

The Success of Communication in  
the Adventures of Joe Fin campaign  
- Self-evaluated effects on health behaviour

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Master's thesis  
Jyväskylä University  
Organisational Communication and PR  
2010

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# ABSTRACT

Tiedekunta – Faculty Humanities	Laitos – Department Communication
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Työn nimi – Title The Success of Communication in the Adventures of Joe Finn campaign -Self-evaluated effects on health behaviour	
Oppiaine – Subject Organisational communication and PR	Työn laji – Level Master's thesis
Aika – Month and year April 2010	Sivumäärä – Number of pages 112 + appendix
<p>Tiivistelmä – Abstract</p> <p>More than half of the Finnish population do not include enough physical activity in their daily lives. Middle aged men are among the least active population groups. The Joe Finn campaign launched by Finnish Fit for Life program in 2008 aimed at improving health behaviour of middle aged men. The campaign included physical activity and cooking courses, a website providing information and tests, brochures, and lorry tour events around Finland in 18 cities. The tour consisted of day long events where people undertook various health tests as well as were inspired by a physician's lecture and humorous shows. About 7000 people attended tests and other events.</p> <p>The aim of the current study was to determine if the campaign affected health behaviour of the people who attended a lorry tour event. It is important to find out if this kind of campaign with integrated communication including health tests, with immediate feedback, as well as advice for healthier lifestyle, was effective.</p> <p>The research was conducted with a mailed questionnaire approximately one year after the lorry tour events took place. Questionnaires were sent to people who had left their contact information for the organisers during the events. The response rate to the questionnaire was 48 % (N=278). The questionnaire included questions of the participants' eating habits and physical activity before and after the event, and what kind of changes they had made due to the campaign with 5-point Likert scales. In addition, the respondents were asked to evaluate the event, campaign material, supplementary program, and the fitness tests with 5-level semantic differential scales and open ended questions.</p> <p>The results show that the campaign did have a positive effect on the participants' health behaviour. About 37 % of the respondents stated that the event and/or the campaign material had had positive effects on their physical activity, and almost 50 % said that their eating habits had been better since the event. In addition, over 90 % of the respondents thought they understood and were able to use the information they received. When evaluating the event with 5-point semantic differential scales with 5 being the positive value, people felt strongly that the event was encouraging in average 4.4 (sd. ± 0.7) and positive in average 4.6 (sd. ± 0.6).</p> <p>The modern approach of combining an event with several other methods of communication proved to be meaningful and helpful for the participants. The health tests with immediate feedback seemed to support the other campaign material and strengthened the message. Therefore, future campaigns should utilise this model as a template and develop communication strategies further.</p>	
Asiasanat – Keywords health campaign, behaviour change, integrated communication, target group communication, social marketing	
Säilytyspaikka – Depository University of Jyväskylä – Tourula Library	
Muita tietoja – Additional information	

# TIIVISTELMÄ

Tiedekunta – Faculty Humanistinen tiedekunta	Laitos – Department Viestintätieteiden laitos
Tekijä – Author Martta Mäkilä	
Työn nimi – Title SuomiMies Seikkailee –kampanjan itsearvioidut muutokset osallistujissa	
Oppiaine – Subject Yhteisöviestintä	Työn laji – Level Pro gradu tutkielma
Aika – Month and year Huhtikuu 2010	Sivumäärä – Number of pages 112 + liitteet
Tiivistelmä – Abstract <p>Yli puolet suomalaisista liikkuu terveytensä kannalta riittämättömästi. Keski-ikäiset miehet ovat yksi vähiten liikkuvista väestöryhmistä. Kunnossa kaiken ikää -ohjelman SuomiMies seikkailee -kampanja alkoi vuonna 2007, ja sen tavoitteena oli kannustaa keski-ikäisiä miehiä liikkuman enemmän ja syömään terveellisemmin. Kampanja sisälsi liikunta- ja kokkauskursseja, informaatiopitoisen nettisivun, esitteitä sekä 18 Suomen kaupungissa kiertäneen rekkakiertueen. Kiertue sisälsi päivän mittaisia tapahtumia ympäri maata, joiden aikana ihmiset suorittivat terveystestejä, kuuntelivat maalaislääkäriin ohjeita ja näkivät humoristista ohjelmaa. Noin 7000 ihmistä testattiin kiertueen aikana.</p> <p>Tämän tutkimuksen tarkoituksena oli selvittää vaikuttiko kampanja päivä tapahtumiin osallistuneiden terveystietoisuuteen. On tärkeää selvittää voidaanko tämän tyyppisellä, modernilla, useita viestinnän muotoja käyttävällä terveystietoisuuskampanjalla vaikuttaa ihmisten tapoihin. Tässä tutkimuksessa kampanjaa tarkastellaan sosiaalisen markkinoinnin näkökulmasta. Käyttäytymisen muutosta arvioidaan terveystietoisuusteorioiden pohjalta.</p> <p>Tutkimus suoritettiin postikyselynä, jonka vastausprosentti oli 48% (N=278). Kysely sisälsi 5-asteisia Likert-asteikon kysymyksiä ihmisten terveystietoisuudesta ennen ja jälkeen tapahtuman. Lisäksi ihmisiä pyydettiin arvioimaan tapahtumaa, kampanjamateriaalia, oheisohjelmaa ja terveystestejä 5-asteisilla Semanttinen differentiaali -skaaloilla sekä avoimilla kysymyksillä.</p> <p>Tulosten mukaan kampanjalla oli vaikutusta osallistujien terveystietoisuuteen. Noin 38 % vastanneista kertoi liikkuneensa enemmän tapahtuman jälkeen, ja jopa 50 % väitti kampanjan vaikuttaneen positiivisesti ruokavalintoihin. Yli 90 % vastaajista uskoi ymmärtäneensä ja voineensa käyttää kampanjan aikana saamaansa informaatiota. Ihmiset kokivat tapahtuman olleen kannustava keskiarvolla 4.4 keskihajonnan ollessa ± 0.7 sekä positiivinen keskiarvolla 4.6 keskihajonnan ollessa ± 0.6 asteikolla yhdestä viiteen.</p> <p>Moderni lähestymistapa, jossa tapahtumaan kuului useita erilaisia viestinnän metodeja, näytti olevan merkityksellinen ja auttavainen osallistuneille. Terveystestit ja niistä annettu palaute näyttävät tukeneen kampanjamateriaalia ja voimistaneen viestiä. Tulevaisuuden terveystietoisuuskampanjojen tulisi käyttää tätä mallia tukenaan ja kehittää viestintäkeinoja vielä pidemmälle.</p>	
Asiasanat – Keywords terveystietoisuuskampanja, kohderyhmäviestintä, integroitu viestintä, käyttäytymisen muutos, sosiaalinen markkinointi	
Säilytyspaikka – Depository Jyväskylän yliopisto – Tourulan kirjasto	
Muita tietoja – Additional information	

## **1 INTRODUCTION**

Encouraging people to do physical activity and eat a healthy diet is becoming important in today's society. Despite the healthier foods the Finns eat these days (National Public Health Institute 2007), the increased portion sizes and changed lifestyles have led to increasing numbers of overweight and obese people. The greater usage of TV, the Internet, computer games, and videos as well as the lesser amount of physical labour people need to do these days are causing weight problems that can lead to medical problems. Health communication aims at influencing individuals toward healthier lifestyle. Improvements in communication, as well as in the means of communication, can lead to better health outcomes.

The advertising of unhealthy foods and commercial availability of unhealthy foods have also encouraged people to eat larger quantities and more often. However, as a countermeasure, there is more available health communication than ever before. The challenge is to make the communication effective. Almost everyone has been exposed to health messages through public campaigns that seek to encourage healthy behaviours, create awareness, change attitudes, and

motivate people to adopt recommended behaviours (Thomas 2006, 2). The campaigns have traditionally relied on mass communications, such as radio and TV, but nowadays health campaigns are increasingly taking advantage of digital technologies, such as the Internet that can target audiences and tailor messages (Thomas 2006, 2).

Communication plays a major role in determining people's health status. Effective communication can e.g. increase knowledge and awareness of health issues, prompt action, demonstrate skills, show the benefits of behaviour change, and influence attitudes and beliefs (Thomas 2006, 4).

The Fit for Life program inspires adults over the age of 40 to include more physical activity to their daily routines. The Adventures of Joe Finn health campaign was organised by the program aimed at changing the health behaviour of middle aged men. The campaign, and especially the campaign communication, investigated in this study offers a new, integrated approach of communication methods combined with other strategies to influence the targeted group.

## **1.1 THE PURPOSE OF THE STUDY**

The purpose of this study is to shed light on how campaigns may contribute to a healthier life style. Current literature suggests that behaviour is not easy to change by using only mass communication, but that it takes more tailored or targeted approach of communication and facilitation.

The communication analysis of the Adventures of Joe Finn campaign can reveal how health campaigns can contribute to a healthier lifestyle. This is important because overweight and obesity are among the biggest problems in the public

health causing 200-500 million euro expenses each year (Pekkarinen, Pokka-Vuento, Salo & Idänpään-Heikkilä 2000). Physical inactivity is estimated to cause 1.9 million deaths globally (World Health Organization 2010). Overweight is the whole society's problem, and if the problem is not solved, there will be more and more economical, social, and health problems caused by overweight in the future.

Promoting a healthy lifestyle is an essential task that the Fit for Life Program has been doing for 15 years. The Adventures of Joe Fin campaign is just one example of the several campaigns the program has executed over time. However, no research has been performed regarding how successful the campaigns have been to an individual. This study is aiming to examine how this particular campaign has succeeded and how to enhance the future campaigning.

The communication of Joe Finn campaign will be analysed by theories (chapters 2 and 3) presented in the current study and reflected on based on this campaign in discussion (chapter 8).

## **1.2 THEORETICAL FRAMEWORK**

Kotler and Zaltman (1971) were the first ones to introduce the term social marketing. Social marketing means promoting voluntary behaviour change that benefits the target audience instead of the organisation promoting the change (Stellefson & Eddy 2008). The campaign promotes a healthier lifestyle to the target audience of working-aged men for the benefit of the target audience. Social marketing and target audience communication thus provide the basic theoretical frameworks for this study and are presented in chapter 3.

However, no matter how influential and effective the communication of any campaign may be, the final decision of changing one's lifestyle is up to the



person him- or herself. Thus, also behaviour change theories need to be taken into consideration when analysing the success of the campaign. The current study concentrates on the Integrative model of Theories of Planned Behaviour (TPB) and Reasoned Action (TRA), Social Cognitive Theory (SCT), and Health Belief Model (HBM) theories to analyse the success or failure of the behaviour change. According to several authors (see Noar et al. 2007, 275 for a review), these are among the most commonly used theories of health behaviour and behaviour change. These theories are presented in chapter 2.

In the current study it is analysed how the communication of the Adventures of Joe Finn campaign was build, based on the aforementioned theories. In addition, an experimental part was designed to evaluate how effective the communication was. The following combination of results are possible; 1) communication was constructed according to the theories and the results of the behaviour change were positive (++); 2) communication was not built according to the theories, but results were still positive (-+); 3) communication was done according to the theories but results were still negative (+-); or 4) communication did not match theories and the results of the aimed behaviour change were negative (--). The possible results of the combinations are presented in table 1.

Table 1. A four-field map of the possible results of communication theory and behaviour change results.

Communication Theory	+	-	+	-
Behaviour Change Results	+	+	-	-
<b>Combination of the results</b>	1) ++	2) -+	3) +-	4) --

### 1.3 RESEARCH QUESTIONS

- **RQ1: How was the Adventures of Joe Finn campaign constructed in the perspective of behaviour change theories and social marketing?**

Behaviour change theories will be presented in chapter 2 and social marketing in chapter 3.

- **RQ2: What were the results of the campaign for the participants of the Joe Finn event?**

- **Did the campaign result in behaviour change?**
- Did the participants receive and understand the communication of the campaign?
- How did the participants experience the event?
- How did it affect them?
- How was the targeted communication approach experienced?
- How did the participants experience the event and supplementary material?

The participants' health behaviour and experiences with the event were investigated with a questionnaire and presented in chapter 7.

### 1.4 DEFINITIONS

Defining the meaning of some terms often appearing in the text will help to understand the theories behind health campaigning and its possible success.

**Communication** is a process of sharing meanings by using a set of common rules (Northouse & Northouse 1998, 2). At its simplest, it means the transfer of information between a source and one or more receivers; communication

requires a sender, a message, a receiver, and a channel of communication (Berry 2006, 14). The receiver translates the message to his or her own experience and gives it significance (Vos & Schoemaker 2005, 17). Nowadays, communication is not seen anymore as one-way traffic, a linear movement from sender to receiver, but as a cyclical process, where the mutual participation in the communication process needs to be taken into consideration (Vos & Schoemaker 2005, 18).

**Integrated communication** in an organisation means that all communication of the organisation should be harmonised, also on the microlevel the various components of a campaign (Vos & Schoemaker 2005, 18). Organisations should aim at the **two-way asymmetrical communication**, which means that communication should flow between the organisation and the public, leading to mutual understanding and responsiveness between the two (Grunig & Hunt 1984, 23). Integrated methods or means of communication in the current study refer to different methods of communication, such as interpersonal communication and mass communication. The campaign evaluated here used integrated means of communication as well as facilitation to affect the health behaviour change of the participants.

**Health communication** has been defined as “any kind of human communication whose content is concerned with health” (Rogers 1996, 15), where “the focus is on transactions that are health related and on the factors that influence these factors” (Berry 2007, 15).

Communication can take place e.g. between health personnel and a customer, between medical experts, or public health officer and large audience (Rogers 1996, 15). Communication can occur as discussions between people, as mails for targeted people, or via mass media (Rogers 1996, 15). Health communication

aims at e.g. enhancing health, preventing illnesses, and healing sicknesses (Wiio & Puska 1993, 16). The goal is to empower people to make choices that improve their health behaviour. However, knowledge alone does not necessarily lead to behaviour change. Models of behaviour change are introduced in chapter 3.

It is vital to ensure that the targeted people receive the health messages, because only then communication can change health behaviour. According to Berry (2007, 17), the emphasis of health communication needs to be on effective communication. Communication has to be receiver centred and informative, and needs to promote trust and confidence (Berry 2007, 17).

Health communication is typically used in **health campaigns** (Wiio & Puska 1993, 130). According to Rogers and Storey (1987, 817) a communication health campaign is purposive and intended to cause specific human behaviour changes, it is aimed at a large number of individuals, it is conducted over a specific period of time; and it involves an organised set of communication activities. In most health campaigns, the aim is to change behaviour, for example, encouraging people to stop smoking, start exercising, or eat healthy etc. (Berry 2006, 25).

Health campaigns rely often on mass media interventions that focus on one health issue at a time (Wiio & Puska 1993, 127). Ways of interpersonal communication, such as personal advice, small group actions, and health checkups, are added to the interventions to improve effectiveness. Several means of mass media (TV, radio, posters, newspapers, brochures) as well as principles and rules of commercial marketing (social marketing introduced in chapter 4) are often used in health campaigns (Wiio & Puska 1993, 27). As a matter of fact, according to several studies (see Schooler, Chaffee, Flora & Roser

1998, 410) health communication campaigns that use multiple channels to deliver messages are more effective in changing behaviour than those that rely on a single modality.

A population measure of obesity is the **body mass index (BMI)**, a person's weight (in kilograms) divided by the square of his or her height (in metres). A person with a BMI of 30 or more is generally considered obese. A person with a BMI equal to or more than 25 is considered overweight. (WHO 2010.)

## **2 BEHAVIOUR CHANGE**

In order to design and develop health campaigns that aim to successfully increase health behaviour there are several decisions that need be made in order for the campaign to be effective. For example, decisions about the primary goal of the campaign, its target population, and the selection of the messages for the campaign (Fishbein & Yzer 2003, 164). Nevertheless, the final decision to make a health behaviour change is made by the person him- or herself. Behaviour science theory and research can give campaign designers guidelines for developing effective behaviour change programs (Fishbein 2008, 834).

However, it is obvious that the more knowledge the campaign designers have about the underlying factors of a given behaviour, the more likely it is that they can design a successful intervention to change or reinforce that behaviour (Fishbein 2008, 834).

Health behavior theories are attempts to describe why individuals do or do not engage in particular health behaviors and how individuals go about changing

their unhealthy to healthy behaviors (Noar, Chabot & Zimmerman 2007, 276). Thus, each theory suggests behavioral principles that are proposed to be common across health behaviors.

Several authors (see Noar et al. 2007, 275 for a review), have suggested that the most commonly used theories of health behaviour and behaviour change are Health Belief Model (HBM), Theories of Planned Behaviour (TPB) and Reasoned Action (TRA), Social Cognitive Theory (SCT), and Transtheoretical Model (TTM). Fishbein and Yzer (2003, 165) claim that there HBM, SCT, and TPB have been most widely used in health behaviour research and interventions.

This current study concentrates on the Integrative model of TRA and TPB, SCT, and HBM theories to analyse the success or failure of the behaviour change.

## **2.1 THE THEORIES OF REASONED ACTION AND PLANNED BEHAVIOUR**

The Theory of Planned Behaviour (TPB) and the associated Theory of Reasoned Action (TRA) study the relationships between behaviour and beliefs, attitudes, and intentions (Ajzen 1988). According to Allport (1935, 818) "attitude is a learned predisposition to respond to an object in a consistently favorable or unfavorable manner." These two theories assume that the behavioural intention is the most important determinant of behaviour, meaning that motivations and attitudes have a major role in behaviour prediction. The theories suggest that a given performance is mainly determined by the strength of a person's intention to perform the behaviour (Fishbein & Yzer 2003, 165); the single best predictor of whether one will, or will not, perform any given behaviour is the person's intention to perform that behaviour (Fishbein 2008, 836).

The intention to perform the given behaviour is viewed as the person's attitude toward performing the behaviour and/or the person's perception that others think that he or she should or should not perform the behaviour (Fishbein & Yzer 2003, 165). TPB and TRA assume that all other factors (e.g. culture and environment) operate through the model's constructs, and do not independently explain the likelihood that a person will perform certain behaviour (Glanz & Rimer 2005, 16).

According to Glanz and Rimer (2005, 16), the TPB differs from the TRA in that it includes one additional construct, perceived behavioural control. This construct refers to people's beliefs that they can actually control certain behaviour. Ajzen and Driver (1991, 197) argued that people might try harder to perform any behaviour if they feel they have a high degree of control over it.

Fishbein (2008, 834) introduces his latest formulation of the Reasoned Action approach. He calls it the Integrative Model of behavioural prediction (IM). IM includes the Theory of Reasoned Action and the Theory of Planned Behaviour. The reasoned action approach attempts "to identify a relatively small set of variables that can account for a substantial proportion of variables in any given behaviour" (Fishbein 2008, 834).

Fishbein (2008, 835) argues that the major variables, which need to be considered in order to predict, understand, change, or reinforce any given behaviour, are intention, attitude, perceived norms, self-efficacy, behavioural beliefs, normative beliefs, and control beliefs. Thus, to understand or to predict whether an individual will or will not eat fruits or exercise, a consideration of these seven variables should provide insight into how to intervene to increase



the likelihood that people will make informed decisions to engage in health-protective behaviours.

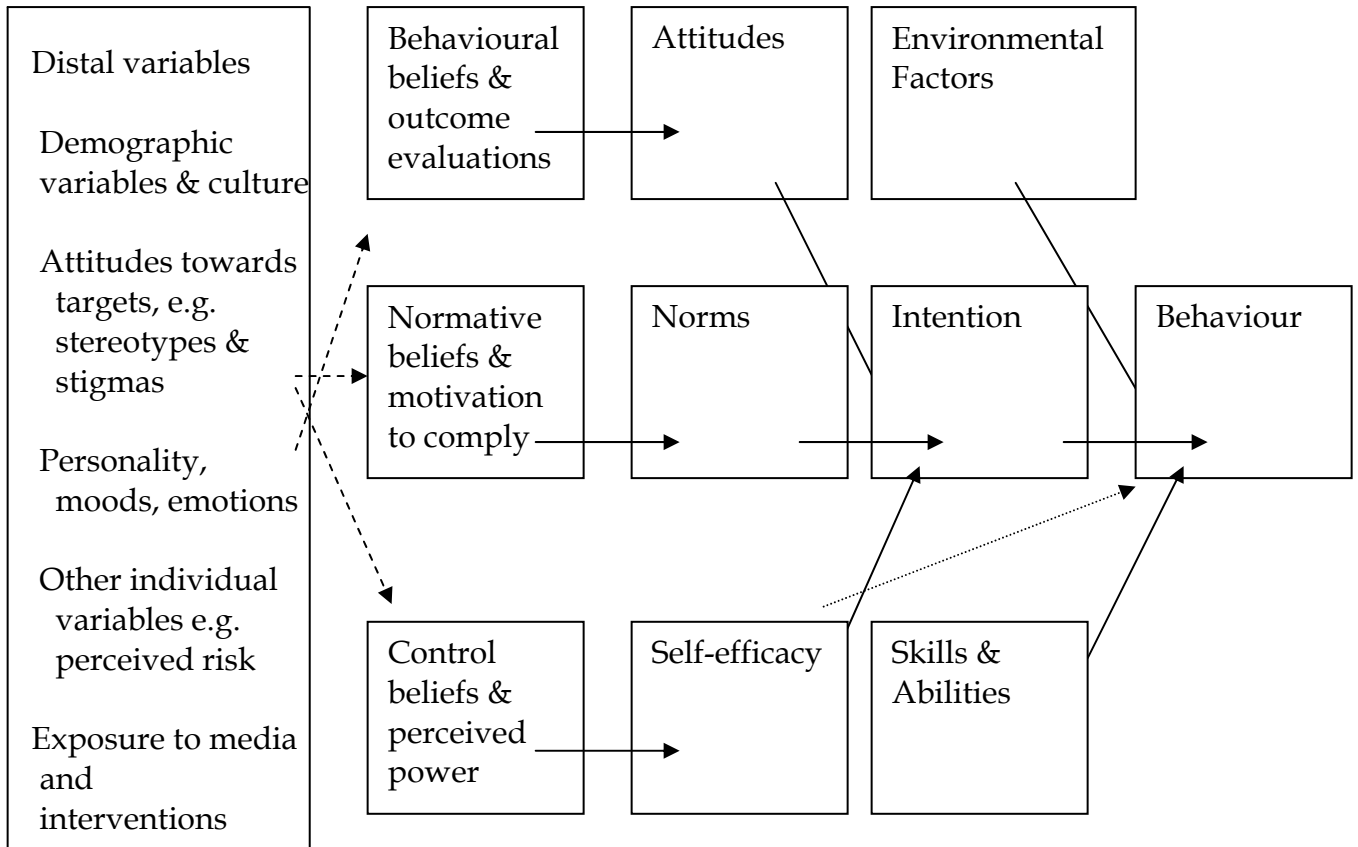


Figure 1. A reasoned action approach (Fishbein 2008, 838). (Modified from the Integrative Model of behavioural prediction figure (Fishbein & Yzer 2003, 167).

According to IM, there are three primary determinants of intention; (1) the attitude toward performing the behaviour, (2) normative influence or the amount of social pressure one feels, and (3) the individual's beliefs that one has the necessary skills and abilities to perform the behaviour (figure 1) (Fishbein 2008, 839). Therefore, if a person has a strong intention to perform a given behaviour, has necessary skills and abilities to do it, and if there are no environmental constraints to prevent to performance of that behaviour, there is a high probability that the given behaviour will indeed be performed (Fishbein

& Yzer 2003, 166). Thus, it is important to determine the degree to which a certain intervention is under these three determinants when planning campaigns.

As mentioned, according to this model, the intentions are the best single factor to predict whether one will or will not perform the given behaviour. However, intentions do not always predict corresponding behaviours. As can be seen in figure 1, several different factors might prevent an individual from acting upon his or her intentions (Fishbein 2008, 838). It should be noted that different interventions are needed depending on the factors that are actually stopping the individual performing the behaviour. For example, lacking skills or abilities to perform the behaviour requires different interventions than if one has little or no intention to perform that behaviour (Fishbein 2008, 838).

Figure 1 recognises the attitudes, perceived norms, and self-efficacy all as functions of underlying beliefs about the outcomes of performing the given behaviour, the normative prescriptions of specific references, and specific barriers to behavioural performance (Fishbein & Yzer 2003, 168). The more one believes that performing the behaviour will lead to positive outcomes and prevent negative outcomes; the more favourable one's attitude is toward performing the behaviour. Furthermore, the more an individual believes that specific others think the individual should perform the behaviour, the stronger will be the subjective norm to perform (or not to perform) that behaviour. In addition, the more a person perceives that he or she can perform that behaviour, the stronger is the person's self-efficacy in respect of performing it. (Fishbein & Yzer 2003, 168.)

Figure 1 also shows the role played by more traditional demographic, personality, attitudinal, and other individual difference variables (such as perceived risk, moods, and emotions). According to Reasoned Action theory, these variables mainly play an indirect role in influencing behaviour. However, the external variables should be reflected in the underlying belief structure.

There are guidelines how to put the reasoned theory approach into action. For example, according to Fishbein and Yzer (2003, 168), the most effective interventions are those that are directed at changing specific behaviours (e.g. walk for 30 minutes every day) rather than behavioural categories (e.g. exercise) or even goals (e.g. lose weight). Furthermore, campaign designers need to understand the behaviour from the perspective of the population they are considering to be targeted (Fishbein 2008, 840). In addition, as mentioned before, one size does not fit all, so it should be clear that campaigns, which are successful with one population or culture may be a failure in another (Fishbein 2008, 839.)

According to Dzewaltowski, Noble and Shaw (1990, 389), intention significantly predicts physical activity participation. However, the strength of the relationships between variables was weak in their study. TRA and TPB have been criticised for rationality and some limitations, such as demographics and personality, which are included in HBM, are still not included in the models. The theories assume that people are rational and make systematic decisions based on available information. This ignores unconscious motives.

## 2.2 SOCIAL COGNITIVE THEORY

In 1941, Miller and Dollard proposed the theory of social learning, and in 1963 Bandura and Walters broadened the social learning theory with the principles of observational learning and vicarious reinforcement (Twente University 2004). Bandura provided his concept of self-efficacy in 1977, while he contested the traditional learning theory for understanding learning (Baranowski, Perry & Parcel 2002, 165). Bandura updated social learning theory by adding the construct of self-efficacy and renaming it Social Cognitive Theory (SCT) (U.S. Department of Health and Human Services 2005, 20). SCT describes a dynamic and ongoing process in which personal factors, environmental factors, and human behaviour influence each other (Glanz & Rimer 2005, 19).

According to SCT, there are three main factors that affect the likelihood that a person will change his or her behaviour: self-efficacy, goals, and outcome expectations (Glanz & Rimer 2005, 20). The person has to be convinced of that he or she can actually perform the recommended behaviour, even in the face of various circumstances or barriers that make it difficult to perform the action (Fishbein & Yzer 2003, 165). The individual has to also believe that the positive outcomes or performing the behaviour will outweigh the negative outcomes (Fishbein & Yzer 2003, 165).

Since SCT integrates concepts from cognitive, behaviourist, and emotional models of behaviour change, it includes several constructs. Bandura formulated these constructs that are essential to understand and intervene in health behaviour. These constructs have been summarised by Baranowski et al. (2002, 169) and are presented here.

Table 2. SCT constructs. Baranowski et al. 2002, 169.

<b>Concept</b>	<b>Definition</b>	<b>Implications</b>
Environment	Factors physically external to the person.	Provide opportunities and social support
Situation	Perception of the environment.	Correct misperceptions and promote healthful norms
Behavioural capability	Knowledge and skill to perform a given behaviour.	Promote mastery learning through skills learning
Expectations	Anticipatory outcomes of behaviour.	Model positive outcomes of healthful behaviour.
Expectancies	The values that the person places on a given outcome, incentives.	Present outcomes of change that have functional meaning.
Self-control	Personal regulation of goal-directed behaviour or performance.	Provide opportunities for decision making, self-monitoring, goal setting, problem solving, and self-reward.
Observational learning	Behavioural acquisition that occurs by watching the actions and outcomes of others' behaviour.	Include credible role models of the targeted behaviour.
Reinforcements	Responses to a person's behaviour that increase or decrease the likelihood of reoccurrence.	Promote self-initiated rewards and incentives.
Self-efficacy	Person's beliefs about his or her ability and capacity to accomplish a task.	Approach behaviour change in small steps to ensure success; seek specificity about the change sought.
Emotional Coping responses	Strategies or tactics that are used by a person to deal with emotional stimuli.	Provide training in problem solving and stress management; include opportunities to practice skills in emotionally arousing situations.
Reciprocal determinism	The dynamic interaction of the person, the behaviour, and the environment in which the behaviour is performed.	Consider multiple avenues to behavioural change including environmental, skill, and personal change.

The concepts of the 11 constructs provided above refer to the environment in which the given concept functions. Compared to TRA and TPB, SCT takes into consideration observational learning, reinforcements, emotional coping responses, and reciprocal determinism.

Observational learning refers to the process by which people learn through experiences of others, rather than through their own experiences. Reinforcements mean responses to the given behaviour, and that will affect whether a person will repeat the behaviour (Glanz & Rimer 2005, 21). Emotional coping responses refer to situations in which people face obstacles when attempting to perform the given behaviour. Reciprocal determinism is the continuing interaction between personal factors, environmental factors, and human behaviour (Baranowski et al. 2002, 168). The three components are constantly influencing each other, and a change in one variable also has implications for the other two (Baranowski et al. 2002, 168). Implications in table 2 give an example how each concept should be taken into consideration and could be used in a health intervention.

TRA, TPB, and SCT all postulate cognitive based mechanisms that influence self-regulation of an action (Dzewaltowski, Noble & Shaw 1990, 392). However, according to the authors, self-efficacy and perceived behaviour control are not similar constructs. Perceived behaviour control means an individual's perceived ease or difficulty (Dzewaltowski et al. 1990, 392) of performing the behaviour, where as self-efficacy is an individuals' own judgement of his or her ability to cope effectively in a certain situation (Clark, Abrams, Niaura, Eaton & Rossi 1991, 739). According to Dzewaltowski et al. (1990, 399), self-efficacy has direct effect on behaviour and is a better predictor of behaviours than intentions.

Another difference between TRA/TPB and SCT is that SCT lists goals as one of the most important factors in causing behavioural change. According to Fishbein (2008, 837) and his IM, interventions directed at changing specific behaviours are more effective than those directed at behavioural categories or goals, whereas SCT emphasises the importance of goal setting in addition to self-efficacy and outcome expectancies. According to Bandura (2001, in Latham, 2006, 71), behaviour is both determined by and, also, affects consequences of the given behaviour, which in turn affect the person's conscious intentions and goals, and vice versa.

### **2.3 THE HEALTH BELIEF MODEL**

The Health Belief Model (HBM) is another psychological model that attempts to explain and predict health behaviours by focusing on the attitudes and beliefs of individuals (Rosenstock, Strecher & Becker 1994, 5). The model was originally introduced by Rosenstock in the 1960's and further developed by Becker and Rosenstock in the 70's and 80's (Berry 2006, 44). HBM has been one of the most widely used psychosocial approaches to explain health-related behaviour since the 1950's (Rosenstock et al. 1994, 5; Glanz & Rimer 2005, 13).

According to their theory, people's beliefs about the real threat of the disease for themselves, and their perceptions of the benefits of trying to avoid it, influences their readiness to act (Glanz & Rimer 2005, 13.) According to HBM, perceived threat motivates people to take action, but beliefs about potential behaviours determine the final behaviour (Berry 2006, 44). Threat is evaluated in terms of both perceptions of the severity of a particular health problem and perceptions of the person's vulnerability to that health problem. This means that effective health communications need to emphasise both of these factors in order to

influence health beliefs and behaviour. Relevant beliefs concern the perceived benefits of taking appropriate action as well as any perceived barriers to taking that action. (Berry 2006, 44.) The persons must believe that the benefits for performing the recommended behaviour outweigh the costs of performing the behaviour (Fishbein & Yzer, 2003, 165).

In other words, according to the HBM, the probability that someone will take action in order to prevent illness depends on the individual's perception that they are personally vulnerable to the condition, the consequences of the condition would be serious, the precautionary behaviour effectively prevents the condition, and the benefits of reducing the threat of the condition exceed the costs of taking action (Rosenstock et al. 1994, 6).

Table 3. HBM constructs. LaToya, Ahmad, McNally & Stewart 2002, 124.

<b>Concepts</b>	<b>Definition</b>	<b>Implications</b>
Perceived susceptibility	One's opinion of chances of getting a condition	Define populations at risk, risk levels; personalise risk based on a person's features or behaviour; heighten perceived susceptibility if too low
Perceived severity	One's opinion of how serious a condition and its consequences are	Specify consequences of the risk and the condition
Perceived benefits	One's opinion of the efficacy of the advised action to reduce risk or seriousness or impact	Define action to take; how; where, when; clarify the positive effects to be expected
Perceived barriers	One's opinion of the tangible and psychological costs of the advised action	Identify and reduce barriers through reassurance, incentives, assistance
Cues to action	Strategies to activate "readiness"	Provide how-to information, promote awareness, reminders
Self-efficacy	Confidence in one's ability to take action	Provide training, guidance in performing action



The HBM has six fundamental constructs; perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Rosenstock, et al. 1994, 7-13). Table 3 provides each concept a short definition and an implication of how to use it in a health intervention. Together the six constructs provide a useful framework for designing both short-term and long-term behaviour change strategies (Glanz & Rimer 2005, 13).

Health campaigns often identify people, who are at risk of diseases, (e.g. smokers for lung cancer or obese people for coronary heart disease) but currently have not had any symptoms. Due to the individuals not feeling sick, they may not follow instructions to stop smoking or lose weight. The HBM can be useful for developing strategies to deal with non-compliance in such a situation (Glanz & Rimer 2005, 14).

According to the HBM, people who do not have symptoms, may not follow a prescribed treatment regimen unless they accept that even though they do not have any symptoms, they do have for example high blood pressure (perceived susceptibility). They must realise that arterial hypertension can lead to cancer or heart attacks (perceived severity). Quitting smoking or following a recommended weight loss programme will reduce the risks (perceived benefits) without negative side effects or excessive difficulty (perceived barriers). Print materials, reminder letters, or flyers might encourage people to consistently follow their physician's recommendations (cues to action). For those who have had difficulty in the past with losing weight or maintaining weight loss, a behavioural plan might help establish achievable, short-term goals to build confidence (self-efficacy). (Glanz & Rimer 2005 14.)

HBM has been applied to several health behaviours, such as smoking, dieting, and exercise, and number of studies have provided support for the model (Berry 2006, 44).

## **2.4 SELF-EFFICACY**

Since self-efficacy is mentioned as a variable affecting behaviour change in all the three theories presented here, further introduction of the term is needed.

In 1977, Bandura presented his theory of self-efficacy expectations in his article "Self-efficacy: Toward a Unifying Theory of Behavioural Change." Bandura (1977) claimed that expectations of personal efficacy determine whether certain behaviour will be initiated, how much effort will be expended, and how long it will be sustained in the face of obstacles. Self-efficacy is an individual's own judgement of his or her ability to cope effectively in a certain situation (Clark et al. 1991, 739). Self-efficacy beliefs provide the foundation for human motivation, well-being, and personal accomplishment (Pajares 2002). Perceived self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives (Bandura 1994). Thus, self-efficacy beliefs determine how a person feels, thinks, motivates him or herself and behaves (Bandura 1994).

### **2.4.1 Self-efficacy and behaviour change**

According to Bandura (1977), changes in a human's behaviour, achieved by different methods, derive from a common cognitive mechanism. Self-efficacy affects people's choice of activities and behavioural settings, such as how much effort they will put into something, and how long they will persist when facing

obstacles (Bandura & Adams 1977, 288). Thus, the level of one's perceived self-efficacy will affect whether the person will even try to change.

Bandura and Adams (1977, 290) studied the changes of snake phobic adults behaviour and self-efficacy in their research of 18 subjects. The subjects' pre-tests included performance capabilities, degree of fear with snakes, and efficacy expectations on a 100-point probability scale. The subjects expressed significantly higher self-efficacy results at the post-tests. The results reveal that desensitisation enhances strength and level of efficacy expectations. Furthermore, the stronger the performance expectations at the completion of the treatment were, the higher the level of approach behaviour was (Bandura & Adams 1977, 297).

Bandura and Schunk (1981, 588) studied 40 children for the effects of self-efficacy in their mathematical skills. Along the results of the study, it is shown that setting proximal sub goals increase the perceived self-efficacy and even further gains in the post-tests. The group with proximal sub goals exceeded all other groups in self-efficacy. This study shows the importance of setting smaller goals on the way to the finale.

Schnoll and Zimmerman (2001, 1007) investigated how goal-setting and self-monitoring affected college students fibre consumption. The goal was to enhance dietary fibre self-efficacy and foster a positive change in fibre consumption. According to the results, goal-setting had a significant effect on fibre self-efficacy and on fibre consumption. Scholl and Zimmerman (2001, 1006) believe that combining goal-setting and self-monitoring enhances dietary behaviour change significantly.

The study of Schnoll and Zimmerman (2001) highlights the importance of self-efficacy as mediator in a relationship between knowledge and behaviour change. However, it is obvious that dietary change does not occur from knowledge alone. If that was the case, labelling cigarette cartons and fatty foods dangerous would reduce the consumption of such products. Setting specific goals and keeping written records are essential in order to achieve change. The act of keeping written records further enhances self-regulation (Schnoll & Zimmerman 2001, 1010).

The mentioned studies show the importance of strengthening self-efficacy in order to people to achieve their goals. Setting smaller goals on the way to the final aim, keeping records of one's progress, and desensitisation can reinforce people's self-efficacy, and thus, make people to reach their target.

### **3 SOCIAL MARKETING**

The theories of behaviour change help us identify the critical behavioural, normative, or control beliefs that must be addressed if a campaign wishes to reinforce or change any given behaviour (Fishbein 2008, 842). According to Fishbein (2008, 842), the biggest challenge at the moment is how to design communications or other types of interventions that will successfully change beliefs. Even with the most sustained and concerted efforts to implement detailed and focused health education programmes, the chances of a successful outcome are limited (Whitehead & Russell 2004, 164). Informing individuals about health and health risk does not necessarily lead to a change in health behaviour. The natural reluctance of individuals to incorporate new health related information into their existing cognitive processes means that new information will be, at best, only slowly incorporated (Whitehead & Russell 2004, 164).

Social marketing theory gives campaign designers one framework for trying to affect those beliefs.

### 3.1 DEFINITION AND DEVELOPMENT

According to the American Marketing Association Board of Directors (2007), marketing is an organisational function and a set of processes for creating, communicating, and delivering value to customers and for managing customer relationships in ways that benefit an organization and its stakeholders.

The term of social marketing was first introduced by Kotler and Zaltman in 1971 according to several sources (e.g. Bloom & Novelli 1981; Lefebvre & Flora 1988, 301; MacFadyen, Stead & Hastings 1999, 1; Weinreich 2006). Kotler and Zaltman defined the term as "the design, implementation, and control of programs calculated to influence the acceptability of social ideas and involving considerations of product planning, pricing, communication, distribution, and marketing research" (1971, 5). According to Weinreich (2006), Kotler and Zaltman are the founding fathers of the term, when they realised in the 1970s that the same marketing principles for selling products could be used in order to sell ideas, attitudes, or behaviours to the consumers.

In addition to Kotler and Zaltman's research, similar developments were taking place at the same time around the world (McKie & Toledano 2008, 320). At the end of 1950's and the beginning of the 1960's several marketing academics were already considering potential limitations and possibilities in applying marketing principles to politics and social changes (MacFadyen et al. 1999, 1). Already in 1952, G. D. Wiebe asked the question "Why can't you sell brotherhood like you sell soap?" (Kotler & Zaltman 1971, 3). There were concerns to include marketing strategies in promoting social causes, but the marketing concept was eventually redefined to include the marketing of ideas. Furthermore, early examples of social marketing were already emerging in the 1960's as a part of

international development efforts in third world countries (MacFadyen et al. 1999, 2).

Later, researchers have further defined the term that Kotler and Zaltman were the first ones to use. Kotler (1975) said that social marketing includes raising the acceptability of ideas or habits within a target group. Social marketing applies marketing ideas to the introduction and dissemination of marketed issues (Fine 1981, 20) and is a strategy that translates scientific knowledge into effective communication strategies (Manoff 1985). Social marketing promotes voluntary behaviour change and the goal is not to benefit the marketing organisation, but the targeted individuals (Stellefson & Eddy 2008, 489).

Lefebvre and Flora (1988, 300) point out that social marketing methods and concepts are close to those of traditional marketing, but social marketing is distinguished by its emphasis on so-called intangible products. Those are ideas, attitudes, lifestyle changes etc.; things that cannot be physically touched. Traditional marketing, on the other hand, focuses on tangible products and services (Lefebvre & Flora 1988, 300). However, Lefebvre and Flora (1988, 300) point out that sometimes the differences between business and social marketing can be blurred, for example when fast food restaurants offer the nutrition value of their meals or condom manufacturers provide information of AIDS.

According to Kotler and Andreasen (in Weinreich 2006), the only difference between business and social marketing is the goals of the marketer and his or her organisation. Social marketing is an attempt to influence the behaviour of the target audience. The goal is not to seek profit for the organisation but to benefit the target audience and general society. (Weinreich 2006). Social marketing is also mainly based in local and national government and non-profit

sectors where social marketers also tend to work in or for those sectors (McKie & Toledano 2008, 319).

According to MacFadyen et al. (1999, 1), social marketing is more difficult than business marketing. Social marketing involves changing behaviours with often very limited resources (Lefebvre & Flora 1988, 302). Furthermore, the ultimate goal for business marketing is to meet shareholder objectives and make profit, whereas "for the social marketer the bottom line is to meet society's desire to improve its citizens' quality of life" (MacFadyen et al. 1999, 1).

Traditionally business marketers have used production and sales orientated marketing strategies (Lefebvre & Flora 1988, 301). Production orientation strategy, which was predominant in the first half of the 20th century, means increasing output and reducing costs. Sales orientation is characterised by high sales and high profits. (Lefebvre & Flora 1988, 301). Fine (1981, 20) has described these types of orientations as push marketing, where the organisation pushes its products or services to the consumers without paying much attention to their needs. "The role of the client is to buy, or be persuaded to buy, the product" (Lefebvre & Flora 1988, 301).

In modern business marketing, the focus is on the needs and interests of a client (Lefebvre & Flora 1988, 301). Fine (1981, 20) calls this type of marketing pull marketing, where consumers "pull" certain ideas or services out of organisations. As in business marketing, the main focus in social marketing is on the consumer. Marketers are attempting to learn what people need and want rather than trying to affect them to purchase what the organisations wants to sell (Weinreich 2006). As Donaldson (2008, 152) points out, making the change of behaviour sound appealing to the individuals is vital in social marketing.



## **3.2 MARKETING MIX IN HEALTH PROMOTION**

McCarthy (1968) was the first one to introduce the famous four P's of marketing. These four distinct elements of marketing; product, price, place, and promotion, called the marketing mix, have been researched actively in the business and advertising sectors (Lefebvre & Flora 1988, 306). Kotler and Zaltman (1971) were the first to introduce how the four P's apply to social marketing.

### **3.2.1 The Product**

In business marketing, organisations research the needs and wants of the target market and then attempt to design and sell products and services to meet the audiences needs (Kotler & Zaltman 1971, 7). In social marketing the product is not necessarily a tangible object but can also mean an idea, a social cause or behaviour change (Weinreich 2006; Lefebvre & Flora 1988, 306). The marketers need to study the target audiences and create a package which is desirable for a consumer to purchase (Kotler & Zaltman 1971, 7). In social marketing the primary product is often a behaviour (e.g. eating more vegetables, exercising more) that might be accompanied by secondary products (gym tickets) or goods or services (e.g. personal trainer services) (Pirani & Reizes 2005, 132).

According to Weinreich (2006), the audience must first realise that they have a real problem and that the product that is offered is the right solution for the problem. MacFadyen et al. (1999, 5) point out the complexity of the social marketing products. The complexity (Figure 2) makes social marketing products hard to conceptualise and thus harder for social marketers to define their exact products and the benefits of using the products.

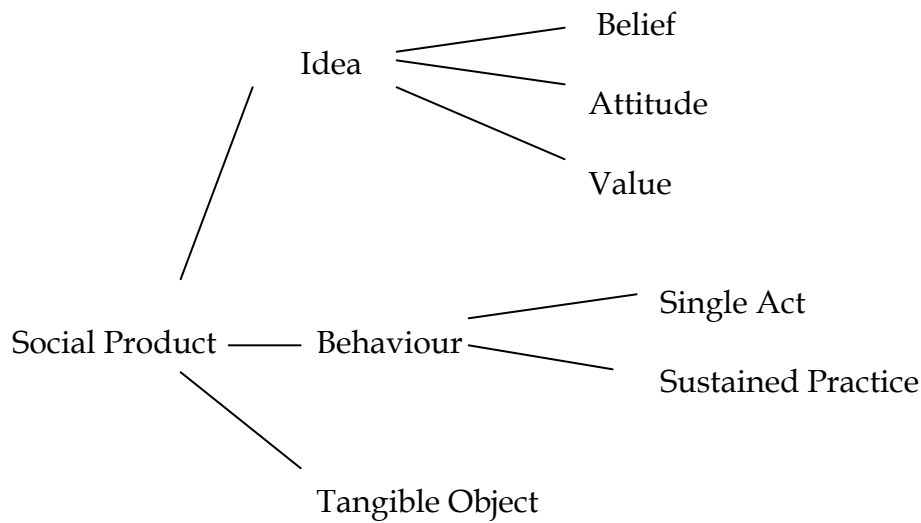


Figure 2. The complexity of social marketing products. (MacFadyen et al. 1999, 5.)

### 3.2.2 The Price

In business marketing, the price is usually given in currency, and it is clear for the consumer. However, costs also include opportunity costs, energy costs, and psychic costs (Kotler & Zaltman 1971, 9). Thus, the cost could require the consumer to give up some intangibles, for example time or effort (Weinreich 2006). The costs should not outweigh the benefits for the consumer, since the perceived value of the offered product will be low and will be unlikely to be adopted. However, if the benefits are valued as greater than the costs, chances of adopting the product are much more likely (Weinreich 2006).

Lefebvre and Flora (1988, 307) call the costs in social marketing “barriers” for the consumer. In health promotion these barriers for the consumer tend to receive the most attention (Lefebvre & Flora 1988, 307). One of the biggest challenges in health promotion, and in social marketing in general, is to reduce these barriers and make the results of certain behaviour override the barriers. In health promotion people can exchange time, physical effort, and lifestyle for a

healthier life. The benefits should always be acknowledged clearly in the marketing plan.

According to exchange theory (Bagozzi 1978, 34), people act primarily out of self interest when they seek ways to optimise value by doing what gives the greatest benefit for the least cost (Grier & Bryant, 2005, 321). The theory of exchange in social marketing means that the audience adopt or reject or maintain a new behaviour and in return receive benefits that they believe outweigh the costs of that behaviour (Pirani & Reizes 2005, 132).

### **3.2.3 The Place**

Place refers to the way the product reaches the consumer (Weinreich 2006). Place can also be described as arranging the accessible outlets which allow the translation of motivations into actions (Kotler & Zaltman 1971, 9). In business marketing this means the distribution system, for example stores that products and services are sold. In social marketing the place is less clear, “but refers to decisions about the channels through which consumers are reached with information or training” (Weinreich 2006). For health promotion, this could mean for example doctors’ offices, worksites, or shopping malls.

According to Lefebvre and Flora (1988, 307), the place decisions should be made based on in-depth channel analysis before the implementation. Knowledge of where people will most likely encounter messages during their everyday life can be used when making distribution decisions. In addition, places can increase costs and barriers to consumers due to their possible inaccessibility and distance (Lefebvre & Flora 1988, 307). Social marketer should always make the distribution channels available and easy to access.

### 3.2.4 The Promotion

The last of the four P's is promotion. As Weinreich (2006) points out, promotion is only one piece of and not the whole of social marketing, as can be mistakenly thought due to its visibility. Promotion consists of advertising, public relations, publicity, personal contact, promotions etc. According to Kotler and Zaltman (1971, 7), promotion is "the communication-persuasion strategy and tactics that will make the product familiar, acceptable, and even desirable for the audience."

Promotion focuses on creating and sustaining demand for the product (Weinreich 2006). Research is essential in order to design the most effective ways reach the target audience and increase the demand. When used correctly, promotion can be a major tool when trying to make health promotion products more acceptable, and enhancing their utilisation by the consumers (Lefebvre & Flora 1988, 308).

Determining the four P's in any marketing campaign requires strategy development. The right product, price, and distribution channels should always be developed before considering promotional activities (Steffelson & Eddy 2008, 491). In addition, Donaldson (2008, 152) and Weinreich (2006) introduce additional P's for social marketing. Publics refer to both external and internal groups involved in a program. Partnership means cooperating with other organisations in the community in order to be effective. Policy change is often needed in order to sustain the change in the long run. Purse strings (Weinreich 2006) mean finding funds for the program from, for example, foundations, grants, and donations. Donaldson (2008, 152) also mentions politics that can influence the promoted change.

### 3.3 CHALLENGES OF SOCIAL MARKETING

One challenge for social marketers is the fact they do not try to only influence an individual, but also society as a whole, as well as groups or organisations. Levy and Zaltman (1995, in MacFadyen et al. 1994, 4) provide a six fold classification of the types of change sought in social marketing, incorporating two dimensions of time (short term and long term) and three dimensions of level in society (micro, group, and macro). Thus, social marketing can influence not just individual consumers, but also the environment in which they operate (Table 4). Also according to an ecological model for health promotion, the environmental changes (macro level) to promote e.g. physical activity will encourage and reinforce individual behaviour (micro level) changes (Foster 2000, 22).

Table 4. Types of social change, by time and level of society. (MacFadyen et al. 1999, 4) The table's examples have been modified to represent health promotion.

	<b>Micro level</b> (Individual consumer)	<b>Group level</b> (Group or organisation)	<b>Macro level</b> (Society)
Short term change	Behaviour change	Change in norms Administrative change	Policy change
EXAMPLE	Attending a health promotion campaign	Removing candy machines from schools or work cites	Adding more tax for unhealthy food
Long term change	Lifestyle change	Organisational change	'Socio-cultural evolution'
EXAMPLE	Starting to eat more healthy foods	Providing gym tickets for employees	Reduction of obesity related diseases

The changes in group and macro level are significant because they also impact on health and lifestyle decisions (MacFadyen et al. 1999, 5). For example, a

person might want to eat healthier foods or starts going to the gym, but the monetary costs are too big of a barrier. Decisions made by the government as to the price of vegetables and fruits and to add tax to hamburgers and lemonade may encourage people to make changes in their lifestyles.

Bloom and Novelli (1981, 80-87) introduce several problems and challenges that social marketers may face compared to business marketers. To mention a few, social marketers have more difficulty formulating product concepts, more difficulty selecting and implementing long-term positioning strategies, difficulties measuring their prices, difficulty utilizing and controlling desired intermediaries, and social marketers also often face rejection by consumers to adopt certain kind of behaviours.

MacFadyen et al. (1999, 5) mention the differences between business and social marketing to be challenging for the social marketer. According to MacFadyen et al., (1999, 6), in social marketing, products are more complex (as mentioned in the Marketing mix -section), demand is more varied, and target groups are more difficult to reach. However, the authors also mention that consumer involvement is often more intense and that the competition is more subtle and varied.

### **3.4 SOCIAL MARKETING AND HEALTH PROMOTION**

Health promotion means here promoting healthy lifestyles, such as eating and exercise habits, avoiding sexually transmitted diseases, using tobacco products, and drugs.

The aim of social marketing is to change behaviour within a target group. The focus and starting point in social marketing is the individual, by placing the emphasis on understanding the individual's situation, which includes social environment, beliefs, knowledge, and current behaviours (Donaldson 2008, 152).

According to Pirani and Reizes (2005, 132), social marketing is a useful tool in health promotion when an audience is ready for the message but not yet ready to adopt the behaviour. Social marketing can help to understand and address the specific needs of different segments and, furthermore, can also help to identify their specific barriers by using the marketing mix (Pirani and Reizes 2005, 132). According to Stellefson and Eddy (2008, 489), marketing and health education both aim towards the same goal of influencing behavioural changes that are voluntary.

Nowadays several organisations and governments are using tools of social marketing in promoting health issues (Grier & Bryant 2005, 319; Donaldson 2008, 153). According to the U.S. Agency for International Development (1999), "social marketing has been the single most important contribution that the family planning field have made to the prevention of HIV/AIDS and other STI's (sexually transmitted illnesses)" (Donaldson 2008, 153).

Even though social marketing seems to be a useful way of promoting healthy lifestyles, there are also challenges and contradictions with its usage. According to Peattie and Peattie (2003), there is a danger that the direct translation of business marketing principles as well as practices into social contexts can create practical problems and confusion regarding the theoretical basis of social marketing. Among the literature there are also concerns about the degree to which relationship marketing, branding, and an analysis of competition are

useful when marketing public health products (Grier & Bryant, 2005, 334). Furthermore, as Stellefson and Eddy (2008, 490) point out, theory can suggest what needs to be done in order to achieve change, it can not necessarily show health educators how to initiate change.

However, there are several examples of successful health promotion campaigns in the literature (e.g. Lefebvre & Flora 1988, 309-313; Grier & Bryant 2005; Donaldson 2008, 153). The tools of social marketing when correctly used and embraced in each campaign with care can be successful in promoting a healthy lifestyle.

### **3.5 TARGETED COMMUNICATION**

The promotion of social, or any marketing, needs to focus on a certain group in order to be effective. Targeted communication means defining a certain population group, usually based on one or more demographic characteristics that all the members of the group share, such as age, gender, or ethnicity (Marcus, Nigg, Riebe & Forsyth 2000, 122). The approach assumes that the members of the group are similar enough in order to successfully receive the sent message (Marcus et al. 2000, 122). The level of audience specificity can vary considerably from, for example, all men to 30–40 years old working men living in the certain area (Kreuter & Wray 2003, 228). Targeted communication is based on the principles of market segmentation, where the goal is to find the accurate consumer group for certain products (Kreuter, Farrell, Olevitch & Brennan 1999).

#### **3.5.1 Advantages and disadvantages of targeted communication**

Targeted communication is a quite commonly used approach (Suggs & McIntyre 2007), and it is more cost effective than tailored or personalised



communication since there is no need for gathering data from the target population for example (Kreuter & Wray 2003, 230). Personalised communication means communication that has a standardised content, but has the recipient's name placed on the material (Kreuter et al. 1999). Tailored communication is communication that is tailored to reach one specific person, and it is based on the characteristics of the individual (Kreuter & Skinner 2000, 2).

A message receiver is more likely to perceive a message as more relevant if it is seen as a response to the individual's wants and needs (Kreuter & Wray 2003, 228). There is evidence from studies that targeted communication has helped to promote behaviour change, and sometimes it may be financially the only feasible option (Kreuter & Wray 2003, 228). In addition, when there is no considerable variation within the population, there is no need for tailored communication (Kreuter & Wray 2003, 228).

However, there are some limitations in targeted communication. Targeted communication makes the assumption that there is a certain homogeneity within the targeted population and that justifies using the same approach for the whole group (Kreuter et al. 1999, 5). Targeted materials can not address naturally occurring variations that are important but not demographic, in the population (Kreuter et al. 1999, 5). These variations may include beliefs, knowledge, and behaviours (Kreuter & Wray 2003, 228). As a result, according to Kreuter et al. (1999, 5), targeted communication lacks "the depth of understanding that is often necessary in order to develop truly individualised strategies to address complex lifestyle behaviours."

Tailored communication has been found to be more effective than targeted communication (Kreuter & Strecher 1996, 98). Studies have shown that compared to non-tailored messages, tailored messages are more likely to be read and remembered, saved and discussed with others, rated as attention catching, and perceived as personally relevant (Kreuter & Wray 2003, 229). In addition, providing tailored feedback has also been found to be effective (Marcus et al. 2000, 122).

### **3.5.2 Targeted communication in health campaigns**

It is commonly believed that by knowing and understanding the cultural characteristics of a given group, public health and health communication programs and services can be customised to better meet the needs of its members (Kreuter & McClure 2004, 439). Culture is often described as learned and shared group's values, beliefs, norms, practices, patterns of communication, familial roles, as well as other social regularities. The cultural characteristics of a certain group might be directly or indirectly associated with health-related priorities, decisions, behaviours, and acceptance and adoption of health education and health communication programs. In addition, concordance between the cultural characteristics of a certain group and the public health approaches used to reach its members may enhance receptivity, acceptance, and salience of health information and programs. (Kreuter & McClure 2004, 440-441.)

The process of partitioning large and heterogeneous populations into smaller and more homogeneous subgroups based on, for example, demographic, behavioural, psychosocial, geographic, cultural, and risk-factor characteristics is called audience segmentation (Slater 1996, 267). Audience segmentation is a well-accepted best practice in health communication based on decades of

experience and research (Slater 1996, 267). Once an audience segment has been defined and a profile for that segment has been created, a comprehensive communication approach that is targeted to that group can be developed (Kreuter & McClure 2004, 441).

Successful population-based interventions for physical activity are based on the ability to communicate to large number of individuals in an efficacious yet cost-effective manner (Marcus et al. 2000, 122). Targeted communication to a certain segment follows that guideline.

## **4 THE FIT FOR LIFE PROGRAM**

The Fit for Life Program (KKI in Finnish) was established in 1994 ([www.kki.likes.fi](http://www.kki.likes.fi)). The program is a section of the Foundation for Sport and Health Sciences (LIKES). The aim of the program is to inspire adults aged over 40 to include (more) physical activity into their daily routines. The program creates physical activity services that are easily available and close to the middle-aged and senior population. The local Fit for Life projects (over 700 in Finland) are organised in cooperation with different organisations, such as municipal sports and health services, workplaces, occupational health care, sports clubs, various associations, and public health organizations. These local projects can apply for funding from a national program, which is funded by the Ministry of Education and Ministry of Social Affairs and Health. ([www.kki.likes.fi](http://www.kki.likes.fi))

The Fit for Life Program is located in Jyväskylä, Finland, and it employs eight people. The program is mainly funded by Ministry of Education and Ministry of Social Affairs and Health. In addition, Ministry of Transport and

Communication, Ministry of the Environment, and Metsähallitus (Forest institution) support it.

The program has a website, a magazine appearing four times a year, and several other publications. The printed publications can be ordered from the program for free or for a small price. The books, magazines, and leaflets aim at encouraging people toward a healthier lifestyle. There are publications about nutrition, exercise, mental health, and self-confidence, to mention a few. Some are aimed at professionals, who work as instructors in exercise groups, and some are aimed at different age groups.

The Fit for Life program is a non-profit organisation, and its primary goal is to encourage people toward a healthier lifestyle.

## **5 THE ADVENTURES OF JOE FINN CAMPAIGN**

The idea of the Adventures of Joe Finn -campaign was first created in Pirkanmaa, when the Heart Association of Pirkanmaa, Physical Activity and Sports of Häme and Pirkanmaa health care district together had a prevention program against type II diabetes for middle-aged men, and then decided to plan a physical activity course for men who do not include enough physical activity into their daily lives. The course successfully reached the target group and the idea was then further developed with the Fit for Life -program into the Adventures of Joe Finn campaign. The target group was men, who have not included physical activity into their daily lives for a long time and who might be overweight and have an unhealthy lifestyle.

The goal of the campaign was to carry out a nation-wide physical activity campaign to men, in order to create a permanent action culture to activate the target group of physically inactive men. The aim was to awake the target group's interest towards physical activity and their health. The campaign offered models and practical tools for both nation-wide and local groups promoting physical activity. The campaign was to inspire them to notify the

target group and network with each other. The goal was also to awake discussion and be visible in different mediums.

The parts of the campaign were the Adventures of Joe Finn lorry tour, the fitness guide of Joe Finn, the physical activity courses of Joe Finn, combined courses on cooking and experimenting with different sports, and the internet site [www.suomimies.fi](http://www.suomimies.fi). This research concentrates on the lorry tour and supplementary materials (the fitness guide and the Internet site). The first lorry tour took place in September 2007 touring in nine cities around the country. The second tour was arranged in May 2008, and the participants who left their contact details during that tour, are the target group of this research.

## **5.1. LORRY TOUR**

The lorry tour was arranged by the Fit for Life program together with local organisers, such as the cities and the local Finnish Sport Federation organisations. The main partner of the program was Etera, Mutual Pension Company. The other partners were Polar, Silja Line, Finnfood, Benecol, Hyvä Terveys -magazine, Omron, Diabetesliitto, Honda, Finland Heart Organisation, Suomen Matkatoimisto (travel agency), Suomen Latu (Finland Ski track Association), KTOL (the Finnish Association of Adult Education Centres), Heli (Pulmonary Association) and Mega Electronics (Biosignal Monitoring Technology). Each partner had its own little tent on the market place and offered health guidance etc. to the participants.

The tour in May 2008 visited Rovaniemi, Kemi, Vaasa, Seinäjoki, Pori, Turku, Lappeenranta, Kouvola, and Helsinki in that order. The daily events were arranged in each city's market place, except in Lappeenranta where the happening was arranged in the city harbour. The day included fitness tests in the lorry, health measurements and guidance, nutrition guidance, information

about local physical activity possibilities and sport clubs, and also sketch entertainment, advice from the country physician, information bulletins on stage. There were also pea soup and coffee offered for the participants.

The package of fitness test offered by the Fit for Life program included a Polar fitness test, weight measurement, gripping strength test, and body mass index. All tests were performed in everyday clothes without breaking a sweat. Polar fitness test was performed by lying on a bed with a heart rate monitor belt around the participant's chest and a watch on their chest. Other tests offered by the partners included e.g. cholesterol and blood pressure measurements. After attending the Fit for Life program's tests, the participants received either personal or shared feedback about the results. In addition, each participant was given the test results, directions for reading them, and a Joe Finn folder that included the Joe Finn fitness guide, Fit for Life fitness card, and a man's maintenance booklet put together by Duodecim and Hyvä Terveys ("Good Health") -magazine.

The lorry tour event was meant to be a relaxed and positive happening, since the men were encouraged towards physical activity and a healthy lifestyle through positive experiences. During the mornings in each city, about 300 employees visited from organisations insured by Etera Mutual Pension Company, such as building, forestry machine, and earth moving trades. These men were informed about the event by their employer. In the afternoons the event was open for the Joe Finn -target group and also for everyone interested in the event. Middle-aged men were prioritised for fitness testing, but in case of available testers, also e.g. women were allowed to have tests.



## 5.2 THE COMMUNICATION OF THE ADVENTURES OF JOE FINN CAMPAIGN

All communication messages of the campaign were to support the goals of the Adventures of Joe Finn campaign. All potential Joe Finns (working age men) were to be targeted and encouraged to participate the lorry tour and Joe Finn courses or start another physical activity related hobby with the means of communications. In addition, the goal was to receive nation-wide and local media attention.

The main messages were *Miehet liikkeelle!* ("move the men") and that health related physical activity affects working abilities positively; physically active and healthy men can work longer. The communication was guided by the following principles; (1) different needs of different target groups (the men, partners, media) should be taken into account, (2) the messages should be targeted as effectively as possible to different target groups, (3) the messages aimed at Joe Finns should be relaxed but at the same time proper, supportive and positive, yet not too edifying, (4) each communication procedure has its own organiser person(s), (5) communication needs to be easy to receive, e.g. there are no attachments on emails and the website can be used with the most common browsers and computers, (6) all the messages related to the campaign need to be recognisable and similar to each other, e.g. the graphic outlooks remains the same and identical.

The challenges of the communications recognised by the Fit for Life program were reaching the potential Joe Finns, helping the local Finnish Sport Federation organisations in right way by offering needed communications assistance, and receiving nation-wide media attention.

The communications were divided into internal and exterior communications. The internal communication groups included the Fit for Life program's office and board, the local Finnish Sport Federation organisations, partners, LIKES, the Ministry of Education, Ministry of Social Affairs and Health, Ministry of Transport and Communication, Ministry of the Environment, Metsähallitus, and the participants of the lorry tour (e.g. performers, care takers of fitness tests and local organisers). The exterior communication groups were Joe Finns (i.e. middle-aged men who do little or no physical activity), nation-wide media, local media, different organisations and local policy makers.

The means and instruments of the Adventures of Joe Finn campaign included the internet site, emails, press releases, press conferences, the lorry tour, the supplementary material, Joe Finn courses, personal contacts to partners, Kunnon Laiva (Cruise of Fitness), radio and television advertisements, and Kipinät-magazine. All visual materials have an identical graphic look with similar fonts and colours.

Program director Jyrki Komulainen and field manager Kaisa Saarentola were the main organisers of the campaign. In charge of the communications of the campaign was Kaisa Räsänen, assisted by Jenni Lintula. Communication officer Katri Väisänen started working for the program in 2007 and has been in charge of communications since then. She has been assisted by communications secretary Anna Suutari. Communications office Kontakti Ky from Jyväskylä has also worked for the campaign's communications.

The follow-up and estimation of the communications has been mainly done within the Fit for Life program. Keeping up with the schedule and the communications plan have been evaluated by the program. In addition, all the newspaper and magazine clips have been send for the program through the

Cision-media follow-up during the lorry tours. The clips have been collected to follow the media attention. The external communications has been evaluated by asking Joe Finn course participants how they found out about the course. In addition, the participant numbers of different Joe Finn courses also reveal part of the success of the communications. The success of the internal communications was surveyed via a Webropol-questionnaire for the partners during December 2007 and May 2008.

It is clear that there have been various ways to monitor the communication success; however, the Joe Finns had not been contacted after attending a lorry tour event. The Fit for Life program did not set any specific target numbers for the lifestyle change, because they did not have a way to monitor this. The main target of the campaign was to get the Joe Finns interested in physical activity and healthy nutrition, and that way encourage them to change their lifestyle. The goal of the current study was to find out if there has been a change in the participants' health behaviour, and the success of communication plays an important part in influencing people.

## 6 RESEARCH METHODS

This research was conducted to determine the images and opinions of the Joe Finn truck tour campaign. In addition, the effects on the behaviour change were under investigation.

Quantitative research methods were used in order to collect a large pool of data. Quantitative data can be collected quite easily using a survey questionnaire. This allows a larger sample size than, for example, interviews. Survey questionnaires provide better representativeness of the population. Furthermore, qualitative research methods benefits are relative easiness of the administration, tabulation, and analysing of data compared to qualitative methods. (Hirsjärvi, Remes & Sajavaara 2000, 195.)

According to Gunter (2002, 214), survey questionnaires are often used to collect information about facts, behaviour, knowledge, attitudes, values, beliefs, ideas, and opinions. In addition, questionnaires can be used to ask for evaluations and arguments on opinions and actions. These kinds of accurate facts should be

asked with direct and simple open or multiple choice questions (Hirsjärvi et al. 2007, 197). Most questionnaires also include information about the respondents' age, gender, education, profession, and family relationships.

## **6.1 EXPLANATION OF METHODOLOGY**

This study was a quantitative study using a postal questionnaire, since it offers a possibility for a large data, it is very suitable for studying opinions and behaviour change, and it has low cost of data collection and processing (Oppeneheim 2001, 102). Possible disadvantages of postal questionnaire are low response rates, no control over what questions are answered and what not, and no possibility to correct misunderstandings or give guidance (Oppenheim 2001, 102). In addition, response rates to some categories may be higher than for others (Gunther 2002, 216).

The sample was consisted of the participants of the Joe Finn adventures tour, who had left their contact information for the Fit for Life program during the event they participated in the spring 2008. The Fit for Life program had a collection 626 of these names and addresses. The questionnaire (Appendix 1) was then sent to all of them in July 2009. A return envelope with paid postage was included in the questionnaire.

## **6.2 QUESTIONNAIRE DESIGN**

It is clear that the design of the questionnaire can affect the results (Hirsjärvi et al. 2000, 198). This was taken into account when designing the questionnaire for the study. The questionnaire consisted of both structured and open ended questions. The advantage of structured questions is that they are easy to code

into statistical programs and that the answers are easy to compare. Open ended questions give the respondent a possibility to describe his/her feelings with their own words, but the data is wider and harder to code. (Hirsjärvi et al. 2000, 201.)

The first page of the questionnaire is an information page. It reminds the reader on participating at the event in 2008 and tells what the survey is used for. In order to receive the maximum number of answers, two Polar heart rate monitors were raffled between the respondents. This was announced on the first page. The first page includes information on how to reply and researcher's contact information in case of questions. The respondents had about five weeks to reply. In addition, three photographs from the tour were on the first page to arouse attention.

The questionnaire is divided into four parts. The first part is only three questions about the respondents' participation at the event asking whether they participated in the tests and received material or not. The second part includes questions about the respondents' health and fitness. The third part, headlined "The Adventures of Joe Finn campaign", includes questions about the event and their opinions about it. There are five open ended questions at the end of it asking for ideas and opinions. The last part includes background information questions.

The second part included six questions about the respondents' health and how he/she has changed his/her health behaviour since attending the tour. Five of these questions were in a five-level Likert scale. Likert scales are often used in questionnaires to specify a respondent's level of agreement with the given statement (Hirsjärvi et al. 2000, 200). Question number six asked for the

respondents reaction to the performed test and their results with yes, as expected; no, better than expected; no, worse than expected. This question was asked in order to find out the respondents' knowledge about their own health.

The questions from 10 to 24 were mainly questions about the respondents' opinions about the campaign. Questions 10 and 11 were a-five-level Likert scale questions. Question 10 inquired if the respondents found it positive that the campaign was targeted especially to men. This was done to find out if the targeted communication approach was experienced positively in this campaign. Question number 11 asked if the respondents had understood the information they received and were also able to take advantage of it. This was asked in order to discover how clear the campaign messages were.

The next three questions (12 to 14) dealt with the respondents' change since the event they took part. The experienced change in one's behaviour was asked to be shown with a-five-level semantic differential scale from positive to negative. Semantic differential is a type of rating scale offering a bipolar pair of adjectives and the respondent is asked to choose where his/her opinion lies between the two (Heise 1969, 406). The respondents also had a possibility to expand on their change with an open ended question about how they have changed.

The questions 15 to 19 were a-five-level semantic differential questions about the opinions and images of the event. The respondents were asked to value the event, their own results, the campaign material, doctor's presentation, and the shows during the event. The results for each adjective are presented in tables including mean, standard deviation, and response rate. In addition, a snake diagram for each question shows the mean results, and it clearly demonstrates possible problems and highlights.

The questions from 20 to 24 were open ended questions. The respondents were asked for the highlight of the event, the image, ideas for improvement, and what kind of health related information would they like receive. These questions were presented in order to have more varied feedback of the event as well to receive ideas for future campaigns. Since open ended questions give the respondent a possibility to answer what they really think without given options, they were a reasonable choice for these questions (Hirsjärvi et al. 2000, 201).

The last page included six questions about background information presented in a form of multiple choice. Even though the event was targeted at working aged men, also women and men of all ages were allowed to attend. The Fit for Life program was interested in finding out opinions from everyone who attended the events, and thus all answers were taken into account in this study. It is interesting to find out, if the women found the campaign positive, since their opinions and feelings about it will most likely affect their spouses' opinions and behaviour. In addition, from the targeted communication point of view, it was investigated how a group that was not in the targeted group felt about the campaign to evaluate pros and cons of a targeted communication approach.

However, the main target group's (men aged 35-64, without highest levels of education (bachelor's degree or higher), N=117) answers have been evaluated and are partly presented at the end of results and analysis section. This is done to evaluate how well the communication succeeded especially with the main target group.

The appearance of the questionnaire was kept simple and spacious. The respondents were encouraged to continue or comment their answers on the back side of the paper if they felt necessary to do so.



The results have been analysed using Microsoft Office Excel and SPSS programmes. One way ANOVA was used to determine differences between groups. Post hoc tests (Tukey HSD) were used to determine where the differences lie between gender, age, living environment, and education.

## 7 RESULTS AND ANALYSIS

There were 626 questionnaires sent, but 11 questionnaires were returned unopened, which means that 615 people received the questionnaire. The number of respondents was 278, which means that the response rate was 45.2%. According to Hirsjärvi et al. (2000, 196), mailed questionnaires usually have a response rate of 30 to 40 %, hence the response rate of this questionnaire is very positive. Due to the great response rate, it can be estimated that people remembered the event over a year after it.

There are questionnaires that are not fully completed, e.g. some open ended questions were not answered or not all semantic differential questions were answered. This is partly explained by the fact that not all participants attended or saw everything asked in the questionnaire. The response rate (N value) of each question is given in the figures. The significant differences ( $p < 0.05$ ) between gender, age, living conditions, or education have been mentioned after each question. If there is no mention, there were no significant differences between these variables.

## 7.1 THE RESPONDENTS

The following paragraphs provide the background information of the 278 respondents concerning their gender, age, type of occupation, living arrangements, and education level.

### 7.1.2 Gender and age

Question numbers 25 and 26 asked for the respondents' gender and age. Of the respondents (N=278), 83% (N=228) were men and 17% (N=48) were women. The tour was mainly aimed at men, but women were also allowed to participate if the organisers had time to test them. Hence, it is no surprise that the majority of the responses came from men. The results are presented in figure 3.

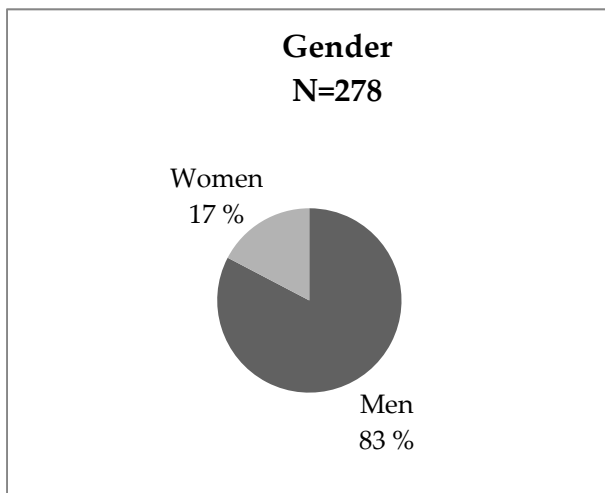


Figure 3. Gender deviation of the respondents.

The biggest age group was 55 to 64-year-olds with 33.9 % of the respondents. This was expected as well, because the target population was working aged men. The second biggest group was over 64-year-olds with 30.0 % of respondents. The third group was 45 to 54-year-olds (22.0 %), and 10.1 % of the

respondents were in the age bracket of 35 to 44. The age deviation of the respondents is presented in figure 4.

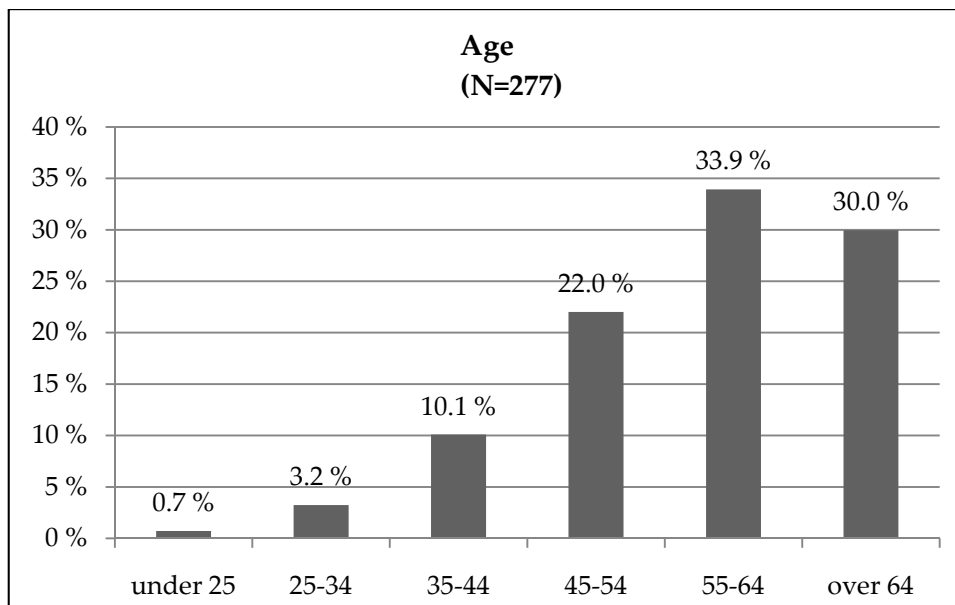


Figure 4. Age deviation of the respondents.

Due to the fact that the two youngest age groups are quite small, under 25-year-olds (N=2) and 25-34-year-olds (N=9), and the younger age groups were not the major target groups of the campaign, the two youngest groups are considered as one group (under 34, N=11) when analysing the results.

### 7.1.3 Working environment

The respondents were given three options for working environment in question 27. They were asked if their work was office job, light physical labour, or hard physical labour. Most people worked in an office (34.6 %), 28.4 % of the respondents estimated their work as lightly physical and 22.2 % said their work is physically hard. In addition, 14.8 % of the respondents announced that they are retired, even though it was not a given option. Percentages are shown in the figure 5.

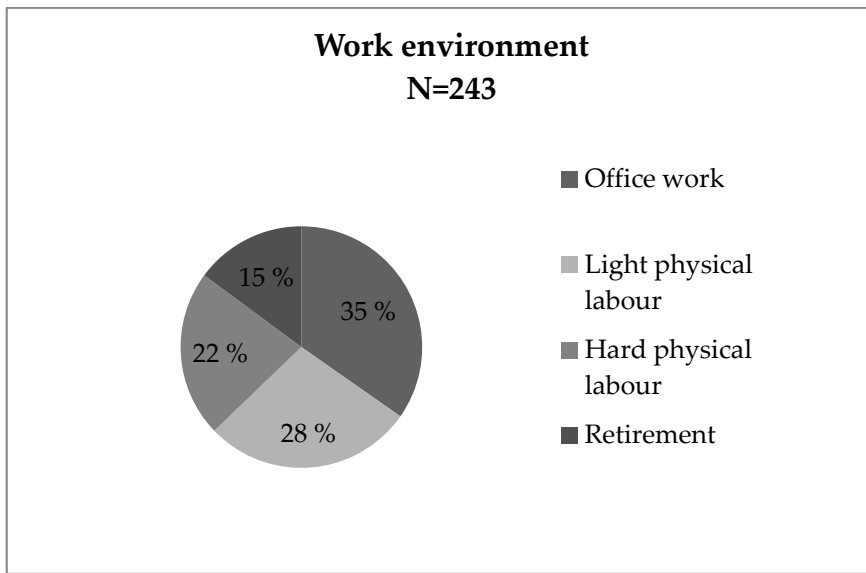


Figure 5. Work environment deviation of the respondents.

Since the options given to this question were very limited, e.g. no options for students or unemployed were given, the work environment has not been taken into account when analysing the answers.

#### 7.1.4 Living environment

In question 28, the respondents were asked whether they live by themselves, with a partner, with children, or with a partner and children. Also the option “else, what” was given. The majority, 52.7 %, of the respondents lived with a partner. About a quarter of the respondents lived alone, and 18.2 % lived with a family. The results for the question are shown in figure 6.

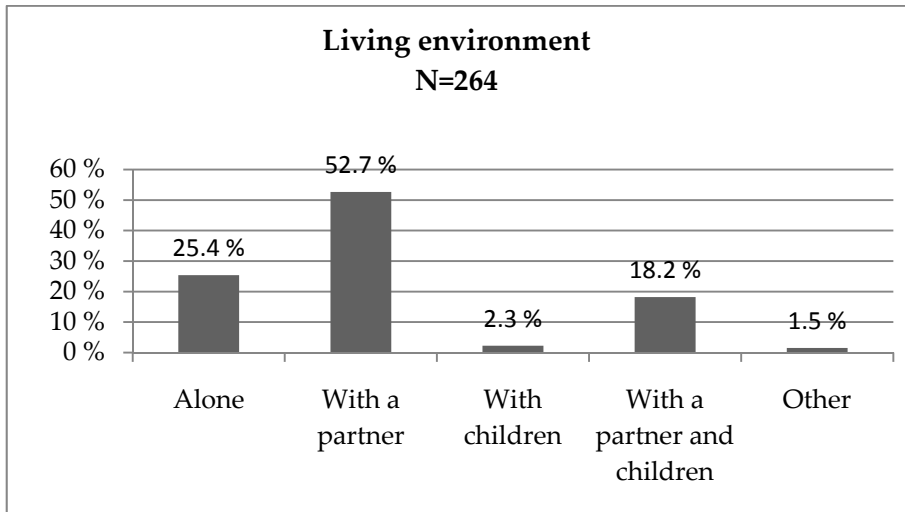


Figure 6. Living environment deviation of the respondents.

### 7.1.5 Level of education

The respondents were asked for their highest level of education in question 29. The most common answer was vocational school with 29.3 %. Institute level was the highest education level for 21.6 % and primary school 19.7 % of the respondents. Some people gave several answers, but only the highest level was taken into account. The results are given in figure 7.

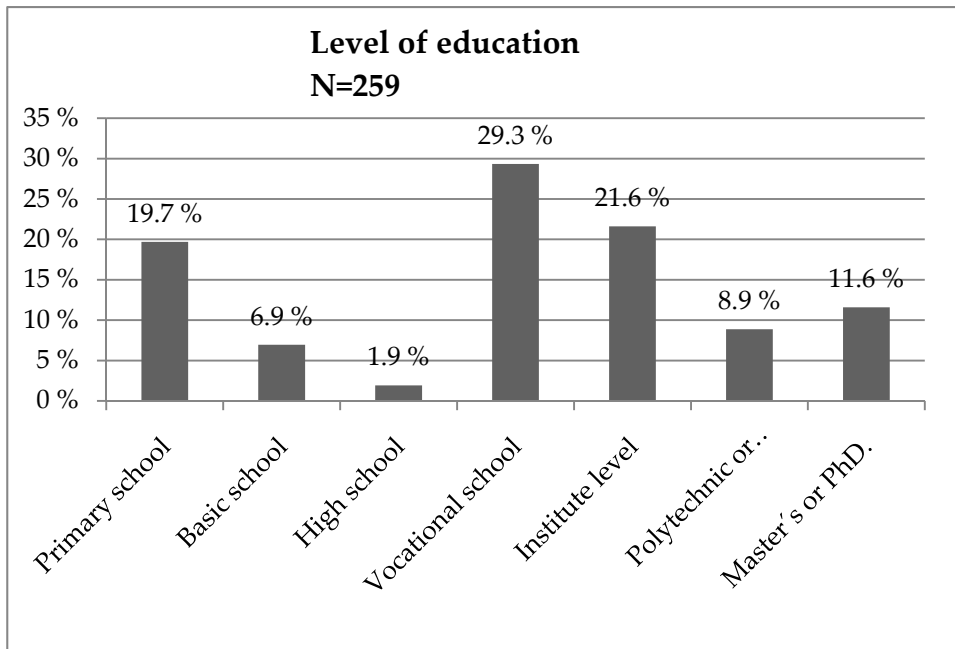


Figure 7. Level of education deviation of the respondents.

The main target group of this campaign were middle-aged men without the highest levels of education (polytechnic or university level). Thus the deviation of the level of education is expected and shows that the main target group was reached well.

## 7.2 RESPONDENTS' HEALTH BEHAVIOUR

### 7.2.1 Reasons for health behaviour

Question 30 inquired what reasons affect the respondent's health behaviour. The respondents were given 11 options and they were allowed to choose three at most. The most common reason given was clearly worry about health almost a third choosing this option. Other popular answers, receiving more than 10 % of the answers, were time (14.6 %), sport facilities (12.5 %), group support (11.9 %) and partner's or friend's support (11.5 %). Some people gave more than three

answers, but they were all taken into account. The reasons deviation is presented in figure 9.

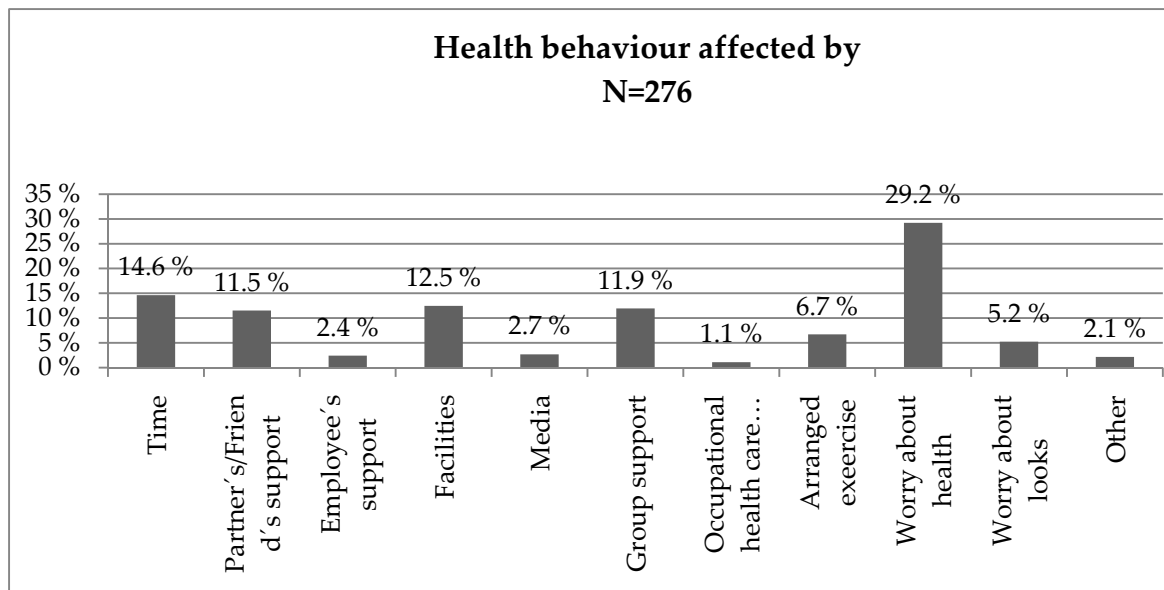


Figure 9. Effects of health behaviour.

### 7.2.2 Eating and exercise habits

In questions four and five, the respondents were asked to give their opinion about their health behaviour before attending the Joe Finn -event. Question four (figure 10) asked if before the event they had exercised enough and question five (figure 11) measured the respondents' eating habits. Clearly over the half of the respondents agreed or totally agreed that they exercised enough (67.1 %) and ate healthy (65.5 %) before attending the event. Over 20 % disagreed or totally disagreed that their health behaviour was healthy before attending the tour.



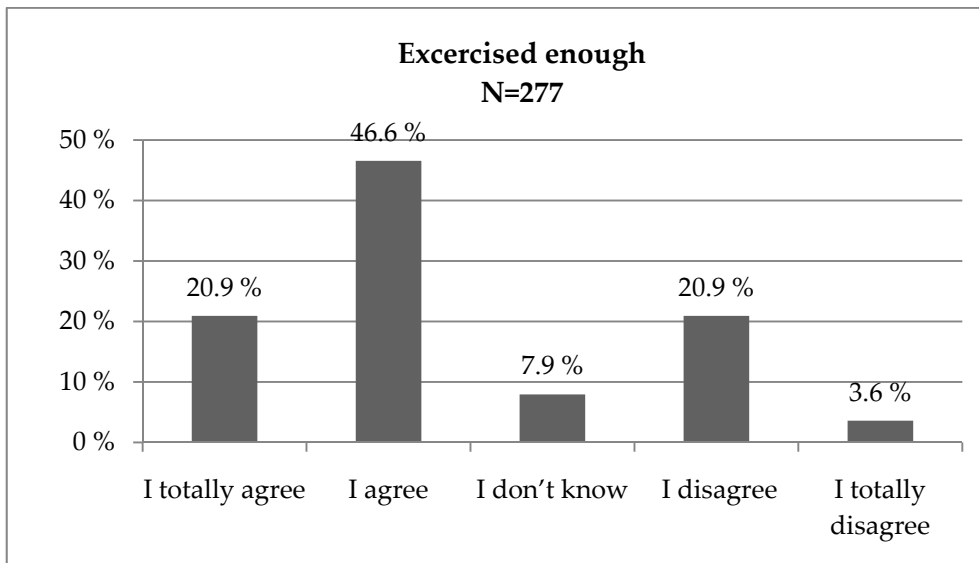


Figure 10. Respondents' exercise before the event.

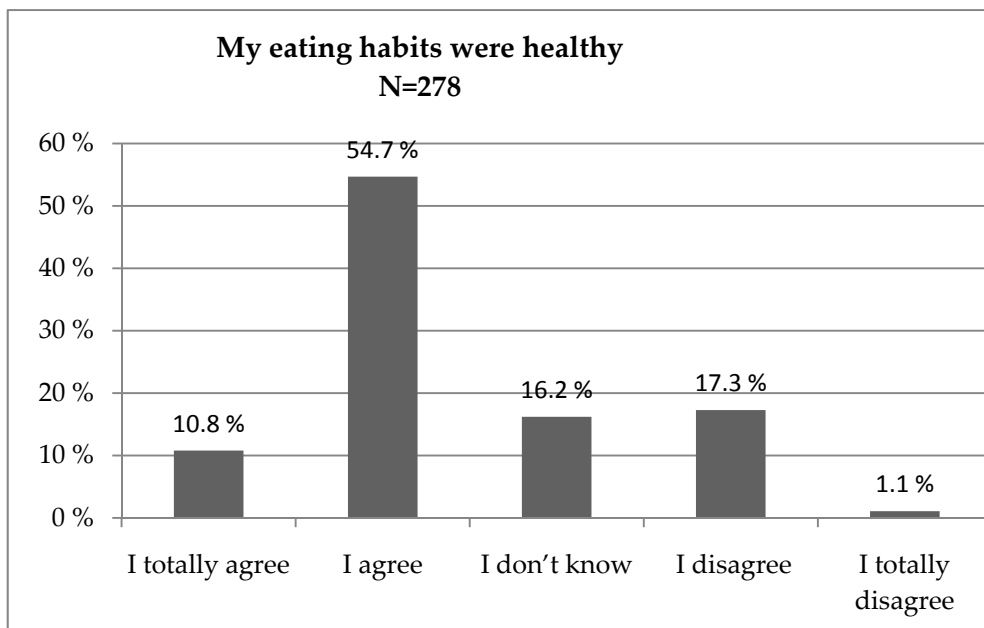


Figure 11. Respondents' eating habits before the event.

According to the Finnish National Institute of Health and Welfare (2008), 56 % of Finnish men, and 44 % of Finnish women are overweight, meaning that they have a BMI 25 or over. Thus, based on these answers, the respondents do not represent Finnish population in large but are healthier. It is possible that people

with healthier lifestyle were more likely to answer this questionnaire, because they did not find answering the questions about health obnoxious or annoying. Overweight people or people with unhealthier lifestyles might be fed up with questions and information about their health. In addition, it might be possible that people answered more positively about their health behaviour than what it really is, in order look better in paper.

### 7.2.3 Test Results

Question number six revealed that 58 % of the tested people received results that they expected from the health and fitness tests during the event. About a quarter received better results than they expected and 16 % received worse results than they expected. The results are presented in figure 12.

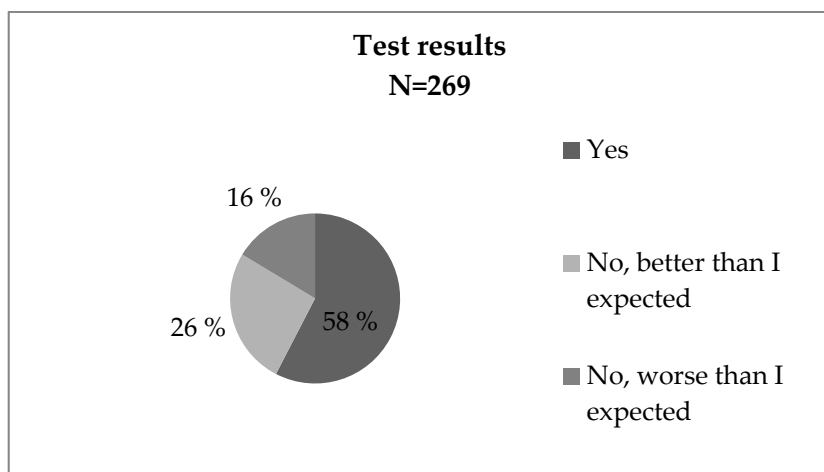


Figure 12. Expectations of the test results.

Answers to this question show that most people had quite realistic expectations about their own fitness and health.

## 7.2.4 Change

Questions seven and eight were to find out whether the event had changed the respondents' health behaviour. According to the respondents, about 38 % have exercised more or lot more since the event. Almost 60 % say there had been no change in their exercise habits. The results are presented in figure 13.

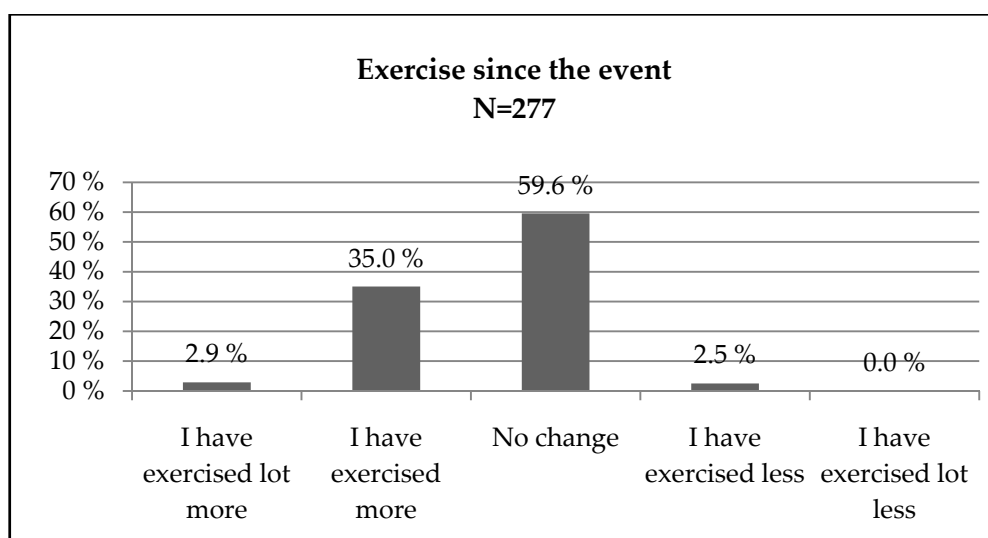


Figure 13. Respondents' exercise since the event.

According to the answers to question number eight, about 50 % of the respondents have eaten healthier or lot healthier since the event. The rest have not changed their eating habits. No one of the respondents admitted eating unhealthier foods since the event. The results are presented in figure 14.

There were no significant differences in the respondents' ratings of exercise or eating habits based on gender, age, or level of education ( $p > 0.05$ ).

There is a significant difference in eating habits after the event with those respondents living with children and those who answered "else" ( $p < 0.05$ ).

People answering "else" for living environment were more likely to eat healthier ( $1.8 \pm 0.84$ ) after attending the event than people living with children ( $2.8 \pm 0.41$ ). The option "I have eaten a lot healthier" was marked as 1 and "I have eaten a lot unhealthier" as 5.

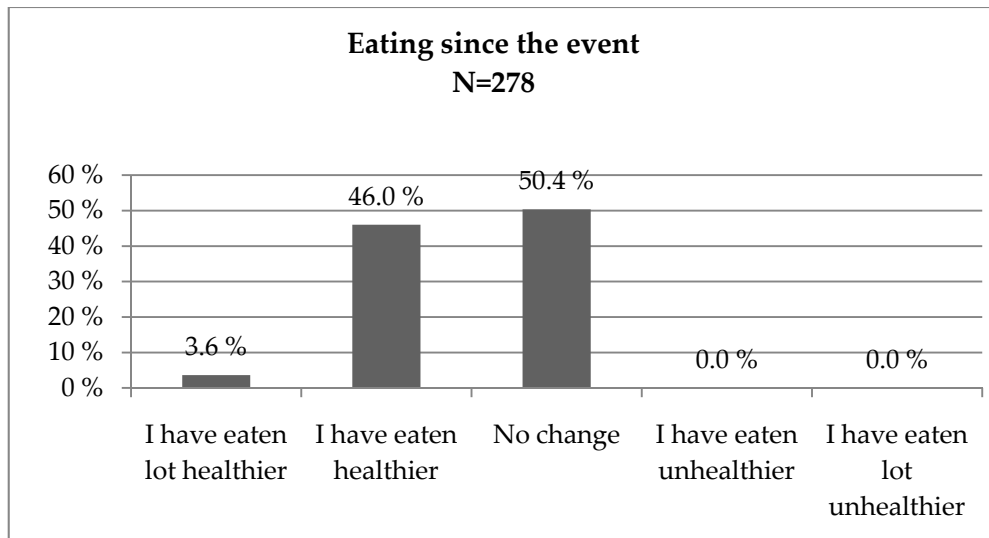


Figure 14. Respondents' eating habits after the event.

These answers show that the event had some positive effects on several respondents. These results are very positive when evaluating the campaign. People answering "no change" might have felt that there was no need for change.

There is no significant difference ( $p > 0.05$ ) between people who felt they ate healthy and people who felt they did not eat healthy before the event in answering question about eating after the event. In addition, exercise habits before the event and after the event were not related ( $p > 0.05$ ). This means that the experienced change has happened evenly among all groups, since background information does not show any significant differences between different groups either. Even though the campaign had a primary target group,

these answers show that the campaign effected several people despite their background information or previous health behaviour habits.

### 7.2.5 Personal fitness

According to the respondents own valuation, 44 % felt they are physically in good condition, and 45 % said their fitness is moderate. Only 4 % believed their fitness is poor or very poor. About 8 % said they are in excellent condition. The results are shown in figure 15.

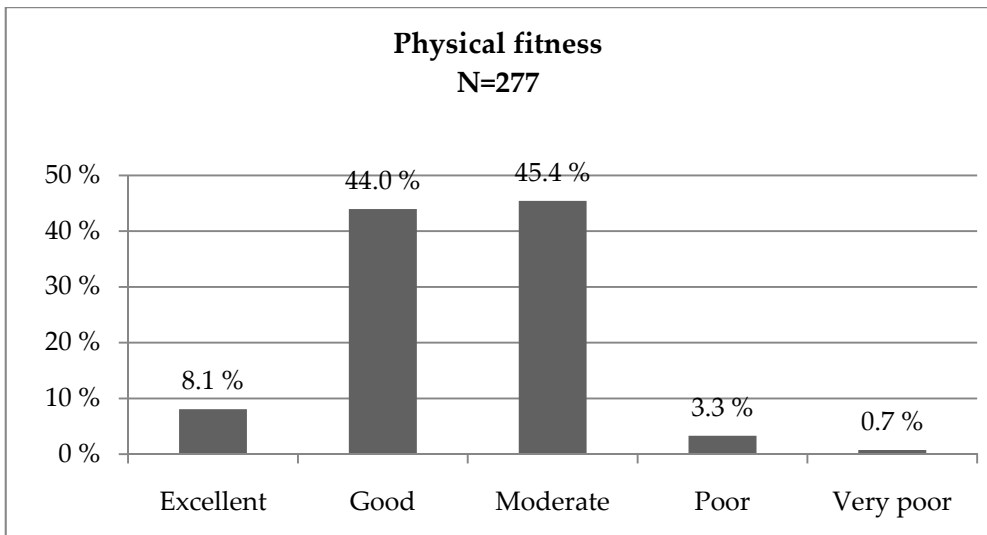


Figure 15. Respondents' own evaluation of personal physical fitness.

Figure 15 reveals that almost nobody believes that their physical fitness is worse than moderate. Again, this might be explained with the idea that healthier people answered the questionnaire or that people evaluated themselves overly positive.

## 7.3 THE ADVENTURES JOE FINN CAMPAIGN

### 7.3.1 Target group approach

The campaign's target group was middle aged working men. However, also other men as well as women were allowed to participate and also tested in case there was time for them. Question 10 revealed that the respondents found it positive that the campaign was mainly targeted to men. Almost 85 % of the respondents agreed or totally agreed with the statement that they find it positive that the target group was especially men. Little less than 8 % did not know whether this was a positive or a negative thing. Almost six per cent disagreed and 1.8 % totally disagreed with the statement. The results are presented in figure 16.

There were no significant differences in the responses to finding the target group approach positive based on age, living conditions, or level of education ( $p > 0.05$ ). However, there is a significant difference in the feelings between men and women ( $p < 0.001$ ). Women were more likely to disagree ( $2.57 \pm 1.37$ ) with the statement than men ( $1.65 \pm 0.73$ ). "I totally agree" was marked as 1 and "I totally disagree" was marked as 5. Over 62 % of people answering "I disagree" and 100 % of people answering "I totally disagree" were women.

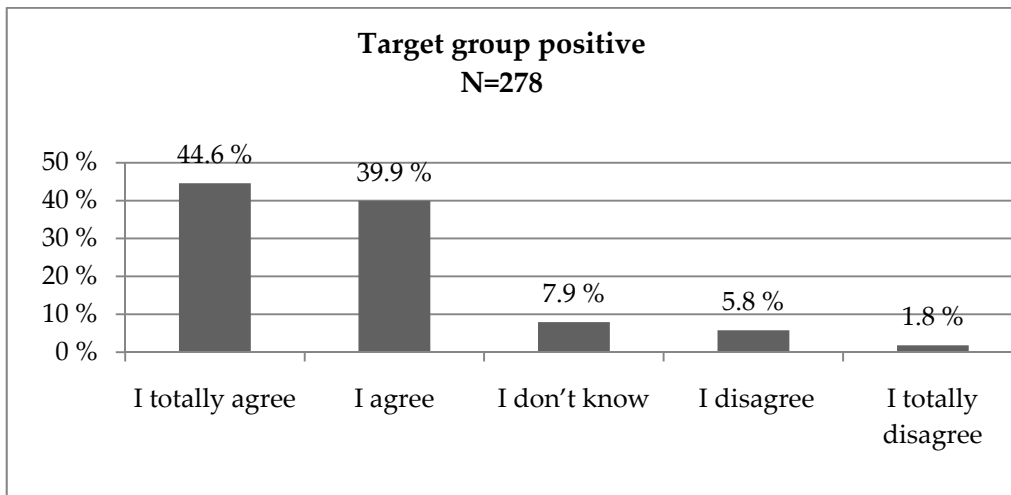


Figure 16. Target group approach.

The answers to this statement were quite expected. People who are at the target group feel positive about it and people who have been left out do not appreciate the method. However, there were also women that commented that there is enough information and events for women and that it is very important to have targeted health messages for this target group.

### 7.3.3 Understanding and being able to use information

Over 90 % of the respondents agreed with the statement that they understood and were able to take advantage of the information they received during the event asked in question 11. The results are shown in the figure 17.

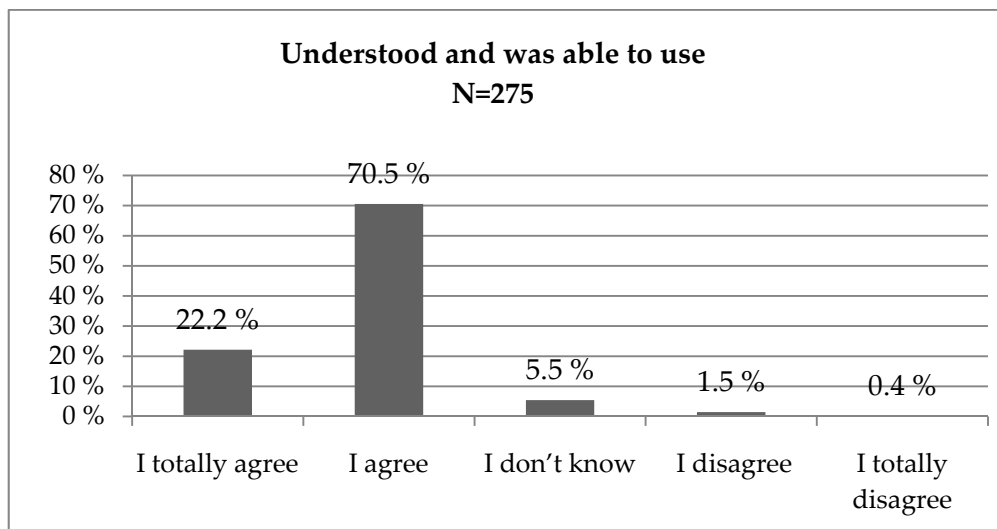


Figure 17. Understanding information.

The numbers are encouraging and reveal that the communication was simple enough for people to understand. The answers to this question show that the communication of the campaign and event was planned well.

### 7.3.4 Effects of event and material

Responses to questions 12 and 14 show that the event had some positive effects on the respondents. Question 12 asked whether participating the event had positive (5) or negative (1) effects on the respondents' health behaviour with a five point Likert scale. Over half of the respondents admit that since the event their eating and exercise habits have improved. The results are shown in figure 18.

Like other variables (gender, age, education), level of education does not seem to have much effect on the responses, however, there is a significant difference ( $p < 0.05$ ) between people with institute level education ( $3.6 \pm 0.62$ ) and people with primary school level education ( $4.12 \pm 0.69$ ) telling that the participation affected people with primary school level education more positively.



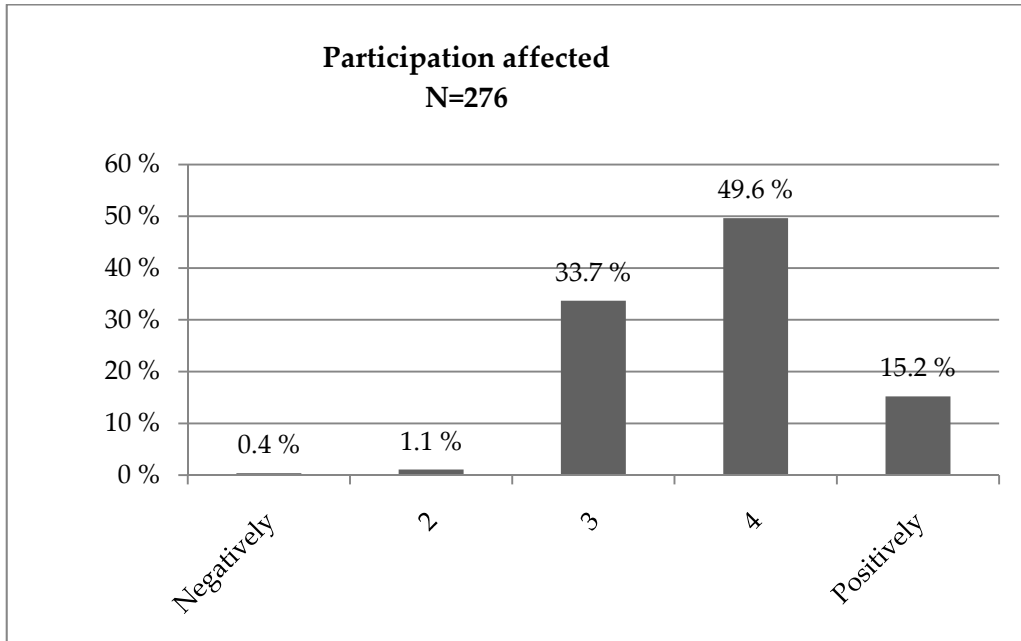


Figure 18. Effects of participation.

According to question 13, 73 % of the respondents received and familiarised themselves with the Joe Finn campaign material that they received at the event.

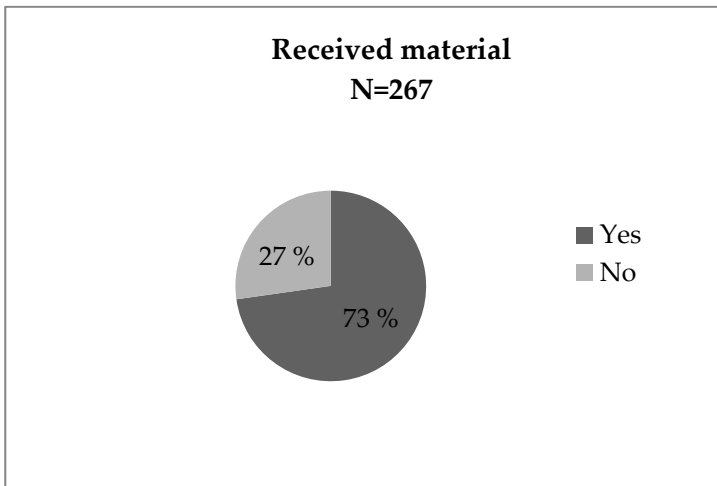


Figure 19. Receiving material.

Question 14 inquired if the material had positive (5) or negative (1) effect on their health behaviour. The majority said that the material had affected their health behaviour positively with almost 70 % of the respondents replying four or five. One third of the respondents did not believe that the event had any effect on their health behaviour. The results are shown in figure 20.

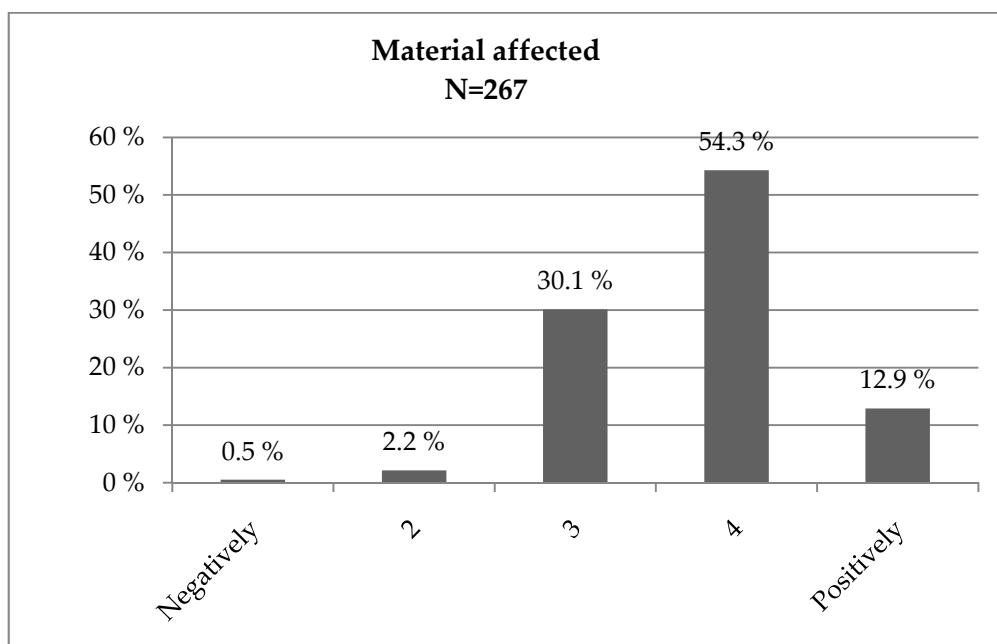


Figure 20. Effects of the campaign material.

In questions 12 and 14, the respondents were also asked for some concrete examples of the change with an open ended question. Almost half of the respondents, 48.6 % (N=135), answered the open ended question. One third of the people answered that there was not much of a change, but the event encouraged them to keep doing what they were already doing concerning exercise and nutrition. Most people answering the questions said that the event affected their exercise habits (21%), eating habits (16%), or both of them (24%) positively. In addition, 12% mentioned some other changes, e.g. losing weight and quitting smoking.

Question 14 gave the respondents an option to explain if the Joe Finn material had affected their health behaviour. There were 60 answers concerning the material. The answers were in line with the other open ended questions. To this question also some tips for cooking and the stretching exercises were mentioned. It was clear in the answers that the event and material had given the respondents some positive suggestions.

Answers to questions 7, 8, 12 and 14 reveal the positive impacts of the event and the campaign material. If a person with a BMI 25 or over, loses even 5 to 10 % of their body weight, this can reduce noticeable the risks of cardiovascular diseases (WHO 2010). Losing weight can also help with several other health risks. Healthy diet and physical activity are the basics of healthy lifestyle, thus even small changes can lead to more health, less diseases, and less money spent for health services (WHO 2010). Thus, even minor positive changes can have influence on a person's health.

#### **7.4 EVALUATION OF THE EVENT**

The respondents were asked to evaluate their own experiences of the event, the fitness tests, the campaign material, Tapani Kiminkinen's lecture, and the supplementary program in questions 15 through 19. The questions were a five-point scales, on which the opposite ends represented opposite adjectives.

The answers to all questions were very positive. The mean values, response rates, and standard deviations are presented below.

Question 15 asked for the respondents' experiences on the event. The results show that the respondents' experiences were very positive. The results are shown in table 5.

Table 5. Experiencing the event.

Q15. I experienced the event	Mean Value	Standard deviation	Response rate			
encouraging - discouraging	4.36	± 0.67	89.6% N=249			
positive - negative	4.58	± 0.59	94.2% N=262			
aimed at me - not aimed at me	4.01	± 0.91	89.2% N=248			
easily attained - hard to attain	4.37	± 0.72	90.6% N=252			
suitable for men - not suitable for men	4.53	± 0.65	90.3% N=251			
<b>I experienced the event</b>						
Encouraging	5	4	3	2	1	Discouraging
Positive	5	4	3	2	1	Negative
Aimed at me	5	4	3	2	1	Not aimed at me
Easily attained	5	4	3	2	1	Hard to attain
Suitable for men	5	4	3	2	1	Not suitable for men

In option "aimed at me - not aimed at me" there was a significant difference between men and women ( $p < 0.001$ ). Men ( $4.1 \pm 0.83$ ) felt expectedly that the event was targeted at them more than women did ( $3.4 \pm 1.0$ ). Apart from that, there were no significant differences ( $p > 0.05$ ) between men and women in experiencing the event.

There were no significant differences in the respondents' ratings of experiencing the event based on living conditions or education ( $p > 0.05$ ).

However, age played a significant role in experiencing the event. Older respondents found the event more aimed at them than younger groups did. Results for age differences in statement “aimed at me – not aimed at me” are presented in table 6 in appendix 2. Each age group’s mean, standard deviation, and response rate are also presented in the table.

These differences between age groups show clearly that the communication was successful with making the middle-aged people feel the event was more targeted at them than the younger ones. The advertisements and campaign material had photos of middle-aged men and the advice given was basic information about food and exercise. Younger men might have more knowledge with these due to better health education at schools and more information at young people’s magazines, for example. In addition, older people tend to always be more worried about their health than younger ones, since young people are less likely to have health problems than older ones.

There was also a significant difference ( $p < 0.05$ ) in thinking that the event was easily attained between under 34 year olds ( $3.82 \pm 0.98$ ) and 44-54 year old respondents ( $4.50 \pm 0.65$ ). This might be explained with the fact that some people were allowed to participate during work day and went together in bigger groups. The events were always organised in a central place of each city, e.g. market place, in order to make access easy to as many people as possible.

In addition, there was a significant difference ( $p < 0.05$ ) finding that the event was suitable for men between 35 to 44 year old respondents ( $4.25 \pm 0.59$ ) and group of 45 to 54 year olds ( $4.71 \pm 0.46$ ).

Question 16 reveals that the respondents found fitness tests performed at the event encouraging and meaningful. The results are shown in table 7.

Table 7. Experiencing the fitness tests.

Q16. I experienced the fitness tests and my results	Mean	Standard deviation	Response rate
encouraging - discouraging	4.34	± 0.72	91.0% (N=253)
meaningful - akward	4.49	± 0.66	92.4% (N=257)
<b>I experienced the fitness tests and my results</b>			
Encouraging	5	/	4 3 2 1 Discouraging
Meaningful	5	/	4 3 2 1 Akward

There were no significant differences in the results of experiencing the fitness tests and results based on gender, age, education, or living environment ( $p > 0.05$ ).

According to question 17, the campaign material was found encouraging, meaningful, suitable for men, and handy. The results are shown in table 8.

Table 8. Experiencing the campaign material.

Q17. I experienced the campaign material	Mean	Standard deviation	Response rate			
encouraging - discouraging	4.21	± 0.71	75.5% (N=210)			
meaningful - awkward	4.31	± 0.66	78.1% (N=217)			
suitable for men - not suitable for men	4.31	± 0.77	76.6% (N=213)			
handy - unhandy	4.20	± 0.74	75.5% (N=210)			
aimed at me - not aimed at me	3.97	± 0.82	73.4% (N=204)			
<b>I experienced the campaign material (if you have familiarised yourself with it)</b>						
Encouraging	5	4	3	2	1	Discouraging
Meaningful	5	4	3	2	1	Awkward
Suitable for men	5	4	3	2	1	Not suitable for men
Handy	5	4	3	2	1	Unhandy
Aimed at me	5	4	3	2	1	Not aimed at me

Level of education or living environment did not show significant differences ( $p > 0.05$ ) in the respondents' opinions about the material.

There was a significant difference ( $p < 0.001$ ) in the respondents' opinions finding the material being aimed at them or not between men ( $4.04 \pm 0.79$ ) and women ( $3.55 \pm 0.83$ ). This was expected with the target group being middle aged men. The campaign material including fitness hand book, website, and different brochures picture middle-aged men exercising and cooking. The written text is also for targeted more for men by presenting some sports more common with men, such as fishing, hunting, and football. In addition, it is clearly stated in text that the material is for men who do not exercise or eat healthy and are starting to have some health problems.

There were significant differences in experiencing the campaign material depending on the respondent's age. Results for age differences in statement "meaningful - awkward" are presented in table 9 in appendix 2.

Older age groups found the material more meaningful than younger ones. Again, this might be explained with the younger people's more knowledge about healthy nutrition and exercise. The most meaningful the material was to the age group of over 64 year olds. This probably means that the campaign material had advice that was quite basic, and these men got a lot of new information from it.

Results for age differences in statement "suitable for men - not suitable for men" are presented in table 10 in appendix 2.

Results for age differences in statement "aimed at me - not aimed at me" are presented in table 11 appendix 2.

Table 11 shows well how the older age groups felt clearly that the material was more targeted at them than the younger ones. Again, explanations are probably in the photos and advice given in the material. In addition, the material mentions some health problems, such as type 2 diabetes, blood pressure problems, and high cholesterol, which are more likely to begin at older age.

In addition, there was a significant difference ( $p < 0.05$ ) in finding the material "handy - unhandy" between under 34 year olds ( $3.64 \pm 1.02$ ) and over 64 year olds ( $4.38 \pm 0.66$ ). The older group most likely appreciated the advice given to different sports as well as easy-to-fill calendars for exercise. Younger people are more used to computers and the Internet, where people can find several exercise programs and calorie calculators.



Table 12. Opinions about Tapani Kiminkinen’s lecture.

Q18. Physician Tapani Kiminkinen’s lecture was in my opinion	Mean	Standard deviation	Response rate				
understandable - unclear	4.53	± 0.69	50.7% (N=151)				
pleasant - unpleasant	4.41	± 0.78	49.3% (N=137)				
useful - useless	4.48	± 0.81	51.1% (N=152)				
<b>Physician Tapani Kiminkinen’s lecture was in my opinion (if you heard it)</b>							
Understandable	5	}	4	3	2	1	Unclear
Pleasant	5		4	3	2	1	Unpleasant
Useful	5		4	3	2	1	Useless

Answers to question 18 indicate that physician Tapani Kiminkinen’s lecture to the participants was found to be understandable, pleasant and useful. The results are shown in table 12.

There were no significant differences ( $p > 0.05$ ) in respondents’ opinions about the lecture based on sex, age, or living conditions.

There was a significant difference ( $p > 0.05$ ) in finding the lecture understandable or unclear between people with basic school education ( $4.92 \pm 0.28$ ) and people with master’s degree or PhD. Level education ( $3.86 \pm 0.69$ ). There are also significant differences in finding the lecture pleasant - unpleasant based on education. Table 13 in appendix 2 shows the differences between master’s degree or PhD. level education ( $3.43 \pm 0.79$ ) compared to the ones with a significant difference.

The answers to this statement are very encouraging that the communication during Tapio Kiminkinen’s lecture was easy to understand and follow. The lecture was targeted exactly at men with lower level education by presenting health problems and solutions in a way that everyone understands.

The results to question 19 are shown in table 14. The supplementary program received quite positive results as well.

Table 14. Opinions about the supplementary program.

Q19. The supplementary program (e.g. sketches, singing and other performances) that I saw was	Mean	Standard deviation	Response rate			
fitted in – did not fit in	4.16	± 0.77	66.9% (N=186)			
clear in the message – unclear	4.09	± 0.80	65.8% (N=183)			
unforgettable – easily forgettable	3.86	± 1.02	62.6% (N=174)			
<b>The supplementary program (e.g. sketches, singing and other performances) that I saw was</b>						
Fitted in with the subject	5	4	3	2	1	Didn't fit in
Clear in their message	5	4	3	2	1	Unclear message
Unforgettable	5	4	3	2	1	Easily forgettable

There were no significant differences ( $p > 0.05$ ) on respondents’ opinions about the supplementary program based on age or living conditions.

Gender and level of education showed some significant differences in the opinions. The results between genders for the options in order (fitting in, clear in the message, unforgettable) in question 19 are shown in table 15 in appendix 2.

The level of education also showed some significant differences in respondents' opinions about the program. People with primary school education (mean 4.49,  $\pm 0.61$ , 67.3%, N=37) as well as respondents with basic school education (4.36,  $\pm 0.79$ , 89.5%, N=17) thought that the program fitted in more than people with master's or PhD. level education (3.53,  $\pm 0.92$ , 46.9%, N=15) showing significant differences ( $p < 0.001$  and  $p < 0.05$  respectively) in the respondents' opinions.

People with basic school education (4.33,  $\pm 0.66$ , 70.9%, N=39) also thought the program was clearer in the message than people with master's or PhD. level education (3.5,  $\pm 1.16$ , 43.8%, N=14) ( $p < 0.05$ ). In addition, there was a significant difference ( $p < 0.05$ ) between respondents with these two levels of education in opinion about the program being unforgettable with people with lower level of education (4.12,  $\pm 0.78$ , 60%, N=30) giving the program again more praise than people with highest level of education (3.14,  $\pm 1.17$ , 43.8%, N=14).

The answers to the statement about the supplementary program again show that the program was well-chosen for the target group. People with lower level education found the program more fitting in, clearer in the message, and more unforgettable. The program included e.g. sketches, and people with lower education probably felt more alike with the characters in them.

## **7.5 OPEN ENDED QUESTIONS ABOUT THE EVENT**

Questions 20 to 24 were open ended questions. Question 20 asked for the highlight of the respondents' event day. The clear majority of the respondents, 62.6 %, valued the different kinds of tests, measurements and results as the highlight of their day. Physician Tapani Kiminkinen's lecture for the

participants was a highlight for 11.4 %. Nine per cent thought the whole event was great and could not decide on their highlight. The rest of the respondents (17.1 %) named several other things, e.g. the shows, participation rate, weather, and seeing old friends. The results are shown in table 16.

Table 16. Highlights of the event.

<b>Highlight of the day (N=211)</b>	
Tests and measurements	62.6%
Tapani Kiminkinen's lecture	11.4 %
Whole event	9 %
Other (e.g. shows, weather)	17.1 %

The tests and measurements were clearly a great success of the event. People were able to perform them without breaking a sweat, and this clearly encouraged people to participate. The participants received a lot of information about their own health and were probably more likely to change their life style if needed after a possible "scare" given by the results.

The next open ended question asked for the image the respondents had looking back to the event. The majority, 81.5 %, of the answers were positive people praising the event as nice, good, very positive, OK, or interesting. There were only 2.8 % of the respondents, who had something negative to say about the event. Those people were mainly complaining about the long queues or still having too many women around. Seven and half per cent said the even should be organised more often and 2.8 % thought that it is needed and useful. Little over 5 % of the respondents named various images, such as nice personnel, good turnout, or cold weather. The results are presented in the figure 21.

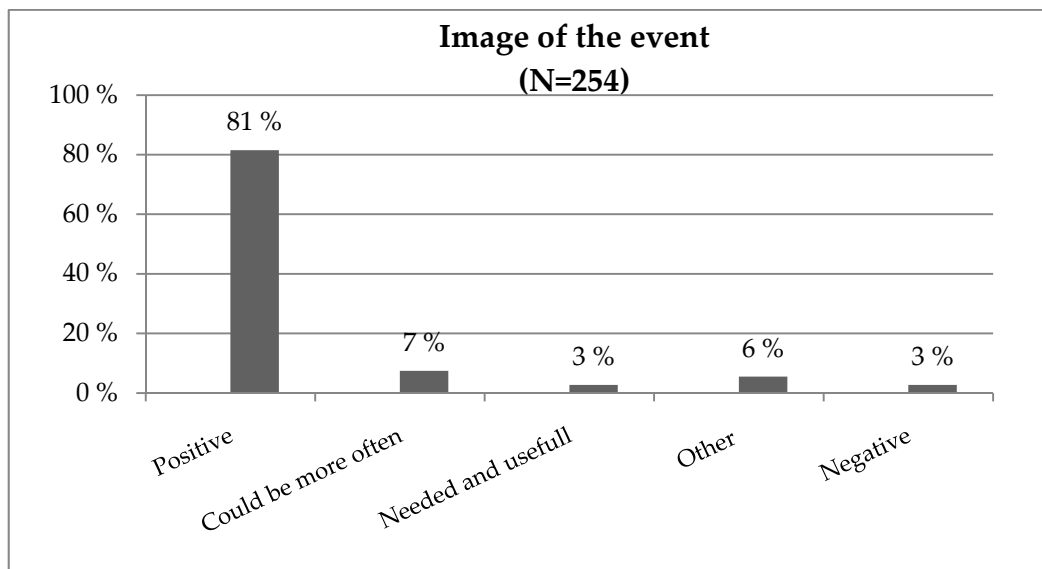


Figure 21. Respondents' images of the event.

The image of the event was positive according to so many people that the organisers have clearly been successful with the event. Since people had such a positive image, they were more likely to think back about it and the advice given during the day, which hopefully leads to healthier lifestyles. Several people asked to have the event again, and this is important in order for people to follow their health and remind them about the healthy habits. However, the negative answers need to be taken into account as well, so the organisers should try to solve the queue problems for the next event.

### 7.5.1 Preferences of the respondents

Question 22 asked what respondents would add or change to the event. Over a third of the respondents said they would not want to change anything and that the event was good just the way it was. About 24 % of the respondents wished for some additions to the event. Things like more tests, sports presentations, personal advice, and an evening dance were mentioned. Thirteen per cent said that the event should be either also for women or that women should have their

own event and campaign. Of that 13 %, 98 % were women. Six per cent of the people, who answered the question, did not know how to change the event. Almost every tenth respondent had had problems with the queuing and they wished for some change in that, e.g. by not letting any women to come, having more personnel, or handing out queue numbers instead of people standing and waiting. Other ideas (22 %) were e.g. having the tour also at smaller towns, more advertisement, and more privacy when doing tests. The results are shown in figure 22.

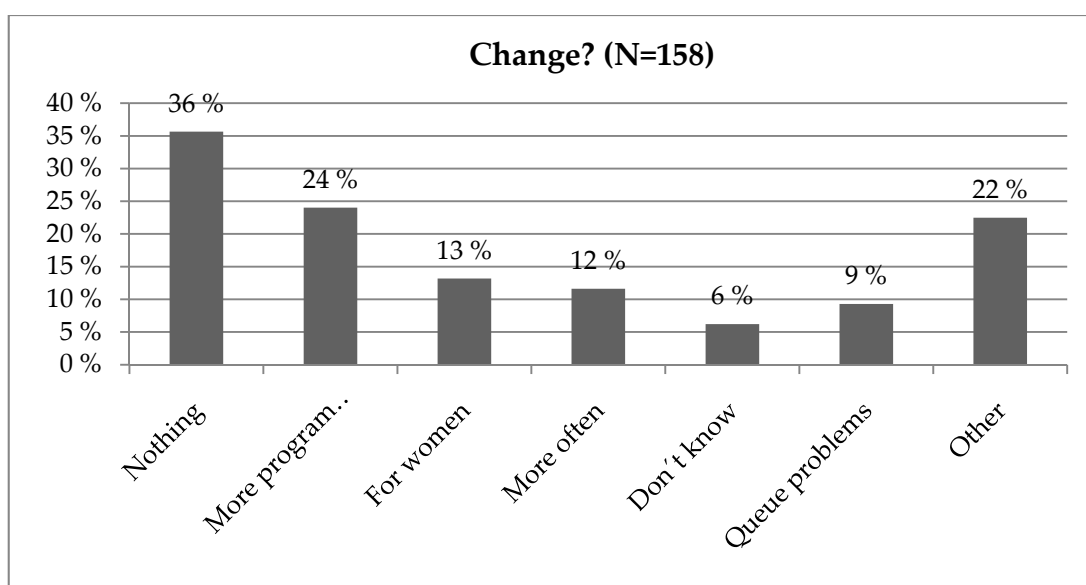


Figure 22. Ideas for changing the event.

The amount of people answering that they would not change anything about the event is very encouraging. People clearly found the event suitable for them and positive. The queue problems mentioned again in this answer is something though that the organisers should think about arranging better for next time.

The respondents were asked in two open ended questions what kind of health information they would like to receive more and how they would prefer to receive it in question 23. There seems to be the biggest need for more

information about nutrition among the respondents. About a third wanted more information about how to eat and 14.2 % were hoping for more advice in overall weight control. Exercise tips were wanted by 9.7 % of the respondents. Almost 16 % of the respondents asked for aid to cope with mental health issues, such as overall wellbeing, stress problems, gender and relationship problems, as well as social life. Seven and half per cent of the respondents felt that there is already information around and they know enough. About a fifth of the respondents had other ideas, such as alcohol, smoking, illnesses, and age related issues. The results are shown in figure 23.

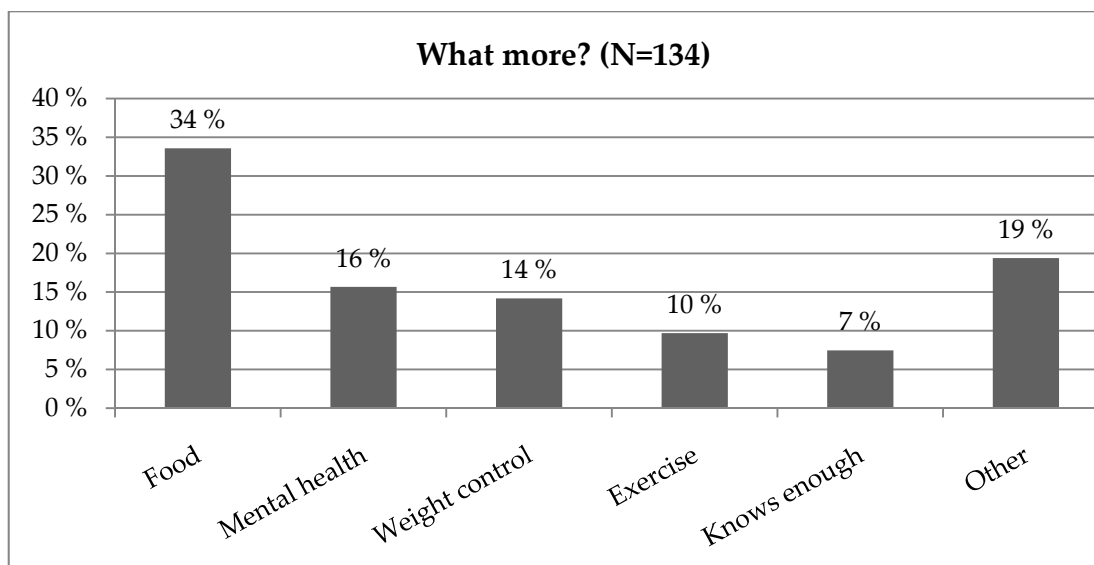


Figure 23. Areas that additional information is wanted.

The results for the question show that there still is need for giving information about nutrition, exercise, and weight control. Even though this kind of information can be found in several different places, such as the Internet, magazines, and TV, at least people attending this event thought there is still need for more. This probably shows that information does not reach everyone or that it is not provided in a way that people find it interesting. Mental health problems could be something added to the event next time.

According to 29.4 % of the respondents in question 25, the best way to receive material about health related issues is the Internet, email or mail. In addition, 9.6 % said they would like written material. About 28 % of the respondents said a lecture or a personal advice session with an expert would help them the most. Joe Finn event type of happenings or other mass events were the favourite way of receiving health related material for 23.5 % of the respondents. Other ways mentioned (9.6 %) were e.g. TV and radio. Results are shown in figure 24.

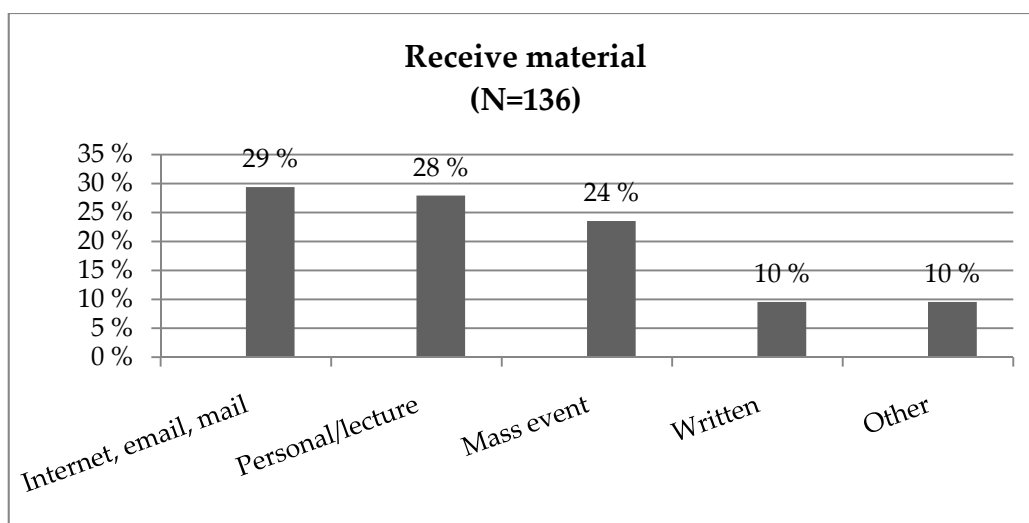


Figure 24. Preferable ways of receiving material.

These answers definitely encourage the organisers to arrange these type of events again. As mentioned in the previous answer, the people attending the event probably do not find mass media messages interesting enough, but prefer more personal ways. In addition to mass events, other ways, such as mail and email, could be used when there are no resources for mass events. Mail and email could also be used as a supporting way with an event.



## 7.6 MAIN TARGET GROUP EVALUATION

The main target group of the campaign and event were middle aged working men, who did not have the highest levels of education. Respondents, who were men aged 35-64 and had lower level of education than polytechnic or university, were chosen as main target group. The amount of men in the main target group was 117, which was 42.1% of all respondents.

Independent T-tests with SPSS were done to all questions between the means of main target group's and the rest of the respondents' answers to find out significant differences between the groups.

There were only two questions that show significant differences ( $p < 0.05$ ) between target group and the rest of the respondents. Those questions were 5 and 7. Question five stated "Before participating the event, I ate healthy in my own opinion." The respondents were given options from "I totally agree" (1) to "I totally disagree" (5). Question number seven inquired if the respondents had changed their exercise habits since attending the event. The options given varied from "Exercised a lot more" (1) to "Exercised a lot less" (5). Those results in order of the question numbers are presented in table 17 in appendix 2.

The minor differences between the main target group and rest could be explained by the fact that these groups did not differ much from each other based on their health behaviour before the event. The majority of all respondents said their eating and exercise habits were positive before the event and that their physical fitness was at least moderate.

## 8 DISCUSSION

The results in behaviour change after the Adventures Joe Finn campaign are encouraging. Almost 38 % of the respondents said that they had exercised more since attending the campaign event, and close to 50 % of the people claimed that the campaign had had positive effects on their eating habits. In addition, over 90 % of the respondents thought they understood, and were able to use, the information they received. The image of the event also received very positive evaluations. It is important to consider why this kind of campaign, including health tests with immediate feedback, as well as advice for healthier lifestyle, was effective when planning future health campaigns. Furthermore, the limitations of the study need to be taken into consideration to further develop possible future studies and campaigns.

The theories presented in chapters 2 and 3 are combined in table 18. The table provides a name, creator, short version of the theories, and each theory's relation to the Adventures of Joe Finn campaign. The table shows how the

theories relate to this campaign, which might be one explanation for the positive results of the campaign.

Table 18. A summary of the theories presented in this study.

<b>Theory</b>	<b>Creator</b>	<b>Brief description</b>	<b>Relation to the current study</b>
Theory Of Reasoned Action (TRA)	Fishbein and Ajzen (1975)	One's attitude towards behaviour	Campaign aimed at changing attitudes about nutrition and exercise
Theory Planned Behaviour (TPB)	Ajzen (1985)	TRA plus perceived behavioural control	People were reminded that small changes can affect their health
Social Cognitive Theory	Bandura and Walters (1963)	Self-efficacy, goals, and outcome expectations	Goal setting and small changes were introduced
The Health Belief Model (HBM)	Rosenstock (starting in the 1960's)	Perceived threats and benefits	People were shown the risks of unhealthy lifestyles
Self-Efficacy	Bandura (1977)	One's own judgement of his or her ability to cope effectively in a certain situation	Self-efficacy was strengthened by showing people easy ways to start changing
Social Marketing	Kotler and Zaltman (1971)	Selling ideas like products for the benefit of the receiver	The campaign promoted a healthier lifestyle as a non-profit organisation
Targeted Communication		Aiming communication to a selected group/demographic	Target group communication enabled concentration on a certain group

## 8.1 THE SOCIAL MARKETING POINT OF VIEW

According to social marketing point of view, the goal is to promote voluntary behaviour change, not to benefit the marketing organisation, but the targeted individuals (Stellefson & Eddy 2008, 489).

According to the theory of social marketing (Kotler & Zaltman 1971), the four P's of marketing; product, price, place, and promotion, are essential in the success of social marketing. The Joe Finn campaign marketed health behaviours to middle aged men. In our society, where obesity is turning into one of the biggest health problems, there is a definite need and demand for health as a **product**. According to the answers in question 25, when the respondents were asked what kind of health information they would want, there is a need for more information on nutrition and exercise for health.

The **price** that people need to pay in order to change to a healthier lifestyle is their old, unhealthy lifestyle. Although the questionnaire did not ask for reasons of behaviour change (see study limitations), the campaign aimed at making the price seem small. Participants were encouraged to make small changes in their lifestyle (e.g. by adding some exercise to their lives or by making small changes in nutrition). The campaign material, as well as physician Tapani Kiminkinen's lecture, encouraged men to take little steps toward a healthier life. As Bandura and Schunk (1981) showed in their test related to self-efficacy, smaller and short term goals are important in order to accomplish the final goal. Also, according to the Health Belief Model (Rosenstock 1970), self-efficacy is strengthened by achieving short term goals. Therefore, this is strength of the campaign.

About 7000 people took part in the campaign events that were organised in different cities around Finland. The events took place in nine cities around the country. Some respondents hoped to see the events in smaller places as well, and this would have obviously reached more people in the rural areas. However, it is obviously not possible to arrange the tour everywhere due to cost and time limits. The cities chosen were large Finnish cities, hoping to reach as many people as possible. Furthermore, the number of people who attended was encouraging, and the organisers were happy with the number of participants. The events took place in a central location of each city. Often, a market place in a city centre was chosen. According to question 3, there were a few people who had not heard about the event beforehand but just happened to see it taking place. This illustrates that the **places** chosen for the events were smart decisions in the chosen cities.

The **places** for the events were chosen in order to gather as many people as possible. The program tried to include as many people as possible by choosing places from city centres. The central locations obviously also enabled people from outside the target group to attend as well, however, the central location enabled easy and quick access for the target group that had pre-arranged permission to attend the event through Etera Mutual Pension Company and Fit for Life program cooperation.

Even though some people just happened to just show up to the event, the majority of the respondents said they found out about it from a newspaper, radio, or work place. In addition, people had heard about the event from their friends or spouses. The **promotion** of the event via work places was a good idea, since people are less likely to miss direct communication via public announcements at the work place, for example. Furthermore, several employers

allowed their workers to participate the event during working hours, which increased the participant numbers even more and added support. According to an ecological model for health promotion, environmental changes to promote physical activity will encourage and reinforce individual behaviour changes (Foster 2000, 22). Thus, the support of employees towards physical activity is very important.

## **8.2 TARGETED COMMUNICATION**

The target group chosen for the campaign were middle-aged men. According to Statistics Finland (2005), at the end of 2005, 53 % of Finnish working aged men were overweight. This group is in great risk of cardiovascular diseases, diabetes 2, and musculoskeletal diseases due to increasing weight and limited exercise. Thus, this target group definitely needs attention when promoting healthy lifestyle.

There are an increasing number of health advices, encouragement for exercising more, and recipes for healthy foods in newspapers and magazines these days. However, the targeted readers of those articles are usually women. Generalised mass media communication is not enough to target the group of middle aged men. That is why tailored or targeted communication are the correct ways to try to reach this target group.

Targeted communication is cost effective compared to tailored communication, and it enables communication to larger audience than tailored communication (Kreuter et al. 2003). Communication without any target audience would have been too wide for this type of campaign, and most likely the campaign's target audience of middle aged men would have not found it as positive as they now

thought it was. Thus, targeted communication was the best option for this campaign.

The opinions of the respondents about the targeted communication approach were somewhat expected; the people outside the target audience, especially women, felt that it would not have been right to exclude them. Women were allowed to participate in the tests, and this received both negative and positive feedback from the participants. However, the comments of the target group were mainly positive about the approach, and even some women commented that there are enough events and material for women and that the chosen target group needs more attention.

The targeted communication approach was the right decision to get the middle aged men interested. The method's negative side is that people outside the target group tend to be against the approach, as in this study. However, in order to awake interest in a certain group, this was the best method with the available resources.

### **8.3 BEHAVIOUR CHANGE**

The successful promotion of the campaign and the high participation rates show that the message reached the audience (or at least a significant number) and the audience noticed it. The channels chosen for communication, as well as choosing the target audience, were successful.

Mass communication is often the way used to communicate health messages to a larger audience (Berry 2006; Wiio & Puska 1993, 130). However, it has been proven that health campaigns, which use several channels, are more likely to

succeed (see Scholer et al. 1998, 410). The Adventures Joe Finn campaign used this modern approach of several channels. The campaign included health tests with immediate feedback, interpersonal communication, small group communication, the internet, as well as mass communication. The various elements of the campaign communication strengthened the effect of the individual communication means.

According to answers to question 11, 84.8% (N=236) of the respondents felt that they understood and were able to use the information given during the event. This shows that the information was well planned and communicated.

According to Fishbein's (2008) integrative behaviour theory, there are several variables that affect behaviour change. The Joe Finn campaign attempted to affect people's motivation, skills, attitudes, and self-efficacy. The material and information given during the event, as well as the Joe Finn website, provided a large amount of practical information to the audience. People were encouraged to start exercising not only them verbally and with material, but also by providing them immediate feedback of their own health status through the fitness tests that were the highlight of the event for the majority of the participants.

In addition to the major events, the Adventures Joe Finn campaign included cooking and exercise classes for middle aged men. These classes were advertised online on the campaign's website as well as during the day long events. The classes gave men concrete examples of healthier nutrition and exercise and thus, strengthened their skills. The classes served as an environmental factor and most likely encouraged people toward a healthier lifestyle.



The campaign used several ways to persuade the audience towards a healthier lifestyle. According to Wiio and Puska's model (1993, 131), the audience needs to accept the message in order to change. According to HBM, people are more likely to change if they accept that they are in danger of health problems if they do not change their habits (Rosenstock et al. 1994, 5). In addition, they need to believe that, by changing their habits, the results outweigh the price (Fishbein & Yzer, 2003, 165). As mentioned before, the price of the change was made to look small during the campaign. The event and campaign material was evaluated as very positive, understandable, and aimed at the target group, which illustrates that the respondents accepted the messages. About 30 % said that worrying about health has a major effect on health behaviour.

After understanding and accepting the message, people need to actually change their habits. The campaign followed the "rules" of HBM. It was targeted to men who do not exercise enough, and, who are at the age where health problems are starting to appear due to an unhealthy lifestyle (perceived susceptibility). Without overly worrying the participants, physician Tapani Kiminkinen's lecture gave examples of health problems that the target audience has, and thus, they can relate to (perceived severity). The positive outcomes of a healthy lifestyle were presented during the lecture and in the material (perceived benefits) without demanding an overwhelming amount of work or major change (perceived barriers). Printed materials and the website encouraged people consistently to follow directions even after the event and campaign (cues to action), and short-term goals were introduced to build confidence and self-efficacy. In addition, people in the photographs of campaign material were normal or slightly overweight and not skinny models. This most likely enabled the audience to relate to the material and encouraged people to think they can exercise as well.

Social cognitive theory emphasises the fact that people need to believe that they can change. As mentioned before, the campaign communication was planned so that making changes was made to look easy, and people were reminded that even small changes matter.

Since there was a little over a year between the event and the questionnaire, the respondents might not have remembered everything about their event or their health behaviour (see limitation of the study). However, there were no comments of the respondents about not remembering specific details, which shows that the event had really affected the audience and people still remembered it. Furthermore, since it was such a long time since the event, the changes in behaviour had already lasted for about a year. The stability of change is the last step of Wiio and Puska's (1993, 131) model and often the hardest to succeed in. People frequently tend to start diets and exercise, but give up after a short period of time. The aim of the campaign was not to offer quick fixes, but provide tools for long-term behaviour change. This goal seems to be achieved, at least one year after the campaign.

#### **8.4 LIMITATIONS OF THE STUDY**

The current study was performed approximately a year after the campaign events took place in order to see if at that stage behaviour change had happened and if it was maintained. This naturally affected the questionnaire design. It could not be expected that the respondents would have remembered and reported reliably how much time they spent each day exercising, or for example, if they ate six portions of fruit and vegetable every day. Furthermore, it might have affected the response rate negatively if people had felt the questionnaire was too difficult to answer. Thus, questions of people's exercise and nutrition

had to be based on their own evaluation. This might not give accurate answers, since each individual might have different ideas what constitutes enough exercise and/or healthy dieting.

This study was based on the respondents' own evaluations. According to social identity theory (Tajfel 1978), people more often have a positive than a negative image of themselves. This might affect the results of the study if people have evaluated their health and health changes more positively than the actual situation is. It is also possible that those people who had enjoyed the campaign, and were affected by it, answered the questionnaire more than people with negative experiences and no behavioural change (a non-response investigation was not implemented). In addition, the respondents might have answered more positively than the actual change has been to please the researcher in anticipation of what they perceive would be the correct or better answer (Hirsjärvi et al. 2004, 195).

The questionnaire design could have been improved. For example, options given for work environment were too limited upon reflection. There was no choice given for students, unemployed, or retired people. Only people working currently were able to answer what type of work they do physically. In addition, the respondents could have been asked to give reasons for their change/no change in order to evaluate the campaign communication even further. However, the latter minor changes to the questionnaire would not likely have changed the main findings of the study.

## 8.5 IDEAS

Future health campaigns could use such an integrated communication model that consists of various methods including health tests with immediate feedback. In order to test the actual change, objective measurement tools, such as heart rate monitors or pedometers, could be used e.g. a year after the event. Several respondents mentioned that similar events should be organised more often, preferably annually. This would give the participants an option to follow their health with the tests and see whether the changes made have had an actual affect on their health.

According to the questionnaire results, the men did not appreciate the supplementary programme as highly as for example the tests and campaign material. The campaign could include e.g. opportunities to test different sports and sports equipment. There could be cooperation with local sports clubs and sports stores, who would provide discounts in sports classes and equipment. Perhaps a traditional Cooper test (12 minutes of running or walking) or another more modern endurance test would encourage some participants to test their fitness and compare it to their previous results.

The campaign communication could, in the future, include social media, such as a Facebook site or a personal health diary online. According to behaviour change theories, it is important that people have support from others and that they can set smaller goals on their way to the finale. Interactive mediums could help people to share their stories, form exercise groups, and encourage others. Food and exercise diaries can help people to follow their progress and in setting goals.

The Fit for Life Program is now planning a new tour as a part of the Adventures Joe Finn campaign. The results of the current study have given the personnel some ideas for further developing the campaign. The tour will take place in Finland in May and September 2011. The events enable people to go back and see if their changes in their lifestyle have improved their test results. The campaign material will also include a man's "maintenance" booklet. The maintenance booklet provides information about nutrition, exercise, and mental health for men at different ages. The future tour will have fewer programmes on the stage and more tests. In addition, queuing numbers will be introduced on the tour in order to avoid long queues and standing around, which were mentioned in the questionnaires most often as a problem during the event.

This campaign and study show that much can be changed from old-style campaigns containing mainly one-way messages about health to the audience. This new form of campaign with integrated communication including personal health tests with immediate feedback to targeted audience has showed to be successful and, therefore, future campaigns should utilise this model as a template and develop communication strategies further.

## 9 CONCLUSIONS

The aim of the study was to analyse the communication of the Adventures of Joe Finn campaign in the perspective of behaviour change and social marketing theories. According to the analysis, the campaign was constructed based on the theories presented in the study. In addition, the results of the campaign for the participants of the Joe Finn event were very positive. According to the empirical research results, people experienced that they benefitted from the campaign and felt that it affected their health behaviour positively. The possible result combinations were presented in the four-field map in the introduction section of this study. It can be concluded that the result combination was positive-positive (++), since communication was constructed according to the theories and the results of the behaviour change were positive. That this coincides may explain the positive results of the campaign.

According to the results of the current study, the respondents found the campaign events very positive and encouraging. About 38 % of the respondents of the questionnaire said that the event had had positive effects on their physical

activity levels, and about half claimed that they had eaten healthier since attending a Joe Finn event. These numbers are encouraging and show that this type of modern approach, combining different methods of communication and other strategies, can be effective.

The campaign received mostly positive evaluations among all respondents. However, the slight differences in answers show that the campaign was valued more by older, less-educated men. This means that the information provided was basic and understandable for everyone, just as the Fit for Life program had planned. This shows that the communication aimed at the target group chosen for this campaign was successful.

The majority of the respondents hoped that the campaign and local events would continue, and in 2011, the Fit for Life program is launching another tour around the country. This will give the participants an opportunity to see whether their changes in their health behaviour have had effects on their health. According to behaviour change theories, people need to believe that by changing their habits the results can outweigh the price. When people see that their results have improved due to their changes, they are more likely to maintain their new behaviour. The immediate feedback given from the different tests is an important role of the campaign communication.

According to behaviour change theories discussed in the current study, it is important to realise that only knowledge via mass communication is not enough to change behaviour. This campaign used an integrated approach that combined communication methods with other strategies, such as health tests with personal feedback that strengthened the effect of the individual communication means. The campaign did not only provide information what people should do,

but also gave the participants assistance on how to change health behaviour as well as results about their own health and made them realise the possible risks of their unhealthy lifestyle.

The integrated communication method has proven that it can be effective and memorable. Future campaigns should utilise this model and take it further for development and to achieve more results, perhaps using social media.



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# Appendix 1

**Dear Joe Finn/Ms. Finn!**

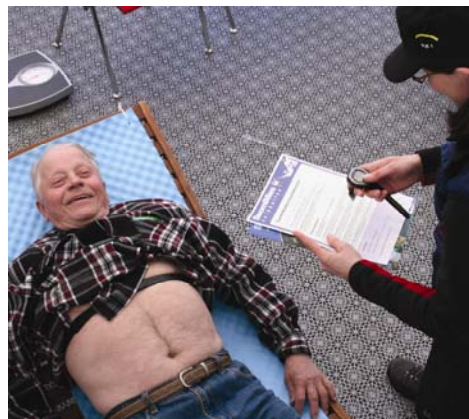
In the spring 2008 you participated in the Adventures of Joe Finn tour arranged by Fit for Life –program. This questionnaire inquires your experiences about the event and the possible effects of the event on your personal health behaviour. Your answers would be a significant help for the future projects and events.

It takes about 10 minutes to answer the questionnaire and two Polar heart rate monitors will be raffled between all participants. Please answer the questions, place the papers in the envelope that is attached here and send it back to us. The postage has naturally been paid. Please mail the questionnaire back by the end of August.

The answers are also a base for my thesis, so I am hoping for several replies! Please do not hesitate to contact me on the email address below in case you have any questions.

Thank you for your time!

Martta Mäkilä  
BA  
Communications Assistant, LIKES  
martta.makila@likes.fi





**Circle your answer or answer in the given space. You can also continue on the other side of the paper if necessary.**

1. Did you participate the fitness test at the Adventures of Joe Finn event? Yes/No

2. If you did, did you receive the test feedback? Yes/No      Did you receive Joe Finn material? Yes/No

**3. How did you find out about the event?** \_\_\_\_\_

**Your own fitness**

**4. Before participating the event, I exercised enough in my own opinion**

1. I totally agree    2. I agree    3. I don't know    4. I disagree    5. I totally disagree

**5. Before participating the event, I ate healthy in my own opinion**

1. I totally agree    2. I agree    3. I don't know    4. I disagree    5. I totally disagree

**6. Were the results of your fitness test as you expected?**

1. Yes            2. No, better than i expected            3. No, worse than I expected

**7. Since the Joe Finn event, I have**

1. Exercised a lot more                    2. Exercised more            3. I haven't exercised  
more or less than before    4. Exercised less            5. Exercised a lot less

**8. Since the Joe Finn event, I have**

1. I have eaten a lot healthier            2. I have eaten healthier            3. I haven't eaten  
healthier nor unhealthier foods            4. I have eaten unhealthier            5. I have eaten a  
lot unhealthier foods

**9. I feel like my own physical fitness is**

1. Excellent            2. Good            3. Moderate            4. Poor            5. Very poor

**The Adventures of Joe Finn -campaign**

**10. I felt it positive that the campaign was aimed especially at men**

1. I totally agree    2. I agree    3. I don't know    4. I disagree    5. I totally disagree

**11. I understood the information that I received during the event and I was able to take advantage of it**

1. I totally agree    2. I agree    3. I don't know    4. I disagree    5. I totally disagree

**12. Participating at the event affected my physical activity habits and/or eating habits**

Positively                    5                    4                    3                    2                    1                    Negatively  
**How?**

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**13. Did you familiarize yourself with the Adventures of Joe Finn campaign material? (SuomiMiehen kunto-opas, internetsivut tai Miehen huoltokirja?)**

1. Yes    2. No

**If not, go to question no 15.**

**14. If yes – How did the campaign material affect your physical activity and/or eating habits?**

Positively                    5                    4                    3                    2                    1                    Negatively  
**How?**

---

---

**15. I experienced the event**

Encouraging	5	4	3	2	1	Discouraging
Positive	5	4	3	2	1	Negative
Aimed at me	5	4	3	2	1	Not aimed at me
Easily attained	5	4	3	2	1	Hard to attain
Suitable for men	5	4	3	2	1	Not suitable for men

**16. I experienced the fitness tests and my results**

Encouraging	5	4	3	2	1	Discouraging
Meaningful	5	4	3	2	1	Awkward

**17. I experienced the campaign material (if you have familiarized yourself with it)**

Encouraging	5	4	3	2	1	Discouraging
Meaningful	5	4	3	2	1	Awkward
Suitable for men	5	4	3	2	1	Not suitable for men
Handy	5	4	3	2	1	Unhandy
Aimed at me	5	4	3	2	1	Not aimed at me

**18. Physician Tapani Kiminkinen's lecture was in my opinion (if you heard it)**

Understandable	5	4	3	2	1	Unclear
Pleasant	5	4	3	2	1	Unpleasant
Useful	5	4	3	2	1	Useless

**19. The supplementary program (e.g. sketches, singing and other performances) that I saw was**

Fitted in with the subject	5	4	3	2	1	Didn't fit in
Clear in their message	5	4	3	2	1	Unclear message
Unforgettable	5	4	3	2	1	Easily forgettable

**20. What was the highlight of your day during the event?**

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**21. What kind of image you were left with the event?**

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**22. What would you add into or change with the campaign?**

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**23. What kind of lifestyle matters would you like to receive information about?**

---

**24. How would you receive it best?**

---

**Background Information**

**25. Gender**    1. Man                    2. Woman

**26. Age**

- 1      less than 25
- 2      25-34
- 3      35-44
- 4      45-54
- 5      55-64
- 6      over 64

**27. Profession**    1. Office work (sitting down)                    2. Light physical job  
3. Physically heavy job

**28. I live**    1. By myself            2. With a spouse            3. With children  
4. With children and spouse            5. Other, how? \_\_\_\_\_

**29. Highest education**

- 1      primary school
- 2      basic school
- 3      high school
- 4      vocational school
- 5      institute level
- 6      polytechnic or Bachelor's degree
- 7      Master's degree or Ph.D.

**30. My own health behaviour is most affected by (choose 3 at most)**

- 1. Time            2. Support from spouse/friends            3. Support from employer
- 4. PA places    5. Media education            6. PA in a group
- 7. Support from occupational health care    8. Arranged PA    9. Worry about health
- 10. Worry about the way I look            11. Other, what?

We will raffle two Polar heart rate monitors with all the participants. Please put your contact information below if you want to participate.

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**THANK YOU FOR YOUR PARTICIPATION!**

## Appendix 2

Table 6. Answers to “aimed at me – not aimed at me” concerning the event.

Age (years)	Mean	Standard deviation	Response rate	Compared to age	Sig. (p-value)
under 34	3.10	± 0.54	100% (N=11)	35-44	0.328
				45-54	<b>0.007**</b>
				55-64	<b>0.010*</b>
				over 64	<b>0.001**</b>
35-44	3.68	± 0.98	100% (N=28)	under 34	0.328
				45-54	0.301
				55-64	0.407
				over 64	0.035
45-54	4.10	± 0.88	95.1% (N=58)	under 34	<b>0.007**</b>
				35-44	0.301
				55-64	0.995
				over 64	0.785
55-64	4.01	± 0.91	91.5% (N=86)	under 34	<b>0.010*</b>
				35-44	0.407
				45-54	0.995
				over 64	0.468
over 64	4.25	± 0.82	77.1% (N=64)	under 34	<b>0.001**</b>
				35-44	0.035
				45-54	0.785
				55-64	0.468

Table 9. Correlations between age groups between options “meaningful – awkward” concerning the campaign material.

Age (years)	Mean	Standard deviation	Response rate	Compared to age	Sig. (p-value)
under 34	3.91	± 0.54	100 % (N=11)	35-44	0.929
				45-54	0.220
				55-64	0.607
				over 64	<b>0.011*</b>
35-44	4.10	± 0.55	71.4 % (N=20)	under 34	0.929
				45-54	0.556
				55-64	0.969
				over 64	<b>0.027*</b>
45-54	4.35	± 0.53	78.7 % (N=48)	under 34	0.220
				35-44	0.556
				55-64	0.668
				over 64	0.330
55-64	4.20	± 0.77	85.1 % (N=80)	under 34	0.607
				35-44	0.969
				45-54	0.668
				over 64	<b>0.004**</b>
over 64	4.59	± 0.63	69.9 % (N=58)	under 34	<b>0.011*</b>
				35-44	<b>0.027*</b>
				45-54	0.330
				55-64	<b>0.004**</b>

Table 10. Correlations between age groups between options “suitable for men – not suitable for men” concerning the campaign material.

Age (years)	Mean	Standard deviation	Response rate	Compared to age	Sig. (p-value)
under 34	3.91	± 0.94	100% (N=11)	35-44	1.000
				45-54	0.131
				55-64	0.863
				over 64	0.054
35-44	3.95	± 0.79	71.4% (N=20)	under 34	1.000
				45-54	<b>0.049*</b>
				55-64	0.836
				over 64	<b>0.012*</b>
45-54	4.49	± 0.58	80.3% (N=49)	under 34	0.131
				35-44	<b>0.049*</b>
				55-64	0.079
				over 64	0.980
55-64	4.14	± 0.87	81.9% (N=77)	under 34	0.863
				35-44	0.836
				45-54	0.079
				over 64	<b>0.010*</b>
over 64	4.57	± 0.60	67.5% (N=56)	under 34	0.054
				35-44	<b>0.012*</b>
				45-54	0.980
				55-64	<b>0.010*</b>

Table 11. Correlations between age groups between options “aimed at me – not aimed at me” concerning the campaign material.

Age (years)	Mean	Standard deviation	Response rate	Compared to age	Sig. (p-value)
25-34	3.09	± 0.54	100% (N=11)	35-44	0.614
				45-54	<b>0.002**</b>
				55-64	<b>0.007**</b>
				over 64	<b>p &lt; 0.001***</b>
35-44	3.50	± 0.76	71.4% (N=20)	under 34	0.614
				45-54	0.065
				55-64	0.164
				over 64	<b>0.001**</b>
45-54	4.04	± 0.80	78.7% (N=48)	under 34	<b>0.002**</b>
				35-44	0.065
				55-64	0.942
				over 64	0.437
55-64	3.93	± 0.79	80.9% (N=76)	under 34	<b>0.007*</b>
				35-44	0.164
				45-54	0.942
				over 64	0.066
over 64	4.30	± 0.74	59% (N=49)	under 34	<b>p &lt; 0.001***</b>
				35-44	<b>0.001*</b>
				45-54	0.437
				55-64	0.066



Table 13. Correlations between education level groups in opinions about Kiminkinen's lecture.

Education level	Mean	Standard deviation	Response rate	Compared to	Sig. p-value
Primary school	4.50	± 0.83	61.8% (N=21)	Master's or PhD. level	<b>0.015*</b>
Basic school	4.77	± 0.44	68.4% (N=13)	Master's/ PhD. level	<b>0.004**</b>
Profession	4.46	± 0.64	48.1% (N=39)	Master's/PhD.	<b>0.019*</b>

Table 15. Gender differences in opinions about the supplementary program.

Gender		Mean		Standard deviation		Response rate		Sig. p-value
Men	Women	4.10	4.16	± 0.77	± 0.73	68.1% (N=156)	62.5% (N=30)	<b>0.031*</b>
M	W	4.01	4.47	± 0.80	± 0.73	66.8% (N=153)	62.5% (N=30)	<b>0.005**</b>
M	W	3.77	4.31	± 1.02	± 0.89	63.3% (N=145)	60.4% (N=29)	<b>0.008**</b>

Table 17. Correlations between the main target group and rest in questions 5 and 7.

Population		Mean		Standard deviation		Response rate		Sig. p-value
Target group	Rest	2.55	2.35	± 1.0	± 0.88	99 % (N=116)	99 % (N=159)	<b>0.009**</b>
TG	Rest	2.56	2.66	± 0.64	± 0.55	100% (N=117)	98.1 % (N=158)	<b>0.008**</b>