



keeping up to date

Keeping Up to Date – the fourteenth 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 **Advocacy and public health: roles and challenges**

Author(s) Simon Chapman, Department of Public Health and Community Medicine, University of Sydney

Context Advocacy is a key tool in public health but its study and skill training is neglected and health researchers do not use it well.

Overview Public health researchers want their work to influence policy and practice, but only a tiny fraction informs advocacy efforts. Postgraduate public health courses pay advocacy only passing attention. There are many examples of the critical role advocacy has played in translating research into policy and practice and gaining sea changes in supportive public opinion. Why is the study and teaching of advocacy so neglected? It may be a reflection of advocacy's perceived incompatibility with the criteria and language of science, especially epidemiology. Three recurring concerns about public health advocacy are discussed. Firstly, 'when is state regulation of individual liberty justified?' Secondly, 'with advocacy, does the end justify the means?' Thirdly, 'what evidence is there that advocacy actually works?' Case studies on Australian gun control, road toll reduction and banning workplace smoking illustrate points. The hesitancy of academic public health to embrace advocacy will hopefully erode, with the growing acceptance of important multi-disciplinary analysis in reducing health problems and a growing recognition of advocacy as a core skill needed by public health practitioners trying to play productive roles in building safer and healthier communities.

Comments Challenging and useful paper for anyone working in public health wanting to discuss and understand more about advocacy. Reasonable to read.

Source *International Journal of Epidemiology*, 2001, Vol 30, pp 1226-1232. Available to download from the journal's archives at <http://ije.oupjournals.org/>

Title **Riding the Waves: The politics and funding context of twenty-five years of research on community action to reduce alcohol harm in New Zealand**

Author(s) Kim Conway and Sally Casswell, Social Health Outcomes Research and Evaluation Centre(SHORE), Massey University, Auckland

Context SHORE and its predecessor, the Alcohol and Public Health Research Unit, have been involved in several community action projects on alcohol between 1982 and 2003.

Overview Different approaches were required in the community action projects to ride the waves of change in research funding and national alcohol and health related policy. The political context included more liberal liquor licensing and alcohol advertising environments. ALAC, the government's major funder of alcohol and prevention projects, was instructed in the 1990s to work more closely with the liquor industry. The health system provider/purchaser split resulted in concern about sharing ideas and strategies and little resource or time was built into contracts for networking and advocacy. The projects are discussed chronologically from 1982 and cover broad based community action on alcohol; liquor licensing; a Maori collaborative drink-driving project; rural drink driving; youth and alcohol; youth and drugs and reducing youth access to alcohol. Aims, main sustainable outcomes and issues such as health promoter and community capacity, funder expectations, research and community partnerships, working within Maori communities, strategies and political context are discussed. A list of ten optimum elements for effective community action is given based on learnings from the projects .

Comments Valuable insights into political, ideological and health system context to community action. Useful even if you don't work in alcohol. Fairly easy to read.

Source Nordisk Alkohol (English Supplement), 2003, Vol 20, pp1-24. Available from SHORE, contact l.r.morice@massey.ac.nz

Title **Learning from differences between ordinary and expert theories of health and physical activity**

Author(s) Colin MacDougall, Department of Public Health, University of South Australia

Context Reports on a qualitative study in Adelaide that asked 'how do ordinary people theorize about health, physical activity and constraints on choice to increase physical activity?'

Overview Common strategies to promote physical activity have relied on health professionals telling people lack of physical activity is a health risk. Social marketing campaigns have hoped for universal behaviour change to more activity. Professional dominance in designing health promotion campaigns can lead to experts blaming people for not exercising, rather than considering their views and knowledge. People in focus groups discussed health and physical activity. Theorising included 'I know physical exercise is supposed to be good for me but it's not always and that's not why I do it.' There were complex motivations for activity including social and self esteem reasons, stress release, weight loss, increasing bone density and reducing cardiovascular risks. Listening to one's own body and making tradeoffs re exercise and a reservoir theory (the body has only so much capacity for exercise under the right conditions) were other theories. Practical implications of the research are important because there are poor results from mass-reach campaigns. It is important for health professionals to resist professional dominance and instead undertake research and practice that engages the participation of people and communities in their health and listens to their views.

Comments Highlights the need for people working in public health to consider ordinary people's knowledge and understanding of health in relation to their own selves and circumstances. Fairly readable.

Source *Critical Public Health*, 2003, Vol 13(4), pp 381-397

Title Health inequality: an introduction

Author(s) Elizabeth Harris and Sarah Simpson, Centre for Equity Training Research and Evaluation, University of New South Wales and Division of Population Health, South Western Sydney Area Health Service.

Context One of a series in the *Australian Journal of Health Promotion* exploring technical issues in health promotion.

Overview Concepts and issues around health equity are discussed. The terms 'health inequality' and 'health inequity' are often used interchangeably, but there is a fundamental difference. Health inequalities refer to measurable differences, variations and disparities in the health of individuals and groups. Health inequities refer to those health inequalities judged to be unfair or unjust and which are considered avoidable, for example the high mortality rates of Indigenous peoples. Policy for equity and health aims to reduce or eliminate differences resulting from factors considered to be both avoidable and unfair. A case study of lead exposure looks at the various determinants of health difference and comments on issues of fairness and justice. Deciding that a health status difference is inequitable involves making value judgements. Health promoters need to be clear why tackling health inequity is important. Three arguments are given: that inequities are unfair, they affect everyone and they are avoidable. The challenge for health practitioners is finding how they can make a difference, rather than feel immobilised by the complexities. Local level programmes can be made accessible so people with the poorest health can participate. Resources can be allocated to ensure programme benefits are shared equally and the workforce is skilled to work in the area. At national level, there should be investment in research, evaluation and structural change. Health promoters need to be proactive in articulating our values and beliefs and being open to them being challenged.

Comments Short readable article with useful explanations and points for workplace discussions.

Source Health Promotion Journal of Australia, 2003, Vol 14(3), pp 208-212

Title Community capacity building: starting with people not projects

Author(s) Lyn Simpson, Leanne Wood, Centre for Service Innovation, Queensland University of Technology and Leonie Daws, Kihl Consultancies, Allentown, Australia

Context Explores the impact of and general lessons from a government sponsored community development project to set up an Internet Cafe in a small rural Queensland town.

Overview Rural areas face significant socio-economic challenges. In response, governments encourage community empowerment and ownership of development initiatives. Communities need to take responsibility for their own development. The Internet Cafe project experience raised questions about such rhetoric regarding capacity building, community empowerment and community decision-making. The community regarded the Internet Cafe as a positive and popular initiative, with many potential benefits re information access, networks, employment and education. However, it closed within two years. It left behind a community struggling to come to terms with what residents thought was their own failure to sustain a project with long-term benefits for their community. The authors argue the project model was flawed. It was under-resourced, focused on short-term objectives and assumed the community had renewable resources of time, energy and money when in fact they were finite and limited. Government interventions that neglect or undermine the social infrastructure of a community can go seriously awry by creating new pressures on previously sound community networks. Poor communication and consultation can create alienation and seriously affect the community's self image and future viability. Such projects will be unsuccessful long term and can have a serious impact on the community's social wellbeing.

Comments Lessons and discussion are relevant and generalisable for any community development initiatives in health or other areas. Readable.

Source Community Development Journal, 2003, Vol 38(4), pp 277-286.

Title Walking, transport and health: do we have the right prescription?

Author(s) Les Lumsdon and Jayne Mitchell, School of Health, Staffordshire University, UK.

Context Discusses the extent to which sustainable transport strategies and physical activity promotion, especially around walking, could be combined.

Overview Sedentary lifestyles and decline in physical activity are causing concern. Reduced physical activity is partly explained by the dominance of cars. Walking is seen as an ideal form of physical activity to encourage in sedentary populations for many reasons. Strategies are needed which motivate, empower and enable individuals to act upon their intention to walk, by constructing transport and environmental plans which value walking as a mode of transport. Walking may be taken for granted by transport planners because it is not a contributor to major problems like congestion or pollution. Walkers in urban areas face problems like heavy traffic, excessive speed and difficulty in crossing major roads. Car dependency, feeling little personal responsibility for congestion or pollution and social stigma attached to walking and cycling to work are other barriers. Walking policy needs to be linked with sustainable travel policies, adopting a holistic approach to the management of streets for the benefit of residents, users and the environment. Health promoters are well placed to stimulate and support required changes. Health promotion core skills provide a range of practical methods for working with and across sectors to achieve improvements in health. Approaches should embrace local cultural dimensions, intersectoral provision of facilities, accessibility issues and land use planning.

Comments Fairly easy to read paper that provides down to earth advice and reasons to encourage transport, planning and health promotion sectors to get together.

Source Health Promotion International, 1999, Vol 14(3), 271-279

Title A new approach to design and implement a lifestyle intervention programme to prevent type 2 diabetes in New Zealand Maori

Author(s) Eleanor Murphy, Nga Tahu no Otakou, Diabetes Department, Dunedin Hospital; Kirsten McAuley, Department of Human Nutrition, University of Otago and eight other authors.

Context Increasing frequency of diabetes is a major health issue for Maori as it is for other indigenous people worldwide. Attempts to recruit Maori participants into mainstream lifestyle programmes have not been successful.

Overview Following a 6-12 month consultation with Maori community groups in the Otago region, Te Whai matauranga o te ahua noho/ Lifestyle Intervention Programme was specifically designed for Maori. Maori community leaders agreed to participate and recruited other family members and work colleagues. The programme was based in a building which provided offices, dietary education and clinical rooms, kitchen facilities for healthy kai practical sessions and group exercise rooms. It employed a Maori Diabetes Educator and a non-Maori dietician and physical exercise trainer. Programme activities included regular clinical assessment of participants, healthy kai cooking classes and physical exercise classes. Foods helpful for diabetes control and food important to Maori were emphasised. Exercise was designed to be inexpensive, home and community based. It included waka ama and kapahaka. Qualitative kaupapa research showed the programme was acceptable to the local Maori community. Important aspects were regular contact, monitoring, ability to discuss food issues with a dietician, flexible visit times, weekly motivation from an exercise trainer and ongoing support and participation of Maori staff in the programme's activities. Continued programme development, ideas for future recruitment and the need for the ongoing level of support are discussed.

Comments Easy to read, informative details about the programme including examples of the dietary and exercise components.

Source Asia Pacific Journal of Clinical Nutrition, 2003, Vol 12(3): pp 419-422. Contact diabetes.research@stonebow.otago.ac.nz