



# Health Promotion Strategies in Heart Health

Part of the Heart Health Orientation Session

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# Overview

 In the beginning...(30 mins)

 Theoretical history, rationale, first findings

 Using theory (60 mins)

 Key health promotion theories today, population approach, **the cube**, logic models...

 Questions

## Part 1. In the beginning...

- ✍ Health promotion not new, been around for centuries (Rootman 1993)
- ✍ Took off with “ A New Perspective on the Health of Canadians” (Lalonde report 1974)
  - ✍ Introduced health field concept: biology, environment, lifestyle and health care organization
  - ✍ Lifestyle got most press
  - ✍ Ignored for 5 years but picked up by US Surgeon General in their report Healthy People



Then....

✍️ Canada got on board (better late than...)

✍️ Established federal Health Promotion Directorate to:

✍️ Promote healthy lifestyles

✍️ encourage avoidance of health risks

✍️ assist people with disabilities and chronic diseases cope with their circumstances

✍️ **Clear focus on individual**



But....

- ✍ Lifestyle/individual focus critiqued widely for blaming the ‘victim’, ignoring life circumstance, power (Labonte, Bunton, Pederson, WHO)
- ✍ Kickbusch’s WHO document in 80’s
  - ✍ Defined health promotion as “ the process of enabling people to increase control over, and to improve, their health”
  - ✍ Focused on whole population not just those at risk
  - ✍ Called for diversity of methods and approaches

So...



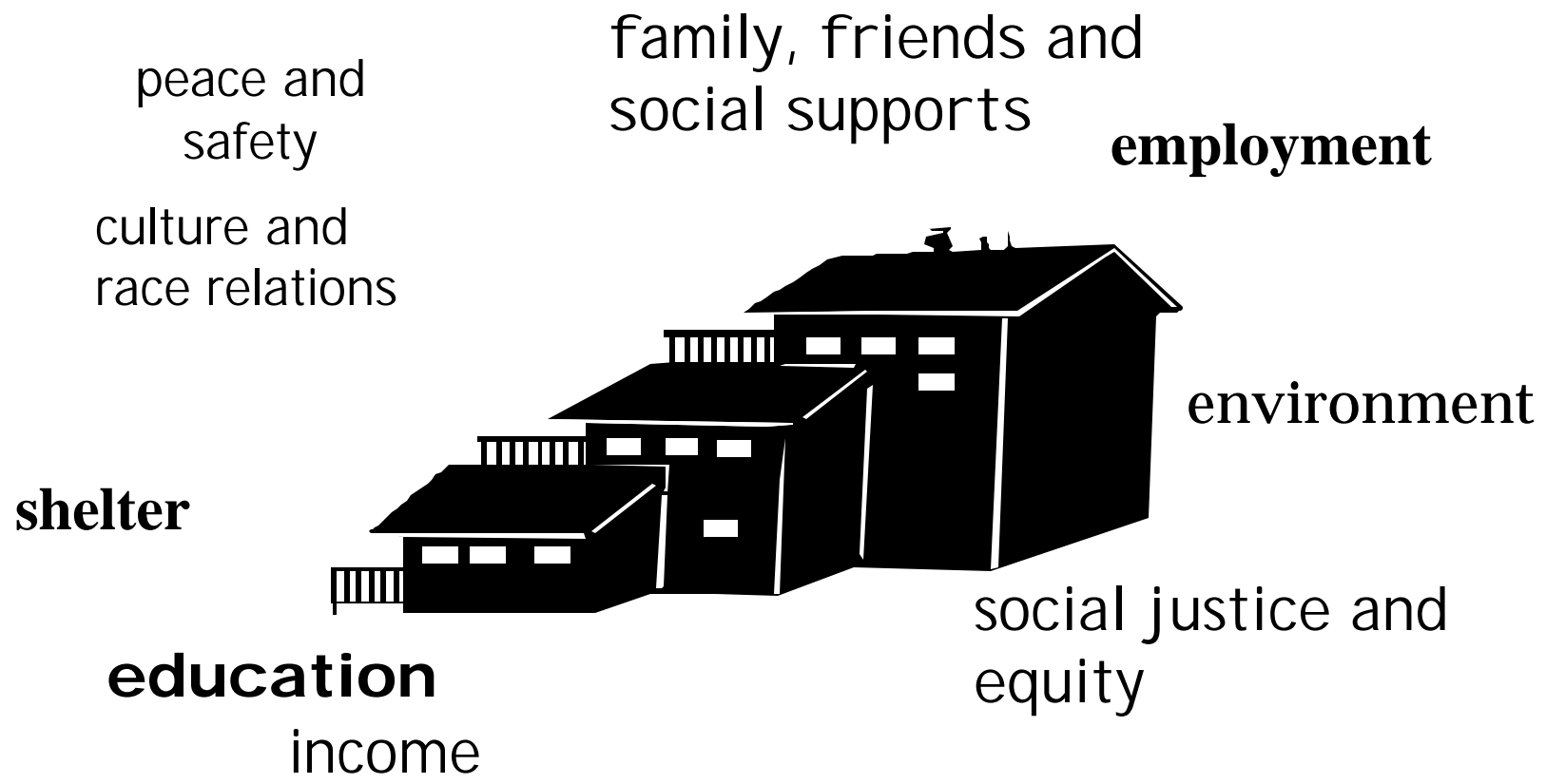
- ✍ Idea of healthy public policy (Toronto) and health communities (Europe) introduced
- ✍ First international conference on health promotion in Ottawa, 1986
  - ✍ Created famous 'Ottawa Charter' with 3 key mechanisms: self-care, mutual aid and healthy environments
  - ✍ Four areas for action: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, reorient health services
- ✍ Had dramatic international affect, still used today but the report never approved by cabinet!

## In other words...



- ✍ We've been organizing health promoting activities for centuries
- ✍ Became 'official' in Canada mid 1970's
- ✍ Early focus on individual widely critiqued
- ✍ Broadened in Ottawa charter to include **social determinants of health**
- ✍ Theoretical tug of war between individual and environmental focus continues....

# Social Determinants Re-visited



# Part 1 cont'd: Rationale For HH

- ✍ Heart disease is one of leading causes of death (Hyndman et al 1993-excellent resource!)
- ✍ Three main strategies to reduce number of deaths:
  - ✍ Use emergency medical services, identifying people likely to have heart disease through population screening
  - ✍ Offer community-based programs to reduce the risk of heart disease in whole populations
- ✍ Third preferable as most deaths occur in moderate risk zone, less expensive
- ✍ “efforts that go beyond the individual and deal with community factors more likely to succeed” (Hyndman et al 1993)

# How do we know this?

## First Findings-“Forefathers” of HH

### 1. Pennsylvania County Health Improvement Project (CHIP)

- ✍ 1980, used behaviour change methods and media campaigns, educational materials, worksite health promotion programs and school based programs
- ✍ Saw changes in smoking, hypertension, cholesterol levels, body weight and physical activity

## 2. Minnesota heart health program

- ✍ Started by school of public health
- ✍ Three communities
- ✍ Goal: to reduce number of deaths and risk of heart disease
- ✍ 9 strategies: community analysis, education, community leaders, mass media, population-based screening, adult education classes, youth and parent education, education for health professionals and risk factor health education

### 3. North Karelia



- ✍ Rural county in Finland, pop. 180,000
- ✍ One of highest rates of heart disease in world
- ✍ Citizens asked government to help, started North Karelia Project in 1970's
- ✍ 6 strategies: providing information, persuasion, training, building natural support systems, making healthy environmental changes and encouraging community organization



## 4. Pawtucket

 City in Rhode Island

 Started in late 1970's by hospital because of high levels of heart disease

 Methods: trained volunteers to deliver project activities such as community-based screening, counselling and referral



## 5. Stanford Five City Project

✍ 5 communities

✍ Started 1978

✍ Activities: broadcast media programs, print media, community interpersonal programs (school and worksite-based health education)

## Part 2: Using theory in heart health

- ✍ Know (the basics of) the top theories today.
- ✍ Understand a population based approach.
- ✍ Get to know the cube.





# Health Promotion Theory

- ✍ “devised to analyze, predict or otherwise explain the nature or behaviour of a specified set of phenomena that could be used as the basis for action.” -Van Ryn and Heany (1992)
- ✍ “Something that makes me feel ill.” (Heart Health Co-ordinator 2003)



# Health promotion theories:

- ✍ Explain factors promoting and inhibiting change at the individual and societal levels (Hyndman 2003)
- ✍ Are a tool for ‘seeing’ (Poole 2003a)
- ✍ Overlap
- ✍ Are imperfect, Western
- ✍ Prone to fashion
- ✍ Inform what we do, plan, fund

# Key health promotion theories



Based on analysis of research, practice  
(Poole 2003a):

1. Diffusion of innovation
2. Community capacity building
3. Ecological model
4. Network Analysis
5. Stages of change

# Diffusion of Innovation

- ✍ Developed by Rogers in 1960's (focus: groups)
- ✍ *In trying to 'spread' or diffuse a new idea through a social system, we can make use of 6 kinds of community members, categorized by how long it takes them to adopt a new idea or practice.*
- ✍ Innovators, early adopters, early majority, late majority, late adopters, laggards
- ✍ Decisions made on how compatible, flexible, reversible, easy, 'good', cheap and risky the innovation is.
- ✍ Pros: Ideal for education campaigns, assumes community members not same, can help us tailor messages
- ✍ Cons: May ignore other factors influencing decision, not focus on whether behavior is lasting, assume innovation 'better', put too much onus on early adopters
- ✍ **Hastings-Prince Edward, Wellington-Dufferin, CHHIOP (Riley 2001)**

# Community Capacity Building



- ✍ McKnight, Kretzman, Mattesich et al., Raphael, 1990's
- ✍ Focus: Individual, organization, community
- ✍ *Individuals in a community or organization have assets such as skills and relationships that can be enhanced to address key problems.*
- ✍ Includes development of training, participatory decision-making, shared vision, developing collective processes, increasing access to information, skills and networks that help folks participate in communities and organizations
- ✍ Pros: Focus on assets, social determinants of health, brings power back in, popular in Ontario over last decade
- ✍ Cons: time-consuming, in more rural areas 'neighbourhoods' may not exist, much debate around meaning of and use of key concepts, recent work suggests shift in application from community to individual with some see as problematic
- ✍ **Chatham-Kent, HKPR**

# Ecological Model



- ✍ Skinner, Laurin, Barker, Bronfenbrenner 1950's, 60's, 70's
- ✍ Focus: Individual, community, environment
- ✍ *To understand 'health' and health behavior, we must focus on people's transactions with their physical and social surroundings or 'environment' (buildings, community design, safety).*
- ✍ I.e.. To get people walking more may need to hand out pamphlets as well as build sidewalks, establish walking clubs, improve cross walks
- ✍ Pros: useful when working on widespread issues, encourages in-depth analysis, involvement of multisectoral groups may enhance funding/sustainability, congruent with Ottawa charter
- ✍ Cons: multisectoral collaboration often difficult to create, may be issues around negotiation of goals, may not work in tighter time-lines often faced by health promoters, analysis of environmental influences may uncover issues outside 'scope' of program, if collaboration not supportive, may lead to power struggles and burn-out
- ✍ *Thunder Bay and....the overall HH initiative in Ontario! (Riley 2001)*

# Network Analysis



- ✍ Valente 1990's (group, organization, community, region)
- ✍ *Refers to a set of theories and tools for understanding connections between people in a group, community or other 'unit' such as a region. Connections create a structure or network, which when analyzed, helps us understand (health) behavior and how to change it.*
  - ✍ One tool is 'Opinion Leadership Model': Can change health behavior through a network by focus on opinion leaders or champions who can help spread an idea to opinion followers
- ✍ Pros: Cost-effective, may work well when used in conjunction with other methods, makes 'common sense' to many
- ✍ Cons: not widely applied in Ontario yet, criticized for being too similar to Diffusion of Innovation model, may simplify qualitative connections to measurable 'units', use of opinion leaders may get point across but with little dialogue around how 'good' it might be for other members of a network
- ✍ **Etobicoke/ York**

# Stages of Change



- ✍ Prochaska and DiClemente, 1970's, 80's
- ✍ Focus: individual
- ✍ *An individual goes through 5 stages as s/he learns a new health behavior.*
  - ✍ Precontemplation: S/he is not thinking about changing (i.e. quitting smoking)
  - ✍ Contemplation: S/he starts thinking about it.
  - ✍ Preparation: S/he prepares to change.
  - ✍ Action: S/he begins to change.
  - ✍ Maintenance: S/he maintains the change over 2-3 years.
- ✍ Pros: Tells you more about your 'audience', does not assume everyone same, developed in practice setting
- ✍ Cons: Very American, not much research, may ignore reasons why people might be at different stages, assumes the 'change' will be good for everyone
- ✍ *Rhode Island, Women at heart project*



# Questions for reflection

- ✍ Which one(s) made more sense to you?
- ✍ Which one(s) could you see yourself using?
- ✍ Why?
- ✍ Are there problems with the theories?



## 2. Understand the population based approach

“aims to produce a large effect on the reduction of cardiovascular disease by creating a small risk reduction in a large number within the population. A population approach includes all people living in the community; not just those who are considered at highest risk” (Mitchell 1998: 60)



# How? Make it comprehensive

 Following the ecological model, this means:

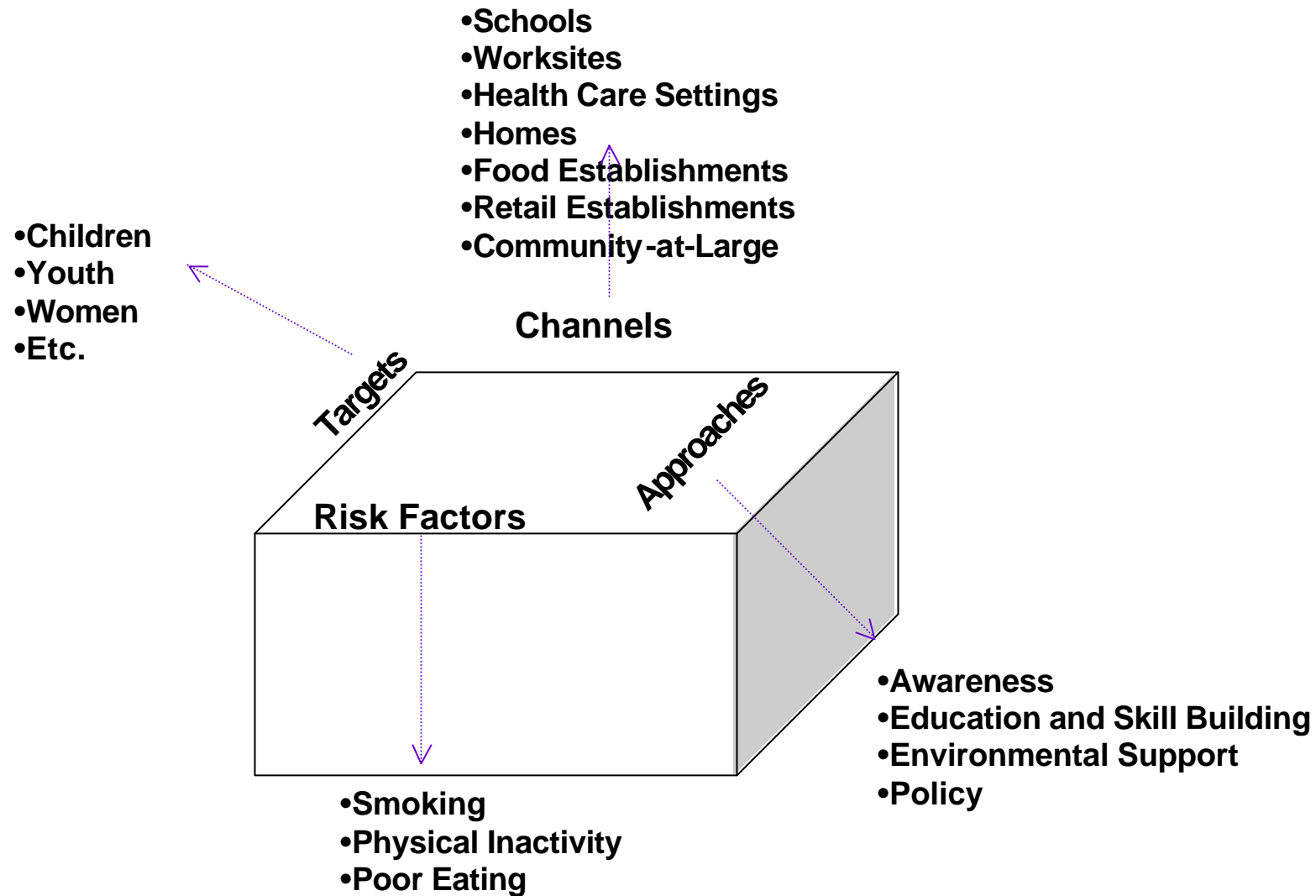
“interventions are implemented through various community channels; target many groups; use a mix of education, environmental support and policy approaches; and address various risk behaviours...also means involving many sectors (gov’t, media)” (HHRC 1997)

# Use the cube



- ✍ Conceptual organizing principle for HH
- ✍ Takes ecological model, comprehensive population based approach and gives us a visual of how to work
- ✍ **Building blocks:**
  - ✍ **Targets:** your audiences, market, focus (kids, women, south asian youth, native elders)
  - ✍ **Risk Factors:** the issue (inactivity, tobacco use)
  - ✍ **Approaches:** any kind of strategy including programs, pilots, contests or workshops that helps to produce the desired change (peer education, breakfast program)
  - ✍ **Channels:** the sites you'll use reach your audience (schools, homes, restaurants, malls, parks)

# 3. Get to know the cube





I.e. **Women at heart program**

✍ **Part of larger community wide population approach**

✍ **Target:** marginalized women in London

✍ **Risk factors:** overall heart health (poverty, language issues, low social support, education)

✍ **Channels:** community resource centre, aboriginal community, agencies for newcomers

✍ **Approach:** training of peer educators, provision of resources for peer education



# A quick look at logic models...

- ✍ Evaluative tool
- ✍ Very popular in last decade
- ✍ Part of trend towards evidenced-based programming/funding
- ✍ Build on the cube nicely i.e.. approaches becomes programs/activities, targets=intended populations

# Wrap up....



- ✍ From Lalonde to the cube
- ✍ Parking lot (bicycle rack)
- ✍ What have we missed?
- ✍ Extra resources
- ✍ Where to go for help

The characteristic that has always separated the successful health education researcher and practitioner from those less effective is the use of theory; that is, the capacity to translate it into interventions.

(Clark [in Glanz et al] 2002: xiv)

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We hope this session has enabled some of that success

# References/resources

- ✂ Bunton, R., Nettleton, S. and Burrows, R. (Eds). 1995. *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*. New York: Routledge.
- ✂ Glanz, Karen; Rimer, Barbara K. and Lewis, Frances M. (Eds.) 2002. *Health Behaviour and Health Education: Theory, Research and Practice*. 3rd Edition. San Francisco: Jossey Bass.
- ✂ HHRC. 2004. *@ Heart*. 16, Winter
- ✂ HHRC. 1997. *Executive Summary*. Toronto. HHRC
- ✂ Hyndman, Brian. 2003. *Health Promotion Theories and Concepts*. Toronto: The Health Communication Unit.
- ✂ Hyndman et al. 1993. *The Use of Social Science Theory to Develop Health Promotion Programs*. Toronto: Centre for Health Promotion/Participation.
- ✂ Mitchell, Donna. 1998. *Comprehensive Heart Health Program Planning*. HHRC/OPHA.
- ✂ Napoli, Maria. (2002). Holistic health care for Native women: An integrated model. *American Journal of Public Health*, 92(10): 1573-1575
- ✂ Poole, J. 2003a. *The Use of Theory in Heart Health Promotion: What it can and cannot tell us*. Toronto: HHRC. \*
- ✂ Poole, J. 2003b. *Literature review on self-help, social support and stroke*. Toronto: SHRC ([www.selfhelp.on.ca](http://www.selfhelp.on.ca))
- ✂ Riley, Barbara et al. (2001). Dissemination of Heart Health Promotion: Lessons from the Canadian Heart Health Initiative Ontario Project. *IUHPE-Promotion and Education Supplement* 1. 26-30
- ✂ Rootman, Irving. 1993. *Lectures in Health Promotion Series. #3 Health Promotion: Past, Present and Future*. Toronto: Participation.
- ✂ Rozanski, A., Blumenthal, J. and Kaplan, J. (1999). Impact of psychological factors on the pathogenesis of cardiovascular disease and implications for therapy. *Circulation*, 99(16): 2192-2217.