer was not able to move on to the next statement, which meant that the community had not yet reached a specific stage, the score for this readiness level would therefore be at the preceding stage. This process was repeated for each dimension until all of the dimensions were scored for each interview. The score for each interview was recorded in the Community Readiness Scoring Sheet (Appendix S). When scoring had been completed for all of the interviews, the researcher and the second scorer met to discuss both sets of scores. Where scores differed, the assigned scores were examined and discussed with explanations provided from each scorer about why

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the score was assigned. This discussion was conducted until both scorers had reached a consensus on the score, with an account provided on how this consensus was reached. The final scores agreed by the researcher and the second scorers were documented in the consensus scores table, as presented in Appendix T.

On completion of the consensus score table, the average of this table was calculated, i.e. Dimension A Efforts were added across all 12 of the interviews (8+5+7+7+7+6+7+6+4+6+6+6) and this score (75) was divided by the number of interviews conducted (12) in order to get the average, which as can be seen in more detail in Appendix T. This score was then entered into the last column on the consensus score chart. This was repeated for the remaining five dimensions. Following this, the overall community readiness score was calculated by finding the average of the 6 averaged dimension scores, established by adding the 6 averaged dimension scores and dividing this number by 6.

3.15 Summary

Chapter Three has detailed the methodology of this study in responding to the central research question of the study. This chapter outlined the philosophical and epistemological stance of the researcher. This chapter also provided an account of the study's strategies of enquiries, procedures and rationale for the sampling process and protocols for conducting interviews and focus groups as well as the ethical considerations relating to the study. This chapter also provided an overview of the data analysis approach used for each phase of the study. This chapter has set the scene for the next Chapter, which outlines the Findings, by presenting the main trends and arguments from the data.

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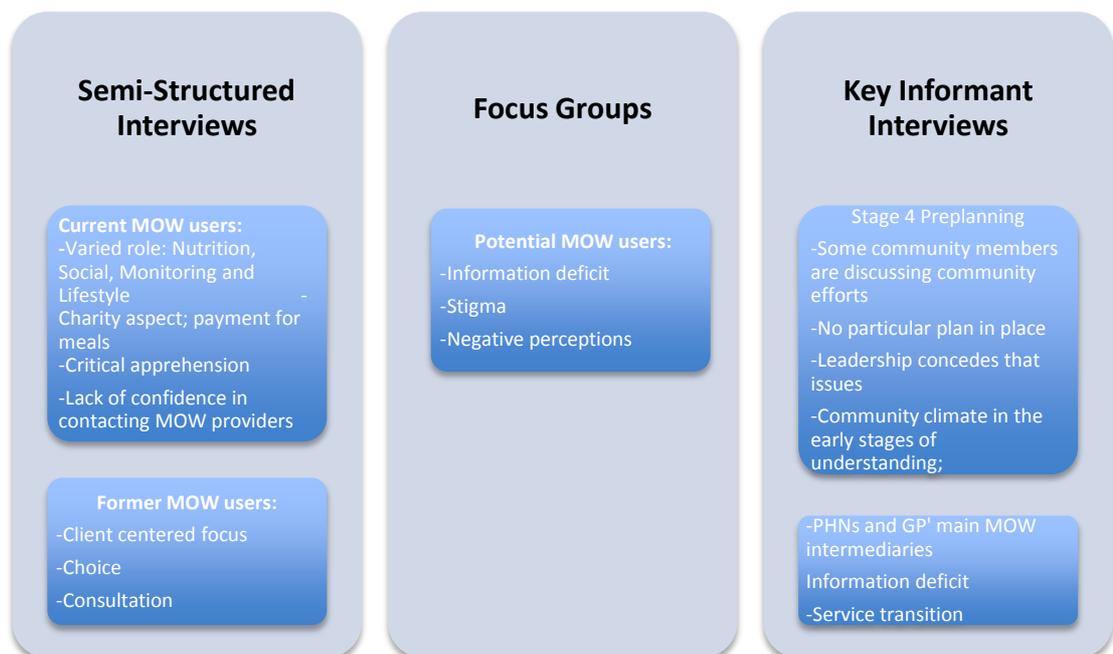
4.1 Introduction

Drawing on the empirical data collected, this chapter reports on findings from the research as they relate to the research question and objectives. This chapter provides an overview of the findings, as outlined in Figure 4.1. Given that research objectives one, three and four have been addressed in Chapter Two, this chapter presents findings in response to the remaining research objectives:

Research Objective 2: To determine how MOW services are perceived by the older population of current, former and potential MOW users in Ireland.

Research Objective 5: To establish the levels of readiness to change of key stakeholders involved in MOW services.

Figure 4.1: Overview of Findings



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The first section of this chapter answers the first of the remaining research objectives by comparatively reviewing data from interviews with current and former MOW users as well as from focus groups conducted with potential MOW users. Based on the experiences of current and former MOW users, findings highlight similarities and differences in older persons' MOW perceptions.

The second section of this chapter discusses the community readiness model score arising from key stakeholders' interviews. This responds to the second remaining research objective. Additional depth is added to meeting this objective with further analysis conducted to contextualise the scoring process. This is achieved through the addition of thematic analysis to the key informant interviews, adding a further dimension of scope and insight into the key informants, thus complementing the CRM score.

The findings are examined using the social marketing mix construct to examine the issues found relating to MOW and to assist in providing guidance and resource allocation for mobilising the MOW community towards change. This speaks to MOW, including the product, which is defined as "any market-offering intended to satisfy a want or need" (Kotler and Armstrong, 2000, p. 5), which in this instance refers to the meal element of MOW. Some findings respond to a broader element of MOW, which is referred to as the MOW service that follows the definition of a service as being "an act or performance that benefits the customer by bringing about a desired change in or on behalf of the recipient" (Lovelock and Wright, 2001, p. 66). The MOW service reflects the service offered by MOW providers, encompassing elements such as service delivery and client feedback. The third section of this Chapter provides an overview of the secondary data analysis findings, used to contextualise the study's findings.

4.2 Phase One Findings: Current and Former Meals on Wheels Users

This section explores data from current MOW users (n=11) in both urban (n=7) and rural areas (n=4) and former users (n=2) in the West of Ireland.

4.2.1 Meals on Wheels User Profile

Due to the qualitative nature of this study, the MOW user profile information has been compiled from semi-structured interviews conducted with current and former MOW users. The MOW profile contextualises the interview data, providing insights into the perspectives and lives of those who took part in this phase of the research. The MOW profile refers to MOW duration and frequency and other aspects of MOW that relate to MOW. The main aim of this MOW profile is to contextualise the richer data that will be presented after the MOW profile in the MOW social context section. An emphasis is placed on social aspects of MOW in recognition of a paucity of research in this area, as identified in Chapter Two.

Meals on Wheels Duration

MOW duration refers to the amount of time that users have been using MOW. There was variation evident in MOW duration as a MOW provider in one of the areas studied had recently started providing MOW. Consequently two participants had been using MOW for under six months. All other users had been using MOW for between three and eleven years. This shows that, for these users, using MOW represented a long-term reliance.

Meal Frequency

The number of meals received by users on a weekly basis varied from twice a week to seven days a week. Issues that were seen to impact on the frequency of

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meals are related to MOW provider capabilities and/or participant health issues. A number of MOW providers only offer meals Monday to Friday, with the option of an extra delivery of chilled meals on Fridays for use over the weekend. Three participants varied the number of meals used, based on health issues. These participants used MOW more regularly when they felt too unwell to prepare their own food. The remaining participants occasionally varied their level of meal use based on lifestyle rather than health reasons, such as times when family or friends were visiting or when they did not require the meal. Such changes in meal frequency preference provide an initial suggestion of the need for regular and consistent feedback and communication between MOW providers and users.

Living Situation

All of the current MOW users involved in this research lived alone in their own homes (n=11). It is important to ascertain if older people who do not live on their own perceived themselves to be ineligible to use MOW. This represents a broad issue across the older population and was noted by potential MOW users in this study, suggesting this issue warrants further investigation in future research.

Meal Type

Eight MOW users reported receiving a hot meal, with only three in receipt of a chilled meal. This finding is representative of the emerging shift with MOW providers towards chilled meals, which are seen as being more time efficient by MOW providers. However, as outlined in Chapter Two, there should be greater emphasis on ensuring that the preferences of MOW users are incorporated, with a choice provided in the meal type offered; such as hot or chilled meals. Three participants expressed dissatisfaction in relation to the temperature of hot meals, where the meals were not seen to be adequately hot by MOW users. In

these instances, providing the user with the option of a chilled meal that can be reheated is a viable option, with the issue of choice central to this.

Following the MOW profile overview that provided a snapshot of the MOW users who participated in this Phase of the research, the focus now turns to the dominant themes that emerged from current MOW users. Analysis of interviews with current users revealed a wide range of views in relation to the different preferences and experiences of current MOW users. The findings that emerged from current MOW users can be grouped into three dominant themes, commencing with the multiple roles of MOW, which is now discussed.

4.2.2 Multiple Roles of Meals on Wheels

The role of MOW refers to the relationship users have with MOW, or the main reason for using MOW from a user perspective. Analysis of the data revealed several different perceived roles that MOW has in the lives of MOW users. The dominant roles to emerge from the data are a nutritional role, a social role and a lifestyle role.

Nutritional Role

The first role identified by current users was the *nutritional role*, where MOW was viewed predominantly as a source of a healthy meal. Three participants had consciously decided to use MOW, solely as a regular source of a healthy meal and nutritional support. The nutritional role of MOW provides a sense of reassurance for these users that their health needs are satisfied:

“It was just to make sure that I’d have enough energy and strength and healthy food to keep going, so now I pay for it and that’s that out of the way” (U6).²

² “U” refers to participants living in an urban area, number refers to each individual participant

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However, other users did not value the health aspect of using MOW as highly. In these cases, the primary importance of MOW was as a delivery service:

“I mean the important thing about the meals is that they bring the meal, that’s the important thing...otherwise how would I get a meal?” (U5).

As well as the health focus associated with the role of nutrition, one respondent discussed a different perception of the role, which relates to living circumstances. This respondent indicated that using MOW demonstrated in a visible way to family members that a reliable and regular source of nutrition was being provided, illustrating that living independently at home alone continued to be a viable option:

“Well if I hadn’t done, I’d have no reason at all to tell the children that I am all right on my own. Well if I hadn’t it I’d be living with one of my sons now, or else I’d be in a nursing home” (U1).

Social Role

The second role of MOW identified from the data was the *social role*, whereby users discussed the importance of the social contact provided by the delivery of the meal:

“I can’t see how I wouldn’t see someone everyday really getting the Meals on Wheels” (U3).

The social contact associated with having someone deliver a meal, which provided a sense of peace of mind, was found to be particularly important for one participant, who following a recent retirement from employment had experienced a reduction in levels of social contact:

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“You see I was so used to being at work and having people all around me, coming in and out to the office, but when all that finishes you’re a bit isolated. With the meals it’s the human contact during the day” (U2).

Although not all respondents specifically identified the social aspect of MOW as an important role from their individual perspective, overall respondents recognised and referenced the social aspect associated with MOW. This illustrates that MOW users acknowledge the social side of MOW. Respondents viewed the social aspect as a source of reassurance, guaranteeing that they would see someone every day or at least as frequently as they received MOW:

“Getting the meals on wheels you know there is somebody coming everyday” (U3).

In general, participants valued the social aspect associated with using MOW.

“Having people knock on the door everyday if you are living alone, it’s that human contact during the day” (U6).

One participant referred to issues of loneliness and isolation, albeit in a humorous sense:

“Well I like that it is human contact, at least if I died and nobody called they would see a big heap of dinners at the door” (U2).

Lifestyle Role

The final MOW role identified by several respondents was that of a *lifestyle* role. For these respondents, the role of MOW was perceived more as a lifestyle choice, rather than the previously identified roles of nutrition or social roles.

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Those users who identify MOW as a lifestyle choices ordered meals as needed, rather than on a regular basis. This relaxed approach towards MOW saw users availing of MOW due to the convenience of the MOW service accommodating the user's preferred lifestyle. In the instances of respondents identifying this lifestyle role, it was evident that a strong support system of either family, friends or a combination of both was in existence. This seemed to imply that such respondents did not rely as strongly on MOW, either for nutrition or social contact. Instead, they adopted a more casual relationship with MOW:

"It's very handy like, you know, because sometimes if I rang them at ten or half ten in the morning and say 'I am stuck for a dinner today, would you be able to send me a dinner?' that would be fine" (U7).

One particular respondent spoke about a unique approach to using MOW, whereby during times that family were visiting extra meals were ordered, allowing the MOW user and family members to eat and enjoy the MOW together.

"And my daughter, I'd order one for her if she was here with me and she loves them" (U4).

This augmented role of MOW, which didn't solely focus on the nutritional aspect, but was also seen to encompass a social and lifestyle role provides new insights into the concept of a product from a social marketing intervention mix perspective. This focus on accommodating lifestyle choices is reflective of broader changes currently faced by MOW as it transitions from the traditional charity-type service towards a more client-centred service. This issue of service transition emerged as a dominant theme in this research, and is outlined in more detail in the next section.

4.2.3 Service Transition

As described in Chapter Two, MOW services in Ireland are transitioning from a charity-based approach to public-private partnerships service approach. This transition has implications for service providers in meeting increasing requirements and expectations of service users' and in needing ways to manage the different community models emerging around the country. However, for service users, difficulties are evident, particularly relating to the charity aspect of the service.

Several respondents made reference to the charity aspect of MOW. This reference to charity was linked to the role of volunteer drivers delivering meals. The fact that the majority of MOW drivers were volunteers and not in receipt of payment for their time changed the way respondents perceived MOW. These respondents were conscious of the fact that people were giving their time free of charge to deliver meals. As a result, they felt hesitant to complain or be critical of MOW, particularly in relation to delays in the time meals were delivered and the temperature of meals received:

“There are different drivers, who they cannot guarantee because it’s going to be a voluntary individual, am and I think it’s unrealistic to start screaming and shouting you know ‘where were you’” (U5).

As well as the voluntary aspect of MOW, some respondents spoke about the stigma related to perceived negative connotations of the origins of MOW as a charity service. Such perceptions continued to resonate with one urban user:

“There were some connotations of sort of charity needs, doing good for the unfortunates” (U6).

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This issue of stigma was also evident in one of the rural MOW users:

“There’s a lot of people that needs it, but they wouldn’t like to see the van coming to the house. But I don’t mind about that. Let them talk if they like” (R2)³.

All but one urban user referred to the service by name as MOW. One respondent considered a more generic name for the service to be preferable, although this view was the only one such expressed:

“I’d prefer a more generic name which actually means nothing at first, and I don’t know to what extent that other thing, you know the charity element of MOW, because there is always that thing ‘the poor unfortunates they can’t cook for themselves’, or ‘they are too weak to cook for themselves or whatever’” (U6).

Similarly, for the majority of rural users the name was not of concern. However one user did express strong views on the name of the service, conveying uncertainty about the charity connotations associated with the name MOW:

“Meals on Wheels seem to be, ah, a begging thing I think” (R3).

Additionally, in relation to the voluntary aspect of MOW, several respondents were conscious of delaying the volunteer drivers. This impacted on the amount of time they spent interacting with the driver. Respondents in both urban and rural areas shared similar concerns about the amount of time spent with the person delivering the meal:

“I wouldn’t want to delay them either because they have other people to deal with you see” (U2).

³ “R” refers to participants living in a rural area, number refers to each individual participant

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Again, these concerns are underpinned by the voluntary nature of MOW, where although users pay for their meals, there is a voluntary aspect to the preparation and delivery of the meals. These concerns also relate to an awareness of users of restricting the amount of time spent with the next person who was waiting to receive their meal:

“Because it will delay, for instance I’ll be waiting for my dinner while you are talking to someone, you know, that’s my aspect, no they don’t really talk” (U5).

“I’d also be conscious that somebody around the corner might be waiting for their meal” (U6).

A common issue identified by the majority of both urban and rural dwelling respondents was a sense of *critical apprehension* with respondents appearing to be apprehensive about being in any way critical of the MOW service. This critical apprehension relates a lack of relaying negative information or communicating issues of dissatisfaction with MOW providers due to the voluntary aspect of the service. Typically, users felt it was unfair to be negative towards a service where people were not getting paid for delivering or preparing the meals:

“Well I can’t say that. Sure I have to suit it you know. I can’t be gone off expecting a lunch here to be left outside the door [laughs]” (U1).

Although MOW users were aware that there were aspects of the service that they would like to see improved, it was assumed that such expectations were not feasible due to the voluntary aspect of the service:

“Well you couldn’t say that I like mine hot, and if people are going around with it out delivering things, you know you really can’t say that. I don’t think that you can make much of a fuss about it” (U3).

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The critical apprehension towards MOW services indicated implications regarding MOW users' means of expressing dissatisfaction with the service, which appear to currently be limited. This restricted means of conveying issues with the MOW service lends to a disparity between the MOW providers and MOW users, whereby the MOW providers aren't fully aware of the barriers, benefits and experiences of MOW users:

"Ah I wouldn't like to report anything to them you see, I wouldn't like to be giving out about it" (R1).

Although the transition in the MOW service is being conducted in a professional process with structured management processes in place, the view from the perspective of MOW users is clear; due to the majority of MOW staff working on a voluntary basis, service users feel they cannot expect as much from the MOW service which they are paying for, compared to other services:

"I have to live with that on the grounds that this is all done by volunteers, ideally of course I'd like to know that it was coming between twelve and twelve fifteen every day" (U6).

This sense of critical apprehension reflects the transitions within MOW services, where the traditional charity aspect is associated with negative connotations. Traditionally the most vulnerable used the service at a time when voicing concerns or dissatisfaction with the service would not be the norm.

As MOW transitions away from the traditional charity model, it is evident that service users require service providers to encourage and support open communication and feedback on the service. The critical apprehension that emerged from this study speaks to the element of *people* in the social marketing mix, whereby issues that are occurring at a broader level are reflected in the

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perceptions of MOW users. This sees the need for societal issues, which are impacting MOW users to be recognised and responded to at a management and organisational level in the MOW community. This finding resonates with the *process* element of the social marketing mix, identifying a potential barrier to MOW use as the mode of providing appropriate and effective channels for feedback and complaints for MOW users.

The issue of payment for MOW also emerged as a theme from the data. Several respondents spoke about paying for MOW, illustrating for these respondents that from their perspective the fact that they paid for MOW clearly meant that they were not receiving a charitable service. These issues, reflecting the *price* aspect from the social marketing mix perspective, recognise an increased sense of value and decreased sense of the voluntary aspect of the service where users pay for MOW. The issue of price doesn't just focus on the actual cost of the product, in this context is also closely related to the traditional charity origins of MOW, such as stigma. It would appear that paying for MOW was a definite and clear indicator that they were not availing of a charity service, and that this was a reason for them not to associate a stigma with using the MOW service:

"I didn't mind at all, no I don't mind anyone knowing it what so ever. Well you know, the people who get them, we pay for them" (U1).

This concept of paying for the meal in some way distanced its association with being in receipt of a charity service was also evident in the rural group, where the act of paying for the service lessened the sense of negative connotations with MOW:

"You see people have this feeling that you were begging, whereas now that you have to pay for it, it's not begging anymore, you know, how big minded people

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get. But I think they'd be very glad to avail of the meals, rather than someone to have a chat about you getting a free meal" (R3).

The payment process for MOW was a common service transition theme, reflecting the element of *people* in the social marketing mix, whereby efforts at a management level of MOW were seen to require greater consultation with users to ensure the most convenient and appropriate methods to pay for the product were provided. A number of respondents voiced apprehensions about the current payment approach, related to the lack of traceability of payments, as well as a lack of up-to-date billing. These were underpinned by concerns that the volunteer drivers would be held accountable for any discrepancies with payments:

"I think it would treat their volunteers and essentially clients better to have a more structured payment system. I have a set of envelopes that have my own number on them. I put €30 into it every Friday and I seal it and I give it to the driver. She doesn't know how much I have given to her. When she delivers it back nobody opens the envelope and tells her how much is in it. I think that anybody handling money needs protection. You don't want money to go missing in a voluntary organisation" (U6).

As well as a more transparent payment approach, the need for a more regular billing system was also identified to ensure both MOW users and providers were aware of costs owing:

"The docket I get about paying for the meals, I pay them by cheque at the end of every month, I give it to the driver, but they don't hand it into the office until a week later, and when they send out the account I never know whether I'm coming or going, because it takes a while for them to drop it in" (U1).

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Issues were also identified relating to the billing of MOW, which was seen as not being kept up to date, presenting difficulties for MOW users in relation to efficiently managing their finances:

“They mention at the end of the bill you get every month that sometimes last month’s payment would not be included. I looked at [it] and it was €74. The following week it had gone up to I think €210, so something was going on with the system where the books weren’t being reconciled, but then I’d put that down to volunteer book-keepers or something like that” (U2).

Having discussed the varied perceptions of MOW and the implications for transition in the service, the next section looks at the theme of information deficit.

4.2.4 Information Deficit

The third common issue that emerged relates to an information deficit, where issues around a lack of information and information sharing emerged strongly from the data. The theme of information deficit is divided into MOW users and MOW stakeholders.

Information Deficit: MOW Users

In relation to sourcing information about MOW, the majority (n=9) of respondents identified the local newspaper as their source of information or awareness of MOW:

“Ah well they were just advertising in the local papers and different ways and means like that you know” (U1).

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The majority of respondents heard about MOW from either a friend or family member who had read about MOW in local newspapers:

“My friend had told me that it was so nice, it’s as good as you’d get in any restaurant, so I thought I’d only try it out for one day and when I saw how nice it was I extended it” (U7).

As well as local newspaper, local radio stations were also identified by current MOW users as a source of MOW information:

“Well you used to hear about it on the wireless. One time there used be a man who’d write about food in the Advertiser (local newspaper), so he went out and visited it (the MOW provider) at that time and he had a great report about them” (U2).

Several respondents identified a lack of adequate information about MOW eligibility, with several misconceptions about MOW, particularly in relation to MOW eligibility criteria. A misconception that was identified by several respondents was the perception that only people living on their own are entitled to use MOW:

“I live on my own, because I think the meal is only available for people living on their own, old people, elderly” (U5).

Similarly, there was a lack of clarity about employment status and eligibility to use MOW, with several respondents citing that people who were in employment are ineligible to use MOW:

“In this building I’m the only one using them, but they wouldn’t be eligible you see because they’re workers” (U5).

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One experience in particular detailed how a MOW user had potentially put their health at risk due to a lack of information on the different meals and dietary options offered by MOW providers:

“I have diabetes alright, but I have only just been discovered, so I don’t know really what to do about it, I mean I’ve been talking amongst the family and that but I haven’t been talking to people about MOW” (U3).

This experience highlights the need for regular information and dissemination as well as regular monitoring of MOW users’ health changes. This experience also had elements of critical apprehension, whereby the respondent was concerned that if they were to let the MOW provider know that they required a meal suitable for someone with diabetes, that they would not be able to accommodate this, resulting in the respondent no longer being able to use MOW:

“I didn’t [inform the MOW provider] and I was saying I’m not right to be taking those meals if they are not set up for me as a diabetic, but how do I know they’d do that or not? As soon as I say I’m a diabetic they might say “Oh well I’m sorry we can’t help you anymore” (U3).

A lack of MOW user confidence in relation to contacting the MOW provider was also raised. This further emphasises the need for strong and open communication networks between users and providers:

“I didn’t feel like ringing up to ask anything because I felt, this was a time that they are all very busy, there must be some reason, and I wasn’t going to ring up and ask them, so I didn’t. They didn’t want to hear anything until after three” (U3).

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“You know, you’re not open to phoning them any time, now they don’t say ‘you can only ring us at this time’, they don’t say anything like that, but they’d prefer if you didn’t ring them too soon after dinner, at least that’s what I picked up anyway” (U3).

Information Deficit: MOW Stakeholders

One respondent gave the following account, which highlighted a barrier to MOW referrals concerning health professionals’ awareness of MOW. Lack of information from the perspective of referral agents and health care professionals also emerged as a concern, with a respondent giving an account of going to their local General Practitioner (GP) in order to start using MOW. They were surprised to learn that the GP did not have any information on MOW:

“One thing I remember was that somebody mentioned it, and they said that the GP would have it, but I went in and asked in the GP’s office and they didn’t have any contact for it, and I was surprised” (U6).

This example of a lack of awareness amongst a health professional, who also has a role as an intermediary in MOW, is of interest from the *place* aspect of the social marketing mix. There also appeared to be an assumption that MOW was something that the general public knew about, when this was not necessarily always the case:

“I have a feeling that they know that if they want it it’s there, they probably don’t know very much about the details” (U6).

It is apparent that greater information is required on MOW, particularly for health care professionals who act as intermediaries in the distribution channels for MOW information, to ensure that MOW meets the needs of those who currently use or intend to use the service. The identified examples of lack of

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information and awareness of MOW relate to *place* and *promotion* elements of the social marketing mix. From a social marketing perspective, this information would comprise part of the CRM scoring strategy, with particular focus on the client orientation, ensuring that client needs are fully understood.

Another aspect of information sharing that arose was the rapport and communication between the MOW provider and MOW user:

“They are giving me too much food and I have asked them again about it, I got a heap of food today and there was too much left over. I have phoned many times and asked could I have a smaller one, and today’s one was far too big” (U2).

This user’s experience highlights the need for a stronger communication and information sharing process to ensure that MOW users’ preferences were identified and responded to, with changes being made where necessary. This example relates to the *people* aspect of the social marketing mix, where greater communication and client orientated efforts need to ensure a strong rapport is developed and maintained between MOW providers and MOW users. An example of the effect of this lack of communication between providers and users is presented below. In this example, meal preferences were not followed up by the MOW provider. Although the MOW user had contacted the MOW provider to inform them of dietary preferences, the provider repeatedly failed to accommodate the request:

“I can’t eat cabbage, it doesn’t agree with me, I get desperate cramps in my stomach and the runs, the Doctor said I was as well off without it. I’d be ringing them telling them I got cabbage again, and they say “Oh I have a big note up”. Several times I rang about it, she says half the time they don’t even look at the notes” (U7).

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Other issues emerged relating to MOW stakeholders lacking accurate information to disseminate. MOW stakeholders are underutilised as intermediaries in the distribution channels for MOW information. A lack of both MOW knowledge and information materials was found to impact health care professionals' likelihood to referring new MOW users. PHNs and GPs were identified as the main MOW intermediaries, with the information sharing process moving away from the traditional closed model, to a more open and dynamic exchange process. One respondent spoke about how recent changes were made to the delivery of meals without consultation with the MOW user. This change in the service is a considerable inconvenience for the MOW user:

“Now somebody must always be there to pick up the meal when they come. Well that is a big difficulty for me, because I mean I go out quite a bit.. I won't be here all the time waiting for the meal to come” (U3).

As well as lack of consultation about delivery times and options, one MOW expressed dissatisfaction with the MOW provider changing to providing the meal chilled rather than hot:

“Well we used to get a hot dinner, and you can get used to anything, you can fit it in, we thought, well at least I thought it was hard in that I wouldn't like it, but it's better now” (U3).

A dissatisfaction of MOW users following changes imposed by MOW providers identified a need for greater communication and feedback between the MOW providers and users. A greater emphasis is required to involve older people in shaping MOW, where processes are put in place to ensure regular and consistent feedback loops to encourage dialogue between providers and users. The evident lack of consultation reflects the *people* aspect of the social marketing intervention mix, where the client service aspect of MOW from a management

perspective warrants a more dedicated client centred approach with systematic and transparent efforts to ensure strong client service relationships are built, monitored regularly and maintained. Greater consultation with MOW users could be achieved not alone by increasing information sharing and communication efforts, but also by encouraging service users' feedback.

Overall findings from urban and rural MOW users were similar, with common issues emerging for both areas. Issues such as stigma were just as prevalent in remote and rural areas as they were in inner city communities. A sense of critical apprehension due to the voluntary aspect of MOW was identified in both areas, as was a sense of a greater sense of detachment from the voluntary nature of MOW through paying for the meals. Having identified the principal similarities and differences from current urban and rural MOW users, the next section examines the perspectives of former MOW users.

4.3 Differences and Similarities between Current and Former MOW Users

The findings from interviews with two former MOW users presented several similarities with the issues that were raised in the current users' data. In particular, issues emerged around a lack of consultation with MOW providers. The first former user cited a lack of choice and lack of consultation with the MOW provider as the prime reason for ceasing to use MOW. This came about when the MOW provider changed from providing hot meals to providing chilled meals, without discussing this change with the user:

"In the beginning I was using them every day, and after a while I used them three times a week. I did that for a long time, for at least two years, then they changed it, you got a chilled meal then instead of a hot meal, and that didn't appeal to me" (F1).⁴

⁴ "F" refers to former MOW users, number refers to each individual participant

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Both former users valued the nutritional role of MOW, with both having started to use MOW following discharge from hospital:

“I found it great because I didn’t have to cook, I was just recovering so I couldn’t cook a lot, now the first couple of weeks I didn’t cook at all myself, so, ya I found it great not having to cook everyday” (F1).

“I had a replacement knee and I was suffering very bad with it and after spending a week or two in the Bons (hospital), I spent a bit of time in the Nursing Home, and after that then I came home, a week or two after that then the MOW came” (F2).

Both respondents were open to returning to use MOW, but only if there was a significant deterioration to their health. From their perspective, returning to MOW was seen as a last resort rather than a conscious decision for any other reason such as nutritional, social or convenience:

“Ya, when my health is not good, you know, and when I have problems doing shopping” (F1).

“Oh, I would if I was, as the fella says snookered again, if I was in a situation that I was in again, oh by all means ya, if I hadn’t my right footing under me” (F2).

Concerns around reheating meals were highlighted with the former users, covering issues around lack of familiarity using microwaves to reheat meals, and personal preferences towards microwaves, where health concerns related to using microwaves were voiced:

“I don’t have a microwave and I even don’t like to heat something in the microwave, so am.. so ya, I had a bit of a thing with that” (FG1 1).

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The second respondent, despite having a microwave in the home, was unable to use the appliance. This respondent had to be shown how to use the microwave by the person who delivered the MOW:

“I used have to put it in the microwave. She showed me, I didn’t know how to use the microwave because my wife, she got a brain tumour and she’s in a home” (FG2 4).

These concerns expressed by former MOW users provided useful insights into different MOW perceptions, and assist in indicating barriers to MOW. They also reflect components of the marketing mix, specifically the *people* and *promotion* elements where client service efforts would capture and address such concerns, as well as tailor the dissemination of promotional materials and efforts to address concerns around the use of microwaves with MOW users.

This section has outlined the central issues from semi-structured interviews with current urban and rural MOW users as well as former MOW users. It is evident that there are strong similarities in the key issues for both current and former users, particularly in the lack of information sharing and regular communication between MOW users and MOW providers. The identification of varied perceptions of the role of MOW illustrates the need for MOW to segment its target audiences. Based on the varied perceived role of MOW, the target audience for MOW needs to expand its focus to encompass several different groups who use or may potentially use MOW due to three different needs; Nutrition, social and lifestyle. Each group would require specific targeting in relation to developing specific and tailored information channels and approaches to ensure MOW meets the needs of this diverse population. Furthermore, issues relating to a lack of appropriate MOW user consultation, which were identified at the current user level, reappeared as a core aspect in a former user’s decision

to cease availing of MOW. The importance of ensuring that the individual needs of MOW users are listened to is evident from these findings.

Having examined the findings from Phase One of the fieldwork, the next section examines key findings of Phase Two, which involved focus groups with potential MOW users.

4.4 Phase Two Findings: Potential Meals on Wheels Users

This section discusses the focus groups (n=3) conducted with potential MOW users; older people who had not previously used MOW. Two key areas, MOW awareness and perceptions as well as the future of MOW, emerged from the potential MOW users' focus group data (comprised of people aged over 65 who had not previously used MOW). The following section examines and discusses the significance of these findings in anticipating potential future MOW user needs.

4.4.1 Meals on Wheels Perceptions

In each of the three focus groups, several participants made reference to negative experiences of family and friends who had used MOW. These negative experiences ranged from issues around the time the meal was delivered, a difficulty also for current MOW users discussed in the previous section, to negative assumptions about the look and taste of the food itself, which wasn't identified as an issue by current users:

"I know this man, he had MOW for a long time, but what he found was that they were coming too early in the morning for him, and then he wouldn't eat his

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dinner until maybe three or four o'clock, and he found then that it was kind of gone off then" (FG1 4)⁵.

Several participants who had no previous experience with MOW discussed their perceptions about MOW. Their perceptions detailed a negative picture of MOW, perceiving the MOW meal to be something similar to *"hospital dinners"* (FG1 2) with *"small helpings"* (FG3 2), with another participant summing up what they had heard about MOW as *"bad reviews really"* (FG2 5). Although the majority of participants had not seen a meal provided by MOW, they still held negative perceptions of what MOW would be like:

"Do you not think that they would be a bit like ah, no disrespect, but a bit like hospital dinners? People were always complaining about them" (FG1 5).

The perceptions of MOW from the perspective of potential MOW users illustrated concerns about using MOW. These concerns are based predominantly on accounts of negative experiences of the MOW product from family and friends who had used MOW coupled with preconceived negative notions of what they believed MOW was like. Discussion from two focus groups with potential MOW users saw participants associating the use of MOW as being something of a last resort, something they would not necessarily be willing to choose unless extremely necessary:

"I think that if you got MOW you'd be on the way out" (FG2 1).

This view reflected that of former MOW users, who shared similar sentiments on the likelihood and reasoning for returning to use MOW. For the former users

⁵ "FG" refers to focus groups participants

FG1 refers to focus group number one

FG1 5 refers to focus group number one, participant number five

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involved in this research, they also viewed using MOW again as somewhat of a last resort.

One distinct perception of MOW raised related to a sense of a failure associated with the use of MOW. Though this was discussed in one of the groups, it is of significance in gaining further understanding of the different underpinnings of potential users perceptions with MOW:

“I suppose it would be a sense of failure to yourself, a failure that you’ve cooked all your life, if you reared a big family and looked after yourself and, you know, a sense of failure” (FG2 4).

This sense of failure and potentially associated sense of reduced independence related to using MOW warrants further investigations. It also signals that an additional component of the *price* aspect of the social marketing mix is associated with a potential sense of failure for MOW users. Greater examination of this issue in relation to MOW users, particularly potential MOW users, to ascertain if this is a common barrier to using MOW and explore behavioural initiatives that can be made to overcome this barrier. This sense of reduced independence using MOW was unique to the potential MOW user participants in this study.

4.4.2 Meal Preparation Knowledge

The strongest issue to emerge from the focus groups with potential MOW users was the lack of knowledge and awareness concerning reheating food. It was evident from participants that there was a general sense of dislike and uncertainty when it came to owning and using microwaves in the home:

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“A lot of people don’t like to use the microwave, oh a lot of people don’t want to use the microwave, no they don’t, I don’t like using it either” (FG1).

Additional concerns were also raised, where respondents voiced worries about the levels of radiation associated with microwave use:

“I hear that once you cover the food in the microwave there isn’t as much radiation from it” (FG2 3).

This concern relating to microwave use was also expressed with one former MOW user, with the issue of using the microwave one of the factors in a decision to stop using MOW. No issues about microwave use were identified by current users. Furthermore, one respondent commented on the fact that not everyone has a microwave in their home, presenting further challenges to reheating chilled meal options:

“You have to think about people who might not have the skill to use the oven or the microwave, or they might not even have one” (FG2 4).

There was a sense of lack of awareness of the practicalities involved in reheating MOW, particularly for people who didn’t own a microwave or who didn’t like to use microwaves:

“It would be easy enough heat them up, over a sauce pan of water or something” (FG1 2).

The concerns regarding reheating meals highlight a barrier to using MOW, particularly as MOW is seeing an increase in the delivery of chilled meals that require reheating in a microwave. For older people who demonstrate concerns

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about radiation from use of microwaves, a significant educational and awareness challenge is posed for MOW providers.

There was also an apparent lack of information and clarity in relation to MOW eligibility criteria, with participants expressing uncertainty in relation to who could use MOW:

“Well I think it’s for old people, I’m just thinking you know, but I hadn’t heard of them giving it to young people, maybe there is some young people that need it” (FG3 2).

As well as confusion over eligibility, there was also a lack of awareness about how the meals were paid for and if any financial support was available to those who used MOW:

“They have to pay for the meals though don’t they, it’s subsidized though isn’t it?” (FG2 1).

This lack of awareness in relation to MOW eligibility was also found amongst current MOW users, particularly around the living situation of MOW users and payment of meals. This lack of awareness and information signals that greater awareness is needed amongst the older population to ensure that those interested in using MOW have access to accurate information. This is required to ensure that those who need or have interest in using MOW are fully aware of MOW and how it operates. An increase in awareness of MOW would assist in ensuring potential MOW users were not excluded from using MOW due to a lack of accurate information.

This section has examined the data from potential MOW users. Issues relating to MOW awareness and perceptions dominated the findings. Lack of information

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around service issues, such as eligibility and payment, pose barriers to future use of MOW. Issues that have emerged with current users were reflected in the potential users' cohort, with concerns over the restrictive time of meal delivery once again acting as a potential deterrent for future users. Findings that are particularly insightful from this cohort relate to health concerns in using microwaves for food reheating, acting as a potential barrier to MOW use. Further investigation into the link between feelings of failure and loss of independence with MOW users was also evident. The barriers encountered represent challenges for MOW providers in awareness and education in order to address the concerns of potential users. Table 4.1 collates the barriers and benefits as identified by current (CU), former (FU) and potential (PU) MOW users as well as from the MOW key informants (KI).

Figure 4.2 provides an overview of how the findings reflect elements of the social marketing intervention mix. This table draws together the elements that have been discussed so far in this section. This mix recognises the original 4 P's (McGrath, 1960), while also incorporating the broader 7 P's approach (Booms and Bitner, 1981) in recognition of the service aspect of MOW. The purpose of this table is to present methods for responding to the needs of the different audiences involved in MOW.

Having established the MOW perceptions from the view of potential users, the next section examines the KII and CRM findings.

Table 4.1: Summary of Barriers and Benefits

Barrier	Group	Benefit	Group
Critical apprehension	CU	Nutritional role	CU, FU
Stigma	CU, KI	Independent living	CU
Charity connotations	CU	Social role	CU
Lack of confidence relaying negative information or service dissatisfaction	CU	Sense of reassurance	CU
Reduced expectations related to voluntary nature	CU	Lifestyle role	CU
Lack of information on MOW services provided	CU, FU, KI	Convenience	CU, FU
Lack of regular consultation with client and MOW provider	CU	Taste	CU
More up-to-date billing and payment system	CU	Monitoring	CU
Lack of MOW information amongst health care professionals	CU, KI		
Lack of clarity on MOW eligibility criteria	CU, PU, KI		
Lack of clarity on MOW payment options	CU		
Use of distribution channels relevant to MOW target audience	CU, KI		
Lack of communication and consultation between MOW users and providers	FU		
Lack of choice	FU, KI		
Lack of consultation about changes to the MOW service	FU		
Health concerns / dislike of using microwares to reheat meals	FU		
Lack of knowledge in relation to reheating MOW meals	FU, PU		
Sense of failure associated with using MOW	PU		
Negative perceptions of MOW	PU		
Lack of information on MOW/MOW alternatives provided based on geographic areas	KI		
Disjointed approach to MOW services working with other services	KI		
Impact of reduced funding on MOW options, particularly in rural areas	KI		
Gaps in MOW provision	KI		

Figure 4.2: Social Marketing Intervention Mix



Source: Adapted from Booms and Bitner, 1981.

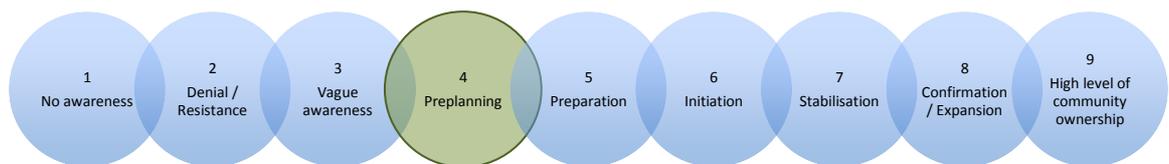
4.5 Phase Three Findings: CRM and Key Informant Interviews

This section examines the findings from the CRM scoring process as well as the thematic analysis of the key informant interviews.

4.5.1 CRM Scoring

To first establish what the different stages of the CRM are, Figure 4.3 below identifies the 9 different Stages of Readiness, as well as providing a brief description of what each stage entails.

Figure 4.3: MOW CRM Stages of Readiness



Source: Plested et al., 2006.

Following the application of the CRM to the MOW community, 4.08 was calculated to be the overall community readiness score, representing the fourth phase of community readiness; the Preplanning stage. This stage of readiness indicates that some community members have started a discussion in relation to developing community efforts. However, there is no particular plan in place. Stage 4 also suggests that some people in the community do recognise the issue of the current MOW services and acknowledge that some action is required to address the issue. This stage implies that leadership concede that issues with the current MOW service exist in the community, which warrant attention, seeing community climate as being in the early stages of understanding what is required to address the issue (Flashstone, 2011).

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A breakdown of the scoring process is outlined in Appendix T. Following the Stage of Readiness calculated to be at the Preplanning stage, the Dimensions of Readiness are outlined in Figure 4.4.

Figure 4.4: MOW CRM Dimensions



MOW CRM Dimension Scores:

- A. Total Dimension A 75 / 12 interviews: 6.25
- B. Total Dimension B 54 / 12 interviews: 4.5
- C. Total Dimension C 37 / 12 interviews: 3.08
- D. Total Dimension D 42 / 12 interviews: 3.5
- E. Total Dimension E 41 / 12 interviews: 3.4
- F. Total Dimension F 46 / 12 interviews: 3.8

The strongest MOW stakeholder dimension focused on Community Efforts, which refers to existing community efforts, compared to Leadership, which recorded the lowest dimension score. The individual dimension scores signal that strategies to mobilise MOW community readiness require greater efforts in addressing leadership and community climate.

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Having conducted the CRM with MOW key informants interviews and ascertained the CRM stage of readiness, the next step focuses on increasing community readiness. This is achieved by using the specified stage of readiness to develop appropriate strategies, which aim to increase the level of readiness and in turn further mobilise the community to bring about change. It is important to note, as previously discussed in the limitations of this study, that for the purpose of this research project, the implementation of the strategies are outside the remit of this current project.

Guidelines to develop strategies were documented for the community research partner. A brief account of the strategies is provided to give insight into the content and process. The goals and general strategies for each stage of readiness are included in Appendix U, with the goals and general strategies for Stage 4; Preplanning is outlined below, with additional contributions made to the original strategies through greater inclusion of social marketing efforts that further extend the strategy efforts.

The application of the CRM to the MOW community provides the opportunity for the key MOW stakeholders to work collaboratively at micro and meso-levels to bring about societal change. By adapting and applying the general strategies outlined above and through facilitating plenary community groups the MOW service can develop a systematic and sustainable approach to increasing the levels of community readiness, leading to a more open and collaborative service. The general strategies have an additional level of community relevance where the social marketing intervention mix, as outlined in Table 4.1 is linked to each of the strategies, allowing for a more tailored set of strategies relevant to the MOW community.

Table 4.2: Extended Goal and General Strategies for the Preplanning Stage

Preplanning Goal	Preplanning general strategies	Intervention Mix Tool
Raise awareness with concrete ideas to combat condition	Stakeholder mapping and management to establish key stakeholders in the community	Physical evidence
	Undertake competitive analysis with stakeholders	Price, Place
	Visit and invest in community leaders	People
	Introduce information about the issue through presentations and media	Promotion
	Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts	Place, People, Process, Physical evidence
	Conduct local focus groups to discuss issues and develop strategies	Physical evidence
	Knowledge generation, transfer and exchange through target audiences and stakeholders	Promotion, Process
	Increase media exposure through radio and television public service announcements	Promotion, Process

Source: (Adapted from Plested et al., 2006; Booms and Bitner, 1981).

This section has examined the CRM score following application of the model with MOW key informant interviews. The next section takes these findings further, by examining the key themes to emerge from the key informant interviews.

4.6 Themes

In addition to the scoring of the CRM questions, a further level of analysis was conducted to provide more in-depth insights into the key informant interviews. Three common themes emerged from the key informant interview data, Information deficit, service transition, and provision gaps, which will now be discussed.

4.6.1 Information Deficit

The most common issue to emerge from the key informant interviews was an information deficit in relation to MOW. This theme of information deficit is discussed in relation to MOW users and MOW stakeholders.

Information Deficit: MOW Users

There was a sense that a general lack of information existed about MOW, in terms of what MOW offered, eligibility for the service and how to start using MOW. Similar issues, particularly around eligibility, were also common to the groups of potential MOW users, as outlined in the previous section:

“They’re not aware of it. They are certainly not. I mean, we think they are but they are not. Not alone that, it’s difficult to get the information of who to contact. I’d say if you went into a GP and asked where’s the nearest MOW and how would I go about getting it, I don’t think they’d know. And the other thing is, the older person would never instigate it, I’ve a feeling they’d do without it rather than instigate it” (KI 4).

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As well as a lack of awareness from health care professionals, as outlined in the previous example, there was also an assumption that family members or neighbours were aware of MOW:

“It’s possible that they mightn’t know how to start using MOW alright, now having said that if any of them saw the van coming you’d think would a neighbour tell them or maybe a son or daughter” (KI 12).

Information Deficit: MOW Stakeholders

There was general consensus that there was a lack of information about MOW. This lack of information includes lack of clarity in relation to MOW user eligibility, uncertainty about what MOW services are offered in different geographic areas and insufficient knowledge into information channels used by the older population to access information in relation to the MOW:

“Well, I’d say lack of awareness might be the main one, you know, I think it’s in the church newsletters and that, as far as I know, and the public health nurses. But for whatever reason I think there certainly is room for development, particularly in rural areas” (KI 12).⁶

This lack of information on MOW was also reported as an issue by key informants, some of whom were involved in making MOW referrals. Some key informants described how a lack of information was affecting the likelihood of making referrals, due to inadequate information relating to issues such as geographic areas where MOW are and are not provided, along with a point of contact for MOW services in different areas:

⁶ “KI” refers to the key informant interview participant

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“I think it could be highlighted a bit more, I must say. How could we highlight it? Well we always go back... but a notice board in the waiting room still works. Now, clearly for complex patients generally they are reasonable attenders, you know if anything they are on the high attenders’ side. So I think ya, I think it could be improved” (KI 12).

Health professionals also sought greater information in relation to how to access MOW providers for specific geographical areas:

“It would be very useful for me to know what MOW services were in an area immediately, and how do we access the service. I know as a professional working in the area that would be very useful for me, because it could take me five phone calls before I can track down who does MOW. I’d also be interested to see where the gaps are, I’d love to see that, so at least when I am looking I can see what services are available in each area. And it would also highlight the areas where there are gaps in the service” (KI 8).

As well as a lack of information on where MOW is provided from a geographic perspective, a lack of information on MOW in relation to issues such as MOW eligibility and payment was also identified, where key stakeholders felt there was a need for new ways to disseminate MOW information to potential MOW users:

“We don’t have a ready supply of MOW information for them (older people) no, we mention it to them and pass on the number. We have other leaflets for new Mums and that. It’s handy to have them in your bag for when you are going in. And especially for the elderly, they forget, you’re writing notes down for them and they are forgetting numbers and things like that as well” (KI 5).

Additionally, a deficit was evident in relation to information sharing between MOW providers and other organisations and services, as emphasised by several

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key informants. A specific example of this relates to information sharing between MOW and organisations which provide social support for older people, particularly in relation to increasing awareness in detecting cases of concerns or mistreatment of older people:

“There could be a need for the MOW drivers to be training in recognition of issues and older people’s needs... if someone delivers a meal, which has built up a relationship with the client, and they disclose sometimes to the driver, so that they have an awareness to flag any issues, I mean they are a great source on the ground from a monitoring perspective” (KI 8).

Furthermore, a lack of health care professionals working together was identified, presenting a potential barrier to disseminating MOW information:

“Sometimes they (GPs) don’t realise that it (MOW) is there, it’s only with us (PHNs) promoting it and giving them information and coordinating with the Home Helps, let’s say to tell the Home Help that the meal has been delivered and can they heat the meals for them” (KI 5).

This lack of information and awareness about MOW from a variety of health care professionals who act as service intermediaries for MOW, acting as distribution channels for information indicates an example of a weakness from the promotion element of the social marketing mix.

Having discussed the theme of information deficit that emerged from the key informant interviews, the next section looks at the theme of service transition.

4.6.2 Service Transition

Several elements of service transition were evident from the key informant interview data, which reflect the transitions in the MOW service. Such elements that will be discussed are the impact of health service changes on MOW, changes in MOW perceptions and MOW provision.

Impact of Health Service Changes on MOW

The impact of health service changes was strongly evident from the key informant interviews. The negative impact of recent reductions to home care support for older people, as documented by the key informants, saw the reduction of Home Help hours and Home Help duties restricted due to time and budget constraints. Changes to the role of the Home Help, impacted on the role of MOW. Based on the consultation with current, former and potential users in this research, it is evident that in order for MOW to best meet client needs and preferences, the decision to use MOW must be an option and a choice made freely by the older population, whether it is for nutritional, social or lifestyle reasons. However current practice goes against this concept, Home Help changes have lessened the service being seen as an option, with reduced Home Help hours and duties seeing some older people being left with no alternative but to use MOW, as Home Helps are no longer supported to prepare food for older people in their own home due to financial and time constraints:

“We have an issue as well at the moment around Home Helps and cooking in the home, and we are moving away from sort of a house hold duty the more personal care element of it, that again is because of resources, and while there is a lot of value in cooking a meal in a person’s home and in taking that away and suddenly having a meal just brought in” (KI 2).

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Other challenges faced by MOW reflected a lack of funding and resources, particularly with the current difficult economic climate. This lack of funding and resources was seen to impact on the use of MOW as a means of monitoring the health and social situation of older people. This reiterates the need for greater resources to ensure that MOW was provided to people as and when needed, in an attempt to limit minor health issues developing into complex issues:

“With regard to the PHNs, they are so under resourced at the moment. There could be a lot of elderly people in need of MOW that may not be on the radar, unless they have something that warrants the PHN calling to see them for things like dressings or incontinence issues or whatever” (KI 3).

Further issues that impacted on MOW services were limitations to HSE mileage expenses. Reduced HSE expenses particularly affected older people in rural areas, as Home Helps were no longer in a position to prepare food in older people’s homes. This presented a challenge in relation to older people’s decisions and choices in how nutritional needs are met, where a sense of choice about using MOW is impacted by a reduction in home care supports for older people, particularly those living in rural areas. Ideally, older people would have several options for home care support that meet their nutritional or social needs. However with reduced funding, older people are losing a voice in making decisions about their health care needs:

“There has been such huge cut backs with the home help service, travel is a huge thing, and the length of time it would actually take to prepare a meal, we hadn’t got the time for it, so what we would do is we’d say there are lots of super markets that prepare a cooked hot meal, and if they had an account in the local supermarket the home help would go up, pick it up and bring it to the client” (KI 3).

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With HIQA (the Health Information and Quality Authority) anticipated to commence reviewing community health services in the coming years, MOW services will face closer scrutiny. Several participants felt that this would negatively impact on the MOW service:

“I suppose the other part of it is that we are going to be audited by HIQA, and, I mean, I think if they [HIQA] do go down to the client with the Care Plan, if there is a Care Plan and see that a person got MOW, I think it will start to open up an awful lot of questions” (KI 9).

The effects of reduced funding for community based health service such as MOW resonates with the social marketing mix from the aspect of *place*, with the provision of MOW affected due to lack of funding, which was seen to directly impact MOW users and MOW stakeholders. This challenge provides the opportunity for MOW providers to work with MOW users to develop innovative and client led approaches of overcoming the shortfalls of the current service.

Stigma as a MOW Barrier

The matter of stigma was evident from the key informant interviews as an on-going issue. Interestingly, the key informant interviews identified three primary sources of stigma amongst older people: stigma from MOW users, families and neighbours. The association of stigma in the family and neighbour contexts had previously been documented in the literature. This newly identified source of stigma identified was with families of older people. Several respondents cited the embarrassment felt by families as a potential barrier for a family member to use MOW:

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“Pride, I presume, maybe a family might tell them that they don’t need to get the meals delivered, maybe their daughter doesn’t like the idea that someone is coming to the door to feed them, you have to look at it like that as well” (KI 11).

Furthermore, the issue of stigma associated with using MOW and users’ neighbours was also discussed as a barrier to MOW use. Several key informants noted that older people, in both urban and rural areas with were unhappy to avail of MOW due to fear of their neighbours seeing the meals being delivered:

“Well, it’s my opinion that they (MOW users) might feel that they mightn’t like a neighbour seeing the van pull up. Now, it’s just from experience I feel that it might be an attitude, especially in rural areas (KI 12).

Key informants alluded to the charity origins of the service as being a potential source of stigma:

“There is still a residual stigma attached I think to having food delivered by MOW services, because they tend to have this image of it being back in the sort of 50’s when it was a free service and it was given to people who were poor, particularly in the more rural areas, people don’t particularly like the idea of it” (KI 7).

Generally, the term MOW was perceived positively by key informants, reflecting findings from earlier phases of research that the name MOW isn’t an issue for the majority of current and potential MOW users. However one key informant did have concerns regarding the name of the service:

“To a person who is living in a neighbourhood and has all sorts of ideas about stigma and charity and stuff, it’s one I’d avoid you know. Am, that’s why I like services that don’t use the words MOW, I think they have gone the right way

there, if you are an older person you can be very sensitive towards it you know” (KI 1).

4.6.3 Gaps in Meals on Wheels Provision

A fragmented and ad hoc approach to MOW provision was a common feature in the key informant interviews, with a number of key informants observing the lack of consistency in where MOW was available across urban and rural Galway. In particular, due to the lack of MOW in certain rural areas, older people in these areas are not offered MOW. A number of respondents suggested that this was due to the high cost of delivering a small number of meals to people living in remote areas:

“You could have certain pockets where there is absolutely no service, it hasn’t been developed at all, and that’s where there is a great difficulty there, am, and it sometimes has to be set up in a voluntary basis and it just hasn’t started up, then that leaves a big gap really” (KI 8).

In rural areas, a combination of approaches to MOW provision is adopted, comprised of using local volunteers and local food establishments to bridge the gap created by a scarcity MOW services:

“In rural areas then there would be a miss-mash of services, it can be done through the Home Help service who pick up meals from local pubs, in another area a local lady makes meals and goes around delivering them, then in other area sit could be yes something else. In some areas there is no services, you know in very rural areas, maybe where Home Helps won’t go out that far, that’s a difficult as well” (KI 8).

Chapter Four: Findings

Based on the research from the perspectives of current, former and potential MOW users as well as the majority of the key informants, it would seem that the current MOW approach is not sufficiently meeting the needs of older people. A more flexible MOW approach is required, where users have a greater choice in how MOW are provided. However, due to funding and resource issues this is not currently an option, particularly in rural areas:

“Some areas are more covered than others; obviously there is no MOW on the islands. What we do because it works in a lot of other areas, the Home Help calls into local shops or hotels. Some people object to that, they want it cooked in their own home, but it takes us too long to cook the meal in the home, it would be a great social service for the people getting the Home Help, but we don’t have, it’s an unfortunate thing to say, but we don’t have the time to do that” (KI 4).

Concerns raised by MOW key informants regarding the lack of MOW availability in some rural areas resonate with the *process* aspect of the social marketing mix. This highlights inadequacies with the range of MOW facilities available, which in turn have a knock on effect on the delivery of MOW.

This section has examined the data from the CRM key informant interviews, which firstly examined the CRM score assigned to the MOW community. An overview was provided of the implications of the *Preplanning* level of readiness on the MOW community, and what can be done to mobilise the community to a higher level of community readiness. Further context was added to the CRM score by examining the most common issues to emerge from each key informant interview, which focused on the issues of a lack of MOW information, the negative impact of health service challenges on MOW and the stigma associated with MOW. With the principal findings from the empirical research outlined, the next section provides an overview of the findings from the secondary data analysis.

4.7 Secondary Data Analysis

As outlined in Chapter Three, secondary data analysis of HSE questionnaires was conducted to contextualise the findings of this research, as well as to add rigour to the findings through this additional perspective of MOW. In 2010, the HSE disseminated a questionnaire to each service in receipt of the HSE Section 39 grant funding, for services that provide either MOW or centre-based meals. The questionnaire administered was developed by Timonen and O’Dwyer and used in a study on MOW (Timonen and O’Dwyer, 2008). A copy of this questionnaire is presented in Appendix K.

The first question of interest related to MOW referral pathways:

Q.14. *Which of the following refer clients to the meals-on-wheels service most often? Using the numbers 1-4, please put the following in order, where 1 is the most common source of referral and 4 is the least common.*

Figure 4.5: Referral Pathway

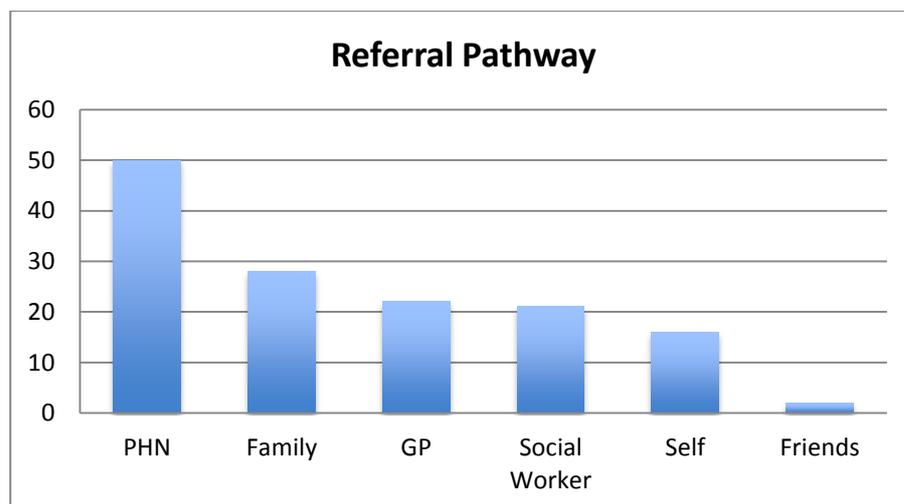


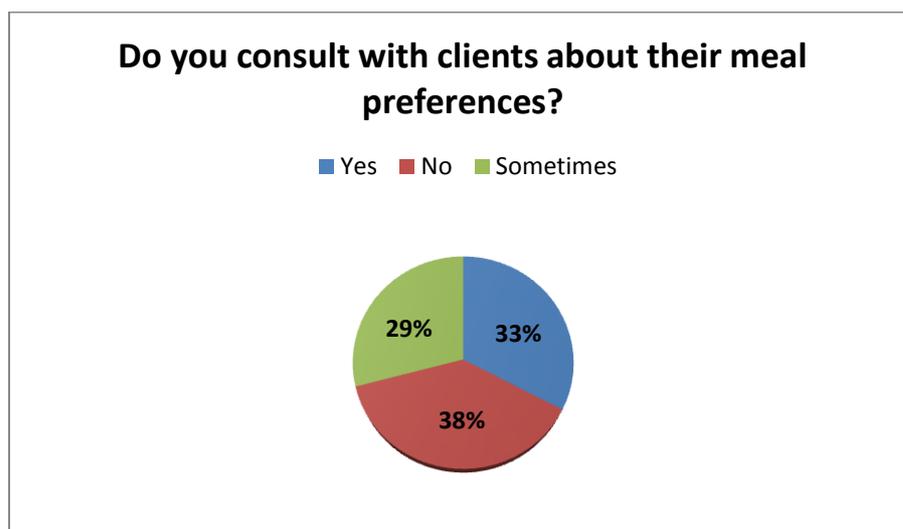
Figure 4.5 indicates that the principal referral pathway to MOW from the perspective of MOW providers were Public Health Nurses (PHNs). Forty-two respondents identified PHNs as the main source of referrals. This HSE finding

resonates with the views of current MOW users in the empirical FG phase of this study, which identified the PHN as the main MOW intermediary. Although the role of the PHN is identified from this doctoral research as an influential role, previous research highlighted that PHN's do not identify themselves an important stakeholder in MOW services (Timonen and O 'Dwyer, 2008).

The second question of interest examined client consultation with meal preferences:

Q. 28. *Do you consult with clients about their meal preferences?*

Figure 4.6: Client Consultation



The response rate for Q.28 which examined client consultation in relation to meal preferences showed that the majority (n=18) of MOW providers did not consult clients about meal preferences. Those who said that they did consult clients stated that the extent of consultation regarding to meal preferences was limited to establishing "extreme dislikes".

The third question of interest addressed the type of meal delivered and if choice was offered in relation to the meal type:

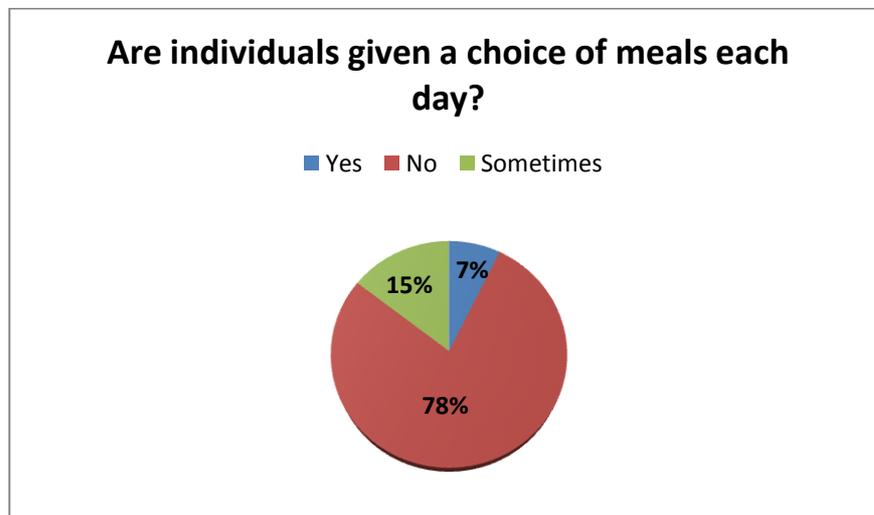
Q. 29 (a) *Are the meals delivered to client's homes; Hot, Cold or Frozen/Chilled or is a choice provided?*

All of the MOW providers (n=55) stated that hot meals were the sole type of meals offered. This indicates that the chilled meal approach is still an emerging option with MOW providers in Ireland. This finding further illustrates a lack of choice in relation to different approaches to MOW, where a lack of client focus and personalisation is evident. The low response rate (n=7) relating to those who answered whether or not a choice of meals is provided further indicates a lack of choice for clients.

The fourth question of interest looked at meal choice provided:

Q. 30. *Are individuals given a choice of meals each day?*

Figure 4.7: Daily Meal Choice



The lack of choice in daily meals reiterates the lack of client consultation in MOW, specifically in the choice offered in relation to daily meal options.

The fifth question of interest related to special dietary needs:

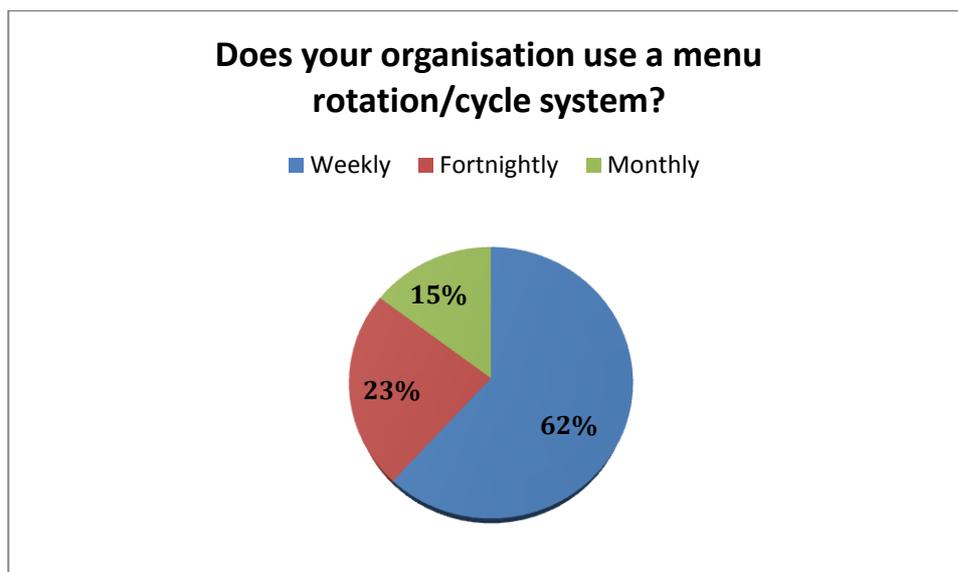
Q. 31. *Do you cater for special dietary requirements?*

The majority (n=40) of MOW providers failed to answer if special dietary needs were catered for, which suggests a lack of consultation with clients. This low response level indicates potential negative health implications whereby dietary requirements, such as diabetes or a low sodium diet, were not investigated or identified by MOW providers.

The sixth question of interest looked at rotation of menus:

Q. 33. *Does your organisation use a menu rotation/cycle system?*

Figure 4.8: Menu Rotation System



While some MOW providers (n=36) indicated that they do provide of a menu rotation service, specific information into the types of rotation were not provided, meaning that it is difficult to establish from the data the level at which rotation was conducted.

Chapter Four: Findings

The seventh question of interest referred to systems for feedback and complaints:

Q. 37. *Does your organisation have a system in place for taking feedback / complaints from clients?*

While some MOW providers (n=38) were found to have a system in place for receiving feedback and/or complaints from clients, specific information in relation to the feedback processes in place or the frequency of use was lacking. Further clarity is required in relation to the number of providers who claimed that they did provide a system related to service feedback, service complaints or both of these.

Overall, the secondary data analysis presented contextualises the empirical research in responding to the central research question of this study. Of particular significance is the issue of lack of choice and options for MOW users, where no opportunity was provided for MOW providers to select hot or chilled meals, resonating with Phase One findings concerning a lack of flexibility in the service, as well as a failure to recognise and respond to the lifestyle role of MOW. A lack of regular consultation with MOW users, particularly in relation to altered dietary preferences was identified in both the secondary data analysis and in the primary empirical research was identified primarily by MOW users as opposed to MOW stakeholders. Although several providers stated that a feedback system was in place for MOW users, it was unclear to what extent this was operationalised. This indicates a need for this area to be further examined, particularly in light of the importance of such feedback mechanisms, which were identified in this research by current MOW users as well as key stakeholders in MOW.

4.8 Summary

Chapter Four has set the scene for Chapter Five, the Discussion Chapter, by presenting the main trends and arguments from the data, as outlined earlier in Table 4.2. This chapter used insights from the research findings to answer the central research question, detailing the themes that have emerged and the assigned CRM scoring. This chapter has added to the body of knowledge associated with MOW research, contributing new and varied perceptions of MOW from the perspective of current and former MOW users. Issues around information deficit and service transition were also highlighted; particularly in relation to MOW eligibility criteria and concerns relating to reheating MOW meals.

This chapter also detailed the perception of potential MOW users, where potential barriers to future use of the service were identified as a perceived lack of choice, negative perceptions and reheating meal concerns. Insight into MOW stakeholders illustrated a community readiness score of *Preplanning*, as well as more insightful understanding into the stakeholder perspective, highlighting issues around information deficit, service transition and gaps in MOW provision. This chapter, by examining primary and secondary data sources, has identified specific issues with MOW, which are reflected in both sets of data.

The findings presented in this chapter are further examined with reference to the central research question of this study in the final chapter, Chapter Five.

Chapter Five: Discussion, Conclusions and Recommendations

5.1 Introduction

This thesis has explored what key stakeholder behavioural changes are required to facilitate MOW to support an ageing Irish population. This Chapter reviews the main findings, combining results from the different methods used in this study and considers the findings in light of existing knowledge in the different areas of interest. In this concluding Chapter, the overall research purpose will be discussed, whereby the central research question and objectives will be addressed in relation to contributions to theory, methods, policy and practice. The limitations of the study as well as future research directions will also be discussed.

5.2 Purpose of Thesis

The purpose of this study was to explore the key stakeholder behavioural changes required in a MOW community. The key behaviours were explored by examining MOW from the different perspectives of current, former and potential MOW users as well as key stakeholders within the MOW community. A client-centred, multi-stakeholder approach was undertaken, encompassing a micro and meso-level view in response to the overarching research question: *'What key stakeholder behavioural changes are required to facilitate Meals on Wheels services to support a growing and diverse older Irish population?'*

Following a review of literature on Social Marketing, MOW and Irish social policy for older people, as presented in Chapter Two, the following research objectives assisted in responding to the research question:

Research Objective 1: To establish the role of social policy in MOW services in Ireland.

Research Objective 2: To determine how MOW services are perceived by the older population of current, former and potential MOW users in Ireland.

Research Objective 3: To establish what community social marketing efforts exist relevant to MOW services.

Research Objective 4: To adapt and test a community social marketing model suitable for wider application to different MOW services in Ireland.

Research Objective 5: To establish the levels of readiness to change of key stakeholders involved in MOW services.

In light of the central research question and research objectives, Table 5.1 identifies the research approach utilised. This table outlines how each of the research objectives was addressed, indicating the method and form of analysis used. Table 5.1 builds on Table 1.1 (Research Gaps) to provide an overview of the main findings relating to each research objective.

The next section examines the relevance of the findings by locating them within existing research knowledge.

Table 5.1: Bridging the Research Gap

Research Gap	Research Objective	Method	Analysis	Finding
Lack of literature on community social marketing applications to behavioural ecological issues in MOW	To establish what community social marketing efforts exist relevant to MOW services	Literature review	Critical Literature Review	Identification of the dominant community social marketing models in SM literature
Lack of mapping of social policy origins and developments on MOW in Ireland	To establish the role of social policy in MOW services in Ireland	Literature review	Critical Literature Review	Irish social policy for older people key events mapped and used to identify the role in MOW development, Identification of changes and challenges faced by MOW
Limited research on MOW use and experiences from a micro-level, with current and former users	To establish how MOW services are perceived by the older population of current and former MOW users in Ireland	Qualitative semi-structured interviews	Thematic analysis Analytic memos	Information deficit with users, Lack of client centred approach, Stigma remains prevalent, Role of volunteers impacting on service perception, Social, monitoring and lifestyle roles of MOW

<p>Limited research on MOW use and experiences from a micro-level, with potential MOW users</p>	<p>To establish how MOW services are perceived by the older population of potential MOW users in Ireland</p>	<p>Focus groups</p>	<p>Thematic analysis Analytic memos</p>	<p>Negative perceptions of MOW, Barriers; lack of choice, loss of independence, sense of failure, Lack of awareness on MOW entitlement, Health concerns regarding reheating meals</p>
<p>Limited application of the CRM in multi-stakeholder communities</p>	<p>To adapt and test a community social marketing model suitable for wider application to different MOW services in Ireland To establish the levels of readiness to change of key stakeholders involved in MOW services</p>	<p>Key informant interviews</p>	<p>Anchored rating scales Thematic analysis Analytic memos</p>	<p>MOW CRM assessment readiness score, Information deficit with MOW stakeholders: impacting on referrals to the service, Lack of MOW information and materials for dissemination, Lack of MOW information amongst the MOW community, Negative impact on health service challenges on MOW</p>

5.3 Discussion of Research Findings

The empirical research component of this thesis sought to address the central research question and the research objectives of this study. In this section, findings arising from the empirical research are discussed to illustrate how and where the study's findings complement or contrast with existing knowledge. To assist with this, particular focus is given to four dominant themes emerging from the study: information deficit; client-centred approach; varied roles of MOW and service transition.

5.3.1 Information Deficit

The first key theme to be discussed relates to the existence of an information deficit, which was evident in all three phases of the research (semi-structured interviews, focus groups and key informant interviews). Current, former and potential MOW users, as well as MOW stakeholders, identified lack of information as an issue. Lack of information about MOW amongst older people, such as eligibility criteria, has previously been shown as a barrier which prevents older people from using MOW (Wilson and Dennison, 2011; CMDHB, 2007). This research has contributed to this body of knowledge, outlining additional sources pertaining to how a lack of information presents a barrier to older people using MOW services.

There was strong evidence of a lack of information and awareness around the issue of reheating meals provided by MOW, with health concerns expressed in relation to having to reheat meals using microwave ovens. This barrier to MOW services offers new insights into perceptions and potential changes required to ensure older people's health concerns are acknowledged. This insight not only identified the effect of a lack of information on the likelihood of older people using the service, but also its effect on the likelihood of MOW stakeholders

making MOW referrals due to this information deficit. This finding indicates a need for behaviour change from the perspective of MOW users and stakeholders, where greater efforts are required to understand barriers to using MOW for users and emphasising the importance of preparing and disseminating clear and accurate information on MOW. An example of a behaviour change programme could be for MOW providers - or other community stakeholders, such as active retirement associations - to facilitate demonstration classes and cooking classes to raise awareness and inform older people on microwave usage in order to overcome this particular barrier to using MOW.

Through the application of the CRM with key MOW stakeholders, findings showed disparities between where stakeholders perceive that older people source information on MOW services and the actual sources older people use to seek information. One such example saw a MOW stakeholder who was a health care professional discuss the use of internet search engine Google to seek information on MOW services. This pointed to a distinct mismatch with older people, where local media were the dominant source of information; most older people involved in this research did not have access to, or proficiency in, using the internet. Such findings indicate the need for intermediaries involved in disseminating MOW information to reassess the distribution channels from a collaborative perspective, involving current, former and potential MOW users in the shaping and co-creation of developing and sharing of MOW information. In this respect, broader policy goals associated with promoting digital inclusion are also relevant. Policy and practice orientated towards encouragement and familiarity amongst older people with relevant digital technologies can potentially assist in overcoming this particular barrier to use of MOW.

This study supports previous findings that have shown a lack of collaboration relating to inter-departmental and local level co-ordination as being a barrier to community-based services such as MOW (NESF, 2005). This is similar to previous

research, which found deficiencies in collaboration between formal and informal care providers in community-based services (Considine and Dukelow, 1999). The application of the CRM facilitated collaborative efforts in the MOW community as opposed to traditional hierarchical efforts, which lends new insights into the collective approach. Furthermore, this study provides specific information on the effect of an evident lack of clarity on what MOW efforts exist in specific geographical areas in creating a barrier to increasing referrals to MOW.

5.3.2 Client-Centred Approach

The second research theme to be discussed concerns a client-centred approach in MOW. The findings from this research echoed those of previous studies (Timonen and O'Dwyer, 2008) in relation to the need for MOW services to have a greater focus on the client. Due to the multi-level perspective applied in this study, the findings were able to contribute further to this area by comparing the perspectives of MOW users and a range of MOW stakeholders. Interestingly, while the issue of a more client-centred service featured strongly from the perspective of older participants, it was largely absent from the perspective of stakeholders. This suggests that a gap remains between the behaviour of some MOW key stakeholders, in both the thoughts and actions towards a client-centred approach to MOW services.

While the first Irish report into MOW recommended that a regular feedback system for MOW users was required to bring focus to MOW users (Timonen and O'Dwyer, 2008), this study found that where feedback systems were in operation, they were not always being used appropriately. This finding was evident in the empirical research as well as in the secondary data analysis. In most cases, feedback was only sought several months after users had begun using the service, with a lack of regular follow-up consultations evident thereafter. Taking these findings further, the implications of such feedback

discrepancies can be seen in clients' decisions to stop using the service, where a lack of consultation on changes to the service led to some people withdrawing from the service.

A lack of sufficient client consultation relating to meal preference was also identified in interviews with MOW clients. In this study, this critique was directed in particular towards MOW providers offering chilled meals as a substitute for hot meals. This is especially pertinent in the cultural context of Ireland, where a hot meal at midday continues to be highly valued by older people. Although this approach can provide significant financial and time benefits for the MOW service (Krester et al., 2003), the option was typically not well received by older participants in this study. Indeed, while a negative reaction to chilled meals in MOW has been identified previously (Powys, 2007), the significance of this change appears to have increased for current service users. The requirement for MOW users to be consulted on changes in the MOW service remains as important as ever.

MOW service users also expressed a desire to have greater choice in order to satisfy their personal preferences concerning features such as meal type, meal temperature and delivery time. A client-centred approach that encompasses a broader more personalised support structure for older people can assist in meeting this stated need. Furthermore, from a behavioural perspective, there is value in engaging older people more effectively in relation to changes to the types of meal offered by MOW. One way in which this could be achieved would be for a stronger rapport to be developed between MOW providers and potential MOW users. While providers might seek to establish a sense of trust and place greater focus on initiatives such as trialling service delivery options in consultation with service users, it is incumbent upon potential MOW users and their family members to be willing to engage with community services on the

basis that not all personal needs and preferences can be met when resources are constrained.

This study revealed what can happen when a client-centred approach falls short or when consultation with MOW users fails to occur. For example, a lack of regular communication and consultation about personal preference and dietary or health changes meant that one MOW provider was unaware of a user having been diagnosed with diabetes. The MOW user in question was concerned that the service provider would be unable to meet the change in dietary circumstances, pointing to a lack of information sharing and client monitoring. While an isolated example, this finding aligns with previous research that identified the need for an on-going focus on each individual client's specific nutritional needs (Winterton et al., 2012). Such information deficits have implications for behaviour change efforts, illustrating the need for MOW to adopt and adhere to a systematic and regular information sharing process. They also identify a need for MOW users and their family members to make use of opportunities that are available to inform MOW providers of their changing personal circumstances.

The findings in relation to shortcomings in client-centred approaches to MOW services emphasise the importance of adopting complementary social marketing efforts to address such issues. A citizen-centric focus is at the core of social marketing (French, 2011). This study's findings have moved beyond an individual behaviour change focus to other levels, adding weight to the changing emphasis adopted in recent social marketing research (Cairns and Rundle-Thiele, 2014; Luca and Suggs, 2013). This extended approach captured the disparities between the behaviour of MOW stakeholders and the older population. The disparities identified relate to a client-centred approach, which is an issue of concern for MOW users, yet did not feature strongly in accounts of stakeholders in the service. The CRM score of *Preplanning*, which recognises that something must be

done, yet efforts are not focused or detailed, further illustrates this. The CRM score and the proposed strategies to mobilise behaviour levels from this study take into account broader social issues that impact both on behaviour and behaviour change, where an awareness is on the interaction of individuals in the social environment where behaviour takes place (Fry, 2014; Lefebvre, 2012; Wymer, 2011; Szmigin et al., 2011).

5.3.3 Multiple Roles of Meals on Wheels

The third research theme to be discussed relates to the multiple roles of MOW, with the research presented here contributing to existing knowledge about the roles of MOW. Previous research in MOW has primarily examined the service's nutritional role (Keller, 2006; Millen et al., 2002; Shoviv and Geoghegan, 1997). While this research accepts the centrally important nutritional role of the service, with MOW perceived by users as a nutritious and healthy food option, the emerging social role of the service identified in the literature (Winterton et al., 2013) has been reinforced. The social role of the service strongly resonated amongst service users and was cited as being of key importance to users. The findings also extend the scope of MOW roles beyond the previously identified nutritional and social roles, through two additional aspects; a monitoring and lifestyle role, which is an emerging concept in the area of home care support and monitoring (Alwan, 2009). The lifestyle role reflects the transition in MOW services, where for some older people, MOW services are seen not in the traditional sense of a meal being delivered, but as a food choice based around lifestyle and convenience. This role represents broader changes taking place, where the perception of the service is moving away from traditional charity connotations to a lifestyle choice. An example of this role shift can be seen where one user orders additional meals for visiting family members. This emerging role of the service contributes to the literature as a new role reflective of transitions in the service.

The reassurance provided by using MOW, where users have a sense of reassurance knowing that the MOW service provides a monitoring aspect, is an area that warrants further investigation. Although the monitoring role was not explicitly mentioned by research participants, the implied role emerged from data analysis. From a broader health monitoring focus, MOW users relied heavily on this aspect of the service. The monitoring role of the service, if harnessed, has the potential to assist in ensuring that older people have sufficient supports and to assess any changes in individual circumstances, thus helping older people to remain living in their own home independently. This monitoring role reflects previous suggestions that a greater emphasis on this area is required from a MOW provider and health care perspective, which these findings extend to illustrate as a current topic of relevance for service users.

5.3.4 Service Transition

The fourth research theme refers to a service transition in MOW. The dominant issues from the findings that relate to service transition focus on issues of stigma and changes in the health service. In relation to stigma, the stigmatised nature of MOW has been identified in previous research, with more recent findings indicating that this issue was becoming less of an issue of concern for MOW in Ireland (Timonen and O'Dwyer, 2008). Contrary to such reports, this study found that stigma remains an on-going issue in relation to MOW services. Not only did older people, in both urban and rural areas, display awareness of the issue of stigma, but the findings also extend this issue to other sources, such as families and neighbours. The stigmatised nature of MOW service use presents an additional barrier that confronts the MOW community. Stigma related to feelings of pride and embarrassment, with some individuals unhappy for family members to be seen to use the service. This contribution provides a deeper insight into the rooting of stigma beyond direct MOW users.

Payment for meals emerged as a factor that appeared to reduce stigma associated with using MOW services. This finding aligns with Timonen and O'Dwyer's (2010) earlier study in Ireland, suggesting that this approach is continuing to cast the service in a positive light. However, findings also indicate that the lack of awareness of MOW information, such as payment methods, posed a challenge to implementation of the service. Inadequate information and a lack of clarity in this area were evident amongst potential users and stakeholders involved in delivering the service.

Challenges, particularly related to funding in the wider health service, were also seen to be significant. In particular, reduced funding was seen to limit the role, availability and duties of Home Helps, which have seen significant reductions in the amount of time allocated to provide support to older people. The reduced role of Home Helps was seen to present particularly significant challenges for older people living in rural areas.

This reduction in care hours has limited the scope of duties provided by Home Helps to providing assistance with only the most essential tasks. Such tasks are predominantly focused on activities of daily living, such as assistance with personal hygiene, getting out of bed and getting dressed. As a result, the role of the Home Help in preparing food has changed, with many older people no longer having the option of having a meal prepared or receiving assistance in the preparation of a meal in their own home. This change, reflecting attempts to contain public expenditure in the wake of Ireland's economic downturn, has significant implications for MOW services. In this context, stakeholders were quick to voice the dissatisfaction of older people with such service retrenchment.

Older people who no longer have a Home Help to assist in meal preparation, due to reduced Home Help funding, are left with limited options for social and nutritional assistance. MOW offers the potential to provide a more efficient use

of resources if MOW continues to move towards a public-private partnership model. However, challenges faced by MOW warrant attention to ensure that the service can be offered and provided to older people throughout the country, which currently is an issue. As seen previously, there is an on-going problem in relation to gaps in MOW provision throughout Ireland. This raises concerns for older people who no longer have Home Help support to prepare meals, and who lives in communities without MOW services. This also changes how MOW are perceived and the client base, taking a step backwards from a service that is focused on ensuring a service tailored to client needs and choice.

These findings are significant in terms of providing insights into the effects of health service challenges on the MOW service. The altered role of MOW services, which is distanced from the client-centred focus of MOW services, indicates that MOW services could potentially see a new cohort of users emerging, for whom MOW is not a preferred nutritional option. This finding speaks to MOW services competition, which can be seen to include efforts such as local hotels, pubs and shops being used to assume the role of MOW services. This is particularly relevant in rural communities in which MOW services are under-developed. MOW stakeholders are challenged to understand and meet this cohort's needs and preferences. Exploring potential alternatives to existing MOW services warrants further investigation, but was beyond the scope of this study.

To summarise the study's key findings, the principal areas for consideration by different MOW stakeholders as well as by older people are outlined in Table 5.2. The Table indicates specifically what is required to bring about behaviour change in the MOW community, both from the perspective of MOW stakeholders, as well as from that of older people. Drawing further on this and based on the study's findings and a critical review of relevant literature, Table 5.3 acts as a signpost to guide the complex process of behaviour change with MOW key stakeholders by identifying specific behaviours warranting change from MOW

key stakeholders, with behaviour needs segmented into the following sectors to maintain respondent anonymity; state, community, MOW provider and health care professionals.

Table 5.2: Extended Goal and General Strategies to Address MOW Key Stakeholder Behaviour Change

Preplanning Goal	Preplanning general strategies	Intervention Mix Tool	Required Behaviour Change
Raise awareness with concrete ideas to combat condition	Stakeholder mapping and management to establish key stakeholders in the community	Physical evidence	Greater rapport across the MOW community, community members and stakeholders
	Undertake competitive analysis with stakeholders	Price, Place	Greater focus on client orientated service
	Invest in community leaders	People	Increased client centred focus, Feedback loops
	Introduce information about the issue through presentations and media	Promotion	Accurate and up-to-date information on MOW with MOW intermediaries
	Review existing efforts in community to determine who the target populations are and consider the degree of success of the efforts	Place, People, Process, Physical evidence	Segment target audience using the three perceived roles of MOW
	Conduct local focus groups to discuss issues and develop strategies	Physical evidence	Client-consultation with segments of target audience
	Knowledge generation, transfer and exchange through target audiences and stakeholders	Promotion, Process	Greater rapport with the different stakeholders involved in the MOW service
	Increase media exposure through radio and television public service announcements	Promotion, Process	More client orientated and segmented target audience specific information channels

Source: Adapted from Plested et al., 2006; Booms and Bitner, 1981.

Table 5.3: Key MOW Stakeholder Identified Behaviour Change Needs

Sector	Identified Behaviour Need
State	<ul style="list-style-type: none"> • Increased financial support from the HSE for MOW services • Greater provision of MOW services; fill current gaps in MOW service provision • Recognition of reduced funding and impact on MOW services • Greater resources to support older people’s meal preferences
Community	<ul style="list-style-type: none"> • Building rapport with older people in the community • Greater awareness of MOW services amongst the older population • Increased efforts to build community efforts and mobilisation with MOW providers and the community • Increasing the awareness of MOW services in operation amongst the community • Address issues of stigma towards MOW services • Explore different approaches to disseminating MOW information to older people
MOW Providers	<ul style="list-style-type: none"> • Greater clarity on MOW eligibility and payment details for older people • Greater awareness of MOW services amongst the older population • Increased efforts to build community efforts and mobilisation with MOW providers and the community • Assessment of reheating facilities within the homes of MOW users (Resources) • Enhanced MOW service collaboration and information sharing • Greater rapport with MOW providers and PHNs • More regular feedback from MOW users to MOW providers • Greater integration and accountability of MOW services (Incorporate into care plan)

	<ul style="list-style-type: none"> • Increased interactions with services involved in MOW services and care for older people • Greater collaboration between PHNs and Home Helps with MOW providers • Address issues of stigma towards MOW services • Provide specific information on MOW eligibility criteria and details of how to access MOW services • Use examples of positive experience of MOW users to increase positive image of MOW • Greater shaping of MOW services with older people • More relevant targeting of MOW information • Explore different approaches to disseminating MOW information to older people • Greater integration with the different agencies involved in MOW services • Increased sharing of information between Social Workers and MOW providers • Greater collaboration with MOW providers and Social Worker in the training of MOW volunteers • More detailed information on MOW provision and MOW alternatives based on geographic areas • Increased collaboration with the different stakeholders and services involved in MOW services • Greater traceability and accountability on the use of MOW services • Potential to link MOW services to broader home care package plans • Build greater rapport with PHNs and GPs around MOW information and referrals • Dissemination pathways of MOW information to older people via the PHN
<p>Health Care Professionals</p>	<ul style="list-style-type: none"> • Assessment of reheating facilities within the homes of MOW users (Resources) • Enhancing MOW service collaboration and information sharing • Greater rapport with MOW providers and PHNs • Increased awareness amongst GPs and PHNs in relation to MOW service details • Need for greater integration and accountability of MOW services (Care plan) • Increased interactions with different services involved in MOW services and care for older people

	<ul style="list-style-type: none"> • More focused efforts on regular feedback systems with MOW users (Incorporate into care plan) • Greater collaboration with PHNs and Home Helps with MOW providers • More specific information on MOW eligibility criteria and details; Access MOW services • Explore different approaches to disseminating MOW information to older people • Greater integration with different agencies involved in MOW services • Increased sharing on information between Social Workers and MOW providers; the training of MOW volunteers • Greater traceability and accountability on the use of MOW services • Linkage of MOW services to broader home care package plans • Build greater rapport with PHNs and GPs around MOW information and referrals • Dissemination of MOW information to older people via the PHN
<p>MOW Users</p>	<ul style="list-style-type: none"> • Engaging with services (ARA) to increase knowledge on food preparation and reheating • Greater rapport with MOW providers; greater confidence in updating dietary requirements • Openness towards meal choice and food options provided by MOW providers • Increased interactions with the different services involved in MOW services and care for older people • Greater collaboration with MOW providers, PHNs and GPs in relation to information channels

5.4 Contributions

This section outlines the contributions of this study through five key areas; theoretical, conceptual, methodological, practice and policy contributions.

5.4.1 Theoretical Contributions

This research is theoretically significant to the domain of social marketing in that it extends the application of community social marketing models. Through this, this research provides further consideration for debate around the broadened era of social marketing to encompass not just the individual but also the environment in which behaviour takes place (Wymer, 2011).

From an empirical perspective, the research findings have provided first-hand evidence concerning a MOW community in the West of Ireland. This research is also theoretically significant to social marketing in that it extends current knowledge in the area of community social marketing. This research contributes empirical support to discussions around broadening the scope of social marketing theory beyond the individual (French, 2009), to include social and environment factors. An additional contribution to social marketing theory from this research concerns the gap between the different levels; as evident between MOW current users and MOW stakeholders in relation to accessing information on MOW. The application of the CRM identified a gap between the key stakeholders of the service and the older population.

This research indicates that the CRM process is lacking an introductory script to provide a clear introduction into the CRM and setting the scene for the person who is being interviewed as a key informant. In order to ensure that key informants were fully aware of the CRM and their role in the process, an introductory script was developed for this study. The use of this script is valuable for future applications of the CRM. With the development of the introductory

script, modification, piloting and application of the CRM, this research presents a framework for assessing community readiness in communities facing complex challenges with multiple stakeholders. This framework offers unique advantages as a theory-based model, possessing the ability to classify communities by dimensions and stages of readiness, with the overall aim of mobilising communities to the next stage of readiness. Such contributions are recognised in the social marketing domain as having the potential to improve effectiveness of social marketing efforts by increasing strategies' suitability and therefore effectiveness, laying the foundation for both a successful and sustainable behaviour change outcome.

Through adopting a qualitative focus, this research placed greater emphasis on the experiences of MOW community members at different stages of service use. The utilisation of a multi-perspective approach assisted in this study moving beyond individual behaviour change to examine multi-level change and its broader social implications. This research looked at behaviour change as an experience between citizens (Wymer, 2011) as opposed to one sole activity. Recognising behaviour change as a process rather than an event supports the broader view of behaviour change within the environment in which the change takes place. With a variety of different MOW communities at different levels of change readiness, the application of the CRM was effective in capturing and managing the diverse nature of MOW communities. The applied nature through the utilisation of the CRM highlights the strong knowledge transferability of this research.

In terms of MOW services, this research has provided deeper insights and understanding into the scope of perceived roles of MOW services, with additional roles identified that are new contributions to this area. Furthermore, this research has provided evidence that shows how changes in the health service are altering the role of the MOW service, indicating that this emerging

issue needs to be fully understood and catered for to ensure a client-centred approach is maintained.

5.4.2 Conceptual Contributions

The conceptual social marketing contributions from this research encompass three key areas. Firstly, by lending itself to the social marketing process of consultation, mobilisation and management strategies, as well as to the process of policy and decision-making, how the CRM has contributed to social marketing processes. Secondly, the CRM provides a conceptual example of the concept of scaling out the co-creation of value from the individual level to the community level. Thirdly, through the application of the CRM as an action tool providing an outline of the dimensions and stages of readiness of the CRM from a conceptual perspective.

This research presents substantial mid-stream contributions, specifically related to the lack of informational MOW materials. The opportunity for MOW information to be disseminated to older people whom stakeholders believe could benefit from using the service was identified. This finding presents an opportunity for information to be disseminated to a wider audience of older people, primarily through the Public Health Nurse and GP. This contribution to practice is warranted based on the lack of information available for older people as well as health care professionals, where a gap was identified in this information process, particularly with the GP service.

The development of a directory of MOW services based on geographic areas is a simple but effective tool which could assist with stakeholders' knowledge about the MOW provision areas, making for a more transparent and more effective approach to issuing MOW referrals. The current lack of a directory reflects the need for greater cooperation between MOW stakeholders, the community and

services such as inter-agency training. Other contributions to practice include new approaches to segment MOW users, resulting in changes to Home Help hours that are likely to see an increased number of older people looking to MOW to substitute the former meal preparation role of Home Helps.

5.4.3 Methodological Contributions

This study has made significant contributions to community social marketing efforts, through the addition of supplementary methods to enhance and extend the CRM. This extension of the CRM, through the utilisation of semi-structured interviews and focus groups to shape the process of identifying key informants and the question schedule, illustrates a more rigorous approach to previous application of the CRM. Having tested this extended approach in this study, this process is transferable to future applications of the CRM.

A further contribution was the development and testing of a systematic approach to mapping and identifying relevant key informants, which had been identified in the literature as a potential limitation of the CRM. Drawing on dominant approaches from stakeholder literature, this study tests for the first time this approach to ensure that key informants most accurately represent different segments and perspectives of a particular community.

An additional element to the CRM was established and tested through the development and testing of an introductory script, adding rigour to the CRM process by ensuring key informants are fully aware of the process and their role as a key informant.

Through the adaptation of the CRM for the Irish context, where the CRM is tested in a new domain and a new community, together with the extension of the CRM from a methodological and analysis perspective, this study has resulted

in a rigorous approach to application of the CRM in a new area, increasing the transferability of the model.

5.4.4 Practice Contributions

From a management perspective, the CRM and other dominant community social marketing models identified display an approach, whereby rather than working 'for' the community from a traditional expert-led only or top-down approach, the focus is on the community/client, ensuring client orientation and working deeply 'with' the community. Such approaches offer a solution to overcoming the challenges posed in managing community behaviour change and developing programmes and strategies. A critical obstacle to change is the exclusion of people or citizens from a system (McHugh and Domegan, 2014) and there are a greater variety of actors engaged as change agents in community social marketing frameworks. This engagement of community members in the CRM model goes beyond individual-level behavioural modifications to meso-level and social changes due to the CRM's ability to recognise that different groups require different approaches to change. In essence, the CRM recognises that different groups of people have aspects of change reflecting the interdependencies of diverse communities, contexts, content and actors. Communities themselves can be the source of fully formed innovative ideas, responsive to their genuine needs. Such bottom-up approaches tend to be widely accepted and communities can also act as willing partners in actions related to their ideas, where consultation is a core part of this process.

The need for greater collaboration and information sharing between services was acknowledged, with opportunities for several organisations to benefit from a more open system of information sharing. One immediate route where greater management would result in benefits for two groups of stakeholders is in relation to social workers for older people and the MOW staff. One suggestion

offered by a key informant was to involve MOW staff in training provided by social workers in relation to elder abuse awareness. With this training, MOW staff could liaise with social workers on any concerns they may have, thus expanding the monitoring aspect of MOW.

Furthermore, this study indicates that refining the community mechanisms to detect gradual change could further strengthen the internal detection mechanisms within MOW. The application of the CRM in this context acts as a means of monitoring gradual change by identifying resources and efforts in place, allowing the development of greater control in relation to setting goals within the management structure.

5.4.5 Policy Contributions

In relation to MOW and policy, the findings reinforce the issue of a lack of focus on implementing recommendations around social policy for older people, with community-based services, such as MOW in particular, continuing to be under-researched and over-looked. Community-based services, such as MOW, operate in response to the policy aim of assisting older people to live independently in their own homes. However, as this research has shown, there are a variety of different issues at stake from the perspective of older people that impact on the decision to use MOW. This relates primarily to a lack of information, but is coupled with additional issues such as independence and stigma. With additional emerging issues impacting on the service, related to decreased funding in home care services, this research emphasises the importance of considering that the current approach to MOW is not appropriate for the increasingly diverse older population. This emphasises the need for a more client-originated and customised approach to MOW services. This warrants policy makers to adopt a broader perspective towards MOW, similar to that utilised in this research. Such a perspective involves up-stream, mid-stream and down-stream elements, with

collaboration and information sharing between these three levels essential. The application of the CRM is beneficial from this perspective as it provides insights into the community that other entities such as policy makers and media cannot capture.

This research contributes to the body of knowledge used by organisations, health professionals and policy makers in relation meeting the needs of an increasing population through MOW services. Significant contributions to MOW practice also arise from this research. Such contributions range from a need for informational material on MOW to training opportunities with multiple organisations and a directory of service provision.

Findings from this research, such as the varied MOW role, information deficits and the impact of health cuts on MOW services offer key insights for policy makers to ensure MOW meets the needs of older people. The adaptation and testing of the CRM in the Irish context benefits not just the older population and stakeholders, but also can act as a guide for change for other key areas of community life in Ireland requiring change such as health, social justice, transport and energy sustainability, through its community engagement and co-creation approach to increase community capacity making. This research equips Irish community projects with a tool to implement strategies based on a long-term social approach. The findings have committed to providing guidelines and strategy approaches for future utilisations of the CRM as a tool to ensure resources are utilised effectively in communities that help shape the co-creation of the content and processes of strategies.

5.5 Scope and Limitations of Research

In considering the findings of the study, it is important to be cognisant of limitations of this study. It is also noteworthy to reiterate the context in which the CRM was applied: the MOW community. As outlined in Chapter Two, the MOW community in Ireland is in the midst of a transitional period, moving from a charity led approach to a public private partnership approach. Faced with a lack of support from the state and coupled with reduced funding, the MOW community is currently dealing with significant challenges and change. Additionally, the growing older population present significant implications for community based services such as MOW services, which are already facing substantial challenges. It is in the light of such complex social issues and community setting that the findings have emerged.

Firstly, the scope and limitations of the study, from a literature perspective, are outlined, surrounding the main bodies of literature of social marketing, social policy and MOW. This study focused on the key behaviours, *the actions and thoughts of members involved in MOW services*, in order to address the central research question. While exploring behaviour may suggest the study relates to the domain of psychology, the scope of the literature review is limited to establishing the role of psychology in developing the CRM. It is the domain of social marketing, rather than applied psychology, which is of primary interest to the objectives of this study.

Secondly, the scope and limitations from a methods perspective related primarily to the MOW target groups who were consulted for this study were the older population. It is important to note that MOW service users are not solely comprised of members of the older population. People with a disability (physical, sensory and intellectual) or younger people with health issues also use the service. However, for the scope of this research, and with the central research

question focusing on the older population specifically, this study solely focused on MOW users from the older population. An opportunity remains, therefore, to adapt the central research question and methods to other groups who use MOW services, with the potential to compare findings from different groups.

The application of the CRM has two primary uses; assessment and mobilisation, which can be used either individually or together. This study focuses on the use of the CRM as an assessment tool through the development of mobilisation strategies. The implementation of these strategies is outside the scope of this study, these strategies were provided to the community research partner; a local organisation providing MOW, to implement in the organisation at a later stage. A potential future application of the CRM, following this initial application in Ireland, could entail adapting the application and mobilisation aspects of the model to address a community issue, with suitable funding, to enhance the body of knowledge around the CRM.

The CRM reinforces key social marketing principles by focusing on the community as opposed to the individual in both measurement and mobilisation to action. In this regard, the CRM's assessment process is useful as a method of community analysis, more so than for provision of an adequate target audience analysis. As a community mobilisation approach, the CRM merits further investigation into the model's capability of enhancing social marketing efforts and facilitating a unique method of providing a systematic means of assessing developmental readiness at the community level. Further investigation is also warranted to expand the different levels of readiness of several key informants within a particular community, where the community is viewed as a series of sub-systems. In a community that is going through significant community change, such as the MOW community, there is the risk that a particular subsystem within a community could be masked due to the transitional nature of the community. For this reason, in such a context of change, the application of

the CRM may warrant application to assess readiness within the subsystem of a community, as well as to the community itself. Furthermore, due to the ever changing nature of communities, the application of the CRM to communities experiencing a time of change may prove difficult to capture a representative assessment score, with the potential for different parts of the community being more or less progressed than others, further warranting adapting a subsystem perspective to community readiness assessment in a community going through significant change.

From the perspective of the scope of this research and the involvement of the community research partner, this particular research lacked sufficient time and resources to allow for a collaborative forum, whereby the findings from the application of the CRM were reported to the community research partner, to allow for increased validity and to check that the findings were representative from the perspective of the community stakeholder.

5.6 Future Research Directions

This research saw the application of the CRM to the MOW community, which provided a conceptual example of up-scaling the co-creation of value from the individual level to the community level, while also examining the application of the CRM as an action tool from a conceptual perspective. This research illustrated how the CRM has the potential to be applied and evaluated to a variety of social marketing settings and behavioural challenges. This study allowed the opportunity for the CRM to be adapted and applied to a new community and a new issue, providing new insights into the expansion of the CRM to address a broad range of issues. The application of the CRM to other communities and complex issues such as social, health, environmental issues to further test the model would assist in establishing the full potential of the model in different contexts. As is the nature of qualitative approaches, the findings

from this research cannot be generalised, which presents the opportunity for future research to be conducted, where the addition of a quantitative element would assist in validating these findings and assisting in a form of generalisation. In order for this to be rigorous, the application area would need to be more encompassing than previously, with a larger scale focus required.

From the perspective of MOW users, recommendations for the future of MOW were identified. Issues related to the use of chilled meals instead of hot meals saw this new approach being met with concerns by service users. Where chilled meals may be a viable option, it is vital that MOW providers ensure that the correct facilities to safely reheat food are in place in the homes of MOW users. Greater recognition of the different types of MOW users is also required, necessitating increased efforts in segmenting the diverse MOW target audience. From the varied roles of MOW identified in this research, it is clear that different people have different perceptions of the role of MOW. The findings of this research indicate a need for greater recognition of the varied roles of MOW and the dissemination of information in appropriate channels relevant to these diverse groups.

Complex social issues, such as those currently faced by MOW, require innovative and comprehensive solutions, shaped around consultation with the community, as offered by the CRM. This study culturally modified, piloted and applied the CRM to the MOW community, which resulted in an overall readiness score indicating the readiness levels for the MOW community, with strategies to mobilising this readiness level outlined. It was beyond the scope of this PhD study to apply these strategies to a MOW community, due to time and funding constraints. However, the CRM scoring and strategies were transferred to a management report for a local MOW provider, which acted as the community research partner for this study. It is anticipated that the report can be used to apply the strategies and recommendations on a practice level. It is evident that

issues relating to inadequate information about the service are apparent with both older people and health professionals. In itself this has negative implications for the current and future MOW services and warrants further investigation.

The application of the CRM to the MOW community assessed and captured behavioural and societal change. The findings from this research suggest that the MOW community may benefit from a systems approach perspective, due to the composition of the MOW community, which can go beyond one particular community to be comprised of a number of communities within a systems approach. This research further supports the value of a systems approach which is cognisant of both the MOW and social marketing literature. MOW literature reflects demographic and funding constraints which have been found to impact on the current MOW system, a system which is currently under resourced yet is likely to see increased demand in the coming years. In recent years emerging social marketing literature is also recognising this systems approach (Bryant et al., 2014).

5.7 Conclusion

This study sought to respond to the central research question of this study, which asks '*What key stakeholder behavioural changes are required to facilitate Meals on Wheels services to support a growing and diverse older Irish population?*'. In responding to this central research question, the study explored the key behaviours of current, former and potential MOW users as well as that of stakeholders within the MOW community. The study utilised a multi-level approach to ensure that insights from different perspectives of the MOW community were captured, representing a micro and meso-level approach to responding to the research question.

Based on the CRM assessment, which was shaped by consultation with current, former and potential MOW users, the levels of readiness within the MOW community were found to be at Stage Four - Preplanning. This indicated the key stakeholder behaviours that require change in order to facilitate the MOW service to support a growing and diverse older Irish population focused on raising MOW awareness to combat MOW challenges. In order to move the level of readiness within the MOW community to a mobilised level, particular efforts are required to increase knowledge and information with key MOW stakeholders in relation to MOW. Such efforts include transparent eligibility criteria, up-to-date information on the different areas where MOW or MOW alternatives are provided based on geographic areas and the use of appropriate target audience information channels for different segments of the older population to access MOW information. The varied roles of MOW (nutrition, social, lifestyle and monitoring) assist in the segmentation of the target audience. Greater awareness of the impact of MOW service transition is required, particularly in relation to a review of the current efforts in relation to community-based services. Information efforts to create awareness of the different types of stigma towards MOW use with key stakeholders; particularly with MOW intermediaries (GPs, PHNs) are required. Increasing support and recognition of MOW with community members as well as bringing about a change in the community attitude is required to ensure the MOW service can meet the needs of the growing diverse older population. Specific steps to achieve this have been outlined previously in Table 5.2.

Using a qualitative design, this study looked beyond individual behaviour to incorporate a systematic community behaviour view through the lens of mid-stream and down-stream perspectives. The findings from this research support and extend a broader base of international evidence on community social marketing efforts, as well as providing a deeper and broader understanding of MOW. The results from this study highlight the important role of a client-centred

approach to MOW, where the focus must be on recognising and including individual choice and needs within a growing and diverse older population. Such needs must be acknowledged and incorporated into MOW if the state seeks to ensure that older people can rely on MOW to support them to live in their own homes.

As identified in the research, there are factors from the MOW users' and stakeholders' perspectives that are limiting MOW, which need to be understood and recognised to ensure MOW meets demands. MOW stakeholders should not take for granted the role that choice plays in the service. Assumptions that an increasing older population will automatically use MOW would be a risky assumption to hold. For this reason, MOW should be viewed in different segments and relating to different target groups, shaped around the different value that MOW holds for each individual.

These findings are particularly significant given the lack of research on the area of MOW, with this study contributing valuable information in relation to MOW services. Key issues identified in this study include an information deficit amongst key stakeholders in MOW services, as well as highlighting a gap between stakeholders and the older population, particularly in the perceived ways older people source information and provide feedback.

This study has successfully adapted and applied the CRM to a new culture, community and issue. Through the adaptation and application of the CRM in this study, a systematic approach to assess community readiness with MOW stakeholders, shaped by additional methods with the broader community has been developed and tested. This study has resulted in the development of MOW community-specific strategies to generate community mobilisation. These unique strategies indicate from a CRM and social marketing intervention mix perspective, how the CRM acts as a tool kit to bring about not only behaviour

change with different segments of the MOW community, but also to bring about broader societal change. The application of the CRM to the MOW community in Ireland paves the way for further application of the social action tool to a diverse range of issues.

At a broader level, the findings from this study contribute to the advancement of knowledge regarding the planning, implementation and effectiveness of MOW services in Ireland. This research succeeds in capturing the richness of data from the perspectives of the older population as well as a variety of stakeholder groups within the MOW community that has not previously been captured by other community social marketing models. This research has listened to and responded to the fluid nature of the MOW community in Ireland. Implementing the recommended practices and policies can ensure that the voices of the older population are heard and can shape the MOW service to continue to support older people to live independently at home.

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Appendices

Appendix A: Anchored Rating Scales for CRM Scoring Interviews

Dimension A. Existing Community Efforts (Programs or activities)

1. No awareness of the need for efforts to address the issue.
2. No efforts addressing the issue.
3. A few individuals recognize the need to initiate some type of effort, but there is no - immediate motivation to do anything.
4. Some community members have met and have begun a discussion of developing community efforts.
5. Efforts (programs/activities) are being planned.
6. Efforts (programs/activities) have been implemented.
7. Efforts (programs/activities) have been running for several years.
8. Several different programs, activities and policies are in place, covering different age groups and reaching a wide range of people. New efforts are being developed based on evaluation data.
9. Evaluation plans are routinely used to test effectiveness of many different - efforts, and the results are being used to make changes and improvements.

Dimension B. Community Knowledge of the Efforts

1. Community has no knowledge of the need for efforts addressing the issue.
2. Community has no knowledge about efforts addressing the issue.
3. A few members of the community have heard about efforts, but the extent of their knowledge is limited.
4. Some members of the community know about local efforts.
5. Members of the community have basic knowledge about local efforts (e.g., purpose).
6. An increasing number of community members have knowledge of local efforts and are trying to increase the knowledge of the general community about these efforts.
7. There is evidence that the community has specific knowledge of local efforts including contact persons, training of staff, clients involved, etc.
8. There is considerable community knowledge about different community efforts, as well as the level of program effectiveness.
9. Community has knowledge of program evaluation data on how well the different local efforts are working and their benefits and limitations.

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Dimension C. Leadership (Includes appointed leaders & influential community members)

1. Leadership has no recognition of the issue.
2. Leadership believes that this is not an issue in their community.
3. Leader(s) recognize(s) the need to do something regarding the issue.
4. Leader(s) is/are trying to get something started.
5. Leaders are part of a committee or group that addresses this issue.
6. Leaders are active and supportive of the implementation of efforts.
7. Leaders are supportive of continuing basic efforts and are considering resources available for self-sufficiency.
8. Leaders are supportive of expanding/improving efforts through active participation in the expansion/improvement.
9. Leaders are continually reviewing evaluation results of the efforts and are modifying support accordingly.

Dimension D. Community Climate

1. The prevailing attitude is that it's not considered, unnoticed or overlooked within the community.
2. The prevailing attitude is "There's nothing we can do," or "Only 'those' people do that," or "We don't think it should change."
3. Community climate is neutral, disinterested, or believes that the issue does not affect the community as a whole.
4. The attitude in the community is now beginning to reflect interest in the issue. "We have to do something, but we don't know what to do."
5. The attitude in the community is "we are concerned about this," and community members are beginning to reflect modest support for efforts.
6. The attitude in the community is "This is our responsibility" and is now beginning to reflect modest involvement in efforts.
7. The majority of the community generally supports programs, activities, or policies. "We have taken responsibility."
8. Some community members or groups may challenge specific programs, but the community in general is strongly supportive of the need for efforts. Participation level is high. "We need to keep up on this issue and make sure what we are doing is effective."
9. All major segments of the community are highly supportive, and community members are actively involved in evaluating and improving efforts and demand accountability.

Dimension E. Community Knowledge about the Issue

1. Not viewed as an issue.
2. No knowledge about the issue.
3. A few in the community have some knowledge about the issue.
4. Some community members recognize the signs and symptoms of this issue, but information is lacking.
5. Community members know that the signs and symptoms of this issue occur locally and general information is available.
6. A majority of community members know the signs and symptoms of the issue and that it occurs locally, and local data are available.
7. Community members have knowledge of, and access to, detailed information about local prevalence.
8. Community members have knowledge about prevalence, causes, risk factors, and consequences.
9. Community members have detailed information about the issue as well as information about the effectiveness of local programs.

Dimension F. Resources Related to the Issue (People, money, time, space, etc.)

1. There is no awareness of the need for resources to deal with this issue.
2. There are no resources available for dealing with the issue.
3. The community is not sure what it would take (or where the resources would come from) to initiate efforts.
4. The community has individuals, organizations, and/or space available that could be used as resources.
5. Some members of the community are looking into the available resources.
6. Resources have been obtained and/or allocated for this issue.
7. A considerable part of support of on-going efforts are from local sources that are expected to provide continuous support. Community members and leaders are beginning to look at continuing efforts by accessing additional resources.
8. Diversified resources and funds are secured and efforts are expected to be - ongoing. There is additional support for further efforts.
9. There is continuous and secure support for programs and activities, evaluation is routinely expected and completed, and there are substantial resources for trying new efforts.

Appendix B: CRM Readiness Assessment Question Schedule

CRM Readiness Assessment Question Schedule

Introduction:

1. CRM assessment question
 - (Prompts)
 - (Guide)

-> Use the CRM Readiness Assessment Introductory piece to start the interview

1. On a scale from 1-10, how ready is the MOW community to support the provision of MOW?

- With 1 being “not at all” and 10 being “very much so”
- Could you please explain

2. Are there any efforts, such as programmes or activities, in the MOW community that you are aware of in relation to the provision of MOW?

- If Yes, continue to question 3
- If No, skip to question 14
- If No, could you explain why

3. Can you please describe these (efforts)?

4. How long have these efforts been going on?

5. Who do these efforts serve?

- Who are these aimed at?
- For example, individuals of a certain age or with particular types of need
- Why do you think that is?

6. Are there any segments of the community that these efforts might appear inaccessible or unavailable for?

- For example, individuals of a certain age, income level, geographic region
- Why do you think that is?

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7. What do you consider to be the strengths of these efforts?

- Why do you think these are strengths?

8. What do you consider to be the weaknesses of these efforts?

- Why do you think these are the strengths?

9. Are you aware of any formal or informal evaluation of the current efforts?

- (If Yes) Could you tell me what formal or informal evaluation are you aware of?
 - If Yes, continue to 9a
- (If no) do you think this is a problem?
 - If No, skip to question 10

9 (a). On a scale of 1 to 10, how thorough is the evaluation-with 1 being “not at all” and 10 being “very thorough?”

- This figure between one and ten is not figured into the scoring of this dimension in any way – it is only to provide a reference point

9 (b). As far as you are aware, are the evaluation results being used to make changes in efforts or to start new ones?

- (If yes) Could you tell me about how the evaluation results will be used?
- (If no) Could you tell me about why you think they are not being used?

10. Are there any other plans for efforts going on in your community surrounding Meals on Wheels?

- Could you please explain?

11. Excluding those directly involved in planning or implementing these efforts, approximately how many organisations or stakeholders in the MOW community are aware of these efforts?

- Would you say none, a few, some, or most?
- Could you please explain why you think this is?

12. What, in your opinion, do these organisations or stakeholders know about these efforts or activities?

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- Can you identify specific efforts; do you know the purpose of the efforts, who they are targeted to, what they do, the effectiveness of the efforts?

13. Is there information readily available to the broader MOW community about the efforts? (e.g., pamphlets, bulletins, posted notices, meetings, etc.)

- In your role, could you tell me about what information, if any, is available about t=such efforts?
- In your view, how little or how much do community members take advantage of this information?
- Could you please explain
 - Only ask #14 if respondent answered “No” to #2

14. Is anyone in the MOW community trying to get something started in relation to Meals on Wheels?

- (If yes) Could you tell me about what is planned?
- (If no) Could you tell me why you think there isn’t anyone trying?

- I’m going to ask you now about leadership and how the leadership in your community recognises MOW.

15. Could you name who you would could consider leaders in the MOW community? By leaders, I mean people who have influence in the MOW community, and who could affect the outcome of the MOW community in helping it achieve its goals.

16. Using a scale from 1-10, how much of a concern is the provision of MOW to the leaders you mentioned?

- With 1 being “not a concern at all” and 10 being “a very great concern”? Please explain
 - 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

16. Do leaders believe that this is an issue that should be addressed in your community?

- Could you please explain
- If so, which leaders believe that it is?

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17. How is the leadership involved in efforts regarding Meals on Wheels?

- For example, are leaders just supportive or are they more actively involved, e.g., are they involved in a committee, do they speak out publicly, have they allocated resources to address the issue?

18. In your view, would the leadership support additional efforts?

- If so, how might they do that?

-
- Next, we are going to talk about community climate, about what is the general attitude of the community towards Meals on Wheels?

19. By community members I mean MOW users. As far as you are aware, do you think that community members believe that MOW is something that needs to be addressed?

- If Yes, continue to 20a
 - If Yes, what do they believe should be addressed?
- If No, skip to question 21. 19a
 - (If no) Could you tell me why you think they don't?

19 (a) If yes, how might they show this support?

- E.g., passively or actively by being involved?

20. On a scale of 1 to 10, how much knowledge do community members have about Meals on Wheels? Again, by community members I mean MOW users.

- Where 1 is no knowledge and a 10 is detailed knowledge
- Could you explain what type of knowledge community members have?
- Where do they get this information?
- In terms of the causes and consequences, the signs and symptoms, the risk factors, and so on
- Please explain

21. How much do community members know about Meals on Wheels?

- E.g., do they know how much it occurs locally

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- Could you give me an example of what you think they know?
- How do you think they find out about MOW?

22. What type of information is available for community members about Meals on Wheels?

- E.g. newspaper articles, brochures, posters
- Could you tell me about where this information is available?
 - If there are efforts to address this issue locally, begin with question 26
 - If there are not efforts, go to question 28

23. How are current efforts funded?

24. What (other) resources are currently being used in relation to Meals on Wheels in the community

- E.g. Volunteers, location, experts on the issue?

25. What (other) resources are available to address this issue in the community

- E.g., space, volunteers, financial donations from organisations, experts on the issue?
- Is anyone in the community looking into using these resources to address this issue?

26. Would the community support using these resources to address this issue?

- Can you explain why you think that is?

27. Do efforts that address Meals on Wheels have a broad base of volunteers?

- Could you tell me more about the volunteer base

28. On a scale from 1 to 10, what is the level of expertise and training among those working on Meals on Wheels?

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- With 1 being —very low and 10 being —very high
- Could you please explain
 - 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

29. Are you aware of any proposals or action plans that have been submitted for funding in relation to Meals on Wheels in your community?

- Please explain

END OF CRM SCORING QUESTIONS

[Appendix C: Current MOW Users Study Information Sheet](#)

Meals on Wheels Study Information Leaflet



Thank you

Thank you for agreeing to take part in the study. This information leaflet explains what the study is about and what your part in the study is.

What is the study about?

The study is about Meals on Wheels. I am interested in hearing about your experiences with the Meals on Wheels service. By taking part you can help shape the future of the service.

Why have you been invited to take part?

You have been invited to take part because you currently use the Meals on Wheels service. By taking part you can help shape the future of the service.

What is your part in the study?

You will have the chance to chat about your own experiences with Meals on Wheels.

How will your privacy be protected?

Your privacy will be protected at all times, with your name and information kept confidential. The interview will be recorded by tape, and written notes will be taken, which will be kept secure. All information will only be accessible by my supervisors and myself, and will only be used for this study. Any information you provide will **not** be made available to any organisations.

Thank you for reading this Information Leaflet. Please feel free to contact me with any questions:

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This study is supervised by

Prof Tom Scharf

091 495459

Dr Christine Domegan 091 492730

If you have any concerns about this study and wish to contact someone independent in confidence, please contact: Joanne O'Connor, Office of the Vice President for Research, NUI Galway. 091 492047.

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Appendix D: Geographic Boundaries for Study Sample Selection

COUNTY GALWAY LOCAL POVERTY PROFILE 2005

A. POPULATION

Table 4.1.1 Population of County Galway 2002

Area	Population 2002	Male		Female	
		Number	Percentage	Number	Percentage
County Galway	143,245	73,352	51.2%	69,893	48.8%

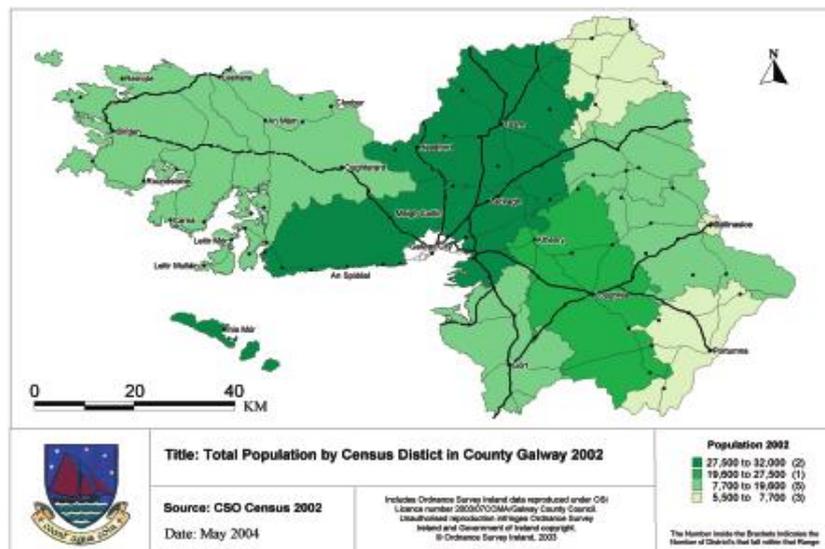
According to the Census of Population 2002, County Galway has a population of 143,245 people, 73,352 of whom are male (51.2%) and 69,893 of whom are female (48.8%). There are a total of 33,868 family units in County Galway.

Table 4.1.2 Population of County Galway 2002 by Urban and Rural Area

Urban/Rural Area	Population 2002
Ballinasloe Urban Area	5,984
Ballinasloe Rural Area	8,169
Clifden Rural Area	9,037
Galway Rural Area	31,901
Glenamaddy Rural Area	5,546
Gort Rural Area	10,028
Loughrea Rural Area	19,609
Mount Bellew Rural Area	7,775
Oughterard Rural Area	11,600
Portumna Rural Area	6,082
Tuam Rural Area	27,514
Total	143,245

The highest percentage of the population in County Galway live in the Galway Rural Area, followed by the Tuam Rural Area. The lowest percentage of the population live in the Glenamaddy Rural Area.

Map 4.1.1 Population 2002 of County Galway by Urban and Rural Area



Appendix E: Consent Form (Current, Former, Potential Users and Key Informants)



PARTICIPANT CONSENT FORM - INTERVIEW

Title of Study:

Exploring Behavioural Change in the Provision of Community Meals for Older People.

Name of Researcher:

Christine FitzGerald.

Please initial boxes

1. I confirm I have read the Information Sheet dated for the above study and have had the opportunity to ask any question
2. I am satisfied that I understand the information provided and have had enough time to consider the information.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
4. I agree to take part in the above study.

Name of Participant: _____ **Date:** _____

Signature of Participant: _____

Researcher: _____ **Date:** _____

Signature of Researcher: _____

Appendix F: Interview Schedule with Current MOW Users



- ❖ Main question
- Probe question
- Follow up question
- Topic

➤ Introduction: Key points to include before interview starts

- Thanks for agreeing to take part
- Introduce myself, student at NUIG, not working for COPE Galway
- What I'm interested in hearing about and why
- I want to let you know that today is just about having a chat, there are no right or wrong answers, all that matters is me hearing what you think
- I was interested to speak with you to hear about how you started using CC and how you find the service
- The information you provide will help shape the future of the service
- You are taking part in the interview voluntarily; if at any time you would like to stop or leave the interview you can do so
- Your name and what you say will be kept confidential. It will all be made anonymous. I will use a number instead of your name.
- If you are happy to go ahead with the interview, can I just ask you to sign this consent form; it means that you are aware your information will be kept confidential, and you can stop the interview at any time
- Is it ok with you if I tape record the interview? This is to help with taking notes from the interview.
- I will also be writing down some notes during the interview, if that's ok with you?
- If you need me to repeat anything please let me know.
- Just to remind you, there are no right or wrong answers, what is important to know is that this is all about your experiences and opinions.

Appendices

➤ 1. Opening questions

- ❖ 1. A. Can I just begin by asking what you call the meals service? I know that this is called different names in different places, but I would like to find out what you call it?
- ❖ Could you describe what the first thing that comes to mind when you think of your meal service?
 - Why is it you think that?
 - Could you explain?
- ❖ 1.C. Can we talk now about a typical day for you, what you usually do for meals?
 - First of all to help me get an idea of your mealtime, where do you usually eat?
 - Is there usually anybody else that eats with you?
 - Do they live with you?
 - How many days a week do you receive meals?
 - The days that you don't get the meals, what do you do for meals?
 - Do you have any trouble getting to the shops?
 - Does anybody help out with your shopping?
 - And what about cooking, is it something you have an interest in?
 - If no, is there any reason that you don't cook?
 - If yes, do you enjoy cooking?
 - Can you tell me about how your meal is delivered?
 - Usually what time?
 - Who delivers the meal?

Appendices

- How long does the visit last?
- Do you have a chat with the driver?
- Is the visit from the driver / delivery person important to you?
- Could you tell me, how do you think the [meal service] fits in with your day?
 - Is delivery time of meal convenient / inconvenient?
 - Meal type: Hot / chilled
- We've been talking about [meal service], but apart from the [meal service], have you used any other meals services? E.g. Lunch clubs, Meal options.
 - If yes, could you tell me about how you heard about this, our experiences?
 - If no, would you be interested in any other meal services?
- Apart from using the meal services, what other type of support do you have?
 - Family, friends, neighbours?
 - Who would you see most?
- How about meeting people, would you have a lot of contact with other people?
 - Who are you in contact with?
 - Family, friends, neighbours
 - How often would you see / meet people?
 - Do you get out often?
 - Where do you like to go?
- Do you use any other community services e.g. Home Help, Carer, GP, Day centre

Appendices

- Yes; Could you tell me about them (e.g. Home help)
- No; Are you interested in any other services?

- ❖ 2.a. I'm interested to learn about when you first started to use the meals service. If you could take a minute and think back to when you were first introduced to the [meal service]
- How did you first hear about [meal service]?
- Thinking back to when you first starting using [meal service], would you say that there was anything that happened or changed in your life around this time
 - Was there any changes in your health around this time?
 - Were there any changes to your mobility around this time?
 - What do you think were the main reasons that influenced your decision to start using the meals service?

- Was this a decision you made yourself, or did someone suggest that you think about using the meals service?

- ❖ 2.b. People have quite different views about using a service, such as [meals service] for the first time. Can you tell me how you felt about starting to use the meals service?
- Had you any idea about what you thought it might be like?
 - Any concerns?
- What do you like about [meals service]?
- Could you give me an example?
- Why do you think this is?
- What do you not like about [meals service]?
- Could you give me an example?
- Why do you think this is?

Appendices

- Since you started using [meal service], has your opinion of the service changed?
 - How?
 - Could you give me an example?

- ❖ 3. Thinking now about the other people in your community and meals services
 - In your opinion, how are meal services thought of in your community?
 - Positive or negative view

 - Do you think that the meals services are something that people in your community are aware of?
 - (If yes) Could you explain more how people are aware
 - (If no) Could you explain why you don't think people are aware
 - For example; Where / who to go or contact

- ❖ 4. I'd like to ask you about your own experiences and opinions with [meals service]
 - Could you tell me how would you describe your overall experience with [meal service]?
 - Overall would you say you are satisfied or dissatisfied with the service?
 - Why do you say that?
 - Could you give me an example of a time that you were satisfied with the service?
 - Could you give me an example of a time that you were dissatisfied with the service?

 - And apart from the food, how has your experience with [meal service] been?

Appendices

- Is there any way for you to tell the staff or volunteers what you like and don't like?
 - Have you ever been asked for any feedback on how you find using the service?
 - Would you feel comfortable letting the service know about any problems or things you didn't like?
- If you were to suggest changes in the service, what would you like to change?
 - Why do you say that?
 - In your opinion, what do you think would make using the meals service a better experience?
- ❖ 5. You spoke earlier about when you first started using the meals service
- How long have you been using [meal service]?
 - Since you started using [meal service], overall, would you say that using [meal service] has made any sort of difference to your life?
 - Could you give me an example of any differences; Good /bad differences that using MOW has made for you?
 - Would you recommend the meals service to a friend?
 - Why would / wouldn't you?
- ❖ 6. In finishing up, can you think of anything else that you would like to add?
- Is there anything that you would like to ask me?

Appendices

Additional follow up probes:

- Elaboration probes
- Attention probes
 - That is very interesting, can we come back to talk more about that?
 - Yes..
- Continuation probes
 - Go on..
 - What happened then?
- Clarification probes
 - Could you run that by me again? I am afraid I still don't understand how you did that
 - Can you explain that again?
 - What do you mean by..?
- Completion probes

Appendix G: Interview Schedule with Former MOW Users



❖ Main question

○ Probe question

▪ Follow up question

➤ Topic

➤ Introduction

- Thanks for taking part
- Before we start just to remind you what the study is about. This study will provide important information on peoples experiences with the Meals on Wheels service and will explore if changes are needed to better support people to live in their own homes.
- You have been chosen to take part in the study because you previously used Meals on Wheels. Although you no longer use the service, your experiences are very important, and can help shape the future of the service.
- If at any time you would like to stop or leave the interview you can do so.
- Is it ok with you if I record the interview? This is to help with taking notes from the interview.
- I will also be writing down some notes during the interview, if that's ok with you?
- If you need me to repeat anything please let me know.
- Just to remind you, there are no right or wrong answers, what is important to know is that this is all about your experiences and opinions.

Appendices

- ❖ 1. a. Can I just begin by asking what you call the meals service? I know that this is called different names in different places, but I would like to find out what you call it?
- ❖ 1.b. When you think of your meal service, what comes to mind?
 - Can you tell me what [meal service] means to you?
- ❖ 1.c. Can we talk now about a typical day for you.

To help with this could you describe what you usually do for meals?

- First of all to help me get a sense of your mealtime, is there usually anybody else that eats with you at meal time?
 - Do they live with you?
 - Can you tell me, is cooking something that you have an interest in?
 - If no, is there any reason that you don't cook?
 - If yes, do you enjoy cooking?
 - How often do you cook?
 - Do you have any difficulty getting to the shops?
 - Have you ever tried other meals services? Such as lunch clubs?
 - If yes, could you tell me about how you heard about this, our experiences?
 - If no, would you be interested in any other meal services?
 - Apart from meal services, are there any other services that you use?
 - Yes; Could you tell me about them (e.g. Home help)
 - No; Are you interested in any other services?
-
- ❖ 2.a. I'm interested to learn about when you first started to use the meals service. If you could take a minute and think back to when you were first introduced to the [meal service]
 - How did you first hear about [meal service]?

Appendices

- Thinking back to when you first starting using [meal service], would you say that there was anything that happened or changed in your life around this time
 - Was there any changes n your health around this time?
 - Were there any changes to your mobility around this time?
- What do you think were the main reasons that influenced your decision to start using the meals service?
 - Was this a decision you made yourself, or did someone suggest that you think about using the meals service?

- ❖ 2.b. People have quite different views about using a service, such as [meals service] for the first time. Can you tell me how you felt about starting to use the meals service?
 - Had you any idea about what you thought it might be like?
 - Any concerns?
 - What do you think are the strengths and weaknesses of mow?
 - Has your view changed over the time that you have been using the service?

- ❖ 3. You spoke earlier about when you were using the meals service,
 - How long did you use MOW for?
 - How often did you receive meals?
 - When did you stop using MOW?
 - Did anything change or happen in your life around this time?
 - What would you say was the main reason that you stopped using MOW?
 - Overall, would you say that using MOW made a difference, if any to your life?

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- Could you give me an example of any differences; good or bad, that using MOW has made for you?
 - How would you say using the meals service has made you feel?
 - Do you think that using the meals service has been a good or bad experience for you?
 - What do you think about using MOW again in the future?
 - Do you think you would recommend using the meals service to a friend?
- ❖ 4. I'd like to understand more about your own experiences with [meals service]
- Could you tell me how would you describe your overall experience with [meal service]?
 - Overall would you say you are satisfied or dissatisfied with the service?
 - Why do you say that?
 - Could you give me an example of a time that you were satisfied with the service?
 - Could you give me an example of a time that you were dissatisfied with the service?
 - Any other examples?
 - And how about apart from the food?
 - Apart from the food, how has your experience with [meal service] been?
 - Dealings with members of the service?
 - Delivery person
 - Contact with the service; phone, post
 - If you were to suggest changes in the service, what would you like to change?
 - Why do you say that?

Appendices

- In your opinion, what do you think would make using the meals service a better experience?

❖ 5. Thinking now about other people in your community and meals services

- In your opinion, how are meal services thought of in your community?
 - Positive or negative view
- Do you think that the meals services are something that people in your community are aware of?
 - For example: Where / who to go or contact
 - (If yes) Could you explain more how people are aware
 - (If no) Could you explain why you don't think people are aware

❖ 6. In finishing up now, can you think of any thing else that you would like to add?

❖ Is there anything that you would like to ask me?

Thank the participant for their valuable time.

Additional follow up probes:

- Elaboration probes
- Attention probes
 - That is very interesting, can we come back to talk more about that?
 - Yes..
- Continuation probes
 - Go on..
 - What happened then?

Appendices

- Clarification probes
 - Could you run that by me again? I am afraid I still don't understand how you did that
 - Can you explain that again?
 - What do you mean by..?
- Completion probes

Appendix H: Invitation Phone Schedule – Former MOW Users

- Topic
 - Guide

- Invitation to take part
 - Hello (name of client), it's Fiona here from Community Catering. How is all with you?
 - You might be wondering why I am getting in touch. I am ringing to you to invite you to take part in a study about Community Catering

- Who is doing the study?
 - The study is being done by a researcher at the University in Galway, Christine FitzGerald, she is interested in hearing about your experiences with Community Catering as a former client, to help shape the future of the service

- What is the study about?
 - The study is looking at people's experiences using Community Catering. You are invited to take part in the study, but you don't have to take part if you don't want to. The decision to take part is entirely up to you

- Why are you invited to take part?
 - You are being invited to take part because you have used Community Catering in the past

- What will you have to do?
 - You will have the chance to talk about your own experiences with Community Catering in an interview. Anything you say will be kept confidential

- How long will it take?
 - It will take around sixty minutes to complete. If at any stage you would like to leave the interview you can do so

- Where will it be?
 - If you agree to take part in this study, the researcher can visit you

Appendices

in at home at a time that suits you, if you are comfortable with this?

- If you would prefer for the researcher not to call to your home that is no problem. The researcher will be in touch to arrange somewhere close to your home where you can meet, e.g. A hotel, restaurant
 - Your privacy will be protected at all times, with your name and information kept confidential. The interview will be recorded by tape, and written notes will be taken all, which will be kept secure. All information will only be accessible by my supervisors and myself, and will only be used for this study. Any information you provide will **not** be made available to any organisations.
-
- **Would you be interested in taking part in the interview?**
 - If yes, follow next question
 - If no: Thanks for taking the time to talk about the study (If a reason is provided why the client does not want to participate, please take note of this)

 - **What happens next?**
 - If you **agree** to take part, I will post you out an information sheet about the study as well as a consent form. You will need to sign the consent form and post back to me. By signing the consent form it means that you agree for me to give the researcher your name and phone number to get in touch with you
 - I will also post out a stamped addressed envelope for you to post back the filled in consent form to me here in Community Catering
 - Once you post me back your signed consent form, the researcher will be in touch with you to arrange a time and place for the interview

 - **Have you any other questions about the study?**
 - (Look to FAQ section)
 - (If unsure of answer, let the client know you will check it out and get back to them)

 - **Thanks**

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- Thanks for taking the time for this phone call. I will send you out the information leaflet consent form and stamped addressed envelope.
- If you have any questions in the meantime please get in touch.

Additional Information

1. Phone call guide FAQs

- Who is doing the study?
 - The study is being done by NUI Galway. The person who will be doing the interview is a researcher at NUI Galway, Christine FitzGerald
- What is the study about?
 - The study is looking at the Community Catering service. It will provide important information peoples experience with Community Catering and will see if changes are needed to better support people to live in their own homes
- Why have you been chosen to take part?
 - You have been chosen to take part in the study because you currently use Community Catering. Your input into the study can help shape the future of the service
- What will happen at the interview?
 - You will have the chance to discuss your own experiences or opinions of Community Catering
 - It will take around sixty minutes to complete. If at any stage you would like to leave the interview you can do so
- How will your privacy be protected?
 - Your privacy will be protected at all times. Your name and information will be kept confidential. The interview will be audio-recorded, and written notes will be taken which will be kept secure. All information will only accessible by me and will only be used for this study.
- Where will the interview take place?

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- The interview can take place in the clients own home, if they are comfortable with this. If they agree for the interview to take place in their own home, the researcher will contact them to arrange a time and day that suits them
- If the client does not want the interview held in their own home, the researcher will arrange for a location close to the clients home to meet
- How long will the interview take?
 - The interview will last approximately one hour.
- What benefit is it for the client to take part?
 - It gives the client the chance to help improve and shape the future of Meals on Wheels
 - It gives the client a voice to air their experiences or opinions about the Meals on Wheels service in a confidential way
- Who will be doing the interview?
 - Christine FitzGerald, an independent researcher from NUI Galway will be doing the interview. The entire interview will be confidential.

2. If the client agrees to participate

- Thank them for agreeing to take part
- Let them know that you will post them out;
 - Information on the study
 - A consent form which they need to sign and post back in the attached stamped addressed envelope
 - The consent form shows that they agree to take part in the study, but if at any time they no longer want to take part they can do so
- When they have posted back the signed consent form, explain that the researcher will be in touch with them by phone to arrange to meet

3. If the client does not agree to participate

- Thank them for their time
- If the client does not voluntarily declare the reason for not taking part there is no need to ask why

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- If the client voluntarily states the reason for not taking part this reason is documented (As requested from MOW providers).

Appendix I: Fieldwork Timeline

Fieldwork Activity	Date Completed
Pre-pilot: Current and Former MOW Users Interview Schedule and Documents	January 2013
Pilot: Current MOW Interview	February 2013
Semi-Structured Interviews: Current Urban MOW Users Former MOW Users	February 2013
Pilot: Focus Group	May 2013
Focus Group: Potential MOW Users	April 2013
Pilot: Key Informant Interview	May 2013
Semi-Structured Interviews: Current Rural MOW Users	June 2013f
Key Informant Interviews: MOW Stakeholders	June - September 2013

Appendix J: CRM Readiness Assessment Introductory Script



CRM Readiness Assessment Introductory Script

(Adapted from Krueger & Casey, 2009)

1. Welcome:

Good morning and welcome. I'd like to thank you for taking the time to meet me today to talk about Meals on Wheels.

2. Overview of the topic:

I am a researcher in the University and I am interested in hearing about your thoughts and opinions on Meals on Wheels. The research I am doing is supported by the HSE and COPE Galway (a charity who provide social and nutritional support in Galway) and has secured ethical approval from NUIG.

You were invited as you were identified as a key stakeholder in the Meals on Wheels service. Meeting with you today and discussing Meals on Wheels can help shape the future of Meals on Wheels in Ireland.

I am using a Community Readiness approach to the interview, which is developed around community engagement. Through the course of the interview, I will be using words like community; what I mean by community is the Meals and Wheels community. Due to this approach, some questions will be more relevant to you than others. I will talk about an issue, what I mean by this is the current provision of Meals on Wheels.

The aim of these interviews, which I am doing with several key MOW stakeholders, is to assess if the community (current MOW) is ready to support an increasing and diverse older population to live in their own homes. The current provision of Meals on Wheels refers to a service which is undergoing changes, moving from a traditional charity led approach, to a customer orientated public private approach. Coupled with other changes which will impact on MOW; predicted increase of the older population who are increasingly diverse.

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3. Ground rules

If it is ok with you, I will be recording today's discussion, so I don't miss out on anything. Your name, details and any comments you make will be kept anonymous and confidential.

If at any stage you have any questions just let me know. If you need to leave any time that's fine as well.

4. Opening question (Lead in with Schedule)

Appendix K: HSE Questionnaire

Organisation Profile Form

Meals-on-Wheels (MOW) Service in Ireland

SECTION A – CONTACT DETAILS

1. Name of Organisation 2. Year established

3. Address

4. Telephone No

5. Fax No

6. E-mail

7. Website

8. Contact Person

9. Position

10. Contact No

11. Local Health Office Area

12. Catchment area of organisation's activities (i.e. do you target a specific area, town, city or county)? (Please tick one box only.)

Neighbourhood/Parish	<input type="checkbox"/>	Please name:	<input type="text"/>
Village/Townland	<input type="checkbox"/>	Please name:	<input type="text"/>
Town	<input type="checkbox"/>	Please name:	<input type="text"/>
City/County	<input type="checkbox"/>	Please name:	<input type="text"/>
Other	<input type="checkbox"/>	Please give details:	<input type="text"/>

13. Does your organisation provide meals to individuals' Homes or within a Centre e.g. Day Care Centre/ Social Centre or Club/ Active Retirement Club/ Sheltered Housing/ Other... or both?
 (Please tick one box only.)

<input type="checkbox"/> ► To individual's Homes only	<input type="checkbox"/> ► PLEASE COMPLETE SECTION B (below)
<input type="checkbox"/> ► Provided within a Centre (i.e. Day Care Centre/ Social Centre or Club/ Active Retirement Club/ Sheltered Housing/ Other...)	<input type="checkbox"/> ► PLEASE COMPLETE SECTION C (go to Page 5)
<input type="checkbox"/> ► Both	<input type="checkbox"/> ► PLEASE COMPLETE SECTIONS B AND C

SECTION B – MEALS-ON-WHEELS (HOME DELIVERY SERVICE)

NOTE – THIS SECTION REFERS ONLY TO HOME DELIVERED MEALS

14. Which of the following refer clients to the meals-on-wheels service most often? Using the numbers 1-4, please put the following in order, where 1 is the most common source of referral and 4 is the least common. (Please mark N/A where a referral source is not applicable to your organisation):

GP	<input type="text"/>
Public Health Nurse	<input type="text"/>
Social Worker	<input type="text"/>
Family/Friends/Neighbours	<input type="text"/>
Self-referral	<input type="text"/>
If other please specify	<input type="text"/>

15. Do clients have to meet certain conditions before being allowed to use the service (e.g. be a certain age)?

Yes	<input type="checkbox"/>	→ GO TO Q. 16
Sometimes/It depends	<input type="checkbox"/>	→ GO TO Q. 16
No	<input type="checkbox"/>	→ SKIP TO Q. 17

16. If YES or SOMETIMES, tick all that apply and provide details in brief in the box below:

Age	<input type="checkbox"/>	Please give details	<input type="text"/>
Disability	<input type="checkbox"/>	Please give details	<input type="text"/>
Income	<input type="checkbox"/>	Please give details	<input type="text"/>
Living alone/no other support available	<input type="checkbox"/>	Please give details	<input type="text"/>
If other please specify	<input type="checkbox"/>	Please give details	<input type="text"/>

17. How many people are currently on the meals-on-wheels (home delivery service) waiting list?

18. For approximately how many weeks would an individual remain on the waiting list? (weeks)

19. How many individual clients does the meals-on-wheels service currently have?

20. On what days does the meals-on-wheels service operate? (Please tick all that apply.)

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

21. Approximately how many meals in total are prepared each day for home delivery?

Monday Tuesday Wednesday Thursday Friday Saturday Sunday

Total meals per week

22. Does the service operate on bank holidays and other public holidays? Yes No

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23. What meals does the service provide on a typical day? (Please tick all boxes that apply.)

Breakfast	<input type="checkbox"/>
Lunch (midday meal)	<input type="checkbox"/>
Dinner (evening meal)	<input type="checkbox"/>
Tea (light evening meal)	<input type="checkbox"/>
Snacks	<input type="checkbox"/>

24. Please indicate the number of meals-on-wheels clients that are:

a.	Male	<input type="text"/>	Female	<input type="text"/>
b.	Under 65 years old	<input type="text"/>	Over 65 years old	<input type="text"/>
c.	Living alone	<input type="text"/>	Living with family	<input type="text"/>
d.	Housebound	<input type="text"/>	Mobile outside the home	<input type="text"/>

25. Are clients charged for or asked to contribute to the meals-on-wheels delivery service?

Yes ► GO TO Q. 26 No ► SKIP TO Q. 28

26. If yes, approximately what percentage of the clients pay? (Please tick one box only.)

1%-24%	<input type="checkbox"/>
25%-49%	<input type="checkbox"/>
50%-74%	<input type="checkbox"/>
75%-99%	<input type="checkbox"/>
100%	<input type="checkbox"/>

27. How much does each client pay/contribute per meal (approximately)? €

28. Do you consult with clients about their meal preferences?

Yes	<input type="checkbox"/>	Please give details	<input type="text"/>
Sometimes/It depends	<input type="checkbox"/>	Please give details	<input type="text"/>
No	<input type="checkbox"/>	Please give details	<input type="text"/>

29(a) Are the meals delivered to client's homes; Hot, Cold or Frozen/Chilled or is a choice provided?

(Please tick one box only.)

Hot Cold Frozen/Chilled Is a choice provided

29(b) Who delivers the meals to clients in their homes? (Please tick one box only.)

Volunteer staff Centre staff (paid) Home Help Staff Other

If 'Other' Please specify

29(c) Does the MOW service fund the transport of meals to client's homes?

Yes No

OR

Do Volunteers provide their own transport?

Yes No

If 'Yes' are volunteers paid for travel expenses?

Yes No

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30. Are individuals given a choice of meals each day? *(Please tick one box only.)*

Yes	<input type="checkbox"/>	Please give details	<input type="text"/>
Sometimes/It depends	<input type="checkbox"/>	Please give details	<input type="text"/>
No	<input type="checkbox"/>	Please give details	<input type="text"/>

31. Do you cater for special dietary requirements?

Yes → **GO TO Q. 32** No → **GO TO Q. 32**

32. IF YES, for which ones? *(Please tick all that apply.)*

Low sodium	<input type="checkbox"/>	Gluten-free	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Low fat/low cholesterol	<input type="checkbox"/>
Vegetarian	<input type="checkbox"/>	Chewing/swallowing difficulties	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Other	<input type="checkbox"/>
If other please specify		<input type="text"/>					

33. Does your organisation use a menu rotation/cycle system? *(i.e. a series of menus repeated at regular intervals)*

Yes → **GO TO Q. 34** No → **SKIP TO Q. 35**

34. If yes, how often does the menu rotate **(approximately)**? *(Please tick one box only.)*

On a weekly basis	<input type="checkbox"/>	Please give details <input type="text"/>
On a fortnightly basis	<input type="checkbox"/>	
On a monthly basis	<input type="checkbox"/>	
Other	<input type="checkbox"/>	

35. Does a dietician or another nutrition expert have any input into the menu?

Yes No

36. What percentage of your staff/volunteers have completed:

A food hygiene ~~safety training~~ course? %
 A training course on nutrition? %

37. Does your organisation have a system in place for taking feedback/complaints from clients?

Yes No

38. What are the broad aims and objectives of your meals-on-wheels service?

IF YOUR ORGANISATION:

Provides meals within a Centre.

Does not provide meals within a Centre

COMPLETE SECTION C (next page)

SKIP TO SECTION D (Go to Page 6)



THIS SECTION REFERS ONLY TO MEALS PROVIDED TO OLDER PEOPLE WITHIN A CENTRE (Day Care Centre/ Social Centre or Club/ Active Retirement Club/ Sheltered Housing/ Other

39. Please rank from 1-4 the main sources of referral of clients to the Centre, where 1 is the most common referral source and 4 is the least common (please mark N/A where a referral source is not applicable to your organisation):

GP	<input type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>
Public Health Nurse	<input type="text"/>	
Social Worker	<input type="text"/>	
Family/Friends/Neighbours	<input type="text"/>	
Self-referral	<input type="text"/>	
If other please specify	<input type="text"/>	

40. Do clients of the Centre have to meet certain conditions before being allowed to use the service (e.g. be a certain age)?

Yes	<input type="text"/>	Please give details	<input type="text"/>
Sometimes/It depends	<input type="text"/>	Please give details	<input type="text"/>
No	<input type="text"/>	Please give details	<input type="text"/>

41. Please indicate that number of meals-on-wheels clients that are:

a.	Male		Female		
b.	Under 65 years old		Over 65 years old		
c.	Living alone		Living with family		
d.	Housebound		Mobile outside home		

42. How many CLIENTS in total avail of the MOW (in centre) service on a weekly basis?

How many MEALS in total does the MOW (in centre) service currently provide on a weekly basis?

43. Do you provide a transport service for your clients?

Yes <input style="width: 30px; height: 20px;" type="text"/>	No <input style="width: 30px; height: 20px;" type="text"/>
For some clients <input style="width: 30px; height: 20px;" type="text"/>	Transport provided by Volunteers <input style="width: 30px; height: 20px;" type="text"/>

44. How many people are currently on the Centre's waiting list?

45. On average, for how many weeks would an individual remain on the waiting list? (weeks)

46. Are clients charged for or asked to contribute to the meals provided within the Centre? Yes No

47. Are individuals given a choice of meals each day?

No choice Choice given

THIS SECTION TO BE COMPLETED BY ALL ORGANISATIONS

48. What is the legal status of your organisation? (Please tick all that apply.)

Registered Charity	<input type="checkbox"/>	Limited Company	<input type="checkbox"/>	Please give details	<input type="text"/>
Public Sector (HSE)	<input type="checkbox"/>	No Formal Status	<input type="checkbox"/>		
	<input type="checkbox"/>	Other	<input type="checkbox"/>	Please give details	<input type="text"/>

49. How many staff work for the meals provision service?

Paid (full time)	<input type="text"/>
Paid (part time)	<input type="text"/>
Voluntary (full time)	<input type="text"/>
Voluntary (part-time)	<input type="text"/>
TOTAL	<input type="text"/>

50(a). Please indicate the amount of funding that your organisation received in 2009 from the Health Service Executive:

Meals-on-Wheels	Community Meals to Centre (i.e. on-site meal service)	TOTAL
€	€	€

50(b). What percentage of your organisations overall funding is provided by the HSE? %

51. Does your organisation have insurance to cover any of the following? (Please tick all that apply)

Transportation (i.e. motor insurance)	<input type="checkbox"/>
Premises	<input type="checkbox"/>
Staff (i.e. liability coverage)	<input type="checkbox"/>
Service (i.e. liability coverage)	<input type="checkbox"/>

52. Does your organisation receive any non-financial support from other sources (e.g. advice or training)?

53. What do you perceive to be the biggest challenges to the future development of your organisation? Using the numbers 1-5, please put the following in order of preference, with 1 as the most preferable alternative and 5 as the least.

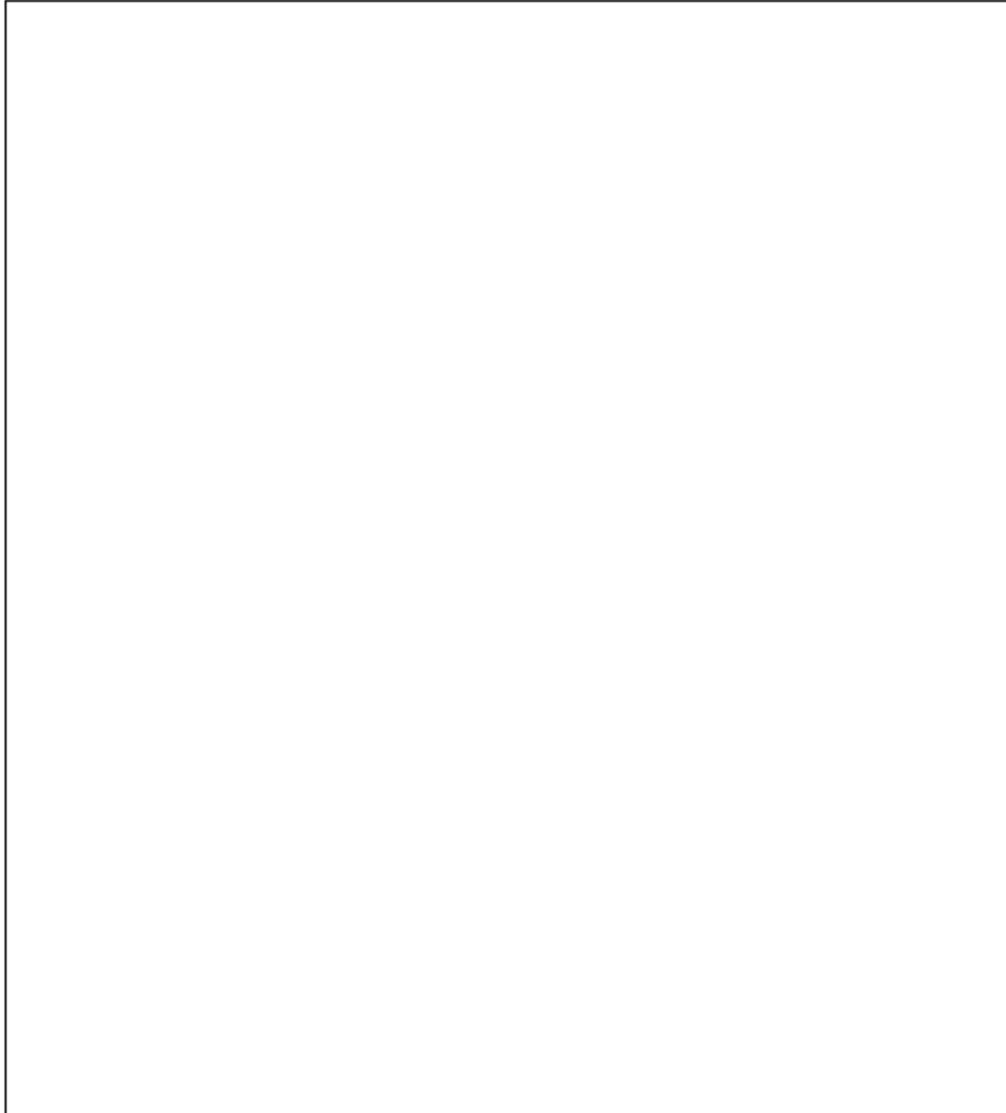
Recruiting new volunteers	<input type="text"/>	Paying for insurance coverage	<input type="text"/>
Recruiting new (paid) staff	<input type="text"/>	Complying with health and safety regulations	<input type="text"/>
Securing adequate levels of funding	<input type="text"/>	Meeting increased demand for the service	<input type="text"/>
Sourcing insurance coverage	<input type="text"/>	Other	<input type="text"/>

54. Who do you think should be responsible for funding the meals-on-wheels services? Using the numbers 1-3, please put the following in order of preference, with 1 as the most preferable alternative and 3 as the least.

State	<input type="text"/>
Community/voluntary organisations	<input type="text"/>
Families	<input type="text"/>
Other	<input type="text"/>

Appendices

If you have any other comments to make regarding the issues raised in this questionnaire please include them in the space provided below.

A large, empty rectangular box with a thin black border, intended for the respondent to provide additional comments or feedback regarding the questionnaire's issues.

THANK YOU FOR YOUR HELP

Appendix L: Protocol for Distressed Participants

Application Form

Version 4.0/13.08.2009

NUI Galway Research Ethics Committee

Ethics Protocol for Distressed Participants Contact Sheet



Contact Sheet

Please find below the contact details of local and national help groups if you feel you would like to get some support.

- Society of Saint Vincent de Paul 01 838 6990
- Senior Help Line (Confidential Listening Service for Older People) 1850 44 0444
- Samaritans (Confidential Emotional Support) 1850 60 90 90
- Aware (Mental Health Support) 1890 30 33 02
- GROW (Mental Health Support) 1890 47 44 74

Appendix M: Procedures for Dealing with Potential Disclosures

Guidelines re reporting concerns /Issues raised in the PhD interviews with Community Catering clients.

DRAFT 15.11.2012. AK



It is unlikely that a client of CC informs the student at an interview of abuse or provides information in relation to health and safety issues. Even though the risk is small of this occurring we need to have a procedure in place to guide the student in how to deal with this appropriately if it occurs.

We also need to consider what to do if a client informs the student about a general issue/concern about the service they receive. This is separate from the feedback they are giving through the interview process which will be used to inform the future development of the service. (Some situations require service follow up -

- Clients could be advised to call the service and inform staff of the issue. In the case of general issues the student could advise the older person to talk to CC re meals/finance/admin/volunteer support).
- Clients could be asked if the student can pass on the issues and get FG to call.

These procedures cover:

1. Disclosures of historical abuse /current abuse/ /risk of abuse.
2. Client Health & Safety.

Appendices

Disclosures of historical abuse /current abuse/ /risk of abuse.

If an older person discloses that they have been abused in the past, are being abused, or give information that suggests they are at risk of abuse then the interviewer has a responsibility to ensure that the older person is fully supported and the information is managed appropriately. Following disclosure the interviewer should reassure the older person and inform them that this information will be treated in confidence and as much as possible, will be handled in a way that respects the wishes of the older person (You're your Eyes TO Elder Abuse). They will be fully supported to deal with this issue. Decision will need to be made as to whether to continue with the interview or to stop (is the older person upset, anxious or fearful). If the older person is ok to continue a short break may be required. If the abuse is in the past they may have received support or this could be the first time they have talked about it. It is important to find out if they are currently safe and have support. Advise them to talk to a trusted family member or close friend, a COPE Galway Community Catering (700800) or the Senior Support Help line (1850 440 444). The approach adopted by the student will be led by the older person. The student should inform the service manager as they will assess what follow up is required with the older person and the HSE designated officer. Any information that is shared at interview by the older person in relation to disclosures of abuse or a risk of abuse must be dealt with as per the COPE Galway Vulnerable Adults policy and the Trust in Care guidelines that are in place in COPE Galway. The student will be supported through this process.

Health & Safety.

If the older person is in poor health at the scheduled interview time then the student should ask the client if they are happy to go ahead or would they prefer to reschedule the interview when they are feeling better.

If during the course of the interview it becomes apparent that there is an H&S risk to the older person the student should record the risk and ask the older person if they want the risk passed on to Community Catering staff or another suitable person.

A H&S risk may be in relation to their physical environment (poor state of repair of their home including no heating, poor security, hygiene concerns etc.). Or it may relate to the older person's self-care for example inadequate or inappropriate clothing or poor presentation.

Appendix N: Former MOW Users Study Information Sheet



Study Information Leaflet

Thank you

Thank you for deciding to take part in the study. This information leaflet explains what the study is about and your part in the study.

What is the study about?

The study is about the Meals on Wheels service, which can be known by different names such as Community Meals or Community Catering. The study will provide important information on people's experiences with the Meals on Wheels service and will help explore if changes are needed to better support people to live in their own homes.

Why have you been chosen to take part?

Although you no longer use the Meals on Wheels service, your input into the study is still valuable and can help shape the future of the service. You have been chosen to take part in the study because you are a former user of the Meals on Wheels service.

What will you be asked?

You will have the opportunity to discuss your own experiences and opinions of the service. I will be in contact by phone to arrange a suitable time, date and location to meet, where you can discuss your experiences with Meals on Wheels. The interview will take around ninety minutes to complete. If at any stage you would like to leave the interview you can do so.

How will your privacy be protected?

Your privacy will be protected at all times, with your name and information kept confidential. The interview will be recorded by tape, and written notes will be taken all, which will be kept secure. All information will only accessible by my supervisors and myself, and will only be used for this study. Any information you provide will **not** be made available to any organisations.

The study is funded by NUI Galway, with support from COPE Galway and the HSE.

Thank you for reading this Information Leaflet. Please feel free to contact me with any questions:

Christine FitzGerald

National University of Ireland Galway

091 492546

Appendices

This study is supervised by	Prof Tom Scharf	091 495459
	Dr Christine Domegan	091 492730

If you have any concerns about this study and wish to contact someone independent in confidence, please contact: Joanne O'Connor, Office of the Vice President for Research, NUI Galway. 091 492047.

Appendix O: Potential MOW Users Study information Sheet



FOCUS GROUP INFORMATION SHEET

Name of the study: “Exploring Behavioural Change in Meals on Wheels for Older People”

Thank you for voluntarily agreeing to take part in this focus group.

What is a focus group?

A focus group is a group discussion with a small group of people. It is used to gather information on people’s views about a specific topic.

What is the focus group about?

I am interested in hearing about your thoughts and opinions on the Meals on Wheels service and other issues for a study I am doing in NUIG. By taking part, your input will help shape the future of the Meals on Wheels service, to better support people to live in their own homes.

Why have you been chosen to take part?

Although you do not use the Meals on Wheels service, your thoughts and opinions on the service are very important for the future of the service. Your valued input into the study can help shape the future of the service.

What does taking part in this focus group involve?

You will have the opportunity to discuss your own thoughts and opinions of the service. The focus group will take around ninety minutes to complete. If at any stage you would like to leave you can do so.

Appendices

How will your privacy be protected?

Your privacy will be protected at all times, with your name and any information will be kept confidential. The focus group will be recorded by tape, with written notes be taken, which will be kept confidential All information will only accessible by my supervisors and myself, and will only be used for this study. Any information you provide will **not** be made available to any organisations.

Follow up

If at any stage you feel there is something that you would like to ask during or after the group, please contact me through the below details.

Thank you for reading this Information Leaflet. Please feel free to contact me with any questions:

Christine FitzGerald

National University of Ireland Galway

091 492546

c.fitzgerald1@nuigalway.ie

This study is supervised by

Prof Tom Scharf

091 495459

Dr Christine Domegan

091 492730

If you have any concerns about this study and wish to contact someone independent in confidence, please contact: Joanne O'Connor, Office of the Vice President for Research, NUI Galway. 091 492047.

The study is funded by NUI Galway, with support from COPE Galway and the HSE. COPE Galway is a charity that provides services including social supports for older people, a refuge for women and children affected by domestic violence and accommodation for those experiencing homelessness.

Appendix P: Study Information Sheet MOW Key Informants



**Study Information Leaflet
Key Informant Interviews**

Title of Study: Exploring Behavioural Change in the Provision of Meals on Wheels for Older People.

What is the study about?

The study is about the Meals on Wheels service. The aim of the study is to provide important information on peoples experience with the Meals on Wheels service. This information will be used to help identify if and what changes are needed to better support people to live in their own homes.

Who have you been invited to take part?

You have been identified as a key stakeholder in the Meals on Wheels community, making your voice and views critical to this research. Your input is invaluable, since the study's success depends on your active involvement along with that of other stakeholders. By taking part, you can provide vital insights into Meals on Wheels as well as contributing to a strategic approach to understanding the current service.

What will you be asked?

As part of this study, I am interested to hear, from your perspective, how you view the current Meals on Wheels service and its resources, and how you think it meets older people's needs. The interview will take around forty minutes to complete. If at any stage you would like to leave the interview you can freely leave.

How will your privacy be protected?

Your privacy will be protected at all times, all names and information will be kept confidential. The interview will be recorded by tape, and written notes will be taken all, which will be kept secure. All information will only accessible by my supervisors and myself, and will only be used for this study. Any information provided will **not** be made available to any organisations.

Thank you for reading this Information Leaflet. Please feel free to contact me with any questions:

Christine FitzGerald

National University of Ireland, Galway

091 492546

c.fitzgerald1@nuigalway.ie

This study is supervised by Prof. Tom Scharf (091 495459) and Dr. Christine Domegan (091 492730). If you have any concerns about this study and wish to contact someone independent in confidence please contact: Joanne O'Connor, Office of Vice President for Research, NUI Galway (091 492047). This study is funded by NUI Galway, with support from COPE Galway and the HSE.

Appendices

Appendix Q: Documentation Pre, During and Post Assessments

During Interview Assessment

Date	
Location	
Interview start time	
Interview finish time	

Notes:

Appendices

Semi Structure Interview Observations

Date:

Time:

Code:

Category	Description	Follow up (If required)
Atmosphere		
Housing		
Appearance		
Verbal behaviour and interactions		
Physical behaviour and gestures		
Human traffic		
Anything that stands out		
General impression		

Notes:

Appendices

Post Interview Notes

Date	
Location	
Gender	
What was the atmosphere?	
How were the surroundings?	
What did I do?	
What did I see?	
What did I feel?	
What stood out?	
Themes?	
Anything different?	
Anything similar?	
Any other observations?	
Anything of concern?	
Warrant further action?	

Appendix R: Codebook

Purpose	This sense of purpose in going for a social /entertainment reason rather than getting a meal may address independence issues & independence & age issues.
now Delivery time	no issue w time now delivered
now Hot/Chill Choice	gets a chilled meal, which she likes because it allows her more choice around when she wants to eat her meal.
ps. now social	Ex: The time /social contact is ppl. deliverin meal isn't something she "thought about". Shows perhaps that the social side of now isn't u. relevant to her.
Unkness	The ppl. delivery means she says she "in a hurry".
Expectations	Again, concern that if they spend time w her then someone else's meals delayed.
Other food options	hasn't tried ready made meals from shops. doesn't seem that interested in the idea.

<p>15</p> <p>Hot/Chill</p> <p>- @Chill</p> <p>- Choice</p>	<p>The idea of getting a chilled meal was received positively, it was felt this option gave more choice to the user regarding when they'd eat.</p>
<p>Reheat:</p>	<p>Due to the concern over using unclean microwaves, the group thinks that they'd reheat the food over a pan of water.</p>
<p>16</p> <p>How</p> <p>Perception</p> <p>Reviews</p> <p>↓</p>	<p>The feeling in the group seems to be that overall it'll been negative reviews from ppl who use How</p> <p>not seen even for some in the group who've never seen the meal; they don't seem keen on the idea</p>
<p>17</p> <p>How</p> <p>Stigma</p> <p>pp seeing</p> <p>the How</p> <p>won't</p>	<p>[2] concerns about ppl being able to see the How being delivered</p>
<p>Using How</p> <p>Self failure</p>	<p>EX4 in group identify that using How would be a sense of failure to the person getting the meal; that they no longer cook for themselves</p>

Appendix S: CRM Scoring Sheet

Community Readiness Assessment Scoring Sheet

Scorer: _____ Date: _____

INDIVIDUAL SCORES: Record each scorer's independent results for each interview for each dimension. The table provides spaces for up to six interviews.

Interviews	#1	#2	#3	#4	#5	#6
Dimension A						
Dimension B						
Dimension C						
Dimension D						
Dimension E						
Dimension F						

COMBINED SCORES: For each interview, the two scorers should discuss their individual scores and then agree on a single score. This is the *COMBINED SCORE*. Record it below and repeat for each interview in each dimension. Then, *add across each row* and find the total for each dimension. Use the total to find the calculated score below.

Interviews	#1	#2	#3	#4	#5	#6	TOTAL
Dimension A							
Dimension B							
Dimension C							
Dimension D							
Dimension E							
Dimension F							

CALCULATED SCORES: Use the combined score *TOTAL* in the table above and divide by the number of interviews conducted. Add the calculated scores together and enter it under total.

	Stage Score
TOTAL Dimension A _____ ÷ # of interviews _____ = _____	
TOTAL Dimension B _____ ÷ # of interviews _____ = _____	
TOTAL Dimension C _____ ÷ # of interviews _____ = _____	
TOTAL Dimension D _____ ÷ # of interviews _____ = _____	
TOTAL Dimension E _____ ÷ # of interviews _____ = _____	
TOTAL Dimension F _____ ÷ # of interviews _____ = _____	

Average Overall Community Readiness Score: _____

OVERALL STAGE OF READINESS: Take the TOTAL calculated score and divide by 6 (the number of dimensions). Use the list of stages below to match the result with a stage of readiness. *Remember, round down instead of up.*

TOTAL Calculated Score _____ ÷ 6 = _____

Score	Stage of Readiness
1	No Awareness
2	Denial / Resistance
3	Vague Awareness
4	Preplanning
5	Preparation
6	Initiation
7	Stabilization
8	Confirmation / Expansion
9	High Level of Community Ownership

COMMENTS, IMPRESSIONS, and QUALIFYING STATEMENTS about the community:

Appendices

Appendix T: CRM Scoring Consensus

Combined Scores

Interview Number	1	2	3	4	5	6	7	8	9	10	11	12	Total	Av.
Dimension A	8	5	7	7	7	6	7	6	4	6	6	6	75	6
Dimension B	4	3	4	5	4	6	4	4	3	6	5	6	54	4
Dimension C	4	3	2	2	4	3	3	3	3	3	4	3	37	3
Dimension D	3	4	4	4	3	3	4	4	3	3	3	4	42	3
Dimension E	3	3	4	3	3	3	5	4	3	3	4	3	41	3
Dimension F	5	5	3	4	3	4	5	4	3	3	4	3	46	4
Average Community Readiness Score														4.01

- A. Total Dimension A 75 / 12 interviews: 6.25
- B. Total Dimension B 54 / 12 interviews: 4.5
- C. Total Dimension C 37 / 12 interviews: 3.08
- D. Total Dimension D 42 / 12 interviews: 3.5
- E. Total Dimension E 41 / 12 interviews: 3.4
- F. Total Dimension F 46 / 12 interviews: 3.8

Overall stage of readiness: 4.01 "Preplanning Phase"

Appendix U: CRM Goals and General Strategies

Goals And General Strategies Appropriate For Each Stage

1. No Awareness

Goal: Raise awareness of the issue

- Make one-on-one visits with community leaders/members.
- Visit existing and established small groups to inform them of the issue.
- Make one-on-one phone calls to friends and potential supporters.

2. Denial / Resistance

Goal: Raise awareness that the problem or issue exists in this community

- Continue one-on-one visits and encourage those you've talked with to assist.
- Discuss descriptive local incidents related to the issue.
- Approach and engage local educational/health outreach programs to assist in the effort with flyers, posters, or brochures.
- Begin to point out media articles that describe local critical incidents.
- Prepare and submit articles for church bulletins, local newsletters, club newsletters, etc.
- Present information to local related community groups.

(Note that media efforts at the lower stages must be lower intensity as well. For example, place media items in places where they are very likely to be seen, e.g., church bulletins, smaller newsletter, flyers in laundromats or post offices, etc.)

3. Vague Awareness

Goal: Raise awareness that the community can do something

- Get on the agendas and present information at local community events and to unrelated community groups.
- Post flyers, posters, and billboards.
- Begin to initiate your own events (pot lucks, potlatches, etc.) and use those opportunities to present information on the issue.
- Conduct informal local surveys and interviews with community people by phone or door-to-door.
- Publish newspaper editorials and articles with general information and local implications.

4. Preplanning

Goal: Raise awareness with concrete ideas to combat condition

- Introduce information about the issue through presentations and media.
- Visit and invest community leaders in the cause.
- Review existing efforts in community (curriculum, programs, activities, etc.) to determine who the target populations are and consider the degree of success of the efforts.
- Conduct local focus groups to discuss issues and develop strategies.
- Increase media exposure through radio and television public service announcements.

5. Preparation

Goal: Gather existing information with which to plan strategies

- Conduct school drug and alcohol surveys.
- Conduct community surveys.
- Sponsor a community picnic to kick off the effort.
- Conduct public forums to develop strategies from the grassroots level.
- Utilize key leaders and influential people to speak to groups and participate in local radio and television shows.
- Plan how to evaluate the success of your efforts.

6. Initiation

Goal: Provide community-specific information

- Conduct in-service training on Community Readiness for professionals and paraprofessionals.
- Plan publicity efforts associated with start-up of activity or efforts.
- Attend meetings to provide updates on progress of the effort.
- Conduct consumer interviews to identify service gaps, improve existing services and identify key places to post information.
- Begin library or Internet search for additional resources and potential funding.
- Begin some basic evaluation efforts.

7. Stabilization

Goal: Stabilize efforts and programs

- Plan community events to maintain support for the issue.
- Conduct training for community professionals.
- Conduct training for community members.
- Introduce your program evaluation through training and newspaper articles.
- Conduct quarterly meetings to review progress, modify strategies.
- Hold recognition events for local supporters or volunteers.
- Prepare and submit newspaper articles detailing progress and future plans.
- Begin networking among service providers and community systems.

8. Confirmation / Expansion

Goal: Expand and enhance services

- Formalize the networking with qualified service agreements.
- Prepare a community risk assessment profile.
- Publish a localized program services directory.
- Maintain a comprehensive database available to the public.
- Develop a local speaker's bureau.
- Initiate policy change through support of local city officials.
- Conduct media outreach on specific data trends related to the issue.
- Utilize evaluation data to modify efforts.

9. High Level of Community Ownership

Goal: Maintain momentum and continue growth

- Maintain local business community support and solicit financial support from them.
- Diversify funding resources.
- Continue more advanced training of professionals and paraprofessionals.
- Continue re-assessment of issue and progress made.
- Utilize external evaluation and use feedback for program modification.
- Track outcome data for use with future grant requests.
- Continue progress reports for benefit of community leaders and local sponsorship. At this level the community has ownership of the efforts and will invest themselves in maintaining the efforts.