Consumer involvement in nutritional issues: the role of information¹,²

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ABSTRACT  Finding a strategy to improve diets is a concern of many politicians and health promoters. Distribution of information is one strategy, but seems to be relatively unsuccessful. There is public awareness of the role of diet in health, but this awareness has not led to sufficiently improved eating habits. What people buy and eat depends not only on individual but also on social, cultural, economic, and environmental factors. These factors are interrelated and food choice is a complex process, which explains why information supply on its own is insufficient as a strategy to promote healthy eating. Public health professionals in eight European cities therefore decided to use the health promotion approach as an alternative strategy to promote healthy eating. The essence of this approach is community action in which participation and multisectoral collaboration are key elements. Each of the sectors, such as consumers, supermarket managers, social workers, school teachers, restaurant keepers, and health workers, try to undertake actions that support positive individual behavior change. This so-called SUPER project has been running for five years and results to date are promising. Nutrition is emphasized in several places in the community. In this way people are involved in the process and become interested in and curious about healthy eating. Experiences of working with this strategy and opportunities for primary care physicians to apply this approach are presented. Am J Clin Nutr 1997;65(suppl):1980S–4S.

KEY WORDS  Health promotion, Healthy Cities, Ottawa Charter, nutrition issues, public health, community

INTRODUCTION  The relation between diet and health has often been discussed because of the concurrent effects of several behaviors (1). Although there is consensus among nutritionists that Western diets have become unbalanced and that the best diet to reduce the risk of heart disease is the best diet to protect against obesity, diabetes, common cancers, and other Western diseases (2), the current state of knowledge seems to be continually changing. Consumers are overloaded with healthy nutrition recommendations and in their view professionals seem to be continually changing their minds about what is healthy. Although viewpoints on dietary influences are changing, this does not mean that strategies to promote healthy eating should not be developed. However, people working on these strategies (such as primary care physicians) have to be critical of their own work and must be open to adapting their ideas according to new insights. In other words, not only consumers but also health promoters (in this case primary care physicians) have to take part in the learning process.

Finding a strategy to improve diets is a concern of many politicians and health promoters. Although the role of diet and illness is widely recognized, there is relatively less understanding of the factors that bear on how people choose, use, and change their food habits (3). Under the wing of preventive medicine, health education was advocated in many countries in the early 1970s. Rather than by just treating patients, it was believed that improvements in health would arise from promoting lifestyles conducive to health. Health education at that time involved individual behavior-modification techniques and was seen as a form of treatment (4). The individual was simply regarded as a “receiver” of health information and was expected to act according to the health messages. Nutrition educators were concerned about the question “How do we get the healthy eating message across?” Such efforts focused on specific nutrition problems and were largely limited to the use of printed materials, posters, and audiovisual aids. Interpersonal communication was confined to patient education in clinics.

Practical experience and several studies, however, showed that information and knowledge are important but not sufficient factors in behavior change. Predictably, this conclusion led to the question “why don’t they do what we want them to do?” One explanation is resistance of the public. Another explanation is looking at the nature of the offering. Consumers often know the facts and might even be motivated to change their behavior but the people around them, such as family and friends, and the situations in which they live do not always make it easy to change.

Food intake is shaped by social, cultural, economic, and political processes (5). Food habits are often inculcated early in life and are on the whole stable and long-lasting but are nevertheless subject to change. Such change may be induced by educational programs based on the idea that poorly balanced nutrition is due to a lack of knowledge. However, knowledge is just one aspect of nutrition behavior; personal taste, cultural traditions, patterns of social behavior, the foodstuffs available in supermarkets, and the menus in cafeterias, restaurants, and fast-food outlets all have important effects on food choice.

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Furthermore, the development of food-processing technology has influenced agricultural production and food availability and therefore nutrition patterns, more than any deliberate education campaign on nutrition (6). In other words, what people buy and eat depends not only on individual but also on social, cultural, economic, and environmental factors (7, 8). These factors are interrelated and altogether food choice is a complex process that explains why information supply on its own is insufficient as a strategy to promote healthy eating. Health education without this broader context taken into account has therefore been criticized as “victim blaming.” This led to a revised consideration of social models of health and a shift occurred from health education to health promotion.

From the perspective of health promotion, improving eating habits is not a question of nutrition education alone. It follows that the whole issue of nutritional behavior includes education, information, culture, trade, transport, distribution, industry, and social services. At the community level a community system is made up of various subsystems or sectors, individuals, and the interrelationships among them. The subsystems of a community include the political sector, the economic sector, the health sector, the education sector, the communication sector, the religious sector, the recreational sector, the social and welfare sector, and the voluntary and civic groups (Figure 1). All these elements could work on their own and still be effective to some extent, but it is clear that such a complex phenomenon as dietary behavior is most likely to change through an intersectoral approach that implies a contribution of all parties involved (9). From a systems perspective, change in one sector usually implies that adjustments or responses also have to occur in other parts of the system (10).

Communities can be considered as systems of power and influence with formal and informal functions for maintenance: management of conflict and competition, allocation of resources, and formation of public policy. The distribution of information is central to these maintenance functions, which are carried out through the interaction of subsystems including mass media and other institutions, organizations, and groups (11).

Organizations learn and change through a process of diffusion. Networks between organizations and actors in the community facilitate diffusion of ideas and practices. Mobilization and involvement of key community organizations will provide the impetus for total community participation in a program for change. The key organizations network with each other and, in a manner congruent with the diffusion theory, the change spreads throughout the community. For many proponents of this view, community change is nothing more than the aggregated activities of organizations, also referred to as intersectoral collaboration (12–14). These viewpoints are not present only in the field of health. The ideology behind government policies related to environmental problems, for example, is also shifting from regulation to facilitating communication among various stakeholders (15).

This is a major shift in thinking. The conventional model assumes that nutritionists generate knowledge that is transferred by nutrition educators to the consumers. This transfer of information model has been criticized mainly because the model does not consider consumers as experimenters but as passive receivers of expertise from the outside. The alternative is to put emphasis on building on consumers’ capacities to access external information when they need it, on developing consumers’ ability to experiment and draw conclusions, on enhancing consumers’ individual and collective ability to take sound decisions, and on empowerment.

Consumers themselves know best why they behave in a certain way. They are therefore also able to come up with solutions for improvements in health. Health promoters have to try to facilitate discussion among professionals and consumers. They have to work with consumers rather than telling them what to do. When consumers are involved in the discussion there is a greater chance that they do not stand alone in this changing process but that they change together. Organizations in the health, social, or economic field then change with them. Overall, the emphasis is on facilitation and perceiving consumers as equal partners. Thus, an important aspect of the intervention is to create a shared perspective on the local and context-specific problem and help develop a decision-making capacity to deal with it.

Because of this different way of thinking, the nature and scope of the role that communities are expected to play in the health development process changes. Instead of mere compliance and acceptance of health advice, this new model requires much greater involvement of communities in planning and managing health care. Furthermore, there has been an increasing realization that knowledge alone is not enough for behavior change. Society must make it possible for people to live healthy lives. Empowerment, therefore, aims not only at fostering healthy lifestyles but also at enabling people to mobilize social forces and create conditions, including health-supportive

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FIGURE 1. Schematic of a community as a system (9).
policies and responsive systems, that are conducive to healthy living. The challenge for us all is to find how to empower people to become advocates of health. Information and knowledge are important, but not sufficient, for us to be able to change.

In conclusion, a strategy improving public health nutrition should be based on this broader perspective, incorporating changes in the physical and social environments of the individual. This is not a vision that concerns only improving nutrition but is a basic starting point of health promotion in general (7). Public health professionals in eight European cities therefore decided to use the health promotion approach as an alternative strategy to promote healthy eating.

THE SUPER PROJECT

The SUPER project, or the nutrition MCAP (Multi-City-Action-Plan), is an eight-country project with a focus on improving diets. The basic assumption of this project is that a health promotion approach is necessary for implementing healthy nutrition behavior (9). Eight European cities are participating: Liverpool (United Kingdom), Valencia (Spain), Horsens (Denmark), Rennes (France), Amadora (Portugal), Eindhoven (Netherlands), Cagliari (Italy), and Charleroi (Belgium). The cities are all members of the Healthy Cities Project of the World Health Organization (WHO). In general, WHO documents have defined health promotion as including several key characteristics: the process of enabling people to increase control over and to improve their health, action to build a healthy public policy, the creation of supportive environments, the strengthening of community action for better health, the development of personal skills for health, and the reorientation of health care (6, 16).

The SUPER project tries to put these characteristics of health promotion in practice in the field of nutrition. It was decided to start on a small scale; therefore, each city identified two geographically defined pilot project areas. Partnership is developed between the community, the local government, the commercial sector, the health and social professions, and community structures (schools and neighborhood organizations). This implies that working committees with representatives from these sectors were established and exchanged information and try to achieve joint agreement on local priorities, targets, and plans. Efforts are made to focus on possible adjustments in the physical and social environments of individuals and to make these environments supportive for change. The aim of the project is to produce practical ways of improving nutritional status in different European country settings. The objectives can be divided into outcome objectives and process objectives:

The outcome objectives are 1) a positive change of environmental factors (physical and social) that influence public nutrition and 2) a positive change in knowledge and attitudes regarding healthy diets and a change in dietary behavior to improve public nutrition as a contributing factor to the long-term reduction of nutrition-related diseases (cardiovascular disease, cancer, etc).

The process objectives are 1) to incorporate the networks and activities initiated in the project into local structures so that community-based nutrition promotion becomes a structural approach and 2) to develop practical tools for health promotion programs. On the basis of experiences in five cities, a resource pack to be used in other cities will be developed that contains guidelines for planning, implementation, and evaluation of community-based health-promotion activities, with special reference to cooperation, communication, management, and research techniques.

Activities are organized within supermarkets (which can be made to be supportive environments because choice of food is often made at point of purchase) and other settings such as schools, neighborhood centers, restaurants, and local festivities. Each of the actors, such as consumers, supermarket managers, social workers, school teachers, restaurant keepers, health workers, and primary care physicians, try to undertake actions that support positive individual behavior change.

RESEARCH FOCUS WITHIN THE SUPER PROJECT

The participating cities agreed to link research with the project because the approach was relatively new for Europe and an aim of the project was to develop models of good practice. Initially, the role of research was thought to be important mainly for two parts: planning of the interventions and evaluation of the effects. It was decided to work with a 3-y plan. This started with a preliminary study to document frequencies of food consumption, nutrition knowledge, and attitudes of inhabitants of the project areas and to carry out an inventory in supermarkets to explore the selling policy of local supermarkets. The findings were translated into an intervention and the preliminary study was repeated to show the effects. Each step took 1 y, so it became a project of 3 y (17).

During the development of the project it became more and more clear that working according to the principles of health promotion also has implications for research (18). The goal of providing support for intersectoral and community participation assumes a learning process. This process requires collaborative problem posing and problem analysis as prerequisites to problem solving (19). The classic type of research in which it is up to the behavioral scientist to discover the basic facts and relations and up to others to somehow make use of what has been discovered was therefore too restricted. Furthermore, communities differ from each other in almost every dimension, including the number and type of residents and the particular type of problems that the community experiences. A health promotion approach must be a process that takes a more holistic perspective by assisting the community in assessing and improving health. This new approach is not a research study or experimentation-style scientific inquiry, but an investigation that leads to results and solutions specific to a particular community. This new approach will not eliminate epidemiologic studies but will utilize the knowledge from these studies to arrive at a local solution. Both for the advancement of science and the improvement of human welfare strategies, it was realized that research and action within health promotion should be closely linked.

It was discovered that the researcher acts less as a disciplinary expert and more as a coach in team building and in seeing to it that as much of the relevant expertise as possible is mobilized from all over the organization (20). This approach
calls for organizing ourselves for innovation more effectively (21). By working this way, the researcher is constantly challenged by events and by ideas, information, and arguments put forward by the project participants. If the advance of science is a learning process, clearly this continuous learning can be efficient.

Overall, health promotion is an ongoing participatory process of decision making that requires a flow of regular inputs rather than a one-intervention-evaluation situation. Health promotion is not a fixed and controlled approach but the implementation of flexible and multiple interventions or solutions.

RESULTS TO DATE AND EXPERIENCES OF WORKING ACCORDING TO THIS STRATEGY

The SUPER project has been running for 5 y and results to date are promising. The project has been successful in meeting the preconditions for change. Networks and the activities initiated in the project cities have been incorporated into local structures so that the health promotion approach in the field of nutrition has become a structural approach. Intersectoral collaboration resulted in complementary strategies including the creation of supportive environments, organizational change, and social and individual development. The interactive character and the importance of incorporation of the activities into existing local structures have resulted in independence of the projects, ie, projects don’t rely only on outside funding and outside human resources. Furthermore, practical tools for health promotion programs have been developed. On the basis of experiences in the five cities, a resource pack to be used in other cities and communities is being developed that contains guidelines for planning, implementation, and evaluation of health promotion activities, with special reference to cooperation, communication, management, and research techniques.

There have also been positive changes in environmental factors (both physical and social) that influence public nutrition. Examples of these changes are the willingness of supermarket managers to continue with activities, repetition of successful nutrition promotion activities in different community settings, and schools paying more regular attention to nutrition education. Most important, actors within the local nutrition and health systems are communicating with each other. Interest, curiosity, and awareness have been created and those involved have experienced ways of working together effectively. By means of encounters and discussions, mutual dependencies have become clear, creating possibilities for negotiation.

By initiating the discussion among actors in the food and health system, the subject of nutrition is emphasized in several places in the community. Consumers start asking questions instead of being overloaded with information. However, involving primary care physicians in this process has not been easy although they are important key representatives in the community. Most doctors have the attitude that they are the health professionals and that they have limited time to get involved in activities other than consulting patients; furthermore, they often find it hard to believe that (for example) neighborhood workers can promote healthy nutrition. In other words, they tend to be suspicious mainly because the approach means having to work with a level of uncertainty and keep several options open. At the same time, this approach also confuses patients, who expect their general practitioner to give them advice instead of asking the question “What do you think?”

Intersectoral collaboration and community participation involves a learning process for both professionals and community members. Whereas downstream movement of information (information transfer from professionals to the public) used to be dominant in the past, health promotion requires that the upstream movement of information become equally important. Health promotion requires an interactive approach with active sharing of information and dialogue between professionals and community members for a food and health system to achieve its full potential.

This interaction involves a radical cultural change. Actors have to learn what this means and how it can be beneficial for themselves as well as for the system as a whole. The focus is on cumulative learning by all participants and not only learning by consumers. The target of change is the community system as a whole, made up of its various subsystems or sectors, individuals, and the interrelationships among them. Old role definitions have to be abandoned and new ones are required. For example, a health promotion officer’s role might change from sitting behind a desk developing health education material to becoming a facilitator with close links in the community who provides a communication infrastructure for the actors of the food and health system. A primary physician’s role might change from giving patients individual advice to supporting their problem-solving capacities and assessing and translating their needs into local health policy requirements. The general practitioner is a key representative in a community who has an opportunity to be an advocate for health improvements. A willingness of intermediaries to change themselves before they can expect others to change is therefore a prerequisite. On the other hand, community members have to learn that their contribution is valuable.

Visibility of wants, possibilities, and expectations of all actors involved in the health promotion process is also critical. Actors in the food and health system have to recognize common ground and responsibilities and need to have the feeling that working together is worthwhile. Because of the multidisciplinary nature of the networks, a variety of skills and expertise is available, because each participant, institute, or organization has different qualities. Visibility of the fact that their combined contribution becomes more than the sum of their individual contributions (synergy) is therefore important. “Looking in each other’s kitchens” creates better understanding of each other’s goals, working strategies, and possibilities. By being involved in such an approach, primary care physicians, for example, can learn that community workers can mobilize consumers who are hard to reach and community workers can learn that primary care physicians know much about the perceived health problems and needs of community members. The exchange of ideas and debate about differences leads to sophisticated information and definitions of the situation at hand and gives insights into situations requiring improvement. Successful collaboration is related to clear role descriptions of participants that are based on their own wishes and possibilities. It must become transparent what actors
contribute themselves but also what others contribute to the process.

INFORMATION ON DEMAND

On the basis of experiences in the SUPER project, it is crucial that national and local governments start facilitating the debate between actors in the food and health system. Although there should be more emphasis on links and dialogue among actors, this does not mean that nutrition information itself is redundant. However, present-day nutrition education is still strongly focused on distribution of information, whereas there is a need to move toward an information-on-demand strategy. The information-on-demand strategy could be extended in terms of health promotion principles because the emphasis is on self-activity, taking responsibility for oneself and supporting the search for problem solving. Consultation media such as telephones, databases, teletexts or the Internet are suitable for supplying people with information at the time that they themselves need this information. Overall, educational material is necessary, but it is important to make more use of what is available and to try to improve connections to existing questions or questions that are raised through the interaction and participation processes.

CONCLUSION

Thinking about strategies for improving healthy eating has changed dramatically over the years. Multifaceted strategies have been designed and applied, with emphasis on community organization, group discussion, and public debate, often involving media such as television, radio, and press. Today there is a need to accelerate, intensify, and expand health promotion projects to the point where national leadership is the driving force. Primary care physicians need to become aware of their possible role in this approach and the opportunities they have as influential key representatives of communities.

CONFERENCE IN JANUARY 1996

To celebrate the fifth anniversary of the SUPER project and to share the experiences of the project with others, the project team organized The International Conference on Health Promotion and Nutrition, held on 25–26 January 1996 in Wageningen, Netherlands. The conference aimed to bring together professionals from the fields of health promotion and nutrition with a commitment to the WHO principles of health for all and health promotion. The purpose was to share scientific and practical experiences gained from the SUPER program to illustrate how to achieve the goals of equity, participation, and collaboration in practice.

The 2-d conference aimed to assemble all persons actively involved in the promotion of health and nutrition, eg, health promotion professionals, public health researchers, nutritionists, community dietitians, and community workers. There were plenary sessions by invited speakers, including Nancy Milio, Professor of Health Policy and Administration, from the United States, and Cecily Kelleher, Professor of Health Promotion, from Ireland. Besides plenary sessions, parallel workshops took place.

REFERENCES