Community Outreach for Stroke Education

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See related article, pages 2331–2335.

Educating the public on the warning signs of stroke is considered a critical part of the chain of survival and of better stroke care.1 Repeated studies have demonstrated that high-risk groups, such as the elderly, minority groups, or those of low socioeconomic status, often have the poorest knowledge of stroke warning signs.2–4 Although mass media can be a powerful tool in stroke public education,5 it is not without its limitations. To be effective, mass media needs adequate reach and frequency to break through the advertising “clutter”—which requires significant and sustained funding. Moreover, the ability of mass media to target specific high-risk subgroups, whether ethnic, socioeconomic, or linguistic, is unclear.

In this issue of Stroke, Kleindorfer et al6 describe a community-based project in which beauticians were used to deliver stroke education to black women, a group at increased risk of stroke. Community settings, such as churches, barber shops, and beauty salons, have been used to deliver a variety of health promotion programs in the United States, particularly among black and Latino populations.7–11 Thus, although the Beauty Shop Stroke Education Project (BSSEP) may be unique to the field of stroke prevention, it is rooted in a growing discipline of community-based, participatory health promotion and research.

Like many community-based projects, the BSSEP is rooted in the Health Belief Model (HBM), one of the most widely used conceptual frameworks in health promotion and health behavior research. The HBM focuses in large part on people’s perceptions, such as their perceived susceptibility to diseases, the seriousness of the target condition and its sequelae, and the barriers to, and benefits of, taking action.12 Because these are perceptions and thus inherently subjective, they require an understanding of how individuals acquire and use beliefs about health and the dynamics of human behavior, approaches characteristic of medical anthropology.13

Community-based health promotion requires flexibility and a willingness to listen on the part of investigators; an “ivory tower” approach does not work. For instance, Kleindorfer et al describe how investigators had to recode data when discussions with the beauty shop operators helped them to understand that a response of “sugar” was actually a reference to diabetes. Researchers and those delivering programs must spend time in the target setting, learning about the physical and social environments.14 And, perhaps most importantly, collaboration is needed to ensure that researchers and participants share a similar vision of the program goals and priorities, particularly in light of other pressing community concerns and challenges.15

The anthropological or ethnographic nature of community-based, participatory research can pose a challenge to publication in mainstream clinical journals. Those trained in, or used to, the methodological rigor of clinical trials can view the convenience samples and self-selecting nature of community-based projects as weak or even flawed. Mechanisms such as strict randomization, control groups and blinding can be difficult, if not impossible, to implement. Furthermore, as noted by Kleindorfer et al, privacy regulations have in some respects added to the challenges of collecting and analyzing data in community settings.

Despite the challenges, it is important that projects such as the BSSEP be implemented, evaluated, and communicated among people working in the area of stroke public education. Although the BSSEP is labor-intensive, it does not require the funding commitment of large-scale mass media campaigns (which can run in the millions of dollars). As such, it may offer a viable alternative for local-level programming, one that not only educates members of high-risk groups but actively engages them in the health promotion process.

In planning such programs, health promoters and investigators must not only adapt a participatory mentality but think carefully about what messages are most appropriate. For example, Kleindorfer et al report that even though their program significantly increased knowledge of the warning signs of stroke (particularly for the mnemonic FAST) it had no effect on knowledge of stroke risk factors, suggesting that this approach may be more effective for some types of messages than for others. In short, community-based, participatory health promotion may not constitute a “silver bullet” for all types of stroke messaging. However, it is encouraging to have yet another option within our arsenal of stroke education programs.

Disclosures

None.

References


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