AUSTRALIAN BETTER HEALTH INITIATIVE

DIET, EXERCISE AND WEIGHT

DEVELOPMENTAL COMMUNICATIONS RESEARCH

RESEARCH REPORT

Prepared for the Australian Government Department of Health and Ageing

April 2007

Notes on Research

Qualitative research deals with relatively small numbers of consumers and explores their in-depth motivations, attitudes, feelings and behaviour. The exchange of views and experiences among participants is relatively free flowing and open, and as a result often provides very rich data that can be broadly representative of the population at large.

The findings however are not based on statistics: they are interpretive in nature, and are based on the experience and expertise of the researchers as they analyse the discussions.

TABLE OF CONTENTS

D   Using This Research

1 EXECUTIVE SUMMARY

1.1 Background to the Research

COAG has set aside $500 million over four years for the Australian Better Health Initiative (ABHI). The initiative aims to reduce morbidity and mortality caused by lifestyle related chronic diseases. A range of interventions is planned including a rolling program of social marketing campaigns. These will aim to enhance awareness of healthy lifestyle choices and stimulate behaviour change.

Research was required to build on existing learning about attitudes and beliefs in relation to lifestyle change. Findings are intended to feed into the development of the social marketing program as a whole and specifically an initial campaign focusing on diet, exercise and weight. A key aim of the research was to explore whether the threat of chronic disease can be leveraged effectively in communications to stimulate behaviour change.

1.2 Research Overview

The research program consisted of twenty-two group discussions and six telephone in-depth interviews amongst people who do not currently have any lifestyle related chronic diseases but who may potentially be 'at risk' of developing them. Eight group discussions and three telephone in-depth interviews with people with chronic diseases were also conducted. The qualitative research was conducted in metropolitan, regional and remote areas in New South Wales, Victoria, South Australia and Queensland.

Four of the group discussion and three of the in-depth interviews were conducted amongst Aboriginal and Torres Strait Islander audiences. This part of the research was conducted by CIRCA (Cultural and Indigenous Research Centre Australia, formerly Cultural Perspectives). Findings were incorporated with those from the rest of the sample at the analysis stage.

1.3   Key Findings

This study built on existing learning about beliefs that prevent lifestyle change. Findings supported the conclusion from the SNAP-O research[1] that modifying lifestyle behaviour requires an appreciation of 'what' change is needed, 'why' it is necessary and 'how' it can be achieved.

Low appreciation of 'why' change is needed in relation to nutrition and activity was evident amongst those most 'at risk' of chronic diseases. There was only slightly higher appreciation of the importance of maintaining a healthy weight. Many people underestimated their personal susceptibility to chronic conditions as well as the severity of lifestyle related diseases, such as type 2 diabetes and heart disease. As a result, a 'healthy lifestyle' is often not considered to be a high enough priority in people's lives and social norms tend not to support change.

There was also low appreciation of 'how' lifestyle change can be achieved. Modifying behaviour was therefore not considered to be worth the effort involved and was seen as requiring too much deprivation. Moreover, appreciation of 'what' change is needed seemed to be impaired by a lack of appreciation of 'why' change is necessary and 'how' it can be achieved. Lack of appreciation of 'what' change is needed was expressed in the form of self-exemption from recommendations on healthy behaviour.

Six attitudinal segments were identified. Each of the segments relates to a different perspective on the possibility and desirability of lifestyle change overall. In conjunction with the 'stages of change', these provide a full picture of an individual's behaviour, beliefs about the relationship between their lifestyle and health and attitudes to change.

'Defiant Resisters', 'Quiet Fatalists', 'Apathetic Postponers' and 'Help Seekers' all have a limited appreciation of 'why' lifestyle behaviour change is important and 'how' this can be achieved. The aim of social marketing could therefore be to shift these people's attitudes so that they become 'Endeavourers' or 'Balance Attainers'. These latter groups have a better appreciation of 'what' change is needed, 'why' it is important and 'how' it can be achieved. They are therefore likely to be 'at lower risk' of developing lifestyle related chronic diseases.

---

[1] Blue Moon, SNAP-O Concept Testing, June 2006

Some awareness of the link between lifestyle and chronic diseases already exists amongst all attitudinal groups. However, there was low appreciation of what constitutes a 'healthy weight'. There was also low appreciation of the health benefits of exercise, and to a lesser extent diet, other than in avoiding overweight / obesity.

Findings indicate that there is scope to leverage the perceived severity of certain chronic diseases in order to enhance appreciation of the need for behaviour change. In particular, emphasising the impact on quality of life of diseases such as type 2 diabetes and heart disease could be effective. There is also scope to increase awareness of the impact of lifestyle related chronic diseases such as colorectal cancer and heart disease on life expectancy.

Awareness of the prevalence of chronic diseases in Australia was high. However there was low appreciation of people's personal susceptibility in terms of the numbers of people who are affected by lifestyle related chronic disease. There also seems to be scope to raise awareness of who is 'at risk' beyond smokers and morbidly obese people.

The threat of chronic disease seemed to have potential to convey 'why' change is necessary because this can enhance the belief that change should be a priority. Basing communications on this theme may also have the potential to challenge social norms that obstruct change in relation to diet and exercise. Messages about chronic disease and lifestyle seemed to be particularly effective for 'Apathetic Postponers', 'Help Seekers' and 'Endeavourers'. These people already had some appreciation of 'what' change is required and therefore found this approach highly credible and motivating. Shocking imagery, in the style of recent anti-smoking campaigning, seemed to have a great deal of impact and was surprisingly acceptable to the majority of people.

However, findings indicate that care would be needed in developing communications that aim to leverage the threat of chronic disease. The correlation between health and diet, exercise and weight is complex and there is a great deal of potential for miscommunication. Moreover, there is potential to cause harm by stimulating 'victim blaming', as well as by leaving people feeling depressed and helpless. Response indicated that these challenges might be mitigated to some extent by also conveying the positive benefits of change and / or also presenting messages about 'how' change can be achieved.

Aboriginal and Torres Strait Islander participants recognised that lifestyle related chronic disease is a particular problem in their communities. This was perceived to be a symptom of a much bigger problem stemming from cultural displacement and resulting social problems. Conveying health facts in a culturally appropriate way may have some impact on attitudes to change. However, there appears to be less opportunity to leverage the threat of chronic disease for this audience because of the enormous structural barriers to change and distrust of government advice.

1.4 Summary of Research Recommendations

Recommendations, based on these findings were as follows:

1. The ABHI social marketing program as a whole should aim to drive appreciation of 'what', 'why' and 'how' amongst all target audiences and attitudinal segments. Campaigns should also seek to migrate as many people as possible to 'Endeavourer' and 'Balance Attainer' segments.

2. In 2007, the focus could be to raise appreciation of 'why' change is a priority amongst 'Apathetic Postponers', 'Help Seekers' and 'Endeavourers'.

3. Consider aiming to leverage the threat of chronic disease in relation to nutrition, activity and weight by conveying the severity of these conditions that can result from inaction, as well as people's susceptibility to them.

4. Convey 'what' constitutes a 'healthy weight', ideally using waist measurement information.

5. Consider also using positive supporting messages to help make the more negative approach of conveying the threat of chronic disease more palatable. For example, this could cover the short term benefits, where to get more information and support and the short and long term health *benefits* of better nutrition and more activity.

6. Use a direct, factual tone when expressing messages about the link between lifestyle and chronic disease, for maximum credibility.

7. Explore the opportunity to use graphic, unpleasant imagery that people find difficult to avoid. However, it will be important to handle this type of message

bluemoon

sensitively.

8. In the longer term, explore other creative means of enhancing appreciation of 'why', with the aim of engaging 'Defiant Resisters' and 'Quiet Fatalists', including those in Aboriginal and Torres Strait Islander communities.

BACKGROUND AND METHODOLOGY

2 BACKGROUND TO THE RESEARCH

2.1 Overview

The Australian Better Health Initiative (ABHI) was announced by the Council of Australian Governments (COAG) as a joint Australian State and Territory government initiative in February 2006. $500 million over four years has been assigned to this national program, which aims to reduce the prevalence of risk factors contributing to chronic disease, limit the incidence and prevalence of diseases in the population and reduce morbidity rates to enhance workforce participation. The program is also intended to enhance the capacity of the health system to achieve these outcomes. A range of intervention approaches will be adopted, including the introduction of a Medicare Benefits Schedule item for people who are at an age at which lifestyle diseases are most likely to be diagnosed due to a major risk factor such as smoking or obesity.

One of the activities within ABHI will be a rolling program of social marketing campaigns to raise awareness of healthy lifestyle choices. A Campaign Reference Group (CRG) has been convened with responsibility for the development, implementation and evaluation of these campaigns. The CRG includes a representative from each State and Territory as well as the Australian Government and is overseen by a Senior Officers Working Group (SOWG). A clear strategic vision for the social marketing campaigns is required, which all of the States and Territories can unite behind to pursue the aims of ABHI.

The campaign will seek to present consistent, evidence based messages to all Australians. Specific objectives will be determined using best practice evidence and the findings from developmental research, however there is likely to be a strong emphasis on encouraging behaviour change, not just shifting attitudes. In terms of Prochaska's Transtheoretical Model[2], the campaign will need to attempt to encourage people to move through the five stages from Pre-contemplation, Contemplation and Preparation to Action and Maintenance.

The campaign strategy will be informed by social psychology theory on behaviour change in relation to health. In particular it will take into account the Health Belief Model[3], which states that behaviour change is influenced by beliefs about the relationship between the perceived costs and benefits of change and that these are determined by perceptions about personal susceptibility to diseases and their

---

[2] Prochaska, Redding and Evers, The Transtheoretical (Stages of Change) Model 1997
[3] Strecher and Rosenstock, The Health Belief Model 1997

severity.

The strategy will also be based on learning from research findings to date about how behaviour change may be stimulated. Previous research has indicated that there is relatively high awareness of the impact of smoking and excessive alcohol consumption on both mortality and morbidity but lower appreciation of the long term consequences of inactivity, poor nutrition and overweight/obesity.[4] The initial campaign will therefore focus on physical activity, nutrition and healthy weight, to help address this imbalance.

Another key research finding that will be taken into account is that a 'healthy lifestyle' is not necessarily aspirational for those who are most at risk of developing lifestyle-related chronic diseases. Campaign messages may therefore need to focus on improvement rather than perfection as the goal by stressing the importance of making small incremental changes and that benefits have cumulative effects over the long term. As a result of this existing learning, it was hypothesised that one way of shifting attitudes may be to enhance public understanding of the causal link between lifestyle choices and chronic disease.

2.2   The Need for Research

A great deal of research has been undertaken by the Commonwealth and individual States and Territories on beliefs, attitudes and behaviour in relation to the lifestyle risk factors. However, much of this research amongst adults, has been focused on the individual lifestyle factors in isolation. Further, there has been no national campaign in Australia aimed at conveying the long term consequences of lifestyle overall, and in particular the link between chronic disease and poor nutrition, inactivity and overweight/obesity.

This research was therefore intended to assist in determining the types of communication messages and approaches that could help achieve the extremely difficult task of stimulating lifestyle behaviour change. In particular, there was a need to ascertain whether communicating about the relationship between lifestyle and chronic disease could encourage shifts in attitudes and, ultimately, could lead to behaviour change.

---

[4] Blue Moon, SNAP-O Concept Testing, June 2006

3 RESEARCH OBJECTIVES

The overall aims of the developmental research were as follows:

- to understand the beliefs and attitudes that influence behaviour change in relation to the risk factors that could prevent chronic disease;

- to explore key motivations for attitude and behaviour change, in particular those that could be used to inform messages in social marketing campaigns;

- to establish demographic and / or attitudinal audiences that have differing communication needs; and

- to provide an understanding of the types of messages and styles of communication that are most likely to achieve the desired behaviour changes, in particular whether the threat of chronic diseases can be leveraged effectively in communications.

More specifically, this was achieved by exploring:

- existing lifestyles, including the presence of risk factors and reasons for current levels of intention and motivation to change;

- awareness and understanding of the relationship between risk factors and chronic disease, as well as understanding of terms such as 'chronic disease' and those related to specific diseases such as type 2 diabetes and cardiovascular disease;

- perceptions of the severity of chronic disease in general and key specific diseases in terms of the impact these have on quality of life and life expectancy;

- perceptions of personal susceptibility to chronic disease based on current lifestyle behaviour both at a general level and in terms of a range of specific chronic diseases;

- beliefs about the potential that exists for individuals and families to reduce risks;

- current awareness of specific ways of reducing the risk of chronic disease, in particular sources of information, support channels and infrastructure that is

available; and

- reactions to a range of messages and styles of existing advertising to identify ways of communicating that are motivating, credible, relevant and likely to have an impact in terms of stimulating behaviour change.

4 RESEARCH METHODOLOGY

4.1 Overview

A program of qualitative research was conducted including 20 'standard size' group discussions, 9 'mini groups' and 9 in-depth telephone interviews in total. These represented the key target audiences:

1. Primary targets

- adult Australians most 'at risk' of developing lifestyle related chronic diseases primarily due to being overweight/obese, inactive/insufficiently active or having an unhealthy diet;

- people suffering from one of the 'lifestyle related' chronic diseases.

2. Secondary target:

- the remainder of the adult population 18-80 years.

The fieldwork was conducted between 24 January and 21 February 2006 across metropolitan and regional areas of the four states of New South Wales, Victoria, South Australia and Queensland. Fieldwork was conducted in each of the four capital cities and in the regional areas of Wagga Wagga (NSW) and Bendigo (VIC) as well as a range of remote, rural areas in New South Wales, Queensland and Victoria via telephone interviews.

4.2 Rationale for the Methodology

Qualitative research was conducted in order to understand and explore the issues in depth, to assist in the strategic development of the proposed social marketing campaigns. Qualitative research allows for a full and detailed identification of issues as the research instruments are inherently flexible.

Group discussions were used as the primary methodology for this project as these provide an environment in which ideas and experiences can be exchanged, which is essential in exploratory research. However, individual telephone interviews were also conducted with those in rural and remote areas as these people are difficult to gather together in group discussions.

4.3 The Qualitative Sample

The qualitative sample for this study was as follows:

Table 1: Sample amongst those 'at risk' of developing chronic diseases

GRP	STAGE OF CHANGE	AGE	SEX	LIFESTAGE	SES	LOCATION	STATE
1		24-35	Mix	Pre-family	Blue	Urban	NSW
2		25-40	Female	Young family	White	Urban	VIC
3		30-50	Mix	Family	White	Urban	SA
4	Pre-contemplation	40-64	Mix	Post-family	Mix	Regional	QLD
5		18-22	Mix	Pre-family	Mix	Regional	QLD
6		22-35	Female	Young family	Blue	Urban	SA
7		25-45	Mix	Family	Blue	Urban	NSW
8		40-64	Mix	Post-family	White	Urban	VIC
9		18-25	Mix	Pre-family	White	Urban	SA
10		22-35	Female	Young family	Blue	Urban	QLD
11	Mix of Contemplation and Preparation	30-50	Mix	Family	Mix	Regional	VIC
12		40-64	Mix	Post-family	Blue	Urban	NSW
13		22-35	Mix	Pre-family	Blue	Urban	VIC
14		25-40	Female	Young family	Mix	Regional	NSW
15		25-45	Mix	Family	Blue	Urban	QLD
16		40-64	Mix	Post-family	Blue	Urban	SA

Table 2: Sample amongst those 'at risk' in rural areas

GRP	STAGE OF CHANGE	SEX	LIFESTAGE	STATE
1	Precontemplation	Male	Family	VIC
2	Contemplation	Female	Young family	QLD
3	Precontemplation	Female	Post-family	SA
4	Contemplation	Male	Pre-family	NSW

Table 3: Sample amongst people with chronic diseases

GRP	AGE	SES	LOCATION	STATE
1	30-50	White	Urban	NSW
2	50-64	Mix	Regional	NSW
3	25-35	Mix	Regional	VIC
4	35-50	Blue	Urban	VIC
5	25-35	White	Urban	SA
6	50-64	Blue	Urban	QLD

bluemoon

Table 4: Sample amongst people with chronic diseases in rural areas

DEPTH	TYPE OF DISEASE	AGE	SEX	STATE
1	Weight related	25-35	Female	QLD
2	Inactivity related	45-64	Male	VIC

Table 5: 4 'standard sized' groups with the remainder of the adult population 18-80

GRP	STAGE OF CHANGE	AGE	SEX	LIFESTAGE	SES	LOCATION	STATE
1	Mix of 'Action' and 'Maintainers'	22-40	Female	Yong family	Blue	Urban	QLD
2		18-25	Mix	Pre-family	White	Urban	VIC
3		60-80	Mix	Post-family	Blue	Urban	SA
4		30-60	Mix	Family	Mix	Regional	NSW

Table 6: 4 'mini' groups in Aboriginal and Torres Strait Islander Communities (CIRCA)

GRP	TYPE	AGE	SEX	LIFESTAGE	LOCATION	STATE
1	Chronic diseases	20-35	Mix	Pre family / family	Urban	QLD
2	Chronic diseases	35-64	Mix	Family / post family	Regional	VIC
3	At risk	20-35	Mix	Pre family / family	Urban	SA
4	At risk	35-64	Mix	Family / post family	Regional	NSW

Table 7: 3 telephone in-depth interviews with Aboriginal and Torres Strait Islander participants in rural areas (CIRCA)

GRP	TYPE	AGE	SEX	STATE
2	Chronic disease	40-64	Male	VIC
3	At risk	25-40	Female	SA
4	At risk	25-35	Male	NSW

4.4   Sample Detail

The main sample included the following:

- people at all of the stages within the Transtheoretical model in terms of their diet, exercise and weight. Those at high 'risk' of chronic diseases and also those at lower risk were included;

- an equal mix of those who were overweight or obese, insufficiently active and had an unhealthy diet. People who were overweight / obese included those

who did not feel they were at a 'healthy weight' or had been told by their doctor that they needed to lose weight for their health. Insufficient activity was defined as not doing thirty minutes activity on most days. An unhealthy diet was defined as not eating two portions of fruit and five portions of vegetables per day or eating more than 2000 kilojoules per day. Some respondents were also smokers and / or drank more than the recommended amount of alcohol;

- representation from non-English speaking backgrounds fell out naturally;

- a broad distribution of singles and couples with no children, those with older and younger families, empty nesters and older Australians from 18 to 80;

- an equal number of men and women were included in most groups, except in 'Young families' groups, which were restricted to females;

- groups were segmented according to socio-economic background. Quotas were set to ensure that an approximately representative proportion of the sample were employed, unemployed, students and retired within each relevant group; and

- groups were conducted in disadvantaged areas beyond the 'usual' research locations.

Groups with people with chronic diseases were recruited as follows:

- all had one or more diagnosed chronic disease for which they were receiving treatment on a regular basis;

- within each group, every respondent had a different chronic disease, including a representative spread of the key chronic diseases caused by excess weight, diet and lack of activity;

- all respondents were recruited on the basis that they attributed the onset of the disease to lifestyle related behaviour;

- groups were split by blue and white collar areas and age; and

- active members of organisations that campaign on behalf of those with lifestyle related diseases were excluded.

Across the sample, a representative set of the metropolitan groups were conducted in areas with comparatively high non-English speaking background (NESB) populations, such as Parramatta in Sydney and Richmond in Melbourne.

The sample amongst Aboriginal and Torres Strait Islander communities focused on those already suffering from chronic diseases and those most 'at risk' of developing them. Blue Moon partnered with CIRCA (Cultural and Indigenous Research Centre Australia, formerly Cultural Perspectives) for research amongst Aboriginal and Torres Strait Islander Australians.

4.5 Recruitment of Respondents

Recruitment for all audiences was from commercial lists by specialist Interviewer Quality Control Australia (IQCA) accredited recruitment companies, according to the described characteristics. The full recruitment screeners can be found in Appendix A.

4.6 Group Size and Duration

Each of the discussion groups included between four to nine respondents. Each was of 1.5 and 2 hours duration. Individual in-depth telephone interviews lasted from thirty minutes to one hour.

4.7 Discussion Coverage

Semi-structured discussion guides were developed for use in all discussion groups and in-depth interviews to ensure that all the issues were covered in every interview. The use of semi-structured guides allows the respondents themselves to dictate the flow of discussions with guidance from the moderator, rather than the questions being administered in the question/response format common in quantitative research.

Separate guides were prepared for those 'at risk' and the general population and for those with chronic diseases. The discussion guides are appended (Appendix B). Each guide was approved by members of the Department prior to use.

4.8   **Stimulus**

All respondents were shown a range of stimulus. It should be noted that this material was not evaluated but rather was used to help stimulate discussion about the relationship between lifestyle and chronic disease and to explore reactions to different advertising approaches. Copies of all stimulus can be found in Appendix C and includes the following:

- a list of facts about lifestyle and chronic disease, focussing on nutrition, activity and weight;

- a series of visuals and phrases that described and illustrated the link between chronic diseases and lifestyle; and
- existing social marketing campaigns:
    – the 'Find 30' from Western Australia, including the 'Dancing' and 'Dog' executions;

    – the national '5&2' campaign, including 'Eat More', 'Looking Good' and 'Mum, I'm hungry';

    – the 'Small Steps' campaign from the US, including 'Belly' and 'Love Handles';

    – the 'Get Moving' commercial from Australia;

    – the Australian anti-smoking pack warnings 'Gangrene', 'Teeth', 'Graph' and 'Quitline'; and

    – the most recent Australian anti-smoking campaign featuring 'Gangrene' and 'Mouth Cancer'.

Respondents in the Aboriginal and Torres Strait Islander groups were also shown the following:

    – an Aboriginal diet and nutrition fact sheet;

    – a poster on the benefits of exercise; and

    – a Lifescripts poster with advice for healthy living.

DETAILED FINDINGS

5   CURRENT ATTITUDES AND BEHAVIOUR

5.1   The 'What', 'Why', 'How' Model

In the SNAP-O research conducted by Blue Moon in June 2006, consumers and health professionals were asked to 'map' a wide range of existing government messages covering each of the five risk factors; smoking, nutrition, alcohol, physical activity and overweight / obesity. Respondents were instructed to arrange the messages into different types, using their own criteria to group them. They were then asked about how they typically responded to the different types of messages and which types they felt would be more or less effective in encouraging them to change their behaviour.

As a result of analysis of the mapping exercise, three key types of messages emerged:

- 'What' messages: conveying what consumers should do, that is the behaviour recommended by the government;

- 'Why' messages: conveying the outcomes of the behaviour, including:

  – the consequences of inaction, encompassing both long term health and social outcomes;

  – the benefits of improving behaviour in this area; and

- 'How' messages: providing advice on how to achieve the recommended behaviour.

Analysis of discussions about the role and effectiveness of the different types of messages indicated that consumers are unlikely to modify their lifestyle behaviour unless they have an appreciation of the 'what', 'why' and 'how'. This is summarised in Figure 1.

Figure 1: The 'what', 'why' and 'how' model

Intention and motivation to change
behaviour driven by appreciating …

WHAT?	WHY?	HOW?
What should I be doing? i.e. Recommended behaviour	Consequences of inaction	How to achieve goals
	Benefits of action	

NB: Based on analysis of mapping of messages by consumers (SNAP-O, June 2006)

It is important to note that 'appreciation' is used in this model to mean more than awareness. 'Awareness' refers solely to knowledge in one of the areas. For example, a person might be 'aware' that two portions of fruit and five portions of vegetables are recommended each day. In contrast, someone who is described as 'appreciating' the recommendations has accepted the personal implications of this knowledge and does not self-exempt from it. A person who is *aware* of the '2 & 5' message may not *appreciate* this fact because they do not see '2 & 5' as a realistic and credible goal. Similarly, someone may be *aware* that obesity can lead to diabetes but not *appreciate* that they themselves are in fact obese and are at risk of premature death from diabetes.

Some examples of the different types of messages are as follows:

- 'What': 'Eat at least two serves of fruit and five serves of vegetables every day.'

- 'Why', consequences of inaction: 'Every cigarette is doing you damage.'

- 'Why', benefits of action: 'Maintaining a healthy diet will help to improve vitality and energy levels throughout life.'

- 'How': 'Eat smaller servings. Try using a smaller plate.'

bluemoon

A key finding from the SNAP-O project was that the long term health consequences of not following recommended behaviour are much more strongly appreciated for smoking than for physical activity, diet, weight and alcohol. That is, there is low appreciation of 'why' change is necessary. Findings also indicated that appreciation of 'why' change is important is lagging behind appreciation of 'what' change is required. These findings were used as hypotheses for further testing and refinement in the ABHI exploratory study.

5.2 Consumer Descriptions of People with 'Unhealthy' and 'Healthy' Lifestyles

Respondents in the SNAP-O research were asked to describe a 'day in the life of a person with a healthy lifestyle'. They were then asked to discuss the type of person who would lead this lifestyle and how they would feel about such a person. This technique was useful in eliciting underlying beliefs that act as barriers to change. The key insights that emerged were that a 'healthy lifestyle' is often not considered to be realistic or possible, nor is it necessarily aspirational.

The ABHI research built on the SNAP-O findings by taking the 'day-in-the life' technique a step further. Respondents were asked to describe the lifestyle and personality of an 'unhealthy person' as well as a 'healthy' person. In addition, they were asked to imagine the state of health and well-being of both these people in ten or twenty years' time. This was a means of exploring people's perceptions of how lifestyle behaviour could affect their health in the future.

There was a high level of consistency in descriptions of the timetables of the 'healthy' and 'unhealthy' people across the groups. Descriptions of the 'person with the healthy lifestyle' were also consistent with findings from the SNAP-O project. Figure 2 gives a flavour of the findings by amalgamating the most commonly occurring responses.

Figure 2: Descriptions of the day in the life of an 'unhealthy person' and a 'healthy person'

TYPICAL DAY IN THE LIFE OF AN 'UNHEALTHY PERSON'	TYPICAL DAY IN THE LIFE OF A 'HEALTHY PERSON'
• Get up at 8am – coffee and cigarette instead of breakfast	• Get up at 6am - exercise before breakfast
• Drive to work – in a rush	• Healthy breakfast (cereals, fruits, yogurt)
• Snacks and too much coffee / soft drinks all day	• Walk / cycle to work
• Walking outside for cigarette the only 'activity'	• Stretch, sit on a ball all day
• Take-away burger / pizza for lunch	• Mid-morning healthy snack (fruit, nuts, water)
• Sit in bad posture all day	• Healthy lunch (including fish, salad, fruit, water) plus stretch, go for a walk
• Take away for dinner with too much beer / wine	• Mid-afternoon snack, herbal tea, stretch
• Watch TV, sit behind PC, shout at kids	• Home via gym or play in yard with kids
• Fall asleep on couch	• Prepare and eat nutritious dinner (stir-fry, lean mean, fruit, veg, glass of red wine)
• Bed after midnight (no sex)	• Early to bed in preparation for next day (sex)

Descriptions of the 'Unhealthy Person'

Most felt that the lifestyle of the 'unhealthy person' was not desirable. This person was assumed to be a 'slob' and slovenly with no self-discipline or motivation. The short-term negative outcomes of this lifestyle were expected to be that the person would be tired and stressed. This was likely to be due to a combination of the effects of their health-related behaviour, such as not getting any exercise and smoking, and also as a result of their disorganised lifestyle. There was broad agreement that an 'unhealthy person' who continued to smoke, eat unhealthy food, avoid exercise and drink alcohol might well be diagnosed with conditions such as heart disease and diabetes at some point in the future. This person's lifestyle was therefore seen as compromising their life expectancy.

> *"In twenty years time the couch potato person will probably have a load of those things we talked about: heart disease, diabetes...they probably won't be here in fact."*

However, the 'unhealthy' lifestyle was considered to have benefits. Many felt this person would have fun and enjoy life, and would therefore be fun to spend time with. Moreover, many expected the 'person with the unhealthy lifestyle' to 'grow out of' this behaviour and that s/he probably had time to change before the health-effects

were felt.

Descriptions of the 'Healthy Person'

The person with the 'healthy' lifestyle was described as highly organised and motivated. Some described this person as 'relaxed' because their life is in order. S/he was expected to be in good health in ten or twenty years' time, without any of the chronic conditions and with better mental health than the 'unhealthy' person.

However, as in the SNAP-O study, the 'healthy' lifestyle was not necessarily aspirational for many people. The 'healthy person' was described as a 'control freak', boring because s/he tries to convert other people to his/her lifestyle, too serious and highly-strung. There was an assumption that this person would not have time for a social life and would have few friends as a result of his/her busy schedule and off-putting personality characteristics.

5.3 Barriers Relating to 'What' Needs to Change

Awareness of 'What'

Descriptions of the two types of lifestyle illustrate that there is broad awareness of 'what' constitutes a healthy diet and exercise program. There was high spontaneous recall of the '2 & 5' campaign across groups and prompted awareness of the 'Get Moving' campaign, especially amongst parents (see section 7.1). As a result, the facts featuring recommendations on healthy lifestyle that were presented to respondents (see figure 3) were broadly familiar, even if the details were new for some. This suggests that raising awareness of 'what' in relation to diet and exercise is not likely to be a key priority for ABHI social marketing.

Figure 3: Facts used as stimulus[5]

> 'The government recommends adults should eat 2 portions of fruit and 5 of vegetables each day for health'
>
> 'Adults should get at least 30 minutes of moderate intensity physical activity on most days, children need an hour'

---

[5] The Department of Health and Ageing, www.healthyactive.gov.au 'Go for 2 & 5 factsheet' page, 'Get Moving: Just for parents' page and 'An active way to better health: national physical activity guidelines for adults' leaflet

There was a strong tendency for people to think of an extreme stereotype when describing a 'healthy lifestyle'. This is likely to be a reflection of the fact that many do not currently see lifestyle improvement as a credible goal. It is important to note that this excessive and unaspirational lifestyle is not an ideal that the social marketing program should be attempting to 'sell', given this goes well beyond the government's recommendations on healthy living and is clearly not realistic for the majority of people. Findings from this research support the conclusion from the SNAP-O project that *improvement* towards the government's recommendation on nutrition, activity and weight is likely to be a more credible and motivating goal than aiming for 'a healthy lifestyle'.

Appreciation of 'What' for Nutrition and Activity

Despite high awareness of the recommended behaviour, many exempted themselves from following advice on nutrition and physical activity. Those who self-exempted from the *nutrition* recommendations tended to claim that 'healthy food' advice changes too frequently and is therefore difficult to keep track of. For *physical activity*, many claimed that they did not know what specific forms of activity they could personally do because of their circumstances, weight or health problems.

Some also self-exempted from the activity guidelines by rationalising that they already get 'activity' in their day, such as walking around the office at work or playing with their children, and are therefore not 'at risk'. However, on further probing, these people often did not seem to be achieving thirty minutes of moderate activity per day. There was potential for this form of self-exempting to be reinforced by advertising that attempts to show realistic ways of incorporating activity into lifestyle, such as the 'Dancing' commercial in the 'Find 30' campaign (see section 7.2).

Awareness of 'What' for Weight

A great deal of confusion was evident over what constitutes an 'unhealthy' weight. Most agreed that the proportion of overweight people in Australia is high and increasing. However, many did not feel they had a credible means to judge whether they were 'at risk' and were interested in specific and unambiguous guidance on how to judge a 'healthy weight'.

The body mass index (BMI) measure was known to many. People from white collar backgrounds had often heard about BMI through the media and some clinically obese people had been told they were at an 'unhealthy' weight in terms of their BMI by their doctor. People from blue collar backgrounds, especially in regional areas,

seemed less likely to be aware of the BMI measure.

The woman in the visual in figure 4 was described in the stimulus as 'clinically obese' according to the BMI scale. This generated a great deal of discussion and was regarded as helpful by some because it allowed them to compare their body size with that of the person depicted, in order to make an assessment about whether their weight was healthy or not.

"It makes me think 'if she's got a problem, how big is my problem?'"

Figure 4: Visual used as stimulus

For others, however, the BMI scale was rejected on the grounds that this person was a 'normal' size in contemporary Australia. People who knew, or guessed, that they were 'overweight' or at the low end of the 'clinically obese' range according to the BMI were most likely to challenge the veracity of the measure. This indicates that the BMI definition of 'clinical obesity' does not correspond with lay understanding of 'obesity'. In addition, some rejected BMI on the grounds that people who have a muscly physique but no fat can be judged to be 'clinically obese' according to this scale.

Some were also concerned about using images that demonstrate an 'unhealthy' weight because of the potential to fuel unhealthy perceptions of body image amongst girls and young women:

"I would be worried about how teenage girls would react to that [image of the 'clinically obese' woman]."

Information about a healthy waist circumference was more widely accepted and compelling because it provided a tangible, credible and easily understandable goal. There was a positive response both to the verbal message and visual image about waist circumference, see figure 5

"I'm going to measure my waist when I get home."

Figure 5: Visual and text used as stimulus[6]

'Fat around the waist and abdomen is a greater health risk than fat carried on the hips / thighs….men should aim for a waist circumference below 94cm. Women should aim for below 80cm.'

The lack of a clear, commonly held understanding of 'healthy' and 'unhealthy' weight appears to have allowed many to avoid interrogating whether their weight is a problem. Clarifying the definition of an 'unhealthy weight' and challenging misconceptions about the term 'obesity' could therefore be a useful focus for the ABHI social marketing campaigns. However care may need to be taken to avoid compromising the credibility of the campaign by presenting the issue in a way that is disputable and may ultimately therefore be rejected.

5.4 Barriers Relating to 'Why' Change is Necessary

Change is not a priority

One of the most common reasons given by respondents for not changing their lifestyle was that they said they did not have time to devote to physical activity and eating healthily. However, further analysis suggested that the underlying belief that prevents change is that a 'healthy lifestyle' is not viewed as a priority in day-to-day life.

It should be noted that many people from disadvantaged backgrounds may have limited capacity to change how their lives are organised because of social determinants that are beyond their control, such as their working hours, income

---

[6] The Cancer Council, www.cancer.org.au, 'Stay in Shape' page

levels or where they live. However some respondents felt that they were in a position to make choices about how they spend their time and acknowledged that they focus on the things that they consider to be important:

> *"We should remember that we have the same amount of time in our day as Michelangelo had and he painted the Sistine chapel…we can find the time to do anything if we want to."*

A 'healthy lifestyle' did not seem to be a priority for many because ill health is not seen as a real and immediate threat and no clear image of the specific consequences of inaction in relation to nutrition, activity and weight has been established in people's minds. In other words, people have low appreciation of the severity of, and their personal susceptibility to, conditions that result from their lifestyle (see section 8).

Behaviour change challenges social norms

As was described above, the 'healthy lifestyle' regime is unaspirational at a personal level. It was also seen as anti-social in many parts of the community. In particular, respondents from blue collar and Mediterranean backgrounds complained that their peers cajole them into 'bad' behaviour and criticise virtue.

> *"When you're socialising, it's really hard to have the healthy option."*

This seems to be compounded by minimal social pressure on people to change for the better, even for those most 'at risk'. Respondents admitted to being reluctant to encourage friends and family members who are overweight to try to lose weight, unless they had begun to experience the symptoms associated with excess weight. Moreover, there was obvious embarrassment associated with talking about the importance of being a 'healthy' weight in groups where at least one person was overweight / obese. In contrast, many were comfortable with openly criticising fellow respondents who were smokers.

5.5 **Barriers Relating to 'How' Change Can be Achieved**

Change requires too much effort

Change was perceived as requiring more effort than it is worth for many. People

seemed to feel they would need to restructure their whole lives in order to undertake more exercise, eat more healthily and lose weight. This was expressed in terms of time and financial costs:

> *"I don't have time to go to the gym."*

> *"It's too expensive buying healthy food."*

> *"I looked into Weight Watchers but it's too expensive."*

Many noted that the right choice is not easy when it comes to eating healthily and getting enough exercise. Complaints about the accessibility and advertising of junk food were expressed by those who already had an appreciation of 'why' change is necessary.

> *"I think they should ban advertising for all these things...it's so hard when you have [junk food advertising] going on around you all the time."*

> *"I'd like to see tuck shops at the schools only selling healthy food."*

Change requires too much deprivation

For many, the recommended behaviour was seen as boring and unenjoyable. In one group, respondents complained about the white bread and processed cheese sandwiches they were offered during the group discussions because they felt these were 'too healthy'. In another group respondents had easy access to a platter of a range of sliced, fresh fruit and most of it was left untouched. This illustrates that, even when no effort is required to take the healthy option, many will still not do so. This suggests that healthy habits should ideally be established during childhood, since it is extremely difficult to change preferences amongst adults.

There were also complaints that exercise is boring, especially going to the gym. Many were therefore interested in the idea that walking is an acceptable form of physical activity (see figure 6). However, it was common for respondents to self-exempt from the need to change their level of activity when walking was mentioned because they claimed to walk enough already. Communications are therefore likely to have more impact if they are specific about the length of time people need to walk for and if they make clear that walking should be brisk.

Figure 6: Text used as stimulus[7]

> 'We can prevent about 25% of cancers by being physically active for at least 30 mins a day'
>
> 'People diagnosed with breast cancer who walk 3 to 5 hours per week reduce the risk of dying from the cancer by 40%'
>
> 'A healthy diet including enough fruit and vegetables can protect against cancers of the liver, oesophagus, lung, stomach, colon and rectum.'

The unpalatability of the recommended behaviour meant that many did not seem to see permanent change as realistic. For these people, the 'healthy' extreme (described above) was often seen as the only worthwhile goal, yet this was not believed to be *sustainable* over the long term. The result of this attitude seemed to be a tendency to give up after a relapse, rather than trying again.

> *"The problem I have is with keeping going. I was going to the gym quite regularly for a few weeks last year and then I was sick so stopped and I haven't been since...I don't know how I can keep it up."*

5.6 Perceptions of the Benefits of Change

There was widespread awareness that a healthy lifestyle would have short term benefits. The potential to look slimmer and younger was universally appreciated and motivating at all ages.

> *"The person with the 'unhealthy' lifestyle is going to look twenty years older than the 'healthy person.'"*
>
> *"Let's face it, if I was thinner I'd have a better chance of getting a slim, attractive woman."*

The prospect of feeling better and fitter in the short term was also appealing. Many expected that a 'healthier lifestyle' would mean they would have more energy, would get more sleep and would have better mental health. In addition, the prospect of better long term health in general was widely acknowledged. As discussed above, few disputed that the person with the 'healthy lifestyle' was very likely to be in better

---

bluemoon

health than the person with the 'unhealthy lifestyle' in ten or twenty years' time.

Parents were more likely to be interested in their long term health than those at the pre-family lifestage because they said they wanted to live to see their children grow up. The prospect of long term health was also more compelling for those who were aware that they were 'at risk' because they are overweight / obese or had a chronic condition already.

> *"With the diabetes I know I've got to keep myself in shape and watch what I eat otherwise bad things could happen."*

However, for many, the benefits of a 'healthy' lifestyle were perceived as an out-of-reach luxury. The rewards would be a nice idea in theory but were expected to take too long and too much effort to achieve in reality. Healthy behaviour seemed especially unrealistic for those with 'complicated' lives in the short term.

> *"I work all week and I only get to see my daughter on the weekends, because I split up with my wife, so I can't do exercise then."*

Another reason why the benefits of healthy behaviour are not as motivating as they could be seems to be that future ill health is difficult to conceptualise or visualise. This appeared to be a particular barrier for adults under twenty-five, those who were not yet feeling any symptoms as a result of their behaviour and people who were a 'healthy' weight.

5.7 Perceived Costs versus Benefits of Change

The costs of lifestyle change in relation to diet, exercise and weight loss were perceived as vastly outweighing the perceived benefits. Figure 7 summarises the beliefs that act as barriers to change compared with the beliefs that drive change, discussed above. This imbalance helps explain why change does not get on to people's 'to-do today' list or is easily displaced by other matters that are perceived to be more 'pressing'. This also helps explain why overweight / obesity is increasing in prevalence.

Figure 7: Perceived costs versus benefits of change in relation to diet, exercise and weight
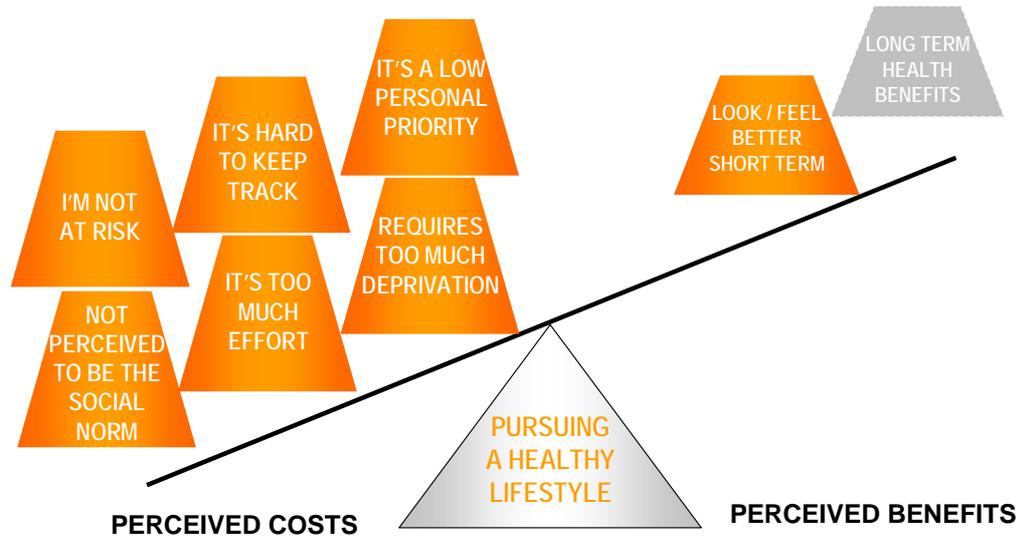
The number of smokers, in contrast, continues to decline[8]. Commonly held beliefs about smoking evident in this and other studies[9] provide some cause for optimism about the possibility of shifting attitudes to behaviour change. As was noted above, there seems to be much wider appreciation of the 'what', 'why' and 'how' for quitting smoking than for change in relation to diet, exercise and weight.

Analysis of the findings suggests that positive attitudes to quitting smoking may have been driven by appreciation of 'why' change is necessary. There is high appreciation of the consequences of smoking in terms of severity (both quality of life and life expectancy) and personal susceptibility, compared with appreciation of the consequences for the other risk factors (see section 8).

Moreover, the high appreciation of 'why' change is necessary seems to have affected social norms so that it is less common for social groups to be supportive of smoking than to be accepting of poor nutrition and inactivity. Several respondents in this study mentioned that their children, friends and other family members had encouraged them to give up smoking.

Over the long term, appreciation of 'why' giving up smoking is necessary seems to have helped enhance appreciation of 'how' change is possible. Findings from this research indicate that it is more common to believe that giving up smoking is 'worth the effort' than to believe that having a healthy diet and getting enough exercise is 'worth the effort'. This seems to be because people understand 'why' change is

---

[8] Simon Chapman, *Deadly Custom in Steady Decline,* Weekend Australian January 3 2007
[9] Blue Moon, SNAP-O Concept Testing, June 2006

necessary and therefore view 'making the effort' as a priority.

It is also the case that the social context has changed as a result of legislative action to restrict the marketing and consumption of tobacco. Making the 'right choice', that is quitting, is therefore cheaper and more convenient than continuing to smoke and there is less temptation to make the 'wrong choice'. It seems probable that public support for this structural change has been high because many years of anti-tobacco advertising have increased awareness of 'why' change is necessary.

There is also relatively affordable and accessible support for those who want to give up, for example in the form of Quitline and nicotine patches and gum. This seems to mean that the deprivation involved in quitting is more likely to be perceived as bearable than the deprivation involved in modifying behaviour in relation to diet and exercise. Perceptions that the deprivation is bearable in turn seems to encourage the belief that change is sustainable and, as a result, people seem more likely to try quitting again after a relapse.

Finally, appreciation of the 'why' and the 'how' seem to have reinforced appreciation of the 'what' since self-exempting rationalisations seem less convincing in this context. Figure 8 summaries the beliefs that seem to have been triggered by challenging the notion that quitting smoking is not a priority.

Figure 8: Common Beliefs about Quitting Smoking
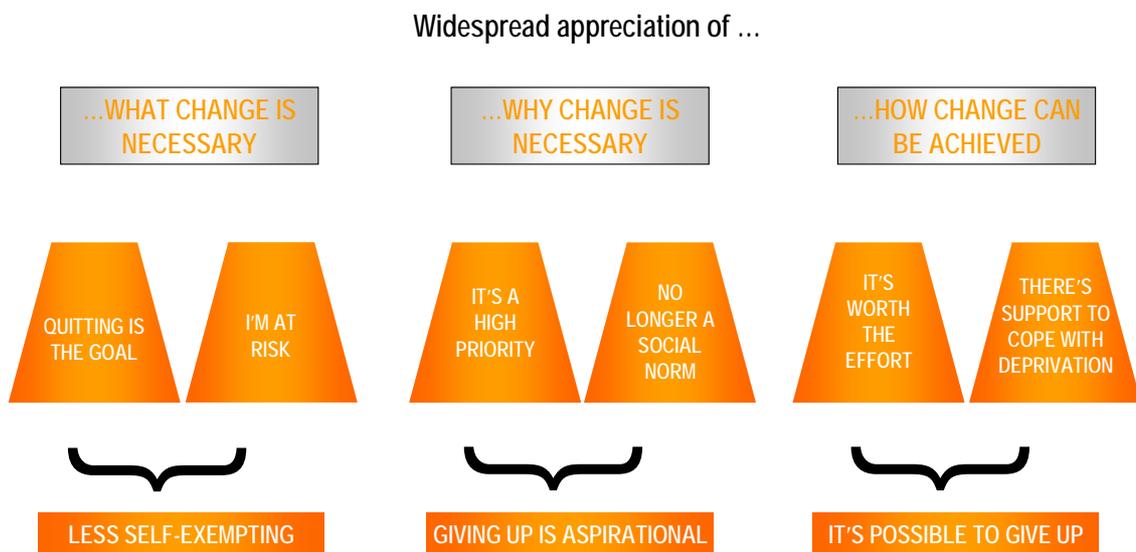
6 ATTITUDINAL AND DEMOGRAPHIC SEGMENTATION

6.1 Building on the 'Stages of Change'

The sample structure for this study segmented respondents by the 'stages of change' in terms of their past and anticipated behaviour in relation to nutrition, activity and weight (see section 04.4). This was useful in that it ensured that people at all 'stages of change' were included in the sample and therefore all the key barriers to change for each risk factor are likely to have been expressed across the groups.

This recruitment structure generated a certain degree of homogeneity within groups, in that many who were at an early 'stage of change' for diet were often at an early 'stage of change' in relation to weight and exercise. However, it became clear as the fieldwork progressed that it was also common for people to be at different 'stages of change' across the five lifestyle risk factors; smoking, nutrition, alcohol, physical activity and overweight / obesity. This meant attitudes to change overall varied markedly in some groups.

A young mother, for example, was at the Preparation stage for weight, nutrition and activity but at the Contemplation stage for smoking and Pre-contemplation stage for alcohol consumption. In another case, a young man with no children in his twenties was at the Maintenance stage for weight and smoking, at the Action stage for activity, the Preparation stage for nutrition and the Contemplation stage for alcohol consumption.

There seemed to be a tendency for people to be at a more advanced 'stage of change' for smoking than the other risk factors. This could be explained by the fact that appreciation of 'why' change is necessary seems to be highest for smoking[10]. Someone who wants to improve their health prospects is therefore likely to begin by quitting smoking before tackling the other risk factors. There was also a tendency for the 'stage of change' for alcohol consumption to lag behind the others, which may be because social norms are particularly unsupportive of change in this area.

This pattern was not universal, however. For example, some overweight respondents were at a more advanced 'stage of change' for weight than for smoking. This may be because the perceived short-term benefits of losing weight, such as being more attractive, are more motivating than the short-term benefits of

---

[10] Blue Moon, SNAP-O Concept Testing, June 2006

giving up smoking.

6.2   Attitudes to Lifestyle Change Overall

The lack of homogeneity within the groups led the researchers to explore attitudinal commonalities across groups. Six key segments relating to attitudes to lifestyle change were identified and these are illustrated in figure 9. Each of the segments represents typical over-arching beliefs about the desirability and possibility of lifestyle change for the purpose of improving future health outcomes.

Figure 9: Attitudes to Lifestyle Change Overall
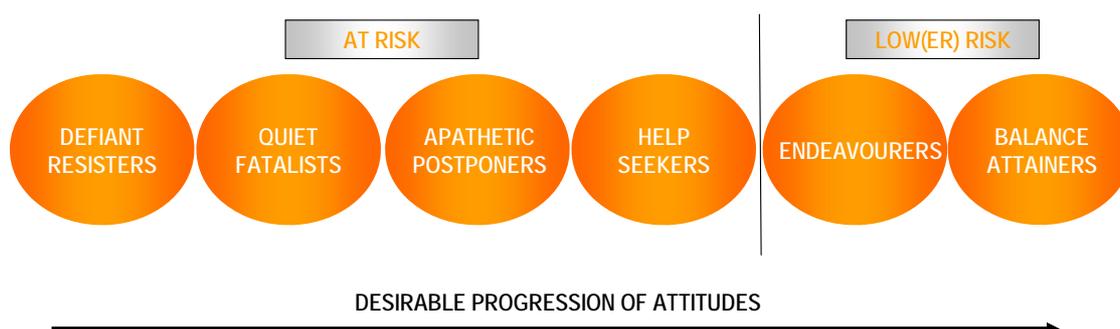
These segments are not intended to replace the 'stages of change'. Indeed it is important to identify both the 'stage of change' *and* the attitudinal segment to which a person belongs, in order to fully understand their behaviour, motivations and beliefs. Figure 10 illustrates how the 'stages of change' and attitudinal segment provide a clear picture of an individual's position in relation to lifestyle and health.

Figure 10: Examples of how 'Stage of Change' and Attitudinal Segment Provide a Full Picture of Individual's Behaviour and Attitudes in relation to Lifestyle

Suzanne is a 27 year old 'Help Seeker'. She is a mum of two small kids and is clinically obese. She wants to lose weight and knows she should but can't envisage being successful. She also occasionally smokes when drinking socially. She is at the following 'Stages of Change':
Smoking: Contemplation
Weight: Preparation
Activity: Preparation
Nutrition: Preparation
Drinking: Pre-Contemplation

Gary is a 32 year old 'Endeavourer'. Most of the time he wants to have a healthy lifestyle and continually makes efforts to achieve this – though he regularly relapses.
He is at the following 'Stages of Change':
Smoking: Maintenance
Weight: Maintenance
Activity: Action
Nutrition: Preparation
Drinking: Contemplation

bluemoon

An attitudinal segmentation that identifies beliefs across all the lifestyle risk factors is potentially useful because it allows for the identification of attitudinal target audiences when communicating about lifestyle and health as a whole. Those from different attitudinal segments appear to have different levels of appreciation of 'what', 'why' and 'how' messages about change (see figure 11). They also have different levels of receptiveness to these messages (see section 7).

Applying the segmentation in determining the marketing strategy could therefore help to ensure the best possible value from the social marketing program by identifying audiences that are more and less likely to respond to social marketing messages about lifestyle and health. The segmentation could also help establish which messages and styles of communication have most potential to shift attitudes amongst the chosen target audiences.

It seems likely that intention to change behaviour across all of the risk factors will increase as people progress along the spectrum of attitudes. The aim of marketing activity could therefore be to shift people from the 'at risk' attitudinal segments to the 'at low(er) risk' segments. Tracking awareness and appreciation of messages amongst the different segments would then provide a guide to the effectiveness of communications and to the ABHI social marketing program more broadly.

It should be noted that those with 'at low(er) risk' attitudes have a good appreciation that a healthy lifestyle is an important goal in general, and therefore intend to change their behaviour across all risk factors at some point. However, they will not necessarily attempt behaviour change across all of the risk factors simultaneously. For example, a person in their twenties may find that reducing the amount of alcohol they consume requires much more effort and deprivation than eating healthily and getting enough activity. They may therefore put off attempting to change their alcohol consumption and focus on what they perceive to be more easily achievable healthy goals, such as improving their diet.

However, from a social marketing point of view, this person may have an 'at low(er) risk' attitude because they have appreciated that their lifestyle affects their health prospects, that they have some degree of control over their future health and that they are capable of change. They are therefore likely to tackle all areas of their health in time. There is scope to reinforce this person's intention to change and it may be possible for communications to expedite change. However, this audience may be considered a less important target than people at earlier points in the

spectrum who may never change without encouragement. Figure 11 illustrates the different levels of appreciation of 'what', 'why' and 'how' at different points on the attitudinal spectrum.

Figure 11: Awareness and Appreciation of 'What', 'Why' and 'How' Across Attitudinal Segments
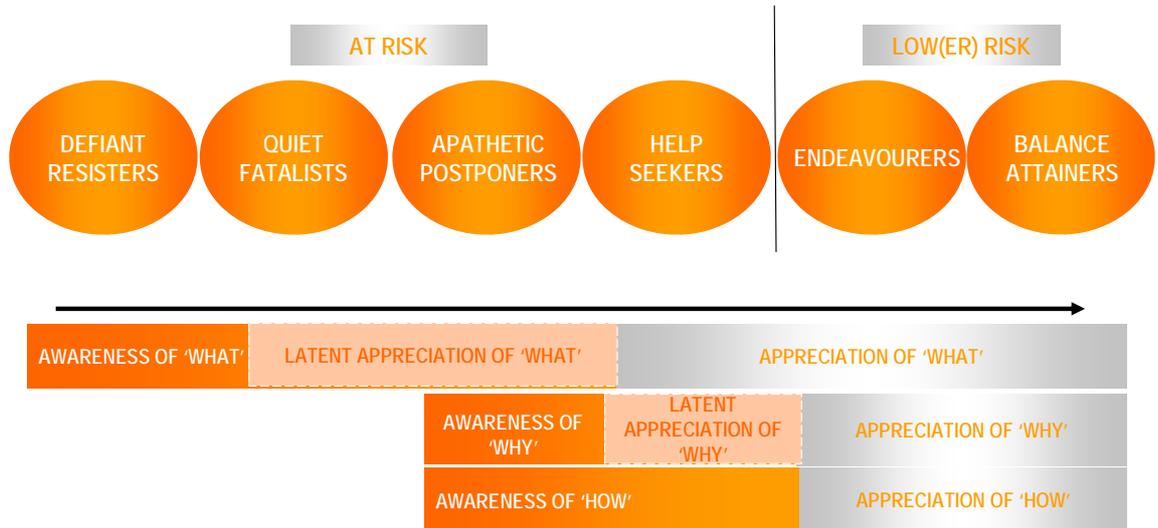
6.3 Descriptions of the Attitudinal Segments

'Defiant Resisters'

These people did not believe change is possible or desirable. They were *aware* of 'what' change is recommended, in most cases but had limited *appreciation* of 'what', 'why' or 'how'. They were often at risk across all five factors and actively and assertively rejected all forms of messages that encouraged them to change their behaviour. Most did not admit to experiencing any heath effects as a result of their lifestyle and were likely to post-rationalise their behaviour by claiming that change requires too much effort. This was summarised as *"Life's too short [to have a 'healthy lifestyle']"*

'Defiant Resisters' were more likely to be from socially disadvantaged groups and to be either at the pre-family or post-family lifestages (see section 6.4, for a more detailed discussion of demographics across the segments). Many seemed to be comfortable that they would never change and saw themselves as 'set in their ways'.

'Quiet Fatalists'

These people were similar to 'Defiant Resisters' from a behavioural point of view. They were often 'unhealthy' across all risk factors and were unreceptive to messages about change. However their reaction was more passive. They were not vocal in the groups and did not attempt to justify their position, apparently because they did not post-rationalise their behaviour, even to themselves. They seemed to have a latent appreciation of 'what' change is necessary but seemed not to believe change is possible so preferred to avoid thinking about it. They shrugged off advice about giving up smoking or losing weight from friends and family and had a 'what will be will be' attitude overall. However, it may be possible to influence this audience gradually over time.

'Quiet Fatalists' were disproportionately represented amongst people from lower socio-economic groups for whom change seems very costly and difficult. Some young blue collar mothers, for example, fall into this group because they would like to lose weight but say they cannot afford to join a gym or WeightWatchers, nor can they pay for childcare so that they can spend time engaging in physical activity.

'Apathetic Postponers'

'Apathetic Postponers' seemed to believe that they probably should, and could, change their lifestyle. However they did not see change as a high enough priority in the short term to do anything about it today. This group comprised people of all ages, though younger 'Apathetic Postponers' were more likely to think in terms of changing when they are older, whereas those over twenty-five were more likely to think in terms of putting off change for the short term, that is until next month or next year. 'Apathetic Postponers' were represented across all demographic audiences but were more likely to be blue collar.

This group had a *latent* appreciation of 'what' change is necessary and had some awareness of both 'why' is should be undertaken and 'how' it can be achieved. They therefore responded positively to 'why' and 'how' messages about change which enhanced their appreciation of the need for short-term action.

'Help Seekers'

'Help Seekers' tended to be people who were starting to see the effects of their lifestyle on their health or weight. They tended to have been told by a GP they were overweight / obese, were aware from 'what' messages in the media that their weight

was unhealthy or had already been diagnosed with a lifestyle-related chronic disease. This meant they appreciated 'what' needs to be changed and had either a latent or manifest appreciation of 'why' change is needed. However, they had low appreciation of 'how' change can be achieved, in some cases they had tried and failed to improve their lifestyle and were therefore scared because they did not believe change is possible.

This audience found 'why' messages effective as this helped to reinforce their resolve to make the effort to change. They also welcomed 'how' messages that provided them with hope that change was possible. However, 'Help Seekers' seemed most likely to come from socially disadvantaged backgrounds where social and cultural norms make change more difficult and individuals' capacity to affect change in their life is constrained by lack of money and limited control over their time.

'Endeavourers'

'Endeavourers' were people who had a good appreciation of 'what', 'why' and some appreciation of 'how'. However, they had strong urges to relapse in two or three risk areas and tended to cope with the difficulty of maintaining healthy behaviour by trading off vices for virtues. For example, they might to go the gym in order to justify having ice cream. Overall, however they were on the right track and had a positive attitude towards sustaining behaviour change and bouncing back after a relapse. Their view was that they would 'start again on Monday' or 'try again, fail again better'. That is, they accept that they may relapse but each time they do so, they learn about why they fail and have a better chance of succeeding ultimately.

This segment tended to be from socially advantaged groups and had already picked up on messages about 'why' change was necessary in the media. 'Endeavourers' were open to 'what' and 'how' messages that reinforced their intentions to have a healthy lifestyle. However, some were unsure about the need for 'why' messages in social marketing campaigns because, for them, this message was already strongly established.

'Balance Attainers'

'Balance Attainers' were people who had incorporated healthy behaviour across most or all of the risk factors into their lifestyle and no longer struggle to avoid relapse. These people may have a minor vice that they would like to overcome but

consistently follow recommendations and do not need to radically change either their behaviour or attitudes.

'Balance Attainers' may be advocates for healthy living and seemed happy to draw others' attentions to marketing messages. However, it should be noted that respondents from other attitudinal segments could reject the advice of 'Balance Attainers' on the grounds that it is likely to come across as smug. This audience was represented by a small number of white collar people who tended to be at the family lifestage.

6.4 Demographic and Behavioural Characteristics of the Segments

NB: Observations on the demographics of the attitudinal segments are based on analysis of the qualitative findings from this study only. The segments would need to be measured through quantitative research to provide an accurate picture of the total size of each, as well as of its demographic make-up. It is likely that all attitudinal types would be found in all demographic groups. However, some demographic variables are likely to be disproportionately represented in particular segments.

Lifestage and Age

Those at the pre-family stage, especially those aged eighteen to twenty-five, tended to be in an 'at risk' segment, such as 'Defiant Resister', 'Quiet Fatalist' or 'Apathetic Postponer'. In some cases, they were at the 'Action' and 'Maintenance' 'stage-of-change' for some of the risk factors, but were unlikely to have a strong sense of the importance of their lifestyle in preventing future ill health. Rather, their lifestyle behaviour seemed more likely to be related to their personal preferences and the habits they had developed as children. For example, those who enjoy sport were more likely to be getting thirty minutes of activity per day than those who do not like sport.

Younger people, especially those without children tended to be at an earlier 'stage of change' for drinking than all other areas. They were also more likely than older people to have taken action in relation to diet and exercise before tackling smoking. This was because their main goal was to look better, rather than to improve their health.

The health consequences of a poor lifestyle seemed to be more serious and

relevant for people from approximately the age of twenty-five onwards. Having children also seemed to stimulate a desire to be more healthy, both individually and as a family. Those at the family stage were therefore more likely to be 'Help Seekers' or 'Endeavourers' than younger people without children. However, having a family was perceived to reduce people's capacity to change their individual behaviour because family commitments are seen as a higher priority than lifestyle improvements. There may therefore be scope to enhance appreciation of opportunities for families to undertake healthy activities together.

Those at the post-family lifestage sometimes claimed that they could not change their behaviour because they were too old to change their habits. However, those who were beginning to experience poor health, either as a result of their lifestyle or otherwise, were more likely to be receptive to messages about health.

SES and Cultural Background

Social and cultural background appeared to have a strong impact on beliefs about the possibility of change. Social norms in some socio-cultural groups reinforce unhealthy lifestyle behaviour more than others. For example, blue collar and young people seemed more wedded to junk food, Mediterranean culture can encourage over-eating at social events and overweight was reported to be more acceptable in some Asian communities.

The social context seems to have an impact on individuals' beliefs about the extent to which change is possible, as well as affecting people's capacity to change. 'Defiant Resisters', 'Quiet Fatalists' and 'Help Seekers' were therefore disproportionately represented amongst people from socially disadvantaged groups, including blue collar and NESB audiences.

Aboriginal and Torres Strait Islander Australians in particular saw unhealthy lifestyles as part of a bigger problem in their communities. Cultural displacement and social problems were felt to be the underlying cause of poor lifestyles. This seemed to be compounded by lower awareness of 'what' healthy behaviour is than in the population more broadly. Aboriginal and Torres Strait Islander Australians were more likely to be 'Defiant Resisters'; the *life's too short [too change behaviour]'* attitude was considered particularly relevant in Aboriginal and Torres Strait Islander communities.

Location

There was a sense across the sample that having a healthy lifestyle is easier for those living in smaller cities than in a big city or remote rural area. This is because smaller regional centres are perceived to have all the amenities and support services that are available in bigger cities but commuting times tend to be shorter and the pace of life is less hectic, allowing more time for physical activity. There was no mention of differences in costs of nutritious food, gyms or weight loss programs between areas. They only structural barrier to change in relation to location that was raised was that those living in the outer suburbs of large cities and in rural areas are more car-bound.

> *"I live forty-five minutes drive from work. I can't walk or cycle to work."*

However, many felt that location alone was not a convincing reason not to have a healthy lifestyle and that people living anywhere could get enough exercise if they wanted to:

> *"At the end of the day, if you want to do it you can find a way….I've been trying to park further from the shops and walking the last part."*

Overweight / Obesity

People who appeared to be clinically or morbidly obese seemed more likely to be 'Quiet Fatalists' or 'Help Seekers' than to be in any other segment. There seemed to be a tendency for people who needed to lose weight to feel helpless and impotent when it came to affecting change. They often had a high appreciation that something needed to be done and several admitted to having been told to lose weight by their doctor but they seemed to feel powerless to follow this recommendation.

> *"This [discussion] has really got me thinking I need to do something but I don't know how I'm going to do it."*

> *"I know I've got to change but I can't."*

Overweight people, that is people who appeared to have a BMI of approximately 25 to 30, seemed to be more widely dispersed across the segments. Some seemed to appreciate the need to change their weight while others did not. This may be a result of the perception that overweight is considered 'normal' in many communities.

Chronic Disease Status

Diagnosis of a chronic disease enhanced appreciation of the need for change for many. Those with lifestyle-related chronic diseases tended to be 'Help Seekers' or 'Endeavourers'. Few were 'Defiant Resisters' but some were 'Quiet Fatalists' or 'Apathetic Postponers', especially if they were at the early stages of diagnosis or did not consider their condition to be directly related to their lifestyle. However, despite positive attitudes to change amongst this audience, an individual's ability to change was perceived to be affected by having a chronic condition, as the following quotations illustrate:

> *"With arthritis and depression, some days I can't get out of bed because I can't afford to and I don't want to...I won't be doing exercise or eating much on those days either."*

> *"Since my by-pass and the fact that I'm overweight, I can't do anything too strenuous."*

> *"Sometimes exercise makes [my arthritis] worse and sometimes it makes it better."*

7 RESPONSE TO EXISTING MARKETING CAMPAIGNS

7.1 Response to 'What' Campaigns

Many existing and past social marketing campaigns on lifestyle as a whole have focused on conveying 'what' needs to change. The 'Life be in it' campaign of the 1980s featuring 'Norm' focuses on highlighting undesirable behaviour and the current 'Go for 2&5' and 'Get Moving' campaigns depict the desired behaviour.

The 'Go for 2&5' advertisements were perceived as engaging and informative. Parents felt that they reinforce the message that children are picking up from elsewhere about the importance of healthy eating. This was welcomed because it helps to tackle the barrier that healthy eating involves deprivation.

> *"My kids have asked me for fruit."*

> *"They're getting it from everywhere now. Did you know the Cookie Monster [on Sesame Street] only has cookies as 'sometimes food' now?! That's a great idea...[I say to my children] 'you can have sometimes food' now too."*

The 'Get Moving' campaign was felt to convey the message that children need more physical activity and some parents reported that their children find it engaging. There was high prompted recall of 'Get Moving' but lower spontaneous recall than for the 'Go for 2&5' campaign. This may be because the 'Go for 2&5' campaign was on air in some states at the time of fieldwork, whereas 'Get Moving' was not.

Both these campaigns were welcomed and considered effective by 'Endeavourers' and 'Help Seekers' who already had an appreciation of 'why' change was necessary. However, 'Apathetic Postponers', 'Quiet Fatalists' and 'Defiant Resisters' seemed less likely to be influenced by this type of message as it does not challenge their sense that change is not a priority. Further, the style and tone of both campaigns tended to be seen as having limited relevance to adults and teenagers.

bluemoon

7.2 Response to 'How' Campaigns

Western Australia's 'Find 30' campaign and the US's 'Small Steps' both focus on 'how' people could go about changing their behaviour. They are interpreted as challenging the belief that it is too much effort to do enough exercise each day and that small, realistic changes are the goal. This approach can be effective in that it reassures people that improvement is ultimately possible.

Most responded very positively to the 'Find 30' executions, especially 'Dancing'. In addition to conveying that it is not too much effort to fit in exercise each day, this was also seen as providing helpful suggestions for how to achieve the physical activity recommendations. This particularly appealed to 'Apathetic Postponers' and 'Help Seekers' who have a limited appreciation of 'how' change can be achieved.

Reactions to the 'Small Steps' campaign from the US were polarised. Some found these advertisements slick and amusing and therefore felt the campaign was engaging. For those who understood the campaign, this was seen as having a similar message to the 'Find 30' campaign. However others were confused about the message and did not take out very much from this at all.

Neither of these campaigns addresses 'why' change is necessary. They therefore had limited capacity to influence those who did not already have an appreciation of 'why' change is needed. There was also a propensity for those who had not appreciated 'why' change is necessary to acknowledge the message in these campaigns, but then to self-exempt from it. 'Apathetic Postponers', in particular, often claimed that they were already doing enough exercise and therefore did not need to change their lifestyle, after seeing these advertisements.

> *"That's good. I dance to the Wiggles with my daughter already…maybe not for half an hour but I'm doing something."*
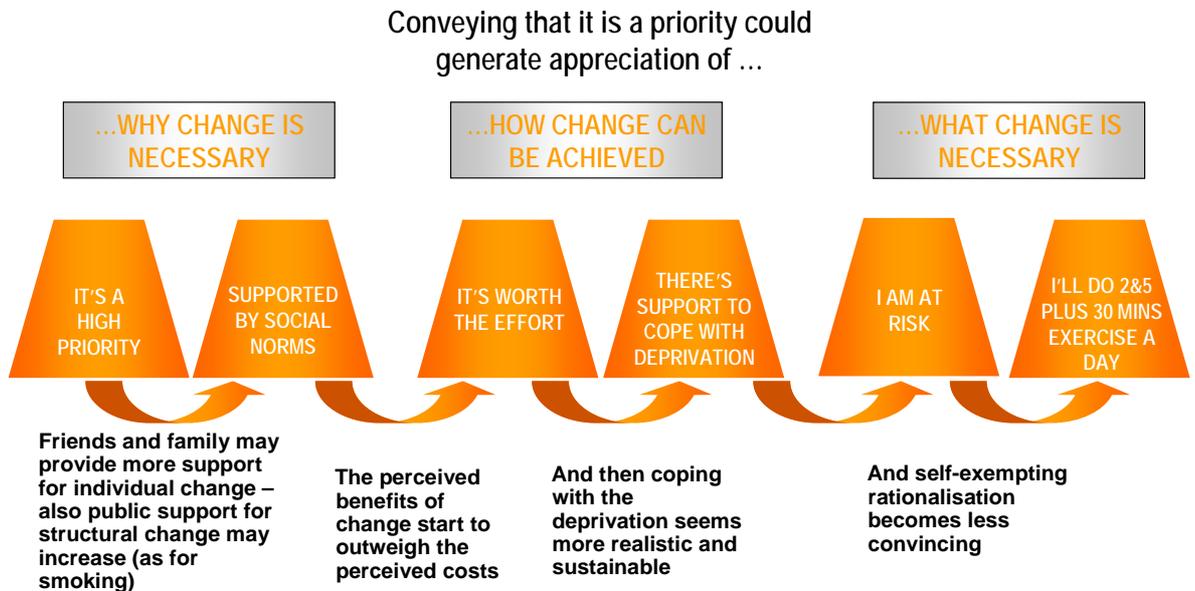
7.3 Implications for ABHI Social Marketing Campaigns

Response to the existing marketing, suggests that messages about 'why' change is necessary are a prerequisite for shifting attitudes to change. An absence of appreciation of 'why' means that 'how' messages are less convincing. This then allows self-exemption from the 'what' to seem justifiable. This suggests that the

initial priority for ABHI social marketing campaigns could be to focus on challenging beliefs about 'why' change is necessary, which could subsequently help open the way to challenging other barriers. The possible chain reaction this could set in motion is illustrated in figure 12.

Figure 12: Potentially most effective order in which to challenge beliefs about diet, exercise and weight

Conveying that it is a priority could generate appreciation of …

| …WHY CHANGE IS NECESSARY | …HOW CHANGE CAN BE ACHIEVED | …WHAT CHANGE IS NECESSARY |

| IT'S A HIGH PRIORITY | SUPPORTED BY SOCIAL NORMS | IT'S WORTH THE EFFORT | THERE'S SUPPORT TO COPE WITH DEPRIVATION | I AM AT RISK | I'LL DO 2&5 PLUS 30 MINS EXERCISE A DAY |

Friends and family may provide more support for individual change – also public support for structural change may increase (as for smoking)

The perceived benefits of change start to outweigh the perceived costs

And then coping with the deprivation seems more realistic and sustainable

And self-exempting rationalisation becomes less convincing

Analysis of the beliefs held by those 'at (low)er risk' in relation to lifestyle in general suggest that conveying 'why' change is important could encourage individuals to see change as a priority. This may then mean that social norms become more supportive of change in that people's friends and family may provide more support for healthy behaviour.

This, in turn, may lead to increased public support for structural changes that help people to modify their behaviour. As a result, there may be a stronger belief that the deprivation involved in behaviour change is realistic and sustainable. Finally, once appreciation of 'why' and 'how' is high, self-exempting rationalisations may become less convincing.

8.1   **Understanding of the Relationship Between Lifestyle and Chronic Disease**

Lifestyle in general and health

Respondents were shown a list of conditions including kidney disease, oral disease, diabetes, heart disease, stroke, depression, osteoporosis, arthritis and colorectal cancer and were asked to discuss what these had in common. In general, there was a broad understanding that lifestyle and health are related. All conditions shown were felt to be, at least in part, caused by or treatable by lifestyle, or both.

In particular, kidney disease, oral disease and colorectal cancer were perceived to be caused by lifestyle, through risk factors such as alcohol, smoking and poor diet. In contrast, conditions such as asthma, arthritis and osteoporosis were not necessarily believed to be *caused* by lifestyle, rather they were seen as conditions which could be *treated* or *managed* through healthier lifestyle habits such as exercise, diet and not smoking.

Conditions which respondents believed lifestyle had the most impact on, that is in 'prevention' and 'cure', included (type 2) diabetes[11], heart disease, stroke and depression. There was a strong acknowledgement that diabetes could be caused by poor diet and excessive weight, with many aware of increased media attention surrounding this. Similarly, many recognised that poor diet, stress, lack of exercise and smoking could lead to heart disease and stroke. Depression was slightly unique in that it was perceived to be caused by a number of factors both in and out of someone's control. Despite many believing that its onset was often uncontrollable, there was recognition that it could also be caused and / or exacerbated by poor diet, excess weight and lack of exercise.

The perceived strength of the correlation between the condition and lifestyle varied depending on the condition, with no one condition being attributed solely to lifestyle. Those believed to have the strongest correlation to poor lifestyle included (type 2) diabetes, kidney disease, heart disease and stroke. It was also acknowledged however that all four conditions could also be caused by bad luck or genes.

---

[11] Most respondents did not spontaneously use the term 'type 2 diabetes' but there was widespread understanding that two type of diabetes exist and one of them is related to lifestyle.

bluemoon

Depression, asthma and colorectal cancer were placed in the middle of the continuum, with respondents recognising some correlation between lifestyle, but less so than the former set of conditions. For these conditions, other factors were also attributed to their cause, including the impact of environment on asthma, or the influence of relationships, circumstances and hormones on depression. Colorectal cancer was also associated with bad luck and genes.

Conditions believed to have the weakest correlation with lifestyle tended to be those associated with the natural ageing process ('old age'), in particular arthritis and osteoporosis. As with other conditions already mentioned, some respondents believed that these could also be the result of bad luck or genes. Another condition with a weak perceived association to lifestyle was oral disease. This was perhaps in part due to the ambiguity surrounding what oral disease entailed, including suggestions it may be anything from an ulcer to throat cancer. There was also an assumption that lack of oral hygiene was the predominant cause of poor oral health.

Obesity and health

Obesity and poor health were perceived to be directly related. Most were aware that diabetes and heart disease can be caused by obesity, however there was low awareness of weight being a risk factor for conditions such as asthma, osteoporosis and colorectal cancer. Moreover, there was a lack of understanding around how much (or little) weight gain was actually regarded as being dangerous to health (see section 5.3). Reactions to figure 13 illustrate this. Respondents were incredulous that such a 'small' / 'normal' amount of weight gain could have so much impact on health.

> *"9 kilos! That's nothing. I don't see how that can be right. Most women have children and it would be hard not to put on weight after that."*

Figure 13: Text used as stimulus[12]

> 'Women who gain more than 9 kilos from age 18 to midlife double their risk of postmenopausal breast cancer, compared to women whose weight remains stable.'

---

[12] US Department of Human Services, www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences. NB: other studies show a less strong correlation with a greater gain in weight (see Journal of the American Medical Association 2006;296:141). Caution should therefore be adopted in using facts on this subject in advertising.

bluemoon

Findings indicate that highlighting the link with chronic disease can reduce the perceived acceptability of self-exempting about weight. The text and images in figure 14 were found to be effective on a number of levels. Firstly, this helped to convey that weight loss is a priority, something which many had failed to realise previously. Secondly, it established a healthy weight as an important social norm, which in turn has the potential to generate greater advocacy for weight loss. Thirdly, the humour in the message helped reduce any sense of victim blaming.

Figure 14: Visuals and text used as stimulus[13]

'Being overweight isn't genetic if the dog and cat are overweight too… being overweight increases your and your family's chances of developing chronic diseases like type 2 diabetes…it's time to do something about it.'

Perhaps the only short-fall in the expression of the message was that many were more worried about the pets than the people, and as such often missed, or chose to overlook, the point of the message.

> *"That poor cat! Who could do that?!"*

Nutrition and physical activity and health

Overall, there was a low appreciation of the detail underpinning the relationship between disease and diet and exercise. Not surprisingly, there existed a general awareness that poor diet and lack of exercise lead to weight gain and associated health problems. Conversely, most were aware that a good diet protects against poor health and / or improves one's ability to fight sickness.

Respondents were surprised and interested to hear, however, claims that stated the impact of specific behaviours, especially where the behaviour required seemed realistic and the benefits stated seemed to make the change worth the effort. For example, the facts in figure 15 all evoked surprise and interest. Moreover, they appeared to create a sense of ownership of the solution.

---

[13] Adapted from comment made by GP in the SNAP-O project, Blue Moon, June 2006

"I'm really surprised that exercise can do that...40% sounds like a big reduction."

"I didn't know diet can prevent all those cancers.'

Figure 15: Text used as stimulus[14]

> 'We can prevent about 25% of cancers by being physically active for at least 30 mins a day'
>
> 'People diagnosed with breast cancer who walk 3 to 5 hours per week reduce the risk of dying from the cancer by 40%'
>
> 'A healthy diet including enough fruit and vegetables can protect against cancers of the liver, oesophagus, lung, stomach, colon and rectum.'

Perceptions of the link between lifestyle and health in Aboriginal and Torres Strait Islander communities

Aboriginal and Torres Strait Islander Australians recognised chronic disease as being a particular problem in their communities, and were aware that the prevalence of these conditions is particularly high. The high prevalence was typically associated with both lifestyle and heredity. Lifestyle related conditions were linked particularly to diet, smoking and alcohol, and to a lesser extent, lack of exercise. For many, diabetes and depression were considered 'the norm', that is, conditions which many of their friends, family and probably even themselves were likely to have at some stage.

"These are all diseases that Aboriginal people suffer from."

8.2   Language issues in leveraging the threat of chronic disease

Describing the relationship between lifestyle and chronic disease

In communicating facts to the general public, it is important to understand that describing the relationship between lifestyle and health can often confuse people. Certain phrases and terms were found to be ambiguous, showing a strong potential to be misinterpreted. Terms such as 'relationship' or 'related to' were often interpreted to mean 'caused by', whether or not this was intended. It was found that any reference to 'treatment' needs to be spelled out in order to convey the correct

---

[14] The Cancer Council, www.cancer.org.au, 'Move your body' and Journal of the American Medical Association (2005, 293 (20) 2479) cited in Weekend Australian 9.12.06

message.

'Lifestyle' was perceived by respondents to mean more than the five risk factors. In many people's minds, lifestyle encompasses relationships with others, one's degree of stress, socio-economic standing, occupation and the suburb they live in. The term 'increase / reduce the risk' also raised potential issues, as it was often seen as too scientific, intangible and lacking relevance for many. These terms should be used with caution, and ideally qualified in order to remove the risk of misinterpretation or confusion.

In contrast, some terms were completely unambiguous and worked well in communicating the desired message. 'Caused by' is used colloquially by many, and hence was fully understood. 'Can lead to' was also interpreted correctly as meaning one of a number of contributory factors. Including the phrase '…is recommended' was felt to be credible, authoritative and something to take heed of.

Describing chronic disease(s)

Reference to the conditions themselves also created some confusion. While most of the conditions shown to respondents were familiar, oral disease was not entirely understood by many, as mentioned above. There was also lower awareness of osteoporosis in Aboriginal and Torres Strait Islander communities. Furthermore, there was low awareness of the term 'colorectal cancer', though referring to 'bowel' or 'colon' cancer addressed this.

The term used to refer to the collective group of lifestyle related illnesses was found to play an important role in the overall interpretation. 'Lifestyle related chronic disease' was found to be more appropriate than terms such as 'lifestyle illness' or 'chronic disease'.

'Lifestyle illness' was interpreted as something which is self-inflicted, it was also perceived to be manageable and / or treatable through drugs and / or behaviour, and as such lacked any sense of severity or alarm. 'Chronic disease' conveyed high severity and was therefore alarming. However, this did not necessarily suggest a self-inflicted condition, nor one for which there is an opportunity to prevent or treat through behaviour.

'Lifestyle related chronic disease' was found to be the most appropriate because it conveys severity, was perceived to relate to behaviour and to conditions that were

preventable and / or treatable. Given this, the term suggested there was potential for improvement or prevention through lifestyle change.

It is important to note that chronic disease was not readily understood as a discrete entity. Respondents struggled to link all of the conditions without being prompted, particularly as some conditions were associated more strongly with old age. The concept of chronic disease was most effectively conveyed when shown in the context of examples, as in figure 16. Too many examples however, can overwhelm, as in figure 17. A campaign on chronic disease would therefore ideally focus on a small number of suitable conditions.

"You lose interest when there's a whole list…it's difficult to take in."

Figure 16: Text used as stimulus[15]

'Getting enough exercise and the right diet are vital to avoid or reduce the impact of chronic diseases like type 2 diabetes'.

Figure 17: Text used as stimulus[16]

'Being overweight increases your and your family's chances of developing chronic diseases like diabetes, heart disease, depression, arthritis, asthma and kidney disease'

8.3   **Avoiding Causing Harm in Linking Lifestyle and Health**

In any campaign initiative, the potential for 'victim blaming' should be taken into account. Although the research clearly found that some people with chronic diseases have no problem with their condition being linked with lifestyle, others were concerned that people will think their condition is their fault. For them, there was a real potential of feeling shame and embarrassment. The sensitivities of this situation highlight the importance of noting that the relationship between lifestyle and chronic disease is not as clear cut as it is for smoking.

"I don't like where it says 'being overweight increases your chance of…kidney disease. I could lose some weight but that's not why I got it….I had a urinary tract infection and had to have [a transplant of] one of my Dad's kidneys."

---

[15] The Cancer Council, www.cancer.org.au, 'Move your body' page and adapted from the 'Stay in Shape' page.
[16] The Cancer Council, www.cancer.org.au, 'Move your body' page, adapted from the 'Stay in Shape' page.

bluemoon

Another important factor to consider is the potential of leaving some people feeling more helpless and depressed than they may already be feeling. Smokers and overweight respondents often said they resented being targeted so much in the media. Smokers in particular, attested to the influence smoking advertising has had on them, and the pressure and guilt that these can cause. While in some ways this may be viewed as an effective approach, particularly if it is able to effect behaviour change, some felt that it served only to make them feel worse, rather than helping them to change.

> *"I really like where it says 'anyone can get heart disease' because the doctor has told me it's because of my weight [that I have it] but I know lots of unhealthy people who are thin."*

8.4 Perceived Severity of Chronic Diseases

The perceived severity of some conditions seemed clear cut. Heart disease, colorectal cancer, stroke and kidney disease were all expected to have a serious impact on both quality of life and life expectancy. Arthritis and osteoporosis were consistently seen as likely to have a serious impact on a person's quality of life, if not their life expectancy.

Some of the other chronic diseases, in contrast, were perceived to vary considerably in severity. Diabetes was not seen as particularly severe in the early stages of the condition whereas the later stages were expected to be more serious. Oral disease was expected to vary from a mild condition such as bleeding gums to mouth cancer, which was seen as potentially fatal. Interestingly, awareness of the threat of mouth cancer seems to have increased as a result of the use 'mouth cancer' visuals in recent anti-smoking campaigns.

Depression and asthma were also considered to vary from conditions that are controllable through medication, so that they may have a minimal impact on both quality of life and life expectancy, through to life threatening conditions, which could also have a serious impact on quality of life.

Perceptions of how 'treatable' the conditions are varied. Diabetes and heart disease were considered to be treatable after diagnosis, through medication and lifestyle changes. Oral disease was seen as treatable through dentistry. Some believed

osteoporosis is treatable with calcium supplements. Medication and counselling were often considered to have the potential to keep depression under control and asthma was understood to be controlled through medication and exercise. In contrast, colorectal cancer, stroke, kidney disease and arthritis were not perceived to be easy to treat once they have been diagnosed.

The conditions that are perceived to be 'treatable' tended to be seen as less severe than those that were not. In particular, (type 2) diabetes was often seen as something to become concerned about once it is diagnosed. Heart disease was also considered to be highly manageable in many cases.

> *"All these things you'd start doing something about when your health starts to be affected...like if you were told you had diabetes, or pre-diabetes, you do something about it then."*

> *"You can have medication for a heart condition...as long as you don't just drop dead!"*

8.5 Opportunities to Enhance Appreciation of Severity

Conveying preventability

Challenging perceptions of 'treatability' is likely to be important if the prevention message is to be appreciated. There may also be an opportunity to raise awareness of the preventability of conditions that are seen as less 'treatable'. Cancer was often seen as caused predominantly by luck and genes and there was therefore surprise at, and interest in, the statements in figure 18.

Figure 18: text used as stimulus[17]

'Women who gain more than 9 kilos from age 18 to midlife double their risk of post-menopausal breast cancer...'

'A healthy diet...can protect against cancers of the liver, oesophagus, lung, stomach, colon and rectum.'

There was low awareness of the potential to prevent osteoporosis through improved nutrition and exercise. However, osteoporosis was strongly associated with old age and avoiding it may therefore be less of a deterrent than for diseases associated with middle age, such as diabetes, cancer and heart disease.

---

[17] US Department of Human Services, www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences. See note in section 8.1. and The Cancer Council, www.cancer.org.au, 'Eat for Health' page.

> *"[Osteoporosis] is something people get when they're really old. I think of my aunt, who's all bent over."*

Conveying impact on life expectancy

Awareness of the impact of diseases on life expectancy was not motivating for 'Defiant Resisters' and 'Quiet Fatalists', who took the view that *'we've all got to die sometime'* or *'what will be will be'.* However, all other audiences found the threat of reduced life expectancy to be compelling to some degree.

'Premature death' as a term was not picked up in the stimulus but diseases associated with premature death received a great deal of attention. Colorectal cancer was associated with high rates of mortality and therefore seemed to have potential to raise awareness of its high prevalence and preventability through lifestyle change.

> *"Cancer sounds scary…some of these things you'll get when you're older but cancer means you could die young."*

Heart disease was also associated with premature death. Highlighting the link between lifestyle and disease had impact because of the high perceived prevalence of the condition. There may also be potential to surprise people by conveying the high mortality rates, as this is a condition that is seen as relatively 'treatable' (see above).

Conveying impact on quality of life

Conveying the impact of lifestyle related diseases on quality of life seemed to be a rich territory for communications. Previous research[18] has highlighted that social marketing which focuses on the impact of behaviour on quality of life can have even more impact than marketing that focuses on reduced life expectancy. This may be because people can imagine poor health more readily than they can imagine death.

Type 2 diabetes seems to be a particularly appropriate condition to highlight the impact of lifestyle on quality of life. Diabetes was perceived as very prevalent but there was relatively low awareness of the severity of the condition at later stages. Those who did not know someone who had experienced the late stages of diabetes tended not to know that diabetes could result in amputation, blindness and premature death. There was therefore interest in the statement that there are '2600

---

[18] For example, SNAP-O, Blue Moon, June 2006

lower limb amputations in Australia each year'.

Perhaps surprisingly, those with diabetes (both types 1 and 2) in this sample were happy for communications to remind them of the potential outcomes at the late stages of their conditions because, they said, this helped reinforce their intention to maintain a healthy lifestyle.

Oral disease may also be a condition that could be used to highlight the impact on quality of life. There was low awareness of the link between oral health and other diseases and there is also an opportunity to raise awareness of the prevalence of oral health problems.

Reactions to 'threat arousal'

Illustrating the link with both diabetes and oral health had impact because respondents could identify with the outcomes. Debilitating, external and unattractive damage was easy for people to relate to (see figure 19). Conditions that cause internal damage, in contrast, such as colorectal cancer, were more difficult for people to relate to because they could not imagine their own organs. Shocking visual images therefore had huge emotional impact.

> *"I don't really care when I die, we've all got to die sometime…but I don't want to live with no leg."*

> *"I'll remember those teeth and the horrible hand."*

Figure 19: Visuals used as stimulus

This approach was also effective because it is emotional rather than rational and difficult to avoid, unlike information in a graph. Threat arousal seem particularly effective amongst those who have limited appreciation of 'why' change is necessary, such as 'Apathetic Postponers', especially as these people are less likely to engage

with less dramatic social marketing messages.

> *"I wouldn't even look at the graph…but once you've seen [the amputated limb] it's in your head."*

Contrasting the experience of the disease with the effort involved in changing behaviour seemed to be an effective way of enhancing appreciation of the severity of chronic diseases. Figure 20 was felt to illustrate this and was described as being similar to the anti-smoking 'echo' campaigns in which smokers give reasons why they cannot give up and medical staff highlight the outcomes of not giving up.

Figure 20: Visuals and text used as stimulus

'What's worse? Walking to work today or not being able to walk to work someday'?'

It should be noted, however, that the specific behaviour used in this statement was not ideal as many were able to self-exempt from the recommendation on the grounds that it is not possible for them to walk to work. A more generic activity, such as walking to the shops, might therefore be more appropriate.

> *"I can't walk to work because it's too far. So I don't think that was a good one."*

> *"It's good, but it would be better if it said something else like 'walking to the shops'. Everyone does that."*

Focusing on the impact of lifestyle related diseases on quality of life seemed to have most impact on those who already had some appreciation of 'what' change is necessary. 'Apathetic Postponers' were often brought up short by this type of message because they found it credible and it challenged their apathy. 'Help

Seekers' and 'Endeavouerers' also found messages about the impact of lifestyle on quality of life effective because they provided them with a reminder of 'why' lifestyle change and maintenance of healthy behaviour is important.

'Defiant Resisters' and 'Quiet Fatalists' however, tended to claim they would ignore this approach, in the same way that they disregard similar messaging about the impact of smoking. However, the use of high-impact visual images, which are difficult to avoid, may mean that the message is gradually absorbed by these audiences over time.

Anti-smoking campaigns appear to have raised people's tolerance to the use of shocking imagery in government advertising. Many saw the anti-smoking campaigns as effective because they have raised awareness that the consequences of smoking are severe. These campaigns were also felt to have increased social pressure on smokers to quit.

> *"My children say to me 'stop smoking Mummy, I don't want you to be like that [gangrene foot]."*

Findings indicate there is a surprisingly high level of acceptance of the idea of using 'threat arousal' in relation to lifestyle more broadly. Images of the diabetes related amputated limb, oral disease and arthritic hand were seen as memorable and impactful.

> *"I think they should go with the shocking pictures...I'm not going to take much notice of the others."*

> *"I think the same as the others [in the group]. Go with the shock tactics because people need to realise this is important."*

> *"Use the amputated leg. That's what's going to get people's attention."*

The diabetes related limb amputation seemed to have most potential to be effective because of the high perceived prevalence of diabetes at a relatively young age. Using imagery relating to oral disease and arthritis may be less effective as both conditions were less strongly associated with lifestyle and people's perceived susceptibility to these was lower (see section 8.6)

However, it should be noted that the use of threat arousal has limitations. The relationship between chronic diseases and diet, weight and exercise is more complex than between smoking and health. This means there is potential to cause confusion about the causes of some disease, which could result in 'victim blaming'. There may also be potential for the campaign to lose credibility if it is perceived to over-claim on the health effects of certain risk factors. It will therefore be important to be extremely factual and unambiguous in tone if taking a 'threat arousal' approach.

8.6   Perceived Susceptibility to Chronic Diseases

There was widespread awareness that the prevalence of chronic diseases is rising. (Type 2) diabetes, heart disease, stroke, bowel cancer and depression were all considered to be very common and also on the increase.

In particular, many were aware that diabetes is increasingly common amongst younger people and children; though the media attention on this issue may have led some to over-estimate its prevalence amongst children. Some also wondered whether diabetes appears to be on the increase because more cases are being diagnosed, whereas people might not have known they had the condition in the past.

Arthritis and osteoporosis were considered to be extremely common, if not inevitable amongst older people and asthma was seen as increasingly common amongst children. Little was known about kidney disease, other than that it is a complication of diabetes. This was therefore assumed to be less prevalent that then other conditions. Oral disease was the only condition for which the prevalence in Australia was radically under-estimated by most. This seemed to be a result of confusion about what constitutes oral disease (see above).

8.7 Opportunities to Enhance Appreciation of Susceptibility

Despite high awareness of the prevalence of these conditions, there seemed to be scope to drive appreciation of people's personal susceptibility to them. Many admitted to having had low levels of concern about their own likelihood of contracting these conditions before attending the groups and there was a great deal of surprise across audiences at the statements in figure 21.

> *"That's really surprising. We hear about car accidents all the time and worry about it…but that puts it in perspective."*

> *"That says a lot of deaths are preventable and maybe I could live longer if I change my lifestyle."*

Figure 21: text used as stimulus[19]

> '50% of all deaths in Australia in 2004 were caused by lifestyle-related chronic diseases'
>
> 25,000 deaths from heart disease vs under 3,000 from car accidents per year

Appreciation of personal susceptibility was reinforced by messages that challenged who is 'at risk'. 'Apathetic Postponers' in particular responded to the messages in figure 21. These messages were also welcomed by smokers and overweight people who appreciated the fact that the spotlight seemed to have been taken off them as they indicated that a wide range of behaviours could lead to chronic disease.

Figure 22: text used as stimulus

> 'It's not just smoking that can damage your health'
>
> 'People of all shapes and sizes get heart disease'
>
> 'Your lifestyle could damage your quality of life from the age of 25 onwards'

However, there was potential for messages about who is at risk of lifestyle related chronic diseases to be confusing. In particular there is a danger of people taking-out that anyone is 'at risk', regardless of their behaviour.

> *"That's true, you can get heart disease whether you're fat or thin and whether you eat well or do exercise or not. My brother-in-law was really fit and died of a heart attack."*

---

[19] Departement of Health and Ageing, Chronic Diseases and Associated Risk Factors in Australia, 2006, p ix and xi. 3,000 deaths from car accidents adapted from graph on Australian Government tobacco pack warning.

"So [as a 19 year old] I don't need to worry until I'm 25."

8.8   **Leveraging the Threat of Chronic Disease**

Conveying the threat of chronic disease

Findings indicate that there is a clear opportunity to use the threat of chronic disease to help challenge the belief that lifestyle change is not a priority. Prior to attending the discussions, most of the respondents in the 'at risk' groups believed lifestyle change to be a low personal priority. In many cases, discussion about the link between chronic disease and lifestyle generated appreciation that change should be a higher priority.

Conveying the severity of chronic diseases in terms of the impact on quality of life and life expectancy, as well as people's personal susceptibility to the conditions seems to be fundamental to encouraging this attitudinal shift.

Conveying the accompanying benefits

Section 5.7 highlighted that the benefits of behaviour change were not perceived to outweigh the costs alone and therefore beliefs about the costs of change need to be challenged before people are likely to modify their behaviour. However, findings also indicate that the threat of chronic disease may be more palatable if negative messages about the consequences of inaction are accompanied by positive messages about the benefits of action. Reminding people that there are short term gains to be had, such as looking good and feeling better, is likely to help generate engagement and avoid leaving people feeling hopeless and helpless.

There was strong support for depicting family activity, such as in figure 23. This type of message reminds parents of the importance of staying healthy for the sake of their children and was seen to encourage family fun and bonding. Further, this message helps to convey that prioritising a healthy lifestyle does not need to mean spending less time with the family. Findings also indicate that conveying 'how' change can be achieved will be extremely important once 'why' has been established. Campaigns like 'Find 30' and 'Small Steps' helped reassure people that change is possible.

bluemoon

"I like the Dad playing with his kids. That's something we should all do more of."

"It needs both. What will happen if you don't change and what's good about changing now."

Figure 23: visual shown as stimulus

Effectiveness amongst different audiences

The threat of chronic disease seems most likely to have an impact on 'Apathetic Postponers', 'Help Seekers' and 'Endeavourers' in the short term. 'Apathetic Postponers' in particular were surprised and affected by many of the facts and images about the relationship between lifestyle and long-term health. The 'Help Seekers' and 'Endeavourers' were less surprised by these messages but their motivation to try harder to change and avoid relapse nevertheless seemed to be enhanced by these .

'Defiant Resisters' and 'Quiet Fatalists' seemed closed to messages about the threat of chronic disease. However, it is possible that these audiences will be influenced indirectly by social marketing of this kind in the long term. If 'Apathetic Postponers' and 'Help Seekers' have an increased sense of the importance of the issue, this could lead to social norms being challenged, as they have been in relation to smoking. This may then help to increase social pressure on 'Defiant Resisters' and 'Quiet Fatalists' to change their attitudes and / or behaviour.

Communications aimed at Aboriginal and Torres Strait Islander audiences are likely to require a separate and culturally appropriate approach. Threat arousal in government advertising was more likely to be rejected by Aboriginal and Torres Strait Islander respondents than amongst other audiences. However, health facts had more currency. There was also scope to further promote the importance of exercise. Emphasising the importance of behaviour change that will benefit the individual, family and community is also likely to provide credibility.

As discussed in section 6.4, NESB audiences seemed more likely to fall into the 'Defiant Resister' and 'Quiet Fatalist' segments and there are certain social norms that prevent change that are specific to particular communities. However, responses to the advertising approaches and styles tested were not markedly different amongst NESB respondents to those of the sample as a whole. There does not therefore seem to be a need to develop separate mass communications aimed at NESB audiences, though it may be appropriate to develop some supporting materials that aim to tackle specific issues in a way that will resonate with individual communities. For example, below the line materials aimed at people from Mediterranean backgrounds could provide ideas on how to avoid over-eating during family gatherings.

9   CONCLUSIONS AND RECOMMENDATIONS

9.1   Summary of Conclusions

Findings from this and previous studies indicate that attitudes to lifestyle change can be shifted by enhancing appreciation of 'what' change is needed, 'why' it is necessary and 'how' it can be achieved. This seems to be a prerequisite for behaviour change. There is low appreciation of 'why' lifestyle change is needed amongst those most 'at risk'. For this audience, change is not considered a high enough priority and social norms are not perceived to support change. This leads people to self-exempt in terms of 'what' they should do and limits their perceived need to adopt 'how' advice.

Six attitudinal segments in relation to the desirability and possibility of change have been identified. This segmentation complements the 'stages of change' model and helps to identify different target audiences in terms of their likely reaction to messages about behaviour change. The most 'at risk' attitudes are 'Defiant Resisters', 'Quiet Fatalists', 'Apathetic Postponers' and 'Help Seekers'. Those at lower risk are 'Endeavourers' and 'Balance Attainers'. There appears to be a strong correlation between attitudes to change and socio-economic factors. People from socially disadvantaged groups, including NESB and Aboriginal and Torres Strait Islander communities, were over-represented in the 'Defiant Resister' and 'Quiet Fatalist' segments.

Some awareness of the link between lifestyle and chronic disease exists, particularly amongst those in the lower risk attitudinal segments. However, there is an opportunity to raise appreciation across audiences of 'what' constitutes a healthy weight and 'why' they should do so in terms of the health benefits of exercise and diet.

For those 'at risk', the threat of chronic disease is a potential vehicle to convey 'why' change is necessary. This seems to enhance the sense that change needs to be a priority. Conveying the 'why' could also help challenge social norms that obstruct change. This approach seems likely to be particularly effective in the short term for 'Apathetic Postponers', 'Help Seekers' and 'Endeavourers' who already have either a latent or manifest appreciation of 'why' change is necessary. 'Defiant Resisters' and 'Quiet Fatalists' may not be influenced in the short term because their belief that

change is neither desirable not possible is firmly entrenched and they face structural barriers to making 'the right choices'. However, findings suggest that an enhanced appreciation of 'why' change is desirable amongst other groups could increase acceptance of structural and legislative changes that could help tackle some of the barriers faced by those at highest risk.

Response to the stimulus shown in this research indicates that the threat of chronic disease could be leveraged by enhancing people's appreciation of the severity of chronic diseases and their personal susceptibility to them. Findings from this research suggest that there seems to be scope to enhance awareness of the impact on quality of life of type 2 diabetes and to leverage perceptions of the impact of heart disease on life expectancy by emphasising its prevalence and challenging misconceptions about who is 'at risk'. For both of these conditions, there is scope to challenge the idea that they are 'treatable'. Concept testing research could be used to explore which examples will have most impact in more depth.

It is important to note that care needs to be taken in any campaign that leverages the threat of chronic disease in relation to lifestyle-related chronic disease. The correlation between diet, exercise and weight and disease is less straightforward than the relationship between smoking and disease. There is therefore potential for miscommunication of this relationship, which could damage the credibility of the campaign. This is particularly the case when using shocking imagery.

There is also a need to avoid 'victim blaming', which can be counterproductive since those at most risk can respond by feeling even more powerless and depressed. A 'why' campaign based on the threat of chronic disease is therefore less likely to cause distress to those if it is followed, or accompanied, by 'how' messages.

Leveraging the threat of chronic disease is most likely to have a short-term impact on those from more socially advantaged groups. Indeed, any social marketing campaign is likely to have a more immediate and obvious influence on these audiences. This is because those from socially disadvantaged groups are faced with serious structural and environmental barriers to changing their behaviour, irrespective of their attitudes to change. However, there may be more effective and appropriate means of enhancing appreciation of 'why' amongst 'Defiant Resisters' and 'Quiet Fatalists'. In particular, there is likely to be a need to take a culturally sensitive approach with NESB and Aboriginal and Torres Strait Islander communities. Campaigns aimed at these audiences would ideally recognise the

bluemoon

specific structural barriers faced by these groups and would also take into account the distrust of government sources of information (especially in Aboriginal and Torres Strait Islander communities). Rather than focusing on the relationship between lifestyle and chronic disease, campaigns could aim to challenge misconceptions that are commonly held by these audiences, for example that lifestyle-related chronic disease is inevitable. Further research on specific appropriate approaches for these audiences would be required to develop these appropriate messages.

9.2   Research Recommendations

Recommendations, based on these findings were as follows:

1. The ABHI social marketing program as a whole should aim to drive appreciation of 'what', 'why' and 'how' amongst all target audiences and attitudinal segments. Campaigns should also seek to migrate as many people as possible to 'Endeavourer' and 'Balance Attainer' segments. This should then stimulate movement towards the Action and Maintenance 'stages of change' across all lifestyle risk factors, though the rate of movement may vary for different risk factors.

2. In 2007, the focus could be to raise appreciation of 'why' change is a priority amongst 'Apathetic Postponers', 'Help Seekers' and 'Endeavourers'. Leveraging the threat of chronic disease seems to be a potentially effective means of doing this.

3. Consider aiming to leverage the threat of chronic disease in relation to nutrition, activity and weight by conveying the severity of these conditions that can result from inaction, as well as people's susceptibility to them. Heart disease and type 2 diabetes seem to be the most effective examples because there is potential to enhance awareness of severity and susceptibility in a relation to these in a way that is easy for people to identify with.

4. Convey what constitutes a 'healthy weight', ideally using waist measurement information and taking care to avoid losing credibility when representing an 'unhealthy weight'.

5. Consider also using positive supporting messages to help make the more negative approach of conveying the threat of chronic disease more palatable. For example, this could cover the short term benefits, where to get more information and support and the short and long term health *benefits* of better nutrition and more activity.

6. Use a direct, factual tone when expressing messages about the link between lifestyle and chronic disease, for maximum credibility.

7. Explore the opportunity to use graphic, unpleasant imagery that people find difficult to avoid. However, it will be important to handle this type of message sensitively.

8. In the longer term, explore other creative means of enhancing appreciation of 'why', with the aim of engaging 'Defiant Resisters' and 'Quiet Fatalists', including those in Aboriginal and Torres Strait Islander communities. For example, it may be worth exploring opportunities to challenge misconceptions about the inevitability of chronic disease.

APPENDICES

A RECRUITMENT SCREENERS

1a. Do you or any of your close relations, work in any of the following industries?

Market research	1	**TERMINATE**
Advertising, marketing, public relations	2	
Media and journalism	3	
Water industry	4	**CONTINUE**
Energy industry	5	
Automotive manufacture or retail	6	
Teaching	7	
Medicine or healthcare	8	**TERMINATE**
Department of Health & Ageing	9	
An organisation dealing with health issues	11	

1b. When was the last time you took part in a group discussion or depth interview? (Write in)

TERMINATE IF LESS THAN 6 MONTHS AGO

2a. Have you been diagnosed with any of the following conditions:

Arthritis	1	CLOSE OR CONSIDER FOR CHRONIC DISEASE GROUP
Asthma	2	
Cardiovascular (heart) disease	3	
Cerebrovascular disease (have had, or at risk of, stroke)	4	
Chronic kidney disease	5	
Cancer of any kind	6	
Depression	7	
Type 2 Diabetes	8	
Oral Disease	9	
Osteoporosis	10	
None of these	12	CONTINUE

2b. READ OUT: **This research is on what people think about lifestyle and health issues and will include talking about advertising on this subject. Nearly everyone has at least one area of their lifestyle that could be improved and there will be no perfect people taking part in the discussion (including the interviewer). We are looking for people who are willing to speak honestly about why they do or do not choose to do certain things. Importantly, no one will**

bluemoon

judge your lifestyle or tell you how you should change.

Which of the following statements describes your general attitude and behaviour in relation to…

	I'm not interested in making a healthier change (At Risk - Pre-contemplation)	I'm interested in making a healthier change but I haven't thought seriously about when (At Risk - Contemplation)	I'm planning to make a healthier change within the next 6 months (At Risk - Preparation)	I've made a healthier change in the last 6 months (General Population - Action)	I made a healthier change more than 6 months ago or have always had a healthy lifestyle in this area (General Population - Maintenance)
A. Quitting smoking	1	2	3	4	5
B. Eating healthily, including 2 portions of fruit and 5 of vegetables on most days and consuming under 2000kj per day	1	2	3	4	5
C. Doing 30 minutes of exercise or activity on most days	1	2	3	4	5
D. Drinking a healthy amount of alcoholic drinks, i.e. on average less than 2 units a day (for women)/ less than 4 units a day (for men) / or not drinking alcohol	1	2	3	4	5
E. Getting to a healthy weight	1	2	3	4	5

'AT RISK' GROUPS

ALL must answer 1, 2 or 3 at either B, C or E i.e. they must currently have an unhealthy diet, do less than 30 minutes activity per day or are an unhealthy weight.

In each group, include at least 2 of those who have an unhealthy diet, 2 who do less than 30 minutes activity per day and 2 who are an unhealthy weight. (NB: there is likely to be crossover, this is OK)

Include at least 2 in each group who ALSO answer 1, 2 or 3 at A i.e. they are smokers.

Include at least 2 in each group who ALSO answer 1, 2 or 3 at D i.e. they drink more than the recommended amount of alcohol (2 units for women, 4 units for men)

Those in 'Precontemplation' groups must answer 1 to at least one of B, C or E. Include a mix in each of these groups.

Those in 'Contemplation' and 'Preparation' groups must answer 2 or 3 at B, C or E. Half should be at the 'Contemplation' and half at the 'Preparation' for one of the lifestyle areas in

each group.

<u>'GENERAL POPULATION' GROUPS</u>

Must answer 4 or 5 at B, C and E. Include half who have taken ACTION in the last 6 months on any of the lifestyle areas (i.e. 4 at B, C or E) and half who have been healthy in this area for longer than 6 months and are at the MAINTENANCE stage (5 at B, C or E).

3. (ASK THOSE WHO ANSWER 1 TO 3 AT Q1E) Have you been told by your doctor that you should lose weight to be healthier in the last two years?

| Yes | 1 | **RECRUIT AS OVERWEIGH / OBESE – (TERMINATE FOR 'GENERAL POPULATION' GROUP)** |
| No | 2 | **CONTINUE** |

INCLUDE AT LEAST 2 WHO ANSWER 1 AT Q3 IN EACH 'AT RISK' GROUP

NONE IN THE 'GENERAL POPULATION' GROUPS SHOULD ANSWER 1 AT Q3

4. How old are you?(Write in)

| |
| |

SEE QUOTAS

5. Record gender.

| Male | 1 |
| Female | 2 |

SEE QUOTAS

6a. Which of the following applies to you?

Single, living at home with parents with no kids	1	
Single, living with friends or alone with no kids	2	**SINGLES, COUPLES, NO KIDS**
Married or in a defacto relationship with no kids	3	
At least one child under 10 living at home	4	**YOUNG FAMILY FOR WOMEN / FAMILY FOR MEN**
At least one child between 10 and 16 living at home	5	**FAMILY**
No kids aged under 17 living at home (may have adult children living at home)	6	**POST FAMILY**

SEE QUOTAS

6b. **ASK THOSE WITH CHILDREN ONLY:** How old are each of your children under 18 who live at home with you? **WRITE IN AGES**

Child no 1	
Child no 2	
Child no 3	

Child no 4	

SEE QUOTAS

7.   What is your employment status?

Working full or part time	1
Unemployed	2
Full time student	3
Retired	4

SEE QUOTAS

8.   What is the occupation of the chief wage earner in your household? (Record job and SES)

White collar	1
Blue collar	2

SEE QUOTAS

9.   We need to ensure we include a representative sample of the population in our study. How would you describe your family's ethnic background? **READ LIST AND CODE ANY THAT APPLY**

Aboriginal or Torres Strait Islander	1
African	2
Asian	3
Eastern European	4
Latin American	5
Middle Eastern	6
North American	7
Northern European	8
Southern European	9

SEE QUOTAS

10.   Do you ever speak a language other than English at home?

Yes	1
No	2

SEE QUOTAS

QUOTAS

Each group should include 8 respondents and will last up to 2 hours.

Telephone depths will be up to 45 mins.

Exclude:
- those who work in the usual excluded industries as well as government departments or in medicine or health care

- anyone who has taken part in a group discussion in the last 6 months
- anyone who has been diagnosed with one of the conditions listed

Demographics

Within each group include:
- 4 men and 4 women in mixed groups
- a spread of ages within the defined age bands
- a representative proportion of employed, unemployed people and students for the relevant SES and age group e.g. 18-25 blue collar should have 3-4 working full time, 2-3 students and at least one unemployed person

Lifestage:
- Singles / couples / no kids: include at least 3 singles and at least 3 couples and a mix of those living with parents, friends and partners
- Young-family groups: include women with children from 0 to 10. Include a range of ages of children
- Family groups: include a mix of women with children over 10 and men with children aged 0-16 living at home. Include a range of ages of children
- Post family: include a representative mix of those working full or part time and retired for the age group

Across the sample include:
- a representative mix of ethnic backgrounds and those who speak a language other than English at home for the area that each group is being conducted in

Attitudes and Behaviour

All 'At Risk' respondents:
- all must be either overweight*, have an unhealthy diet or do less than 30 mins activity on most days
- at least 2 per group must ALSO be smokers
- at least 2 per group must ALSO drink more than the recommended amount of alcohol per day on average

* Recruiters are encouraged to find respondents who are overweight through the 'snow-ball' method of asking other potential respondents to nominate people who might fit into this category – this will enable us to find overweight respondents without having to ask people about their weight in too much detail.

'At Risk', Pre-contemplation respondents:
- at least 2 must be overweight / obese and not be planning to do anything about it
- at least 2 must have an unhealthy diet and not be planning to do anything about it
- at least 2 must do less than 30 minutes activity per day and not be planning to do anything about this

'At Risk', Contemplation and Preparation
Include 4 at the Contemplation stage and 4 at the Preparation stage for their 'problem' behaviour in each group.

Of the 4 Contemplation respondents in these groups:
- at least 1 must be overweight / obese and planning to do something about it at some point but haven't thought seriously about when
- at lest 1 must have an unhealthy diet and planning to do something about it at some point but haven't thought seriously about when
- at least 1 must do less than 30 minutes activity per day and planning to do

something about this at some point but haven't thought seriously about when

Of the 4 Preparation respondents in these groups:

- at least 1 must be overweight / obese and planning to do something about it in the next 6 months
- at lest 1 must have an unhealthy diet and planning to do something about it in the next 6 months
- at least 1 must do less than 30 minutes activity per day and planning to do something about this in the next 6 months

<u>'General Population', Action and Maintenance</u>
Include 4 Action and 4 Maintenance in each group.

All must <u>not</u> be an unhealthy weight, must have a healthy diet and must get 30 minutes exercise on most days.

Action:

- have done something about their weight, diet or activity in the last 6 months
- include a mix of those who have done something about each lifestyle area

Maintenance:

- have done something about their weight, diet or activity longer than 6 months ago or have never had an unhealthy lifestyle in this area

CHRONIC DISEASE RECRUITMENT QUESTIONNAIRE

1a. Do you or any of your close relations, work in any of the following industries?

Market research	1	**TERMINATE**
Advertising, marketing, public relations	2	
Media and journalism	3	
Water industry	4	**CONTINUE**
Energy industry	5	
Automotive manufacture or retail	6	
Teaching	7	
Medicine or healthcare	8	**TERMINATE**
Department of Health & Ageing	9	
An organisation dealing with health issues	11	

1b. Are you or have you ever been actively involved in an organisation that works or campaigns on behalf of people with disabilities, diseases or illness.

Yes	1	**TERMINATE**
No	2	**CONTINUE**

1c. When was the last time you took part in a group discussion or depth interview? (Write in)

TERMINATE IF LESS THAN 6 MONTHS AGO

READ OUT: **This research is on how health can be related to lifestyles. We understand that lifestyle is not the only factor that leads to ill health but we want to understand how you feel the two are related. Everyone who takes part in this research will have been diagnosed with an illness and no-one will judge your lifestyle or tell you how you should change. We will be asking for your reactions to some advertising aimed at the general population about lifestyles and health.**

2a. Which of the following conditions, if any, have you been diagnosed with and have regular treatment for? By regular treatment I mean you are taking medication on a daily basis or visit a medical practice or hospital for treatment for your condition on an on-going basis.

2b. (ASK FOR ALL THOSE MENTIONED AT Q2a) Do you believe this condition might be related to or could be made worse by diet or weight?

2c. (ASK FOR ALL THOSE MENTIONED AT Q2a) Do you believe this condition might be related to or could be made worse by inactivity or a lack of exercise?

	Q2a. Have condition	Q2b. Believe it is related to diet / weight	Q2c. Believe it is related to lack of activity
Arthritis	1	1	1
Asthma	2	2	2
Cardiovascular (heart) disease	3	3	3
Cerebrovascular disease (have had or at risk of stroke)	4	4	4
Chronic kidney disease	5	5	5
Colorectal cancer	6	6	6
Depression	7	7	7
Diabetes	8	8	8
Oral Disease	9	9	9
Osteoporosis	10	10	10

All respondents must have been diagnosed with and have regular treatment for at least one of the conditions listed. Within each group, each respondent must have a different condition. All of the diseases must be represented across the sample.

In each group at least half must believe this is related to diet or weight and at least half to lack of activity (it's OK if they believe it is related to both).

3.   How long ago were you first diagnosed with this / these condition(s) (Write in)

Condition	Years since diagnosis

SEE QUOTAS

5.   How old are you?(Write in)

SEE QUOTAS

5.   Record gender.

| Male | 1 |
| Female | 2 |

INCLUDE 3 MEN AND 3 WOMEN IN EACH GROUP

6.   Which of the following applies to you?

Single, living at home with parents with no kids	1	
Single, living with friends or alone with no kids	2	**SINGLES, COUPLES, NO KIDS**
Married or in a defacto relationship with no kids	3	
At least one child under 10 living at home	4	**YOUNG FAMILY FOR WOMEN / FAMILY FOR MEN**
At least one child between 10 and 16 living at home	5	**FAMILY**
No kids aged under 17 living at home (may have adult children living at home)	6	**POST FAMILY**

INCLUDE A MIX OF RELEVANT LIFESTAGES IN EACH GROUP

7.   What is the occupation of the chief wage earner in your household? (Record job and SES)

| White collar | 1 |
| Blue collar | 2 |

SEE QUOTAS

8.   We need to ensure we include a representative sample of the population in our study. How would you describe your family's ethnic background(s)? **READ LIST AND CODE ANY THAT APPLY**

Aboriginal or Torres Strait Islander	1
African	2
Asian	3
Eastern European	4
Latin American	5
Middle Eastern	6
North American	7
Northern European	8
Southern European	9

SEE QUOTAS

9.   Do you ever speak a language other than English at home?

| Yes | 1 |
| No | 2 |

SEE QUOTAS

<u>QUOTAS</u>

Each group should include 5-6 respondents and will last around 1.5 hours.

Telephone depths will be up to 45 mins.

Venues with disabled access will be used.

Exclude:
- those who work in the usual excluded industries as well as government departments or in medicine or health care
- anyone who has taken part in a group discussion in the last 6 months

Within each group include:
- 3 men and 3 women
- a spread of ages within the defined age bands
- a mix of lifestages, relevant to the age band
- each respondent to have a different condition from the list (respondents may have more than one)

Across the sample include:
- a representative mix of ethnic backgrounds and those who speak a language other than English at home for the area that each group is being conducted in
- all of the diseases listed
- a mix in terms of how long ago the disease was diagnosed

bluemoon

B DISCUSSION GUIDES

ABHI DISCUSSION GUIDE – 'AT RISK' AND GENERAL POPULATION GROUPS

1) Background (5 mins)

Moderator will explain we will be talking about awareness of health issues. They will <u>not mention lifestyle at this point</u>.

- What is you first name? What do you for a living / study?
- Who do you live with? If you have children, how old are they?
- What do you like doing in your spare time?

2) Understanding and awareness of terms (10 mins)

Moderator will show respondents a list of chronic diseases. NB: Moderator will <u>avoid using any terms to describe these collectively</u> such as 'disease' or 'chronic disease' in order to explore what terms are used spontaneously.

- Individually write down what these have in common and how you would describe these collectively. What have you written? (Probe fully for spontaneous terms)

Mapping exercise: moderator will give the group cards with the conditions on them:

- Arrange these into groups of those that are similar and different to each other. Why have you arranged them like that? What would you call each group?
- Which are similar to each other and which are different? What would you call each group?
- What do the terms 'lifestyle illness' and 'chronic disease' mean to you?
- Are these terms you have used personally? Are they terms you have heard? If so, where? (Probe: media, in education, friends / family)
- Would you use different terms for any of the conditions on the list?
- How do you feel about each of the terms 'chronic disease', 'lifestyle illness' and any terms generated by the group? What associations do you have with them? (Probe for rational and emotional responses)

3) Perceptions of severity (10 mins)

- Do you know anyone who has any of the conditions on the list? Which?
  Moderator will ask those who know someone with each disease to <u>let the others answer the following question first</u>:

- How would you expect people to be affected by the different diseases?
  Moderator will focus on 4-5 diseases per group that are relevant to the age group of the group, to be rotated across groups but always including coronary heart disease (CHD) and diabetes:

- For each:

  - what impact would you expect this to have on life expectancy?

  - what impact would you expect this to have on quality of life?

  - what symptoms / treatments are you aware of for each?

4) Perceptions of susceptibility (10 mins)

- How common do you think each of these diseases is in Australia? To what extent has this changed over the last 100 / 50 / 10 years?

- How likely do you think people like you are to develop any of these? Which do you think you are most at risk of?

- What do you see as the main causes of these diseases?

- To what extent do you think these diseases can be prevented or the likelihood of them developing can be reduced?

  - how can they be prevented from developing?

  - how can they be prevented from getting worse?

- (If not already mentioned) Which of the conditions would you associate more and less strongly with lifestyle?

- Which, if any, do you associate with each of:

  - overweight / obesity?
  - diet?
  - lack of activity?
  - smoking?

– excessive alcohol consumption?

5) Barriers to and benefits of a healthy lifestyle (10 mins)

Moderator will write up the activities, food, drink etc. of a typical healthy and unhealthy person next to each other on flipchart paper.

- Describe a typical day for a person / family with a healthy lifestyle of the same age / background as you:

  – what time would they wake up? What would they do when they wake up?

  – throughout the day (morning, lunchtime, afternoon, evening), what would they eat / drink / do?

  – what wouldn't they eat / drink / do?

  – what physical activity would they do?

- What is 'healthy' / 'unhealthy' behaviour in general?

- How would the lifestyle of an 'unhealthy person' compare?

- How do you feel about these two people? What are their positive and negative character traits?

- What stops people like you / families like yours and people you know from having a healthy lifestyle in general?

6) Consequences of lifestyle behaviour – positive and negative (10 mins)

- Imagine the healthy person in 10 / 20 years time (depending on age of respondents). How would you describe their state of health? Elicit spontaneous comments and then probe:

  – how active / mobile will they be?

  – what things will they / won't they be able to do that they do now?

  – what illnesses would you expect them to have?

  – describe their sense of wellbeing / mental health.

- Imagine the unhealthy person in 10 / 20 years time (depending on age of respondents). How would you describe their state of health. Elicit spontaneous comments and then probe:

- how active / mobile will they be?

- what things will they / won't they be able to do that they do now?

- describe their sense of wellbeing / mental health.

- would you expect them to have poor health? What type of poor health would you expect them to experience? (Explore spontaneous mentions of poor health fully)

7) Facts about chronic disease (20 mins)

Moderator will hand out a questionnaire to each respondent, which they will complete individually without speaking. The questionnaire includes a list of facts about chronic diseases related to overweight/obesity, physical activity and diet.

They will answer the following for each:

- Which of these did / didn't you know?

- Which could encourage you to think about changing your / your family's lifestyle?

They will then discuss what they have written as well as the following:

- Which are surprising?

- Which are more / less credible?

- Where have you heard this kind of information from?

- How important is the source of the information? How do you feel about information from:

    - the government

    - doctors

    - The World Health Organisation

    - 'researchers'

    - the media, including newspaper and women's magazines

    - TV shows e.g. The Biggest Loser, Honey we're killing the kids etc.

    - Weight loss groups e.g. Jenny Craig, Weightwatchers

8) Concepts and Visuals (15 mins)

Moderator will place all the concepts around the room and ask respondents to look at all of them and complete a short individual response exercise before discussing them as a group. They will explain these are not intended to be advertising ideas. They are ways of talking about the subject and we're interested in what types of words / phrases, messages and visuals could get them thinking about changing their lifestyles. NB: these will be used to explore how confronting and challenging communications can be. Ideally we are looking for messages that could stimulate behaviour change without causing emotional distress to those 'at risk' of chronic diseases and those who have them already.

- Which elements are more and less effective?

- Which elements are more / less surprising? Which are more / less credible?

- How do you feel about the tone / approach taken?

- Which would be more / less likely to stand out from other advertising / messages about lifestyle?

- What key words and phrases do / don't have impact?

- How likely would this message be to influence your views and / or behaviour?

- What do the visuals contribute to the message?

Moderator will show the recent anti-smoking print ads / pack warnings and then visuals for diseases related to chronic diseases.

- What are you feelings about using a similar, visual approach to the anti-smoking campaigns for chronic diseases relating to weight, physical activity and diet?

- How effective do you feel different types of image will be e.g. internal organs, hospital scenes, bar chart, benefits of change etc.

9) Clutter Reel Response (15 mins)

Moderator will present a selection of TVC and print ads and will explain we are not asking them to evaluate these existing ads. Rather we are looking for messages, approaches and ideas that could be effective in making people think about changing their lifestyles.

- Which approaches are more / less effective?

- What key messages stand out?

- Which messages are more / less credible?

- How do you feel about the tone / approach taken?

- Which are more / less likely to stand out from other advertising / messages about lifestyle?

- What key words and phrases do / don't have impact?

- How likely would any of these ads be to influence your views and / or behaviour?

- What can the Government learn from this advertising when developing future campaigns on lifestyle and health?

10) Summing up (5 mins)

- What have you heard today that you found interesting enough to tell someone else?

- What advice do you have for the government in putting together information and advice about lifestyle and health?

ABHI DISCUSSION GUIDE – CHRONIC DISEASES GROUPS

1) Background (5 mins)

Moderator will explain we will be talking about lifestyle and health and everyone has been asked here because they have a condition of some kind. Moderator will reassure respondents that they will not be lectured and that we do not want to suggest anyone is in any way to blame for their condition. The research will help develop advertising to encourage people to improve their lifestyles for better health and we want to get their advice on how to present the relationship between health and lifestyle in an appropriate way.

Paired introductions to help establish rapport – and report back to the rest of the group:

- What is you first name? Do you work / study?

- Who do you live with? If you have children, how old are they?

- What are your interests?

- What condition do you have? How long ago was it diagnosed? What treatment do you have?

- Describe an ad you like and why?

2) Understanding and awareness of terms (10 mins)

Moderator will show respondents a list of lifestyle related chronic diseases. NB: Moderator will avoid using any terms to describe these collectively such as 'disease' or 'chronic disease' in order to explore what terms are used spontaneously.

- What do these have in common? Are there any terms that could be used to describe them collectively?

- What do the terms 'lifestyle illness' and 'chronic disease' mean to you?

- Are these terms you have used personally? Are they terms you have heard? If so, where? (Probe: media, in education, friends / family)

- Would you use different terms for any of the conditions on the list?

- How do you feel about each of the terms 'chronic disease', 'lifestyle illness' and any terms generated by the group? What associations do you have with them? (Probe for rational and emotional responses)

3) Relationship between diseases and lifestyles (15 mins)

Moderator will be particularly careful at this stage to avoid suggesting people with chronic diseases are 'to blame' for their condition.

- How common do you think each of these diseases is in Australia? To what extent has this changed over the last 100 / 50 / 10 years?

- To what extent do you think these conditions can be prevented or the likelihood of them developing can be reduced?

    - how can they be prevented from developing?

    - how can they be prevented from getting worse?

- (If not raised already) what do you see as the relationship between lifestyle and health?

- What impact do you feel lifestyle has had on your condition?

- Which of the conditions would you associate more and less strongly with lifestyle?

- Which, if any, do you associate with each of:

    - overweight / obesity?

    - diet?

    - lack of activity?

    - smoking?

    - excessive alcohol consumption?

- What other benefits, short term and long term, would people get from changing their lifestyles?

- What are the barriers to doing this? In particular, what are the barriers for people with your condition?

- If you wanted to change your lifestyle, where would you go for more information or help?

- What help is available in this area? (Probe: weight loss groups, gyms, medical practitioner advice etc.)

- Have you or anyone you know successfully changed your/their lifestyle? How was this achieved?

4) Case studies on severity (10 mins)

NB: Moderator will aim to explore how the conditions have affected respondents lives, if they seem comfortable with this and when it seems appropriate in the discussion.

- How has your condition affected your life?
- What impact has your condition had on your quality of life?

5) Facts about chronic disease (15 mins)

Moderator will hand out a questionnaire to each respondent, which they will complete individually without speaking. The questionnaire includes a list of facts about chronic diseases related to overweight/obesity, physical activity and diet.
They will answer the following for each:

- Which of these did / didn't you know?
- Which would be most effective in an advertising campaign?

They will then discuss what they have written as well as the following:

- Which are surprising?
- Which are more / less credible?
- Which would not be appropriate to use in an advertising campaign?
- Where have you heard this kind of information from?
- How important is the source of the information? How do you feel about information from:

    - the government
    - doctors
    - The World Health Organisation
    - 'researchers'
    - the media, including newspaper and women's magazines
    - TV shows e.g. The Biggest Loser, Honey we're killing the kids etc.
    - Weight loss groups e.g. Jenny Craig, Weightwatchers

8) Concepts and Visuals (15 mins)

Moderator will place all the concepts around the room and ask respondents to look at all of

them and complete a short individual response exercise before discussing them as a group. They will explain these are not intended to be advertising ideas. They are ways of talking about the subject and we're interested in what types of words / phrases, messages and visuals could get them thinking about changing their lifestyles. NB: these will be used to explore how confronting and challenging communications can be. Ideally we are looking for messages that could stimulate behaviour change without causing emotional distress to those 'at risk' of chronic diseases and those who have them already.

- Which elements are more and less effective?
- Which would not be appropriate to use in an advertising campaign?
- Which are more / less surprising? Which are more / less credible?
- How do you feel about the tone / approach taken?
- Which would be more / less likely to stand out from other advertising / messages about lifestyle?
- What key words and phrases do / don't have impact?
- How likely would any of these messages be to influence your views and / or behaviour?
- What do the visuals contribute to the message?

Moderator will show the recent anti-smoking print ads / pack warnings and then visuals for diseases related to chronic diseases.

- What are you feelings using a similar, visual approach to the anti-smoking campaigns for chronic diseases relating to weight, physical activity and diet?
- How effective do you feel different types of image will be e.g. internal organs, hospital scenes, bar chart, benefits of change etc.

9) Clutter Reel Response (15 mins)

Moderator will present a selection of TVC and print ads and will explain we are not asking them to evaluate these existing ads. Rather we are looking for messages, approaches and ideas that could be effective in making people think about changing their lifestyles.

- Which approaches are more / less effective?
- What key messages stand out?
- Which messages are more / less credible?

- How do you feel about the tone / approach taken?
- Which are more / less likely to stand out from other advertising / messages about lifestyle?
- What key words and phrases do / don't have impact?
- How likely would any of these ads be to influence your views and / or behaviour?
- What can the Government learn from this advertising when developing future campaigns on lifestyle and health?

10) Summing up (5 mins)

- What have you heard today that you found interesting enough to tell someone else?
- What advice do you have for the government in putting together information and advice about lifestyle and health?

C STIMULUS

		Tick if you have NOT heard this before	Tick the THREE that would be MOST effective to use in advertising
A	50% of all deaths in Australia in 2004 were caused by lifestyle-related chronic diseases.		
B	The government recommends adults should eat 2 portions of fruit and 5 of vegetables each day for health.		
C	Almost half of Australian adults do not eat enough fruit and 85% do not eat enough vegetables.		
D	Poor diet, including not eating enough fruit and vegetables, can lead to heart disease, stroke, colorectal cancer, type 2 diabetes, chronic kidney disease, oral disease and osteoporosis.		
E	A healthy diet including eating enough vegetables and fruit which can protect against cancers of the liver, oesophagus, lung, stomach, colon and rectum.		
F	A healthy diet makes your look and feel better, inside and out.		
G	Research shows people diagnosed with breast cancer who walk 3 to 5 hours per week reduce their risk of dying from the cancer by 40%.		
H	34% of Australian adults do not get enough physical activity for good health.		
I	Physical Activity can boost energy levels and improve mood.		
J	Adults should get at least 30 minutes of moderate intensity physical activity on most days, children need an hour.		
K	In Australia there are at least 2,600 diabetes related lower limb amputations each year. Physical activity for at least 30 minutes on most days can help avoid type 2 diabetes or reduce the consequences for those already diagnosed.		
L	We can prevent about 25% of cancers by being physically active for at least 30 minutes each day.		
M	1 in 7 Australians have high blood pressure and many do not know because they have no symptoms. But high blood pressure can lead to heart disease, stroke and kidney disease.		
N	Over half of Australian adults are overweight or obese.		
O	Women who gain more than 9 kilos from age 18 to midlife double their risk of postmenopausal breast cancer, compared to women whose weight remains stable.		
P	People who are obese up to double their risk of premature death from all causes, compared to people of a healthy weight.		
Q	Obesity during pregnancy is associated with an increased risk of death in the baby and the mother and increases the risk of maternal high blood pressure by 10 times.		
R	A body mass index (BMI) of 18 to 25 is recommended for adults.		
S	A waist circumference below 94cm for men and 80cm for women is recommended for health.		
T	Fertility is affected by weight. Fat interferes with ovary function and IVF is more likely to fail if a woman is overweight.		

C1

It's not just smoking that can damage your health
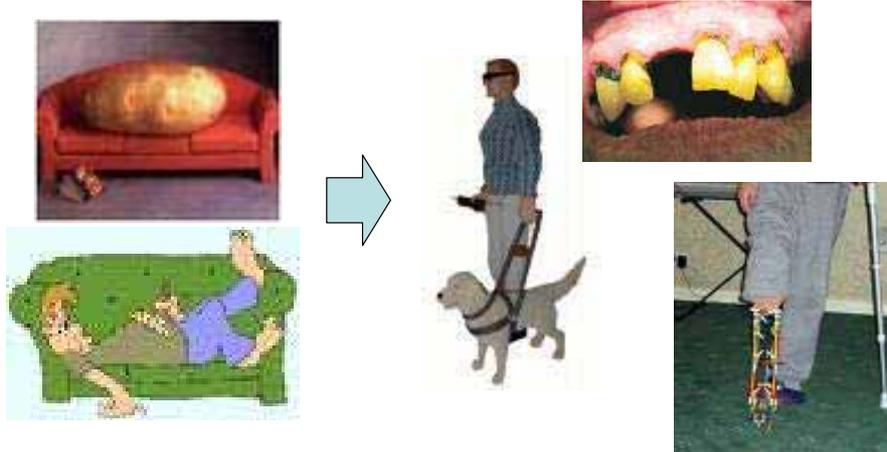
Getting enough exercise and the right diet are vital to avoid or reduce the impact of chronic diseases like Type 2 diabetes and oral disease, which can have a major impact on your quality of life. Did you know diabetes can lead to amputated limbs and blindness? It's never too late to increase your exercise levels and improve your diet.

bluemoon

C2

People of all shapes and sizes get heart disease

You don't have to be obese to get heart disease. If you don't have a healthy diet or don't do enough physical activity you could be doing your body damage. Chronic diseases like diabetes, heart diseases, osteoporosis and arthritis affect people of all sizes

C3

What's worse? Walking to work today or not being able to walk to work someday?

Lack of activity can lead to Type 2 diabetes, osteoporosis and arthritis. The best way to avoid these is to get enough physical activity, like walking briskly for 30 minutes a day. Walking or cycling to work can make you feel more energetic for the rest of the day and will could save you money too!

C4

Being overweight isn't genetic if the dog and cat are overweight too

Being overweight increases your and your family's chances of developing chronic diseases like diabetes, heart disease, depression, arthritis, asthma and kidney disease. It's time to do something about it. Visit the Healthy Active website for advice on how: www.healthyactive.gov.au.

C5

You may not want to live forever but your lifestyle could damage your quality of life from the age of 25 onwards

25 year old diagnosed with Type 2 diabetes →
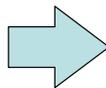
950,000 Australians have diabetes, often as a result of a poor diet, not getting enough exercise of being overweight. People as young as 25 are being diagnosed with Type 2 diabetes. Improving your lifestyle, even in small ways, can help prevent or reduce the impact of chronic diseases.

bluemoon

C6

Your waist size could indicate that your health is at risk

Fat around the waist and abdomen is a greater health risk than fat carried on the hips / thighs for Type 2 diabetes, cardiovascular disease and breast cancer. Men should aim for a waist circumference below 94cm. Women should aim for a waist circumference below 80cm.

C7

It's not just smoking that can damage your health

Deaths in Australia in 2004
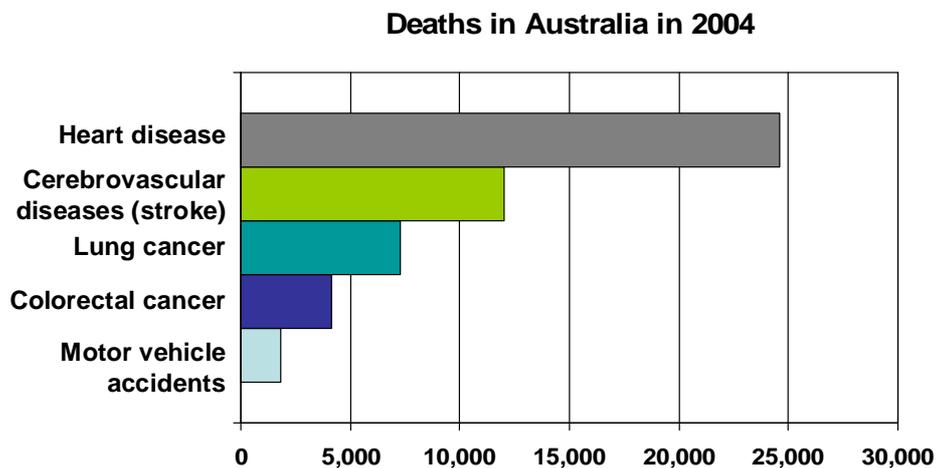
A poor diet, excess weight or a lack of physical activity can contribute or lead to diseases like heart disease that cause premature death.

bluemoon

C8

> **This person is clinically obese – are you?**

Anna is 1.75m and weighs 82kg. Her BMI is 30. She is clinically obese and is therefore at risk of Type 2 diabetes and heart disease.
Is your BMI healthy? Go to www.healthyactive.gov.au to find out what your BMI is and for advice on how to lose weight, eat more healthily and get more active.

C9

> **It may feel like an effort getting enough exercise but you'll enjoy the benefits in the short and long term**

Getting 30 minutes of activity every day could help prevent or reduce the impact of chronic diseases such as diabetes and heart disease in middle age, so that you'll be able to make the most of your life. Visit the Healthy Active website for advice on how to get more active: www.healthyactive.gov.au.

bluemoon

SMOKING CAUSES MOUTH AND THROAT CANCER
Health Authority Warning

MOUTH CANCER

Smoking is the major cause of cancers affecting the mouth and throat. These cancers can result in extensive surgery, problems in eating and swallowing, speech problems and permanent disfigurement.

You CAN quit smoking. Call **Quitline 131 848**, talk to your doctor or pharmacist, or visit **www.quitnow.info.au**

SMOKING CAUSES PERIPHERAL VASCULAR DISEASE
Health Authority Warning

GANGRENE

Smoking damages your blood vessels, which can prevent blood circulation, particularly to your legs or feet. This can result in blood clots, infection, gangrene, even amputation.

You CAN quit smoking. Call **Quitline 131 848**, talk to your doctor or pharmacist, or visit **www.quitnow.info.au**

SMOKING - A LEADING CAUSE OF DEATH
Health Authority Warning

CAUSES OF DEATH IN AUSTRALIA*

TOBACCO - 19,019
Alcohol - 2,831
Motor Vehicle Accidents - 1,731
Illegal Drugs - 863
Murders - 203

Smoking causes more deaths than murder, illegal drugs, motor vehicle accidents and alcohol combined. Smokers not only live shorter lives, they also live more years with disabling health problems.

You CAN quit smoking. Call **Quitline 131 848**, talk to your doctor or pharmacist, or visit **www.quitnow.info.au**

* Source: AIHW Quantification of drug caused mortality and morbidity in Australia, 1998 and ABS Causes of Death, 1998

QUITTING WILL IMPROVE YOUR HEALTH
Health Authority Warning

CALL QUITLINE TODAY

Quitting smoking at **any** age benefits your health and fitness. Quitting reduces your risk of developing diseases such as cancer, heart attack and stroke. In the case of heart attack, the risk is halved one year after quitting.

You CAN quit smoking. Call **Quitline 131 848**, talk to your doctor or pharmacist, or visit **www.quitnow.info.au**

Lifescripts and the Adult Health Check

Keeping you Healthy

I threw away the smokes – for me and the kids

A healthy feed can be easy and taste good too

Things are ok since I cut back on the grog

I like going for a bit of a walk now

I feel better with some of this weight off

This service is taking part in **Lifescripts** – a national program for a healthier you

We're talking to our patients about healthier living

Ask your Health Worker or GP how you can get more out of life

Lifescripts
Advice for Healthy Living

Australian Government
Department of Health and Ageing

Aboriginal diet and nutrition

Before white settlement, Aboriginal people were hunter-gatherers who foraged for uncultivated plants and hunted wild animals. The traditional diet was high in carbohydrates, protein and nutrients, and low in fat and sugars. It seems that diet-related diseases, such as cardiovascular disease and diabetes, were uncommon. However, modern Aboriginal diets are heavily Westernised and tend to be high in fat and sugar, but low in carbohydrate, fibre and nutritional value. The rate of cardiovascular disease and diabetes is now exceptionally high in the indigenous population.

Traditional diet or bush food

The typical traditional diet was low kilojoule and high in carbohydrate, fibre, protein and nutrients. Since Aboriginal people were hunter-gatherers, the daily diet varied according to the type of plants and animals available in the particular location and season. By necessity, they had an extensive knowledge of plants, animals, the land and the effects of the weather and time of year. Popular energy-dense foods, or foods that contained plenty of kilojoules per gram, included animal meat and offal, honey, and insects such as witchetty grubs. Women tended to gather the foods for everyday eating such as plants, reptiles and honey, while men hunted for land and marine animals. Most foods were eaten raw, but some were roasted or baked. Children were typically breastfed until three years of age, and introduced to solid foods once their teeth had come through. The hunter-gatherer lifestyle also meant plenty of physical activity.

Dietary changes during white settlement

Once the Europeans arrived, the traditional Aboriginal diet shifted to include Western foods such as flour, sugar and processed meat. Indigenous people on cattle stations or government settlements had fewer opportunities to forage for food, and tended to rely more and more on European staples. The typical Aboriginal diet started to lack essential nutrients. Protein, vitamin and mineral deficiencies were common. European settlement meant the introduction of animals and plants foreign to Australia, reduced access to land and an increase in bush fires, which further hindered the indigenous people's ability to gather and hunt for food in traditional ways.

Modern-day diet and nutrition

The typical Aboriginal diet today is high kilojoule, low in nutritional value, and high in fats and sugar. There is no need to hunt and forage for food, so physical activity levels are generally low. Surveys show that urban-dwelling indigenous people eat more fast food and salt than non-indigenous people. Living in remote outback communities reduces the range of foods available, particularly fresh fruit and vegetables. Indigenous people of the Northern Territory consume more sugar, white flour and carbonated soft drinks than the Australian average. The typical modern Aboriginal diet, whether city or country, is especially low in vitamin C, calcium and magnesium.

Diet-related diseases

Diet has been linked to a number of diseases and disorders among the Australian indigenous population, including:

- Cardiovascular disease
- Diabetes
- Overweight and obesity
- High blood pressure
- Some cancers
- Circulatory diseases
- Stroke.

Where to get help

- Your doctor
- Victorian Aboriginal Health Service Co-op Ltd Tel. (03) 9419 3000

Things to remember

- The traditional Aboriginal diet was high in carbohydrates, protein and nutrients, and low in fat and sugars.
- Modern Aboriginal diets, for both city and country dwellers, are high in fat, sugar and salt, and low in nutritional value.
- Diet has been linked to a number of disorders among the Australian indigenous population including obesity, diabetes and cardiovascular disease.

This page has been produced in consultation with, and approved by, The Victorian Aboriginal Health Service. The Better Health Channel is part of the Department of Human Services, Victoria.

www.betterhealth.vic.gov.au

bluemoon

D USING THIS RESEARCH

It is important that clients should be aware of the limitations of survey research.

Qualitative Research

Qualitative research deals with relatively small numbers of group participants and attempts to explore in–depth motivations, attitudes and feelings. This places a considerable interpretative burden on the researcher. For example, often what group participants do not say is as important as what they do. Similarly, body language and tone of voice can be important contributors to understanding group participants' deeper feelings.

Client should therefore recognise:

- that despite the efforts made in recruitment, group participants may not always be totally representative of the target audience concerned

- that findings are interpretative in nature, based on the experience and expertise of the researchers concerned

Quantitative Research

Even though quantitative research typically deals with larger numbers of group participants, users of survey results should be conscious of the limitations of all sample survey techniques.

Sampling techniques, the level of refusals, and problems with non-contacts all impact on the statistical reliability that can be attached to results.

Similarly quantitative research is often limited in the number of variables it covers, with important variables beyond the scope of the survey.

Hence the results of sample surveys are usually best treated as a means of looking at the relative merits of different approaches as opposed to absolute measures of expected outcomes.

The Role of Researcher and Client

Blue Moon believes that the researchers' task is not only to present the findings of the research but also to utilise our experience and expertise to interpret these findings for clients and to make our recommendations (based on that interpretation and our knowledge of the market) as to what we believe to be the optimum actions to be taken in the circumstances: indeed this is what we believe clients seek when they hire our services. Such interpretations and recommendations are presented in good faith, but we make no claim to be infallible.

Clients should, therefore, review the findings and recommendations in the light of their own experience and knowledge of the market and base their actions accordingly.