Runanga Whakapiki ake i te Hauora o Aotearoa
HEALTH PROMOTION FORUM
of New Zealand

keeping up to date

Keeping up to date - the seventeenth edition

This summary of recent health promotion literature is intended to help:

- increase health promoters' access to the health promotion literature;
- increase health promoters' awareness of some of the current thinking and latest research findings in the field;
- increase health promoters' use of this information in practice.

Keeping Up to Date is produced four times a year. Assistance with accessing articles in journals/periodicals should be available through university, polytech, DHB or local libraries. However if you have difficulty accessing any of the papers, contact the Forum and we can point you in the right direction.

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Title **Race and ethnicity in public policy: does it work?**

Author(s) Mason Durie, Te Mata o te Tau, Academy for Maori Scholarship and Research, Massey University, Palmerston North

Context Presentation at the Social Policy Research and Evaluation Conference *What works?* in November 2004, Wellington, reviewing historical and contemporary public policy.

Overview 2004 was the 150th anniversary of the opening of Parliament. It passed the 1854 English Acts Act, applying all English laws of the time to New Zealand. A product of an ethnic-English culture, it was New Zealand's first race-based policy. It laid foundations for a policy environment within which English common law was the norm and Maori common law (culture) was the problem. Parliaments introduced race-based legislation and policies to address Maori custom at odds with English custom/common law. Recent debate about race-based policies in New Zealand reveals poor understanding about policy objectives, application and measures of effectiveness. Race and ethnicity should be identified as rationales for policy in their own right. Evidence indicates a needs-based formula, centred on individuals and their socio-economic status, will not meet health, social and educational policy requirements. Increasing diversity of ethnic affiliations is a modern New Zealand characteristic. It is nonsense to ignore this. Whether policies based on race or ethnicity work depends largely on the policy goals and the instruments used to measure impacts. Three broad goals are identified: full participation, certainty of access to indigenous culture and fairness between members of society. If ethnicity is not reflected in policies, diversity will be masked, best outcomes compromised and an assimilatory approach fostered.

Comments Clear, timely and comprehensive discussion which uses policies on social service delivery and affirmative action programmes as examples. Straightforward to read.

Source Available from the Social Policy Research and Evaluation conference proceedings on the Ministry of Social Development website at http://www.msd.govt.nz

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Title **Linking health and human rights: what are the possibilities?**

Author(s) Dianne Otto, Faculty of Law, University of Melbourne

Context In the past few decades there has been a new focus and energy to the implementation of the human right to health.

Overview Discusses what a human rights framework offers public health paradigms. A table outlines the contrasting principles between human rights and traditional approaches to public health. For example, public health has been informed by a utilitarian principle, or focusing on the wellbeing of the majority. Human rights instead are informed by principles of equality and non-discrimination, with a focus on vulnerable groups. The first core principle of human dignity values every human being as an end in him or herself. The second is that of participation, empowerment and self-expression. The third is the indivisibility of human rights. This arises from focusing on the whole person and interconnections between rights to food, housing, work, education, privacy, equality, non-discrimination and freedoms of association, assembly and movement. The fourth focuses on equality and non-discrimination, which moves vulnerable, disadvantaged or stigmatised groups from the margins of public health policy to its heart. The fifth is accountability. States have obligations in relation to all human rights. The last principle is international assistance and cooperation. Many of the principles and their components may already be recognised as essential to good health practices. Human rights principles may contribute a stronger sense of coherence and common purpose to public health.

Comments Clear discussion on the principles and thinking underpinning human rights and application to public health. Fairly readable.

Source Presented at the International Symposium on Human Rights in Public Health: Research Policy and Practice, University of Melbourne, 3-5 November 2004. Available from http://www.rhhr.net/symposium.htm

Title **Program sustainability: focus on organizational routines**

Author(s) P Pluye, Department of Social Studies of Medicine, McGill University, Montreal and L Potvin, JL Denis and J Pelletier

Context Programme sustainability is an ongoing concern in health promotion. The paper looks at how five community health centres in the Quebec Heart Health Demonstration Project dealt with it.

Overview The study of organisational routines is useful in looking at programme sustainability. Four characteristics suggested from the organisational literature are memory, adaptation, values and rules. They were examined in an interview study with five Canadian community health centres about their activities with Heart Health.. Fifteen questions were asked on the four characteristics. For example 'does the formal budget include financial resources necessary to employ key personnel with permanent funding (memory); are the activities included in a formal planning process? (rules); 'are activities carried over from one year to the next because they are enjoyed and in spite of uncertainty about their continuing relevance?' (adaptation); and 'are there established rituals such as periodic meetings related to the activities?'(values). Results varied centre to centre. Staff in one centre agreed to volunteers doing an annual talk in schools about the risks of smoking, despite knowing it was ineffective without follow-up. In another, staff thought heart health activities were not entrenched because there was no management supervision or integrated planning. Staff informally decided what to do. Results suggested four degrees of programme sustainability: absence (no programme activity); precarious (presence of unofficial activities), weak (presence of remaining official activities) and sustainability through routinisation (presence of routinised activities).

Comments The fifteen questions on memory, adaptation, values and rules will help identify organisational 'ways of doing things' and ways to improve capacity for sustaining programmes. Some tables. Reasonable to read.

Source Health Promotion International, 2004, Vol 19(4), pp 489-500

Title **Tale of two churches: differential impact of a church-based diabetes control programme among Pacific Islands people in New Zealand**

Author(s) David Simmons Waikato Clinical School, University of Auckland, JA Voyle Community Research and Evaluation Services, F Fout, S Feot and L Leakehet, Diabetes Projects Trust, Auckland

Context Describes the results of a 2-year diabetes risk reduction programme in the early-mid 1990s in Tongan and Samoan churches in South Auckland.

Overview The study involved a control church and an intervention church in each of the Tongan and Samoan communities. The South Auckland Diabetes Project (SADP) helped develop a diabetes prevention project. Tailored to the Tongan or Samoan community through language and participation of church members, they had different approaches to presentations and different food, cooking methods and exercise. They also had common components. Congregation members were encouraged by the church to participate in base-line personal assessments on diabetes. This included knowledge about diabetes, 'readiness to change' assessments, weight and exercise checks and tests for glucose tolerance. Diabetes awareness, nutrition and exercise sessions were then run by the churches. Two years later most of the tests and assessments were repeated. The results section discusses the baseline and follow-up characteristics. Diabetes knowledge increased significantly in both intervention churches when compared with their control church, more so among Samoans. Weight, waist circumference and exercise improved in the Samoan intervention group, but no significant change was seen in either control group or the Tongan intervention group. Participation was lower in the Tongan church. Its members perceived the church's key interventions as less useful than did the Samoan congregation. Possible reasons for the differences and suggestions for such programmes are discussed.

Comments Interesting overview of the study and interventions, useful for planning similar initiatives. Includes tables and statistics. Fairly straightforward to read.

Source Diabetic Medicine, 2004, Vol 21, pp 122-128

Title **'The glue that binds…': articulating values in multi-disciplinary public health**

Author(s) Jane Wills, Faculty of Health and Social Care, South Bank University, London and David Woodhead, Salford Primary Care Trust

Context An exploratory UK project asked public health workers about values in multi-disciplinary public health.

Overview Major changes in health in the UK have called for a 'multi-disciplinary' public health workforce. The concept conceals tensions and challenges about roles and responsibilities, professional scope, disciplinary perspectives and public health activities. The study had the idea that the process of articulating professional values reveals a professional identify. Values are the 'enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable.' Rarely articulated explicitly, they inform and shape public health practice. Fifteen public health practitioners/specialists were asked 'What do you think are the values informing multi-disciplinary public health?' and 'Would a fuller analysis of those values be beneficial to the profession?' Most did not think it important to consider values, could not articulate any and did not believe they influenced practice. Some thought a consensus on values important, to create a framework and language to unify a workforce and to communicate clearly about public health. Three concerns are identified. Firstly, the current technical-rational emphasis on analysing public health functions gives little attention to value-based questions. Secondly, not questioning values may mean continued biomedical dominance. Thirdly, multidisciplinary public health will remain a marginalised partnership of professional groupings, unless it clearly articulates its values about what it is and what it should be.

Comments The paper raises lots of interesting questions and issues around values, disciplines and functions that should be discussed more explicitly in New Zealand. Readable.

Source Critical Public Health, 2004, 14(1) pp 7-15.

Title **Culture and community development: towards new conceptualisations and practice**

Author(s) Lewis Williams, Director, Prairie Region Health Promotion Research Centre, University of Saskatchewan, Canada.

Context The role of culture in the development of migrant communities is explored through findings of health related projects in Aotearoa-New Zealand and Canada.

Overview Culture is proposed as dynamic and multifaceted. It refers to the web of influences shaping the lives of groups and individuals. It includes social institutions, systems of norms, believes values and worldviews. The paper focuses on development initiatives with migrant communities in economically wealthier countries. Migrant communities are faced with both opportunities and marginalisation. They are faced with choices between cultural preservation and change, and the tensions associated with this. The paper draws on the experiences of a women's advocacy group (WAG) of migrant, low income Samoan and Tongan women in New Zealand, the experiences of Pacific women undertaking community development and of Canadian based community development workers working with migrant communities. It discusses the experiences of migrant members in relation to gender and other aspects of ethnic cultural systems around power, authority, social status and protocols. Exposure to new world-views and cultures by coming to another country could enable community members to adopt a more empowered position. Migrant communities must negotiate cultural and power dynamics within their own communities and between their own marginalised community and more economically and culturally dominant groups. Six questions for communities wishing to investigate culture as a tool for adaptation and empowerment within new cultural contexts are suggested.

Comments Focusing on issues facing migrant communities, its readability is helped through the practical examples and quotes from the community members about their experiences.

Source Community Development Journal, 2004,Vol 39(4), pp 345-359.

Title **The social determinants of the incidence and management of type 2 *diabetes mellitus*: are we prepared to rethink our questions and redirect our research activities?**

Author(s) Dennis Raphael, York University, Toronto; Susan Anstice, Ryerson University, Toronto and four other authors.

Context Explores why the incidence of 'lifestyle' type2 diabetes is increasing amongst people living in low-income communities in Canada and other similar societies.

Overview Reasons for increases in mortality rates amongst people living in low income communities indicate diabetes is a disease of the poor and excluded. Yet conventional thinking attributes increases to changes in dietary and physical activity behaviour. This does not adequately consider the importance of social determinants on the incidence and management of diseases. Income is especially important. It influences the quality of early life, stress levels, food availability and diet quality, physical activity participation, degree of social exclusion and so on. The paper examines how material deprivation might influence metabolic changes leading to the development of diabetes. People suffering from material deprivation are more exposed to such things as hunger, poor quality food and housing, poor environmental conditions at home and work, and less exposed to positive resources such as education, opportunities for recreation and attendance at cultural events. The relationship between psychosocial stress, the adoption of unhealthy behaviours and diabetes is also reviewed. Individuals faced with low income or other stress inducing issues such as unemployment, racism and insecure or unaffordable housing have difficulty maintaining 'healthy lifestyles'. The societal determinants relating to successfully managing diabetes are also reviewed. The diabetes crisis appears to call for new ways of thinking about and redirecting activities in regards to this disease.

Comments Good review and discussion of research around role of social determinants in the development and management of the disease. Straightforward and readable.

Source International Journal of Health Care Quality Assurance, 2003, Vol 16(3), pp 10-20. Available at http://quartz.atkinson.yorku.ca/QuickPlace/draphael/main.nsf/