Perceptions of Cardiovascular Health in Underserved Communities: A Foundation for Disease Prevention Interventions

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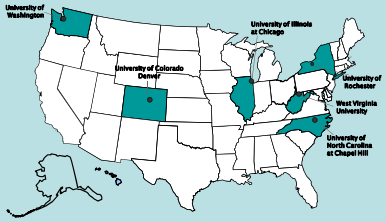
BACKGROUND

Understanding knowledge, attitudes, and practices of people in underserved communities about cardiovascular health/disease can help us develop effective health promotion efforts, through science-based risk reduction strategies that are sensitive to the perceptions, values, and circumstances of the audience. Collaborating with the CDC Heart Disease and Stroke Prevention Division, the Prevention Research Centers Cardiovascular Health Intervention Research and Translation Network (PRC-CHIRTN) is conducting formative research to identify health promotion opportunities.

PRC Cardiovascular Health Intervention Research and Translation Network



The PRC-CHIRTN includes 6 university-community partnerships across the U.S. The geographic, rural-urban, and racial-ethnic diversity of the partner communities provides a laboratory to conduct formative research regarding community-based health promotion efforts.

As part of that research, the PRC-CHIRTN member centers conducted 39 focus groups (CO, IL, NC, WA, WV) and 14 interviews (RO) that yielded audiotaped and transcribed data from 319 adults .

Community-Based Research

- Each member center's Community Team/ Community Advisory Board members contributed to this research
- Contributions varied by site but included
  - Reviewing discussion questions and research procedures
  - Establishing the sampling frame and recruiting participants
  - Co-facilitating groups
  - Coding and analyzing local data

STUDY QUESTIONS

The PRC-CHIRTN CVH Perceptions Group members collaboratively assembled a common set of discussion questions concerning:

- Knowledge and perceptions of heart disease and stroke (signs and symptoms, risk factors)
- Knowledge and perceptions of prevention
- Perceptions of barriers and facilitators to putting knowledge into actual practice
- Sources and usefulness of health information
- Preferred dissemination methods and strategies

■CO = Colorado ■ IL = Illinois ■ NC = North Carolina ■RO = Rochester ■ WA = Washington ■ WV = West Virginia

Barriers to Healthy Behavior

Multiple Role Demands

Sad. I'm so motivated for everything else but not for something that would benefit me . . . I think I tend to take care of other people, get the chores done, and make sure the food is pleasing, and you know that everyone else is taken care of before I think about what I need right now. (CO)

We make sure kids get their care but for whatever reason mom just won't take the time out [for herself]. (NC)

Limited Economic Resources

Sometimes I don't have enough money to buy healthier food and I have to eat whatever I have. (IL)

I've been self-employed and really haven't been able to afford health insurance, so we are definitely lacking going to the doctor…and not going to a doctor unless something happens. (RO)

Social, Cultural, and Environmental Issues

I become so lazy now since living here. It is because the car takes you everywhere, you don't have to walk. (WA)

That's all we have. That's the choices that are given to us. So our population is fast food. We've been raised on that mentality. That's what we're supposed to do. You're supposed to take your kids to McDonalds. (WV)

Health Care Issues

Lack of medical professionals who speak Spanish. (IL)

Or maybe what I feel like when I go to the doctors is that they don't have enough time to sit and talk with you. (CO)

Knowledge of Disease, Risk Factors, Prevention

Newly immigrant populations (IL, WA), compared to more established communities, had only rudimentary understanding of disease, risk factors, and prevention.

All participants, regardless of site, had less knowledge of stroke and its prevention than of heart disease. Stroke also generated much greater levels of fear, primarily related to loss of independence and burden on others.

Facilitators of Healthy Behavior

Social Support

If my family wants me to work on these things, I'll do it but I need a lot of reinforcement. (WV)

It would be nice to have a support group that you go and say how we've done…we're like little kids, we need to be rewarded to stay on track. (CO)

Social Environment

[In reference to a workplace program] I think we started eating a little bit more healthy, we're slowly putting some healthy choices in there. (RO)

Sometimes it's not that easy with strong personal will. So it's important to get lectures and instructions from some kind of programs and meetings. (WA)

I think we need to look at our communities too. (CO)

Motivation

You have to change your buying habits…When you're shopping, you know the things that you really like to eat, you can't go down [that] aisle…If they're not there, I won't worry about it. (NC)

A huge clue is you have to be motivated to do it. (CO)

Dissemination

Preferred Strategies

Language that real people use: "Just being able to present things in a way that people can understand and give them ideas – don't just say "here, eat healthy" (RO)

Tailoring to cultural values and community priorities

Interactive, hands-on activities, personal contact, family-friendly groups: "A little workshop or a little women's retreat or something…I would be more likely to incorporate them in my life." (CO)

Preferred Sources of Information

Family and friends, speaking of their own experiences
Trusted groups (e.g., AARP)
Health care providers, sometimes:
"I wouldn't really listen to a doctor. I would listen to a friend who has been through it." (NC)

SAMPLE AND METHODS

Methods

- Approved by each site's Institutional Review Board
- Common discussion guide
- Investigators at each site coded that site's data (with reliability checks)
- Investigators from all sites met in person and by conference call to complete the grounded theory-type cross-site analysis

Characteristics of the Sample

- Successfully reached desired sample of underserved, understudied adults
- 88.7% Hispanic ethnicity or non-white race; 39.3% African American (especially NC), 24.8% Hispanic (especially IL, CO), 24.2% Asian American (especially WA)
- 84.6% female (some sites by design sampled only women)
- 27.1% with less than a high school education; at 2 sites (CO, IL) , 42.6% had no insurance (almost twice the national average of 23.4%)
- 32.7% rural residents (nearly all CO and WV, 51.3% NC)
- At sites that collected the information, 48.3% self-reported a family history of heart disease (CO, IL, NC), 27.8% a diagnosis of diabetes (CO, NC)
- 21.7% were under age 45 years, 32.4% were between 45 and 64 years, and 28.9% were aged 65 years or older

CONCLUSIONS AND IMPLICATIONS

Many members of underserved populations (but not new immigrants) have adequate knowledge of cardiovascular disease, risk factors, and benefits of healthy behaviors.

It is challenging to put that knowledge into practice, especially for those, primarily women, who care for others.

Participants offered valuable suggestions for culturally appropriate, community-specific intervention approaches that span the social-ecological levels of individual, interpersonal support, community, environment, and policy.

Effective cardiovascular health promotion needs to move beyond (but not abandon) individual knowledge-based interventions to new approaches that involve social marketing, environmental change, and strategies tailored to context.

Potential next steps include the development of culturally and linguistically appropriate materials for new immigrant communities and explicit training in problem-solving skills to improve the capacity of family members with multiple role demands to manage the complexity of their situations.

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