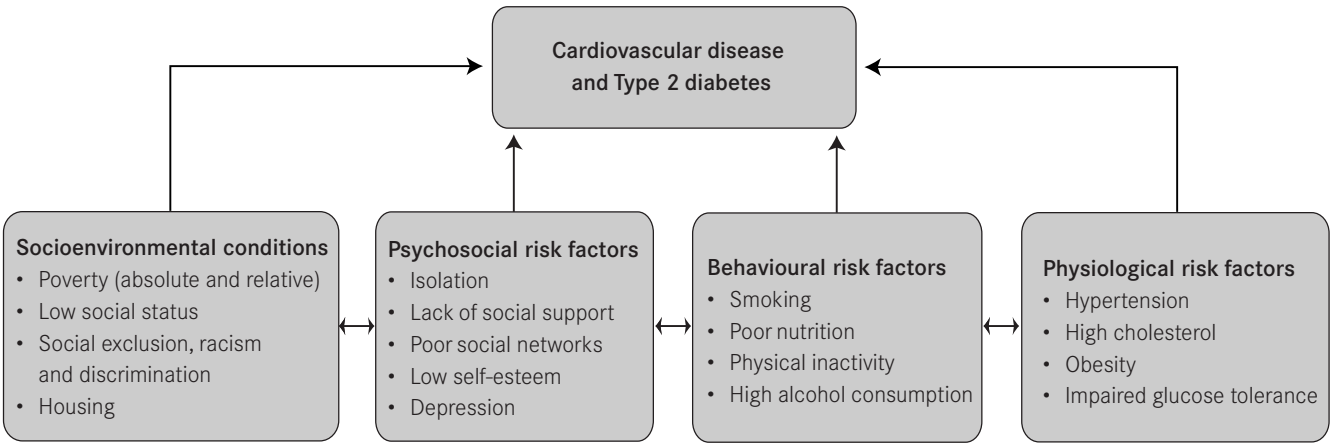
2 Health Promotion

2.1 Creating healthy communities

Health promotion is the process of enabling people to increase control over the determinants of their lives to improve their health (Department of Human Services 2003). It is based on a social-ecological model of health and adopts a population health approach to health policy, planning and practice. The social-ecological approach acknowledges the multiple and complex influences on people's everyday lives and individual behaviour. This approach emphasises the fundamental importance of the interrelationships among individuals and the social, cultural, environmental, behavioural and biological factors that influence their health (McLeroy et al. 1988; Stokols 1992). The social-ecological model of health also identifies relationships among income, poverty, social exclusion, un/employment and work, gender, culture, addiction, social support, food insecurity, adverse childhood experiences, and their effects on wellbeing and health (Marmot and Wilkinson 1999). Figure 1 summarises the multifaceted model of health determinants that underpins health promotion practice.

Figure 1: Determinants of cardiovascular disease and type 2 diabetes

Source: Adapted from Labonte (1993).



Upstream-downstream levels of intervention

The Ottawa Charter for Health Promotion (World Health Organisation 1986) contains the following five action areas that provide a framework for addressing the multiple determinants of health:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services.

These action areas comprise both upstream and downstream levels of intervention. Upstream interventions deal with population-wide influences on health, such as policies surrounding income distribution, education, public safety, housing, work environment, employment, social networks, food supply, transport and pollution. These interventions are extensive and large scale, but they can also be addressed effectively at a more local level via work with communities or groups who share interests and concerns (for example, a local government area). In contrast, downstream interventions are usually discrete, targeted programs with an explicit health purpose. They address a narrower range of benefits and tend to focus more on individuals than whole communities.

2.2 Using population wide approaches

In the past, many strategies for reducing the incidence of CVD and diabetes focused on educating and changing the behaviour of individuals considered to be high risk. The major limitations to this approach have been well documented by Rose (1992), who mounted a strong, evidence based argument for using a population wide strategy to prevent conditions such as CVD and diabetes.

Rose (1992) demonstrated that risk factors such as body fat, blood pressure and cholesterol levels are distributed differently within different populations. The distributions are frequently bell-shaped, but with different mean values (for example, blood pressure) for different populations. High risk individuals fall into the extreme upper 'tail' of the distribution.

However, Rose (1992) demonstrated that a large number of people exposed to a small risk may generate many more disease cases than generated by a small number exposed to a high risk. The MRFIT trial in the United States, for example, found that only 8 per cent of the total fatal heart attacks were attributed to men having high cholesterol (over 7.5 mmol/L), while 39 per cent were attributed to men having moderate levels (5–6 mmol/L), because there were many more of the latter group (Rose 1992).

These findings have a number of important implications:

- If the whole population is moved towards slightly lower risk (for example, if the bell-shaped distribution of cholesterol levels moves to the left), then the number of individuals in the high risk 'tail' of the distribution will decrease substantially. Overall disease burden is also reduced because a large number of people are at slightly lower risk.
- It is difficult to change the tail (that is, high risk behaviours such as being sedentary or eating energy dense foods) without changing the population norms that strongly shape the overall distribution. It is very difficult for overweight or obese people, for example, to achieve and maintain weight loss when the social norms and environments of eating and exercise 'conspire against them' (Nestle and Jacobson 2000).

The population approach seeks to shift the whole population in a favourable direction via strategies that target individual behaviours as well as broader economic, regulatory, social, cultural and physical environments. This approach shifts high risk individuals towards lower risk levels, and also provides small benefits for a large number of people in the middle of the distribution. As a result, the total public health benefit is considerable (Rose 1992; Satterfield et al. 2003).

Population approaches and social equity

An important limitation of individual focused interventions is that they frequently fail to reach and/or have an impact on disadvantaged groups in the community. Population wide approaches are potentially more equitable than individual focused interventions. Policies to reduce the amount of salt or saturated fats in processed foods, for example, have the potential to reach all individuals regardless of their individual level of knowledge, motivation and material resources (table 1). Such interventions have an impact on hard-to-reach groups and those people who are unlikely to respond to nutrition education campaigns or participate in discrete programs.

Table 1: Examples of possible interventions to reduce salt consumption

Intervention	Active[3]	Passive
Population focused	National media campaign promoting reduced salt intake	Regulation to limit salt content in processed foods
Individual focused	Nutrition education in workplaces and primary health care settings	Reduction of salt content of foods in workplace canteens

Nutrition education classes in workplaces and a reduction in the amount of salt added to canteen foods can be effective in reducing salt intake among the employees receiving the intervention. However, similar programs would need to be implemented in nearly all workplaces in the population to bring about measurable change at the population level; even then, the change would be among only the working population.

To produce change at the population level, a balanced mix of population/individual focused strategies and passive/active strategies is required. This multistrategy approach has been successful at the population level in areas such as tobacco control, CVD prevention, road safety, HIV/AIDS prevention, and immunisation (Commonwealth Department of Health and Ageing 2002b).

Improving health among disadvantaged groups

Strategies for improving health among disadvantaged groups can be grouped into:

1. *Targeted intervention programs* designed with and for disadvantaged groups. These interventions generally include education and/or resourcing to support behaviour change. They address inequalities by specifically targeting disadvantaged groups.
2. *Population interventions* that reach everyone in the setting regardless of knowledge, motivation, compliance or socioeconomic status (as in the salt reduction example). These passive strategies often require changes to policies or regulations at local and/or state levels. They represent an equitable approach that avoids the possible stigma associated with targeting particular groups.
3. *Upstream interventions* directed at policies to reduce social inequalities and improve the social and environmental conditions (for example, poverty, unemployment, education and housing) that influence health behaviours and health outcomes.

[3] 'Active' interventions require individuals to actively choose to make the change, whereas 'passive' interventions bring about change without the active involvement of the individual.

Interventions, principally in areas 1 and 2, have led to reduced tobacco use among low socioeconomic groups in Australia in recent years, although the social gradient in tobacco use remains (White et al. 2003). Interventions at levels 2 and 3 are further upstream and can address inequalities at their source. They usually require intersectoral action at the level of governments and peak organisations, and may seem somewhat distant from the work of many health practitioners. However, locally-based practitioners have an important role that includes:

- awareness raising and advocacy for wider policy, economic and regulatory change to address health and social inequalities
- community action and organisational change (around issues such as local public transport policy and workplace cycling support) that provide opportunities to generate change at a local level
- the development of local upstream interventions (such as community building and urban renewal programs) (chapter 10).

These activities frequently require intersectoral cooperation and local partnerships. The concept of integrated health promotion provides a framework for practitioners to work with multisectoral partners to improve health and wellbeing in local communities.

2.3 Integrated health promotion

The most effective disease prevention and health promotion strategies are those that address the individual, social and environmental determinants of health (Nutbeam 1998). This is an integrated approach that incorporates many sectors (for example, transport, urban planning, environment, sport and recreation, food policy and regulation, education, health and welfare) and adopts multiple level strategies implemented concurrently. It offers the greatest potential for having an impact on the health of the population as a whole, addressing health inequalities and sustaining these changes over the long term.

In summary, integrated health promotion refers to agencies and organisations from a wide range of sectors and communities in a catchment working in a collaborative manner, using a mix of health promotion interventions and capacity building strategies to address priority health and well being issues. (Department of Human Services 2003).

2.4 A framework for interventions

Balancing the mix of interventions

Integrated health promotion involves a balanced mix of both individual and population focused interventions. Population focused approaches can complement individual, high risk approaches, and each is valuable for different reasons. Discrete programs focused on individual behaviour change can be effective for the small number of people who participate, but they are unlikely to be sustainable or to have a significant impact on whole communities without the support of broad structural, policy and environmental change. The population health approach outlined by Rose (1992) provides an evidence based rationale for using an integrated approach to health improvement interventions.

With this rationale in mind, this guide provides practitioners with a range of intervention strategies. Some strategies have the potential to contribute to wider, long term structural and environmental change, through changes in policy, laws and regulations, organisational culture, and local environments. These changes are often facilitated by community participation and advocacy. Other strategies involve program based interventions that have been shown to be effective in reducing individual risk factors for CVD and diabetes. These latter strategies provide a springboard for action within the context of wider, slower social change. Importantly, social equity issues can be addressed via a focus on socially disadvantaged groups and communities that are predisposed to CVD and diabetes. If practitioners are to tackle the health effects of disadvantage, then they need to identify the disadvantaged population groups in their community and incorporate this focus into their goals and objectives, planning and evaluation strategies.

Selecting interventions

While individual practitioners cannot be expected to implement large scale, population-wide interventions, an integrated, intersectoral approach to planning assists practitioners to identify which agencies and organisations are best placed to address elements of a comprehensive approach. This guide provides the following CVD–Diabetes Prevention Health Promotion Interventions Framework (figure 2) to assist with planning and decision making (Department of Human Services 2003).

To guide solution generation, the framework identifies five categories of health promotion interventions:

- screening, individual risk factor assessment and immunisation (*Note*: medical interventions are not included in this evidence based resource.)
- health education and skill development (usually group activities to enhance skills for adopting and maintaining healthy lifestyle choices)
- social marketing and health information (coordinated communication strategies involving newspapers, radio, television, outdoor promotions and print communication such as leaflets and newsletters)
- community action (participation of community members and groups in advocacy and action for social and environmental change)
- settings and supportive environments (changes to policies, laws and regulations, physical environments and organisations).

This mix of interventions needs to be underpinned by a range of capacity building strategies to unsure program quality and sustainability.

Figure 2: CVD–Diabetes Prevention Health Promotion Interventions Framework

Source: Adapted from Department of Human Services (2003)

Individual focus ◄——————————————► **Population focus**

Screening, risk factor assessment	**Health education** **Skill development**	**Social marketing** **Health information**	**Community action**	**Settings and supportive environments**
Risk factor assessment and monitoring by general practitioner	Healthy eating/cooking demonstration Supermarket tours Education sessions about the benefits of physical activity	Local advertising campaign about the benefits of cycling to work 'Come and try' day at a local community house	Community reference group to lobby council for safer facilities for physical activity Collaboration with local gym to offer off-peak rates for users	Collaboration with major workplaces to introduce healthy staff canteen policy Collaboration with council and workplaces to provide facilities that encourage active transport (such as showers and bike racks)

Ensuring the capacity to deliver quality programs through capacity building strategies, including:

Organisational development **Workforce development** **Resources**

The following chapters are guided by the above framework of interventions. For some risk factors (such as obesity), evidence is not yet available for all intervention types. The interventions are organised along a continuum from individual focused to population/community focused. Wherever possible, information is included about specific settings and population groups.

3 Review methods

3.1 The evidence based review

The guide has been developed from an extensive review of the Australian and international literature. A copy of the review is available on the Department of Human Services website (http://www.dhs.vic.gov.au/phd/ebhp/). The purpose of the review was to identify and describe what is known about the most effective health promotion strategies for reducing the risk factors for CVD and type 2 diabetes. The review was principally a 'review of reviews', including systematic reviews from the Cochrane Collaboration Library and other sources, narrative reviews (published and unpublished), journal editorials and professional association position statements. The review also aimed to identify key implementation issues, innovative strategies that show promise of success, and research gaps in the area of CVD and diabetes prevention.

3.2 Development of the guide

The guide is a synthesis of the available evidence, providing a narrative summary that draws out the information most relevant to practitioners. For each intervention, the evidence was assessed according to the number of studies, quality of design and execution, consistency of findings, effect size, reach, sustainability and relative costs. Wherever possible, the guide describes the potential of interventions to reach disadvantaged/special population groups. In some cases, the literature identified information about the characteristics of, and barriers to, effective interventions, and the guide includes this information.

The interventions described here are based on the best available evidence; where evidence from intervention trials is scarce or nonexistent, the guide includes evidence from observational studies. Observational studies examine the links between social and/or environmental factors (such as high density urban design, parks and cycling trails) and people's health behaviour (such as physical activity). This type of data has underpinned the development of innovative and ultimately effective population focused strategies for tobacco control (Mercer et al. 2003). It provides valuable clues to potentially effective interventions that have yet to be rigorously evaluated in other risk factor areas.

Development of the guide involved ongoing consultation with, and review by, experts, key organisations and practitioners. The process included the following steps.

1. A literature review conducted in consultation with the expert review panel.
2. Planning consultations with the project advisory group.
3. A review of existing resources, including comprehensive planning resources and existing evidence based guidelines for diabetes and CVD prevention.
4. Consultation with practitioners, including their written feedback on the existing Department of Human Services evidence based resources, and their contribution to planning this guide by identifying key features and information most relevant for practitioners' needs.
5. Drafting and review in consultation with the project advisory group.

6. Piloting with practitioners, including two focus group workshops conducted with practitioners from rural and metropolitan Primary Care Partnerships and community health agencies.
7. A review of the draft guide, with suggestions made for increasing its user friendly qualities.
8. A final review and the production of the guide.

Appendix A lists the members of the project team, the project advisory group, the expert review panel and focus group participants.

3.3 Presentation of the evidence for effective interventions

The following chapters present an overview of the best available evidence about effective community based strategies for preventing CVD and type 2 diabetes. The first two chapters describe programs specifically focused on CVD and diabetes prevention, while the following five chapters identify evidence based strategies for addressing individual risk factors: obesity, physical activity, nutrition, tobacco and socioenvironmental and psychosocial factors. The type of interventions that have been used and evaluated vary for each risk factor, and cannot readily be classified into the five strategy areas outlined in the health promotion interventions framework (figure 2). However, interventions are presented in each chapter in order from individual focused to population focused interventions.