



What role can social marketing play
in tackling the social determinants
of health inequalities?

About The NSMC

The National Social Marketing Centre (The NSMC) was originally established as a Non-Departmental Public Body (NDPB) in November 2006 as a strategic partnership between Consumer Focus (formerly known as the National Consumer Council) and the Department of Health England (DH).

Its origins lay in the Choosing Health Public Health White Paper (November 2004). This recommended that social marketing be used throughout the DH and the National Health Service (NHS) to develop effective behaviour change programmes that would contribute to better health for the nation.

The NSMC's original remit was to build social marketing capacity in England. Having achieved this objective, government funding of The NSMC came to an end in March 2011. Following a robust due diligence exercise, the Consumer Focus Board voted to close The NSMC and a new social enterprise was established to take forward its work. The NSMC's transition from NDPB to Community Interest Company (CIC) is in-line with current government policy and has its full support.

The NSMC CIC remains a world-leading authority on social marketing and behaviour change. We are an asset-locked non-profit company - all revenues generated are used to cover operating costs and to further develop the world's most widely used range of social marketing tools, resources and products (over 20,000 downloads in the past two years by users in over 120 countries).

The NSMC CIC is led by the same team of experts as its predecessor. At the behest of existing stakeholders and social marketing and behaviour change practitioners world-wide, we will continue to maximise the effectiveness of behaviour change interventions through policy, training and practice.

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Mission

To maximise the effectiveness of behaviour change interventions through policy, training and practice.

Vision

We are dedicated to making change happen to improve people's lives.

What we do

We make change happen by supporting organisations to design and deliver cost-effective behaviour change programmes. We use a social marketing approach to focus on the changes necessary to encourage people to adopt desired behaviours.

Core competencies

- Enabling national institutions and NGOs to design and deliver their own behaviour change interventions
- Calculating the Value for Money (VFM) of behaviour change and social marketing projects
- Tailored and online training for practitioners, policy makers and senior managers
- Ownership of the Behaviour Change Research Centre (One Stop Shop)
- Building social marketing capacity at local, regional and national levels
- Development and provision of 'best practice' social marketing tools and resources

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1. Executive summary

The National Social Marketing Centre's (The NSMC) involvement in social determinants of health inequalities began in 2008, shortly after the UK Government commissioned The Marmot Review on Health Inequalities.

The Review was set up to propose evidence based strategies to break the cycle of ill-health and deprivation. The report concluded that concerted and systematic action was required at many levels in society and that no single policy or programme focusing on health could have a large enough or sustained impact on these entrenched inequalities.

Since then, The NSMC has been working with a consortium of partners to highlight and put in place measures to tackle the social determinants of health inequalities

During the last three years The NSMC has undertaken extensive research to find a number of UK and international projects and programmes that have utilised a social marketing approach and that have had a significant impact on inequalities.

This report describes these projects, exploring how using social marketing techniques can have real benefits in developing interventions that tackle health inequalities. By highlighting these case studies we hope to demonstrate how this kind of approach can be replicated elsewhere.

The projects included in this report show that it is possible to have a sustained impact on inequalities by:

- supporting the adoption of very specific behaviours by carefully segmented target groups;
- using research techniques to understand the main barriers and motivators for adopting each specific behaviour;
- using this audience insight to develop the most practical and cost-effective interventions needed to influence the behaviour of target audiences; and
- working to create the enabling environment needed to make it easier for people to adopt and maintain the desired behaviour over time.

The report concludes by calling for a public, third sector and private organisations to implement a range of actions.

Central Government

- **Action 1:** build a comprehensive evidence base of "what works" to ensure all behaviour change programmes are effective and targeted.
- **Action 2:** ensure, without exception, that all national programmes can be translated into action at local level through harnessing the skills, expertise and knowledge of local communities.

Local Government

- **Action 3:** ensure that local government plays a much more coordinated and active role on health inequalities. With the "public health" discipline now situated firmly in local government it is possible to have much more control on the "whole" environment people live in.

National Health Service (NHS)

- **Action 4:** concentrate on developing and implementing more targeted effective behaviour change programmes which are aimed at reducing health inequalities.
- **Action 5:** increasingly turn itself from a service that largely treats sick people to a service that promotes good health and wellbeing through all stages of people's lives and encourages people to take preventative actions against getting sick.

Charities/Non-Government Organisations (NGOs)

- **Action 6:** improve the sharing of good practice and learning together to avoid duplication and wasting of scarce public resources.

The Private Sector

- **Action 7:** work with the education sector and local government to provide training and employment possibilities by investing in local community enterprises.
- **Action 8:** invest in infrastructure which directly benefits residents such as social/activity centres.
- **Action 9:** utilise CSR budgets more creatively and effectively to create employment opportunities.
- **Action 10:** take a leading role in sponsoring local community projects.
- **Action 11:** ensure workplaces become centres of wellbeing.

We hope this report demonstrates the important role that social marketing can play in developing behaviour change strategies to combat the social determinants of health inequalities in England.



2. The top four lessons that social marketing offers policy makers

The top four lessons from social marketing that can help policy makers in their efforts to address the social determinants of health.

1. Social Marketing can help policy makers to focus on the specific priority behaviours we can realistically influence today while also mobilising public demand for the environmental changes that are needed to influence the wider social determinants of health.

2. Social Marketing programmes have a greater chance of sustained success if they take a two-pronged approach to try and influence the internal (psy-

chological) and external (environmental) factors that influence how we behave. For example, any programmes designed to motivate responsible alcohol consumption must also address key environmental factors such as accessibility, price and the intensive marketing of competing products.

3. Social marketing can help to make the most cost-effective use of limited public resources by:

- a. Utilising existing strengths, resources and opportunities from within communities
- b. Pre-testing effective approaches at a local scale
- c. Making preventative action to address emerging social problems

4. Social marketing can provide government agencies, NGOs and the private sector with a transparent platform for working together because it is clearly based on providing evidence of sustained behaviour change as the bottom-line indicator of success.



3. Objective and structure

The National Social Marketing Centre (The NSMC) supported the Marmot Review on Health Inequalities in England by working to identify and disseminate those behaviour change initiatives that have had a positive and sustained impact on the social determinants of health inequalities.

This report evaluates the impact that these selected interventions have had on the social determinants of health (SDH) and makes clear recommendations on how government agencies, NGOs and the private sector could work to deliver similar positive impacts throughout England.

The report:

- Defines the social determinants of health inequalities and provides an overview of the impact they have on people's lives (and premature deaths) in England;
- Outlines the programme of work that has been delivered by The NSMC over the last four years as part of the overarching Marmot Review to reduce health inequalities in England;
- Explains the core principles of social marketing (SM) and how developing and implementing a SM approach can have an impact on the social determinants of health;
- Identifies a number of social marketing projects and programmes that are of importance either because (a) they have had/or could have had an impact on SDH and (b) could be replicable elsewhere in England; and
- Provides recommendations for policy makers working in the social determinants of health sector.

4. The social determinants of health – the Marmot Review, strategic review of health inequalities in England post-2010

The Marmot Review was set up by the Secretary of State for Health to identify the most effective evidence based strategies for reducing health inequalities in England.

One of its most startling findings was that many people who are currently dying prematurely each year as a result of health inequalities in England would otherwise have enjoyed in total between 1.3 and 2.5 million extra years of life. It reveals that people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest neighbourhoods. Even more disturbing, the average difference in disability free life expectancy is 17 years. So people in poorer areas not only die sooner, but they also spend more of their shorter lives with disability.

The Review concludes that the most important determinant as to whether a person leads a “healthy long life” is not poor access to healthcare services or lifestyle issues, but where a person sits on the social gradient. The lower a person’s social position, the worse his or her health and the more likely they are to die prematurely.

When we consider the social determinants of health, it is clear to see why there will continue to be health inequalities. This is because persisting inequalities across key domains remain, including:

- inequalities in early childhood and education;
- employment and working conditions;
- housing and neighbourhood conditions; and
- standards of living.

The key message is that action is required across all of these domains if we are to have any real impact on health inequalities. The Review therefore recommended that reducing health inequalities requires action on six cross cutting policy objectives¹.

These were:

1. Every child has the best start in life
2. All people can maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure a healthy standard of living for all
5. Create healthy and sustainable places and communities
6. Strengthen the role and impact of ill-health prevention

"The key message is that action is required across all of these domains if we are to have any real impact on health inequalities"

1. Further details on the six policy objectives are given in the publication "Fair Society, Healthy Lives". The Marmot Review (2008). Accessed 2012:
www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review



5. The National Social Marketing Centre programme of work

A key focus of the work of The NSMC over the life of the programme has been to disseminate good practice, both from the UK and abroad.

Activities undertaken by The NSMC to date include:

- A research report informing the Marmot Review (Access to public services by hard to reach groups with a particular emphasis on identifying proven models of empowerment);
- Delivery of three international Social Marketing Business Schools where we have trained individuals delegates on how to utilise social marketing approaches to tackle social determinants of health inequalities;
- Attended 15 national/international conferences on health inequalities - providing practical workshops to participants on using social marketing techniques to support projects aimed at reducing health inequalities;
- A research report on access to primary care by disadvantaged groups in England;
- Production of three short films highlighting successful SDH programmes across Europe with the development of an associated on-line learning platform. The films are now used in learning institutions throughout the world and collectively have been viewed by more than 20,000 on YouTube;
- A research study investigating how access to primary care can be improved for disadvantaged groups in England and Wales;
- Developed and implemented a strategic marketing and communications strategy for international collaboration on SDH;
- Provided social marketing advice to each of the international collaboration partners;
- Employed two international high level health specialists to identifying international collaboration and partnering opportunities to address health inequalities within and between countries in Europe and Africa; and
- Technical assistance provided to develop the Health Action Partnership International website to ensure dissemination of SDH learning and global information exchange .

6. What is social marketing and how can it help?

Social marketing is a planning approach that is used to encourage the adoption of specific behaviours that are seen as being beneficial for both individuals and wider society. Social marketing as defined by The NSMC is "an approach used to develop activities aimed at changing or maintaining people's behaviour for their benefit."

Traditionally, social marketing has been most widely applied in health settings and been used to address public health issues such as smoking, obesity, communicable diseases and alcohol misuse.

In order to achieve its specific behavioural objectives a social marketing initiative will look to develop the most effective mix of interventions. These interventions may include: the provision of information, new products and services, regulations and enforcement, incentives, or even changes to the physical environment such as speed bumps or cycling lanes. In recent years the social marketing approach has also been used to develop more effective ways for socially and economically disadvantaged groups to access services such as smoking cessation and cancer screening programmes.

Social marketing is often distinguished by its focus on:

- Supporting the adoption of very specific behaviours by carefully segmented target groups;

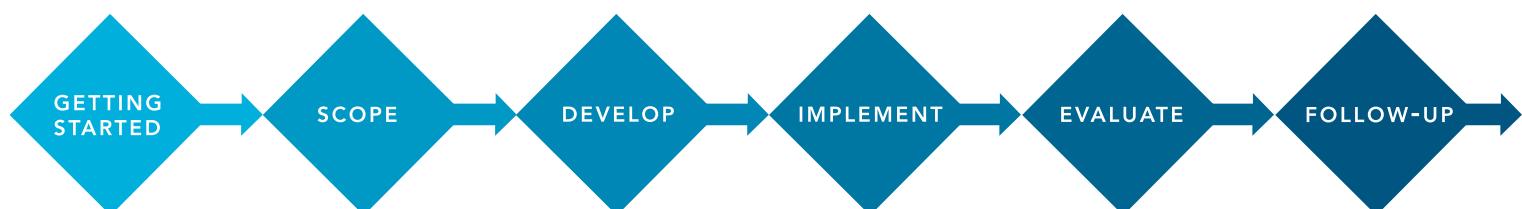
- Using social research techniques to understand the main barriers and motivators for adopting each specific behaviour;
- Using this audience insight to develop the most practical and cost-effective interventions needed to influence the behaviour of target audiences;
- Working to create the enabling environment needed to make it easier for people to adopt and maintain the desired behaviour over time.

Social marketers often use the terms 'downstream' to refer to individual behaviour and 'upstream' to refer to the root causes of various social issues and problems and how policy can address these. A fundamental objective of social marketing is to find the most cost-effective ways to address the most relevant psychological, social and environmental factors that influence an individual's behaviour.



For some public health problems, any interventions designed to influence voluntary individual behaviours are unlikely to have a long lasting impact until the most relevant 'upstream' factors are also addressed. For example, the rise in childhood obesity rates has been influenced by a number of factors such as the increased availability of high energy foods and the reduced physical activity levels caused by factors such as increased television and computer usage.

Social marketing can therefore help policy makers working to tackle the social determinants of health inequalities to gain a deeper understanding of the different barriers and motivations faced by target populations in the voluntary adoption of very specific behaviours. It can also help governments to identify the limits of what they can realistically expect to achieve through programmes designed to influence voluntary individual behaviour. By doing this social marketing can also help to create the awareness and support needed to introduce upstream measures needed to reshape the environment in a way that can accelerate the adoption and maintenance of beneficial behaviours.



The six-stage social marketing planning process

7. Criteria to judge which social marketing projects should be included in the report for analysis

The objective of this report is to highlight a number of social marketing projects and programmes that have had a positive and sustained impact on the social determinants of health inequalities.

To do this effectively we have developed a set of criteria based on the six policy priority objectives developed by Marmot in his strategic review.

This criteria was used to assess over 100 projects which are either contained in our social marketing best practice resource (ShowCase), have been submitted to us by third parties, or have been identified by our Research Department. All cases included in the ShowCase database have been assessed against The NSMC's National Benchmark Criteria², which include the eight key elements that our international research has determined are essential for developing successful social marketing interventions.

Some of the recommendations for action outlined in the Review are high level and require government action - for example, changing taxation and fiscal policies to reduce gaps in absolute and relative income. However, there are some recommendations that can be addressed using social marketing and behaviour change practice especially in relation to ill-health prevention.

Table 1 lists Marmot's six key policy objectives. We have then highlighted in red the priority objectives which evidence suggests could be aided by the application of social marketing.

2. www.thensmc.com/sites/default/files/benchmark-criteria-090910.pdf. Accessed July 2012.

TABLE 1

Policy Object A: Give every child the best start in life <ul style="list-style-type: none">• Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills.• Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.	NSMC Criterion 1: Projects which attempt to reduce inequalities by promoting the health and well-being of parents and children
Policy Objective B: Enable all children, young people and adults to maximise their capabilities and have control over their lives <ul style="list-style-type: none">• Reduce the social gradient in skills and qualifications• Ensure that schools, families and communities work in partnership to reduce the gradient in health, wellbeing and resilience of children and young people• Improve the access and use of quality life-long learning across the social gradient	NSMC Criterion 1: Projects which attempt to tackle the deep seated causes of inequalities through the creation of effective and sustainable partnerships to enhance skills and life chances of people living in their communities
Policy Objective C: Create fair employment and good work for all <ul style="list-style-type: none">• Improve access to good jobs and reduce long term unemployment across the social gradient• Make it easier for people who are disadvantaged in the labour market to obtain and keep work• Improve quality of jobs across the social gradient	NSMC Criterion 1: Projects that promote life chances for people in disadvantaged circumstances over the long term
Policy Objective D: Ensure a healthy standard of living for all <ul style="list-style-type: none">• Establish a minimum income for healthy living for people of all ages• Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies• Reduce the cliff edges faced by people moving between benefits and work	NSMC Criterion 1: Projects that promote improved living standards through providing opportunities to disadvantaged groups in society.
Policy Objective E: Create and develop healthy and sustainable places and communities <ul style="list-style-type: none">• Develop common policies to reduce the scale and impact of climate change and health inequalities• Improve community capital and reduce social isolation across the social gradient	NSMC Criterion 1: Projects that create and develop healthy sustainable communities by improving community capital and reduce social isolation
Policy Objective F: Strengthen the role and impact of ill-health prevention <ul style="list-style-type: none">• Prioritise prevention and early detection of those conditions most strongly related to health inequalities• Increase availability of long-term and sustainable funding in ill-health prevention across the social gradient	NSMC Criterion 1: Strengthen the role and impact of ill-health prevention by prioritising prevention and early detection of those conditions most strongly related to health inequalities

"We have created our own selection criteria based on the overall policy objective and the priority objective that aligns best with social marketing practice"

For each of Marmot's policy objectives we have created our own selection criteria based on the overall policy objective and the priority objective that aligns best with social marketing practice. We then used these criteria to determine which of the social marketing/behaviour change projects should be included in the report for further analysis.

We therefore looked for projects that:

1. Attempted to reduce inequalities by promoting the health and well-being of parents and children
2. Attempted to tackle the deep seated causes of inequalities through the creation of effective and sustainable partnerships to enhance skills and life chances of people living their communities
3. Promoted life chances and living standards for people in disadvantaged circumstances over the long term
4. Created and developed healthy sustainable communities by improving community capital and reduce social isolation
5. Strengthened the role and impact of ill-health prevention by prioritising prevention and early detection of those conditions most strongly related to health inequalities
6. Can be up-scaled to have regional/national impact
7. Demonstrated value for money and are sustainable
8. Provide valuable lessons for policy makers

Clearly we could not expect the projects to pass all the eight criteria set above for inclusion in this report. However, we have judged that projects/programmes must contain elements of at least five of the criteria for them to be included for discussion and dissemination (See table in Appendix 1).



8. Introduction to case studies

This section of the report has also been designed as an interactive page on The NSMC website including links to project videos, communications materials and more detailed information on project design, implementation and evaluation. To enter, please visit www.thensmc.com and go to the section of the site dealing with Health Equity.

The examples of social marketing included in this report have been selected because we believe they provide important lessons for those organisations that want to influence the wider social determinants of health. According to the World Health Organisation (WHO) the social determinants of health are “the conditions in which people are born, grow, live, work and age, including the health system”. Although social marketing is a process that is specifically designed to influence very specific individual behaviours, it has also been used extensively to shape the external conditions that influence the adoption and maintenance of these behaviours by large groups of people.

Social marketing is a planning system that uses research techniques to design behaviour change interventions for large population segments

and we now have compelling evidence that it can achieve measurable and sustained changes in behaviour. This is because it starts by trying to understand the factors that influence specific behaviours the process has already helped a number of government agencies and NGO's to improve the integration of existing influencing tools such as: regulation and enforcement, public services and products, economic incentives and the provision of information.

The case examples included in this report demonstrate how government agencies and NGO's have applied social marketing to successfully increase the adoption of healthy behaviours such as stopping smoking, going for a breast examination, or eating more fruit and vegetables. Other examples looked at how social marketing can be used to address important social issues such as crime, problem gambling, unemployment, and road safety. All of these cases demonstrate practical and cost-effective attempts to change the social and environmental contexts that shape many of our (often unconscious and habitual) behaviours.

The bottom line objective of any social marketing programme is to

achieve measurable and sustainable changes in human behaviour. In their efforts to achieve cost-effective and sustainable change many of these social marketing efforts also reveal important lessons about what government agencies and NGO's in liberal democracies can realistically expect to achieve when working to change the external factors that shape the way people behave on a daily basis. At the very least these case examples clearly demonstrate the need for public bodies to do more than simply tell people how they should behave. All of the examples show how governments and other organisations can work with different audiences to help shape the internal and external factors that enable sustained change to occur.

As social marketing combines focused audience research with a whole systems approach it can help to ensure that public programmes and services are more client-focused, coordinated and cost-effective. But it moves well beyond traditional communications and educational approaches by helping to highlight the need for changes to the wider environment that will make it easier for people to adopt and maintain behaviours that are good for themselves and wider society.

"The case examples included in this report demonstrate how government agencies and NGO's have applied social marketing to successfully increase the adoption of healthy behaviours"

Social marketing can help public bodies to design more targeted programmes to improve the health and wellbeing of people from socially disadvantaged groups. Due to its singular focus on changing very specific "voluntary" behaviours, social marketing also forces programme designers to ask questions about how they can influence the wider environmental factors that make it easier for everyone in society to adopt and maintain these positive behaviours.

Most of our case examples focus on health because many of the main advances in social marketing have been based on hard won successes in areas such as tobacco control, family planning and HIV prevention. Some projects demonstrate how the social marketing approach can help to build greater social capital and stronger community partnerships by providing a shared focus on measurable behaviour change and tangible evidence of success. Yet others demonstrate how government agencies and NGO's can achieve real economies of scale by supporting community-based pilots that generate real insights into what changes are needed to support real and positive change in our societies over the long-term. By trialling these insight-driven interventions at the local level public bodies are in a much stronger position to know how to balance national policy objectives with the realities of local implementation.



Case 1: England's national marketing strategy for tobacco control

2007-2010 • Meets NSMC criteria: 1, 2, 3, 4 and 6

Smoking is the primary cause of health inequalities in life expectancy and the single greatest avoidable cause of death and disease in the UK. Every year 80,000 people die prematurely as a result of tobacco use resulting in £2.7b direct costs to the NHS and £2.5b in sick leave and lost productivity.

Between 1998 and 2007 adult smoking rates in England had fallen from 28 per cent to 21 per cent, representing over 1.6 million fewer smokers. However the Government's national marketing campaigns had not been as successful in helping to reduce higher smoking prevalence among Routine and Manual (R&M) workers.

In 2007 the Department of Health England developed a new and innovative marketing strategy to address smoking prevalence among R&M workers to 26 per cent or less by 2010.

1. How did the project address the social determinants of health?

At the start of the project there were 4.25 million R&M smokers in England but it was estimated that prevalence would fall naturally to 28.2 per cent by 2010. However, with a £45 million investment in marketing activity, it was expected that prevalence would drop further to 26.5 per cent. In order to achieve this target some 317,000 R&M smokers would need to quit as a direct result of the social marketing activity.





2. How did the project apply a social marketing approach?

The Department of Health developed a new marketing strategy that was built on key insights into the R&M target group. The research found that:

- Family was very important but smoking was also much more of a social norm among this R&M group
- Many viewed smoking as one of their few pleasures in life
- Their impression was that the majority of people smoke, yet they are made to feel like 'social lepers'
- Many were unaware of the benefits of using NHS Stop Smoking Services and more likely to try and go cold turkey
- They would often relapse because of the lack of emotional support from partners and peers
- They felt impervious to existing advertising messages and that services weren't designed for people like them
- These insights were used to develop a new two-pronged Marketing Strategy that focused on the harm being done to a smoker's family as a way of driving people towards NHS stop smoking services.
- Rather than simply focusing on "motivation" the new marketing approach focused on:
- Encouraging smokers who want to quit to make a quitting-related action, such as phoning the helpline and;
- Encouraging people to use NHS support (which had been proven to be far more successful in helping people to maintain long-term quits).
- This approach was based on the central insights that:
"I can harm myself if I like but I've got no right to worry my kids"
"The fags might not kill me for years but I know they're worrying my family right now"

Much of the marketing focused on the fact that the children of smokers were 3 times more likely to become smokers themselves. It also focused on the emotional driver that many children worried about the health of their parents and would do anything to help them stop. By making

smoking a family issue it was far more difficult for the audience to deflect this new approach. The marketing effort also worked to raise awareness of the different forms of NHS support and to normalise these services by showing them being used by people like them.

A new "Quit Kit" was designed as a direct marketing tool that would appeal to cold turkey quitters. By taking a pragmatic view that not all R&M smokers would want to immediately use the NHS services they were able to build relationships with a huge number of "new" contacts. Between January and March 2010, over 480,000 'Quit Kits' were ordered, and 95 per cent of these orders were from people who had not responded to previous marketing efforts.

The project also utilised a range of direct community-based marketing activities such as "pop up" shops in R&M "hot spots" and onsite clinics with big employers such as ASDA with 360 separate supermarket sites.

3. What impact did it have?

As a result of the marketing activity it is estimated that over 1.5 million people from the R&M group made quit attempts and nearly 220,000 successfully sustained their quit 1 year later. Over two years, the customer relationship marketing programme increased quitting success rates among participants by 57 per cent.

Key lessons

The insights generated via audience research can be used to determine the best mix of tools needed to support smokers to make successful quit attempts and change the social norms that continue to make smoking normal for significant segments of our population.

The social marketing approach can help to design a more integrated approach that can directly respond to the unique needs of different audience segments such as R&M smokers. This project demonstrated the need to empower people with the confidence and tools to break down a daunting behavioural challenge into manageable steps and to understand how support services can be made more attractive target audiences.

The investment in this national social marketing programme translated into many other local campaigns aimed to tackling the issue of high incidence of smoking in the R&M groups. One of the most successful was a social marketing programme developed by NHS Stockport in North-west England.

NHS Stockport – Lose the Fags: reducing smoking prevalence in a deprived community in North West England

July 2009 to date

This community social marketing project, led by NHS Stockport in partnership with The NSMC, aimed to increase access to smoking cessation services in Brinnington, a housing estate in Stockport ranked in the top 3 per cent of the most deprived areas of England. It suffers high unemployment, low education levels, premature death – with a high smoking prevalence of 54 per cent.

1. How did the project address the social determinants of health?

NHS funded smoking cessation services initially attracted residents of the area but its popularity had steadily declined over a period of years. Smoking is very much part of life in Brinnington and it lies at the heart of many daily social interactions. Indeed stopping smoking was seen as going against the social norm. People complain of being stressed as a result dealing with financial worries, unruly family members and caring for children without the support of partners. For many people in the community, smoking provides an emotional crutch.

Despite these factors, research revealed that many women especially with children did actually want to quit, driven by fear of ill-health while also trying to provide a positive role model to their children. However, low confidence levels and practical issues around childcare prevented them from taking action. For men in the community, who often worked in irregular shift patterns, out of hours access was essential. In addition there was a lack of trust in "authority". Residents perceived that they were being bombarded by "outsiders" offering help. To have any chance of success, the development of the intervention would need to be co-created with key community members and be situated in a trusted safe and familiar environment.

- The intervention for men: A convenient stop-smoking support at a local gym, available from 7am to 9pm where fitness instructors had been trained as smoking cessation advisors and were able to deliver vouchers for NRT, which could be exchanged at the local pharmacy. Additionally an anger/stress management advice was provided.
- The intervention for women: A child/mother friendly service was set-up at a local community centre serving refreshments providing a crèche. The aim of the social marketing intervention was to build skills and confidence to ensure that participants were able to increase their self-esteem to tackle the issue of cigarette addiction.

2. Key impacts and lessons learnt for policy makers

The project was a triumph for developing long-term community partnerships. Many of the established organisations in the local area integrated smoking cessation services as part of their core offering. This singular focus on lowering the smoking rate helped to build greater social capital and belief that local resources could be mobilized to improve the health of the community. Quit attempts increased by 47 per cent in the first year of the project (from 149 to 220 with successful quits rising from 60 to 84.)



Case 2: reducing graffiti vandalism in brent

2006 – ongoing • Meets NSMC criteria: 1, 2, 3, 4 and 5

In 2006, Brent Council was spending approximately £450,000 a year cleaning up graffiti.

The Brent Graffiti Partnership Board used a social marketing approach to design a project that combined stronger enforcement with diversionary activities to help steer young people away from graffiti vandalism. This approach helped to reduce graffiti vandalism by 25 per cent and increased the percentage of residents who felt that the clean streets were a good thing about living in Brent.

1. How did the project address the social determinants of health?

This project was specifically designed to improve the physical and social environment of the Brent community. With no direct funding the project used stronger community partnerships and a greater understanding of young people to build benefits for the entire community.

By working to understand the drivers of graffiti behaviour the project was able to identify alternatives that provided the same sense of risk for young people while also contributing to their self-esteem and greater community pride in the wider Brent environment.

The project led to improved community networks, reducing social isolation of the target groups. It also improved living conditions local residents, a factor which has also been shown to have a positive impact on mental and physical health and wellbeing.

2. How did the project apply a social marketing approach?

Because the Brent Graffiti Partnership Board had no direct budget the project had to take a more integrated approach that built on the strategic objectives of the contributing agencies. The project generated insights from young people, graffiti offenders, victims of graffiti vandalism and local residents to develop an approach that included:

1. Diversionary activities such as:

- The creation of community public artworks
- Workshops and competitions in street art
- Parkour (free running) and
- Football sessions



2. The council also introduced stronger enforcement activities that directly resulted in penalties for 40 prolific taggers. Prior to the project no tagger had been apprehended or punished.

3. What impact did it have?

The project significantly reduced levels of graffiti and helped to provide many of the most disaffected young people with opportunities to build new skills and greater self-confidence. The project also led to greater community pride and a survey found that the percentage of residents who felt that the clean streets were a good thing about living in Brent increased from 13 per cent in 2005 to 21 per cent in 2009. The project also helped to strengthen relationships among a wide range of agencies and community stakeholders and provide a model for addressing other social problems in the community.

Key lessons

The project demonstrated the importance of providing a two-pronged approach that combined enforcement with attractive alternatives based on a deeper understanding of what was motivating the current behaviour of the target audience.

It also found that these alternatives had to provide an appropriate replacement for the benefit that the current behaviour was providing the target audience. That is why the risk and challenge provided by Parkour proved to be one of the most successful activities embraced by young people previously most engaged in graffiti tagging.

The project also demonstrates that, if necessary, local social marketing programmes can be implemented with little or no funding where community partnerships can be adequately leveraged.

Case 3: using marketing to maintain support for Sweden's alcohol monopoly

2002 – ongoing • Meets NSMC criteria: 2, 3, 4, 5 and 6

Social marketing programmes have helped to significantly lower rates of illness and premature deaths among some of the most vulnerable groups in society.

To date most examples of social marketing in the United Kingdom have focused on influencing the behaviour of specific target audiences at the community level. However, in Scandinavia, it is well known that several countries have worked to maintain low levels of alcohol consumption by reducing access through state-owned retail monopolies shops and expensive taxation policies. The following example examines how a national social marketing campaign in Sweden worked successfully to maintain public support for this policy approach, despite major pressures from the private sector.

Alcohol is considered the fifth leading risk factor for death and disability in the world. Sweden once had high rates of alcohol consumption but now it is amongst the lowest in Europe. However, due to factors such as increases in accessibility and disposable income, alcohol consumption increased significantly in Sweden from 7.8 litres of pure (100 per cent) alcohol in 1995 to 10.2 litres in 2005.

As rates of alcohol consumption are affected by accessibility, price and the marketing activities of alcohol companies, the Swedish government decided to use an "upstream" social marketing approach to maintain public support for the country's alcohol retail monopoly.

"Systembolaget" has a nationwide retail network of 418 stores and over 500 agents serving smaller communities. Its vision is to promote a "healthy drinking culture" where people are encouraged to focus on the quality and not the quantity of their drinking. The stores are brand-neutral which means promotion of individual products or producers is avoided, which allows the advice to be provided entirely on the customer's terms. It is based on a non-profit idea because a lack of profit, along with limiting availability to specific shops with restricted opening hours, is expected to limit consumption.

Rather than focus on voluntary behaviour change, this use of marketing focused on influencing the choice architecture that influences the purchasing behaviour for alcohol products. When Sweden joined the EU in 1995 there was increasing pressure to open up the country's alcohol market to the private sector but government marketing activities helped to ensure on-going public support for maintaining the alcohol monopoly.

1. How did the project address the social determinants of health?

A 2002 study estimated the negative societal cost of alcohol consumption in Sweden at 29.4 billion kronor, or 1.3 per cent of GDP. This same study estimated that alcohol consumption led to a net loss of 121,800 Quality Adjusted Life Years. It has also been estimated that an alcohol monopoly keeps consumption down by 30 per cent compared with a free market where alcohol can be bought in any retail store³ (Holder, H. (ED). (2007)

High levels of alcohol consumption are prevalent at relatively higher levels of the social gradient than other "risky" behaviours such as smoking, drug-use and poor diet. Health inequalities exist across the social gradient.

2. How did the project apply a social marketing approach?

A Swedish advertising agency was commissioned to carry out a series of inter-related media campaigns to increase public understanding of the benefits of the alcohol monopoly while also increasing customer satisfaction with the service and selection of products provided by Systembolaget.

From 2002 the campaign focused on presenting facts about what would be likely to happen if the monopoly was removed. For example, the 2007 campaign focused on communicating findings from a report by the Swedish National Institute for Public Health that estimated selling alcohol in grocery would result in 1580 alcohol-related deaths, 14,200 assaults and 16.1 million sick days.

3. What impact did it have?

Before the first campaign was launched in November 2002 public surveys found that 49 per cent of people wanted to maintain the alcohol monopoly. By the end of 2002 this figure had risen to 57 per cent. The 2007 campaign saw this approval rating increase from 57 per cent to 65 per cent in November 2007.

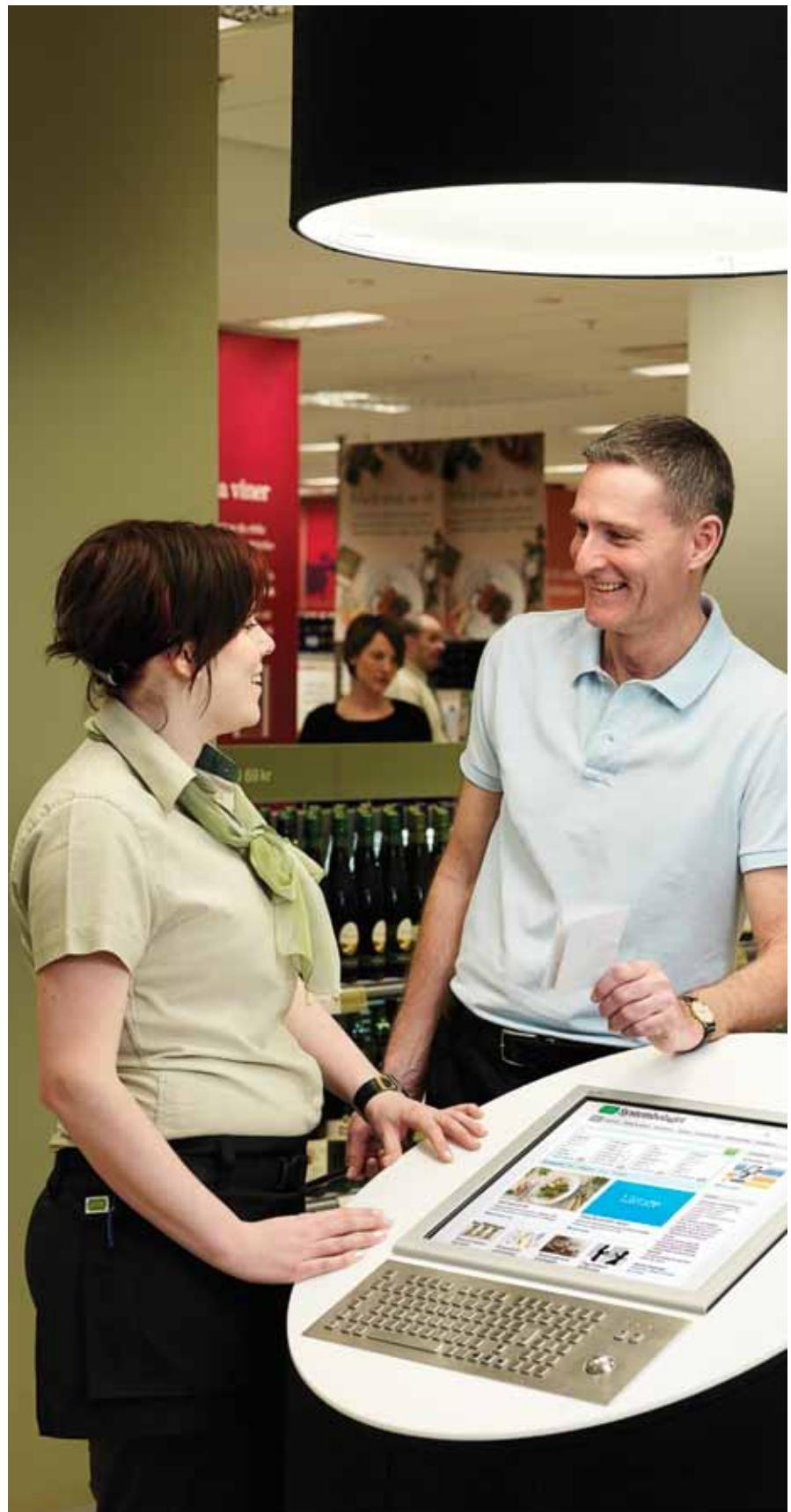
"Rather than focus on voluntary behaviour change, this use of marketing focused on influencing the choice architecture that influences the purchasing behaviour for alcohol products"

3. Holder, H. (ED) 2007: If retail sales in Sweden were privatized, what would be the consequence? Swedish National Institute of Public Health. Via www.fhi.se

4. Key lessons

This project demonstrates the role that social marketing approaches can provide in shaping or maintaining the choice architecture that shapes our behaviours. By increasing customer satisfaction with its alcohol monopoly the Swedish Government has avoided the need for expensive public campaigns focused on increasing responsible drinking at an individual level.

Social marketing campaigns that focus solely on changing individual "voluntary" behaviour without addressing key environmental factors such as accessibility, price and the intensive marketing of competing products are highly unlikely to succeed in reducing ingrained behaviours such as high levels of alcohol consumption.



Case 4: Food Dudes

2005 – ongoing • Meets NSMC criteria: all

There has been considerable debate on what actions are most likely to have the biggest impact on reducing health inequalities.

However, it is accepted that implementing programmes that are aimed at and have an impact on children and young people should be prioritised. The following social marketing programme successfully developed a significant change in eating habits of young people.

The Food Dudes programme has been consistently effective at increasing the consumption of fruit and vegetables among 4- to 11-year-olds. Following significant success in Ireland the programme was launched as a city-wide project in Wolverhampton in 2009 and it was awarded the Gold medal at England's Chief Medical Officer's Public Health Awards 2010.

The programme comprises three key elements:

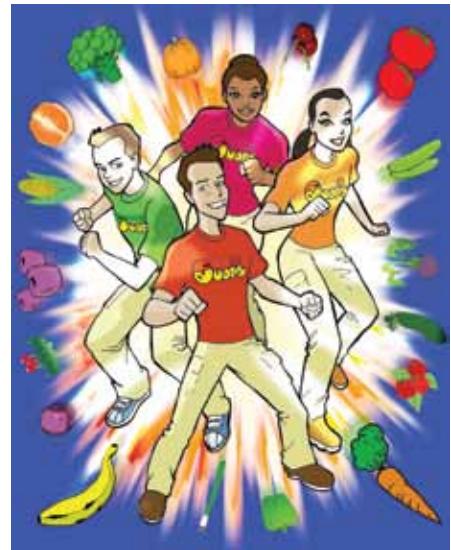
1. DVD adventures featuring hero figures - the "Food Dudes" - who like fruit and vegetables and provide social models for children to imitate
2. Small rewards to ensure children begin to taste new foods
3. Repeated tasting of fruit and vegetables so that children develop a liking for these foods

Food Dudes letters and home packs provide on-going home support to ensure the behaviour change transfers from school to family and is maintained over time.

1. How did the project address the social determinants of health?

Although diet is an individual lifestyle factor, it has been shown that the incidence of poor dietary intake is higher amongst lower socio-economic groups. Changing the eating behaviours of young people can have significant longer term impacts.

A diet rich in fresh fruit and vegetables is vital for health and wellbeing but low fruit and vegetable intake can lead to a variety of serious illnesses, such as cardiovascular disease, stroke and cancer. The recommended "5-a-day" means eating at least 400g of fruit and vegetables a day but the UK has one of the lowest fruit and vegetable intakes in Europe.





Current British consumption levels are estimated to average only 245g and, in some age and social groupings, the real figure is substantially lower, especially among the poorest children.

2. How did the project apply a social marketing approach?

Food Dudes is based on the "Three R's" of role-modelling, rewards and repeated tasting. It uses positive role-models, repeated tasting and rewards to encourage children to try and to learn to like fruit and vegetables. Food Dudes works on the premise that these simple techniques can be used to encourage children to try new foods and to re-categorise themselves as fruit and vegetable likers.

A strong brand was developed to compete with the cartoon figures and imagery used to market high sugar, fat and salt foods to

children. The programme also sought to utilise peer pressure by getting older peers on board and making it "cool" to eat fruit and vegetables.

The programme focused on overcoming the barriers of getting children to eat fruit and vegetables by creating a positive environment (at home and school) in which they are encouraged to try new foods and develop a taste for them. Following the adventures of the Food Dudes DVD is a fun experience to share with friends and giving children pencils, beakers and small toys to reward good behaviour rewards participation.

Children come to see themselves as 'fruit and vegetable eaters' and are proud of this new identity and they gain kudos and self-confidence from being able to succeed on the programme. Early rewards, such as stickers

"A strong brand was developed to compete with the cartoon figures and imagery used to market high sugar, fat and salt foods to children"

and juggling balls, are used to encourage children to taste new foods, but these are eventually phased out and replaced by the longer-lasting incentive of enjoying the taste of these foods.

3.What impact did it have?

Starting in 2005, the programme was piloted over a two-year period in two primary schools in Dublin. In these trials the fruit consumption of five- to six-year olds more than doubled, from 28 per cent to 59 per cent over six months, while vegetable consumption increased from 8 per cent to 32 per cent.

This was true even when popular sweet and savoury snacks were presented alongside the fruit and vegetables, demonstrating

the ability of fruit and vegetables to hold their own against strong food competitors if positive taste patterns can be established. By 2007 the Irish Government had made the Food Dudes programme available to every primary school in Ireland.

In its first year, 22 schools and 5,000 children from Wolverhampton accessed the programme. Initial research in six participating schools found that children increased their fruit consumption by 54 per cent and vegetable consumption by 48 per cent. Following success in Ireland and Wolverhampton the project has been implemented in Bedfordshire, Coventry, Dudley, Yorkshire, Italy, California and Utah.

Key lessons

The use of robust monitoring and evaluation techniques has helped to prove and promote the effectiveness of the "Three R's" role-modelling, rewards and repeated tasting approach in changing and maintain behaviour, and providing value for money for funders.

There are benefits to piloting interventions at the local level. Local pilots can be undertaken with minimal funding and are relatively easy to manage and evaluate. A successful local pilot will generate wide-interest and attract more funding. Pilots that fail to achieve their behavioural objectives will not,



Case 5: increasing the uptake of breast screening in Tower Hamlets

2007 – ongoing • Meets NSMC criteria: 2, 3, 4 and 6

In 2006, breast screening rates in Tower Hamlets were only 51 per cent, compared to the national rate of 76 per cent, and breast cancer was the most common cause of cancer deaths among women in the borough.

In order to address this issue NHS Tower Hamlets allocated £106,000 towards a social marketing project designed to:

1. Encourage members of target audience to attend breast screening; and
2. Make the breast screening service more client-focused.

"Reducing the impacts of illness and premature death has huge impact on all families but it is especially difficult for those from lower social economic groups"

1. How did the project address the social determinants of health?

Specific interventions were focused on white British/Irish and Bangladeshi women, particularly from lower socioeconomic classes, who had been identified as having especially low breast screening attendance rates.

Reducing the impacts of illness and premature death has huge impact on all families but it is especially difficult for those from lower social economic groups where the wider consequences can be particularly devastating for one parent families, wage earners and carers.

2. How did the project apply a social marketing approach?

Interventions included two distinct marketing campaigns for the two different audiences together with associated improvements to the breast screening service.

Bangladeshi women

Research found that this group responded very positively to a clear, directional approach from their General Practitioner (GP) with a message that screening was important for a woman's health and that it was important for her to stay healthy for her

family. A marketing campaign entitled "We're here to help" was fronted by a local female Bangladeshi GP, who was the GP screening lead for Tower Hamlets.

White British/Irish women

The approach for this group emphasised the benefits of screening rather than highlighting the dangers of cancer. A marketing campaign entitled 'I've done it!' was fronted by local white British women who had been screened. Their personal stories were written up as case studies to support media activity and they were also trained to participate in on-going media and community activities.

Service improvements

Specific system changes were designed to encourage greater responsiveness to customer needs:

- A system of "payment per woman screened" was introduced to replace block payments for providers
- A local enhanced scheme was designed to incentivise GPs to increase participation in screening. Payment was based on the number of additional eligible women screened within each practice
- Customer service training was provided for staff and opening times were extended over evening and weekends
- A dedicated breast screening website enabled women to change or cancel appointments can be cancelled or changed
- New communications tools included: redesigned invitation letters, picture-based leaflets, and "talking invitations" aimed particularly at those with poor literacy
- Specific Did Not Attend initiatives were used to follow up women who had missed their appointments
- Community groups called women to discuss their invitation to a breast screening appointment three days prior to their first appointment, or to discuss why they had not attended their appointment during the previous screening round, rebooking their appointments and providing transport for groups of women to attend for screening.

3. What impact did it have?

Breast screening rates increased from 52.3 per cent (2006/07) to 65.9 per cent (2009/10) and overall increase of more than 13 per cent. While rates varied across the participating GP practices, one practice reached a high of almost 80 per cent.

I've done it!

I've been breast screened
Rita

"Having experienced breast cancer first hand, I know how important it is to be breast screened. It's a simple process that doesn't take long and can save your life."

"Don't put it off - get a screen."

Screening is happening in Tower Hamlets today. If you live in the borough and are between the ages of 50 - 70, you'll be sent a letter offering you a screening appointment.

You can also visit your GP to find out more.



Key lessons

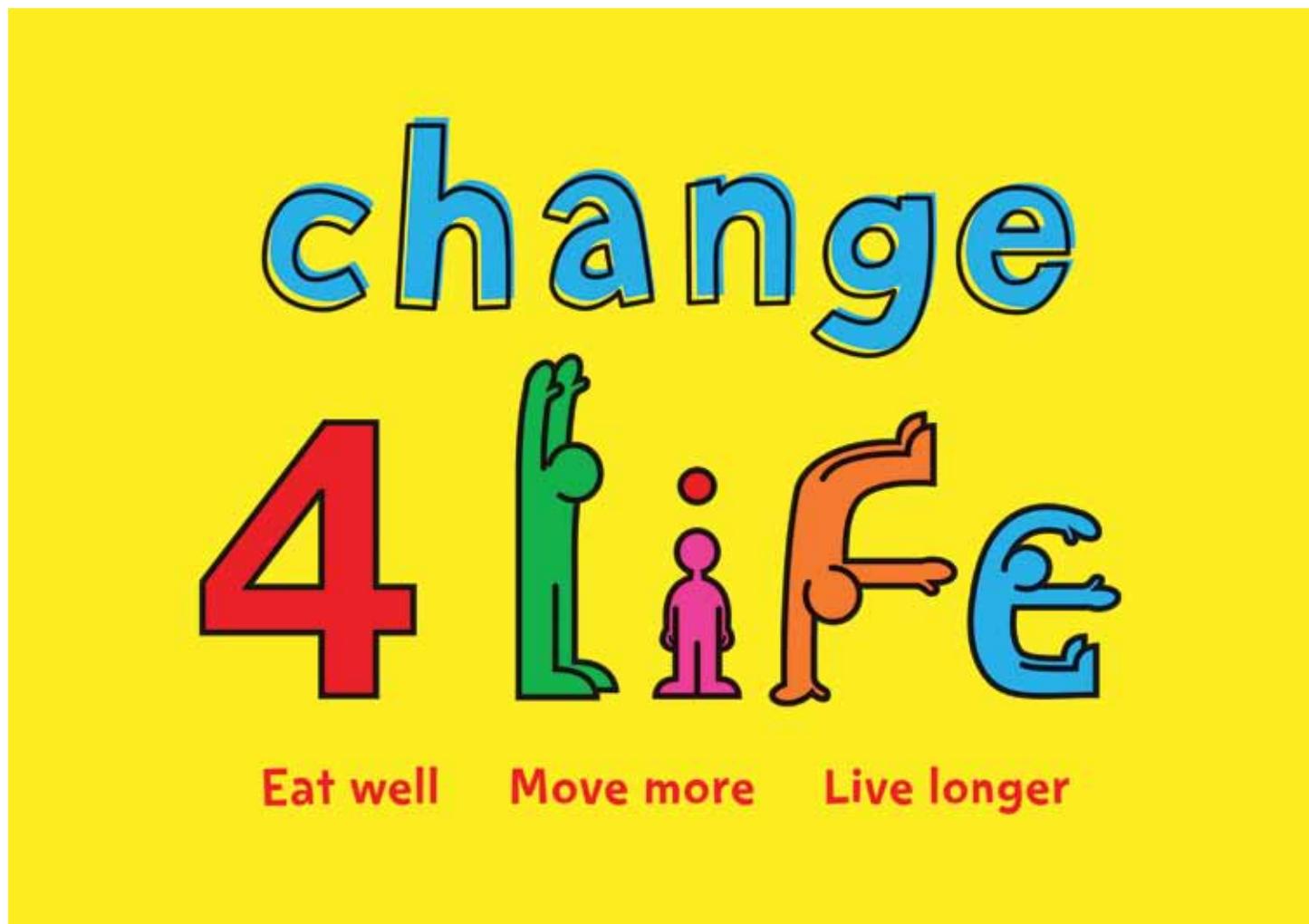
Using a targeted social marketing approach enabled NHS Tower Hamlets to make overall system changes that ensured the whole screening process was more coordinated, client-focused and cost-effective. Extending opening times so that target groups could access screenings at more suitable times is a good example of this as it reduced a key barrier to attendance.

Technology and social media can benefit social marketing programmes. However, it is important to ensure that the level of "internet penetration" is sufficient amongst targeted segments.

The generation of actionable insight greatly increases the chances of success. Tower Hamlets recognised that Bangladeshi women were highly motivated by their need to "stay healthy for their family" and used this insight to shape its messaging.

Case 6: the Change4fe campaign to reduce childhood obesity

2008 – ongoing • Meets NSMC criteria: 1, 2 and 6



The following example investigates an ambitious and challenging national programme that was designed to reducing the rising levels of obesity in children in England.

Change4Life is England's first ever national social marketing campaign to reduce childhood obesity and focuses on changing the eating and physical behaviour of children under 11 from those families at greatest risk. In 2008 the Government announced the allocation of £372 million towards major cross-government

programme designed to change the behaviours and circumstances that lead to weight gain. As part of this programme £75 million was allocated towards Change4Life, a 3-year social marketing programme to help parents make healthier food choices for their children and encourage more physical activity.

1. How did the project address the social determinants of health?

Around one-third of children and two-thirds of adults in England are already overweight or obese. If trends continue as forecast, by 2050 only 1 in 10 of the adult population will be a healthy weight. This could mean a doubling in the direct healthcare costs of overweight and obesity, with the wider costs to society reaching £49.9 billion by 2050.

In order to help all individuals to maintain a healthy weight the government realised it would need to create an environment in which it would be easier for families to make healthier choices. Change4Life recognised the need to:

- Understand the specific attitudes and behaviours needed to prevent obesity in children;
- Work with those families most at risk; and
- Create a wider movement and support for necessary changes to the wider environment that influences our choices and behaviours around eating and physical activity.

2. How did the project apply a social marketing approach?

The campaign initially worked to help families understand the health risks associated with current diets and low levels of physical activity. It then worked to encourage parents to focus on eight behaviour areas including:

1. Reducing sugar intake ('Sugar Swaps')
2. Increasing consumption of fruit and vegetables ('5 A Day')
3. Having structured meals, especially breakfast ('Meal Time')
4. Reducing unhealthy snacking ('Snack Check')
5. Reducing portion size ('Me Size Meals')
6. Reducing fat consumption ('Cut Back Fat')
7. 60 minutes of moderate intensity activity ('60 Active Minutes')
8. Reducing sedentary behaviour ('Up & About')

At-risk families were given the opportunity to sign up to an on-going Customer Relationship Management (CRM) programme designed to support these new behaviours. Delivered online and by post, this programme provided encouragement, information and support for families to get their children eating better and moving more. The 'How are the kids?' mechanism was the main entry point for most of the 200,000 families that joined the Change4Life CRM programme which provided families with helpful information, games and resources such as pedometers.

At the start of the programme seven commercial organisations had signed the Change4life terms of engagement and made pledges to support the campaign. Activity has included:

- Providing lower-cost fruit and vegetables (Tesco)
- Selling 70,000 family bikes at cost (ASDA)
- Sponsoring the London Marathon as the Flora Change4Life London Marathon (Unilever)
- Funding breakfast clubs (Kellogg's)
- Funding free swimming for all customers (British Gas)

With the change in government in Summer 2010, the new coalition government has progressively scaled back Labour's £75 million marketing budget for Change4Life in its plans to cut its advertising spending by up to 50 per cent. The Health Secretary, Andrew Lansley, has been asking the food and drink industry to take greater responsibility for funding the anti-obesity initiative in exchange for no new regulation.

As part of this new approach, the 'Great Swapathon' campaign was

The image is a promotional poster for the NHS Start4Life campaign. It features a stylized green human figure standing against a yellow background. The figure is holding a small red baby in its arms. In the top right corner, the blue and white NHS logo is visible. To the right of the figure, the text "all's well that starts well" is written in a bold, red, sans-serif font. At the bottom right, the "start4life" logo is displayed in a colorful, playful font with a small illustration of a pregnant woman. Below the logo, the tagline "A good start for a healthier life" is written in a smaller, black font.

A healthy future is set up in your baby's first years.
But with so much out there on baby nutrition
and activity, you could feel a little overwhelmed.
So Start4Life has put the latest information on
our website. Go to www.nhs.uk/start4life

NHS

all's well
that
starts well

start
4 life

A good start for a healthier life

launched in January 2011, which aims to urge families to swap at least one unhealthy habit for a healthier one. Partnering with News of the World and ASDA, Change4Life is giving away 5 million voucher booklets, worth over £50 each, with money off healthier foods, drinks and activities.

3. What impact did it have?

A total of 413,466 families joined Change4Life in the first 12 months and over 44,000 families were believed to still be involved with Change4Life after 6 months. Three in 10 mothers who were aware of Change4Life claim to have made a change to their children's behaviours as a direct result of the campaign. This equates to over one million mothers claiming to have made changes in response to the campaign.

The number of mothers claiming that their children do all eight behaviours increased from 16

per cent at the baseline to 20 per cent by quarter four. The proportion of families having adopted at least four of the behaviours has increased, suggesting the campaign has persuaded people with much less healthy lifestyles to make an effort to improve their health.

Shopping basket analysis found differences in the purchasing behaviour of 10,000 families who were most engaged with Change4Life relative to a control group. In particular, there were changes in the purchases of beverages among Change4Life families, who favoured low-fat milks and low-sugar drinks. The proportion of mothers from the target segments claiming to serve child sized portions increased from 60 to 69 per cent, but the proportion of target mothers from the target segments who were aware of the need to provide "Me Size Meals" increased dramatically from 4 to 36 per cent.

"The proportion of target mothers from the target segments who were aware of the need to provide 'Me Size Meals' increased dramatically "

Key lessons

The Change4Life brand identity captured the imagination of the public and provided a rallying call for those already working in the area. It helped to raise far greater public awareness of the personal risks associated with being overweight and it helped to mobilise greater community support for healthier diet and physical activity choices for children.

Change4Life has helped to further the debate about the role of increased personal responsibility within a "choice environment" that has made it far easier for children to eat poorly and to exercise less. While the campaign has resulted in far greater awareness of the obesity issue, it has also posed serious questions about the further actions needed to support the adoption of healthier behaviours related to diet and physical activity.

The Change4Life project has been extremely well funded. However, its success is as much a function of the ongoing nature of the programme as the total amount of funding at its disposal. To achieve sustainable behaviour change, continuity is of paramount importance.

Partnering with the private sector can lead to increased reach and greater impacts. Where possible, social marketing programmes to address the social determinants of health inequalities should seek private sector partnerships where clear synergies exist.



\$2.05 - 2

Black
CHERRY

1¢ Coin	25¢ Coin	50¢ Coin
1000	2500	5000
200	500	1,000
100	200	300
50	100	150
20	40	60
10	20	30
5	10	15
1	2	3
4	A	B

CASH IN
WITH
CASH

THIS MACHINE ACCEPTS
1 5 10 20 50 100 BILLS

Black
CHERRY

WILD

WILD

Case 7: Kiwi Lives addresses problem gambling in New Zealand

2005 – ongoing • Meets NSMC criteria: all

The next case study examines the often “hidden” but rapidly growing issue of problem gambling. This programme aimed to reduce gambling addiction among New Zealand’s among most vulnerable communities.

The impact that gambling can have on those addicted and on their dependants can be extremely detrimental in terms of severely reducing household income as well as the increase in stress, anxiety and often violence related to this highly addictive activity.

The New Zealand Health Sponsorship Council’s Kiwi Lives campaign was designed to prevent and reduce problem gambling and gambling harm among at-risk gamblers (particularly those that frequently play electronic gaming machines).

1. How did the project address the social determinants of health?

Problem gambling affects several groups disproportionately including Māori and Pacific peoples, those of low socioeconomic status, and some Asian communities.

Problem gamblers and those close to them can experience a wide range of problems including: stress-related physical and psychological ill health; family breakdown; domestic violence; criminal activity such as fraud; disruption to or loss of employment; other dependencies such as alcoholism and substance misuse; and social isolation.

2. How did the project apply a social marketing approach?

Due to gambling being a hidden issue, the campaign began by raising awareness of problem. The project then introduced messages on how to seek help, followed by focusing on specific behaviours, such as encouraging those at risk of gambling harm (particularly those that frequently play electronic gaming machines and others in their lives) to

seek help early. The secondary audience for the campaign included friends and family of those at-risk gamblers, and staff within venues with gambling facilities such as electronic gaming machines.

The next stage used real people with real stories to show that it can affect every day New Zealanders, and showed what they have done to make things better. The first advertisements helped to identify risky behaviours and provide an example of how a friend or family member can intervene effectively. The aim was to demonstrate that help-seeking and self-management can be simple and private. A further advertisement demonstrates an example of good host responsibility. The aim of this is to make it acceptable that venue staff, as responsible hosts, can and will intervene with at-risk gamblers.

For problem gamblers or for those worried that someone close to them has a problem with gambling, the programme signposts to a number of support services including:

- **Telephone hotlines** – The 24-hour Gambling Helpline offers free and confidential information and support over the phone, and can help arrange for someone to see a counsellor. Specialist hotlines exist – Māori Gambling Helpline, Pasifika Gambling Helpline, Youth Gambling Helpline, Gambling Debt Helpline, and Problem Gambling Foundation Asian Hotline.
- **Free face-to-face counselling** – Provided through the Problem Gambling Foundation, the Salvation Army Oasis Centre and the smaller Māori and Pacific Services
- **Support groups** – Such as Gambling Anonymous meetings

3. What impact did it have?

The 2006/07 New Zealand Health Survey conservatively estimated that about 119,300 people aged 15 years and over had experienced harm from gambling in the year before the survey. In 2009 an independent evaluation of Kiwi Lives found that the campaign had increased the ability of 51

per cent of the target audience to take greater action about problem gambling.

The campaign also stimulated much greater discussion, understanding and concern about the impact of problem gambling among the wider New Zealand public.

There was a particularly strong response to the advertisements by Māori and Pacific peoples, those who played a number of 'continuous' gambling activities and those who had seen firsthand the effects of problem gambling. Calls to the Gambling Helpline increased approximately 30 per cent during the campaign.

Key lessons

The campaign demonstrates the important role of the government in making the public aware of gambling related harms and in providing appropriate mechanisms for at risk groups to seek help and support.

It also highlights the importance of providing friends, family and responsible "hosts" with the permission and support needed to intervene before gambling becomes harmful.

Case 8: “Take charge. Take the test” campaign to increase HIV testing by African American women

2006 – ongoing • Meets NSMC criteria: 2, 3, 4, 5 and 6

In 2006/7 the United States Centres for Disease Control and Prevention implemented a one-year social marketing campaign in Cleveland (OH) and Philadelphia (PA) to increase HIV testing among African American women at high risk for HIV infection.

1. How did the project address the social determinants of health?

In 2005 there were one million people living with HIV/Aids in the US and approximately 40,000 people were becoming infected each year. Up to two-thirds of new HIV infections are transmitted by persons who do not know they are infected.

Half of all new HIV infections in the US occur among African Americans, despite this group only making up 13 per cent of the US population. Among women 67 per cent of all new cases are African American and HIV is the leading cause of death for black women ages 25 to 34. Poverty contributes significantly to the rising incidence of HIV/AIDS among African-American women. However few African Americans were getting tested for HIV regularly, with many unaware of the alarming HIV trends in their community.

2. How did the project apply a social marketing approach?

A social marketing segmentation approach was used to identify the primary target audience as single African American women aged 18 to 34:

- With some college education or less
- Who earned US\$30,000 or less per year
- That resided in certain zip codes with high HIV-prevalence
- And were having unprotected sex with men

The objective of the programme was to increase the number of women from this segment who were getting an HIV test after having



**You feel as if you've known
him forever, but that doesn't
mean you know everything.**

Get a Free HIV Test

To learn more about free HIV testing or
to find an HIV testing location near you,
call 1-800-CDC-INFO (232-4636)
or visit hivtest.org/takecharge.



unprotected sex but research found a number of barriers and motivators related to HIV testing.

Barriers

- Belief that testing will be expensive and time consuming
- Belief that good, affordable treatment is not available
- Unaware of facilities for testing
- Belief that HIV testing is part of annual physical
- Fear of being positive
- Fear of rejection from family and community if found to be positive
- Loss of insurance and/or employment if results reported to government/state authorities
- Anxiety about waiting for results
- Low perception of personal risk

Motivators

- Concern and uncertainty over whether a partner is being faithful and/or if heard something about a current or previous partner
- Desire to be present and available for children
- Desire to protect others and limit further HIV transmission (if found to be positive)
- Peace of mind and ability to control one's life and future
- Potential to receive earlier treatment if found to be positive

The key message was based on the empowerment that comes with getting tested –

"Take Charge, Take the Test - You feel as if you've known him forever, but that doesn't mean you know everything. Get an HIV test and look out for yourself".

There was a strong emphasis on normative messages that reinforced the idea that many other African-American women were also getting tested for HIV. The programme also worked to improve the availability and convenience of testing with a number of fun community events where rapid HIV tests were also made available.

3. What impact did it have?

The campaign helped to improve the coordination and provision of existing HIV testing services but there was no significant rise in testing rates through existing services. However there was significant increase in rapid testing through the 48 community events that attracted more than 9600 attendees. These events administered 1492 rapid tests identifying 14 HIV-positive cases. The key lessons from this pilot programme have now been used to develop similar initiatives elsewhere throughout the United States.

Key lessons

It is critical that any social marketing effort is designed to engage the support of both the target audience and the wider community that shapes behavioural norms and attitudes.

Campaign messages may motivate the target audience to find out more about HIV testing but expanding the number and reach of community-based testing events may have substantial potential to increase HIV testing by helping to remove the barriers between intention and action.

The project also demonstrates the effectiveness of establishing clearly defined objectives, segmenting the target audience and developing an understanding of barriers and motivators to desired behaviours through audience research.

Case 9: Increasing the use of car seats by Hispanic children in Dallas, Texas

1997 – 2000 • Meets NSMC criteria: 1, 2, 5 and 6

The following case study demonstrates how important people's culture and beliefs are when an external organisation is seeking to have an impact on their behaviour.

It also confirms the dramatic impact a social marketing programme can have when other "top-down educational" approaches have failed.

This community-based, culturally integrated programme aimed to increase the use of child safety seats (CSSs) in a Hispanic neighbourhood in the west Dallas area of Texas. The ultimate aim was to reduce the number of child injuries and fatalities occurring due to the lack of use of car seats and booster seats. Based on structured observational surveys, use of safety restraints among Hispanic preschool-aged children increased from a baseline of 21 per cent to 73 per cent three years after the programme launch.

1. How did the project address the social determinants of health?

Child passenger motor vehicle crashes are the leading cause of death for children aged 1 to 14. However, many of the deaths and injuries associated with motor vehicle crashes can be prevented by using proper child passenger safety restraints, such as car seats and booster seats.

In the US the use of safety restraints in motor vehicles is lowest among minority and low-income populations. In Texas data clearly showed that a disproportionate percentage of car accidents involved people of Hispanic origin.

Dallas has a large Hispanic population, which makes up 43.1 per cent of the city's total population. A preliminary survey of Hispanic preschool children in west Dallas, carried out in 1997, showed much lower child restraint use (19 per cent of those surveyed) than among preschool children of all races in the rest of the city (62 per cent).

2. How did the project apply a social marketing approach?

Mothers of young children within Hispanic communities were targeted because they tended to be responsible for supervising their children and were seen as authority figures within the community. Research with this group found there was a lack of information on child restraint laws, the importance of using car

seats and how to properly install and use them, especially among more recent immigrants.

Fatalistic views and the belief that any potential accidents were in God's hands were key internal competitors to getting parents to use child safety seats. This led parents to believe that using car seats would have very little impact on changing their destiny. Even amongst those who

were aware of the child restraint laws, many parents did not see the value of using car safety seats and felt that their child was safest in their arms. Parents also tended to believe they were safe drivers and therefore less likely to be in an accident, particularly when making 'short' trips. Lack of enforcement of child restraint use only contributed to parents dismissing the use of CSSs.



A number of interventions were designed and adapted to the Hispanic community using the insights gained from the focus groups. Interventions were delivered throughout community venues and by trained bilingual staff, often by people who were also residents of the target area. Key programme components included:

- Information and engagement activities would be provided at various community venues, such as schools, churches, community centres and local botanicas (traditional healers).
- Community based workshops with videos that graphically showed what happens to a child held on an adult's lap during a car crash were therefore created to be shown in the classes
- As an additional incentive, parents who attended the classes would be offered a car seat for a low cost of US\$10.
- To overcome the issue of fatalism in the Hispanic community, local priests would be asked to bless the child safety seats in a ceremony before they were given to parents.

3. What impact did it have?

Three years after the interventions were launched, the use of safety restraints among Hispanic preschool-aged children increased from an initial prevalence of 21 per cent to 73 per cent. Use of restraints among Hispanic preschool-aged children increased significantly in all three settings (health centre, day care and grocery store parking lots). By the sixth year, restraint use among clinic attendees had surpassed 85 per cent.

The programme found that efforts to increase the use of child restraints were only successful if driver seat belt use was also targeted. Only small increases in child restraint use were observed in vehicles in which drivers did not wear a seat belt. Males were also less likely to use a seat belt and child seat.

Key lessons

Social marketing programs targeting behaviour change among ethnic groups can be successful if audience research is used to understand the core barriers and motivators related to the adoption of a specific behaviour. Cultural and religious beliefs must be taken into account.

Success is also more likely if interventions use the right mix of effective messaging, direct community-based support, financial incentives and enforcement.

Case 10: Slovenia – Let's Live Healthy programme

2002 – ongoing • Meets NSMC criteria: all

The following programme is one of the most successful regional public health programmes that utilises social marketing theory and practice. It has had a dramatic result on the lives of its participants and has now expanded countrywide to cover the whole of Slovenia.

Pomurje is the poorest region in Slovenia. Mortality rates - levels of heart disease, diabetes and obesity - are the highest in the country. Historically the local population had been employed in agriculture and an active lifestyle had compensated for a diet high in animal fats with high salt content. Increasingly people have been moving away from the land to more inactive lifestyles in factories. Increasingly there are far fewer communal activities (both work and non-work) in rural areas resulting in social isolation and high levels of stress, leading to further ill-health.

1. How did the project address the social determinants of health?

This region wide programme has been largely community based with village cooking workshops, exercise classes, singing, village walks and community events. The aim of the programme wasn't to just help people choose a healthier lifestyle but to rebuild rural communities and re-establish bonds within rural villages and between neighbouring communities (addressing social isolation, building social cohesion). The development of communal gardens growing herbs for example has produced alternatives to salt for flavouring but most importantly it has brought together isolated members of the community.

2. How did the project apply a social marketing approach?

This project aimed to change behaviours of a whole region but the success of the programme means it has now been expanded to cover the whole country. It has used the exchange of learning and understanding the benefits of healthy behaviour around eating/drinking by giving inhabitants access to communal activities and better healthcare services.

It has also been successful at developing a whole range of activities that have matched the needs of separate communities. They have increased activities that have worked and abandoned those that either are not



popular or have had little impact on lifestyles.

Because the planning and implementation of the project has been based in the influential public health institute of the region there has been a strong history of monitoring and evaluation which has led to constant re-assessment of activities and projects.

3. What impact did it have?

The Institute of Public Health for Pomurje has evaluated the programme over the eight years that it has been operating. It has noted that over this period 52 per cent of communities on the programme had changed their nutritional habits, replacing high fat/salty food with low fat alternatives. There has been a significant decrease in inhabitants that consume alcohol every day from 59 to 33 per cent.

Key lessons

This self-sustaining community project has not relied on a large central budget but it has generated a significant amount of political support and strong community links with the regional public health organisation. The programme has been led by a very influential and charismatic leader who has ensured that there has been long term funding. Programme continuity is (in many cases) a greater predictor of success than the amount of funding available.

Although it has had a major impact on people's health it has had a wider impact on social gradient reintegrating people back into the community reducing social isolation. People now feel better about themselves and community they live in and one local politician stated that the programme had re-energised villages.

Case 11: Denmark – U-Turn project – turning around young people's lives

May 2007 – ongoing • Meets NSMC criteria: all

This programme demonstrates the sometimes heavy investment required to turnaround the lives of the most vulnerable in society especially those youngsters who come from broken homes with generations of under privilege and deprivation.

It is also exemplifies how when the right type of approach is used how successful these intensive programmes can be in rehabilitating young people's lives.

This government funded programme aims to tackle the issues facing some of the most socially isolated and disadvantaged youngsters (15-23) in Copenhagen. Although the primary goal of the project is to reduce young people's dependency on drugs, the project aims are much wider, working with young people in all aspects of their lives to develop their self-esteem so that they have the confidence to overcome their dependency.

1. How did the project address the social determinants of health?

Most of the youngsters referred onto the project come from dysfunctional/disadvantaged backgrounds. Seventy-five per cent of young people on the project parents/guardians were either divorced or had never lived together. Over 80 per cent of the young people had been in out-patient treatment in relation to psychological or emotional problems.

The programme holds daily sessions for clients in a friendly "house" in Copenhagen. The sessions are completely voluntary and comprise of formal lessons, cooking and eating together, counselling, music expression and physical exercise. Talking therapies often include parents/guardians there is also sessions to support friends/peers of the youngsters on the project. Research shows without this form of intensive and person help these people will either end up in jail or live at margins of society often unable to cope, relying throughout their lives on state agencies for support.

The project also provides education and training of young-people to improve their chances of finding a paid job (social mobility).

2. How did the project apply a social marketing approach?

A huge amount of effort has gone into understanding the lives of these young people and what moves and motivates them. For example it offers a valid exchange through enabling these youngsters to get their school certificate that allows them access to further training or work. This is prized by the youngsters as it allows them to move on with their lives. It completely avoids a one size fits all approach treating each client individually tailoring the sessions to the exact needs of the individual. As the leader of the project states, "We try to build a whole picture of their lives. Our objective is to tackle all their issues including housing, nutrition, physical activity – we aim to get young people happier more contented, to get them to have high self-esteem then this will give them the courage to tackle drug addiction".

3. What impact did it have?

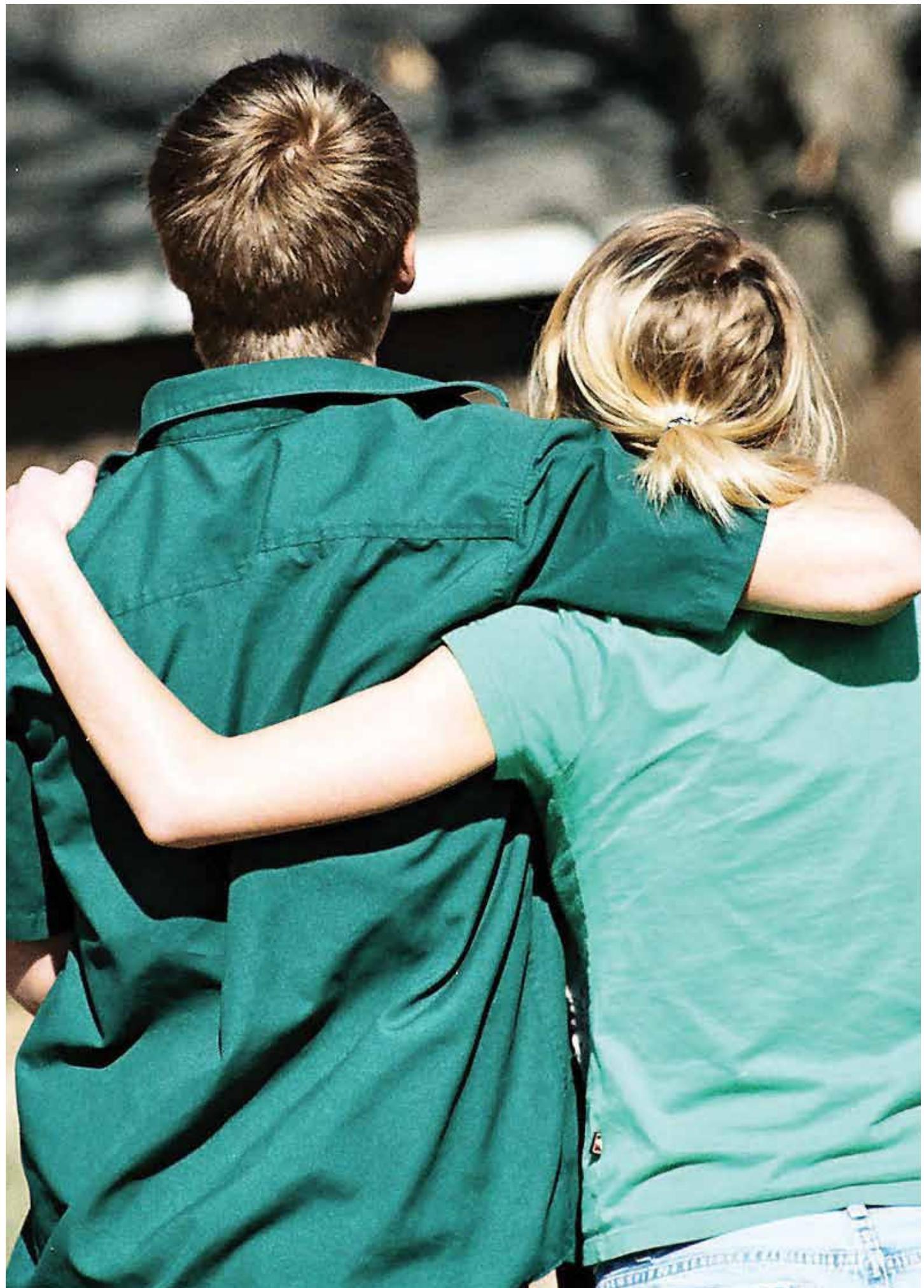
Evaluation of the project demonstrates that 75 per cent of young people referred to the project either cease using or drastically reduce the use of drugs while 80 per cent of young people go into work or full time education on completion of their time with the project. This is an extremely expensive programme – employing over 20 full time staff and the cost per young person on the programme is very high.

Although there is little research on the long-term impact on the costs of getting these young people out of a drugs dependency cycle it is clear that the programme does have a huge impact on the lives of the youngsters it treats.

"Evaluation demonstrates that 75 per cent of young people referred to the project either cease using or drastically reduce the use of drugs"

Key lessons

One of the most important lessons, from the view of those working on the project, is that often for the very first time in their lives these young people's needs are treated holistically - the responsibility for all their care needs are centred in one place instead of being fractured between a number of different agencies.





Case 12: North Tyneside – Sub21 reducing kerbside drinking by young people

2007 – ongoing • Meets NSMC criteria: 1, 2, 5 and 6

This case study describes a project aimed at reducing anti-social drinking behaviour by young people in North-East England. By utilising a two-pronged approach it reduced the supply of alcohol to the target group while also developing attractive alternatives to "hanging around on the street and drinking".

North Tyneside has some of the highest rates of hospital admissions for under 18's due to alcohol-related causes in the UK. Related crime and disorder as well as residents fear of crime and anxieties about young people drinking on the streets

were becoming critical and were having increasing detrimental impact on the quality of people's life in North Tyneside. This collaborative project (between North Tyneside PCT and The NSMC) aimed at reducing underage street drinking and antisocial behaviour.

1. How did the project address the social determinants of health?

Research with young people and off-licences identified three main drivers for underage street drinking. These were a lack of suitable alternative activities for these young people, cheap easy supply of alcohol (with plenty of proxy sales) and finally the fact that street drinking had become the social norm in the area. From these findings a two pronged approach was developed, under the Sub21 brand. The intervention provided a rolling programme of out-of-hours activities designed by and for local young people as an alternative to street drinking. Alongside this, a programme was developed to support off-licences in reducing illegal and proxy alcohol purchases.

2. How did the project apply a social marketing approach?

Considerable effort was put into the research stage of the programme to ensure that the "offer" provided to get youngsters off the streets into alternative activities was made as attractive as possible. Activities included street dance, nail art cookery for girls and graffiti, bike and ramp building computer gaming for boys. These activities provided for youngsters were combined with measures designed to restrict the supply of alcohol to underage drinkers.

There was an extensive package of support for retailers including:

- Dedicated 24 hour Crime line
- Dedicated licensing line
- "Off watch" membership with monthly meetings to share information views and ideas
- Training sessions for staff on conflict management
- At least two visits by police every week
- A Charter Mark

3. What impact did it have ?

The results showed that there had been a reduction in the most harmful types of drinking among females and that drinking in the street had dropped by 50 per cent. In boys there was little change in self-reported behaviour although the research demonstrated that they experienced much greater difficulty in accessing alcohol.

Evaluation of the project demonstrated that young people respond much better when there is a developmental element to the activities. Many projects aimed at young people often provide facilities (drop in centres for example) but the most important element for the youngsters in this particular project was the development of new skills over a series of sessions.

A very small amount of the budget was dedicated to conventional promotion and word of mouth was critical in getting more youngsters involved. The project team also constantly kept in touch with youngsters changing/adapting the programme to suit their needs and aspirations.

Key lessons

Some of the most important feedback from the project team was to emphasise that it is crucial that often community/social marketing projects waste time and effort trying to persuade reluctant and unsupportive partners to participate because there is an apparent good strategic and organisational fit. Their advice was to move on and invest time and energy encouraging those who are enthusiastic and committed.

Case 13: reducing levels of worklessness – Lincolnshire

2009 – 2010 • Meets NSMC criteria: all

Quite often programmes that aim to tackle inequalities and increase social capital ignore the talents, skills and expertise of the very communities they are trying to help.

The following example demonstrates the importance of working to harness existing local enthusiasm and commitment when attempting to strengthen our communities.

This programme aims to reduce levels of worklessness in target communities in North-east Lincolnshire. The programme centres on the development of community teams of local residents and service providers to:

- Inspire individuals to achieve personal change;
- Enable them to access appropriate work; and
- Reduce dependence on benefits in two deprived target areas, (South Ward and East Marsh Ward).

1. How did the project address the social determinants of health?

This project was designed to encourage local people to access existing support services. Initial research found that many people felt local services were “useful” but that they simply didn’t know how to access them. There was also a large amount of mistrust of the “officials” who were running the services, while they preferred and more importantly trusted the talents and resources of locals, peers and family.

With this in mind two community teams, the “specialists” and the “locals” worked together to create community champions and these people helped to signpost people to services by promoting existing opportunities, attending interviews with participants, and provided peer to peer coaching.

A “How2” campaign with very practical information on how to access existing services was also implemented and a resource pack was designed to provide really practical things to help prospective job seekers such as: a list of services; model CV’s; and tips for filling out application forms.

2. What impact did it have and what are the key lessons ?

Often policy makers are tempted to start from scratch when they want to develop programmes aimed at increasing the social capital in communities. This project avoided this by working to adapt existing services and ensured signposting was more effective.

Dealing with public service design can be complex, costly and sap energy. There may be times when a complete overhaul and restructuring is necessary but in the case of this project it was ensuring there was a trusted "guide" and ensuring that the materials could be understood by the target audience.

Many of the project team examined the basic practical materials and commented - "are we insulting people's intelligence here?" However, when they were pre-tested with the target group they were surprised on how well they were received.



Case 14: Riders for Health – providing sustainable transport services in Africa

1992 – ongoing • Meets NSMC criteria: all

Although this project is not based in Europe, we have included it because it demonstrates how a social enterprise can be created and sustained even in the most difficult circumstances.

Many of the funded projects aimed at reducing inequalities in England have limited funding over a short period of time which often means when the funding stops the programme halts. Riders shows what can be achieved by setting up a business to do what has historically been done by government.

This final example also demonstrates the power of harnessing and building local talents and

expertise. When these programmes are successfully scaled up it shows the dramatic impact they can have on a number of the social determinants of health across an entire region.

One of the primary health issues in Africa is not just the lack of medicines and health workers but the transport to get those medicines and workers to the people who need them most. 'Riders for Health' provides a vital



service in ensuring people living in rural areas have access to services by providing an effective and reliable means of transport. Riders for Health is a social enterprise which helps provide health services to over 20 million people living in sub Saharan Africa, in 8 countries managing 4000 vehicles.

It has developed a preventative maintenance system for managing vehicles, people and money involved in the delivery of healthcare and other vital services. The system incorporates training in driving skills, daily preventative routine maintenance procedures – supported by Riders technicians who provide regular servicing. A unique cost per km calculator also provides the true costs of running any vehicle in any given environment.

1. How did the project address the social determinants of health?

One of the most remarkable characteristics of this enterprise is that it is almost entirely funded by indigenous sources. The Ministries of Health of the countries that they operate in pay 'Riders for Health' for their services. The programme is also staffed with indigenous workers so that skills and expertise are built into the local communities. 'Riders for Health' trains the health workers and mechanics that provide the backbone of the organisation. The whole ethos of the organisation is to create business opportunities through development with the aim of pulling whole sections of society out of poverty through better health-care but also developing new businesses.

2. What impact did it have and what are the key lessons?

Because 'Riders for health' is a business it has to monitor and evaluate both health outcomes and its business performance. It is critical that costs are reduced and that the organisation runs efficiently because, without this business ethos, the company would simply cease to exist and the vital services would be discontinued. Because the services 'Riders for Health' provides are so efficient (Introducing Riders services reduces maintenance/transport costs by an average of 60 per cent) it means that often health budgets of the different states where 'Riders for Health' operates are used more effectively.

In terms of direct health benefits in Zimbabwe, malaria deaths decreased by 21 per cent compared with a 44 per cent increase in neighbouring areas where Riders was not operating. In the Gambia there has been a 263 per cent increase in diagnoses in diarrhoea and a 75 per cent increase in the diagnosis of acute respiratory infections.

9. What actions should be taken next ?

Central Government

- Central government has an important role to play in building a comprehensive evidence base for ensuring all behaviour change programmes are effective and targeted. The Tobacco programme is a good example where national support provided necessary practical tools and advice for local actors to enact well researched and evaluated social marketing programmes.
- It also has an important role to play in providing a library of good practice – monitoring what's going on nationally and internationally then disseminating and helping other actors to develop programmes that have tried and tested and have impact.
- One of the key recommendations of the Marmot Review was for a redistribution of income through a change in fiscal policies – “hoping to provide better life chances those down the social gradient”. However our evidence demonstrates that these policies only work well when they go hand in hand with action at local levels. Evidence demonstrates that strong and effective leadership at local levels galvanises communities into action. It's not just about giving people extra income. We need to ensure, without exception, that all national programmes can be translated into action at local levels through harnessing the strengths and commitment of local communities.
- An individuals' health is determined by a range of factors that cannot be addressed by health policy alone. Taxation, transport, social care, environmental, and education are all areas which can impact the health of individuals and entire populations. The European Commission is required (under the EU Treaty) to ensure that all EU Policies use a Health in All Policies approach. The Central government could follow the EU's lead, and require all policy makers to consider and account for health impacts when developing policy in non-health areas.

Local Government

- Local government has potentially a much stronger role than ever before to have real impact on health inequalities as the “public health” discipline is now situated in local government structures. It is now possible to have much more control on the “whole” environment. This means in terms of schools and young people – local action has the ability to reduce the availability of fast food around schools through planning regulations, improve education through investing heavily in local education facilities suited to the needs of local communities in deprived areas while also harnessing the NHS to ensure effective access to wellness services available in schools.

NHS

- Despite numerous reports and programmes over the last twenty years, the NHS has still a long way to go to become a “wellness” service that keeps people well rather than waiting to treat them when they get ill. Our experience in using social marketing techniques to increase uptake of screening, improving services to improve early diagnosis of diseases can have real impact on ensuring people live healthier and more productive lives. Behaviour change programmes to improve nutrition and increase activity in young people also can have large long term beneficial impact on their lives. Both the Food Dudes and the programme tackling anti-social behaviour in North Tyneside are good examples of how motivating young people to change their own lives can have a tremendous impact. The NHS therefore needs to concentrate on developing and implementing many more effective programmes like these.

Charities/NGOs and the Third Sector

- There has been a strong emphasis over the last few years for government agencies to disseminate funding in health promotion to whole panoply of organisations in the charity/third sector. Although this has meant that large-scale top down centralist programmes are now rare, there has been a rise in smaller scale programmes that have not had impact because of a lack of research, testing or evaluation. The third sector and charities need to work much harder at sharing good practice and learning together

Private Sector

- The private sector should play an ever increasing role in tackling the inequalities of health
- Working with the education/ local government to provide training and then employment possibilities by investing in local community enterprises and projects that aim to develop the social capital of areas.
- Investment in infrastructure which directly benefits residents such as supermarkets providing high quality food at economical prices, social/activity/training centres that can be used by locals.
- Utilising CSR budgets more creatively and effectively to create employment opportunities for people living in deprived communities
- Taking a leading role in sponsoring local community projects and pressing public sector to harness their own talents and expertise and not waiting for the public sector to initiate programmes.
- Ensure workplaces become centres of wellbeing – inviting in health and health promotion services to take an active role in people's daily lives

Central Government

Action 1: build a comprehensive evidence base of "what works" to ensure all behaviour change programmes are effective and targeted.

Action 2: ensure, without exception, that all national programmes can be translated into action at local level through harnessing the skills, expertise and knowledge of local communities.

Local Government

Action 3: ensure that local government plays a much more coordinated and active role on health inequalities. With the "public health" discipline now situated firmly in local government it is possible to have much more control on the "whole" environment people live in.

National Health Service (NHS)

Action 4: concentrate on developing and implementing more targeted effective behaviour change programmes which are aimed at reducing health inequalities.

Action 5: increasingly turn itself from a service that largely treats sick people to a service that promotes good health and wellbeing through all stages of peoples' lives and encourages people to take preventative actions against getting sick.

Charities/Non-Government Organisations (NGO's)

Action 6: improve the sharing of good practice and learning together to avoid duplication and wasting of scarce public resources.

The Private Sector

Action 7: work with the education sector and local government to provide training and employment possibilities by investing in local community enterprises.

Action 8: invest in infrastructure which directly benefits residents such as social/activity centres.

Action 9: utilise CSR budgets more creatively and effectively to create employment opportunities.

Action 10: take a leading role in sponsoring local community projects.

Action 11: ensure workplaces become centres of wellbeing.

Appendix

Project	Parents and children (NSMC criterion 1)	Community Partnerships (NSMC criterion 2)	Improving living standards/life chances – to disadvantaged (NSMC criteria 3 & 4)	Improving community capital (NSMC criterion 5)	Ill-health prevention (NSMC criterion 6)	Can be up-scaled	Sustainable /value for money	Important lessons for policy
1. Health Promotion Strategy – Slovenia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Denmark U-Turn	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes
3. Scotland East-end local Development Strategy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. SUB 21 - Young people reducing anti-social/alcohol	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes
5. Stockport smoking – disadvantaged	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Riders for Health, Africa	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7. Worklessness Initiative – North-east Lincolnshire a. P156 Book	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-
8. Dallas Seat-belt in Hispanic community	Yes	Yes	-	Yes	Yes	-	Yes	Yes
9. Change4life	Yes	Yes	-	-	Yes	Yes	-	Yes
10. England's Tobacco Control National Strategy	Yes	Yes	Yes	-	Yes	-	Yes	-
11. Food Dudes	Yes	Yes (schools)	Yes	Yes	Yes	Yes	Yes	Yes

Project	Parents and children (NSMC criterion 1)	Community Partnerships (NSMC criterion 2)	Improving living standards/life chances – to disadvantaged (NSMC criteria 3 & 4)	Improving community capital (NSMC criterion 5)	Ill-health prevention (NSMC criterion 6)	Can be up-scaled	Sustainable /value for money	Important lessons for policy
12. Kiwi Lives (Problem gambling)	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes
13. Reducing Graffiti Vandalism in Brent	Yes	Yes	Yes	Yes	No	Yes	-	Yes
14. Increasing the uptake of breast screening in Tower Hamlets	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15. Systembolaget in Sweden	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16. Take Charge, Take the Test	No	Yes	Yes	Yes	Yes	Yes	-	Yes

Notes

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August 2012