

National Research Program 1: The Community Intervention Strategy

The National Research Program Collaborative Group

1. Introduction

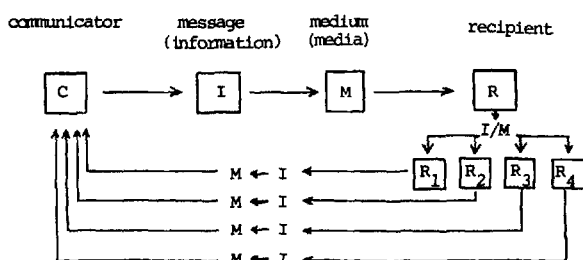
This program centres on the mobilisation of all community resources for a preventive effort. This can be achieved only by promoting active public participation in planning and implementing the program in the intervention communities. Given the intent of the program - namely, to have the community continue the program on its own once support from the National Science Foundation has ended - this participation seems even more important. This suggests thus that successful interventions should be based on the following concepts:

- encouragement and development of self-help groups and training of non-health professionals as group leaders;
- development and integration of social support systems (family members, buddy systems) in the intervention strategy;
- continuous education of local health personnel, including physicians;
- integration of all preventive strategies in the local social and health services;
- recruitment and training of community workers as local preventive agents.

Efforts toward individual action need to be supplemented by interventions designed to reach the whole community. For this purpose, all media have to be included as an integral part of the prevention strategy. In addition, environmental changes are also needed (efforts at reaching distributors and producers of food products, advertisers, cafeteria and restaurant chefs). Finally, rather than stigmatising individuals with risk factors, attempts will be made to motivate the whole population toward a healthier life-style.

2. The communication process model

In dealing with attitude and behaviour change (i.e., with life-style), it is useful to start with the classical and basic model of the communications process. The elements of this process are outlined below:



It should be noted that the roles of communicator and recipient are interchangeable and indeed in the present program, accent is placed on the recipient (i.e., the one who will ultimately benefit from the action) serving as the main communicator, both in determining needs and priorities and in carrying out the action. It should be noted, too, that in a whole communications system a lot of such feedback systems are overlapping and completing each other.

Success in using the communications model depends essentially on the following aspects, which will be illustrated with some practical examples from the two intervention communities: communicator, message/information, medium and recipient (1).

2.1. Communicator

The communicator must possess a high degree of source credibility, the components of which are trustworthiness and recognized expertness. By trustworthiness is meant that he must be seen to be free of motives of personal profit and if possible also be integrated into an existing social group. Expertness, at least to a certain degree, is also expected of an expert, and the ideal communicator combines both of these qualities.

In applying this principle, attempts are made in both intervention communities to avoid "importing" ideas from the outside. For this purpose, committees and local groups have been created, composed of local well-known persons, and a program coordinator recruited from the community (in Aarau, this person is a local school teacher and in Nyon it is a social worker). All of these persons act, in an experimental sense, as intermediary communicators between the local population and the specialists.

To guarantee expertness, the local groups are composed of local specialists (physicians, pharmacists, dietitians, psychologists, educators, nurses, and so forth). At the same time these groups can call upon the scientific knowhow of members of the program's specialist groups. Thus, cooperation is ensured between local and external communicators with a view to optimum credibility.

Efforts are also made to ensure that the action is perceived by the population as a local undertaking, which explains the different slogans adopted in the two intervention communities: "Aarau - eusi gsund Stadt"; "Nyonnais, battez-vous, pour que batte votre coeur" ("Aarau, our healthy

town" and - loosely translated: "Nyonnais, act so that your heart beats"). Thus far, the local groups, for example, have come to view the action as their own and it is hoped that with time the communities as a whole will also share this view.

2.2. Message/Information

The communications model tells us that messages or information must be composed in such a way as to be acceptable to the recipient and applicable to the practice of a healthy life-style. It is also known from health education research (and communications research in general) that fear-arousing appeals have at most a short-term effect, and that individuals are most easily reached when they can perceive an immediate, personal benefit from improved health practice. Thus, not only do the local committees and local groups serve the purpose of "interpreting" program information in terms which are understandable to different community groups, but accent throughout the program is placed on the positive benefits of a healthy life-style rather than on the dire consequences of risk factors. In Aarau, the emphasis in weight control is, for example, on "more physical efficiency and better appearance" and not on "overweight shortens your life-expectancy". In smoking education, the message is "stopping smoking is an achievement worthy of admiration" rather than "smoking can lead to a heart attack".

Naturally, the facts about risk factors are also given, but only when a relevant starting point for the acceptance of the message has been found: in the case of the Nyon groups, this is when participants, having discussed the results of their examination and their own feelings about whatever health problem has been identified, ask for it.

2.3. Media

A guiding principle of communications research is that personal influence is generally more effective than (mass) media contact. One of the important goals of this program, therefore, is to promote the use of both formal and informal information networks in the intervention communities. Although it was deemed necessary in the beginning to use the newspapers, posters and brochures or pamphlets, these were then intended mainly to introduce the program and its broad objectives to the public and to stimulate interest. In the course of the next three years publications of all types will be developed as a mean of introducing new ideas and of stimulating more personal

contacts and involvement. The main thrust of the intervention strategy, however, involves contacts with local associations and groups, and more particularly with individuals and their families. Both personal contact and media use are integral parts of the "two-step-flow" of communications: through them opinion leaders and first presenters are reached in the primary stage of the process and they in turn transmit information and action proposals to their immediate social groups.

2.4. Recipients

While broad program goals have been defined - i.e., the reduction or prevention of certain cardiovascular risk factors - the way in which these are achieved depends entirely on how participants perceive the risk factors and decide what action they wish to take in regard to them. It is here that the recipient becomes communicator, because unless he is actively involved in discussing his health situation and in proposing and carrying out appropriate action, no effective action can take place.

For this purpose, in Nyon for example, immediately at the end of the screening phase, when participants had begun receiving the results of their physical examination, a number of pilot groups were created. These were composed of persons at high risk (particularly those with hypertension) as well as those who had expressed a desire during the screening phase to take part in a preventive action. These groups had several objectives:

- to propose and test methods for helping risk factor carriers;
- to prepare documentation and other material which would meet the expressed needs of participants and at the same time be adapted to local conditions;
- to define the types of group leaders needed and the corresponding training required;
- to prepare public information sessions.

Parallel to and arising from these pilot group experiences was the decision to organize a "Heart Fair" in order to advertise the intervention program and to recruit members of the public to various activities. The success of this Fair is one example showing the effectiveness of participation in such a program. In addition, several persons taking part in the pilot group experience indicated their interest in becoming group leaders and are now wor-

king in further group sessions in preparation for this.

The Aarau health education procedure differs from the Yonnais concept in so far that activities of action groups will begin after the sensibilisation of the community as a whole and the "isolated" individuals within their existing primary groups.

3. Implications of the community intervention strategy

The implications of this strategy should be obvious. By using suitable methods, it is hoped that there will be created a local health consciousness, supported by appropriate local structures and communications channels, which will survive after the period supported by the National Science Foundation. In order to achieve this, it is important to ensure the greatest degree of ego-involvement possible among the population of the communities involved. One important "caveat": establishing hierarchical structures would probably prevent this from happening. In Switzerland, with its extensive cultural diversities, it is necessary to develop a model rather than an overly structured and detailed action plan, for only a flexible model can eventually be adapted by other communities.

Zusammenfassung

Das kommunale Interventionsmodell

Zielsetzung des NFP 1 ist, das Gesundheitsverhalten je einer Gemeinde in der Deutsch- und Welsch-Schweiz während dreier Jahre positiv zu verändern. Erfolg im Sinne der Ueberlebensfähigkeit und Uebertragbarkeit eines solchen Programmes kann nur eintreten, wenn die bestehenden lokalen Einrichtungen und Sozialstrukturen aktiviert werden und damit am Interventionsprozess voll partizipieren (Sicherung des "Ego-Involvement" und Entwicklung von Eigendynamik).

Dieses Modell wird anhand ausgewählter Beispiele (lokale Organisationsformen und Aktionen) diskutiert.

Résumé

Le modèle d'intervention local

Le but du PNR 1 est d'obtenir une modification du comportement relatif à la santé dans 2 villes, l'une en Suisse allemande, l'autre en Suisse romande. Le succès d'un tel programme qui devrait démontrer sa reproductibilité et aboutir à une autonomie durable repose sur la sollicitation des groupes et des moyens existants pour parvenir à une participation locale à l'action par l'implication de chacun et une dynamique propre.

Ce modèle est discuté sur la base d'exemples de formes d'organisation et de modalités d'action.

Literature

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