

## 8 LINKING LIFESTYLE CHANGE AND CHRONIC DISEASE

### 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<sup>11</sup>, 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.

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<sup>11</sup> 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.

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<sup>12</sup>

'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.'

<sup>12</sup> US Department of Human Services, [www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_consequences](http://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.

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<sup>13</sup>

'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.

<sup>13</sup> 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<sup>14</sup>

'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

<sup>14</sup> The Cancer Council, [www.cancer.org.au](http://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<sup>15</sup>

‘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<sup>16</sup>

‘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.”*

<sup>15</sup> The Cancer Council, [www.cancer.org.au](http://www.cancer.org.au), ‘Move your body’ page and adapted from the ‘Stay in Shape’ page.

<sup>16</sup> The Cancer Council, [www.cancer.org.au](http://www.cancer.org.au), ‘Move your body’ page, adapted from the ‘Stay in Shape’ page.



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<sup>17</sup>

'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.

<sup>17</sup> US Department of Human Services, [www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_consequences](http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences). See note in section 8.1. and The Cancer Council, [www.cancer.org.au](http://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<sup>18</sup> 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

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<sup>18</sup> 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 'Endeavourers' 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 than 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<sup>19</sup>

'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."*

<sup>19</sup> Department 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.

*"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 nor 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

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



**'AT RISK' AND 'GENERAL POPULATION' 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. 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	

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



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.

**'GENERAL POPULATION' GROUPS**

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	<b>RECRUIT AS OVERWEIGHT / OBESE – (TERMINATE FOR 'GENERAL POPULATION' GROUP)</b>
No	2	<b>CONTINUE</b>

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

**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 least 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 least 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

'General Population', Action and Maintenance

Include 4 Action and 4 Maintenance in each group.

All must not 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	<b>TERMINATE</b>
Advertising, marketing, public relations	2	
Media and journalism	3	
Water industry	4	<b>CONTINUE</b>
Energy industry	5	
Automotive manufacture or retail	6	
Teaching	7	
Medicine or healthcare	8	<b>TERMINATE</b>
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	<b>TERMINATE</b>
No	2	<b>CONTINUE</b>

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	SINGLES, COUPLES, NO KIDS
Single, living with friends or alone with no kids	2	
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

### QUOTAS

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 lifestyles, 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

## 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 not mention lifestyle at this point.*

- What is your first name? What do you do 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 avoid using any terms to describe these collectively 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 let the others answer the following question first:*
- 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 your 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 your 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 your 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?

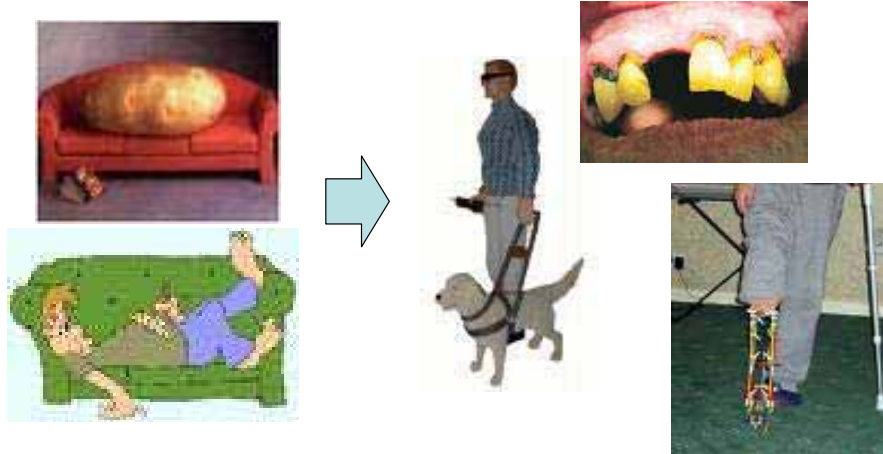
## C STIMULUS



		Tick if you have <b>NOT</b> heard this before	Tick the <b>THREE</b> that would be <b>MOST</b> 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.

## 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**

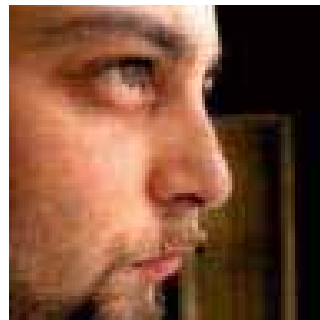
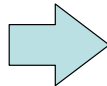


Being overweight increases your and your family's chances of developing chronic diseases like diabetes, heart disease, depression, arthritis, asthma and kidney disease. It's time to do something about it. Visit the Healthy Active website for advice on how: [www.healthyactive.gov.au](http://www.healthyactive.gov.au).

## 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 or 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.

## C6

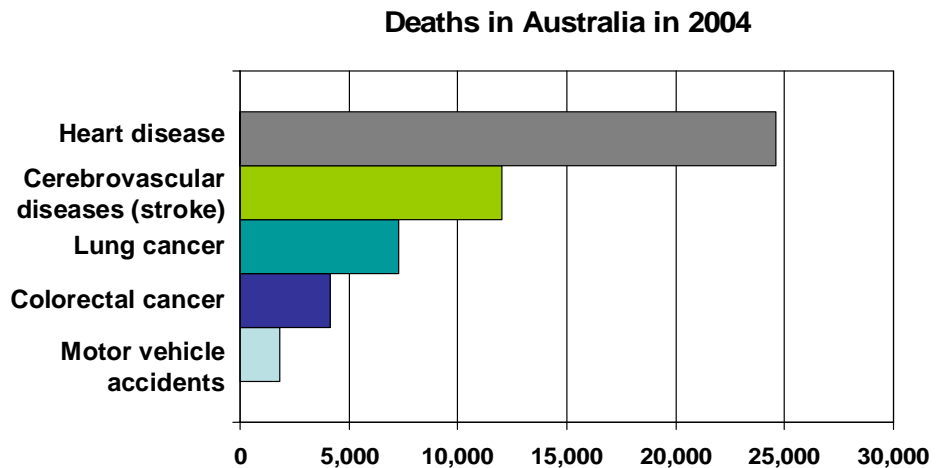
Your waist size could indicate that your health is at risk



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



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

## 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](http://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](http://www.healthyactive.gov.au).

**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](http://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](http://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

**Quitline 131 848**

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](http://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**

Quitline 131 848

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](http://www.quitnow.info.au)





**ANTHONY MUNDINE**  
Athlete

"I like to feel great to get the best out of life, so I make sure I eat the right foods and do something active every day."



**TIMANA TAHU**  
Parramatta Eels

"Fruit, vegetables, breads, pastas, lean meats, chicken and fish are all great foods to ensure enough energy for the day. It's so important for parents to ensure kids eat well and exercise daily."



**CHRISTINE ANU**  
Australian Entertainer

"Diabetes can affect any age, shape or size, but you should always keep healthy with a good balanced diet and lots of exercise and play."



**ADAM GOODES**  
Twice Brownlow Medalist

"Water is the best thing to be drinking. I drink at least three litres each day. I don't drink soft drink because I know it's bad for my teeth and body."



**BANGARRA DANCE THEATRE**

"Move because it's in your blood!  
Dancing is a great way to keep fit."



© Health © 2010 (www.diabetesaustralia.org.au)

[www.diabetesaustralia.org.au](http://www.diabetesaustralia.org.au) 1300 136 588



bluemoon

## Lifescrpts and the Adult Health Check Keeping you Healthy

	<b>I threw away the smokes – for me and the kids</b>
<b>A healthy feed can be easy and taste good too</b>	
	<b>Things are ok since I cut back on the grog</b>
<b>I like going for a bit of a walk now</b>	
	<b>I feel better with some of this weight off</b>

This service is taking part in **Lifescrpts** – 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



### Lifescrpts

Advice for Healthy Living



## 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.

#### Updates

This is a copy of an article from the Better Health Channel website. Articles on the Better Health Channel are updated regularly. For the most recent information on this topic, go to [www.betterhealth.vic.gov.au](http://www.betterhealth.vic.gov.au)

#### Quality assurance

This article, like all articles on the Better Health Channel, has passed through a rigorous and exhaustive approval process.

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## 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.

