Contrasting entry points for intervention in health promotion practice

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June 26, 2018   1:00 – 2:30 pm ET

Health Promotion in Canada

Webinar Series 2018

Teleconference:
1-866-830-9434

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National Collaborating Centre for Determinants of Health
Centre de collaboration nationale des déterminants de la santé

HEALTH PROMOTION CANADA   PROMOTION SANTÉ CANADA

Today's facilitators

Dianne Oickle
Knowledge Translation Specialist

doickle@stfx.ca

Danielle MacDonald
Research Assistant

damacdon@stfx.ca

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To ask questions or share resources during the presentation

Please use the chat box at any time and note that the webinar, including the chat box, is being recorded

Chat (Everyone)

Everyone

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NCC for Aboriginal Health
CCN de la santé autochtone

NCC for Methods and Tools
CCN des méthodes et outils

NCC for Environmental Health
CCN en santé environnementale

NCC for Infectious Diseases
CCN des maladies infectieuses

NCC for Healthy Public Policy
CCN sur les politiques publiques et la santé

NCC for Determinants of Health
CCN des déterminants de la santé

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Land Acknowledgement

The NCCDH is in Mi'kma'ki, the ancestral and unceded territory of the Mi'kmaq People.

This territory is covered by the "Treaties of Peace and Friendship" which Mi'kmaq and Wolastoqiyik (Maliseet) peoples first signed with the British Crown in 1725. The treaties did not deal with surrender of lands and resources but in fact recognized Mi'kmaq and Wolastoqiyik (Maliseet) title and established the rules for what was to be an ongoing relationship between nations.

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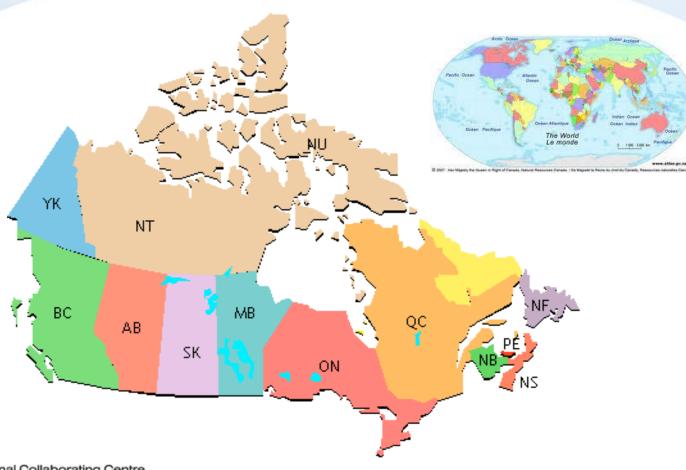
Our focus: Social conditions that influence health & narrowing the gap between the least and most healthy

Our audience: Canadian public health organizations & practitioners.

Our work: Explain and share what's known to help public health positively influence health for *EVERY*one through their work.

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Where do you work?

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Today's speakers

Martine Shareck, PhD

Division of Social and Behavioural Health Science
Dalla Lana School of Public Health

Amanda Hudson-Frigault

Take Home Naloxone Program Coordinator
Health Promotion, Addictions & Mental Health
Nova Scotia Health Authority

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In case you need to leave early…….

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[EVALUATION –
Contrasting entry points for interventions in health promotion practice](#)

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HPC volunteers:

Dr. Irv Rootman

Retired professor, University of Victoria and University of Toronto

irootman@telus.net

Lesley Dyck

Health Promotion Consultant

http://lesleydyck.ca/

Lesley@lesleydyck.ca

Health Promotion Canada

Mission - to advance the practice of health promotion in Canada.

HPC seeks to advance the practice of health promotion by supporting and uniting: students, researchers, practitioners and employers from across Canada in their efforts to collectively enhance health and create healthy and supportive settings.

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HPC Online:

- Health Promoter Competencies

- Health Promotion Canada Newsletter

- Regional Networks

- Competency Tool Kit (members only)

- Member contact list (members only)

www.healthpromotioncanada.ca

HEALTH PROMOTION CANADA — PROMOTION SANTÉ CANADA

Health Promoter Competencies
34 Statements in 9 Domains

Health Promoter Competencies

- Leadership & Building Organizational Capacity
- Health Promotion Knowledge & Skills
- Situational Assessments
- Diversity & Inclusiveness
- Plan & Evaluate Health Promotion Action
- Communication
- Policy Development & Advocacy
- Partnership & Collaboration
- Community Mobilization & Building Community Capacity

Using the Competencies

- Competencies are a building block for workforce development and can be used for various tasks:
  - Creating a job profile to describe the health promoter role & to inform job descriptions
  - Creating a job description
  - Planning job interview questions
  - Competency based self-assessment
  - Planning to meet learning needs
  - Designing curriculum
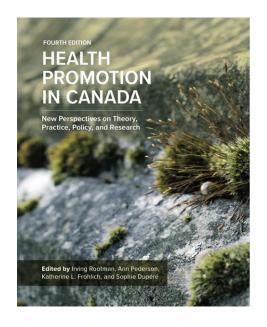
Webinar Series 2018

- Based on the 4th edition of Health Promotion in Canada

What's new?
- New editor
- Fifteen new chapters and new "Afterword"
- Instructors Manual
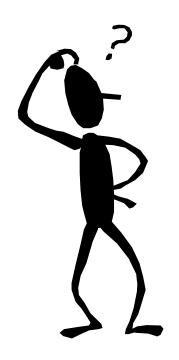
Chapters Covered in this Webinar Series

Ch. 6 - Contrasting Entry Points for Intervention in Health Promotion Practice *(Katherine L. Frohlich, Blake Poland and Martine Shareck)*

Ch. 10 - Indigenous Community Health Promotion (*Charlotte Loppie)*

Ch. 21 - Participatory Practice and Health Promotion *(Jane Springett & Jeff Masuda)*

Ch. 18 - Health in All Policies (*Ketan Shankardass, Lorraine Greaves & Natalie Hemsing)*

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The Future of Health Promotion in Canada

"We can only see a short distance ahead, but we can see plenty there that needs to be done."

Alan Turing

Forces to Consider

That will impede development:

- Elimination and downgrading of University-based Health Promotion research centers
- Elimination and downgrading of health promotion practitioner positions
- Priority given to health **care** services

That will enhance development:

- Core principles that animate health promotion
- Increased integration and collaboration with Public and Population Health as well as other fields and sectors
- Development of Health Promotion Capacities and standards
- Strengthened Health Promotion "Settings" movement
- New transformative leaders
- International engagement
- New national and provincial organizations and networks

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Sponsors thank you!

We would like to thank **NCCDH** for supporting and organizing this webinar series.

Canadian Scholars' Press for their donation of copies of *Health Promotion in Canada, 4th Edition* to each of the practitioner presenters in this series.

Today's speakers

Martine Shareck, PhD
Division of Social and Behavioural Health
Science Dalla Lana School of Public Health

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Contrasting Entry Points for Intervention in Health Promotion Practice: Situating and Working with Context

Martine Shareck, Ph.D.

Health Promotion in Canada: Critical Perspectives 4th Ed.

NCCDH webinar

June 26 2018

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Road map

- Introduction
  - Classical entry points in HP practice
  - Why do entry points matter?
  - Defining "social context"
- Advantages and shortcomings of classical entry points in HP practice
  - Issues & risk factors
  - Populations and specific groups
  - Settings
- The collective lifestyles approach
  - Key characteristics
- Concluding remarks

Introduction

Classical entry points in HP practice

1. Issues & risk factors (eg. HIV/AIDS, obesity, smoking)

2. Populations & specific groups (eg. children, Indigenous communities)

3. Settings (eg. schools, neighbourhoods)

- Different interventions depending on entry point
  - Eg. reducing **smoking** in **youth** from **low income neighbourhoods**
    - Is the problem to do with smoking itself, characteristics of youth, or the settings in which they live and learn?

Why talk about entry points for intervention?

- Influence:
  - How a 'problem' is framed: what shapes (ill) health?
  - How we should analyze and understand a problem
  - What can be done about it: *What* should we intervene on and *how*?

- Ties in directly to HP competencies
  - Eg.: What we measure at the problem identification and needs assessment stage will impact program development, implementation, and evaluation

The importance of the social context
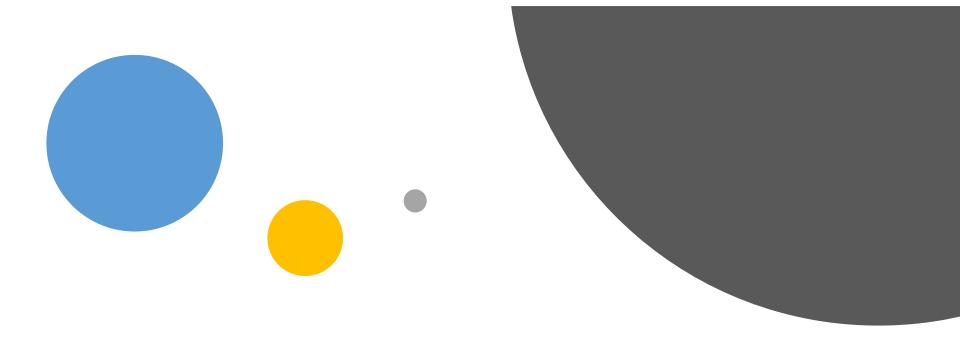
- HP interventions today
  - Complex, ecological, multi-level, inter-sectoral, multi-component
  - Seek to change individuals, communities, organizational structures, and policy
  - Not universally generalizable, one-size-fits-all → social context is important

- What do we mean by social context?
  - Often defined as list of social, political, economic, environmental, and other circumstances
  - Although these can tell us *what* matters, *how?* and *why?* are left unaddressed

Defining the social context for our purposes

"The local mix of conditions and events (**social agents, objects and interactions**) which characterize open systems… whose unique confluence in **time** and **space** selectively activates (triggers, blocks or modifies) causal powers (**mechanisms**) in a chain of reactions that may result in very different outcomes depending on the dynamic **interplay** of conditions and mechanisms over time and space." (Poland et al., 2008)

Polling time!

What challenges do you face in considering the social context in your Health Promotion work?

Classical entry points for HP intervention

1. Issues & risk factors

Entry point
- Diseases (CVD, diabetes, HIV/AIDS), risky behaviours (smoking, poor eating habits) or conditions (homelessness)

Objective
- To reduce the prevalence of these diseases, behaviours or conditions

Intervention
- Providing information and health education to develop personal skills

Target
- Individuals

Advantages
- Fits with risk factor epidemiology and individual-level health theories

An example: Multiple Risk Factor Intervention Trial (MRFIT)

- 6000 men, highest risk group for CVD (smokers, unhealthy diet)
- Well funded; used best behaviour-change techniques available
- Results after 6 years: 62% still smoking, 50% still hypertensive

1. Issues &
risk factors

Shortcomings

- Gains are short lived: new individuals continually adopting risky behaviours we are trying to eliminate in the first place

- "What puts people at risk of risks" is not considered: tobacco/big sugar industry tactics, media, family and community norms // smoking and dietary practices, socio-economic circumstances…

2. Populations & specific groups

Entry point

- Groups who share key characteristic thought to put them at risk of "sub-optimal" health (eg. women, children, elderly, Indigenous communities)

Objective

- To improve the status of these groups
  - *Health* status or *social* status?

Intervention

- Providing information and health education to develop personal skills

Target

- Individuals

Advantages

- Fits with how organizations and funding are set-up
- Allows to understand how multiple risk factors cluster within groups

Shortcomings

- Favours high risk approach: aims to address one issue or risk factor at a time
- What makes a group more vulnerable to multiple issues and risk factors is not considered

An example

- Indigenous peoples as *vulnerable population* because of their shared history of colonization and marginalization which has had psychological, physical, social, and spiritual consequences

3. Settings

- **Entry point:** settings where people live, work, and play (eg., schools, workplaces, neighbourhoods, virtual spaces)

	Settings (narrow)	**Settings (broad)**
Definition	Physically bounded with clear organizational structure	Based on ecological model, more loosely bounded & inter-related
Objective	To reduce the prevalence of diseases/risky behaviours among setting population	To make settings more health-enhancing
Intervention	Health education & mass media campaigns to develop personal skills	Physical, organizational and policy changes to the setting structure (+ information and education)
Target	Individuals	Setting structures (+ individuals)

	Settings (narrow)	**Settings (broad)**
An example	Nutritional education program for kids in schools	Nutritional education in schools + cooking lessons + healthy cafeteria meals + farmers' market to increase access to healthy foods
Advantages	Can reach wide audience at once Can have some control over the intervention	Changes are more sustainable in the long run Has potential to reduce health inequities
Shortcomings	Usually targets one issue/risk factor/group & one setting at a time Gains may not be maintained beyond setting boundaries	Hard to harness settings in their complexity Rarely informed by social analysis of how health and health inequities are produced

An example: The New Deal for Communities, UK

- 10-year strategy in 39 of the UK's most socially deprived neighbourhoods; huge $$$ investment

- Individual- and area-focused interventions tailored to each neighbourhood

- Five themes: health, education, unemployment, crime, and housing and the physical environment

- Evaluation results:
  - **Reduction in inequalities** in mental health and life satisfaction
  - **Widening of inequalities** in long-term illnesses and smoking cessation
    - More educated smokers benefited most from stop-smoking programs implemented

Polling time!

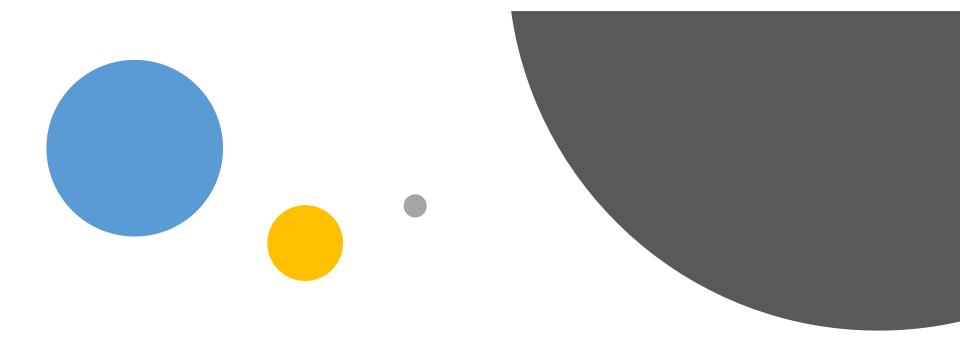## What entry point(s) discussed so far have you used in your Health Promotion work:

a) Issues/Risk Factors

b) Population Groups

c) Settings (narrow)

d) Settings (broad)

e) Other (please describe)

Each entry point falls short of…

… taking into account the social context of intervention and addressing the full complexity of how **individuals** and their **social circumstances** *interact* to produce health/health inequities

- some over-emphasize the individual (agency, choices), others, the environment (structure, opportunities)

… improving our understanding of *how* health and health inequities are produced and reproduced
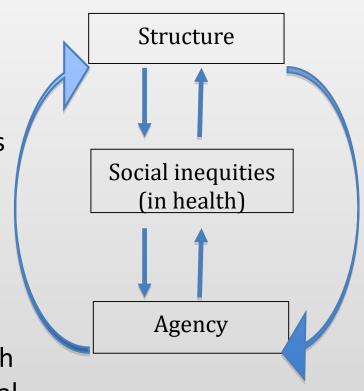
Introducing the collective lifestyles approach

Collective lifestyles approach: a heuristic device

- Explicitly situates behaviours within the broader social structure
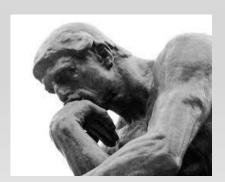 - Akin to socio-ecological approach, but has several additional specificities:

1. Situated within current sociological theory (eg. Bourdieu, Giddens)
   - Social structure (i.e., social conditions such as norms, resources, policies) shapes social practices (i.e., behaviours) which further shape social structure
   - There are inequities in both
   - Explicit and recursive relationship

2. Concerned with social practices broadly (not only health practices)

   - Eg. local norms may create inequitable opportunities to use a park for physical activity or to comply with non-smoking legislation; this in turn may lead to social inequities in behaviours

3. Focus on structural constraints and opportunities for agency and behaviour change

   - Creating opportunities by making the structure/environment more conducive to health is not enough: people need to be empowered and enabled to make use of it

   - Individuals also have the agency to overcome constraints, and this capacity is itself not equitably distributed among social groups

4. Focus on power relations

   - Shape the uneven social distribution of health behaviours and outcomes among groups

   - Create and sustain the social structure and the unequal distribution of the opportunities and constraints different groups face

5. Importance of reflexivity of HP researchers and practitioners

   - Active participants in the social context

   - Power to influence *what* is studied and acted upon, and *how*

   - Need to maintain a self-critical attitude, question taken-for-granted assumptions of our work, its (un)intended effects, and the social distribution of impacts

I assume they will catch me

Polling time!

How could key characteristics of the "collective lifestyles" approach be integrated into your health equity work?

Concluding remarks

Take home messages

- Be explicit about the entry point you choose to focus on, and why, when developing an intervention

- Be aware of its shortcomings and how to overcome or limit them

- Try to anticipate the consequences that focusing on one rather another entry point may have on health inequities

Thank you!

✉ martine.shareck@utoronto.ca

🐦 @martineshareck

🌐 www.martineshareck.weebly.com

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RELATIONSHIPS AS A WAY TO FURTHER A COLLECTIVE LIFESTYLES FRAMEWORK

Amanda Hudson-Frigault, M C. Psych.

Nova Scotia Take Home Naloxone Program Coordinator

Amanda.Hudson@nshealth.ca

HOW HAVE RELATIONSHIPS BEEN IMPORTANT?

- Increase knowledge base
- Increase opportunities for collaboration
- Increase trust
- Decreases focus on individual
- Decrease stakeholder fatigue
- Decrease blaming or aggravating health inequities

HOW IMPORTANT HAS RELATIONSHIP BUILDING PROVEN TO BE TO YOUR WORK IN HEALTH PROMOTION?

❑ Very Important
❑ Somewhat important
❑ Somewhat unimportant
❑ Not important
❑ Not applicable to my work

THE TOTAL IS GREATER THAN THE SUM OF ITS PARTS

- Recognizing and honoring the lived experience of people is critical.

- We must "uncover *HOW* interventions work and through what *Mechanisms*, rather than solely focusing on whether or not interventions have an *effect.*" *(Porter, 1993; Poland et al. 2008; Kontos & Poland, 2009).*

- An individuals Social Circumstances cannot be understood without a relationship being built. Engagement will not emerge.

HOW CAN WE AS HEALTH PROMOTERS ENHANCE LIFE CHANCES?

- Max Weber recognized that "both chances and choices are socially determined, and thus choices cannot simply be individually controlled".

- Recognizing the current social media environment and the tangential nature of relationships nowadays.

IS CHOICE REALLY JUST AN ILLUSION WE HAVE CREATED TO MAKE US FEEL WE HAVE AGENCY?

Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it's the only thing that ever has.

-Margaret Mead

HOW HAS RELATIONSHIP BUILDING CHANGED YOUR APPROACH AS A HEALTH PROMOTER?

My relationships with a community/population;

❑ frequently changes my approach and understanding when working with them.

❑ sometime changes my approach and understanding when working with them, or only as it appears relevant.

❑ rarely changes my approach and understanding, as many approaches are broadly applicable.

RELATIONSHIP BUILDING AS A CORE COMPETENCY

- Relationship building as a measurable skill.

- 5.1. Develop relationships and engage in a dialogue with communities based on trust and mutual respect.
  - Level 2 - Engage in conversations with groups and associations around a complex issue

RELATIONSHIP BUILDING AS A CORE COMPETENCY

- 6.1. Establish and maintain linkages with community leaders and other key health promotion stakeholders (e.g., schools, businesses, local governments, faith groups, non-governmental organizations, etc.)

  - Level 2 - Meet with diverse range of community leaders and stakeholders to develop strategic relationships and understand perspectives on complex issue (e.g., homelessness)

http://www.nshealth.ca/

DISCUSSION

Your feedback is important!

Please complete the
online evaluation survey

EVALUATION – Contrasting
entry points for interventions in
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Upcoming webinars

Promising practices in Indigenous community health promotion (Chapter 10)

July 24, 2018   1:00–2:30 p.m. (ET)

http://nccdh.ca/workshops-events/entry/webinar-promising-practices-in-indigenous-community-health-promotion

Participatory practice and health promotion in Canada (Chapter 21)

September 18, 2018

1:00–2:30 p.m. (ET)

Check our workshops
& events page
http://nccdh.ca/connect
/workshops-events/

Health in all Policies (Chapter 18)

October 23, 2018

1:00–2:30 p.m. (ET)

National Collaborating Centre for Determinants of Health
St. Francis Xavier University
PO Box 5000, Antigonish, NS B2G 2W5
Email: nccdh@stfx.ca and ccnds@stfx.ca
Phone: (902) 867-6133 Fax: (902) 867-6130
www.nccdh.ca and www.ccnds.ca

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