'Top down' and 'bottom up' approaches to health promotion: are hybrid forms possible?

Denise Fry

Stacy Carter, Lucie Rychetnik, Vincy Li and Christiane Klinner

Centre for Values, Ethics and the Law in Medicine (VELiM)

University of Sydney

NSW Health Promotion Symposium, Sydney

15-16 November 2012

THE UNIVERSITY OF
SYDNEY

In the Health Department....

"Here's what you've been after for years - more money for health

promotion. It's from Canberra, and there's lots of it!   It's for obesity

prevention in kids, and you need to come up with a plan by next week that

Canberra and the Minister's office here will agree to. It needs

deliverables, targets and outcomes for the whole state. They want to know

what they'll get for their money.

You keep telling me that health promotion is effective: here's your chance
to show if it actually works – or not."

›

Health Promotion Director:

› *"here's the program you'll be rolling out for the next three years–it's all here, goals, strategies, workshops, resources, fact sheets, PPW presentations, and targets we have to meet".*

Health Promotion Practitioner:

"But what about the programs we've already got, or the one I'm doing with the council next year? We've been planning it for 6 months! What about consulting with the community? How will it go in the new suburbs, with the people who don't speak English, or the single parents? Did you say it's for three years? What if it's a fizzer?"

› It's likely that exchanges not remotely different from these have taken place in NSW hp in the last 3 years

› They illustrate some of the tensions between top-down and bottom-up approaches in hp and other policy areas

› They suggest that *where* and *how* people are placed in their organisations, their *different positions and vantage points*, and the *organisational and political pressures* that go with these positions, influences their approach to program development

› examine the views and practice of HPPs in relation to 'top down' and 'bottom up' approaches to health promotion,

› identify and discuss some of the tensions between these approaches

› consider how organisational position and vantage point influences perspectives on 'top down' and 'bottom up' approaches

› consider if more hybridised programs that draw on the strengths of both approaches could help resolve these tensions.

Part of a larger study (NHMRC 632679) investigating the role of evidence, ethics and values in health promotion

Focused on o/w & obesity prevention programs in health promotion teams in 3 NSW Area Health Services (now 5 LHDs)

Methods

An empirical study using field observation and data from 58 semi structured interviews with 54 health promotion practitioners (HPPs), with a range of roles and experience

Data collected in 2010-2011

We interviewed HPPs, not NSW Health (central office) staff

› National Preventive Health Partnership Agreement between the federal government ($$) and state governments (implementation)

› NSW Healthy Children's Initiative (HCI) – specifies a series of obesity prevention programs designed by NSW Health central office, for uniform, state wide implementation by regional hp teams and other agencies

› Changes to health services administration in NSW – from 8 AHSs to 23 Local Health Districts

'Top down' and 'bottom up': a linked phrase

› Top down – starting from a large, basic unit, originated and directed by the highest rank

› Bottom up – built up from details, with involvement by many, from the bottom of the decision making tree

› Implies a hierarchical decision making structure

› Widely used terms in public policy (Sabatier, 1986), in hp (Laverack and Labonte, 2000), and by HPPs in our interview data

Our data shows various understandings

› Top – above me, usually out of reach or influence. HPPs' interpretations of 'top' included their hp director, or AHS executives, or NSW Health and/or the Federal govt

   'handed down from on high..' B1 162

› Bottom –another more local or specific source of knowledge and/or experience, usually reachable through consultation with community networks & members. HPPs' interpretations of 'bottom' included the AHS (now LHD), or part of its services, or specific localities, community agencies or members.

A shift to mostly 'top-down' programs

› O/w & obesity prevention became the bulk of the work of hp teams

› HPPs' main o/w & obesity prevention work was to implement the mandatory, NSW Health designed HCI programs

› Some versions of programs initiated by regional hp teams have become part of the mandated HCI programs for preschool/child care centres

› Some hp teams added localised components to HCI programs

› Generally the HCI was seen as a 'top-down' program'

But local 'bottom-up' programs continue

› regional hp teams continued to develop and run their own 'bottom up' programs, on o/w & obesity prevention and other health issues

Top-down programs (mostly HCI)

› Munch and Move – preschools and child care centres

› Live Life Well@School – primary schools

› Go4 Fun – children's weight loss program

› Promotion of Measure Up campaign and Get Healthy phone service

Bottom-up programs

› Workshops on school gardens

› Breastfeeding education in Korean, Mandarin, Cantonese

› Climate change program with 20 local agencies

› Food 4 Life Market –healthy and affordable food for low income communities

› Healthy urban planning with local councils

› School playground markings

› Secondary Schools Teacher Network

'Top down' programs

› Within the obesity 'spotlight', most but not all part of HCI

› Some programs informed by some evidence, others less so

› Several programs at pilot/untested phases of development

'Bottom –up' programs – diverse in terms of

› size

› health issues

› collaborating partners

› level of funding

› strategies used

› extent of evaluation

› Designed by others -State/Commonwealth/AHS

› Imposed

› Large scale – aimed at populations

› Focus on diseases/risk factors

› Individual behaviour

› Brings more resources

› Uniform/standardised

› Branded/glossy

› Involves repetitive, directed work

› Managerial delivery – meeting targets

› Quantitative evaluation by selected performance indicators

› Builds on relationships with community groups and members

› HPPs have a role in program design

› Reaches specific groups in the community

› Can address underlying causes – eg social determinants of health

› Diverse and flexible for specific contexts

› Creative, innovative, autonomous

› Multiple ways of evaluating – small scale, quant and qual, intuitive

› Sometimes too small scale to be effective at population level

› Unclear goals and outcomes

HPPs valued some t/d approaches, and supported their expansion

'I think our role is to work at an organisational ..and ..high policy level to make things happen at a policy and legislative level' B8 798-800

'we should be looking at the upstream determinants; ... the obesogenic environments and ..undoing that. A3a 451-3

and parts of the t/d obesity prevention programs – more $$

› *Well, there's more funding for it, and ...that's a good thing. A3a 580-1*

and the focus on children

› *It's intuitive..people look at it and go..yeah,...all our long day care centres and pre-schools should be doing something like that." B8 731-4*

the obesity frame

'obesity is a serious medical problem... but I don't think we're doing any good harping on about it'.. We need to ..look at the causes of the causes...not just point out the problems all the time' C1 872-4, 909-12

'We don't talk about overweight and obesity with our communities ...we talk about physical activity and nutrition and supportive environments... there's an ethical dimension around labelling people around weight.' A1 12017-21

› **imposed uniform programs, with little room to adapt strategies for different communities**

› *'there isn't a one size fits all' A6 663*

› *'we need the flexibility to modify (state-wide programs) to make them work as best they can' A3a 402-3*

› *'these campaigns are dreamt up in glass cages and given to us' C5 222-4*

› **there were fewer opportunities for innovation**

› *'you don't have that opportunity to be innovative and we've got a fairly young workforce who have got great minds and I think they feel a bit constrained' A6 717-18*

› **lack of recognition and valuing of their skills and experience by NSW Health**

'they're looking for state-wide roll out but at times are not listening to the local expertise that should guide the development of good programs' A12 272-4

'it doesn't feel like (our knowledge) is valued by NSW Health' A6 670-71

'the things that make programs work best on the ground are being ignored to some extent' A3b 469-71

› **a narrowing and restriction of their professional role**

› *'we don't have the choices to sort of develop new things any more' B1 1468-9*

› *'the power's taken away from us - in terms of making it more relevant to our population' A19 546-7*

› **Opportunities for innovation & creativity**

› *'The innovation, to plan something and see it come to fruition and ..evaluate it and say, ..that's actually made a difference.'* A15 763-8

› **programs can be adapted to diverse needs and conditions**

› *'it's our community, we know what's going to work, and not work'* A3a 379

› *'It's very rewarding to work with partners to come up with ..strategies that fit the local area that we live in and the local needs of the area'* C1 225-7

› **can focus on environmental and social determinants of health**

› *'..making our environments healthy in the first place'* C11 528-9

› **local – building on previous work and community relationships**

› *'it built on...a very small little project with one school...then 4 schools ..then a much larger scale proposal'* A6 927-33

› **Too small scale**

› *'at a local level, you're sort of stuck with fairly low level interventions' B5a 170-1*

› **Need clearer goals and better evaluation**

› *'no identified outcomes - no plan for what they were actually trying to achieve' A12 603-4*

› **Not intensive enough to change population health**

› *'small group programs are never a way to change the population' B5c 236-7*

...a big space between top and bottom

› *'It's hard to find out how they make decisions. ..there is a huge gap between the workers in the field and whoever makes the decisions at (state) level..' B1 119,128-130*

....and thought there were few opportunities for regional/local HPPs to discuss approaches and/or exchange knowledge with central decision makers

'There is very little consultation that we see at this level' B1 120

› *'I couldn't tell you.... I wouldn't know....I don't know' D4 1523-7*

› *'We get nothing. It's like this black hole' A13 622*
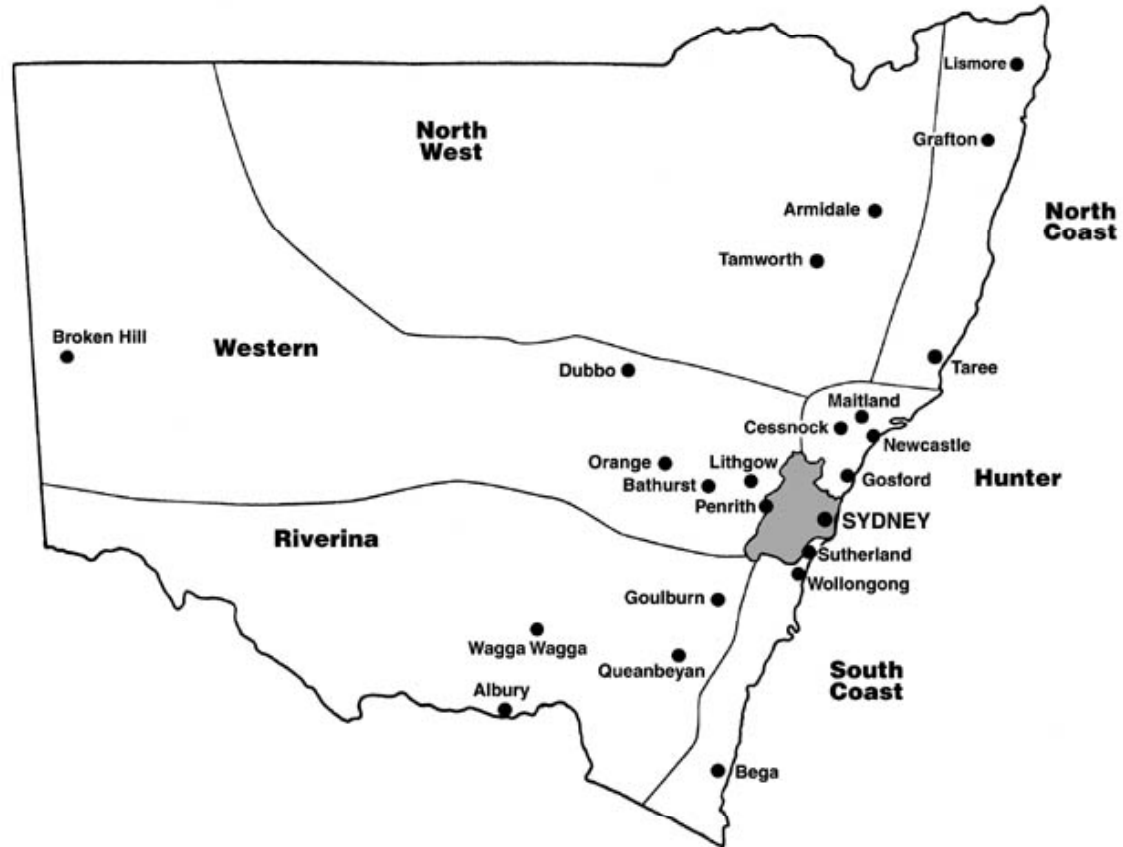
› Health promotion activity is needed at all these levels- state wide, LHD and local/community levels.

› I don't wish to imply some sort of fixed, mechanical relationship between vantage points and the perspectives that people have.

› People's perspectives are influenced by many things, including their other life and work experiences and the resources available to them, as well as their organisational position and vantage point.

Health Dept

› A hierarchical structure

› Many competing interests

› A predetermined framing of the issue – hard to modify at policy level

› Must win others' support

› Tiny $$ for hp to date means evaluation and evidence base is limited

› Not certain if programs will work

› Pressure to meet targets for reward payments

› An imminent election, with a likely change of government and consequent Departmental changes

› AHSs/LHDs also hierarchical structures

› Some HPPs more affected than others

› Sense of obligation to collaborating agencies and groups to maintain links and joint programs

› Balancing existing/new programs

› Expectations of community groups that programs will be adapted

› Job satisfaction – repetitive work, limited roles

› What if low participation jeopardises targets? Is adaptation for local needs possible?

› Organisational position is directly linked to capacity to influence and make decisions

› People on lower rungs of the hierarchy have less opportunity to influence decisions than those on higher rungs

› Nor surprising that tensions arise

› Our research focused on HPPs, we do not have data reflecting perspectives of people in NSW Health

'Scaling up' programs (as in the HCI) brings tensions between t/d and b/u approaches to the fore, raising questions:

› is centralised planning and co-ordination of standardised programs the only way to achieve scale, reach and effectiveness at population level?

› can state-wide programs be more diverse in response to different circumstances and local needs?

› Are top down and bottom up approaches mutually exclusive?

› Are hybrid approaches and programs possible?

› How should programs be developed?

› Laverack (2009 and 2012) - combining approaches to accommodate bottom up objectives in top down approaches

› Castro et al (2009) – identify factors (language, socio-economic status, cultural practices, geography etc) that result in mismatches between program characteristics and participant needs: and conclude program adaptation with appropriate evaluation is needed

› Milat et al (2012) – Delphi process with 14 policymakers and researchers to define scalability and identify factors to be considered for 'scaling up'

› State wide Projects Group (2011) Key Elements report – consider that successful roll-out of large scale programs depends on consultation, co-ordination, communication and resources, from the stages of initial planning to implementation to evaluation.

It is desirable and possible to hybridise t/d and b/u approaches – but it requires consultation and collaboration between policy and decision-makers, practitioners, researchers and community members.

Some ways to hybridise:

› Distinguish between goals and strategies – shared, overall goals can be achieved by a range of different strategies

› Top down programs – keep population focus and shared goals, but diversify the strategies and implementation

› Bottom up programs – plan and evaluate well, articulate program logic, document processes and results, consider adaptations/extensions

› Begin collaboration at initial stage and continue through all stages

› Make space for plurality of program development and evaluation methods

Thank you

denise.fry@sydney.edu.au