Lifestyle interventions – whom to target and how?

In the current issue of the Journal, Steyn and colleagues provide a systematic review of workplace interventions that have been published over an 11 year period and address changes in nutritional knowledge, dietary behaviour, clinical markers or policy outcomes. Of the 30 studies which met the predetermined search criteria, 9 were rated high as far as quality was concerned. Not surprisingly all but one of the 30 studies was conducted in developed countries, the majority in the USA. The only outlier had been conducted in India. The obvious question to be asked is how relevant are the methods and findings to South Africa?

Although South Africa is the industrial hub of the African continent and is considered by many to have a veneer of first world business practices, if one looks at the nutritional issues in this country can one address them by targeting the workplace? Firstly, unemployment rates are very different between countries of the developed world and South Africa, thus if one targets the workplace one is potentially going to miss a large percentage of the population at risk. According to Stats SA,[1] the current unemployment is at 23.6%. Further, the percentage of adults employed in the formal business sector is even smaller than the employment rate as many employed people are in the informal sector, which is difficult to target. Secondly, of those who are employed in the formal sector, how many make use of canteens or vending machines for the provision of their meals and snacks while at work, rather than the informal street vendors or fast food outlets? Thirdly, perhaps most important of all is the question "are we not trying to intervene too late by targeting the workplace?"

As has been noted over the years, South Africa is plagued by the double insult of under- and over-nutrition, with obesity being a major player not only in adults but also increasingly so in our adolescent children – particularly females. Thus, if we are to address the problems associated with obesity (hypertension, stroke and diabetes) we should be targeting those age groups during which the obesity prevalence is rising, in other words the school going adolescent and so paving the way from adolescence to a healthy adulthood. Furthermore, this is not just an urban problem as the obesity prevalence is rising rapidly in rural areas. Therefore, it is critical that obesity and metabolic disease risk are also targeted in rural South Africa, as these communities will be experiencing the greatest transitional pressures in the next five years with greater government emphasis on rural development.

Nevertheless, the workplace may be an appropriate setting in urban South Africa to implement health promotion interventions in adults. The term "health promotion in the workplace" is a multidimensional concept that embraces at least two major philosophies about what health is and how it is influenced. The first philosophy sees health as largely the product of individual behaviour and as an individual responsibility. It may acknowledge the role of genetics and environment to some degree, but the type of health promotion arising from this set of beliefs focuses on individual behaviour. Consequently, the workplace is seen primarily as a venue through which various programmes can be delivered. Examples of programme areas are: fitness, stress management, smoking cessation, back care, weight reduction/nutrition, and medication. The second philosophy sees health as being influenced by a number of forces, a significant number of which are outside the individual's control. While acknowledging the individual's responsibility for his or her own health, this set of beliefs focuses on the role of the environment. Consequently, the workplace is seen as an influence on health in its own right. The attention here tends to be on the organisation and design of work in both its physical and psychosocial dimensions.[2,3]

Enthusiasm for workplace health promotion interventions has been around since 1960 in the developed world. In an earlier review,[4] the potential value of five types of interventions has been highlighted: (1) changes in the workplace food supply; (2) point of choice nutrition information; (3) collaboration with food vendors; (4) worksite nutrition policies and incentives; and (5) changes in the structure of health and medical care related to nutrition. In a later review,[5] Seymour et al concluded that interventions in "limited access" sites, where few other choices were available, had the greatest effect on promoting healthier food choices.

These reviews and that of Steyn and colleagues do provide valuable evidence of best practice and possible barriers. To translate possible interventions into the South African setting, it will be important that the fundamental building blocks (positioning theoretical frameworks of behaviour modification as the first tier for a successful intervention, followed by data from evidence-based interventions, and the final tier best practices) are revisited and supplemented with South African research. In our pursuit to improve health and wellbeing and curb the burgeoning metabolic disease burden in South Africa, lifestyle workplace interventions may be one tool in an arsenal that includes schools, families, peers, and community intervention programmes.

References

1. Statistics South Africa. (2009). Quarterly Labour Force Survey (QLFS), 2nd Quarter 2009. Pretoria.
2. Heaney CA, Goetzel RZ. (1997). A review of health-related outcomes of multi-component worksite health promotion programs. American Journal Health Promotion 11:290–307.
3. Eakin JM. (1997). Work-related determinants of health behavior. In: Gochman DS, ed. Handbook of health behavior research I: personal and social determinants. New York: Plenum Press.
4. Glanz K. (1988). Environmental interventions to promote healthy eating: A review of models, programs, and evidence. Health education & behaviour 15: 395-415.
5. Seymour JD, Yaroch AL, Serdula M, Blanck HM, Khan LK. (2004).Impact of nutrition environmental interventions on point-of-purchase behavior in adults: a review. Preventive Medicine 39: 108-136.

Norris SA BSc (Hon), BA (Hon), PhD (Witwatersrand)
Pettifor JM MBBCh; PhD(Med) (Witwatersrand); FCPaed(SA)
MRC Mineral Metabolism Research Unit
Department of Paediatrics, University of the Witwatersrand, Johannesburg, South Africa
Correspondence to: Dr Shane Norris, e-mail: san@global.co.za