



Eat well    Move more    Live longer

# CHANGE4LIFE MARKETING STRATEGY

In support of Healthy Weight, Healthy Lives

**DH INFORMATION READER BOX**

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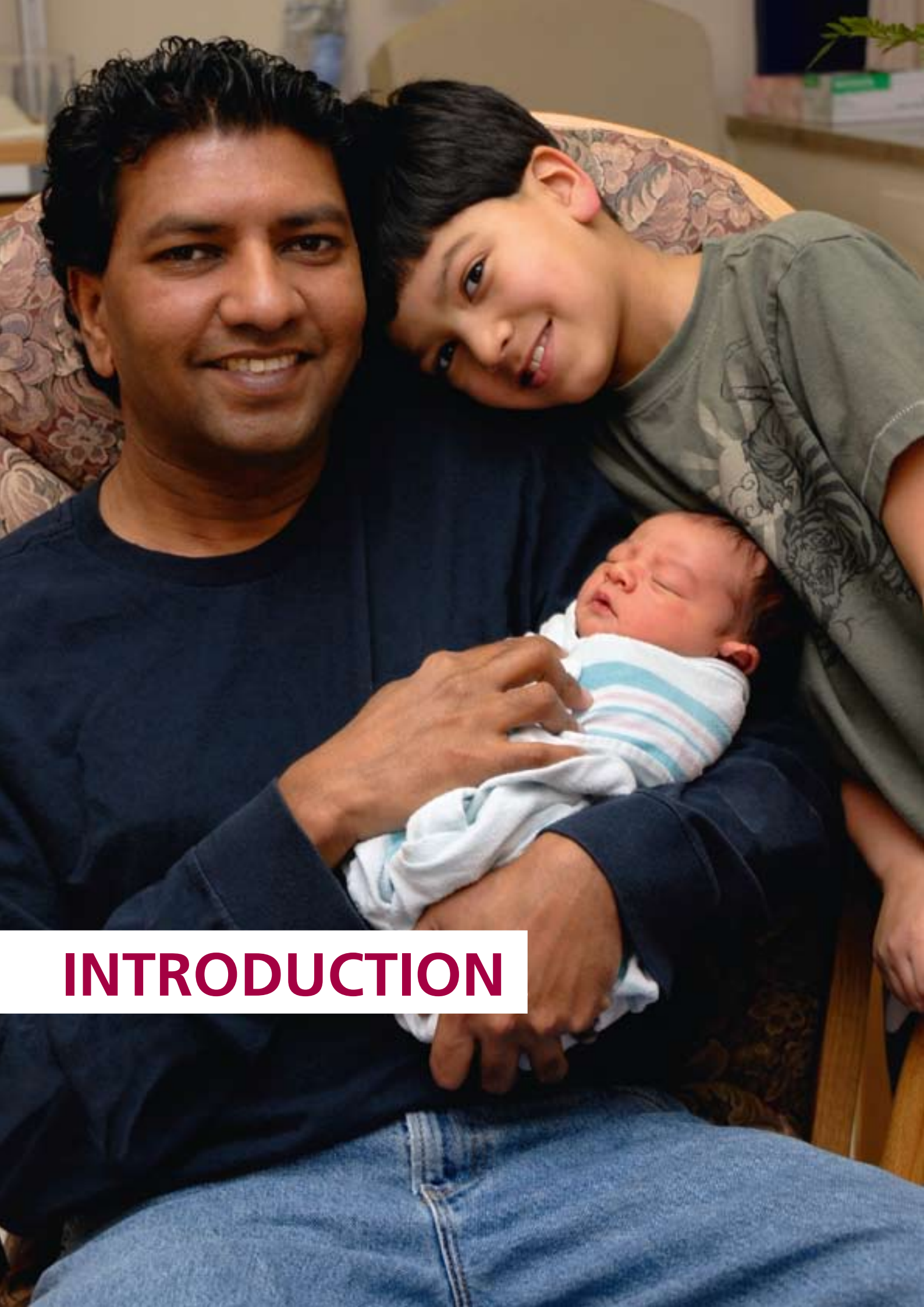
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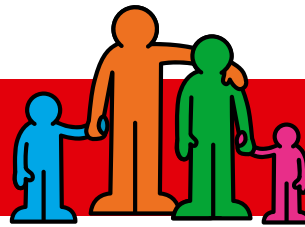


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# INTRODUCTION



This document sets out the Department of Health's marketing strategy for reducing obesity in England. It represents the marketing component of a much broader response to obesity, set out in *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England*, and has been written to coincide with the first annual report of the Healthy Weight, Healthy Lives programme.

This will be England's first ever national social marketing campaign to reduce obesity and the most ambitious to launch anywhere in the world on this topic. Unlike other areas of health promotion, which can draw on a rich evidence base of what has and what has not worked in the past, this campaign will be breaking new ground. In designing it, the Department of Health and its agencies have drawn on academic and commercial sector expertise, behaviour-change theory and evidence from successful behaviour-change campaigns in other categories (particularly tobacco control). The Department of Health has also commissioned a substantial and ongoing programme of research among the target audiences.

This has allowed the authors to create a hypothetical model of the behaviour-change journey and to devise marketing activities to drive, coax, encourage and support people through each stage. We have created the strongest programme we believe we can with the available evidence. However, this is a hypothetical model and the behaviour-change journey has not been proven. It is expected that much of our marketing will achieve its objectives; however, we anticipate that some of it may not work in the way it was envisaged (or not work at all) and there will undoubtedly be some unforeseen and unintended consequences. A programme of monitoring has been put in place to allow us to measure the impact of the marketing campaign, learn and refine. We will document our findings one year from now, detailing what impact the campaign has had and how we will be refining both the marketing and the model underpinning it as a result of what we have learned.

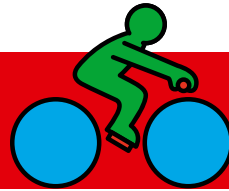
The campaign described in this document launched to the public on 3 January 2009. Called Change4Life, it urged the public to 'Eat well, move more and live longer'.

In its first year, Change4Life will focus on families, particularly those with children under 11. In years two and three, the campaign will expand to address other at-risk groups.

This document is the first version of the marketing plan. As we learn more and refine both our model and our communications, we will be publishing updates. The first of these will be in the spring of 2010.



**EXECUTIVE  
SUMMARY**



## The task

Obesity is rising at an alarming rate. Already, around one-third of children and two-thirds of adults in England are overweight or obese. If trends continue as forecast,<sup>1</sup> by 2050 only one in ten of the adult population will be a healthy weight.

In response to the rise in obesity, the Government has set out its ambition that, in future, all individuals will be able to maintain a healthy weight. The initial focus will be on children under 11, where the Government's target is to reduce the percentage of obese children to 2000 levels by 2020. The children who will be aged 11 or under in 2020 have not yet been born. There is a unique opportunity to influence the lifestyles of these children and the environment in which they are raised from birth.

*Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* announced £372 million for a major programme of measures, including increased funding for pregnancy and early years, promoting a culture of healthy eating in schools, the development of Healthy Towns and building more cycle lanes and safe places to play.

*Healthy Weight, Healthy Lives* also announced £75 million for a three-year social marketing campaign.

The focus of this campaign is on prevention and it sets out to change the behaviours and circumstances that lead to weight gain, rather than being a weight-loss programme for the already obese. At the same time, it will of course influence the behaviours of today's children, leading to a gradual decrease in the prevalence of obesity.

## What is social marketing and how can it help?

Social marketing is 'the systematic application of marketing to achieve specific behavioural goals for a social good'.<sup>2</sup>

Social marketing will support the overall Healthy Weight, Healthy Lives strategy by:

- creating a segmentation model that allows resources to be targeted to those individuals who are most in need of help (i.e. whose attitudes and behaviours place their children most at risk of excess weight gain);
- providing insight into why those individuals hold those attitudes and behave as they do;
- creating a communications campaign to change those attitudes;
- providing 'products' (such as handbooks, questionnaires, wall charts, web content) that people can use to help them change their behaviours;

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1 Government Office for Science, *Foresight. Tackling Obesities: Future Choices*, 2007

2 French J and Blair-Stevens C, *It's Our Health!*, 2006

- signposting people to services (such as breastfeeding cafés, accompanied walks, free swimming and cookery classes); and
- bringing together a coalition of local, non-governmental and commercial sector organisations that will use their influence to change behaviour.

If it is to have an impact on long-term behaviour, this marketing programme will need to achieve a scale never previously witnessed. The programme's targets are to generate 1.5 million responses from at-risk families, with 200,000 of those respondents converting into a customer relationship management (CRM) programme to support behaviour change.

### Who will we target?

The targeting of this campaign has been driven by an extensive body of academic and consumer research, to understand both which audiences are most in need of support and those with whom marketing can have most impact.

The focus will be on pregnant women (an ever-changing universe of up to 600,000 women at any one time), the 1.4 million families who have children aged under 2, the 1.6 million families with children aged 2–10 whose children are most at risk of weight gain and those ethnic minority communities (particularly black African, Bangladeshi and Pakistani) where levels of childhood obesity are particularly high.

### How can we change behaviour?

Since there is no universally accepted model for behaviour change with regard to obesity and since this is the first time any government has implemented a programme of this nature, scale and ambition, we have reviewed existing literature on behaviour change for diet and activity and have derived a set of assumptions, which we will use to drive our marketing campaign.

We recognise that some of our assumptions may be proved wrong. We will monitor our marketing and test which were correct.

### What are our assumptions?

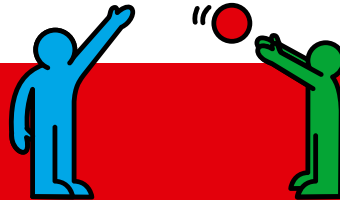
At this stage, we believe that the programme needs two stages. These are:

- creating the right preconditions for behaviour change; and
- supporting people on a behaviour-change journey.

Before we can expect behaviour change on any significant scale, people will need to:

- be concerned that weight gain has health consequences;
- recognise that their families are at risk and take responsibility for reducing that risk;





- know what they need to do to change; and
- believe that change is possible.

We believe that propensity to change can increase when:

- people are asked about their own behaviours;
- information is personalised;
- people are encouraged to create their own goals;
- people can see how their behaviours are benchmarked against others;
- they are able to record their own progress; and
- they are given feedback, reminders and rewards.

These assumptions have implications for the overall shape of the campaign: what we will say and what tools, techniques and products we will provide at each stage.

## Campaign phasing

### Pre-stage: mobilising the network

Unlike traditional public health information campaigns, which begin with top-down and centrally delivered messages, this campaign began with over six months of engagement with partners and with workforces, local service providers, potential local supporters and non-governmental organisations (NGOs), so that, when national marketing started, the public would encounter an informed and supportive local environment. It also enabled those organisations that provide services and commission marketing of their own to join up their activities with the national effort.

This phase included social marketing training (including briefing on the research findings), face-to-face presentations and direct marketing. For example, the Secretary of State for Health wrote to 220,000 individuals who are active in grassroots organisations and the Chief Medical Officer and the Chief Nursing Officer wrote to every general practitioner, practice nurse, midwife, health visitor and health trainer in England.

This phase is ongoing and will grow as the campaign develops.

### Phase one: reframing the issue

On 3 January 2009, Change4Life launched officially to the public with television and print advertising, an information line and a campaign website. People who responded to the campaign were sent a welcome pack of materials, including a handbook for

Healthy Happy Kids, a wall chart detailing the required behaviours and stickers for their children.

The brand identity is 'Change4Life'. This identity was selected because:

- the words contain both an imperative (change) and an aspiration that the change will be long term (4life). The double meaning of '4life' also stresses longevity (i.e. in order to live longer) and quality of life;
- it is accessible and fun; and
- the logo contains little 'people' whose presence gives the identity humanity.

The launch advertising explained the link between weight gain and illness (particularly type 2 diabetes, cancer and heart disease) and reduced life expectancy ('lives cut short'), positioned this as an issue that could affect the majority (nine out of ten) of families in the future and told people where to go for more help and advice.

### Phase two: personalising the issue

The next phase will help people recognise that their own families may be at risk of developing obesity because of their current behaviours.

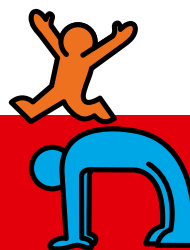
The main marketing mechanic for this phase is 'How are the kids?', a questionnaire on children's health and activity which will be distributed to over 5 million at-risk households. 'How are the kids?' will be positioned as an opportunity to see how modern life is affecting the individual's family and provides a route in to a long-term CRM programme.

### Phase three: rooting the behaviours

The campaign team has defined the behaviours that parents should encourage their children to adopt if they are to achieve and maintain a healthy weight, in consultation with the Healthy Weight, Healthy Lives Expert Advisory Group, the Chief Medical Officer, the Healthy Weight, Healthy Lives policy team and key stakeholders including the Food Standards Agency.

To achieve and maintain a healthy weight in their children, parents need to help their children to:

- reduce their intake of fat, particularly saturated fat;
- reduce their intake of added sugar;
- control portion size;
- eat at least five portions of fruit and vegetables per day;



- establish three regular mealtimes each day;
- reduce the number of snacks they eat;
- do at least 60 minutes of moderate-intensity activity per day; and
- reduce time spent in sedentary activity.

Conveying these behaviours presents a number of challenges for marketing:

- Between them, the behaviours impact on much of family life.
- Many of these behaviours are habitual to the point of being unconscious; all require a degree of departure from the path of least resistance or what is considered normal by many of our families; many require new skills and parenting strategies.
- Some of these behaviours are difficult both to understand and to implement in practice.

To make the behaviours real for people, our partner agencies created user-friendly and memorable language for describing them, supplied tips that translated each behaviour into real situations to which our target audiences could relate and created a mechanism for promoting the behaviours as a set.

#### **Phase four: inspiring people to change**

We believe that, for people to move from intent to change to actual change, they need to be convinced that change is possible (i.e. believe in their own ability to change) and normal (i.e. that people like themselves are already making changes).

This stage of communication will seek to inspire people to believe that change is possible ('I'm in') and convince them that change is already happening ('We're in'). This will include editorial in local press and local radio advertising, detailing local services and events, as well as local people telling stories of how they managed to change their families' behaviours.

#### **Phase five: supporting people as they change**

All campaign materials will give at-risk families the opportunity to sign up to an ongoing CRM programme which will support behaviour change. This CRM programme will provide encouragement, information and support for families to get their children eating better and moving more. Some families will want more support than marketing can provide and Change4Life will signpost these families to face-to-face interventions at a local level.

This programme will be delivered online and by post.

### Information for other audiences

The current breastfeeding communications programme will be broadened to include messages about the importance of nutrition and exercise to maternal health during pregnancy. Additionally, the link between formula feeding and childhood obesity will be made explicitly within the ongoing breastfeeding communications programme.

We will produce messages for parents of children aged 0–2, supporting continued breastfeeding and healthy infant feeding.

New resources will be produced for health professionals working with pregnant women and parents of 0–2-year-olds.

We have appointed a specialist agency to develop culturally specific materials and community outreach programmes for ethnic minorities.



## The future

During years two and three of the campaign (April 2009 to March 2011), we will continue with the core families programme and will also extend Change4Life to reach other at-risk audiences.

## Monitoring and evaluation

The Government is committing substantial public funds to Change4Life and it has a responsibility to ensure that the contribution of the programme to behaviour change is properly measured.

We will evaluate whether we are spending public funds efficiently and effectively. Our evaluation programme will be based around the model of behaviour change. Metrics will track people's progress through this journey.

We have set ambitious targets (see section 16) for the first three and first 12 months of the campaign.



**BACKGROUND**



# 1. Context

Obesity is rising at an alarming rate. Already, around one-third of children and two-thirds of adults in England are overweight or obese. If trends continue as forecast,<sup>3</sup> by 2050 only one in ten of the adult population will be a healthy weight.

Being overweight or obese increases an individual's chances of developing (among others) type 2 diabetes, cancer and heart disease, reducing both quality of life and life expectancy. The cost to the NHS and to society of obesity-related illness is predicted to reach £50 billion by 2050.

Obesity is not increasing because today's generation is more gluttonous or lazy than previous generations. It is increasing because human biology has evolved to favour weight gain. Human beings find it hard to ignore hunger signals but easy to override the signals that they are full. This was an advantage in a world where food was scarce; however, in the modern world, where food is abundant, convenient and cheap (with little physical effort required to obtain it), allowing our biology to dictate our food consumption will result in ourselves and our children gaining weight.

In response to the rise in obesity, the Government set out its ambition that, in future, all individuals will be able to maintain a healthy weight. To meet this commitment, it is necessary not only to encourage individuals and families to desire, seek and make healthier choices but also to create an environment in which those choices become easier.

The initial focus will be on childhood obesity, where the Government's target is to reduce the percentage of obese children to 2000 levels by 2020.

This is not about targeting the already obese. Indeed most children are currently not obese or even overweight. However, it is during childhood that human beings acquire the taste preferences and habits that stay with them for the rest of their lives. While those preferences and habits may not translate into obesity during childhood, they will, if left unchanged, translate into obesity in adulthood. Indeed, if the Foresight prediction is accurate, nine out of ten of today's children could grow up to be overweight or obese adults.

The children who will be aged 11 or under in 2020 have not yet been born. There is thus an opportunity to influence the lifestyles of these children and the environment in which they are raised from birth.

*Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* announced £372 million for a major cross-government programme of measures, including increased funding for pregnancy and early years (for example encouraging hospitals to adopt UNICEF's Baby-Friendly Hospital Initiative), promoting a culture of healthy

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3 Government Office for Science, *Foresight. Tackling Obesities, Future Choices*, 2007

eating in schools and developing Healthy Towns. It also announced the building of more cycle lanes and safe places to play, and more resources for health professionals. This is fundamentally a prevention strategy, which sets out to change the behaviours and circumstances that lead to weight gain, rather than a weight-loss programme for the already obese. At the same time, it will of course influence the behaviours of today's children, leading to a gradual decrease in the prevalence of obesity.

*Healthy Weight, Healthy Lives* set out five key areas for tackling excess weight. These are:

- children: healthy growth and healthy weight – early prevention of weight problems to avoid the 'conveyor-belt' effect into adulthood;
- promoting healthier food choices – reducing the consumption of foods that are high in fat, sugar and salt and increasing the consumption of fruit and vegetables;
- building physical activity into our lives – getting people moving as a normal part of their day;
- creating incentives for better health – increasing the understanding and value people place on the long-term impact of decisions; and
- personalised advice and support – complementing preventative care with treatment for those who already have weight problems.

*Healthy Weight, Healthy Lives* also announced £75 million for a three-year social marketing campaign.





## 2. Role for social marketing

Social marketing is 'the systematic application of marketing to achieve specific behavioural goals for a social good'.<sup>4</sup>

Social marketing provides a framework for behaviour change and applies the techniques of commercial sector marketing to solving health and other social problems.

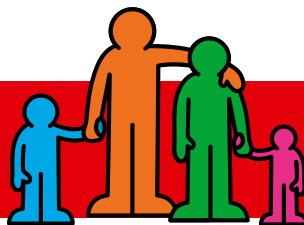
The social marketing campaign will support the overall Healthy Weight, Healthy Lives strategy by:

- creating a segmentation model that allows resources to be targeted to those individuals who are most in need of help (i.e. whose attitudes and behaviours place their children most at risk of excess weight gain);
- providing insight into why those individuals hold those attitudes and behave as they do;
- creating a communications campaign to change those attitudes;
- providing 'products' (such as handbooks, questionnaires, wall charts, web content) that people can use to help them change their behaviours;
- signposting people to services (such as breastfeeding cafés, accompanied walks, free swimming and cookery classes); and
- bringing together a coalition of local, non-governmental and commercial sector organisations that will use their influence to change behaviour.

This will be much more than a government information campaign. The role of marketing will be to create a movement, in which everyone in society plays their part, helping to create fundamental changes to those behaviours that can lead to people becoming overweight and obese.



**UNDERSTANDING  
OUR AUDIENCES**



## 3. Who are we talking to?

Unlike other health promotion categories (smoking, drugs, alcohol), in which a given individual either does or does not exhibit risky behaviours, everyone exhibits the behaviours that can lead to weight gain: we all eat, we all travel, we all have to find ways to spend our leisure time. The difference between a healthy and an unhealthy diet or healthy and unhealthy levels of activity can be remarkably small and marginal imbalances of energy in versus energy out will lead to weight gain, if maintained for long periods. This will vary across the life course and between individuals. In this sense, we are all at risk and the whole population needs to examine its lifestyle if we are to prevent people developing obesity.

It is neither necessary, however, nor cost-efficient to target the entire population. Some people manage to maintain a healthy weight quite successfully without assistance; others have gained weight to levels where they are in imminent risk of, or already suffer from, a number of chronic diseases and clinical (drug and/or surgical) solutions may be necessary. In neither of these cases will marketing have a significant role to play. This strategy will focus resources on areas of greatest need (i.e. those families whose current behaviours, attitudes and beliefs suggest that their children are most at risk of becoming obese) and where marketing can have the most impact (i.e. where there is still scope for a less intensive lifestyle intervention).

Marketing will focus on prevention, recognising that it is easier to prevent weight gain and maintain a healthy weight than to shed pounds once they have been accumulated.

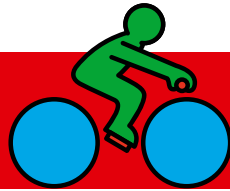
In year one, we will focus on families that have at least one child under 11, both to support the Government's target and to counteract the 'conveyor-belt' effect whereby poor lifestyle habits acquired in childhood result in excess weight in adulthood.

In addition, we recognise that most parents want to do the best for their children and will be more open to trying new behaviours for their children's sake than they might have been for their own.

Particular emphasis will be placed on:

- pregnant women (an ever-changing universe of approximately 600,000 women at any one time);
- families with children aged under 2 (of whom there are approximately 1.4 million), particularly first-time parents (since new parents have to learn parenting behaviours and are therefore open to ideas);
- the 1.6 million families whose current behaviours and/or attitudes suggest that their children are most at risk of weight gain; and
- those ethnic minority communities where levels of childhood obesity are particularly high.

During years two and three, the campaign will be extended to other at-risk audiences.



## 4. Segmenting our audiences

High-risk families are not a homogeneous group. The Department of Health's quantitative segmentation of families with children aged 2–10 identified six different 'clusters' of families,<sup>5</sup> of whom three exhibited behaviours and held attitudes with regard to diet and activity that suggested that their children were at risk of becoming obese.

Collecting height and weight data for the families in our sample confirmed that those groups also had the highest levels of parental obesity and were already beginning to show higher than average levels of childhood obesity.

### CLUSTER 1:

13.3% of families



*We're not like organic types and mums that have the time to cook all day.*

### CLUSTER 2:

18.2% of families



*I kind of make it up as I go along, a lot of it is from the way mum brought me up.*

### CLUSTER 3:

15.6% of families



*Touch wood, my children will not put on weight so I let them have what they want.*

Within the family, our focus will usually be the mother, who is more often the gatekeeper of diet and activity, although we will ensure that all materials are accessible for those fathers and other carers who want to be involved. We will also develop communications aimed at children themselves by working closely with the Department for Children, Schools and Families (DCSF), the Healthy Schools programme and commercial partners.

Additionally, we will produce targeted messages for key influencers such as:

- grandparents and other family members and carers;
- teachers and other educational professionals;
- childminders;
- health professionals; and
- schools.

## 5. What insights do we have into our audience's behaviour?

Our research suggests that:

- while people know obesity is an issue (93% of UK parents agree that 'childhood obesity is an issue of national importance'<sup>6</sup>) they do not realise that it is their issue (only 5% of parents believe that their child is overweight or obese);
- parents routinely underestimate the amount of food that they and their children eat and overestimate the amount of activity that they undertake;
- a host of behaviours the research suggests are unhealthy (such as spending a lot of time participating in sedentary activities) have no perceived risk for parents;
- healthy living is perceived as a middle-class aspiration; and
- parents prioritise their children's immediate happiness over their long-term health (indeed the link between poor diet and sedentary behaviour today and future health outcomes is not understood).

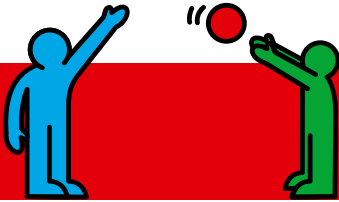
In addition to the overarching insights, research has produced insights in specific areas, outlined below.

### Breastfeeding

- A significant proportion of expectant mothers, particularly those in lower socio-economic groups, do not see breastfeeding as the norm and lack opportunities to see other women breastfeed or talk about it; in these circumstances, the benefits are downplayed and early challenges can feel daunting.

### Weaning

- Parents are currently preoccupied with the practical side of weaning (mashing, freezing, jars/not jars, using a spoon), and are neglecting the values (what food is for) behind it.
- Parents are allowing the immediate (getting the baby to eat something) to take priority over the long term (getting the baby to eat well).



- Parents want to do the best for their children but this desire is currently driving them towards some weaning practices that are unhealthy; for example, parents are currently weaning too early (responding to presumed need and pressure from others such as grandparents or friends).
- Parents are transitioning their babies onto family foods (which are often not healthy) very rapidly in a desire to get the baby 'eating what we eat' and because this is encouraged by health professionals.
- Since there is no clear guidance on how much babies should eat, parents often offer portions that are too large and encourage children to finish everything on the plate (since it is emotionally satisfying to see babies 'eating it all up').
- Parents are introducing unhealthy snacks very early and do not persevere with healthier foods.
- Parents are also introducing juices, squashes and even carbonated drinks very early: water is seen as 'low fun' and tends to be substituted by juices and carbonated drinks.

### Health and weight

- Parents often reject attempts to categorise their children as obese or overweight because of the implied criticism of their parenting skills, because they cannot easily recognise their children's weight status and because they are concerned about labelling their children at a young age.
- Parents believe their children are healthy as long as they are happy and accordingly prioritise things (however unhealthy) that they believe will make their children happy.
- For at-risk families, 'health' (healthy living) is perceived to be a middle-class aspiration which is punitive, dull or simply unattainable.

### Diet

- Many parents have surrendered control over food choices to their children – allowing children to decide what goes in the supermarket trolley, what they eat and when they eat it – in order to avoid rows.
- Parents often prioritise filling children up over feeding them the right foods.
- Snacking has become a way of life in many households and is used in emotionally complex ways, for example as a reward for good behaviour and as appeasement.

- Many parents lack the knowledge, skills and confidence to cook from scratch and rely on convenience food.
- Coping strategies to deal with fussiness can create chaotic, unhealthy family mealtimes.

### Activity

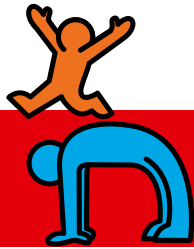
- Most parents believe their children are already active (confusing 'being boisterous' with 'being active') and believe that schools are already doing enough to make sure children are active.
- Sedentary activity (for example watching television and playing computer games) is encouraged by parents because it frees up their own time and they may lack the inspiration or motivation to be more active.
- Parents often believe it is too unsafe for their children to play outside.
- Some mothers lack the confidence to take part in physical activity with their children.
- Parents habitually use cars for short journeys because they believe it is more convenient and they attach status to car usage.

### Ethnicity

Research carried out specifically with families in Bangladeshi, Pakistani and black African communities revealed that:

- education is a top priority for many families. As a result, many children have little free time for activity beyond homework;
- religious faith plays a central role. Many children from Muslim homes (and some from Christian homes) attend religious classes, limiting the time available for physical activity;
- cultural foods play an important role in maintaining cultural and ethnic identities; some of these foods are not healthy, for example due to high levels of fat;
- the prevalence of traditional gender roles means that girls often have fewer opportunities to be active;
- in general, parents exercise more control over their children's routine than was observed in the general population. However, food is often an area where parents relax control and children are allowed greater choice;

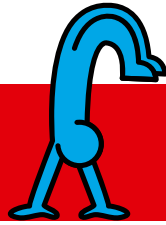




- elders, particularly grandmothers, have a significant influence on parenting styles, particularly diet. Mothers sometimes cite their mothers-in-law as barriers to maintaining a healthy lifestyle, since they regularly indulge their grandchildren with unhealthy snacks and encourage them to 'feed their children up';
- parents generally take a reactive approach to health, being more likely to define it as the absence of illness, rather than a child's overall wellbeing;
- an overweight child is not always perceived negatively; indeed, in some cultures, being big is considered appealing; and
- while families are more likely to sit down together as a family, some are eating on many occasions during the day, either because Western foods are given to children between meals as a 'snack' or because a culture of long working hours facilitates multiple meals (as, for example, when children eat when they come home from school and again when their father returns from work).



**CHANGING  
BEHAVIOURS**



## 6. How we believe we will change behaviour

There is no universally accepted model for behaviour change with regard to obesity and this is the first time any government has implemented a programme of this nature, scale and ambition. In the absence of a proven behaviour-change model, we have reviewed existing literature on behaviour change (both for obesity and for other successful behaviour-change programmes, particularly tobacco control) and we have derived principles for creating successful behaviour change, which drive our campaign.

We recognise that some of our assumptions may be proved wrong. We know that we do not have all the answers, so we will monitor our campaign and test which were correct.

At this stage, we believe that the programme needs two stages:

- creating the right preconditions for behaviour change; and
- supporting people on a behaviour-change journey.

### Creating the right preconditions

We know from our experience with tobacco control that, in order for behaviour change to happen, the following preconditions need to be met:

- dissatisfaction with the present;
- having a positive image of the future;
- having belief and confidence in one's ability to change;
- being subject to positive environmental pressures (normalisation);
- having specific triggers for action; and
- knowing what to do to change successfully.

None of these preconditions is currently met for obesity. Unlike tobacco control (where, thanks to a long history of medical evidence and communication, the vast majority of smokers now accept that their smoking places them – and others – at risk), the health risks of obesity (and obesity-inducing behaviours) are not well known.

Smokers know that they are smokers; obese people do not always know that they are obese and parents seldom recognise that their children are obese or at risk of becoming so.<sup>7</sup>

Smokers know when they are smoking; there is a considerable body of research indicating that people inaccurately observe their own behaviour with respect to diet and activity (optimistically overestimating activity and underestimating calorie intake).

However hard it is, smokers do at least know what to do to reduce their risk of smoking-related illness (stop smoking); at-risk families do not always know what to do and the behaviour change required is more complex (people cannot simply 'stop eating').

Therefore, before we can expect behaviour change on any significant scale, people will need to:

- be concerned that weight gain has health consequences ('This isn't about how I or my children look; it's about type 2 diabetes, cancer, heart disease and lives cut short');
- recognise that their families are at risk and take responsibility for reducing that risk ('This isn't about bad parents or very fat children – it's about my children');
- know what they need to do to change (know the behaviours and be able to relate them to their lives); and
- believe that change is possible (believe that others around them are changing and know that there is help for them to change).

We are confident that the launch programme will start to create these preconditions. However, the number of messages we need people to understand (and the fact that we do not currently have any harder levers such as legislation and taxation) lead us to conclude that we should not expect to see significant levels of behaviour change for some time after launch.

## Supporting people on a behaviour-change journey

There is learning from many often small-scale and face-to-face projects which have managed to change behaviours relating to obesity.<sup>8</sup>

These interventions teach us that propensity to change behaviour is increased when:

- people are asked about their own behaviours (asking increases propensity to change more effectively than telling);

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7 TGI recontact study (BMRB 2008) showed that only 5% of parents believed that their children were overweight or obese

8 Some key examples have been signposted by National Institute for Health and Clinical Excellence evidence reviews and the Cochrane Collaboration



- information about risk is personalised (to prevent dissociation);
- people are encouraged to create their own goals (responsibility);
- people can see how their behaviours are benchmarked against others in their population group (normalising);
- people are able to record their own progress and are given feedback;
- people are given frequent reminders of their goals; and
- people are rewarded for success.

We cannot intervene face to face with everyone in our target audiences (although we can and will signpost to existing and new face-to-face interventions provided by primary care trusts and local authorities). Our greater challenge is to use the media and engagement mechanisms at our disposal to replicate some of these factors on an industrial scale.

The implication for the marketing programme is that consultation and dialogue should play a central role.

We believe the programme needs to include the following elements:

- Ask: use a variety of mechanisms (face to face, direct mail, online, telephony, interactive television, newspapers, point of sale) to get questions into the hands of as many families (with a bias towards at-risk families) as possible.
- Benchmark: use mass media to bring the results to life and to tell people where they and their neighbours stand in relation to the nation.
- Create practical goals: allow families (online, by telephone or by post) to select a behaviour to change, based on their own needs and aspirations.
- Record: provide a mechanism for the individual to record their own behaviour (and for a sub-set to provide that data to us).
- Remind: remind people of the goals they set, recognise achievement and incentivise further change.
- Report back: tell the nation (via PR, follow-up programming) how we are doing.

## 7. What will the marketing programme deliver?

If it is to have an impact on long-term behaviour and ultimately on prevalence of childhood obesity, the programme will need to operate at a scale never previously witnessed. Our targets are to generate 1.5 million responses (a 'response' being either a telephone call, written response or visit to the campaign website) with 200,000 of those responders converting into a CRM programme, which will both nudge people along the behaviour-change journey and track their behaviours over time.

These targets were developed in conjunction with our communications partners and with the Central Office of Information (COI), using its Artemis tool (which forecasts response and conversion based on media spend and mix).<sup>9</sup>

This CRM programme will be only one mechanism to allow people to change their behaviours. Experience in the tobacco control programme tells us that, for every individual changing their behaviour via a CRM programme (in the case of tobacco control, the 'Together' programme), four more do so independently: they see the advertising and, in popular parlance, 'go cold turkey'. We do not yet know how big this 'halo' effect will be for Change4Life. However, we will monitor the number of people claiming to be making changes to their behaviour and will be able to give a figure for this in a year's time. For the purposes of this document, we are assuming that a far greater proportion of our families choose to change their behaviours via Change4Life (since existing knowledge of the desired behaviours and how to change them is poor). As a working hypothesis, we have assumed that, for every family joining the Change4Life programme, one other makes a sustained behaviour change independently – i.e. that, if we meet our targets, the programme will result in 400,000 families attempting to change their behaviours.

It is worth pointing out that, since this is a prevention strategy, the children in these families do not need to lose weight. Indeed, since they are growing they should continue to gain weight. What is required is that they gain weight at a healthy level and do not become overweight or obese. This will be achieved by their families adopting behaviours that prevent unhealthy weight gain. There are eight of these:

- reducing their children's intake of fat, particularly saturated fat;
- reducing their intake of sugar;
- controlling portion size;

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9 COI Artemis was specifically developed to better evaluate government and public sector campaigns whose principal objectives are to bring about changes in behaviour and attitudes rather than drive purchasing



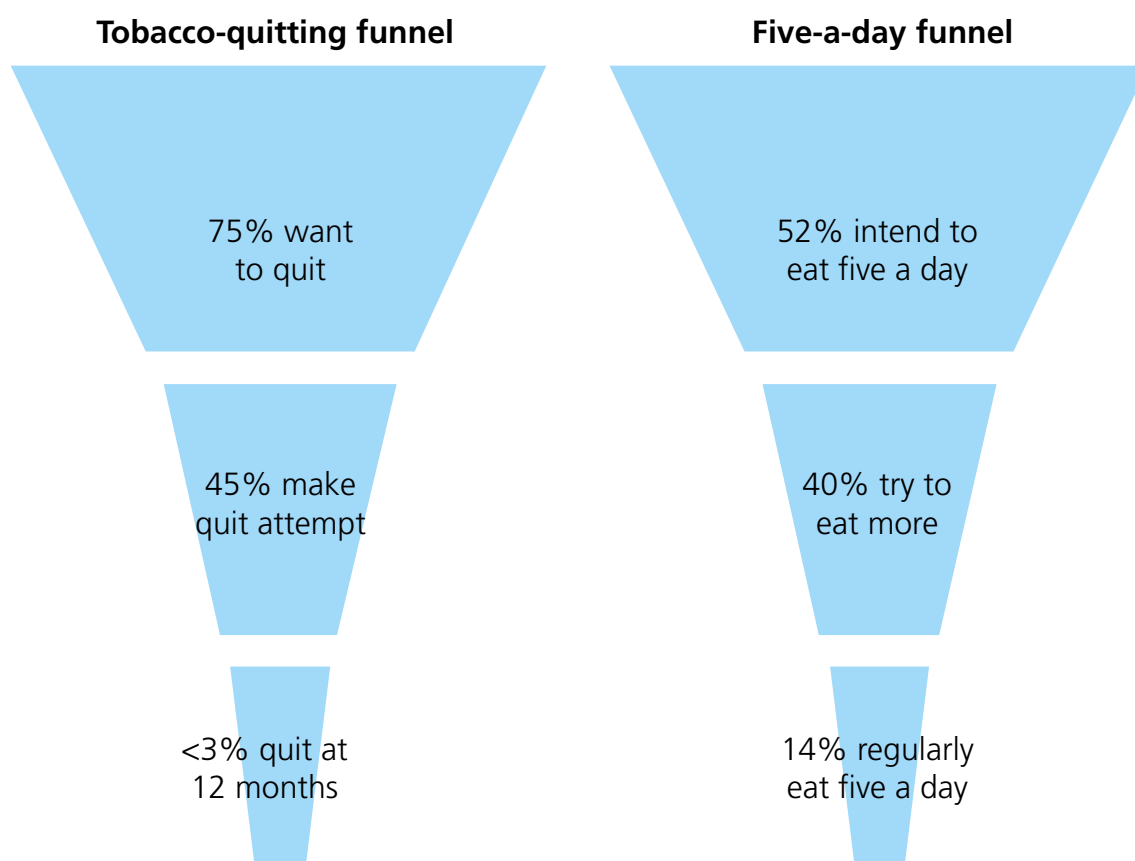
- eating at least five portions of fruit and vegetables per day;
- establishing three regular mealtimes each day;
- reducing the number of snacks their children eat;
- doing at least 60 minutes of moderate-intensity activity per day; and
- reducing time spent in sedentary activity.

## 8. The behaviour-change funnel

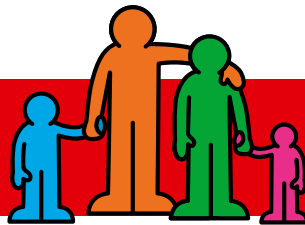
We have to accept that making short-term changes to the family's behaviour is easier than making long-term, sustained change.

All behaviour-change programmes experience a considerable degree of attrition between desire to change, attempting to change and sustained change.

Two illustrations are given below:







The data indicates that, for every five people who want to quit smoking, only three will make a quit attempt. Of those who make a quit attempt, fewer than one in 15 will succeed in quitting long term (defined here as over 12 months). In the case of eating five portions of fruit and vegetables a day, the attrition rate is less acute. Of those who intend to eat five a day, about three-quarters claim that they have made changes to their diet. Of these, however, fewer than one in three succeed in making eating five a day a habit.

There is no historical data for the attrition rate for obesity prevention. One of the by-products of this marketing programme will be data to generate a funnel similar to those above, which we will be able to refer to in future versions of this document. Meanwhile, we need to generate estimates for the attrition rate.

Comparison of the funnels suggests that changing one's diet is considerably easier than giving up smoking. This makes sense. Giving up smoking requires conquering an addiction and even a minor lapse can turn the would-be quitter back into a smoker. Eating five a day on the other hand, while requiring some effort, is not unidirectional and minor lapses are less important (if you don't quite get your five portions today, you can still get them tomorrow).

We might therefore expect the behaviour-change funnel for this campaign to be closer to the five-a-day funnel.

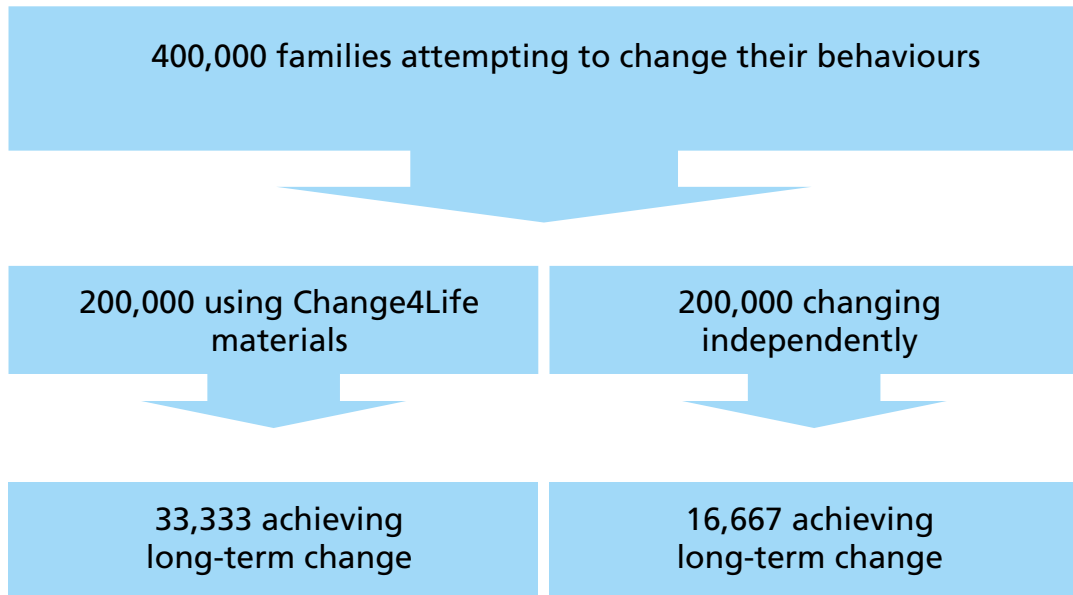
There are, however, two additional factors we need to take into account:

- Both of the above examples involve changing one behaviour. We are asking people to change multiple behaviours. It is sensible to assume that this will be harder than changing one behaviour, although it is unlikely to be eight times as hard (many people will already be doing some of the behaviours and the behaviours inter-relate). However, we cannot know how much harder without further data. At this stage, we propose the hypothesis that changing multiple behaviours will be about twice as hard as changing one, i.e. that for every family successfully changing multiple behaviours in the long term, we will need to recruit six families into the programme.
- In the case of both of the above examples, people are attempting to change their own behaviours. In the case of this programme, people will need to change the behaviours of their children and families. Whether this is harder (persuading someone else to change could be harder than changing one's own behaviour) or easier (children's ability to determine their own behaviour is relative: if they prefer to be driven to school rather than walking, they can complain, but they cannot physically drive the car) is a matter of conjecture. Since there is currently no conclusive evidence one way or the other, we will assume that the impact of this factor is neutral, pending further data.



Finally, we need to consider the success or failure rate of those families who change their behaviours within our programme (i.e. who sign up to the CRM programme) versus those who – albeit with some impetus and initial guidance from our communications – ‘go it alone’. Again, we do not know how effective the programme we are designing will be. However, if it should prove to be no more effective than families changing their own behaviour, it provides no return on investment. Again there is learning from tobacco control, where the data tells us that those who quit with support are four times more likely to succeed than those who ‘go cold turkey’. We are unlikely to see such impressive results at this stage since the Together programme is the culmination of many years’ research and development (and since cold turkey is a particularly ineffectual means of quitting). We therefore propose a target that those who access the full programme of support from Change4Life should be twice as likely to succeed as those who choose their own path.

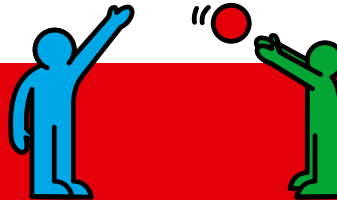
These assumptions lead us to some very approximate calculations:



While these calculations are only approximations, we will refine them as data becomes available.



**MARKETING AND  
COMMUNICATIONS  
CAMPAIGN**



## 9. The marketing approach

Just as the causes of obesity are not exclusively the responsibility of individuals, so its solution will not lie in individuals alone but will require a cross-societal movement, in which everyone plays their part to change the societal norm.

People will need the support of those around them – health professionals, schools, councils, local charities, government departments and non-governmental organisations (NGOs) as well as the institutions and brands that they trust and use every day.

In consequence, we have assembled a cross-societal collaboration of workforces, government departments, NGOs, local activists and commercial brands, so that as our target audiences attempt to change their families' behaviours they feel that everyone around them – the people, institutions and brands they trust – are on their side.



Other government departments will take part in this programme by aligning their communications; for example, the Department for Transport will align the materials it produces encouraging walking and cycling (Walk4Life, Bike4Life), the Department for Culture, Media and Sport (DCMS) will align the cross-government free swimming initiative (Swim4Life) and the Department for Environment, Food and Rural Affairs (Defra) will align its programme to encourage conservation volunteering (MuckIn4Life). The Change4Life brand will be further promoted by its inclusion as a co-brand on other government communications (for example, DCSF's cookbook for schoolchildren and Parent Know How's guides for new parents).

Leading NGOs (Cancer Research UK, Diabetes UK and the British Heart Foundation) will produce advertising which endorses the objectives of the programme and the science behind it. Raising awareness of the link between weight gain and disease is already a priority for the NGOs and this communication will reinforce the message that dangerous amounts of fat in the body can lead to negative health outcomes and reduced life expectancy. The advocacy of these NGOs will build public trust in the government campaign. This is particularly important, since the wealth of 'rogue' media stories around obesity and its causes has created some confusion among the public about what is and what is not to be believed.

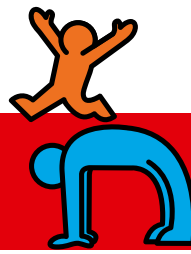
At a local level, we have recruited community activists and organisations to the campaign: at the time of writing (and in advance of any communications spend), over 10,000 grassroots organisations and activists have signed up to be a part of Change4Life.

The campaign will also involve partnerships with the commercial sector. We welcome commercial sector involvement, not only because of the scale it adds to the campaign but also because many organisations have influence with and can reach our target audiences in ways that we cannot.

An industry coalition led by the Advertising Association has pledged £200 million of media value to the Change4Life campaign.

In addition, seven founding partners have made substantial commitments to support the programme.

| Partner                                    | Summary of commitment   |
|--|---|
| Tesco                                      | Promotional activity (Change4Life4Less) on healthier products; features in customer magazine; store-based community champions will organise activities locally  |
| ASDA                                       | Promotions to encourage healthier eating; Change4Life features in ASDA magazine; support for Bike4Life sub-brand, including a sponsored bike ride by Chief Executive Officer Andy Bond to raise money for a new charity to make cycling easier and more affordable for families in deprived communities |
| National Association of Convenience Stores | Will pilot a 120-store programme in the North East to improve the accessibility of fruit and vegetables in low-income areas   |



| Partner                      | Summary of commitment  |
|------------------------------|--|
| Kellogg's                    | Will invest £100,000 per year for three years to expand its breakfast clubs programme (with ContinYou) under the Breakfast4Life sub-brand; will provide an additional £240,000 a year for three years in new Swim Active projects (co-branded Swim4Life) |
| PepsiCo                      | Will support the Play4Life sub-brand by producing public service announcements to promote the benefits of active play; will support Breakfast4Life via the Tropicana brand   |
| Fitness Industry Association | Will create a Change4Life promotion in the summer of 2009, which will involve members opening their doors free of charge to new exercisers   |
| ITV                          | In 2009, ITV will commission and run two hours of national primetime television, encouraging its viewers to pledge to lose weight, eat more healthily and take more exercise, and tracking viewers' progress in meeting personal pledges                 |

All commercial partners have signed the terms of engagement which can be accessed at [www.dh.gov.uk](http://www.dh.gov.uk). These include a commitment to promote both physical activity and good diet (to prevent the use of exercise to justify unhealthy diet) and a commitment to truly incremental activity (to prevent the repackaging of existing initiatives under the Change4Life umbrella).

These commitments are for marketing activity specifically. Beyond these, the Department of Health and Food Standards Agency continue to work with industry on labelling, advertising and reducing salt and saturated fat as part of the Healthy Food Code. The Department is also working more broadly with industry, through the Coalition for Better Health, to improve employee health and promote physical activity.

While marketing can inspire people to seek information and try to change their behaviour, we acknowledge that people will need tools and support if they are to succeed in the long term. For this reason, the programme we create will act as an exchange or marketplace, bringing members of the public together with a series of organisations – NGOs, primary care trusts and local authorities – that can help.

Our CRM programme will include a locally searchable database of the services provided by these organisations, accessible both via the website and by telephone, to enable our target audiences to find activities they can undertake locally.

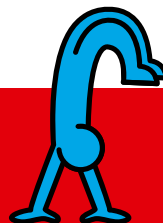
At a local and regional level, we are working with colleagues such as the National Social Marketing Centre and the Government Offices for the Regions to share information about the campaign and ensure that existing services and initiatives – such as walking buses, cookery classes and breastfeeding cafés – are supported by

the national marketing. At the same time, we will encourage new local initiatives to support the behavioural goals, for example workshops providing strategies for structuring mealtimes and healthy snacking.

We have also initiated a communications programme for the NHS workforce so that they feel that:

- preventing overweight and obesity is part of their responsibility (as has been outlined in Lord Darzi's Next Stage Review for the NHS workforce);
- prevention of overweight and obesity will ease the burden on the NHS and society as a whole;
- they are part of the team delivering against the Government's Public Service Agreement targets and ambition to reduce obesity;
- the work that they are already doing can help to make a difference;
- this initiative will act as a vital resource for them in their daily role;
- they are informed in advance about information that is going to the public; and
- there is something in it for them – we are providing them with an overview of all the resources that are available to them to help them combat obesity, including Change4Life.





## 10. Role of communication

One of the most visible elements of the Change4Life programme will be a major communication campaign. The role of communication is to act as a catalyst for a societal shift in English lifestyles, resulting in fundamental changes to those behaviours that lead to people becoming overweight and obese.

Change4Life will not be a government campaign telling people how to live their lives; rather it will use marketing to stimulate a movement, which people can join, and in which everyone can play their part.

### Communication strategy

We believe that we will achieve our objectives by doing the following:

#### For the public:

- reframing obesity in terms of behaviours and consequences rather than obesity as an outcome itself;
- increasing the number of people who recognise that their lifestyle choices around diet and exercise are threatening their own and their children's health;
- increasing the desire among people to take steps to improve their health;
- encouraging a significant number to seek further information or advice;
- providing people with tips and strategies for achieving change; and
- providing a definitive source of advice, backed by sound science.

#### For external stakeholders:

- coalescing disparate partners into a co-ordinated movement to provide advice and ideas on how to tackle obesity-related behaviours;
- changing the way in which overweight and obese people (and the causes of obesity) are depicted and reported in the media; and
- squeezing out rogue and unhelpful fad diet stories in favour of consistent advice.

#### For public sector stakeholders:

- uniting existing service providers under a common banner; and
- providing centralised support for their programmes.

## 11. The communications environment

It is a commonly held lay view that there is no need for communications to combat obesity since the plethora of non-government-funded communication (such as media coverage of obesity as a news item, advertising for diet products and television programming about weight issues) has already raised awareness to saturation levels.

Overweight and obese people, so the argument runs, must know that they are overweight and obese and that they should eat less and take more exercise in order to lose weight. Remaining overweight is thus an issue of personal choice and no matter for government. Those who favour this argument hold that parents of overweight and obese children must be doubly aware of their children's weight status and the attendant risks, given the large amount of media coverage given to the issue every day.

Unfortunately, this view is inaccurate. All the evidence shows that the ability of people to judge their own<sup>10</sup> and their children's<sup>11</sup> weight is not only flawed but becoming more so. As overweight becomes more common, it is even more likely to be seen as 'normal' and therefore not a cause for concern.

Further, the link between overweight and health outcomes is not well understood, particularly in children. In a survey conducted by Cancer Research UK,<sup>12</sup> only 33% of parents believed, for example, that there is a link between weight gain in childhood and incidence of cancer in adulthood.

This may be partially explained by the consideration that public health communication operates in a 'competitive environment'. For every message reinforcing healthy behaviours, there will be many more promoting products that, while they do little harm as occasional indulgences, can lead to weight gain if consumed in excess. For example, in 2007, the food and drinks industry spent £335 million on advertising confectionery, snacks, fast food restaurants and carbonated beverages. This is set against an anticipated spend of £25 million per year for social marketing (including all media and costs) to prevent childhood obesity. This low share of voice is heightened by the consideration that not all media impacts will have equal persuasive power. For an individual viewer, it may be far more tempting to yield to the promise of immediate gratification from foods that are high in fat, salt and sugar (HFSS), than to the more remote promise of better health in the future.

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10 Johnson F, Cooke L, Croker H and Wardle J, Changing perceptions of weight in Great Britain: comparison of two population surveys, *British Medical Journal* 2008, 337: 494

11 88% of parents believe their children are a healthy weight; only 5% say that their child is overweight or obese (BMRB research on behalf of the Department of Health 2008)

12 'Perceptions of Risk', BMRB Face to Face Omnibus, 2–15 October 2008. Commissioned by Cancer Research UK



Encouragingly, Ofcom's interim report on the impact of restrictions on the advertising of HFSS foods has shown a decline in children's exposure to advertising for HFSS foods. However, advertising of HFSS foods continues to reach parents (who are the gatekeepers for most food purchases) and a total ban on advertising HFSS foods is neither feasible nor desirable (comparisons with a ban on tobacco advertising, though often made, are not always helpful: smoking is never beneficial and sales of tobacco to children are illegal). Further progress can be achieved, however, by working with food and drink manufacturers and retailers, to encourage the promotion of healthier variants within each company's portfolio.

While it is true that the media has a high level of interest in obesity and reports on it daily, much of this coverage is sensationalist, focuses on extreme cases (for example *Half Ton Son*) and stigmatises those involved. Research<sup>13</sup> suggests that reporting the issue in this manner is likely to encourage at-risk groups to disassociate themselves from the issue (and therefore make no changes to their behaviour).



Some media coverage does attempt to give advice and provide support on changing behaviours. However, an analysis<sup>14</sup> of the size and composition of the viewing audiences of obesity-related television programmes showed that programmes that sensationalise the issue typically gain the largest and most mass-market audiences. Programmes that seek to provide advice and guidance about healthy lifestyles typically receive smaller audiences, a larger proportion of which come from higher social grades. While lower social grade is not the sole predictor of risk (see target audiences on page 19), this suggests that attempts by the media to provide help and advice are not getting through to some of the people who may need them most.







In order to achieve our objectives, we need to do more than produce new communication. We also need to change the way in which obese and overweight people (and the causes of obesity and overweight) are depicted in mainstream media. This will require co-operation between government and the media.

13 Qualitative project conducted in 2007 by 2CV Research on behalf of the Department of Health

14 Analysis by Manning Gottlieb OMD

## 12. Phasing of the marketing plan

This has implications for the overall shape of the campaign: what we will say and what tools, techniques and products we will provide at each stage.

|                            | Pre-stage  | Phase one   | Phase two  | Phase three   | Phase four   | Phase five   |
|----------------------------|--|---|--|---|--|--|
| Role of marketing          | Mobilising the network   | Reframing the issue of obesity  | Personalising the issue  | Rooting behaviours  | Inspiring people to change   | Supporting people as they change   |
| Sample marketing materials |  |           |  |  |  |  |
| Desired out-take           | <i>Change4Life is coming – we should be part of it</i>                             | <i>This isn't about how my children look: it's about diabetes, cancer and heart disease</i> | <i>This isn't about bad parents or very fat children – it's about my children</i>  | <i>I know what to do to reduce my family's risk</i>                                 | <i>I know people like me are changing their lives so I believe it's possible</i>     | <i>I can see the difference this is making</i>                                       |

### Pre-stage: Mobilising the network

Unlike traditional public health information campaigns, which begin with top-down and centrally delivered messages, this campaign began with over six months of engagement with partners and with workforces, local service providers, activists and NGOs so that, when national marketing started, the public would encounter an informed and supportive local environment. It also enabled those organisations that provide services and commission marketing of their own to join up their activities with the national effort.

Communication included face-to-face and direct marketing; for example:

- the National Social Marketing Centre facilitated training sessions with regional service providers, including exposure to the research findings;
- the Secretary of State for Health wrote to 220,000 people involved with grassroots organisations;
- the Secretary of State also wrote to the chair of every primary care trust;



- the Chief Medical Officer and the Chief Nursing Officer wrote to every general practitioner, practice nurse, midwife, health visitor and health trainer;
- the Secretary of State for Children, Schools and Families wrote to every headteacher;
- regional launches were held in the strategic health authorities;
- regional PR highlighted the significance of obesity and attempts to combat it at a local level;
- commitments to support the campaign were secured from other government departments (DCMS, DCSF, Food Standards Agency, Defra and Communities and Local Government);
- pledges of support were secured from commercial organisations (covering retail, food manufacturing, the fitness industry and the media) and three NGOs; and
- a knowledge bank of existing services was compiled.

Recognising that the workforce is a channel for communicating with the public as well as an audience in itself, materials, such as posters for display in GP surgeries and a *Top Tips For Top Kids* leaflet, were made available for health professionals to order. In advance of the campaign launch, almost a million items had been ordered by the NHS.

The task of mobilising the network is ongoing and will continue as the campaign develops.

### Phase one: reframing the issue

On 3 January, Change4Life launched officially to the public with television and print advertising, consumer PR, a helpline, campaign website and fulfilment materials.

The aim of this phase was to reframe the issue of obesity so that it was seen as being:

- not the fault of individuals or families but the result of modern life;
- not about size or appearance but about fat in the body; and
- not an issue for a minority of very overweight or obese individuals, but an issue for everyone in society.

Change4Life was presented to the public not as a government diktat on how to live but rather as a social movement in which everyone – government, NGOs, industry, schools, the NHS, community groups, families and individuals – could play their part.

## Branding

The brand identity is 'Change4Life'.



This identity was selected because:

- the words contain both an imperative (change) and an aspiration that the change will be long term (4life). The double meaning of '4life' also stresses longevity (i.e. in order to live longer) and quality of life;
- it has been designed to be accessible and fun. Our target parents told us that, if they were to become involved in any change programme, their children would need to find it appealing, it would have to sound fun and it should not contain the word 'obesity'; and
- the logo contains little 'people' whose presence gives the identity humanity, but they have no gender, age, ethnicity or weight status. They include everyone.

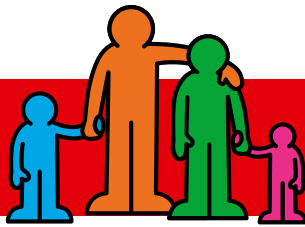
There is no government endorsement on the Change4Life brand identity.

There is a range of sub-brands available for use, such as Breakfast4Life, Cook4Life, Play4Life, Swim4Life and Bike4Life. Local, government and NGO partners may also create their own sub-brands, within defined criteria. The brand guidelines and criteria for sub-brands can be downloaded at [www.dh.gov.uk/change4life](http://www.dh.gov.uk/change4life).

## The launch advertising

The campaign launched to the public via advertising (television, newspaper, outdoor, digital) on 3 January 2009.

The campaign did not talk about obese, overweight or fat people; it talked about 'dangerous amounts of fat in the body' and tackled those behaviours that can lead to people becoming overweight or obese. At its simplest, the campaign urged people to 'eat well, move more and live longer'.



The decision not to use the word 'obesity' sparked some comment. 'Obesity' was not used because:

- the campaign is for all of us, not those who are already obese;
- even among the already obese (and parents of obese children), ability to judge weight status is low, making it likely that many families will ignore a message about obesity as 'not for them'; and
- while to us, obesity is a clinical diagnosis, parents told us that they considered the term an insult and would not use it (or allow their children to use it). The use of the word thus creates disengagement.

The launch advertising:

- explained the link between weight gain and illness (particularly type 2 diabetes, cancer and heart disease) and reduced life expectancy ('lives cut short'). These three conditions were chosen because they are known to be the largest killers. It is possible that in future other health-related consequences of obesity (including mental health) may be featured in the campaign;
- positioned this as an issue that could affect the majority (nine out of ten) of families in the future; and
- told people where to go for more help and advice.

The launch advertising (and all substantial pieces of communication that followed it) were researched in advance with the target audiences.

The creative work was extremely well received. The insight resonated with parents from the at-risk clusters and prompted them to think about their children's future health:

- 'It's true about modern life: when we were little we walked everywhere, now we get in the car to drive to the shops.'
- 'If they're saying that all them kids are going to get heart disease or diabetes, then that's more than just these with obesity.'<sup>15</sup>

## Storyboard of launch TV commercial

Once upon a time, life was pretty simple...

It could be hard... the food was pretty fast... but it could be fun if we caught our mammoth or bison or whatever...

Then gradually life changed... in many ways it got easier...

Nobody had to run around for their food... or for anything else much for that matter

Until one day we woke up and realised that 9 out of 10 of our kids would grow up to have dangerous amounts of fat in their bodies

Which meant that they'd be more likely to get horrid things like heart disease, diabetes and cancer. And many could have their lives cut short

So we thought... that's not more of a life... that's less of a life, and that's terrible because we love the little blighters

Maybe we should get together with our kids and  
Eat better  
Move more  
Live longer

And change4life. And we all lived happily... not exactly ever after... but more ever after than we had done

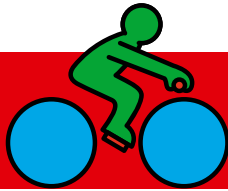
## Phase two: personalising the issue

The next phase will help people recognise that their own families may be at risk of developing obesity because of their current behaviours.

The main marketing mechanic for this phase is 'How are the kids?', a questionnaire on children's diet and activity, which will be delivered to 5 million households where at-risk families are more likely to reside. 'How are the kids?' will be positioned as an opportunity to see how modern life is affecting the individual's family and to start a dialogue with Change4Life. It is not designed to be a scientific study but to generate engagement with our target audience because we know that self-assessment can be a very powerful driver of behaviour change.







The 'How are the kids?' questions are constructed around the eight desired behaviours and are designed to encourage the reader to re-evaluate their children's performance against these behaviours – to make the issue personal.

The survey will be available both online and on paper, and will be distributed through a wide range of channels, to ensure maximum reach, with media upweighted in particular geographic areas to reach high-risk cluster households. It will be:

- door-dropped directly to high-risk cluster areas;
- delivered face to face via field marketing;
- supported with direct response television;
- distributed via doctors' surgeries, pharmacies and post offices;
- distributed as loose inserts in women's magazines and placed in advertorials; and
- posted as an online version on the website.

'How are the kids?' provides a route in to a long-term behaviour-change programme. Responders to the survey will be split into high- and low-risk clusters. Postal and high-risk responders will receive a review of how they have scored against the relevant questions. Within the pack, we will recommend the behaviours that they should focus on changing based on their scores, with hints and tips to help, and information about other resources available to them. Those who have responded online will receive instant feedback on their 'scores' and will be directed to the downloadable resources to help them achieve behaviour change.

It should be noted that 'How are the kids?' is an engagement marketing mechanic and not a risk-profiling (or a monitoring) tool. While the programme will generate a large amount of data, we recognise that, as a picture of what people are really doing, it will be flawed.

It will nevertheless allow us to generate significant PR nationally, regionally and locally, and will provide a rich source of case studies.

A commercial partner, ITV, has committed to producing two hours of primetime television programming which will coincide with the distribution of 'How are the kids?'. The programming will feature celebrities examining their own and their families' behaviour and will follow their progress as they make specific changes.

### Phase three: rooting the behaviours

The campaign team has defined the behaviours that parents should encourage their children to adopt if they are to achieve and maintain a healthy weight in consultation with the Healthy Weight, Healthy Lives Expert Advisory Group, the Chief Medical Officer, the Healthy Weight, Healthy Lives policy team and key stakeholders including the Food Standards Agency.

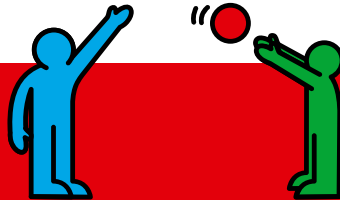
To achieve and maintain a healthy weight, parents need to help their children to:

- reduce their intake of fat, particularly saturated fat;
- reduce their intake of added sugar;
- control their portion size;
- eat at least five portions of fruit and vegetables per day;
- establish three regular mealtimes each day;
- reduce the number of snacks they eat;
- do at least 60 minutes of moderate-intensity activity per day; and
- reduce time spent in sedentary activity.

Although we are still building the evidence base, we are confident that if families adopt these behaviours, they will prevent excess weight gain and maintain a healthy weight.

However, conveying these behaviours presents a number of challenges for marketing:

- Between them, the behaviours impact on much of family life: shopping, cooking, eating, playing, travelling.
- The fact that there are eight of them presents challenges: in research, families told us that they wanted to see all of the behaviours at the outset; however, changing all eight at once is overwhelming and most will need to change one or two at a time.
- Many of these behaviours are habitual to the point of being unconscious. While by no means as challenging as other behaviours we ask people to change (such as giving up smoking or drugs), overcoming inertia will be difficult; all require a degree of departure from the path of least resistance or what is considered normal by many of our families; many require new skills and parenting strategies.
- Some of these behaviours are difficult both to understand (what is saturated fat?) and to implement (what is an appropriate portion size for a 5-year-old?)



To make the behaviours real for people, we asked our agencies to:

- create user-friendly and memorable language for describing them;
- supply tips that translate each behaviour into a real situation to which our target audiences can relate; and
- create a mechanism for promoting the behaviours as a set.

The user-friendly versions of the behaviours can be accessed online at [www.nhs.uk/change4life](http://www.nhs.uk/change4life) and by post.

The eight behaviours will also be promoted together via newspaper advertising and retail partners.

### **Phase four: inspiring people to change**

We know that, for people to move from intent to change to actual change, they need to believe that change is possible (i.e. believe in their own ability to change) and normal (i.e. believe that people like themselves are already making changes).

This stage of communication will seek to inspire that change is possible ('I'm in') and convince them that change is already happening ('We're in').

'I'm in' communications will include national PR featuring stories of real people making changes and the impact those changes are having on their lives.

'We're in' communications will include regional PR and advertising, celebrating local case studies and showcasing locally available services.

To improve the integration of local marketing activity with the national effort, the Department of Health created a bid fund to allow strategic health authorities to fund localised activity from the central budget. In addition, it will fund advertising space in those publications that have good coverage among at-risk target audiences and will invite obesity leads in primary care trusts and local authorities to nominate local services and initiatives for inclusion.

### **Phase five: supporting people as they change**

All communications will give at-risk families the opportunity to sign up to an ongoing CRM programme. This programme will provide encouragement, information and the support families need to get their children eating better and moving more.

This programme will be delivered online and by post.

## 13. Communications for specific audiences

### Pregnant women

The current breastfeeding communications programme will be broadened to include messages about the importance of nutrition and exercise to maternal health during pregnancy. Additionally, the link between formula feeding and obesity will be made explicitly within the ongoing breastfeeding communications programme. This programme currently has two main objectives:

- to normalise breastfeeding and encourage women who don't consider breastfeeding as an option to give it a try; and
- to encourage women who do choose to breastfeed to use the various methods of support available to them, therefore increasing their chances of continuing to breastfeed for as long as possible.

The work to normalise breastfeeding will use the mass media as the audience extends beyond pregnant women, whereas targeted messages about support will be delivered directly from health professionals and through targeted consumer media.

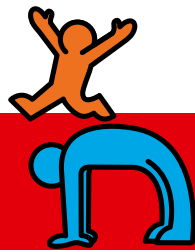
### Parents of 0–2-year-olds

Recognising that taste preferences start in early infancy (if not in the womb), we will produce messages for parents of 0–2-year-olds, supporting continued breastfeeding and healthy weaning.

### Ethnic minority families

Research suggests that these communities have specific attitudes to diet and exercise which will require engagement outside mainstream messaging. We have conducted a programme of research, starting with those ethnic minority populations (Bangladeshi, Pakistani and black African) which the Health Survey for England identified as having the highest rates of childhood obesity, and have appointed two specialist agencies to develop culturally specific materials and support mechanisms. For example:

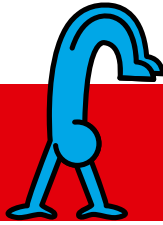
- using marketing to forge a greater link between obesity (currently viewed in some cultures as a sign of good health) and poor health outcomes;
- creating culturally appropriate versions of mainstream messaging;
- developing new messaging linking activity and diet to educational and future attainment (since this is motivating for these groups);



- producing diet advice that takes account of specific cooking styles (such as use of palm oil in the black African community and ghee in the Bangladeshi community); and
- communicating/advising via our audience's preferred channels. In particular, we will use existing community networks to provide face-to-face support.



**YEARS TWO  
AND THREE**



## 14. Change4Life in years two and three

We recognise that our ambition for Change4Life will not be achieved in a single year (or even two or three years) but will require sustained pressure.

During years two and three of the campaign (April 2009 to March 2011), we will continue with the core family programme, producing more materials for pregnant women, parents of 0–2-year-olds, ethnic minority communities and workforces. In addition, we plan to extend Change4Life to reach another at-risk audience.

We are in the process of defining who this new audience will be. Any new marketing will be driven by a similar programme of analysis, research and insight.

This will define:

- the factors that lead to weight gain post-childhood, including:
  - demographics (age, gender, geography);
  - lifestyle triggers (such as leaving education or having children); and
  - other less predictable factors (such as bereavement or redundancy);
- the sub-groups for whom weight gain is most pernicious (for example those living with long-term conditions); and
- the groups whose behaviours are most open to influence through marketing techniques, including:
  - the incentives and barriers to take-up of treatment programmes; and
  - possibilities of challenging demotivating beliefs about weight status, for example the belief that people with low metabolisms cannot maintain a healthy weight.

As we develop marketing materials, we will ensure that we join up our marketing with other campaigns, particularly tobacco and alcohol, to deliver consistent advice.



# EVALUATION





## 15. How will we measure success?

The Government is committing substantial public funds (£75 million over three years) to Change4Life and it has a responsibility to ensure that the contribution of the programme to behaviour change (and ultimately improved health outcomes) is properly measured.

Our objective will be to evaluate whether we are spending public funds efficiently and effectively, specifically:

- Is our media plan reaching our key target audiences (particularly the at-risk segments)?
- Is our creative work and supportive material engaging? Does it inform and persuade people of the need to make changes?
- Are our fulfilment materials (direct mail, digital, mobile, telephony) giving people the support that they need as they start to make changes?

Our evaluation programme will be based around the model of behaviour change set out in this plan. We recognise that this model is artificially linear and simplistic. In reality, each family will make its own journey, sometimes moving rapidly through a number of stages at once, sometimes stalling or going backwards for a time, before hopefully moving on. We will use the model to track change at a population level, always understanding that this aggregate will be a simplification of many complex behavioural journeys. As we learn more about these journeys, we will develop the model to reflect this.

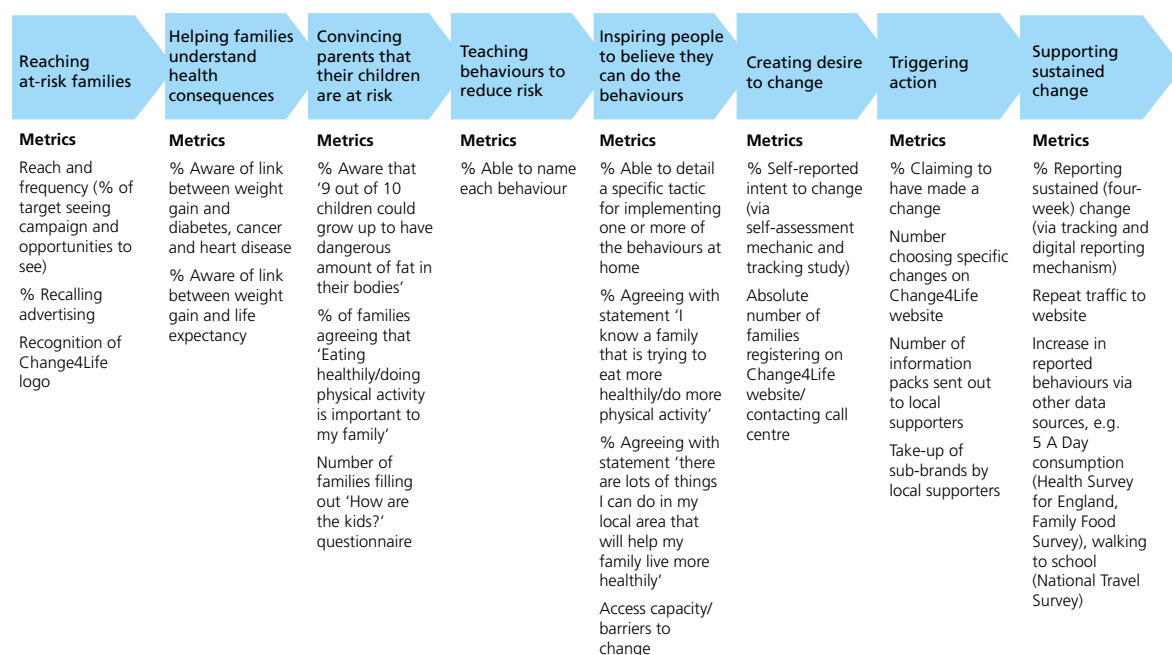
All marketing and key messages will be monitored via a major tracking study, comprising a nationally representative sample (with boosts for families, pregnant women and other key audiences) and fielded continuously for the life of the campaign. The tracking study will measure the impact of the Change4Life programme on awareness, attitudes, understanding of key messages and intent to change and self-reported behaviour change as the campaign progresses. It will identify which channels were most effective in generating change, including partner activities and local initiatives.

Measuring the impact of the marketing campaign, however, is only the beginning. Our longer-term objective is to examine whether there is a causal relationship between marketing activity and behaviour change; then between behaviour change and changing weight status (and ultimately between changing weight status and improved health outcomes). To supplement the population-level tracking, we intend to conduct some small-scale studies to examine the impact of the marketing materials upon the behaviours of families, both in the short term and over the longer term.

More generally, we will work with the wider Healthy Weight, Healthy Lives programme to establish a 'line of sight' from our intermediate marketing measures to longer-term population-level outcome measures, such as levels of the key behaviours that may be affected by a range of factors (for example, changes to the environment and local interventions). Current measures used include BMI and proxy indicators, such as: percentage of children achieving the recommended level of physical activity; percentage of children walking to school; and consumption of fruit and vegetables, fat and sugar. These indicators are gathered from a variety of sources, including the National Diet and Nutrition Survey, which, from 2009, will include food diaries and accelerometers (devices that measure human movement); the Health Survey for England; the National Child Measurement Programme; the Department for Transport's National Travel Survey; and Defra's Family Food Survey.

Specific metrics are aligned to each stage in the behaviour-change journey (as detailed below).

## Measuring Change4Life's impact through the behaviour-change journey



As mentioned on page 25, there are a number of hypotheses and assumptions in this plan which we intend to test, learn about and refine in the coming months. Next year we will publish a second report, which will detail where we were right, where we were wrong and where we have succeeded or failed in meeting our targets.



That report will include answers to questions such as:

- How many people were aware of the Change4Life programme?
- How many people joined up to the Change4Life programme?
- How many people claimed that Change4Life helped them change their behaviours?
- What was the conversion rate between signing up to Change4Life and sustained behaviour change?
- What were the really crucial steps in the behaviour-change journey?
- What are the key metrics which predict the likelihood of a particular family to move through that journey?
- What is the return on investment of the Change4Life behaviour-change programme?

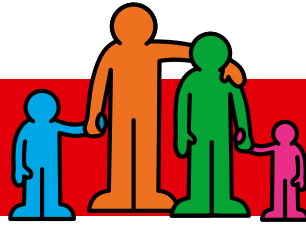
Through our continuous tracking and our wider evaluation programme, we hope to generate the evidence base to drive not only the refinement of our programme but also future campaigns all over the world.

## 16. Targets

We have set the following targets for the first three months and the first 12 months of the campaign.

|  | <b>End March 2009</b> | <b>End December 2009</b> |
|--|-----------------------|--------------------------|
| Reach (percentage of target audience who have an opportunity to see the messages)          | 95%                   | 99%                      |
| Awareness (percentage of target audience who recall seeing the Change4Life advertising)    | 75%                   | 82%                      |
| Logo recognition   | 42%                   | 44%                      |
| Response to 'How are the kids?' (completed questionnaires received)                        | 100,000               | N/A                      |
| Response (number of people responding via internet, post or telephony)                     | 1,000,000             | 1,500,000                |
| Sign-up (number of families signing up for the behaviour-change programme)                 | 100,000               | 200,000                  |
| Sustained interest (number of people interacting with Change4Life for at least six months) | N/A                   | 33,333                   |

These targets were developed in conjunction with our communications partners and with COI, using its Artemis tool (which forecasts response and conversion based on media spend and mix).



# 17. Document approval

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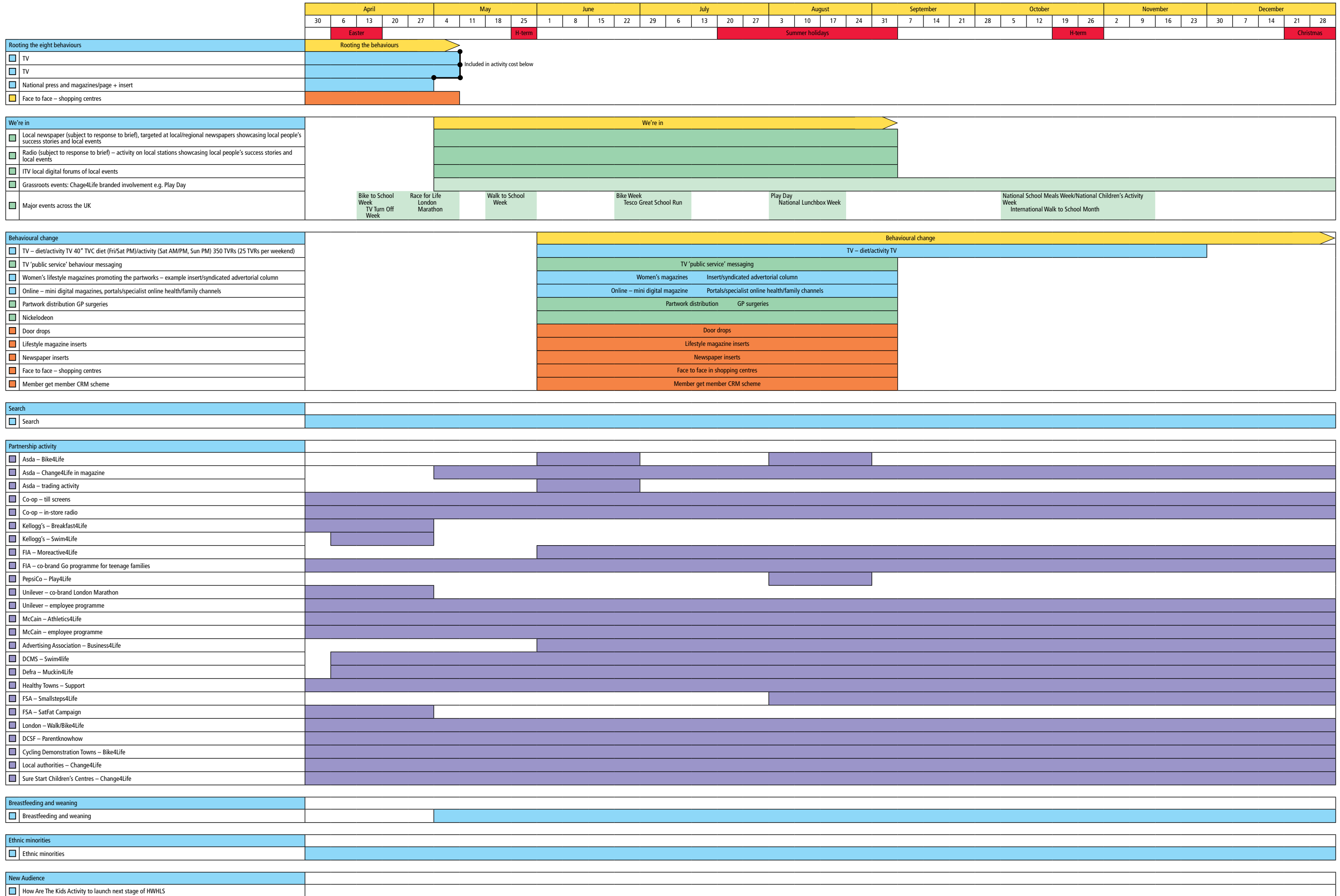
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- EHS Brann
- Freud
- M&C Saatchi
- Media Moghuls
- MGOMD
- Profero

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# Change4Life media plan 2009 – April 2009 to December 2009



Planned activity   
  Briefed activity   
  Booked activity





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