**UNIT 3**

# Introduction Policy and Environmental Interventions

## Introduction

Welcome to Unit 3. This unit focuses on intervention strategies for alcohol problems targeted at a broad or environmental level. Broad, environmental approaches are the essence of the role of the Health Promoter or Public Health practitioner and have great potential for a broad range impact at national, regional or community level, particularly since alcohol problems derive from a reciprocally broad range of determinants.

Although Session 1 focuses on policies and Session 2 on environmental changes, this is really an artificial separation, since many environmental changes depend on legislation to drive them.

By now, you will be aware that the argument for broad impact strategies also arises out of the understanding that some of the highest levels of harm are caused not necessarily by individual dependent drinkers, but also by moderate drinkers who engage intermittently in high risk drinking practices. In addition, an environmental approach takes account of the diversity of societies, and places potential safety nets at different levels for reducing the harm caused by alcohol.

Within this Unit, you will also be reminded of key steps in the planning and implementation of programmes. Session 1 incorporates community mobilisation processes, Session 2 includes collection of relevant data on which to base a prevention programme, and Session 3 includes monitoring and evaluation activities.

**There are three Study Sessions in this unit:** Study Session 1: Control through Policy. Study Session 2: Environmental Changes.

Study Session 3: Multifaceted Integrated Programmes.

In Session 1, we focus on alcohol legislation and its enforcement. In dealing with this, we consider a range of interventions intended to control or limit the coercive marketing and consumption of alcohol.

Session 2 provides an overview of a range of environmental strategies for harm reduction and the introduction of alternative activities that can serve to reduce drinking. Based on these examples, you will consider what would work in your context.

Session 3 explores the value of multifaceted programmes for addressing alcohol problems and links this approach to the Health Promotion principles of the Ottawa Charter. You will again consider the value of this approach to your own potential target group.

## INTENDED LEARNING OUTCOMES OF UNIT 3

**By the end of this unit, you should be able to:**

* Describe and assess different countries’ policy interventions to control alcohol marketing, cost, availability and contents.
* Discuss different approaches to taxing alcohol sales.
* Analyse ways in which alcohol is made attractive to different target groups.
* Demonstrate insight into the process of community involvement in interventions.
* Assess international examples of environmental adaptations to reduce alcohol intake and alcohol-related harm in local settings.
* Discuss the role of a variety of media in supporting the communication of alcohol-related policy and environmental changes.
* Discuss the rationale for a multifaceted approach to alcohol problems.
* Apply the Ottawa Charter framework to alcohol interventions.
* Assess the viability of the multifaceted approach to specific contexts of alcohol use.
* Develop tools for planning, monitoring and evaluating alcohol interventions.

Unit 3 provides substantial preparation for your second assignment: while you work through it, start gathering background information about your target group and their context, e.g. drinking patterns. This will enable you to engage more critically and effectively with tasks in the sessions. Many of them refer you to a range of intervention strategies discussed in the literature and ask you to consider their applicability in your situation. We hope that you will find some fresh and challenging ideas in Unit 3 for addressing alcohol problems in your own context, as well as an effective way of monitoring and evaluating the impact of your programme.

# Unit 3 - Session 1

**Control through Policy**

## Introduction

One of the key action areas in promoting health is the development of health promoting policies. We have seen in Session 1 of Unit 2 that there are many situations in which alcohol abuse can result in harm to the drinker and to others. How to control alcohol use without totally prohibiting it is one of the dilemmas faced by governments in trying to limit harm. A balance needs to be struck between developing and enforcing regulations, and maintaining a free market and freedom of lifestyle.

In this session you will familiarise yourself with different approaches to alcohol legislation and control, and analyse the impact of coercive advertising of alcohol, particularly on young people. You will also consider ways of limiting this impact and educating drinkers.

## Session contents

1 Learning outcomes of this session

1. Readings
2. Legislation and enforcement
3. Marketing alcohol
4. Community mobilisation
5. Session summary
6. Further reading

## Timing of this session

This session contains six readings totalling 93 pages of reading, and four tasks. You will need to put aside at least six hours to complete this session.

## LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Describe and assess different countries’ policy interventions to control alcohol marketing, cost, availability and contents.
  + Discuss different approaches to taxing alcohol sales.
  + Analyse ways in which alcohol is made attractive to different target groups.
  + Demonstrate insight into the process of community involvement in interventions.

## READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Author/s** | **Reference details** | **Page nos in Reader** |
| Parry, C. D. H. &  Bennetts, A. L. | (1998). Ch 5 - Reducing per Capita  Consumption and High-Risk Behaviours. In *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127. | **283-296** |
| Room, R. et al. | (2002). Ch 8 - Targeting Environmental  Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-215. | **349-384** |
| Parry, C. D. H.,  Myers, B. & Thiede, M. | (June 2003). The Case for an Increased Tax on Alcohol in South Africa. *The South African*  *Journal of Economics,* 71(2): 265-281. | **305-314** |
| Jackson, M. C.,  Hastings, G., Wheeler, C., Eadie,  D. & Mackintosh, A. M. | (2000). Marketing Alcohol to Young People:  Implications for Industry Regulation and Research Policy. *Addiction* 95*,* Supplement 4: S597-S608. | **155-166** |
| Webster-Harrison,  P. J., Barton, A. G.,  Sanders, H. P., Anderson, S. D. & Dobbs, F. | (2002). Short Report - Alcohol Awareness and Unit Labelling. *Journal of Public Health*  *Medicine,* 24(4): 332-333. | **463-466** |
| Treno, J. A. &  Holder, H. D. | (1997). Community Mobilization: Evaluation of  an Environmental Approach to Local Action.  *Addiction* 92, Supplement 2: S173-S187. | **447-462** |

## LEGISLATION AND ENFORCEMENT

All governments face the responsibility of developing policies that act to control alcohol use in the interests of public safety and health. At the same time, they face the challenge of ensuring that such policies can be enforced, and are not too elaborate. Political, economic, religious and cultural factors can all affect the extent to which a government attempts to regulate the use of alcohol.

You have already come across some international examples of policies related to controlling access to alcohol and punishing of DUI offenders in the Session 3 of the previous unit (Room et al, 2002; and the Tenth Special Report, 2000).

In the reading that follows, Parry and Bennetts (1998) provide a useful overview of the most common legislative measures relating to alcohol use in South Africa. These measures include reducing drunk driving, generating revenue through taxes on alcohol, requiring liquor outlets to be licensed and to adhere to certain hours of operation, and restricting the advertising of alcohol. Take a look at page 106 of the reading which summarises the legislative measures that could be strengthened in South Africa. Developing a broad knowledge of the kinds of legislation used in other countries and the impact thereof is an important step to contributing to such policies in your own context. Use Task 1 to engage analytically with the reading.

**READING**

Parry, C. D. H. & Bennetts, A. L. (1998). Ch 5 - Reducing per Capita Consumption and High-Risk Behaviours. In *Alcohol Policy and Public Health in South Africa.* Cape Town: Oxford University Press: 103-127. See pp 283- 296 in the Reader.

**TASK 1 – Analyse alcohol legislation strategies**

Select two different legislative strategies described in the chapter by Parry and Bennetts. Decide whether these strategies aim to reduce consumption or reduce harm. Analyse whether you think cultural, religious, political or economic factors have informed these policies. Consider what resources it would take to enforce these strategies, and what limitations may be encountered. Consider the sorts of reactions enforcement is likely to draw from alcohol users. Then assess the potential effectiveness of these legislative strategies.

The National Drug Master Plan was prepared by the Drug Advisory Board, at the request of the then Minister for Welfare and Population Development, and published in February 1999. This document is informed by the United Nations Drug Control Programme (UNDCP) and is ‘the single document adopted by

the government outlining all national concerns in drug control’. Although much of the Plan focuses on illegal drugs, the problem of alcohol abuse is included within the scope of the focus areas:

* Crime
* Youth
* Community health and welfare
* Research and information dissemination
* International involvement

The implementation is being facilitated and monitored by the Central Drug Authority (CDA), based in Pretoria. The implementation of the Plan is to be through provincial forums and drug action committees.

The CDA was brought about through the ‘Prevention and Treatment of Drug Dependency Act, 1999’, which is an amendment of the Act 20 of 1992. The CDA has representatives from most government departments and other national bodies. See website: [**www.CDA.gov.za**](http://www.cda.gov.za/)

The next reading by Room et al (2002) provides some interesting case studies to illustrate some of the main strategies used in regulating alcohol sales and consumption. The authors describe a range of interventions, some of which fall into the “harm reduction” category, and provide evidence of their effectiveness. At this stage, refer only to the specific page numbers listed below, and then read from page 192 - 210. Choose one of the case studies and redo Task 1 with this example.

**READING**

Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO. Focus on the boxed case studies on the following pages:

Page 188: Minimising intoxication at soccer matches in the Netherlands Page 190-1: Legislating against selling alcohol along state highways in Brazil Page 198-9: Prohibition of alcoholic beverages from 1996-8 in Haryana state, India

Page 200: Prohibition of importation of alcoholic beverages in Barrow, Alaska Page 205-207: Grog-free days in Tennant Creek, Australia

Page 208: Alcohol rationing in Greenland in the 1970s

Page 211-213: The women’s lobby for prohibition in Moen, Chuuk, Micronesia Page 213-215: The women’s lobby for prohibition of alcohol in Andra Pradesh, India in the 1990s.

### 3.1 Government Taxation of Alcohol Consumption

Decisions on the level of excise duty (tax) imposed on liquor products are not straightforward. While it can be demonstrated that alcohol abuse is a cause of many social and health problems, the liquor industry has significant economic power and influence.

In general, governments would want to generate a pool of revenue from alcohol taxes to support the services required to deal with the problems it causes. However, if the taxes are set at too high a level, illegal brewing and cross border smuggling is likely to increase. In turn, reduced overall consumption and increased production costs could jeopardise employment in the industry.

In general, liquor products are taxed according to the absolute alcohol content. This is a strategy which has been successfully used in Australia, where lighter beer was promoted by reducing the tax on the product.

Read this article by Parry et al (2003) arguing for an increased tax on alcohol in South Africa. If you live elsewhere than South Africa, see if you can find out the most recent tax levels on alcohol in your country, and whether the rationale to increase tax in real terms has been implemented in your context.

**READING**

Parry, C. D. H., Myers, B. & Thiede, M. (June 2003). The Case for an Increased Tax on Alcohol in South Africa. *The South African Journal of Economics,* 71 (2): 265-281. See pp 305-314 in the Reader.

In the next section, we consider the role of the media in spreading promotional or educative messages, and the control of alcohol marketing strategies, particularly amongst young people.

## MARKETING ALCOHOL

Promoting products in a free market economy is a well established practice, and sophisticated communication methods are used to appeal to diverse needs in different segments of the potential market. In the process of marketing, liquor can be portrayed in a variety of ways and through different media including radio, television, or printed media such as magazines, newspapers, billboards, branded clothes and other products. Such messages could be educative, for example a health discussion on how to drink sensibly, or they may promote the use of alcohol, as do advertisements of different liquor brands. Norms and values about the use of liquor can also be conveyed unintentionally by *movies* and television dramas, through their portrayal of drinking and the associated image of those who drink.

It is because of the powerful impact of marketing that many governments have introduced strict policies to limit the promotion of tobacco and alcohol products. In South Africa, much effort was made by the Health Promotion Directorate in the National Health Department to ensure that the Tobacco Control Policy included a ban on advertising and sports sponsorships, the introduction of packet labeling with health warnings, and the restriction of smoking in public buildings and workplaces. Work is currently being done to promulgate appropriate legislation to further control alcohol availability and marketing, but the issues are unfortunately not as clear-cut as they are with tobacco.

One segment of the market which is particularly susceptible to advertising is the youth. The next reading by Jackson et al (2000) provides a detailed analysis of the marketing of liquor to young people, and makes recommendations about a range of ways in which the production, marketing and availability could be controlled. According to this article there have recently been four major changes in the United Kingdom which impact on the drinking habits of young people:

1. The development of new designer drinks such as “alcopops”, white ciders and alcoholic energy drinks.
2. An increase in the strength of alcohol products, in direct competition with the illicit psychoactive substances market.
3. The use of sophisticated advertising and branding techniques, in keeping with emerging youth culture.
4. The opening of new drinking outlets such as café bars and theme pubs to attract younger drinkers.

Before you read the article, take a look at Task 2.

**READING**

Jackson, M. C., Hastings, G., Wheeler, C., Eadie, D. & Mackintosh, A. M. (2000). Marketing Alcohol to Young People: Implications for Industry Regulation and Research Policy. *Addiction* 95*,* Supplement 4: S597-S608. See pp 155-166 in the Reader.

**TASK 2 - What influences the drinking habits of youth in your area?**

Using the four trends listed above for the United Kingdom to guide you, gather relevant information on the marketing and promotion of alcohol to youth in your local area. Based on the information you gathered, answer the following questions:

* 1. What are young people drinking when they get together?
  2. What is the alcohol content of these drinks?
  3. In what way does current alcohol advertising appeal to young people?
  4. Which of the new venues where alcohol is sold, e.g. restaurants, pubs or cafes, seem to appeal to young people?

Based on your findings, answer this question: *Is there enough evidence to say that in your area there is a similar trend to that in the UK?*

### 4.1 Labeling of alcohol products

Labeling is one of the ways to advertise and promote a product. The packaging of any product serves both to appeal to the potential buyer, as well as to provide information on its contents and possible harmful effects. Liquor producers are only required to reveal the percentage of alcohol content on the package, but nothing else. There remains a potential to have laws that require standard drinks to include warnings and information on labels.

Read the requirements of Task 3, then read the article by Webster-Harrison et al (2002).

**READING**

Webster-Harrison, P. J., Barton, A. G., Sanders, H. P., Anderson, S. D. & Dobbs,

F. (2002). Short Report - Alcohol Awareness and Unit Labeling. *Journal of Public*

*Health Medicine,* 24(4): 332-333. See pp 463-466 in the Reader.

**TASK 3 – Analyse marketing of alcohol to the youth in your area and make recommendations for its regulation**

Spend some time in the next few days purposefully collecting liquor advertisements from magazines and newspapers, and noting down those you see on the television. Review all the examples you have collected, and analyse their appeal in terms of the youth market segment, the type of liquor, and the key message being promoted. An example of a key message is, for example, *If you have this drink you will be part of the trendy set.*

Revisit the five recommendations on alcohol regulation made by Jackson et al (2000) on pages S606-7, and decide which are relevant in your province or area in relation to the youth.

Control of marketing and labeling is one strategy to increase legislative control of alcohol, particularly in relation to groups like youth which are vulnerable to peer and image pressure. In the next section, we discuss the importance of community mobilisation and promotion of ownership in any broad intervention to control alcohol use or reduce harm caused by risky drinking.

## COMMUNITY MOBILISATION

It would not be possible to implement many of the strategies and policies described in this session at a local level without the participation of community based organisations.

The next reading by Treno and Holder (1997) emphasises the importance of community mobilisation in the process of implementing policies and environmental changes. The authors use the concept *community mobilisation* to refer to “… the efforts to involve community members in activities ranging from defining needs for prevention … to obtaining community support for a pre-designed prevention program” (Treno & Holder, 1997: S173).

This is a rather dense article; to begin to process it read the abstract carefully and then focus mainly on the figure and the tables: this will give you a sense of what the “Community Trials Project” in the USA was all about. The purpose of the paper is to be found on page S175, in the right column, second paragraph. Take note of the challenges of bottom-up and top-down approaches to community mobilisation (under *Strengths and limits in both approaches*). Below is a brief introduction to the paper. Read it and then try Task 4 as you read the paper.

**READING**

Treno, J. A. & Holder, H. D. (1997). Community Mobilization: Evaluation of an Environmental Approach to Local Action. *Addiction* 92, Supplement 2: S173-S187. See pp 447-462 in the Reader.

The programme described by Treno and Holder involved three comparable communities - Southern California, Northern California and South Carolina. The main interventions were:

* The Drink/drive reduction
* Responsible beverage service (RBS)
* Controls of access to alcohol
* Youth prevention

In this context, the environmental approach refers to “… implementing policies to reduce alcohol-related trauma” (Treno & Holder, 1997: S173).

A phased approach was undertaken comprising:

1. Project design: an ideal set of interventions was developed including objectives and activities.
2. Staff development: local indigenous workers were appointed and trained.
3. Coalition development: community organisations were involved.
4. Task force development: focused action groups were formed from the coalition and staff.
5. Intervention: implementation was achieved through leader support and community awareness.
6. Evaluation: the evaluation of the programme focused on the extent to which policies were adopted and implemented in the main areas of intervention.

**TASK 4 – Plan community mobilisation strategies for an intervention**

* 1. Borrowing from the conceptual model used in the paper by Treno and Holder (1997) and taking the particularities of your own target group, identify which strategies could be used to mobilise community involvement in an environmental intervention in your context. Specify what organisations you would involve and why they would be critical to the success of a programme.
  2. What is the importance of community involvement in alcohol-related interventions?

### FEEDBACK

a) Deciding on community mobilisation strategies cannot easily be done before your programme development process has begun. Below is an example of community mobilisation strategies from my experience. You could look back at Treno & Holder, pages S174 - S175, and the diagram on page S177, to assess to what extent the Sensible Drinking Project in Cape Town, described below, matches that of the Community Trials Project in the reading.

**CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 1**

**How did the Sensible Drinking Project start?**

This project started in Manenberg and Guguletu, in Cape Town in 2000. Research done by the Medical Research Council (MRC) had shown the strong association between alcohol and trauma at the GF Jooste Hospital, which serves these two communities. The Regional Medical Officer decided that a community based project was needed to try to reduce the amount of alcohol use that was leading to this harm.

A Task Team consisting of representatives from the Department of Health, Unicity Officials, UWC School of Public Health, Cape Town Drug Counselling Centre, SANCA, Arrive Alive, MRC and others came together to plan harm reduction interventions in the GF Jooste Hospital's main drainage areas of Guguletu and Manenberg.

A workshop was held in each community involving faith based organisations, schools, crèches, relevant NGO’s, mass media and community safety and security representatives,

e.g. police. The participants supported the idea of promoting a responsible attitude towards alcohol usage and a stakeholder's group (the SDP Committee), consisting of interested community members, was formed in each area.

It was decided to appoint a person from each community to co-ordinate the various community interventions in shebeens, clinics, sports clubs, schools and in the broader community. Adverts for the position were displayed at libraries, multi-purpose centres and other public places. Applicants were short-listed, interviewed and eventually one coordinator

from each catchment area was appointed. They attended a short course in developing community based alcohol prevention programmes at the UWC Winter School, as well as the Brief Interventions Training offered by the Cape Town Drug Counselling Centre.

**Launch of Project**

The Sensible Drinking Project was officially launched on 5 June 2002 at GF Jooste Hospital. The programme included presentations from the Director of the Unicity Health Services, UWC Public Health, the MRC and Dr Keith Cloete, coordinator of the project. Song items were delivered by Sinethemba and Manenberg Schools. Media liaison resulted in interviews on eight radio stations, and the community and regional newspapers carried articles.

**Lessons Learnt**

1. Spend time in selling the idea to all levels within a community, i.e. from councillors, to teachers, health forums and members of the community. This process could take many months, but is essential to removing obstacles later.
2. Choose a coordinator from the community to ensure that the project has a driver who understands local conditions.
3. Ensure that the coordinator has his/her own motor vehicle.
4. Provide adequate orientation and training to enable the coordinator to carry out the variety of tasks necessary to achieve the project goals.
5. Compile operational plans with each coordinator, so that they are clear as to what is expected of them, and the activities on which they should report.

Consider which of these strategies may be relevant to the community you work in, and do not forget the issue of community mobilisation when you come to design interventions both for your second assignment and in the future.

## SESSION SUMMARY

In this session, you have analysed policy interventions which have been used to control alcohol marketing and availability, as well as the necessity of mobilising communities as part of the development and implementation of policies. You have also considered the ways in which alcohol is marketed to young people and made recommendations on how this could be controlled. Hopefully you have broadened your view of the range of policy-level interventions that are possible, and analysed some of the challenges that face governments in relation to reducing alcohol consumption and the harm caused by it. You were also asked to consider a model of community mobilisation in relation to your target group. Your notes on how some of these issues relate to drinking amongst young people in your own area may be useful in completing your second assignment.

In the next session, we build on the range of possible alcohol related interventions by considering broad environmental changes that can be made in the drinking context.

## FURTHER READING

* Dept of Welfare, South Africa. (1999). *National Drug Master Plan*, RSA, 1999 - 2004.
* WHO. (2002). *Prevention of Psychoactive Substance Use. A Selected Review of What Works in the Area of Prevention*. Geneva: WHO, Dept of Mental Health and Substance Dependence.
* Parry, C. D. H. (2000). Ch 23 - Alcohol and Other Drug Abuse. *South African Health Review 2000.* Durban: Health Systems Trust. [Online], Available: http:/[/www.hst\sahr\2000\chapter23.htm](http://www.hst.org/)/ 11pages. [2001-7-18]

# Unit 3 - Session 2

**Environmental Changes**

## Introduction

As you by now know, a Health Problem approach to drinking would prioritise broad strategies which could be used to steer people away from excessive drinking, or to mitigate the harm caused by it. In this session we explore environmental strategies for harm reduction and providing alternative activities in order to reduce drinking. You will consider whether such strategies could be applied in your local context.

Crucial to environmental interventions is the concept of *drinking patterns*, which was discussed in Unit 2 Session 2: so you may want to refresh your memory on this issue as you work through this session.

This session has relevance to your second assignment, which involves designing appropriate interventions to address alcohol problems. You may find that the international examples of environmental interventions stimulate new ideas for your setting; remember also the importance of community mobilisation as discussed in Session 1. This may be crucial to making your programme successful. Most importantly, you will be able to consider what baseline information you may need in order to evaluate any environmental programme that you may plan.

## Session contents

1. Learning outcomes of this session
2. Readings
3. Alternatives to drinking
4. Harm reduction
5. Health Promotion using the media
6. Session summary
7. References

## Timing of this session

This session includes two readings, constituting 15 pages. There are two tasks which form useful preparation for your second assignment. Allow at least two hours for the session.

## LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Assess international examples of environmental adaptations to reduce alcohol intake and alcohol-related harm in local settings.
  + Discuss the role of a variety of media in supporting the communication of alcohol-related policy and environmental changes.

## READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Reading** | **Publication details** | **Page nos in reader** |
| Room, R. et al. | (2002). Ch 8 - Targeting Environmental  Change to Reduce Alcohol-Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-192. | **349-384** |
| Soul City. | (Undated). *Alcohol and You*. Johannesburg:  Jacana Education: 16-21. | **399-408** |

## ALTERNATIVES TO DRINKING

It has often been asserted that people drink too much alcohol when they are unemployed or when they do not undertake any stimulating activities in their free time; however, probably as many people drink in a risky way although they are employed and alternatives to drinking are plentiful. Providing activities to replace drinking is a fairly common strategy, but its success is questionable and difficult to measure.

In areas of Southern Africa such as on farms where the dop-system operated, or on the mines where there are numerous shebeens, a general shift in culture would be required as well as alternative activities, to reduce the time people spend drinking.

In the previous session, you explored some of the case studies in Room et al’s Chapter 8 (2002). Now read the first part of the chapter in full (pages 181-

1. after reading through the requirements of Task 1. This task provides good preparation for your second assignment.

**READING**

Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol- Related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 181-185. See pp 385-398 in the Reader.

**TASK 1 – Assess alternative activity strategies and develop baseline information for evaluation**

In this task, you are asked to consider whether alternative activities to drinking would have any impact on the community that you have described in previous tasks. Review your description and then:

* 1. List those alternative activity strategies mentioned by Room et al which would potentially work in your target group. Critically assess the strategies in terms of the context and available resources.
  2. Before intervening with alternative activities, you would need baseline information on current patterns of drinking and harm, in order to measure any change that may be due to the alternative activities. How would you develop your baseline information? Refer back to Unit 1 Session 2 where some methods of measuring alcohol consumption and patterns are discussed.

### FEEDBACK

As feedback, we have included another piece of the case study introduced in Session 1 of this unit, as an exemplar of baseline information to make monitoring and evaluation possible.

**CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 2**

**Alcohol availability and drinking habits in Nyanga and Manenberg**

A study by the Medical Research Council (MRC) in 2001 in two Cape Town hospitals assessed the association between alcohol and trauma. The study showed that 50% of patients being treated in the trauma units for injuries had alcohol on their breath when and more than 30% of these had possible chronic alcohol problems. Injuries were due to violence (63%), traffic accidents (22%) and other accidents (15%). More cases were male than female, and the average age was 30 years old.

In late 2000, a researcher from the UWC School of Public Health was asked by the Sensible Drinking Project (SDP) Task Team to collect some qualitative data on the drinking patterns in the target communities of the SDP. Over a two week period, Kirstie Rendall-Mkosi planned the study, recruited and trained two temporary fieldworkers (one Xhosa and one Afrikaans speaking) to collect the data through about 25 interviews. Ferdinand Bomvana, of the Metro Health Dept, collected data from interviews with youth. A presentation of the information gathered was made to the Task Team and to a community meeting in Manenberg, to highlight the nature of alcohol use in the area.

The main questions asked in interviews with alcohol sellers, drinkers, and to women in the community were:

What are the main drinks consumed in this area? When do people drink and how much?

Is food eaten while drinking alcohol?

How available is alcohol – where and at what times?

Is there a difference between men and women’s drinking habits? What are the main reasons for drinking?

What factors influence drinking habits and the liquor trade.

What are the things that encourage more drinking and less drinking (the facilitators and deterrents)

What happens when people have drunk too much? What are some of the controls used by alcohol sellers?

Similarities were found between Nyanga and Manenberg, but also some differences. In both areas, people said drinking mainly happens on weekends, but in the late afternoons and evenings during the week too. Unemployed people can be drinking at any time, while employed people drink mainly on weekends. Alcohol can be bought 24 hours a day from some outlets, and the sellers range from informal (selling a few bottles from the back door) to formal licensed taverns. The habit of drinking until very drunk is common, and generally people drink without eating at the same time.

The reasons given for drinking alcohol were both positive and negative: for enjoyment and relaxation; to socialise and network; to celebrate special occasions; to escape from household problems; to counter boredom; and to make it easier to talk about problems.

There is some difference in what is used and by whom in the two communities: in Manenberg, people drink beer and wine mostly, and spirits are reserved for special occasions, while in Nyanga, mainly beer, brandy and umqombothi are used. In Manenberg, it is acceptable for both men and women to drink alcohol, whereas in Nyanga it is less accepted for women to drink. In both areas, drinking among young people is becoming more common.

The factors which promote alcohol use range from its economic profitability, which results in many outlets, to the need for people to relax and socialise. Some sellers allow alcohol to be bought on credit.

The factors which influence people to reduce intake or abstain are based on cultural and religious norms, expectations that families need to be cared for with available money, the increasing cost of alcohol, and the action taken by some sellers to limit drunkenness.

Drinking too much is said to cause fights between friends as well as strangers, to make people too brave and argumentative, to put them in danger of pedestrian accidents, and also results in domestic violence.

## HARM REDUCTION

Interesting strategies are being implemented across the world to reduce the harmful effects from people drinking. Remember these strategies do not necessarily aim to reduce overall consumption of alcohol, but to put strategies in place to protect drinkers and others from possible harm. These strategies could take the form of boosting the nutritional status of drinkers, containing intoxicated people in overnight shelters or providing lifts home, and equipping servers of alcohol with skills to deal appropriately with the behavioural problems of drinkers.

**READING**

Room, R. et al. (2002). Ch 8 - Targeting Environmental Change to Reduce Alcohol- related Problems. In *Alcohol in Developing Societies: A Public Health Approach.* Helsinki: Finnish Foundation for Alcohol Studies in collaboration with the WHO: 186-192. See pp 349-384 in the Reader.

**TASK 2 – Reducing harm or increasing the appeal of shebeens?**

In trying to make shebeens safer places for drinking, some projects have promoted the idea of having games such as pool available in the shebeen. In addition, it has been suggested that food should be sold on site and water should be made freely available.

The problem is that those who advocate these alternatives could be accused of making shebeens more attractive, and in this way increasing the amount of time and money people spend there.

What is your opinion and how would you respond to people who question this “sensible drinking” strategy or harm reduction approach?

## HEALTH PROMOTION USING THE MEDIA

The influence that visual and auditory images and messages have on people can be considered part of the environmental factors which influence attitudes, values and habits concerning alcohol. In the same way as the media is used to promote the sale of alcohol by producers, there is the possibility of using it to promote responsible drinking, and even to shift the norms of acceptable drinking towards more cautious drinking or none at all. While the media can have limited impact in achieving behaviour change, it can:

* Provide knowledge, and increase awareness of a health problem and its solutions;
* Contribute to changes in knowledge, attitudes and behaviour;
* Demonstrate skills;
* Role model positive health behaviours;
* Link people to resources;
* Set an agenda and bring issues to centre stage in public;
* Contribute to the creation of a social climate that supports both individual and collective action;
* Generate public support for healthy public policy initiatives. (Coulson et al, 1998:117)

Although we do not have sufficient space to go into any detail on developing effective media here, it is worth at least considering the range of media one can use, and the fact that media can sometimes be used in combination:

* Posters and pamphlets
* Newspapers and magazines
* Newsletters and journals
* Drama, puppets and live media
* Radio and community radio
* Murals in public places, billboards and media on commuter vehicles
* Videos
* Television
* Personal media such as stickers and t-shirts.

Some educational strategies utilise mass media in an attempt to counter or balance the messages being promoted by companies marketing alcohol. Sometimes liquor companies will even sponsor the “sensible drinking” message, to demonstrate that they recognise that alcohol can cause problems.

READING

Soul City. (Undated). *Alcohol and You*. Johannesburg: Jacana Education: 16-21.

See pp 399-408 in the Reader.

Take a look at the extract in the Reader from a booklet produced by Soul City on alcohol use. This series of booklets is distributed occasionally in the *Sunday Times* newspaper nationally in South Africa, and at petrol stations and other public outlets. This issue coincided with the Soul City TV show which dealt with alcohol problems, amongst other issues, at the time. Copies of the booklet can still be ordered from Viva Books in Johannesburg.

## SESSION SUMMARY

In this session, you have touched on a number of aspects of environmental interventions including examples of such interventions, and the issue of using media to support healthy environmental changes and harm reduction strategies. You considered and assessed the application of environmental interventions similar to those described by Room et al (1992) in your own

context. In the course of this session an important programme development issue was raised, namely developing a baseline understanding of drinking patterns in your target group, in order to plan and evaluate environmental interventions. In the final session of this unit, we explore the potential of multifaceted programme interventions.

## REFERENCES

* Coulson, N., Goldstein, S. & Ntuli, A. (1998). *Promoting Health in South Africa: An Action Manual.* Sandton: Heinemann.

# Unit 3 - Session 3

**Multifaceted Integrated Programmes**

## Introduction

This session explores the value of multifaceted programmes in addressing alcohol problems, using the example of the Living with Alcohol Programme from the Northern Territory, Australia. This programme uses a multifaceted approach which follows the Health Promotion philosophy formalised in the Ottawa Charter. This provides a useful point to reflect on the importance of those principles in planning programmes to address alcohol problems.

In the second paper that you will read, May (1995) makes the point that it is the multiple influences on drinking behaviour that indicate the need for a broadly targeted response; he puts forward a wide ranging intervention proposal arguing that, “[E]mbracing a narrow paradigm such as the disease model of alcoholism will not be productive for either a full understanding of many behaviours (Illich, 1976) or for a truly successful prevention effort” (May, 1995: 1557).

In the course of the session, you are invited to familiarise yourself with multifaceted programmes and to consider the viability of such interventions in your own context. Programme monitoring and evaluation is covered briefly through the example of the Sensible Drinking Project programme matrix.

## Session contents

1. Learning outcomes of this session
2. Readings
3. Programmes for whole populations
4. Programmes targeting specific risks
5. Programme monitoring and evaluation
6. Session summary
7. References and further reading

## Timing of this session

This session contains 76 pages of reading in four readings. You have, however, been provided with a summary of Crundall’s interventions, and pointers for reducing the time you take to read the article by May (1995). You are also asked to refer to a reading by Croxford & Viljoen, which you studied

in Unit 1. There are three tasks in this session and if you do the reading selectively, it is estimated that it could take you about four hours to complete.

## LEARNING OUTCOMES OF THIS SESSION

**By the end of this session, you should be able to:**

* + Discuss the rationale for a multifaceted approach to alcohol problems.
  + Assess the viability of the multifaceted approach to specific contexts of alcohol use.
  + Apply the Ottawa Charter framework to alcohol interventions.
  + Develop tools for planning, monitoring and evaluating alcohol interventions.

## READINGS

You will be referred to the following readings in the course of this session.

|  |  |  |
| --- | --- | --- |
| **Reading** | **Publication details** | **Page nos in reader** |
| Crundall, I. | (Undated). *The Northern Territory Living with*  *Alcohol Program: Climbing Through a Window of Opportunity.* Australia: 98-105. | **69-78** |
| May, P. A. | (1995). A Multiple-level Comprehensive  Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-related Birth Defects (ARBD). *International Journal of Addiction,* 30: 1549-1602. | **195-222** |
| Medical Research Council (MRC). | (Oct 2000). Stop the DOP ... and more. *MRC News*, 31(5): 7-8. | **233-236** |
| Territory Health  Services. | (1999). The Public Health Bush Book. Darwin,  Australia: Government Printer of the Northern Territory for Territory Health Services: 4.42 - 4.56. | **421-436** |

## PROGRAMMES FOR WHOLE POPULATIONS

Since a number of factors influence people’s drinking behaviour as well as the environment in which they drink, it is logical that any programme aiming to change drinking behaviours or reduce the potential harm from drinking, should have multiple targets and a variety of components. Evaluations of many health promotion programmes relating to health behaviours, such as smoking, have

shown that a multifaceted approach is the most successful (Community Intervention Trial for Smoking Cessation, COMMIT Research Group, 1995).

The Living With Alcohol (LWA) programme in the Northern Territory of Australia is a well known programme designed to reduce alcohol related harm. Legislative, educational and treatment components or services were developed to tackle well established patterns of drinking, and to reduce the harm it causes. This inevitably involved a number of government departments (justice, education, health social welfare etc) as well as agencies from different sectors.

In the first reading, Ian Crundall describes the implementation of this multifaceted programme, discussing its guiding principles and the impact it had. You will note that a careful balance was maintained between bureaucratic top-down interventions such as drink-driving legislation, and community oriented approaches such as community action plans. Below is a summary of the components of this programme. Study the summarising diagram below and familiarise yourself with the requirements of Task 1, before reading the paper.

**TASK 1 – Consider the Living With Alcohol (LWA) programme in terms of the Ottawa Charter**

Revise your understanding of the action areas of the Ottawa Charter, i.e.

* + Healthy public policy
  + Supporting community action
  + Developing personal skills
  + Reorienting the health services
  + Creating supportive environments

1. To what extent do you think the LWA programme uses the Ottawa Charter as a framework?
2. Brainstorm ideas for a programme for your own context which fulfil each of the five principles of the Ottawa Charter. Put down at least three ideas for each.

**READING**

Crundall, I. (Undated). *The Northern Territory Living with Alcohol Program: Climbing Through a Window of Opportunity.* Australia*:* 98-105. See pp 69-78 in the Reader.

**SUMMARY OF THE ACTIVITIES OF THE LIVING WITH ALCOHOL (LWA) PROGRAMME, NORTHERN TERRITORY, AUSTRALIA**

**COMMUNITY ACTION PROGRAMME FAMILY VIOLENCE STRATEGY**

Facilitators: \* Arrest (where enough evidence);

* Information on safe alcohol consumption \* Prosecution;

and developing supportive environments for \* Perpetrator programmes; informed choices, e.g. story board. \* Services for victims;

* Feedback from community for development \* Community based development of of community action plan (targeting *drinkers*, culturally appropriate education & *non-drinkers* and *learners*). schemes, e.g. night patrols; safe

homes.

**EDUCATION LEGISLATION**

“*Drink Sense” \* Liquor Act*: increased penality for

* Media campaigns using slogans; selling to underage or intoxicated;
* NGO funding for awareness work; \* M*otor Vehicles Act:* increased
* Selection of priority areas: youth; workplace; penalties for drink driving;

liquor industry. \* Tax: reduced tax on light beers, increased tax on high % alcohol.

### LIVING WITH ALCOHOL PROGRAM (LWA)

Northern Territory, Australia

Targets: Reduce alcohol related road fatalities and accidents by half; Reduce apparent consumption of alcohol by 40%.

**DRINK – DRIVING TRAINING & PROFESSIONAL DEV**

* Increased penalties; \* Service providers receive training;
* Alcohol training programme; \* Hospitality personnel trained in
* “Sober driver’s pubs”; responsible serving of alcohol;
* Breathalysers in pubs; \* Certificate in PHC & subs abuse;
* “Home safely” campaigns in schools; \* Alcohol handbook & resource kit.
* Media campaign to promote responsible drinking guidelines.

**TREATMENT & REHABILITATION**

\* Health services and NGOs provide counselling; day care and residential programmes.

*Research, Monitoring and Evaluation was undertaken throughout all strategies.*

Although the authors do not mention Health Promotion theory as such, the components of the LWA seem to correspond closely with the action areas of the Ottawa Charter.

* Healthy Public Policy: Various laws were promulgated to control drunk driving, reduce sales of liquor to underage children, and increase tax on higher alcohol content liquor. There was also local policy to increase arrest and conviction of perpetrators of family violence.
* Supporting community action: A localised community action plan was developed.
* Developing personal skills: Various media and educational programmes were developed to raise awareness of the problems and increase knowledge to facilitate behaviour change, e.g., Drink Sense campaign, and interventions with perpetrators of family violence.
* Reorienting health services: Training and resources were made available for health service workers, and there was a shift in treatment to an outpatient model.
* Creating supportive environments: Hospitality server training was provided, community based family violence strategies were developed and breathalysers were made available in pubs.

It can also be seen that any one campaign or component, such as the drink- driving one, has many elements, and each of these could be categorised under different action areas of the Ottawa Charter framework. Depending on which aspect of alcohol related harm is being addressed, so the weighting of policy, skills training and environmental changes will be different.

## PROGRAMMES TARGETING SPECIFIC RISKS

According to Naidoo & Wills (1998), there are three main ways of using targeting in the design of Health Promotion programmes. These include targeting: risk contexts, at-risk groups and risky behaviours. There is, however, a dilemma in using targeting. Although targeting may ensure better use of resources if directed at the people or situations where the problem most often occurs, this approach can lead to *victim blaming* or *culture blaming*. For example, the cause of the problem may arise from the socio- economic context that people find themselves in, or the inequities between groups; in this case, no amount of focus on the target group will improve the situation. Some health determinants require a more universal approach so as

not to label and stigmatise people, but rather to deal with the causes on a broader basis.

In keeping with our themes of youth, women and settings, we will use the paper by May (1995) to apply the Preventive Model in reducing the prevalence of Fetal Alcohol Syndrome (FAS) and Alcohol-related Birth Defects (ARBD). While some of the interventions are aimed at pregnant women who drink, there are many that are directed more broadly at the population or aimed at changing the environment.

**READING**

May, P. A. (1995). A Multiple-level Comprehensive Approach to the Prevention of Fetal Alcohol Syndrome (FAS) and Other Alcohol-related Birth Defects (ARBD). *International Journal of Addiction,* 30: 1549-1602. See pp 195-222 in the Reader.

This is a long paper, so unless you are very interested in the detail of the interventions required for reducing the risk of FAS, I suggest that you focus on Figures 1 and 4, and Tables 4, 5, and 6. Together, these figures and tables will provide you with a summary of the levels of risk related to alcohol consumption, the targeting of prevention activities related to this risk, and the variety of activities required.

In the prevention of FAS, it is problematic to apply a Harm Minimisation Approach, since there is no way to protect the fetus from alcohol. The transmission of alcohol to the fetus is so fast and direct that the ideal remains that no alcohol should reach the fetus at any time during the nine months *in utero*. If one has to accept that a woman cannot stop drinking during pregnancy, the only opportunity to reduce harm is to alter the contents of the liquor, and the frequency and amount consumed.

**TASK 2 – Assess the potential of an intervention programme and consider viable alternatives**

In an earlier reading discussed in Unit 1 (Croxford, J. & Viljoen, D. (1999). Alcohol Consumption by Pregnant Women in Western Cape. *South African Medical Journal,* 89: 962-965), you were given some insight into the main risk factors and drinking patterns resulting in FAS in a Western Cape town. Many of them concur with Table 2 in the reading by May (1995).

1. Bearing these factors in mind, and anything else you may know about the living conditions and level of service provision for women in the rural Western Cape of South Africa, assess the viability of the interventions proposed by May (1995). In other words, identify the activities that could be realistically implemented in such a context, and those that are unlikely to work. Most importantly, say why you say so. Think of the issues of culture, norms and conditions, as well as resource constraints and competing programmes.
2. Can you think of any existing, universally available health and development programmes or services on which some of the FAS prevention activities could piggy-back?

In question (a) you were asked to choose an example that would work and one that would not work and to say why. While I support all the elements listed in the primary, secondary and tertiary prevention plans outlined by May, there are some that could easily be applied in the areas of Southern Africa where maternal drinking is a problem, but some would be impossible mainly due to resource constraints.

The DOPSTOP Association (meaning ‘*stop alcohol’* ) which is based in Stellenbosch in the Western Cape is an example of an organisation working mainly on a primary prevention basis. We have included a short article by the Medical Research Council about its activities which you will find in the Reader.

**READING**

Medical Research Council (MRC). (Oct 2000). Stop the DOP ... and more. *MRC News*, 31(5): 7-8. See pp 238 - 236 in the Reader.

Although the changes in drinking culture and policies related to access to alcohol take a long time to have the desired effect, they are possible to achieve.

However, the aspects of May’s proposed plan that are least likely to ever be realised are the secondary and tertiary levels of treatment for women. Since so many women are potentially damaging their children, it is not feasible to offer intensive rehabilitation for every woman who binge drinks on the weekend. A different model of long term community based treatment and support for changing drinking patterns will have to be developed.

b) The kinds of programmes which could serve to piggy back FAS prevention activities are as follows: There are fairly wide spread antenatal clinics that could take on a more active role in the screening and counseling of women who drink. If they coordinated their work better with family planning services, they may succeed in lowering the rate of unplanned pregnancies amongst women, especially those who drink. Another programme which is being rapidly expanded, and where funds are being directed, is the prevention and care for HIV/AIDS. The link between alcohol problems and HIV could be highlighted and more screening and counseling related to alcohol use could be incorporated into HIV testing, support and care initiatives.

## PROGRAMME MONITORING AND EVALUATION

It is difficult to cover all the intricacies of programme monitoring and evaluation briefly. We have therefore chosen to refer you to the reading below, by the Territory Health Services, which you may recognise from the *Health Promotion II* module, as well as some examples that appear in readings in this module.

Many policy and environmental interventions take years to effect the desired reduction of alcohol related harm, and it is difficult to isolate the effects of specific interventions, when there may be many other influences at the same time. However, one can monitor the achievement *process* and *impact* objectives in the shorter term, and make adjustments, to ensure that the anticipated longer term *outcome* is more likely to occur.

Territory Health Services. (1999). *The Public Health Bush Book.* Darwin, Australia: Government Printer of the Northern Territory for Territory Health Services: 4.42 -

4.56. See pp 421-436 in the Reader.

If you refer back to the reading by Treno & Holder (1997) and look at page S177, the authors discuss the data used for evaluating their community mobilisation model.

In addition, in the paper by May (1995) which you read earlier, you will find a brief, but useful section on programme evaluation at the end of page 1587.

Here is another section of the case study on Sensible Drinking which you have studied in this unit: take a look at Task 3 before studying the evaluation matrix used by the Sensible Drinking Project (SDP).

In the first setting the Health Promoting Schools approach was advocated since this is well known and quite widely used in the Western Cape. It places emphasis on the whole school system, and involves all role players in taking responsibility for developing a healthy learning environment and curriculum.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CASE STUDY – THE SENSIBLE DRINKING PROJECT, CAPE TOWN, PART 3** | | | | |
|  | | | | |
| **MONITORING AND EVALUATION SDP PROJECT WORKSHOP** | | | | |
| **Objectives** | **Activities** | **Indicator** | **Measures** | **Time**  **frame** |
| **Setting: Sinethemba High School and Silver Stream School** | | | | |
| Develop capacity | Initiation of HPS | Commitment | Training report. | Jan – |
| in school to deal | focusing on | and process |  | July |
| with alcohol using | alcohol. | planned. | Training report and |  |
| HPS Approach. |  |  | feedback from |  |
|  | Training of | Number trained. | Coordinator. |  |
|  | teachers and |  |  |  |
|  | learners. | Number of | Baseline questionnaire | Feb - |
|  |  | active leaders. | compared with 6 | August |
|  | Selection and |  | months later. |
|  | training of peer | Number of |  |
|  | leaders. | learners | Number of incidents of |
|  |  | involved. | drunkenness at school |
| Increased level of understanding of consequences, risks and associations with alcohol. | Class sessions  by Coordinator and SANCA. | Reduction in drinking behaviour and attitude towards alcohol. | functions.  Focus groups of learners and teachers to assess effectiveness of programme. |
| **Setting: Clinics, Day Hospitals (Health Centres) and GF Jooste Hospital** | | | | |
| Improvement in  identification, counseling and referral of people with alcohol problems.  Advocate for more resources and better networking in the area related to alcohol rehabilitation. | Further training  of health workers on 3 day course.  Introduction of case and referral form.  Audit of resources.  Meeting with role-players and decide what to lobby for.  Compile document and present to relevant funders and authorities. | Number trained.  Positive attitude development in staff.  Number of clients identified and referred successfully.  Agreement on increased resources from authorities and NGOs. | Baseline knowledge of  CAGE, counseling and resources.  Training report. Feedback from  supervisors. Analysis of forms.  Documentation of meetings. | Feb –  Nov  March  – Nov |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Objectives** | **Activities** | **Indicator** | **Measures** | **Time**  **frame** |
| **Setting: Shebeens in Nyanga and Manenberg** | | | | |
| Establish  commitment of owners to implement various controls.  To increase food intake while people drink.  To increase other activities on premises e.g. pool, cards. | Establish a  group of potentially committed owners (code of conduct).  Agree on controls and developments to be tried.  Promote specific food to be sold on premises.  Monitor the drinking levels, food intake and drunk incidents.  Introduce games and competitions. | Active groups  established.  Plan of action designed by participants.  Food intake to drink ratio.  Drunken incidents.  Number of premises with games.  Number of patrons involved in games. | Minutes of meetings.  Monitoring forms analysed monthly.  Try breathalyser. | Feb –  March  April – Nov  April – Nov |

Using this planning, monitoring and evaluation matrix as a model, develop one for your own planned interventions.

**TASK 3 – Plan your interventions and establish monitoring and evaluation tools**

Draw a table similar to the one above, and map out the strategies, activities and indicators that you are considering for your assignment. You may realise that many interventions are quite difficult to monitor. However, explaining your activities and what evidence there is of their implementation is essential for managing, as well as evaluating a project over time.

## SESSION SUMMARY

In this session you have read three papers which focus on a multifaceted approach to addressing alcohol related problems. On the basis of these papers, one may conclude that no matter what the scale of such programmes, they require a multisectoral approach and components that use different approaches and strategies.

The process of establishing these types of programmes is as important as the actual policies, educational messages or changes that are carried out. Participation by the relevant stakeholders and beneficiaries from the outset is

more likely to result in an understanding of the problems, as well as commitment to the planning and implementation of the strategies and activities.

This is the end of Unit 3. In Unit 4, we address individual strategies.

## REFERENCES AND FURTHER READING

* Naidoo, J. & Wills, J. (1998). Ch 5 - Targeting Health Promotion. In *Practising Health Promotion: Dilemmas and Challenges.* London: Bailliere Tindall: 92-111.