MULTIPLE RISK FACTOR PROGRAMMES AIMED AT REDUCING CARDIOVASCULAR DISEASE

Review 4:

Barriers to, and facilitators for, the effectiveness of multiple risk factor programmes aimed at reducing cardiovascular disease within a given population: a systematic review of qualitative research

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About the Peninsula Technology Assessment Group (PenTAG)

The Peninsula Technology Assessment Group is part of the Institute of Health Service Research at the Peninsula Medical School. PenTAG was established in 2000 and carries out independent Health Technology Assessments for the UK HTA Programme, systematic reviews and economic analyses for the NICE (Technology Appraisal and Centre for Public Health Excellence) and systematic reviews as part of the Cochrane Collaboration Heart Group, as well as for other local and national decision-makers. The group is multi-disciplinary and draws on individuals' backgrounds in public health, health services research, computing and decision analysis, systematic reviewing, statistics and health economics. The Peninsula Medical School is a school within the Universities of Plymouth and Exeter. The Institute of Health Research is made up of discrete but methodologically related research groups, among which Health Technology Assessment is a strong and recurring theme. Projects to date include:

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- Screening For Hepatitis C Among Injecting Drug Users And In Genitourinary Medicine (GUM) Clinics - Systematic Reviews Of Effectiveness, Modelling Study And National Survey Of Current Practice (2002)
- Systematic Review Of Endoscopic Sinus Surgery For Nasal Polyps (2003)
- The Effectiveness And Cost-Effectiveness Of Imatinib For First Line Treatment Of Chronic Myeloid Leukaemia In Chronic Phase (2003)
- The Effectiveness And Cost-Effectiveness Of Microwave And Thermal Balloon Endometrial Ablation For Heavy Menstrual Bleeding - A Systematic Review And Economic Modelling (2004)
- Do The Findings Of Case Series Studies Vary Significantly According To Methodological Characteristics?(2005)
- The Effectiveness And Cost-Effectiveness Of Pimecrolimus And Tacrolimus For Atopic Eczema - A Systematic Review And Economic Modelling (2005)
- The Effectiveness And Cost-effectiveness Of Dual Chamber Pacemakers Compared To Single Chamber Pacemakers For Bradycardia Due To Atrioventricular Block Or Sick Sinus Syndrome - Systematic Review And Economic Evaluation (2005)
- The Effectiveness And Cost-Effectiveness Of Surveillance Of Barrett's Oesophagus: Exploring The Uncertainty (2005)
- The Cost-Effectiveness of testing for hepatitis C (HCV) in former injecting drug users. Systematic Review And Economic Evaluation. (2006)
- The Effectiveness And Cost-Effectiveness Of Cinacalcet for Secondary Hyperparathyroidism in end stage renal disease patients on dialysis. Systematic Review And Economic Evaluation (2007)
- The effectiveness and cost-effectiveness of Carmustine Implants and Temozolomide for the treatment of newly-diagnosed High Grade Glioma**.** Systematic Review And Economic Evaluation (2007)

- The Effectiveness And Cost-Effectiveness of Cardiac Resynchronisation Therapy for Heart Failure. Systematic Review And Economic Evaluation (2007)
- Inhaled Corticosteroids and Long-Acting Beta2-Agonists for The Treatment of Chronic Asthma in Adults and Children Aged 12 Years and Over: a Systematic Review and Economic Analysis (2007)
- Inhaled Corticosteroids and Long-Acting Beta2-Agonists for The Treatment of Chronic Asthma an Children Under the Age of 12 Years: a Systematic Review and Economic Analysis (2007)
- The Effectiveness and Cost-Effectiveness of Cochlear Implants for Severe to Profound Deafness in Children and Adults: A Systematic Review and Economic Model (2008)
- The Effectiveness and Cost-Effectiveness of Methods of Storing Donated Kidneys from deceased donors: A Systematic Review and Economic Model (2008)
- Bevacizumab, sorafenib tosylate, sunitinib and temsirolimus for renal cell carcinoma: A systematic review and economic model

Collaborations

Work for the NICE Centre for Public Heath Excellence is carried out in close collaboration with the West Midlands Health Technology Assessment Centre (WMHTAC) at the University of Birmingham. They were not, however, directly involved in producing this report.

Acknowledgements

With many thanks to Jenny Lowe, Jo Perry, Lianne Perry and Sue Whiffin for administrative project support.

Source of funding

NICE Centre for Public Health Excellence

Declaration of authors' competing interests

No authors have competing interests.

List of abbreviations

Abbreviation	Meaning
CT	Can't tell
CDC	Centre for Disease Control
CVD	Cardiovascular disease
FGD	Focus group discussions
GP	General Practitioner
GT	Grounded Theory
LHA	Lay Health Advisors
NR	Not reported
PenTAG	Peninsula Technology Assessment Group
REACH	Racial and Ethnic Approaches to Community Health
RE-AIM	Reach-Effectiveness-Adoption–Implementation–Maintenance (A framework to evaluate health behaviour interventions)
SALAD	Schools in Leicester Against Diabetes and Heart Disease
UK	United Kingdom
USA	United States of American
WMHTAC	West Midlands Health Technology Assessment Centre

Glossary

Term	Definition
First order concepts	The direct expressions of research participants showing how they interpret their experiences.
Macro-level	Large scale factors, relating to society as a whole, such as legislation.
Meso-level	Medium or intermediate level factors, relating to the immediate community, such as local availability of amenities.
Micro-level	Small scale factors, relating to individuals, such as understanding of risk.
Reciprocal translation	In meta-ethnography, identification of the similarities of study authors' interpretations of research findings across different studies. A method of synthesising findings.
Refutational translation	In meta-ethnography, identification of the differences of study authors' interpretations of research findings across different studies. A method of synthesising findings.
Second order concepts	The interpretations or explanations of research findings made by researcher(s).

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1. Summary

1.1. Introduction

This report presents the findings of a systematic review of qualitative research about the barriers to and facilitators of successful CVD prevention programmes addressing multiple risk factors which are delivered at the population level. It is the fourth of a series of six reports produced for the NICE Centre for Public Health Excellence that examine the prevention of CVD through such programmes. Reviews one to three, on the effectiveness of such programmes, have already been presented by our co-collaborators at WMHTAC, who will also be producing a cost-effectiveness report.

1.2. Aim

The aim of this review is to gain a better understanding of how and why population programmes and interventions to prevent CVD are successfully (or unsuccessfully) implemented, and achieve (or fail to achieve) their intended outcomes, with a particular focus on identifying the factors which militate against or enhance effectiveness ("barriers" and "facilitators").

The review questions were as follows:

- What are the important factors associated with the successful (or unsuccessful) implementation of population programmes and interventions for the primary prevention of cardiovascular disease (CVD) within a given population?
- What are the important factors influencing health or other intended outcomes associated with the primary prevention of CVD?
- How do these factors interact, both with each other, or with other aspects of programme design, implementation processes or context to influence increased or reduced programme and intervention effectiveness?

1.3. Methods

The review used evidence that was identified using three methods: a search of electronic databases using subject terms and qualitative research filters; targeted

searches, using programme and author names, for qualitative research associated with programmes identified in WMHTAC effectiveness reviews; and contact with experts in the field.

Study reports were included if they reported in English on qualitative research that focused on processes associated with population level, multi-risk factor CVD prevention programme design, implementation and evaluation and were from developed countries. Each included study was quality appraised and findings, in the form of key themes, concepts and quotes, were extracted.

Evidence tables were read and re-read by two reviewers who collaborated in the development of a coding scheme that was framed by an understanding of potential macro, meso and micro level influences upon programme barriers and facilitators in order to produce a thematic analysis and synthesis of the findings.

1.4. Findings

Thirty study reports relating to 20 CVD programmes in the USA, Canada, the UK and other European countries, were included in the review. Only six related to programmes which were included in the effectiveness reviews. The quality of the study reports was generally poor.

Summary evidence statement: Macro-level findings
A total of twelve study reports describe findings that relate to barriers and facilitators at the macro level - politics, prices, and the socio-economic context. The broader political context can affect diverse organisational elements of programme development and implementation such as the availability of project funding, the development of partnerships between organisations and a sense of shared purpose at different administrative levels. Individual responses may also be affected through legislation incentives to healthier behaviours. High pricing can impact on people's ability and willingness to adopt healthy eating behaviours and to participate in organised physical activity. Also, because CVD may be most prevalent among communities facing multiple deprivation, heart health may compete with more immediately pressing socio-economic concerns.

Summary evidence statement: Meso-level findings

Project Implementation

Twenty-three of the study reports describe findings that identify barriers and facilitators to successful project implementation at the meso-level – such as community and familial norms, community engagement, local access, organisational and strategic issues, organisational culture and partnerships, staffing and evaluation.

Community and familial norms can affect attitudes to food, exercise and health in ways that are not helpful to CVD prevention, although there is evidence that suggests these can be addressed through enhanced "social health" and community engagement.

To be successful, community engagement needs to be sensitive to the local cultural pattern, and may require multiple approaches across a number of levels. Challenges to success may include competing involvement at strategic levels, breaking into existing networks, competing activities, reaching specific groups such as young people, and lack of interest in the community – perhaps because of previous negative experiences.

The local physical environment may limit access to healthy food, informal physical exercise (such as walking) and formal exercise (such as gyms).

Project Management

Organisational and strategic issues within the programme, such as time limited projects and lack of leadership, can negatively effect success.

Partnerships between involved organisations are enhanced where they share values, priorities and goals, and may enhance learning and the profile of smaller organisations. Differences in culture and expectations between organisations can cause friction and may negatively affect programme delivery.

Staff recruitment and retention are key issues, with the right mix of skills and personal characteristics enhancing programmes. Good communication between members of staff prevented duplication of activities and flexibility allowed them to tailor their role to participant needs. Sufficient resources are required to either free up staff with other existing roles or to provide dedicated staff to focus on heart health. Volunteers can be crucial, but need adequate resourcing and leadership. Skills training can be helpful, but

staff also learn through sharing and implementation and may prefer these informal mechanisms.

While evaluation can raise awareness among staff and promote programme improvement, time limited projects may struggle to provide timely feedback. Conversely, data management is a challenge for long term projects and those with multiple strands across multiple sites.

Summary evidence statement: Micro-level findings

Micro level findings, relating to the individual, were also reported by 16 study reports, and relate to understandings of CVD risk, motivation and resistance and programme perceptions. Understandings of CVD risk vary, and may not translate into healthy behaviours.

One study suggests that people may set greater store by experiences than theoretical knowledge of risk. Experiences which affect self image, and changes in social networks may be the greatest impetus to change (Meillier et al, 1998)

One study developed a typology of six "ideal types" of functional and dysfunctional attitude among programme participants who see it as a blessing, an opportunity, a confirmation, a "watchman", a disappointment or an insult. The latter two are negative or "dysfunctional" in terms of positive health choices and more men have these attitudes (Emmelin et al, 2007).

Being ill or receiving physiological test results could be motivate CVD risk reduction. Families may be targeted as a unit but it may be difficult to initiate and maintain changes when other aspects of family life may compete. Resistance from family members is a barrier to adopting heart health behaviours.

Participant perceptions of programmes benefits included weight loss, increased exercise, increased awareness and use of services and programme activities and the creation of networks providing community support. Participants may doubt the credibility of health messages, due to the volume of, sometimes contradictory, information available. Matching the characteristics of the community may be important.

2. Introduction

2.1. NICE programme about population levels programmes to reduce multiple risk factors for CVD

The National Institute for Health and Clinical Excellence (NICE) has been asked by the Department of Health (DH) to develop guidance on a public health programme aimed at preventing cardiovascular disease (CVD) in different populations.

This report is the fourth of six to be delivered to the Programme Development Group (PDG). This review addresses Question Two of the final scope:

- What barriers and facilitators influence the effectiveness of multiple risk-factor programmes aimed at reducing CVD (or the risk factors associated with CVD) among a given population (including sub-groups experiencing health inequalities where the data allows)?

The PDG has already received three reviews of clinical effectiveness from WMHTAC, from whom they will also receive a report of economic modelling. These address the first question in the final scope:

Which multiple risk-factor interventions are effective and cost effective in the primary prevention of CVD within a given population? Where the data allows, how does the effectiveness and cost effectiveness of interventions vary between different population groups?

3. Aims

3.1. Objectives and Rationale

The main objective was to conduct a systematic review of qualitative research into the processes of planning, implementation and evaluation of population level programmes and interventions (or key components of them), for the primary prevention of cardiovascular disease (CVD), as these aspects relate to their success or failure. The research question focuses on CVD programmes and interventions. For the remainder of this report, we will only use the term "programmes" for conciseness and clarity, but we use this term to include both programmes and interventions aimed at reducing CVD so long as, in line with the protocol (see 0), they are population or community-focused and target multiple risk factors.

The purpose of this review is to gain a better understanding of how and why population programmes and interventions to prevent CVD are successfully (or unsuccessfully) implemented, and achieve (or fail to achieve) their intended outcomes, with a particular focus on identifying the factors which militate against or enhance effectiveness ("barriers" and "facilitators").

This review of qualitative research aims to complement the systematic reviews of quantitative studies carried out by WMHTAC, which look at the effectiveness of CVD prevention programmes, by enabling us to better explain the findings of these reviews. While these mainly address the question of "what works?" our aim with this review is to generate firmer insights about why and how such programmes work or fail, for whom and in what circumstances.

3.2. Review Questions

- What are the important factors associated with the successful (or unsuccessful) implementation of population programmes and interventions for the primary prevention of cardiovascular disease (CVD) within a given population?
- What are the important factors influencing health or other intended outcomes associated with the primary prevention of CVD?

- How do these factors interact, both with each other, or with other aspects of programme design, implementation processes or context to influence increased or reduced programme and intervention effectiveness?

4. Methods

4.1. Identification of evidence

Relevant CVD Programmes

In terms of the types of programmes included, our review has the same definitions as the reviews of effectiveness prepared by WMHTAC. Qualitative research included in this review therefore relates to population level programmes that cover a region or county, or which are aimed at a group sharing a specific characteristic within a defined geographical area, and which aim to reduce multiple risk factors (two or more) for the primary prevention of CVD.

Relevant research

We included qualitative research that contained findings related to factors that facilitate, or militate against, successful CVD programmes that are aimed at general population(s).

4.1.1. Search strategy

Database searches

A search of electronic bibliographic databases was undertaken to identify qualitative research related to reducing cardiovascular risk at a population level. This used the same search terms as the effectiveness reviews in terms of populations, programmes and comparators, but applied qualitative research filters (see Appendix 2).

The following databases were searched:

- MEDLINE
- MEDLINE In Process
- EMBASE
- CINAHL
- PsycINFO
- DH DATA and King's Fund
- ASSIA

- http://www.theses.com/: "Index to Thesis" was also searched for theses submitted in GB.

Targeted searches

We particularly wanted to identify all relevant qualitative research conducted alongside programmes that are included in the systematic reviews of effectiveness conducted by WMHTAC. To ensure that nothing was missed, we therefore undertook targeted searches related to the named programmes, using the databases listed above, and also contacted lead authors of effectiveness evaluations by email.

For the targeted searches, we used the list of programmes aimed at reducing CVD that were identified in the three WMHTAC effectiveness reviews, and searched for associated qualitative research through electronic databases and websites. Due to the timing of the reviews, we were unable to undertake targeted searches of programmes included in effectiveness review three. Details of the search strategy were developed in response to the results from the strategies used for reviews one and two, however we used the following main elements to identify relevant study reports:

- Programme name
- Author names

We also looked for qualitative research in the references of papers used in the effectiveness reviews and undertook citation searches of these.

Finally, we contacted by email experts in the field and personnel associated with programmes included in the effectiveness reviews to ask them whether qualitative research had been undertaken as part of the programme evaluation. Where it had been, we asked for references, or a copy of the research to be provided.

We also checked reference lists and undertook citation searches on the qualitative research reports identified for this review.

Finally, WMHTAC provided details of any references identified through their searches that had been tagged as potentially containing qualitative research.

4.1.2. Inclusion of relevant evidence

4.1.2.1. Inclusion criteria

Study design

Study reports are included if they report on qualitative research which uses recognised methods of data collection and analysis (including, but not limited to, observational methods, interviews and focus groups for the former and grounded theory, thematic analysis, hermeneutic phenomenological analysis, discourse analysis etc. for the latter). Studies using solely qualitative research or mixed methods designs were included.

Programme design

Included studies related to CVD prevention programmes aimed at the population level and at reducing multiple risk factors for CVD.

Study focus

Study reports were included if they focused on *processes* associated with programme design, implementation and evaluation, and particularly, possible barriers to and facilitators of successful CVD programmes.

Language

Written in English.

4.1.3. Exclusion criteria

Availability

Study reports not received by the end of October 2008 were excluded as there was not time to extract and synthesise their findings.

Study focus

Studies which explored people's understandings of CVD risk, or their attitudes towards healthier lifestyles in general, which were not related to the development or evaluation of particular CVD programme were excluded.

Programme design

Studies related to CVD prevention programmes aimed at workplaces or schools rather than the population level, where the participants neither shared a common characteristic nor lived within a designated geographical area, were excluded.

4.1.4. Study selection

Research reports identified using the search strategies were loaded into RefMan. Titles and abstracts (where available) were scanned by one of three researchers (KA, MP, RG) to see if they met the inclusion criteria and, where they did, full text reports obtained. Where it was unclear whether the study reports contained qualitative research, the full text was obtained. A sample of 10% of the titles and abstracts was double checked by a second reviewer. Full text reports were then examined by two reviewers (MP and RG) to see whether they reported on qualitative research and if findings related to barriers and facilitators.

4.1.5. Methods of analysis and synthesis

4.1.5.1. Data extraction

Each included study report was read by one of two researchers (MP, RG) and information was extracted about the population included, the relevant CVD programme to which it was related, the research methods and findings. For each study report, this information is presented in an evidence table (see Appendix 3).

Findings for qualitative research are presented as key themes, concepts and quotes. These were extracted from the included studies by one reviewer.

4.1.5.2. Methods of quality appraisal

The quality of individual studies was informed by checklist methods shown in 0. The checklist was supplemented by critical reading of each study, and limitations recorded in the evidence table produced for each included study report.

4.1.5.3. Analysing and synthesising the findings

Once the key findings from each included study had been extracted, they were read and re-read by two reviewers (RG, MP). A coding scheme was developed which was framed by understandings of potential macro, meso and micro level influences (as outlined in supplement 1 of the original protocol; see 0). These were supplemented and expanded by themes emerging from the data. Codes and their allocation were developed through discussion and further refined during the write-up of the synthesis.

Our original plan had been to undertake a synthesis based on meta-ethnography, however this relies on drawing similarities ("reciprocal translation") and differences ("refutational translation"), or creating a line of argument, using second order concepts from the included study reports (Noblit & Hare 1988). Second order concepts are the interpretations or explanations of the findings made by the researcher(s). First order concepts are the direct expressions of the participants, which show how they interpret their experiences. Most of the study reports included were largely descriptive, with few showing second order conceptualisation. In some cases, where there were no or few quotations provided and no other indication of where first order concepts ended and second order began. This rendered it impossible to determine whether the findings were reported directly from the participants, or represented researchers' interpretations of the data. In addition, headers in the study reports, which sometimes represent key thematic areas, were also usually descriptive, rather than explanatory or conceptual - for example "barriers", "facilitators", "heart disease", "the walking challenge" – and so were not useful as organising principles in the analysis.

We have therefore been restricted to providing a thematic analysis and have reported where studies report similar themes, or have contradictory information. We have also, where possible, used findings from several studies to build a picture of a thematic area where combining information in a kind of "line of argument" seemed appropriate.

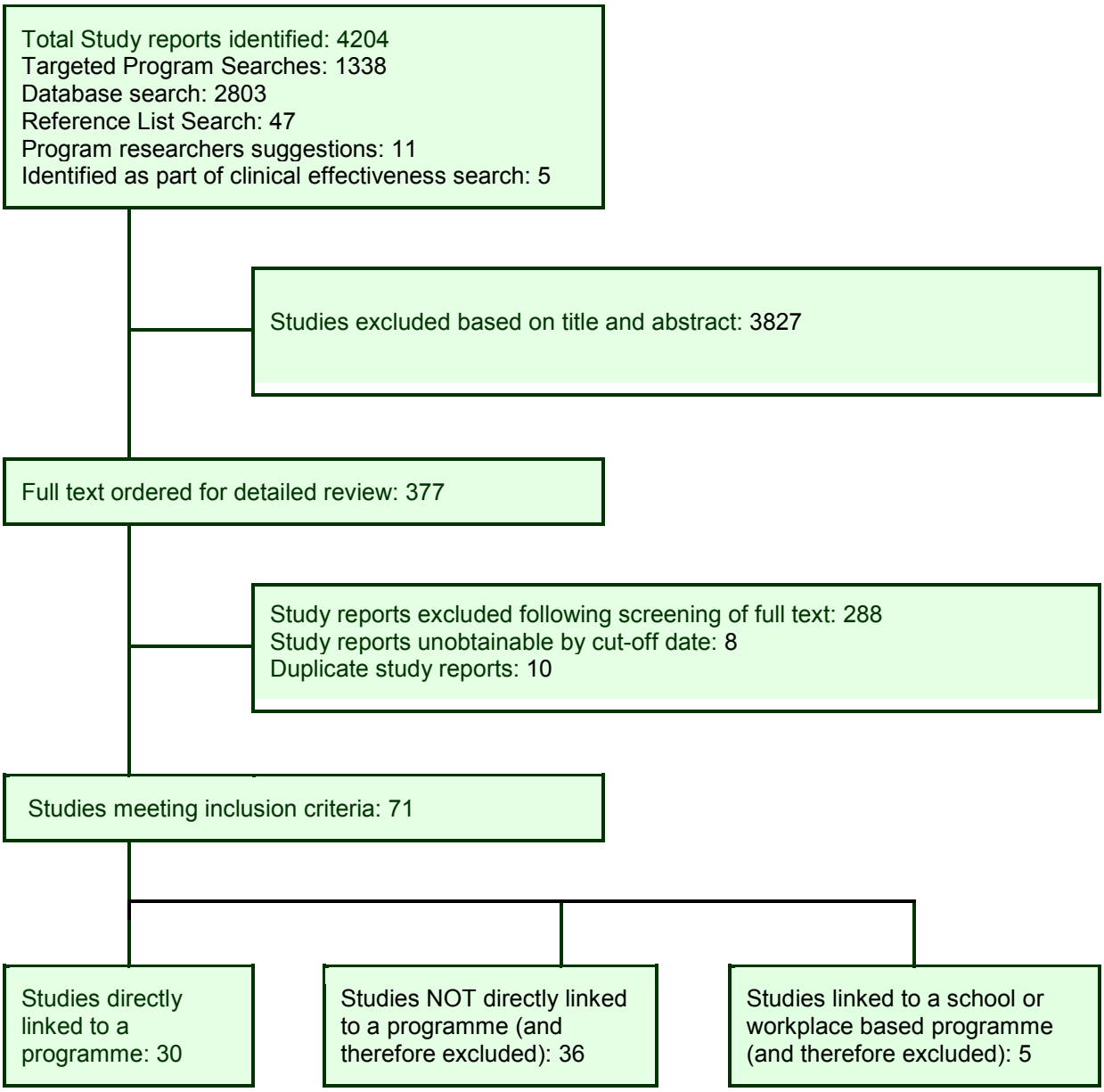
We would caution against assuming that a theme has more weight simply because more study reports note it, or dismissing findings that are only recorded in a single report. The validity of any synthesised finding may relate more to its explanatory power, insightfulness or applicability, than its quantity in the available literature.

5. Findings

5.1. Study reports identified

Figure 1 shows the number of study reports identified by the search strategies and how the included studies were identified.

Figure 1: Flow chart illustrating included and excluded studies



5.2. Included studies

We included 30 research reports related to 20 CVD programmes in the review. In the event, just six of the programmes for which we identified qualitative research also had quantitative data that qualified them for inclusion in the effectiveness reviews. This was either because there was effectiveness data, but not on the outcomes of interest, or because there was no published effectiveness data – in some cases because the programme or its evaluation had not completed. The majority of study reports related to projects based in the USA (17 study reports based on 11 CVD programmes), four study reports related to four UK based projects, four reports related to three programmes based in Scandinavian countries and five study reports about two programmes were from Canada. The names of the programmes are listed in Table 1 which also shows for which programmes there is effectiveness data presented in the WMHTAC reviews.

There were some study reports that drew upon the same substantive piece of research, but were published in separate journal articles. This was the case for two programmes: WISEWOMAN, where much greater detail was provided regarding research methods in a separate paper (Besculides et al. 2006b) from that which reported findings (Besculides et al. 2008b); and Heart Health Nova Scotia, where a core paper (Maclean et al. 2003c) is supplemented by evidence from additional reports that were written-up for different journal audiences (Joffres et al. 2004b) (Joffres et al. 2004d). Reasons for excluding studies from the review are listed in Appendix 4 (p.192). Although the study by Khunti et al (2008b) was about a school based project, we included it because of its direct applicability to the UK situation - it is a recent UK based study and also provides information about British Asian populations. This was felt to be important to help address the research question about subgroups.

We now consider the detail of the programmes to which the study reports related, then the methods of the studies that were undertaken about them. Finally, this chapter describes the synthesised findings of the included studies.

Table 1: CVD programmes for which qualitative research reports were found

Programme name and location	Included in WMHTAC Reviews?
USA	
Bootheel Heart Health Project	Yes (Review 1)
Charlotte REACH 2010 (2 study reports)	No
Chicago REACH 2010	No
Heart to Heart	Yes (Review 1)
Salud para su Corazón	No
Sisters Together (2 study reports)	No
Un Corazón Saludable	No
Unnamed First Nations programme	No
Un-named programme using lay health advisors	No
Various multi-risk factor programmes in Michigan	No
WISEWOMAN (5 study reports)	No
UK	
Family Fit	No
Have a Heart Paisley	Yes (Review 3)
Khush Dil	No
SALAD	No
Scandinavia	
Norsjo intervention programme (Sweden) (2 study reports)	Yes (Review 1)
North Karelia project (Finland)	Yes (Review 1)
Vejle project (Denmark)	No[1]
Canada	
Alberta heart health (2 study reports)	No
Heart Health Nova Scotia (3 study reports)	No

[1] Effectiveness data exists for a related project, but different geographical area

5.2.1. Population characteristics of targeted communities

The range of communities at which CVD programmes were targeted is shown in Table 2. The majority of study reports related to programmes that had been delivered in urban areas, with the exception of Mayer et al (1998) (Bootheel Heart Health Project), Puska et al (1986) (North Karelia Project) and Brännström et al (1994) (Norsjö Intervention Project).

The predominance of included studies that were conducted in the USA is reflected in the emphasis on particular minority ethnic communities (African American, Latino, and First Nation). Four studies specifically focused on disadvantaged mid-life women, although all were linked to a single programme design, delivered at a number of locations in the USA (WISEWOMAN). Nine studies related to programmes with a more generic 'community-level' approach that did not explicitly focus on any particular population sub-group(s) and which were conducted at locations in both North America and Western Europe.

Included studies related to programmes conducted in the UK covered a range of programme approaches, from community-wide (Blamey et al, 2004) to specific focus on South Asian communities (Khunti et al. 2008; Netto et al. 2007) and families where a family member had been identified as at high-risk of CVD Peerbhoy et al. 2008).

Table 2 Target communities of included programmes

Target community	No. studies	Programme names	Citation
South Asian communities (UK)	2	Khush Dil	Netto et al (2007)
		SALAD	Khunti et al (2008a)
Families with a member at high-risk of CVD (UK)	1	Family Fit	Peerbhoy et al (2008)
African American (low socio-economic status) (USA)	7	Bootheel Heart Health	Mayer et al (1998)
		REACH (Charlotte)	DeBate & Plescia (2004)
			DeBate et al (2004)
		REACH (Chicago)	Levy et al (2004a)
		Sisters Together	Goldberg et al (1999)
			Pratt et al (1999)
			Dietz (2001)
Latino (USA)	3	Salud para su Corazon	Moreno et al (1997)
		Un Carazon Saludable	Harralson et al (2007)
		Unnamed programme using Lay Health Advisors	Kim et al (2004)
First Nation (USA)	1	Unnamed programme with school- and store-based components	Rosecrans et al (2008)
Disadvantaged mid-life women (USA)	5	WISEWOMAN	Besculides et al (2008a)
			Besculides et al (2006a)
			Jilcott et al (2007)
			Viadro et al (2004)
			Mays et al (2004)
Generic 'community-level' (UK)	1	Have a Heart Paisley	Blamey et al (2004)
(USA)	1	Heart to Heart	Goodman et al (1995)
(Canada)	5	Alberta Heart Health Project	Alberta Health (1998)
			Dressendorfer et al (2005)
		Heart Health Nova Scotia	MacLean et al (2003b)
			Joffres et al (2004c;2004a)
(Sweden)	2	Norsjö Intervention Programme	Brännström et al (1994)
			Emmelin et al (2007)
Mid-life men (Finland)	1	North Karelia Project	Puska et al (1986)
Men in male-dominated workplaces (Denmark)	1	Vejle project	Meillier et al (1998)

5.2.2. CVD Programme components

Included studies covered programmes that used a broad range of approaches to the delivery of community CVD prevention programmes. Table 3 categorises programmes according to the primary means by which they were delivered:

1) Education and community events and/or classes – programmes in this category endeavoured to address CVD risk factors through a combination of educational and social events in the community. Key areas addressed through education were typically smoking, physical activity and diet, with the delivery of community events (such as health fairs, walking clubs, exercise classes, and cooking demonstrations) used as means of supporting these educational interventions.

2) Environment (also including substantive education and community elements) - programmes in this category were designed not only to influence behaviour change related to CVD risk factors at the level of the individual, but also endeavoured to change the environment so as to facilitate this healthier behaviour. Programme components at this level included raising awareness in communities about the effects of the environment on CVD risk factors (through, for example, public theatre) and working with communities in order to foster the skills that would help them to engage with and influence public policy at a local and national level.

3) Screening and education (including counselling) of individuals or families - programmes in this category involved the assessment of individuals for CVD risk factors by a health professional (usually a nurse or dietician) and the delivery of tailored education or counselling according to the results of the assessment. The screening and education in these programmes was not part of a wider community-based strategy.

4) Provision of information - programmes in this category provided health information about CVD risk factors to communities through health education classes or local 'communication campaigns'.[2] The provision of information in these programmes was not part of a wider community-based strategy.

5) Unclear – insufficient details to allow programmes in this category to be assigned to a category were provided.

[2] Details of the media used for these campaigns were not provided.

In addition, those programmes that explicitly reported a process of community consultation, or which utilised Lay Health Advisors, are identified in Table 3.

Categorisations in Table 3 should not be viewed as definitive. Restrictions imposed by journal word limits means that there are limitations on reporting by authors of the extent of programmes. The purpose of detailing programmes' focus here is to provide a descriptive overview of the nature of programmes rather than a categorical definition.

Table 3 The focus of programmes in the included studies

Programme focus	No. studies	Programme name	Citation	Community consultation	Lay Health Advisors
Educational and community events and/or classes	13	Alberta Heart Health	Alberta Health (1998)	Yes	
			Dressendorfer et al (2005)		
		Bootheel Heart Health	Mayer et al (1998)	Yes	
		Have a Heart Paisley	Blamey et al (2005)		
		Heart to Heart	Goodman et al (1995)		
		North Karelia Project	Puska et al (1986)		
		Un Carazon Saludable	Harralson et al (2007)		
		Unnamed First Nations programme	Rosecrans et al (2008)	Yes	
		WISEWOMAN	Besculides et al (2008)		
			Besculides et al (2006)		
			Jilcott et al (2007)		
			Viadro et al (2004)		
			Mays et al (2004)		
Environment (also including substantive educational and community elements)	5	REACH (Charlotte)	Debate & Plescia (2004)	Yes	Yes
			Debate et al (2004)	Yes	Yes
		REACH (Chicago)	Levy et al (2004)	Yes	
		Norsjö Intervention Project	Brännström et al (1994)		
			Emmelin et al (2007)		

Programme focus	No. studies	Programme name	Citation	Community consultation	Lay Health Advisors
Screening and education (including counselling) of individuals or families	3	Family Fit	Peerbhoy et al (2008)		
		Khush Dil	Netto et al (2007)		
		Various unnamed programmes	Pratt et al (1999)		
Provision of information	3	Sisters Together[3]	Dietz (2001)		
			Goldberg et al (1999)		
		Unnamed programme (Pacoima, USA)	Kim et al (2004)		Yes
Unclear	6	Heart Health Nova Scotia	MacLean et al (2003)		
			Joffres et al (2004a;2004b)		
		Salud para su Corazon	Moreno et al (1997)		
		Vejle Project	Meillier et al (1998)		
		SALAD	Khunti et al (2008)		

[3] Whilst the programme was claimed to include components aimed at strengthening community resources (see Goldberg et al, 1999), it is classified here as 'provision of information' only as no details at all are provided regarding the community resource components.

5.2.3. Quality appraisal

Quality was assessed using the assessment tool shown in 0 and results are shown in Table 4.

Generally, the quality of the included study reports was poor, although most studies did report a clear research question for which qualitative research was appropriate. Only nine clearly reported the theoretical or ideological perspective of the authors. Lack of detail about sampling methods or the study population meant that it was not possible in 20 cases to judge whether the sample was appropriate. In 17 studies, the methods of data collection were not adequately described, and in 16 the analytic methods were either not rigorously conducted, or not well enough described to make this judgement.

As requested, we assigned a quality score of "++", "+" or "–" to each based on the quality assessment tool and a critical reading of the report. Four study reports were given "++": Joffres et al (2004a; 2004b), Emmelin et al (2007) and Netto et al (2007).

Nineteen studies were given a quality score of "–": Alberta Health (1998), Besculides et al (2006; 2008), Blamey et al (2005), Brannstrom et al (1994), Dietz (2001), Dressendorfer et al (2005), Goldberg et al (1999), Goodman et al (1995), Harralson et al (2007), Mayer et al (1998), Mays et al (2004), Meillier et al (1998), Moreno et al (1997), Peerbhoy et al. (2008), Pratt et al. (1999), Puska et al. (1986), Rosecrans et al (2008), and Viadro et al (2004).

The remaining seven gained a quality score of "+": Maclean et al (2003), DeBate & Plescia (2004), DeBate et al (2004), Jilcott et al (2007), Khunti et al (2008), Kim et al (2004), and Levy et al (2004).

Studies were commonly given a score of "-" because of deficiencies or ambiguities about aspects of study design such as, methods of recruitment and sampling, details of data collection or analysis, or lack of reflexive consideration: these make it difficult to assess study validity and reliability. It is not always possible to tell whether such problems are due to inadequate study reporting, or conduct.

Table 4: Quality appraisal

		Theoretical perspective			Sampling				Data collection		Analysis			
	Overall score	Is the research question clear?	Perspective of author clear?	Influenced the study design?	Is the study design appropriate to answer the q	Is the context or setting adequately described?	Adequate to explore range of subjects/ settings?	Drawn from an appropriate population?	Adequately described?	Rigorously conducted so confidence in findings?	Rigorously conducted so confidence in findings?	Findings substantiated /limitations considered?	claims to generalisibility follow from the data?	Addressed and confidentiality respected?
Alberta Health (1998)	-	N	N	CT	CT	Y	CT	Y	N	N	N	CT	NA	CT
Besculides et al. (2006)	-	Y	N	CT	Y	N	CT	Y	Y	CT	CT	CT	Y	Y
Besculides et al. (2008)	-	Y	N	CT	Y	N	CT	Y	Y	CT	CT	CT	Y	Y
Blamey et al. (2005)	-	Y	Y	Y	Y	Y	CT	Y	Y	Y	CT	CT	Y	Y
Brannstrom et al. (1994)	-	Y	CT	CT	Y	Y	CT	Y	N	CT	CT	CT	NA	CT
DeBate & Plescia (2004)	+	Y	N	NA	Y	Y	Y	Y	N	CT	Y	N	NA	N
DeBate et al. (2004)	+	Y	Y	N	Y	Y	N	Y	Y	Y	Y	N	NA	Y
Dietz (2001)	-	Y	N	CT	Y	N	CT	Y	N	CT	N	CT	N	CT
Dressendorfer et al. (2005)	-	Y	Y	CT	Y	Y	CT	Y	N	CT	N	CT	NA	CT
Emmelin et al. (2007)	++	Y	N	Y	Y	Y	CT	Y	Y	Y	Y	Y	NA	Y
Goldberg et al. (1999)	-	Y	N	CT	Y	Y	N	Y	N	CT	N	N	Y	CT
Goodman et al. (1995)	-	N	N	NA	N	Y	CT	CT	Y	N	N	N	NA	CT
Harralson et al. (2007)	-	Y	N	CT	Y	N	CT	CT	N	N	N	CT	Y	Y
Jilcott et al. (2007)	+	N	N	NA	CT	Y	CT	CT	Y	Y	Y	Y	NA	Y
Joffres et al. (2004a)	++	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y	Y	Y	Y

		Theoretical perspective					Sampling		Data collection		Analysis			
	Overall score	Is the research question clear?	Perspective of author clear?	Influenced the study design?	Is the study design appropriate to answer the q	Is the context or setting adequately described?	Adequate to explore range of subjects/ settings?	Drawn from an appropriate population?	Adequately described?	Rigorously conducted so confidence in findings?	Rigorously conducted so confidence in findings?	Findings substantiated /limitations considered?	claims to generalisibility follow from the data?	Addressed and confidentiality respected?
Joffres et al. (2004b)	++	Y	Y	Y	Y	Y	CT	Y	Y	Y	Y	Y	Y	Y
Khunti et al. (2008)	+	Y	Y	Y	Y	N	N	N	N	Y	Y	N	NA	CT
Kim et al. (2004)	+	Y	N	CT	Y	Y	Y	Y	N	CT	Y	CT	Y	CT
Levy et al. (2004)	+	Y	Y	Y	Y	Y	CT	Y	Y	Y	CT	CT	CT	CT
Maclean et al. (2003)	+	Y	Y	Y	Y	Y	CT	Y	Y	CT	Y	Y	Y	
Mayer et al. (1998)	-	Y	N	CT	Y	N	N	Y	N	CT	Y	Y	Y	Y
Mays et al. (2004)	-	Y	N	CT	Y	N	CT	Y	N	CT	N	CT	CT	CT
Meillier et al (1998)	-	N	N	NA	Y	N	CT	Y	N	CT	N	N	CT	CT
Moreno et al. (1997)	-	Y	CT	CT	Y	Y	CT	Y	N	CT	N	CT	Y	N
Netto et al. (2007)	++	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Peerbhoy et al. (2008)	-	Y	N	CT	Y	N	CT	CT	N	N	N	Y	NA	CT
Pratt et al. (1999)	-	Y	N	CT	Y	N	CT	CT	Y	CT	Y	CT	Y	N
Puska et al. (1986)	-	Y	Y	N	CT	Y	CT	Y	N	CT	CT	N	NA	CT
Rosecrans et al (2008)	-	Y	N	CT	Y	Y	CT	CT	N	N	N	Y	Y	CT
Viadro et al. (2004)	-	Y	N	CT	Y	CT	Y	Y	N	N	N	N	N	CT

Key: Y = Yes. N=No. CT = Can't tell. NA = Not applicable.

5.2.4. Applicability

The applicability of the study reports is difficult to gauge. Despite apparent differences in location, time and population, individual findings may well contain useful insights about mechanisms of action, such as the nature of engagement and the challenges of organisational collaboration, which could be applied in other settings. The applicability will be depend on the type of programme and context in which it will be *applied*, as well as the type through which particular evidence was *generated* - for example, all but three studies relate to programmes delivered in urban areas, the exceptions being the Bootheel project, North Karelia and Norsjo intervention. It is hoped that the evidence from all the included studies will be at least partially applicable to the UK context.

There are four reports about programmes that were based in the UK, and all are recent - Family Fit (Peerbhoy et al, 2008), Have a Heart Paisley (Blamey et al, 2004), Kush Dil (Netto et al, 2007) and SALAD (Khunti et al, 2008). These are likely to be directly applicable in many respects related to service organisation and provision and access to services, due to the similarity of most health and local government organisational structures around the UK. Findings from these studies may also be useful in considering the potentially feasibility or applicability of programmes in particular types of community. In particular, Khush Dil and SALAD are both aimed at Asian communities, while the Have a Heart Paisley project targeted those in socially deprived locations. Conversely however, there is a paucity of qualitative research evidence about implementing or tailoring CVD prevention programmes in non-deprived communities or in other localities (e.g. rural areas) where levels of cardio-vascular disease may be average or below average.

5.2.5. Research methods and analytic processes in included studies

An outline of the methodology of each of the included study reports is shown in Table 5. This shows the theoretical approach and analytic process as given by the study reports although, as described below, this does not necessary match with what seemed to have been done.

Included studies used a number of qualitative research methods, with over half (16/30) using focus groups as their sole or predominant method of data collection. Thirteen studies used semi-structured interviews, either alone or in combination with other methods such as observation (three), reflective logs completed by project staff (three) and analysis of documentation associated with the programme (three). Four studies used questionnaires that allowed respondents to express themselves in their own words; for some studies (Puska et al, 1986; Kim et al, 2004) the questionnaire was the predominant method of data collection, whilst for others it was a component of a wider research strategy (MacLean et al, 2003; Khunti et al, 2008). An overview of the participants and research methods used in the included studies is provided in Table 5.

Many of the included qualitative studies were part of a larger evaluation of the programmes concerned, and have significant limitations in terms of their sampling strategies and analytic processes. A minority of studies omitted to report even rudimentary details such as sample size (Alberta Health, 1998; Mayer et al, 1998; Pratt et al, 1999) or the basic characteristics of research participants (Dietz, 2001; Dressendorfer et al, 2005). Inconsistencies in reporting were evident in one study where the number of focus groups that were conducted varies at different points in the report (DeBate & Plescia, 2004). A rationale for conducting a purposive sample was lacking in a number of studies (Brännström et al, 1994; Harralson et al, 2007; Mays et al, 2004) or the limitations of utilising a convenience sample was not acknowledged or reflected upon in the process of data analysis (Goldberg et al, 1999; Kim et al, 2004; Peerbhoy et al, 2008; Pratt et al, 1999; Viadro et al, 2004).

Few authors explicitly align themselves to a particular theoretical perspective driving their research approach. Of the six that do, two state they undertook grounded theory (Emmelin et al, 2007; Meillier et al, 1998), two participatory action research (MacLean et al, 2003; Dressendorfer et al, 2005) and two say they did both of these things (Khunti et al, 2008; Netto et al, 2007). However, this was not always evident from the description of their methods – for example Meillier et al (1998) states a grounded theory was undertaken, but thematic headings were imported rather than grounded in the data, and sampling was random rather than theoretical. Similarly, the description of the methods by Khunti et al (2008) does not support the given label of grounded theory.

A significant number of the included studies used only rudimentary qualitative analytic processes. In certain instances claims were made that a particular approach to qualitative analysis had been used that was not evident in the reporting (for example, DeBate & Plescia, 2004, Mayer et al, 1998), but in many studies the details of the analytic process were simply not reported or were so basic as to communicate little of substance about the process (Alberta Health, 1998; Besculides et al, 2008; Dietz, 2001; Dressendorfer et al, 2005; Goldberg et al, 1999; Harralson et al, 2007; Mays et al, 2004; Peerbhoy et al, 2008; Puska et al, 1985; Viadro et al, 2004). A number of studies utilised a pre-existing framework for analysis (Besculides et al, 2008; Meillier et al, 1998; Moreno et al, 1998) rather than using the data to develop a framework that drew upon the perspectives of research participants – one of the potential strengths of using a qualitative research approach.

Table 5: Outline methodological details as stated by included study reports

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Alberta Health (1998) Alberta Heart Halth Project (USA)	-	None stated	Focus groups	Community members Project staff	Convenience. Unstated	Not described
Besculides et al (2006) Besculides et al (2008) WISEWOMAN (USA)	-	None stated	Semi-structured interviews Observation of interventions Focus groups	Community members Project staff	Not stated. 3 sites	Analytic themes were developed from the interviews and focus groups and were organised within the RE-AIM framework
Blamey et al (2005) Have a Heart Paisley (UK)	-	Non stated	Semi-structured interviews Focus groups	Community members Project staff	Purposive. Interviews (68), focus groups (69 participants)	Analysis was conducted according to pre-defined themes (contextual issues, process findings, outputs and outcomes)
Brannstrom et al 1994 Norsjo (Sweden)	-	Not stated	Semi-structured interviews Document analysis	Project staff	Not stated. 52	Systematic thematic coding with an emphasis on identifying consensus and diverging opinions.

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
DeBate & Plescia (2004) Charlotte REACH 2010 (USA)	+	None stated	Focus groups	Community members Project staff	Not stated. 78	3 Independent coders hand coded following modified Spradley (1979) methods (*The Ethnographic Interview*).
DeBate et al (2004) Charlotte REACH 2010 (USA)	+	None stated	Focus groups	Community members Project staff	Not stated 84	3 Independent coders hand coded following modified Spradley (1979) methods (*The Ethnographic Interview*).
Dietz (2001) Sisters Together (USA)	-	None stated	Focus groups	Unclear – simply states 'adolescents in Atlanta and San Antonio'	Not stated 12 focus groups	None stated
Dressendorfer (2005) Alberta Heart Health Project (USA)	-	Participatory Action Research	In-person and group interviews with site co-ordinators Focus groups Observation of staff meetings Documentary review	Community members Project staff	Not stated. Not stated	'Identified factors and lessons were categorised thematically'

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Emmelin et al (2007) community intervention programme (Sweden)	++	Grounded theory	Interviews	Participants to be approached for 10yr follow up health exam	Not stated. 9	Grounded theory. Interviews read and re-read, summarised, compared and re-coded in selective coding processes
Goldberg et al (1999) Sisters Together (USA)	-	None stated	Focus groups Interviews	Community members	Convenience. 47	None stated
Goodman et al (1995) Heart to Heart (USA)	-	None stated	Interviews	Community members Project staff	Representative. 40	1 person coded transcript for text that completed the following types of sentences: “x is a method for participating in the programme” “Y is a benefit derived from it” “Z is a way the programme might have been improved”. *Ethnograph* used to aggregate all similar codes into taxonomies.
Harralson et al (2007) Un Corazón Saludable (USA)	-	None stated	Focus groups	Community members	Not stated. 24	Not stated

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Jilcott et al (2007) WISEWOMAN (USA)	+	None stated	Semi-structured interviews	Women similar to WISEWOMAN participants from SE North Carolina.	Through informants. 28	A codebook listing codes was developed deductively from interview guide questions. Two coders independently coded interviews. Consensus on codes resolved by discussion.
Joffres et al (2004b) Heart Health Nova Scotia (Canada)	++	Participatory Action Research	Network mapping questionnaires, technical support logs, interviews, ongoing organisational reflection logs	Project staff	Self selection of organisations, individuals were purposively sampled. 6 organisations, 62 staff (interviews)	Grounded theory/ principles of Lincoln & Guba
Joffres et al (2004a) Heart Health Nova Scotia (Canada)	++	Participatory Action Research	Network mapping questionnaires, technical support logs, interviews, ongoing organisational reflection logs	Project staff	Self selection of organisations, individuals were purposively sampled. 6 organisations, 62 staff (interviews)	Grounded theory/ principles of Lincoln & Guba

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Khunti et al (2008) SALAD (UK)	+	Action research "Principles of grounded theory" used	Multiple methods including pre-project engagement, surveys, school identification. Also one observational visit, one baseline and one follow up focus group in each of the five schools.	School pupils Project staff	Not clear. Not clear (5 schools)	Combined qualitative data from focus groups and observational visits involved initial open coding using QSR N6 free nodes, "allowing ideas to emerge from the data".
Kim et al (2004) Un-named programme using lay health advisors (USA)	+	None stated	Questionnaire – mostly closed questions, but including a number of relevant open-ended questions.	Community members	Through the Lay Health Advisors' social networks. 256	"Trends and response categories were identified, and response clusters were then grouped to identify underlying themes"

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Levy et al (2004)(Levy et al. 2004b)	+	Ecological Model of Health Behaviour (McElroy et al., 1998) and generic 'participatory' approaches	Focus groups Semi-structured interviews	Community members Project staff	Purposive. Focus groups (99 participants), interviews (10)	Research team 'generated' thematic areas from data; these were 'discussed and refined' with the project planning council. Themes were triangulated with survey and observational data
Maclean et al (2003)(Maclean et al. 2003a) Heart Health Nova Scotia (Canada)	+	Participatory action research	Network mapping questionnaires, technical support logs, interviews, ongoing organisational reflection logs	Project staff	Self selection of organisations, individuals were purposively sampled. 6 organisations, 62 staff (interviews)	Grounded theory/ principles of Lincoln & Guba
Mayer et al 1998 Bootheel Heart Health Project (USA)	-	None stated	Focus groups	Community members	Not stated. 22	Transcripts were analysed using Spradley's method of delineating domains and sub-domains
Mays et al (2004) WISEWOMAN (USA)	-	None stated	'Facilitated discussion'	'Stakeholders' involved with the programme	Identified by government bureau. 21	None stated

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Meillier et al (1998) Vejle project (Denmark)	-	Grounded Theory	In depth interviews	40-year old men	Randomly selected form the civil registry system. 21	Coding used 24 codes – 14 originated from the interview guide, 7 from themes in the data, 3 contained a single element intended for use in the counting up process. Codes then grouped at a higher level of main categories according to themes of the interview. All text codes that were the same were collected to gather regardless of the interview form which they originated – transverse coupling (Glaser, 1978).
Moreno et al (1997) Salud para su Corazón (USA)	-	None stated	Focus groups	Community members	Purposive (to reflect the demographic make-up of Washington, D.C.). 64	Recordings and written notes were 'analysed to determine trends and identify major themes'
Netto et al (2007) Khush Dil (UK)	++	Grounded Theory Action Research	'Longitudinal focus groups'	Community members using the Khush Dil clinic	Random. 55 (36 in 2nd round of focus groups)	Transcripts were analysed in conjunction with field notes; emerging themes were noted and independently coded by all 3 study co-authors

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Peerbhoy et al (2008) Family Fit (UK)	-	None stated	Semi-structured interviews with Family Fit Officers Focus groups with participating families	Families who had completed the programme	Convenience. 5 families, number of project officers not stated	Interviews - “key points were extracted from a recording” Focus groups - “were noted on a flip chart and digital recordings were used to extract specific quotes to substantiate themes”
Pratt et al (1999) various multi-risk factor programmes in Michigan (USA)	-	None stated	Focus groups	Community members who had taken part in one of the programmes	Convenience. 53	First author reviewed all transcripts and compared conclusions with those of the ‘trained consultant’ – consensus was sought regarding these conclusions.
Puska et al (1986) North Karelia project (Finland)	-	None stated	Survey Interviews	Lay opinion leaders	“Selected” from those answering the survey. 399 (survey), 7 (interviews)	Questions repeated some survey questions, verified answers or asked for suggestions for the future.
Rosecrans et al (2008) Un-named First Nations programme	-	None stated	Semi-structured interviews	Community members Project staff	Purposive. 40	First author read transcripts ‘several times until themes emerged’ – from this, ‘representative quotes were selected’

Author/ programme	Quality score	Theoretical approach	Research method	Population	Type of sample. Size	Analytic process
Viadro et al (2004) WISEWOMAN (USA)	-	None stated	Telephone interviews	Project staff	Convenience. 9	"Extensive notes" taken from telephone interviews.. Responses were categorised into themes and "amplified" by referral to project documentation when considered necessary

5.3. Findings

We present the findings in two ways. In Section 5.4, we consider separately those study reports which relate to CVD programmes for which effectiveness data was presented in effectiveness reviews 1 to 3 by WMHTAC. We then consider the thematic findings across all the included study reports in Section 5.5.

5.4. Reports related to programmes also included in the effectiveness reviews

Evidence relating to five programmes have been included both in this review of qualitative research and in the reviews of effectiveness studies – Bootheel Heart Health (USA, reported in Review 1), the Norsjo project (Sweden, reported in Review 1), the North Karelia Programme (Finland, reported in Review 1), Heart to Heart (USA, reported in Review 1) and Have a Heart Paisley (Scotland, reported in Review 3). A brief summary of the qualitative research relating to these programmes is given below while a summary of the effectiveness data for each is shown in Table 6.

Bootheel Heart Health

Mayer et al (1998) conducted comparative focus groups with members in successful and unsuccessful community coalitions in the Bootheel Heart Health Project. Data were not provided regarding the make-up of these groups, meaning that demographic details of the participants in these groups is not known. Access to resources and participation in training were identified as being associated with successful community coalitions, as was the importance of identifying clear 'endpoints' regarding health behaviour that communities could see and understand. At a wider level, successful community coalitions were associated with having the capacity to make changes to the physical and institutional environment, with empowering communities to take action on issues relating to health, and with being socially inclusive across a wide range of population groups and health issues. Fewer factors were identified with regard to *unsuccessful* community coalitions, but those that were related to how the programme was integrated into the communities concerned. For example, programme events that were designed to be 'fun', and those that took place within traditional or seasonal community events were associated with unsuccessful

community coalitions, but no further details are provided that might explain why this was the case.

Table 6: Summary of programme effectiveness from WMHTAC reviews

Project	Desirable outcomes	Mixed outcomes	Undesirable outcomes	Summary from WHMTAC
Bootheel heart health	Physical activity and cholesterol checking – Increased, significantly so in communities with 'active coalitions'	Diet – number of people consuming >5 portions of fruit & vegetables/ day decreased, but less so than in the control group Overweight – number of people reporting being overweight increased, but less so than in the control group	Smoking – increased	"… Although not always significant, black population showed net improvements in the [risk factors above]" (whereas white population showed only slight improvement) "… project generated considerable community enthusiasm and involvement… although measurements not wholly reliable, project may have had some effect to improve community awareness, attitudes and behaviours"
Norsjo Intervention Project	Cholesterol – Decreased Note from WMHTAC review - No net difference presented for the following, therefore difficult to assess treatment effect over time: Blood pressure – Decreased CVD risk factors – Decreased	Smoking – Varied, no trend established	BMI - Increased	"…a community CVD intervention that actively involves the health care sector may have a positive impact" "… individual counseling appeared to bring about an earlier decrease in some risk factors, but did not reduce risk factors overall"
North Karelia Project	Smoking and cholesterol – Both decreased significantly (for men, but not for women) Blood pressure – Decreased significantly (for both men and women)	None	None	"The high risk community addressed and the novelty of the information may have contributed to its effects… but efforts to change both environmental and behavioural influences were likely to have played a large part"

Project	Desirable outcomes	Mixed outcomes	Undesirable outcomes	Summary from WHMTAC
Heart to Heart	None	Smoking – Decreased, but to a similar extent as in the control group Physical activity – Increased, but to a similar extent as in the control group Cholesterol – Increased, but magnitude of increase significantly moderated in the treatment group Weight – Increased, but to a smaller extent in the treatment group	Blood pressure – Increased significantly	"Appears to have been effective in developing a high degree of community involvement and positive physiological, knowledge and behavioural outcomes"
Have a Heart Paisley	None	No significant differences for behavioural (e.g. physical activity) or knowledge (e.g. regarding diet) outcomes (except for knowing advised number of portions of fruit and vegetables to eat each day).	None	"… may have been insufficient time for implementation or environmental changes" "… contamination of control area may have contributed to lack of programme effectiveness"

Norsjo Intervention Project

Brannstrom et al (1994) conducted semi-structured interviews with decision makers, planners, and medical staff involved with the Norsjo Intervention Project. The majority of participants understood the proposed mechanism for programme success was through the lifestyles of healthy citizens positively influencing the health behaviour of those who were less healthy. Implicit in this understanding was the notion that engaging communities was important for the programme to be effective, but the programme did not attain extensive community engagement. This lack of engagement was understood to be due to a number of reasons. First, there was a

lack of enthusiasm on the part of communities themselves for taking part in a community-level programme. Second, different perceptions on the part of actors at different organisational levels (for example, locally and regionally) meant that there was a significant gap in the way that issues were understood, although this did not prevent co-operation taking place in the delivery of the programme. Third, there was a widespread perception that initiatives were always undertaken by those acting at another level; for example, local level actors perceived initiatives to have been taken by politicians at the provincial level, whilst citizens largely thought that local medical staff or researchers were responsible for taking initiatives forward.

Emmelin et al (2007) conducted semi-structured interviews with participants approached for a follow-up health examination ten years after their initial involvement in the Norsjo programme. Interview findings were used to develop a typology of participants' attitudes that could be used as an explanatory framework for 'functional' and 'dysfunctional' responses to the programme. The typology reflects the locus of control perceived by participants and highlights the role of participants' emotions in their engagement (or otherwise) with the programme; for example, greater numbers of men experienced the programme's efforts to change health behaviour as an unjustifiable 'insult' to their pride.

North Karelia Project

Puska et al (1986) conducted a survey of lay opinion leaders involved in the North Karelia Project. Only a minor part of this research was qualitative in nature. The research identified that lay opinion leaders did not perceive that they required more formal training, preferring to share their experiences with, and learn from, others who had been involved with delivery of the programme.

Heart to Heart

Goodman et al (1995) conducted interviews with advisors, administrators, coordinators, staff from local agencies, and community members involved with the Heart to Heart project. The project timeframe was five years, during which it was required to develop relationships with communities, orientate staff and deliver the project itself in a sustainable manner. This limited timeframe was identified as an important barrier to effective programme delivery. At a strategic level, it was felt that the coordinating council for the programme was not used effectively, and there was a

lack of consensus between project staff, agency staff (responsible for programme delivery) and some council members. As a result there were deficiencies in the delivery of the programme which meant that health inequalities were not addressed as effectively as they might have been, with African Americans, poorer communities, young people and men not reached effectively.

Have a Heart Paisley

Blamey et al (2004) conducted semi-structured interviews and focus groups with Have a Heart Paisley project staff and community members. At an organisational level, the multiple streams of interventions that Have a Heart Paisley was superimposed onto meant that conflict was created between what was already in process and the larger, "badged" programme. Local authority staff felt that health staff were overly-optimistic about how the programme could be delivered and its likely success. Some communities had negative experiences of previous community initiatives and were reluctant to become involved with another one, or did become involved but only in a partial sense (for example, with regard to initiatives promoting exercise, but not to smoking). Many communities were also reluctant to get involved with the programme because they viewed CVD as a low priority compared with other issues such as housing, unemployment and poverty.

The WMHTAC reviews of effectiveness found that some measures of success suggested effectiveness for the first three programmes: Bootheel, Norsjo and North Karelia, while the latter two, Heart to Heart and Have a Heart Paisley, were judged to be ineffective. A summary of the findings reported in WHMTAC is shown in Table 6. It should be noted that staff interviewed about the Heart to Heart project had positive impressions of the programme despite the lack of positive outcome data:

> *I'm afraid that the academic community is going to look at it and say because you didn't make a change in cholesterol, smoking and hypertension rates, you were not effective (Goodman et al 1995).*

We will use terms such as "successful" and "effective" to refer to programmes that have been shown to work empirically, but bear in mind that the project staff and participants might have viewed the projects differently and that formal evaluation may not have captured all the positive (or all the negative) impacts of programme.

For these five programmes, we have examined together and compared the findings of the qualitative research reports related to programmes considered to have effective elements, and those not considered to be effective, to try and identify if there were logical groupings of factors that might help to explain these results. We identified themes where there were similarities reported between the effective or non-effective programmes, and/or differences between the effective and ineffective programmes. These are organised below under two broad thematic areas – organisational and strategic issues (encompassing the time limited nature of some programmes, and programme leadership) and community engagement.

5.4.1. Organisational and strategic issues

Three of the five studies about programmes for which there is also effectiveness data described issues relating to organisational and strategic issues. Study reports about both Heart to Heart and Have a Heart Paisley (judged not to be effective) identified time-limited projects (three years in the former case) as a barrier to success – the impact of this is discussed in greater detail in Section 5.7.6 (Blamey et al 2004; Goodman et al 1995). In addition, they both note elements related to lack of leadership, in the case of Have a Heart Paisley, this related to senior staff not being able to free up time to devote to the project (Blamey et al 2004), while Heart to Heart found that a coordinating council that was supposed to provide input for project planning, was not used effectively. The members were not clear why they had been selected for involvement or the nature of their expected role (Goodman et al 1995). Like Heart to Heart, Have a Heart Paisley also found it difficult to involve community representatives at a strategic level (Blamey et al 2004).

The ability of partner organisations to work together was different between an effective and an ineffective programme, with tensions reported between the local authority and the health authority during Have a Heart Paisley, while territorialism and community politics also prevented participants benefiting from activities in neighbouring areas (Blamey et al 2004). By contrast, cooperation was reported as "relatively friction free" during the Norsjo intervention project, with conflicts resolved constructively, despite differences in frames of reference between local and regional bodies (Brannstrom et al, 1994).

Evidence statement 1: Effectiveness and Organisational and strategic issues
1.a Three studies provide information related to organisational and strategic factors (Blamey et al, 2004; Brannstrom et al, 1994 & Goodman et al, 1995 [all -]). 1.b These suggest that factors influencing success include: time limitations for projects (Blamey et al, 2004 & Goodman et al, 1995), leadership, (including difficulties engaging community members at strategic levels) (Blamey et al, 2004 & Goodman et al, 1995), and cooperation between partner organisations (Blamey et al, 2004 & Brannstrom et al, 1994).

5.4.2. Community engagement

The picture is less clear in relation to community engagement, with both negative and positive experiences reported in the programmes judged successful and positive experiences, as well as negative, in those judged unsuccessful.

Communities had positive expectations that they could would work together with the Bootheel Heart Health Project (which was judged to be successful) to influence positive political and social changes (Mayer et al, 1998). There were more cautious depictions of community engagement with both ineffective and effective programmes. It was noted that some communities were difficult to engage by Have a Heart Paisley, where they had prior poor experience of initiatives that had not addressed their real needs (Blamey et al 2004, programme ineffective). In contrast, it is suggested that a benefit of Heart to Heart was increased community readiness to engage in (future) intervention programmes, although overall, this project was not empirically shown to be successful (Goodman et al 1995).

Difficulties were also seen in the Norsjo project, which was successful, where the programme was regarded as too professional, rather than community focussed and "insensitive to people's habits and cultural patterns" (Brannstrom et al, 1994). It was also reported that there was no consensus about what community participation might involve (Brannstrom et al, 1994).

Evidence statement 2: Effectiveness and Community engagement
2.a Four study reports (Blamey et al, 2004; Goodman et al, 1995; Brannstrom et al, 1994 & Mayer et al 1998 [all -]) show conflicting evidence about the degree and methods of

community engagement important for success.

2.b For programmes that were successful, one study reports that positive community expectations about the potential of the programme to effect wider change facilitated community engagement (Mayer et al, 1998). It is suggested that insufficient community engagement did not significantly impact on another programme's success (Brannstrom et al, 1994)

2.c. For programmes that were unsuccessful, one study reports that previous negative experiences of community programmes discouraged community engagement (Blamey et al, 2004). Conversely, another study reports engagement in the programme increased willingness for future involvement (Goodman et al, 1995).

5.5. Analysis of all identified study reports

Findings below are related to all the included study reports, regardless of whether effectiveness data is also available. We identify findings into those relating to macro, meso and micro level concerns – this grouping was used as an initial framework to explored findings during analysis. Within these levels, findings are reported under thematic headings identified by the research team during analysis. There is some repetition of the above in order to place the findings of the few studies for which effectiveness data is available in the context of all the research included in this review.

We have not separately reported findings using the headings "barriers" and "facilitators" since these are frequently just the converse of each other – for example, one report might report that effective community engagement is a facilitator of success, while another may report that *lack* of effective community engagement is a barrier to success. These, essentially, relate to the same point so it was not felt helpful to report them in separate places.

The themes used to code the data, and which structure the remainder of this chapter are:

- Macro level findings

    - Politics
    - Prices
    - Socio-economic context
- Meso level findings
    - Organisation and strategic issues
    - Organisational culture and partnerships
    - Programme design & delivery
    - Staffing
    - Evaluation
    - Community engagement
    - Local access
    - Community and familial norms
- Micro level findings
    - Understandings of CVD risk
    - Motivation and resistance
    - Programme perceptions

For each of the major sub-headings above, the findings are presented as follows:

- A summary evidence statement at the macro, meso, or micro level.
- The evidence from included studies, structured by analytic theme.
- Detailed, numbered evidence statements for each analytic theme.

5.6. Macro-level findings

Summary evidence statement: Macro-level findings
A total of twelve study reports describe findings that relate to barriers and facilitators at the macro level - politics, prices, and the socio-economic context. The broader political context can affect diverse organisational elements of programme development and implementation such as the availability of project funding, the development of partnerships between organisations and a sense of shared purpose at different administrative levels. Individual responses may also be affected through legislation incentives to healthier behaviours. High pricing can impact on people's ability and willingness to adopt healthy eating behaviours and to participate in organised physical activity. Also, because CVD may be most prevalent among communities facing multiple deprivation, heart health may compete with more immediately pressing socio-economic concerns.

5.6.1. Politics

Five study reports make comments about the effects of the broader political situation on their programmes, although the impacts recorded were disparate and difficult to synthesise (Alberta Health 1998; Blamey et al, 2005; Dressendorfer et al, 2005; MacLean et al, 2003 & Mayer et al, 1998).

One (USA) study notes that health care system reform due to a budget freeze was a major barrier to success as it limited the ability to create new organisational structures, re-evaluate roles and engendered a lack of direction (MacLean et al, 2003).

One UK study notes that a "turbulent political and financial context" within the relevant NHS bodies negatively affected the ability to develop partnerships or recruit staff (Blamey et al, 2005). A similar point is made by Mayer et al, 1998, although in the reverse expression, as they note that successful coalition between collaborating partners in the community required changes to be made in the political environment to accommodate it.

One Canadian study noted that there was a need for provincial level involvement to ensure that the projects under the programme had consistency in terms of the

projects framework, philosophy and focus (Alberta Health 1998). Another report of the same CVD programme adds that policy making locally was important to develop shared vision, mission and political will within the local community (Dressendorfer et al, 2005).

Finally, Blamey et al (2004) suggest that a more conducive national policy making context around key areas such as tobacco control was required to enhance the programme (although note that this predated recent smoking bans in the UK).

Evidence statement 3: Politics
3.a There is evidence from five study reports that community programmes to address heart health can be affected by the broader political context (Alberta Health 1998; Blamey et al, 2005; Dressendorfer et al, 2005; MacLean et al, 2003 & Mayer et al, 1998 [all -]). 3.b This can effect diverse organisational elements such as: the availability of project funding (MacLean et al, 2003), the development of partnerships between organisations (Blamey et al, 2004 & Mayer et al, 1998) and a sense of shared purpose at different administrative levels (Alberta Health 1998 & Dressendorfer et al, 2005). Individual responses may also be affected through legislation incentives to healthier behaviours (Blamey et al, 2004).

5.6.2. Prices

Four study reports highlight the importance of prices in influencing CVD risk behaviours (Goldberg et al 1999; Khunti et al 2008; Rosecrans et al, 2008 and Jilcott, 2007).

Goldberg et al 1999, Khunti et al 2008 and Rosecrans et al 2008 all note this particularly in relation to the higher price of healthy foods (see also section 5.7.3 regarding unfamiliarity with 'new' foods and reluctance to try them out). An unwillingness to "waste" money on these foods exacerbated by the perceived short shelf life of such food (Goldberg et al 1999) and the risk of new, healthier options being "wasted" if they or their family didn't like it (Khunti et al, 2008). Khunti et al (2008) also suggest that school meals provision had a commercial bias, which encouraged cheap but unhealthy options to be offered.

Jilcott et al (2007) identify the expense of gyms as a barrier to their use.

Evidence statement 4: Prices
4.a There is evidence from four study reports that high pricing can impact on people's ability and willingness to adopt healthy eating behaviours and to participate in organised physical activity (Goldberg et al 1999 [-];Jilcott, 2007 [+]; Khunti et al 2008 [+] & Rosecrans et al, 2008 [-]).

5.6.3. Socio-economic context

Six study reports identify elements of the local social environment that affected the success of CVD programmes. They report that problems other than heart disease were considered more pressing in the targeted communities. These included unemployment and attendant uncertainty (Blamey et al, 2004); Brannstrom et al, 1994; Levy et al 2004), stress and fear caused by racism (Netto et al, 2007), housing, (Blamey et al, 2004; Harralson et al, 2007) domestic violence, (Harralson et al, 2007) drug problems (Blamey et al, 2004; Levy et al 2004) and poverty (Blamey et al, 2004; Pratt et al, 1999; Harralson et al, 2007). The Have a Heart Paisley programme was undertaken where the majority of postcode areas had deprivation levels higher than the Scottish average; crime, drugs, and the poor state of community facilities were considered to be major problems in a number of the study localities (Blamey et al, 2004). Four of the other studies are about projects aimed at minority communities - North American first nations, African American, Latino and British Asian. A further study among African American respondents suggests that until the reality of CVD as a major cause of death is accepted in African American communities, they would not take steps to prevent it (Pratt et al, 1999).

CVD may be most prevalent among communities facing multiple deprivation. Where this is the case, heart health may compete with more immediately pressing socio-economic concerns.

Evidence statement 5: Socio-economic context
5.a There is evidence from six study reports that the local socio-economic context (poverty, unemployment, housing, drug problems etc.) meant that communities felt there were more pressing concerns than heart health (Blamey et al, 2004 [-]; Brannstrom et al, 1994 [-]; Harralson et al, 2007 [-]; Levy et al 2004 [+]; Netto et al, 2007 [++]; Pratt et al, 1999 [-]).

5.7. Meso level findings

Summary evidence statement: Meso-level findings

Project Implementation

There is evidence from twenty-three of the study reports describe findings that identify barriers and facilitators to successful project implementation at the meso-level – such as community and familial norms, community engagement, local access, organisational and strategic issues, organisational culture and partnerships, staffing and evaluation.

Community and familial norms can affect attitudes to food, exercise and health in ways that are not helpful to CVD prevention, although there is evidence that suggests these can be addressed through enhanced "social health" and community engagement.

To be successful, community engagement needs to be sensitive to the local cultural pattern, and may require multiple approaches across a number of levels. Challenges to success may include competing involvement at strategic levels, breaking into existing networks, competing activities, reaching specific groups such as young people, and lack of interest in the community – perhaps because of previous negative experiences.

The local physical environment may limit access to healthy food, informal physical exercise (such as walking) and formal exercise (such as gyms).

Project Management

Organisational and strategic issues within the programme, such as time limited projects and lack of leadership, can negatively effect success.

Partnerships between involved organisations are enhanced where they share values, priorities and goals, and may enhance learning and the profile of smaller organisations. Differences in culture and expectations between organisations can cause friction and may negatively affect programme delivery.

Staff recruitment and retention are key issues, with the right mix of skills and personal characteristics enhancing programmes. Good communication between members of staff prevented duplication of activities and flexibility allowed them to tailor their role to participant needs. Sufficient resources are required to either free up staff with other existing roles or to provide dedicated staff to focus on heart health. Volunteers can be crucial, but need

adequate resourcing and leadership. Skills training can be helpful, but staff also learn through sharing and implementation and may prefer these informal mechanisms.

While evaluation can raise awareness among staff and promote programme improvement, time limited projects may struggle to provide timely feedback. Conversely, data management is a challenge for long term projects and those with multiple strands across multiple sites.

5.7.1. Organisational and strategic issues

Five study reports discuss factors relating to organisational and strategic issues, particularly the impact of time limited projects and need for leadership (Alberta Health 1998, Blamey et al 2004, Dressendorfer et al, 2005; Goodman et al 1995 and Viadro et al, 2004).

Four study reports identify short time frames for projects as barriers to effective implementation. These programmes ran for three to five years. Short time frames limit planning time and project development (Alberta Health 1998, Blamey et al 2004 and Goodman et al 1995), and this meant that project goals were unrealistic (Alberta Health, 1998) which in turn limited the durability of the projects (Goodman et al 1995), particularly where no personnel were identified to lead and carry in the work beyond the project end. Time pressures also mean that there was little time to engage with the community, develop and cultivate working relationships between organisations, use community data to inform the project design, orient staff and "institutionalize the project", together limiting the ability for the project to achieve the intended outcomes (Goodman et al 1995). Time constraints were seen to limited planning and start up tasks which further limited the ability of programmes to develop material, foster communication between staff and clarify roles (Viadro et al, 2004).

Evaluators of the Alberta Heart Heath project regard leadership as a key organisational benefit of the project. It was considered, however, that while the project had provided leadership, it had not fostered the development of new leaders within the community – at least partly as a result of time limitation – limiting the shift of power from the project to the community (Alberta Health, 1998). Another study report also cites the mobilisation of volunteers as a crucial element of community capacity building that required good leadership to be successful (Dressendorfer et al, 2005). Leadership is required to develop partnerships, collaborations and linkages

within the target communities (Dressendorfer et al, 2005). "Top-level" leadership is also required – where organisations that were to be involved were identified and encouraged to participate through presentations to top level administrators, board members – and where these leaders embraced and promoted change (Joffres et al, 2004b).

Evidence statement 7: Organisational and strategic issues
7.a Six study reports discuss factors relating to organisational and strategic issues. (Alberta Health 1998 [-], Blamey et al 2004 [-], Dressendorfer et al, 2005 [-]; Goodman et al 1995 [-]; Joffres et al, 2004b [+] & Viadro et al, 2004 [-]). 7.b There is evidence from four studies that short time frames limit the ability to plan and develop the programme, engage the community, develop partnerships and communication, meet targets and leave a positive legacy (Alberta Health 1998, Blamey et al 2004; Goodman et al 1995 & Viadro et al, 2004). 7.c Leadership was identified as a key organisational benefit of programmes by three studies (Alberta Health 1998; Dressendorfer et al, 2005 & Joffres et al, 2004b). It is required to develop partnerships and collaborations within communities, and is important at all levels, from volunteers to with senior administrators (Alberta Health 1998; Dressendorfer et al, 2005 & Joffres et al, 2004b). One study failed to see the desired shift in leadership to the community itself (Alberta Health 1998).

5.7.2. Organisational culture and partnership

Six study reports note themes related to the organisational culture and partnerships of those involved in CVD programme services.

Differences between organisational cultures was noted between local and national organisations and actors:

> *We have different frames of reference, we think differently. There is a small barrier between us (Brannstrom et al, 1994).*

However Brannstrom et al (1994) note that mostly this was resolved constructively. By contrast, in the UK, Blamey et al (2004) note tensions between local authority and

health authority members, with the local authority viewing the health authority plans as over-ambitious, given the inherent difficulties of delivering such a programme. Linked to this possibility of interagency conflict is the suggestion by Joffres et al (2004b) that non-health specialist partners were inhibited in their involvement due to the use of unfamiliar health promotion concepts and terminology. They also noted that such as "us *vs* we" attitude to partnerships hindered positive experiences.

In addition, Blamey et al (2004) note different organisational focuses, so that the local authority viewed CVD work as just one aspect of their wider field of intervention (covering areas such as housing, education, social work etc.) Similar values about heart health between organisations fostered good experiences with partnerships (Joffres et al, 2004b). Maclean et al (2003) note that programme success was enhanced when partner organisations made policy changes to increase the priority of heart health. The reverse position is noted by Joffres et al (2004b), noting, predictably, that lack of interest in heart health was a barrier and that organisations willing to change in order to recognise the importance of heart health and to bring their values into line with other collaborators facilitated of success. Positive partnerships were enhanced where there were shared project goals from the start, for research dissemination and development (Goodman et al, 1995). Goodman et al (1995) also note that there may be different goals for people with different levels of engagement with the project – noting that whereas project staff wanted it to gain acceptance and support within the community, agency staff wanted to deliver the projects well, and council members wanted to shape policy.

More general comments about partnerships were reported in four studies. As noted above (Section 5.7.4.5), positive partnerships could enhance interagency learning and enhance appreciation between groups of each others' work. (Joffres et al, 2004b; Maclean et al, 2003) and smaller organisations benefited from increased credibility and visibility (Joffres et al, 2004b). Positive partnership activities included the project team supporting local groups' applications for funding (Blamey et al, 2004) and Mayer et al (1998) also noted that a key benefit of partnerships was the identification of new funding sources.

Evidence statement 8: Organisational culture and partnership
8.a Evidence from six study reports is related to the organisational culture and partnerships of those involved in CVD programme services (Blamey et al, 2004 [-]; Brannstrom et al, 1994 [-]; Goodman et al, 1995 [-]; Joffres et al, 2004b [+]; Maclean et al, 2003 [+] & Mayer et al, 1998 [-]). 8.b Three studies note differences in culture between partner organisations including frames of reference, terminology and programme expectations (Blamey et al, 2004; Brannstrom et al, 1994 & Joffres et al, 2004b) although this didn't always lead to conflict. 8.c Four studies suggest that CVD programmes are enhanced where partner organisations have aligned values, priorities, focus and goals between organisations (Blamey et al, 2004; Goodman et al, 1995; Joffres et al, 2004b & Maclean et al, 2003). 8.d Partnerships may have positive effects through interagency learning (Maclean et al, 2003), increasing the visibility of smaller organisations (Maclean et al, 2003) and enhanced funding opportunities (Blamey et al, 2004 & Mayer et al, 1998).

5.7.3. Programme design and delivery

Five study reports note themes related to the specific design elements of CVD programmes, although the topics themselves are rather disparate.

Two study reports, one school based, report that dance classes are a popular choice of physical activity for girls and women (Khunti et al, 2008; Peerbhoy et al, 2008). Other options include women only classes, and activities available at the weekend (Peerbhoy et al, 2008).

Levy et al (2004) noted that the promotional materials were not always well designed with to much "technical……and medical jargon", and that non-English speakers were poorly served.

One study found that community projects were almost all based around physical activity, and that only one community group wanted to address smoking; although reasons for this are not explained it is possible that this was related to a wider issue regarding the involvement of community members at a strategic level, where it was

noted that meaningful participation was hindered by the inadequate explanation of roles and group processes (Blamey et al, 2004). In terms of successful innovations, one study found that the introduction of a farmer's market was identified by most as the biggest community change and it was valued as a meeting place as well as a source of food (DeBate et al, 2004).

Provision of healthier food options might not be enough to ensure that they are taken up. Two studies note this in different environments – schools and local shops, and form two perspectives – suppliers and customers. Rosecrans et al (2008) note that, while local shops could be persuaded to try stocking healthier food options, they would not continue to do so if sales were poor. Khunti et al (2008) note that a lack of clear descriptions and pricing on "new" healthy options provided at school meant that students stuck to the "safe" choices, like chips, where they understood what they were getting.

Evidence statement 9: Programme design & delivery

9.a Evidence from six study reports relates to the specific design elements of CVD programmes (Blamey et al, 2004 [-]; DeBate, 2004 [+]; Khunti et al, 2008 [+]; Levy et al, 2004 [+]; Peerbhoy et al, 2008 [-] & Rosecrans et al 2008 [-]).

9.b Two study reports report that dance classes are a popular choice of physical activity for girls and women (Khunti et al, 2008 & Peerbhoy et al, 2008).

9.c Promotional materials need to be accessible in terms of terminology and language used (Levy et al, 2004).

9.d One study found that the introduction of a farmers market was the community change – providing healthy food and a meeting place (DeBate et al, 2004).

9.e Two studies note that to sustain the provision of healthier food options, communities need to take them up and so they need to be made attractive and clear (Khunti et al, 2008 & Rosecrans et al 2008).

9.f One study found that community projects were largely unwilling address smoking, preferring to promote physical activity (Blamey et al, 2004).

5.7.4. Staffing

Six studies reported on two overarching themes about staffing in general that emerged as important: staff hiring and retention, and the types of staff required.

Staff recruitment and retention is important for effective programme delivery, but this may be hindered in a number of ways. As described above, (Section 5.6.1) one study found that a "turbulent political and financial context" within local NHS bodies negatively affected staffing (Blamey et al 2004). At a meso-level, another felt that it was difficult to recruit qualified staff to support new programmes, and that this was especially challenging where the new project work was being integrated into existing health care centres (Mays et al, 2004). One other study notes that high staff turnover and "role overload" were barriers to successful capacity building (Joffres et al 2004b) while another suggests that staff turnover affects the ability of the project to maintain consistent support at multiple levels (Alberta Health 1998).

Staff contributed in a number of ways to the organisational success of programmes. One study notes that that networking between member organisations allowed staff to use their time effectively because they were not duplicating activities (Joffres et al 2004b). In another, the programme required existing organisations to either create new structures, or a re-orientation of existing structures in order to focus on heart health issues (Maclean et al 2003). Staff needed to have role flexibility so that they could spend significant periods of time with some participants and their families (Peerbhoy et al, 2008).

Involving a range of specialist staff (such as school nurses, dieticians and smoking cessation staff) is reported as helping successful programme implementation (Peerbhoy et al, 2008). Knowledge and interest in heart health among staff is seen as important in two studies (Joffres et al 2004b; MacClean et al 2003), although MacLean et al (2003) saw this as a benefit that developed out of being involved in a CVD programme. Another study identified personal characteristics – such as being upbeat and friendly - of staff to be very important and that this could help retain project participation (Peerbhoy et al, 2008).

Evidence statement 10: Staffing
10.a Five studies reported on staffing successful programmes (Alberta Health 1998 [-]; Joffres et al 2004b [++]; Maclean et al 2003 [+]; Mays et al, 2004 [-] & Peerbhoy et al, 2008 [-]). 10.b Three studies report difficulties in recruitment (Mays et al, 2004) and retention (Alberta Health 1998 & Joffres et al 2004b). 10.c Positive staff contributions were defined in three studies where successful networking allowed staff to use their time effectively because they were not duplicating activities (Joffres et al 2004b); where they were assisted by structures that focus on heart health issues (Maclean et al 2003) and where flexibility allowed them to spend significant periods of time with participants (Peerbhoy et al, 2008). 10.d Positive staff characteristics included knowledge and interest in heart health (Joffres et al 2004b; MacClean et al 2003) and being upbeat and friendly (Peerbhoy et al, 2008). A range of specialist staff should be involved (Peerbhoy et al, 2008).

5.7.4.1. Funding and resources

Four study reports note the need for those with existing roles and responsibilities to be given resources to take on the additional CVD programme work. Competing work priorities for staff were barriers to success programme delivery (Joffres et al, 2004b) and, in particular, a failure to free up time for senior staff involvement (Blamey et al, 2004). Two studies report that successful programmes were those for which people and materials were available (Mayer et al, 1998; Mays et al, 2004). One project noted that the creation of a dedicated position for heart health was needed (Maclean et al 2003). Where new roles were taken on by existing services and there was limited capacity, this challenged the ability of the health centres to be integrated into the programme (Mays et al, 2004).

Three projects with a school-based component also noted that demands on teacher workloads were already heavy (Alberta Health, 1998), and there was limited time for extra-curricular activities (Khunti et al, 2008; Rosecrans et al 2008). Achieving an expanded core of volunteer workers was seen as a challenge and, moreover, while

participants saw themselves as a key project resource, they also needed outside resources (Alberta Health, 1998).

Evidence statement 11: Staffing - funding and resources
11.a Six study reports make specific comments about funding and resource requirements (Alberta Health, 1998 [-]; Blamey et al, 2004 [-]; Joffres et al, 2004b [+]; Khunti et al, 2008 [+]; Maclean et al 2003 [-]; Mays et al, 2004 [-] & Rosecrans et al 2008 [-]) 11.b Five study reports note the need for those with existing roles and responsibilities to be given resources to take on additional CVD programme work, or for dedicated positions to be created (Alberta Health, 1998; Blamey et al, 2004; Joffres et al, 2004b; Khunti et al, 2008; Maclean et al 2003 & Rosecrans et al 2008). Limited time for school based staff may be a particular problem (Alberta Health, 1998; Khunti et al, 2008 & Rosecrans et al 2008).

5.7.4.2. Communication

Two studies identify effective communication to be important, but have different project staffing arrangements to achieve this. For the WISEWOMAN programm, Lay Health Advisors (LHAs) were seen as the link between project staff and the community – ensuring that ideas and information flowed in both directions (Viadro et al 2004). For Heart Health Nova Scotia, communication between levels of project staff and between different organisational levels was seen as important and this was facilitated by a full time project co-ordinator, and a project website (Joffres et al 2004b).

Evidence statement 12: Staffing - communication
12.a Two studies identify effective communication between organisations, staff and the community, to be important, but use different mechanisms to achieve this - Lay Health Advisors (Viadro et al 2004 [-]) or having a full time project coordinator (Joffres et al 2004b [+])

5.7.4.3. Volunteers

Recruiting and maintaining volunteers to take programmes into the community was a key element reported in six studies. Two studies suggest that leadership is needed to maintain volunteer interest and support (Alberta Health, 1998; Dressendorfer et al, 2005), although another report notes that witnessing positive change in individuals and the community motivated people to continue volunteering (DeBate et al, 2004). In contrast, a third study suggested that some volunteers are less motivated by the long term goals of health promotion than traditional practices such as patient services, and feel less satisfaction in this health promotion role (Joffres et al, 2004b). Volunteer groups require adequate resourcing, especially if they are to expand (Alberta Health, 1998).

Two studies about the WISEWOMAN programme found that their local, lay health advisors/ promoters (LHAs) were key to programme success (DeBate et al 2004; Viadro et al 2004). In particular they were able to recruit members of the community to take part in the programme, and the fact that they were from the same ethnic group was considered important for this (see Section 5.7.6). They also helped participants to overcome day to day issues such as completing paperwork and helping them to access services (Viadro et al 2004). The LHAs were motivated to join because they were committed to improving their local community, and continued when they saw increased awareness of health issues, felt a sense of community and had support from other LHAs (DeBate et al 2004).

Evidence statement 13: Staffing - volunteers
13.a Four study reports discuss recruiting and retaining programme volunteers (Alberta Health, 1998 [-]; DeBate et al, 2004 [+]; Dressendorfer et al, 2005 [-]& Joffres et al, 2004b [+]).
13.b Volunteers need adequate resourcing and leadership, and may be motivated by witnessing positive changes in the community (Alberta Health, 1998; Dressendorfer et al, 2005).
13.c One study suggest that volunteers find health promotion less satisfying than traditional patient service roles (Joffres et al, 2004b).
13.d Two study reports about the same programme note that Lay Health Advisors, recruited

form the target community, were key (DeBate et al 2004 & Viadro et al 2004).

5.7.4.4. GPs

Two UK study reports mention the role of GPs in community CVD projects, with one noting that GP uptake was slow (Peerbhoy et al, 2008) and another suggesting that GPs were less comfortable in primary prevention and health promotion roles than their traditional role of secondary prevention. It was not clear to them how primary care should operate in the context of a community-based initiative, nor how they could fulfil their role in managing staff (such as community nurses) who were more closely involved with the frontline delivery of the programme (Blamey et al 2004).

Evidence statement 14: Staffing – GPs

14.a Two study reports mention the role of GPs in community CVD projects (Blamey et al 2004 [-]; Peerbhoy et al, 2008 [-]).

14.b GP uptake was slow (Peerbhoy et al, 2008) and it is suggested that GPs may be less comfortable in health promotion roles than their traditional role of secondary prevention (Blamey et al 2004).

5.7.4.5. Training

Issues relating to staff training were identified by six study reports. Two studies simply note that skills training was necessary for staff members for programmes to be successful (Goodman et al, 1995; Mayer et al 1998). For some, it was felt that involvement in the programme and its evaluation itself increased staff knowledge and developed skills (Goodman et al, 1995; Khunti et al, 2008). This is also noted by Maclean et al (2003) who detail the areas where improvement was seen as relating to advocacy, team building, group facilitation, evaluation, population health and heart health issues. This point is extended by three other studies which discuss mechanisms of skill and knowledge development. Joffres et al (2004b) note that informal sharing of information was important, and that using the skills and knowledge acquired in training sessions and through research while implementing activities, helped this information to spread. This was also seen by Maclean et al (2003) who report that training workshops were supplemented by partnerships and community

activation teams, so that theoretical knowledge could gain applied understandings. Puska et al (1986) suggest that most staff preferred sharing experiences with others to formal training sessions which, in some cases, were regarded as project "propaganda." Khunti et al (2008) also note that a reluctance to accept a need for change among staff was a barrier to promoting healthier lifestyles.

Evidence statement 15: Staffing – training
15.a Evidence relating to staff training were identified by six study reports (Goodman et al, 1995 [-]; Joffres et al 2004 [++]; Khunti et al, 2008 [+]; Maclean et al, 2003 [+]; Mayer et al 1998 [-] & Puska et al, 1986 [-]). 15.b While skills training is needed (Goodman et al, 1995 & Mayer et al 1998), involvement in the programme itself increases skills and knowledge (Goodman et al, 1995; Khunti et al, 2008 & Maclean et al, 2003) through sharing information and implementing theoretical knowledge (Joffres et al 2004b; Mayer et al 1998 & Puska et al, 1986).

5.7.5. Evaluation

Four studies report the theme of evaluation of CVD prevention programmes. Process evaluation and action research was seen by two study reports as raising self awareness, establishing areas on which to focus and promoting improvements (Joffres et al, 2004b; Khunti et al, 2008).

> *It's made us look at ourselves, opened our eyes to a few truths we didn't think were there, it has made us more ware of our strengths and weaknesses and gave us a basis to act from. (participant quote. Joffres et al, 2004b)*

However, a further study notes that timely feedback of knowledge, attitude and behaviour data from the target community to the staff is challenging (Blamey et al, 2004).

Challenges of evaluation are also noted in two other studies, one highlighting the problems of managing data for long term programmes (Alberta Health, 1998) and the other finding the same in programmes that had multiple strands and partner organisations (Mays et al, 2004).

Evidence statement 16: Evaluation
16.a Five study reports relate to the evaluation of CVD prevention programmes (Alberta Health, 1998 [-]; Blamey et al, 2004 [-]; Joffres et al, 2004b [+]; Khunti et al, 2008 [+]; Mays et al, 2004 [-]). 16.b Two study reports found that process evaluation and action research raised self awareness among staff and promoted programme improvement. (Joffres et al, 2004b & Khunti et al, 2008) while a third reports that time limited projects limit the possibility of such learning (Blamey et al, 2004). 16.c Data management was a challenges in long term projects (Alberta Health, 1998) and those with multiple strands across a number of organisations (Mays et al, 2004)

5.7.6. Community engagement

As noted above, mobilising the community and changing local attitudes is seen as a key process and benefit of community based projects. Eight studies report issues relating to the theme of community engagement of CVD risk reduction projects.

Mayer et al (1998) regard community engagement as key to successful project coalitions which, additionally, can strengthen the representation of a community's interests in the broader political and social system and increase the ability and confidence of the community to work together to influences political and social actions on health.

In terms of how communities were involved with the planning, design and engagement of the projects, Alberta Health noted that there were mixed results, with the perception that the same small core group was responsibly for most of the decisions made (Alberta Health 1998). Blamey et al (2004) also noted that they were "relatively unsuccessful" at engaging community representatives at a strategic level, but were unclear why. There was a perception among the Alberta Heart Health staff that the community was not ready for this kind of involvement, although involving community members in creating and articulating visions and goals was an aim project:

> *I still think that this was not a community development project. We are still trying to mobilise people. They are not at that level yet – of making decisions on their own. (participant quote, Alberta Health, 1998)*

They suggest that building confidence in community leaders is a challenge for community engagement, particularly in trying to enhance the potential for community leadership. Two-way communication is needed and project staff also need to learn how to successfully work with communities.

Blamey and colleagues (2004) suggest that some communities were difficult to engage because they had negative experiences of previous initiatives, in which they had found that their needs were not addressed properly or where venues or facilities were lacking. Brannstrom et al (1994) also note a lack of enthusiasm for community participation. They suggest that this may be due to the nature of "health" as an issue:

> *We have not equivalent of tree-lovers as regards health- not like people who love forests and the environment. There is no real public participation…It would be very exciting to have an eager participation and people who would almost fight for this concept. (Participant quote, edit in original, Brannstrom et al, 1994)*

By contrast, Goodman et al (1995) suggest that there is increasing community readiness to engage in the health promotion programmes within the community. Similarly, Levy et al (2004) report that staff believed that programmes should be located within the community, and that such programmes would be supported by the community. These are refutational findings that perhaps show some naivety about the challenges of engaging properly with communities. Challenges noted by included studies are described below.

The Alberta Heart Health project suggests a number of challenges to engaging the community, including difficulties breaking into existing community networks and communication systems (Alberta Health, 1998). As discussed below (Section 5.7.1), short time frames limited programme ability to engage communities. One study suggested that multiple approaches were required to engage communities, including through outreach to community leaders and individuals providers (Viadro et al 2004). Similarly, Mayer et al (1998) suggest that success required planned activities to encompass a range of population groups and health concerns.

Two studies suggest that successful programmes need to be sensitive to the community's "habits and cultural patterns," with studies that were too "professional" and not rooted in the local community (Brannstrom et al, 1994). The Alberta Heart Health Program study suggest that competing with other community events (personal, such as weddings and community, such as sports) could be a challenge, and that the "rhythms of rural life" needed to be accommodated although it is not entirely clear to what this latter alluded (Alberta Health, 1998).

The Alberta Heart Health project suggests that community members who responded positively to their project were mostly those who were already aware of heart health issues, suggesting that the target groups were not always reached (Alberta Health, 1998). A possible explanation for this is seen in Brannstrom et al (1994), who suggest that higher levels of education already facilitated healthier lifestyles, while strongly worded "forceful" health information messages were thought to further exclude the less educated.

Two study reports (relating to the same programme) found that staff were not well matched to the social and/or ethnic characteristics of the targeted population, so that some groups, such as Latinos, African Americans, poorer communities and men, were not well reached by the project (Goodman et al, 1995; Levy et al 2004). This could be due to language incompatibility as well as general feelings of exclusion:

> *I still figured it as a white middle class thing, white upper class type program with running and smoking cessation and that type of thing. (Goodman et al, 1995)*

One of these reported that African Americans felt that providers were condescending and disrespectful (Levy et al 2004). Another study noted the importance of local health promoters to ensure familiarity with the local communities (Viadro et al 2004, see Section 5.7.4)

Young people and young families were also found to be hard to reach in three projects (Goodman et al, 1995 and Alberta Heart Health (Alberta Health, 1998 respectively). One study reports that adolescents see changes in eating and exercise habits as more relevant to older people than themselves (Khunti et al, 2008).

Evidence statement 17: Community engagement
17.a There is evidence from eight study reports about community engagement in CVD prevention programmes (Alberta Health, 1998 [-]; Blamey et al, 2004 [-]; Brannstrom et al, 1994 [-]; Goodman et al, 1995 [-]; Khunti et al, 2008 [+]; Levy et al, 2004 [+]; Mayer et al,1998 [-] & Viadro et al 2004, [-]). 17.b Two study reports suggest that successful community engagement requires multiple approaches across populations (Mayer et al,1998 & Viadro et al, 2004). 17.c Two study reports suggest that successful programmes need to be sensitive to communities' habits and cultural patterns (Alberta Health, 1998 & Brannstrom et al, 1994), while a further three describe the important of matching programme staff to the social and/or ethnic characteristics of the target communities (Goodman et al, 1995; Levy et al, 2004 & Viadro et al 2004). 17.d Challenges to community engagement include engaging community representatives at strategic levels (Alberta Health, 1998; Blamey et al, 2004); building confidence in community leaders (Alberta Health, 1998); difficulties breaking into existing networks (Alberta Health, 1998; Viadro et al 2004); competing with other community events (Alberta Health, 1998); reaching young people (Alberta Health, 1998; Goodman et al, 1995); reluctance due to the legacy of negative experiences with previous initiatives (Blamey et al, 2004); lack of enthusiasm in the community (Brannstrom et al, 1994).

5.7.7. Local access

Seven studies report that the local physical environment, issues which we have labelled "local access", had important effects on the ability of community CVD risk reduction projects to be successful.

Five studies reported that access to healthy food options was limited, while unhealthy food was more visible. This was true both for communities in general, and for school based elements where included. Dietz et al (2001) report that low calorie alternatives were not available in school cafeterias or in vending machines. Local fast food outlets were prevalent (Jilcott et al, 2007; Khunti et al, 2008; Peerbhoy et al 2008) with Khunti et al (2008) also noting a that a burger van was parked near the school gates. These were seen by pupils as offering value for money, more choice and a change of

surroundings (Khunti et al, 2008). Rosecrans et al (2008) found that those in remote areas found it difficult to access healthy foods, while Jilcott et al (2007) suggested that urban and downtown areas, as well as rural, might not have large supermarkets where prices were lower and choice greater than the available corner shops. Urban areas also lacked farmer's markets or product stands selling fresh fruit and vegetables (Jilcott et al 2007).

Two studies discuss barriers to physical exercise that related to issues of local access. Walking as a form of exercise was perceived as difficult where there were unmetalled roads (reflecting the urban nature of the community), where dogs were loose and not controlled (Rosecrans et al 2008) and where no sidewalks were provided despite heavy traffic (Jilcott et al 2007).

One UK study found that lack of school facilities such as changing rooms, and safe storage for PE kit and for bicycles prevented pupils bringing in kit for extra-curricular activities (Khunti et al, 2008).

In terms of where people might formally exercise, three studies noted different aspects. One suggested that access to transport limited people's ability to access gyms and other locations (Harralson et al 2007) while the other suggested that facilities available at school should be used by the community generally, but that access and availability were very limited (Jilcott et al 2007). Finally, one UK study noted that "territorialism" and local politics prevented people from using facilities or venues in neighbouring areas and from participating in community activities there (Blamey et al, 2004). This restriction was not confined to exercise facilities.

Evidence statement 18: Local access
18.a Seven studies report that the local physical environment had important effects on the ability of community CVD risk reduction projects to be successful (Blamey et al, 2004 [-]; Dietz, 2001 [-]; Harralson et al 2007 [-]; Jilcott et al, 2007 [+]; Khunti et al, 2008 [-]; Peerbhoy et al 2008 [-]; Rosecrans et al, 2008 [-]). 18.b Five studies reported that access to healthy food options was limited, while unhealthy food was more visible, both in the community and in school based programmes (Dietz, 2001; Jilcott et al, 2007; Khunti et al, 2008; Peerbhoy et al 2008; Rosecrans et al, 2008).

18.c Local barriers to physical activity including no sidewalks, unmetalled roads or loose dogs (Jilcott et al, 2007; Rosecrans et al, 2008); lack of school provision to secure bikes or store kit which discourages extra-curricular exercise (Khunti et al, 2008); and local availability of gyms or other facilities (Harralson et al 2007 & Jilcott et al, 2007).

5.7.8. Community and familial norms

Eight study reports report on issues relating to community and familial norms, including themes of cultural attitudes towards low fat food, exercise and weight, and these are discussed below.

One study among British Asians found that stress was a noted problem among both men and women and this might lead to inability to access essential services or to communicate with professionals (Netto et al, 2007). Men from Sikh, Bangladeshi and Pakistani communities reported feeling under stress because of the pressures of providing materially for their family, both in the UK and extended family living abroad. This might be added to by financial pressures related to the high costs of daughters' weddings. For women, stress was related to isolation, lack of informal support and language barriers (Netto et al, 2007).

Evidence statement 19: Community and Familial Norms

19.a There is evidence from one study report among British Asians that that stress from a variety of sources was a noted problem among both men and women and this might lead to inability to access essential services or to communicate with professionals (Netto et al, 2007 [++]).

Attitudes to food and cooking

Three study reports discuss cultural attitudes to food. Moreno et al (1997) suggest that food is an important expression of cultural identity and this is borne out by the findings of two other studies. All three suggest that cultural food norms were a potential barrier to healthier eating, with preferences for fried foods, a focus on meat dishes, or a preference for food with a high fat content reported among African

Caribbean (Goldberg et al, 1999), Latino American (Moreno et al, 1997) and British South East Asian (Netto et al, 2007) communities.

> *We like our little soups with their fat because they are tastier. And we do not realise that we are hurting ourselves because we are determined to preserve our customs (participant quote, Moreno et al, 1997).*

In addition baking, rather than frying, food was negatively described by some Latinos as a "lazy" method of cooking (Moreno et al, 1997).

These same studies report other potential difficulties related to food intake, for example, respondents from South East Asian communities emphasised obligatory patterns of food intake as part of hospitality and frequent social events, such as weddings, where eating and drinking were central (Netto et al, 2007). Moreno et al (1997) report changed eating habits on immigrating into the USA, so that new work patterns only permitted one or two meals a day, rather than three and that these were often "fast food" because of time pressure.

Evidence statement 20: Community and Familial Norms - attitudes to food and cooking
20.a There is evidence from three study reports that specific foods and eating patterns may be regarded as important expressions of cultural identity. Cultural norms about food types and their preparation may not be the most healthy from a CVD prevention perspective (Goldberg et al 1999 [-]; Moreno et al, 1997 [-] & Netto et al, 2007 [++]).

Attitudes to weight and exercise

Three studies among two different ethnic groups report that obesity is not necessarily seen as negative (Netto et al, 2007; Dietz et al 2001; Goldberg et al 1999). One study reports cultural associations between wealth and weight among Asian communities:

> *We were told that fat children were healthy children. Now there is this concept of skinny children being healthy and all that (participant quote, Bangladeshi woman).*

> *When I went to Pakistan, people remarked on how thin I was and said "Don't you eat in the UK? It is meant to be a prosperous country." (participant quote, Pakistani woman Netto et al, 2007)*

It is also noted that African American girls and women did not perceive that physical attractiveness was linked to lower weight (Dietz et al 2001; Goldberg et al 1999). However, healthier eating was seen to benefit personal appearance, as participants mentioned improved skin and more youthful looks as well as improved mood:

> *You feel better about yourself.*
>
> *You feel energised. (participant quotes, African American women Goldberg et al 1999)*

Khunti et al, (2008) suggest that cultural commitments such as attending mosque may limit time for physical activity. They also suggest that interest in sport is generally higher in boys, than girls.

Dietz et al (2001) explore the understandings of different terms relating to weight and physical activity among African American respondents. They note that "underweight" is a term associated with adolescents with eating disorders, "overweight" is associated with people who eat too much, rather than referring to physical state and that "obesity" is only applied to those who were grossly and morbidly overweight (Dietz 2001).

The same study found that there is a distinction drawn between the understandings of "exercise" and "physical activity", with the former mostly regarded as a response to being overweight (and so perhaps not enjoyable) while the former is seen as more spontaneous, unregimented movement that was enjoyable (Dietz 2001). This is echoed by Kim et al (2004) who found participants enjoyed and benefited from integrating exercise into their daily routine, such as by walking more. In addition, Jilcott et al (2007) identify the expense of gyms as a barrier to their use (see Section 5.6.2), so such "informal" physical activity, which is free, may be more accesible. Peerbhoy et al (2008) also found that gyms were not seen as appealing places to exercise, but participants associated exercise with scheduled classes rather than something they could organise for themselves.

Evidence statement 21: Community and Familial Norms - attitudes to weight and exercise
21.a There is evidence from three study reports about cultural attitudes to weight and exercise (Dietz et al 2001 [-]; Goldberg et al 1999 [-] & Netto et al, 2007 [++]). 21.b These suggest that, among some groups, understandings of greater weight as a sign of wealth and health may persist which may challenge successful adoption of CVD prevention activities (Dietz et al 2001 [-]; Goldberg et al 1999 [-] & Netto et al, 2007 [++]). 21.c Further, specific connotations of language used to describe weight and physical activities may exist, so shared understandings between clinical and community meanings should not be assumed (Dietz et al 2001 [-]).

Fatalism and health

One study among Latinos in the USA suggests that "fatalismo", the acceptance of one's fate as God's will, might impede preventative health practices (Harralson et al, 2007). Fatalistic views were also reported among South Asian participants in the UK (Netto et al 1997)

> *Only God knows why heart disease occurs. I feel that if anyone has heart disease, they will not be cured" (participant quote, Bangladeshi woman, Netto et al 2007).*

Extending this, Emmelin et al (2007) suggest that the CVD programme itself challenged the idea that "health is a gift from God" instilling instead a sense of personal responsibility for health. This was in relation to a long term, 10-year project based in Norsjo, Sweden.

An additional Catholic influence is reported by Harralson et al (2007) in the form of "Marianismo" in which people may emulate the Virgin Mary by enduring suffering, rather than seeking to relieve it.

Thus, fatalistic attitudes to health were reported in three study reports among quite different ethnic groups, suggesting such attitudes cross-cut communities, and may

relate to other factors – such as religiosity or disempowerment. A possible benefit of CVD programmes may be to encourage personal responsibility for health.

Evidence statement 22: Community and Familial Norms – fatalism and health
22.a There is evidence from three study reports, among three different ethnic groups, of fatalistic attitudes where one's state of health is the will of God (Emmelin et al, 2007 [++]; Harralson et al, 2007 [-] & Netto et al, 2007 [++]).

Beyond the individual

Following on from the above, six studies suggest that a benefit of a community CVD programme is in providing leadership that permits local attitudes to change for the better. For example, DeBate et al (2004) suggest that a sense of community was both fostered by, and fostered, a sense of local "fellowship" or "social health" among targeted local residents. This sense of increased "social health", in addition to changes in physical health, and encouraged continued participation (DeBate et al (2004). The Alberta Heart Health project report that the programme gave members of the community the confidence to insist on changes such as banning smoking in the community hall (Alberta Health 1998). Mayer et al (1998) also saw successful programmes as increasing community empowerment which can, in turn, strengthen the representation of a community's interests in the broader political and social system and increase the ability and confidence of the community to work together to influence political and social actions on health.

DeBate & Plescia (2004) also suggested that there was a broader familial benefit, with participants promoting positive eating and exercise behaviours to other members of their family. Brannstrom et al (1994) also believe that active citizens' health behaviours could positively influence those of less active citizens. However, health seeking behaviour may not be affected - Levy et al (2004) suggests that women, especially younger women, are more likely to access health services, because of contact with maternal child health services, whilst adult men "underused available health care services".

Evidence statement 23: Community and Familial Norms – beyond the individual
23.a There is evidence from six study reports to suggest that a benefit of community CVD programmes is in providing leadership that encourages local attitudes to change for the better (Alberta Health, 1998 [-]; Brannstrom et al, 1994 [-]; DeBate et al 2004 [+]; Levy et al, 2004 [+]; Mayer et al,1998 [-] & Netto et al, 2007 [++]). 23.b As well as making personal changes, such "social health" encouraged changes within the family (DeBate & Plescia, 2004), within the local community (Alberta Health, 1998; Brannstrom et al (1994); DeBate et al, 2004; Mayer et al, 1998) and within the wider social and political community (Mayer et al, 1998). Despite this, one study suggests that men remain less likely to use health services (Levy et al, 2004).

5.8. Micro level findings

Summary evidence statement: Micro-level findings

Micro level findings, relating to the individual, were also reported by 16 study reports, and relate to understandings of CVD risk, motivation and resistance and programme perceptions.

Understandings of CVD risk vary, and may not translate into healthy behaviours.

One study suggests that people may set greater store by experiences than theoretical knowledge of risk. Experiences which affect self image, and changes in social networks may be the greatest impetus to change (Meillier et al, 1998)

One study developed a typology of six "ideal types" of functional and dysfunctional attitude among programme participants who see it as a blessing, an opportunity, a confirmation, a watchman, a disappointment or an insult. The latter two are negative or "dysfunctional" in terms of positive health choices and more men have these attitudes (Emmelin et al, 2007).

Being ill or receiving physiological test results could be motivate CVD risk reduction. Families may be targeted as a unit but it may be difficult to initiate and maintain changes when other aspects of family life may compete. Resistance from family members is a barrier to adopting heart health behaviours.

Participant perceptions of programmes benefits included weight loss, increased exercise, increased awareness and use of services and programme activities and the creation of networks providing community support. Participants may doubt the credibility of health messages, due to the volume of, sometimes contradictory, information available. Matching the characteristics of the community may be important.

5.8.1. Understandings of CVD risk

Nine studies discuss community perceptions of CVD risk factors. Six studies report high levels of understanding about CVD risk among the target population – especially around healthy diet, exercise and smoking (Blamey et al, 2004; Dietz, 2001; Goldberg et al, 1999; Moreno et al, 1997; Rosecrans et al 2008) but also stress (Netto et al, 2007).

Two studies suggests that there was a lack of specific elements of basic knowledge among the targeted community, such as how to incorporate low fat food in the diet or reservations about fresh fruit because of concerns about pesticides (Goldberg et al, 1999), or of risk factors in general (Levy et al, 2004). Further, one study notes that knowledge often did not translate into healthy behaviour (Dietz, 2001), potentially limiting the impact of educational interventions.

Only one study report attempts to explain this phenomenon (Meillier et al, 1998). They note that different patterns of logic may be present among recipients of heath messages and the promoters. There were a number of anecdotes about people with unhealthy lifestyles living a long time, and *vice versa* which are seen as a challenge to the credibility of heart health programmes. In addition, participant goals may be more about wellbeing, enjoyment and socialisation than the adoption of preventative behaviour.

Based on Shirriff's 1990 framework (where knowledge is seen as the sum of intuition, information and experience), they categorise four types of knowledge :

- Theoretical knowledge
- Practical knowledge
- Experiential knowledge
- Intuitive knowledge

They suggest that where there is a discrepancy between theoretical and experiential knowledge, the latter gains more stress and this influences what participants say and do. It is therefore difficult for health education messages to penetrate what is, to the holder, a consistent alignment of attitude and experience (Meillier et al, 1998). These links might be challenged by cues to action (as identified by the Health Belief Model) of illness, illness in others, breakdown of self image, overstepping of limits and social networks. Meillier et al (1998) found that the most significant of these were breakdown of self image, and social networks.

Emmelin et al (2007) offer another interpretation of why some people respond positively and others negatively towards the same CVD programme. They note a complex interaction between people's feelings and their willingness and ability to

adopt the new health related norms needed to prevent disease. Emmelin et al (2007) develop a typology of six "ideal types" of functional and dysfunctional attitude sets which are described in Box 1. Participants are defined as seeing the programme as a blessing, an opportunity, a confirmation, a watchman, a disappointment or an insult. The latter two are negative or "dysfunctional" in terms of positive health choices. The

authors hypothesise that there are more men in the "confirmation" and the "insult" types, perhaps as a result of their pride being injured if they were not able to make positive changes, leading to them feeling ashamed.

Box 1: Ideal Types Described by Emmelin et al 2007

The Blessing People who saw the intervention as a blessing saw it as something bigger than themselves, that came from outside of themselves, to their rescue and for which they were grateful. Whilst they had previously known something was wrong, they didn't know how to cope with it and had not attended primary care.

The Opportunity People who saw the intervention as an opportunity were similar to those to above, but had a feeling of relief that was connected to pride and which was about people's own choices and behaviour rather than that of the programme implementers or doctors. The intervention gave them the opportunity to mobilise their own resources against illness which they recognised in themselves, and so they felt proud of themselves.

The Confirmation People who saw the intervention as a confirmation were influenced by both internal and external forces. Internal forces related to feelings of participation and empowerment. They interpreted the intervention as increasing their self-control. It wasn't seen as *changing* individual risk factors, but rather as providing external recognition that these people were already on the right track.

The Watchman People who saw the intervention as a watchman, viewed it as a common good of which they were to be proud. This reflected their general concern for the community and created a feeling of trust in the intervention.

The Disappointment People who saw the intervention as a disappointment had high expectations of the programme that they felt were not met. They felt ignored by the programme, and in need of more help that it could offer. Some had problems that did not fit into the risk groups identified in the programme.

The Insult People who saw the intervention as an insult were ambivalent about it, even though some had applauded it at the start. Their participation was based more on feelings than on heath problems. Whilst they may have had the targeted risk factors, they were unable to meet the demands of the programme, and felt criticised because of this. The ambition of the programme was regarded with suspicion.

Evidence statement 24: Understandings of CVD risk
24.a Nine studies discuss community perceptions of CVD risk factors (Blamey et al, 2004 [-]; Dietz et al 2001 [-]; Emmelin et al 2007 [++]; Goldberg et al, 1999 [-]; Levy et al, 2004 [+]; Meillier et al 1998 [-]; Moreno et al, 1997 [-]; Netto et al, 2007 [++] & Rosecrans et al 2008 [-]). 24.b Six studies report high levels of understanding about CVD risk among the target population (Blamey et al, 2004; Dietz, 2001; Goldberg et al, 1999; Moreno et al, 1997; Netto et al, 2007; Rosecrans et al 2008) while two suggest limited understanding (Goldberg et al, 1999 & Levy et al, 2004) and two suggest challenges in turning knowledge into action (Dietz 2001 & Meillier et al 1998). 24.c Meillier et al (1998) suggest that different types of knowledge are at play (theoretical, practical, experiential and intuitive), and where there is a discrepancy between theoretical and experiential knowledge, the latter influences what participants do. These links might be challenged by cues to action (Health Belief Model) - most significantly breakdown of self image and social networks. 24.d Emmelin et al (2007) develop a typology of six "ideal types" of functional and dysfunctional attitude among programme participants who see it as a blessing, an opportunity, a confirmation, a watchman, a disappointment or an insult. The latter two are negative or "dysfunctional" in terms of positive health choices and more men have these attitudes.

5.8.2. Motivation or resistance

Nine study reports discuss people's motivations for, or resistance to, adopting risk reduction behaviours. Levy et al (2004) and Harralson et al (2007) both report that there was a desire within the community to make lifestyle changes, with the latter adding that women wanted to exercise in order to manage their weight, improve their mood and enhance their appearance and sense of wellbeing. Meillier et al (1998) suggest that healthy habits of diet, exercise, stopping smoking, reducing stress and weight loss are seen as interlinked, and that it is often seen as easier to start with exercise or stress, and these will lead to changes in other areas.

Women were targeted to take heart health practices home in several programmes. However, two studies report on difficulties initiating or maintaining family interest (by which they mean husbands and children) in changing to healthier eating habits (Kim et al, 2004; Levy et al 2004). Kim et al (2004) further report that establishing a smoke free home was difficult where more than one member of the (extended) family smoke. In Peerbhoy et al, 2008, mothers and fathers said that it is difficult to maintain behaviour changes amidst the usual business of family commitments:

> *Something silly like washing and drying the kids hair after swimming is such a hassle. (Mother).*
>
> *I end up thinking "oh stuff it!" and just cooking them chips instead. (Father, Peerbhoy et al, 2008)*

Peerbhoy et al (2008) note that some families have low motivation for change, but do not suggest any mechanisms to address this. Kim et al (2004) also note that resistance to exercise from family members was a barrier to other family members' participation.

Current health concerns were motivating factors to participate (DeBate et al, 2004) with one study going further and suggesting that serious or life threatening illnesses motivated healthy eating (Goldberg et al 1999). Two studies report that feedback of physiological test results was motivating for participants (Mayer et al 1998; Peerbhoy et al, 2008).

Meillier et al (1998) suggest that there is resistance to "being told what to do" – in other words, that people resist the way that they are told, rather than the health issues *per se*. In addition, Netto et al (2007) suggest that there is a need for ongoing support in order for behavioural changes to be made and maintained.

Khunti et al, 2008 found that secondary school pupils enjoyed the freedom to make food choices that hadn't been a feature of primary school and that this was a potential challenge to encourage healthier choices as pupils' food choices were motivated by elements other than health, such as taste, hunger satisfaction and peer pressure. Such influences are not restricted to pupils as Goldberg et al, (1994) found some participants' perceived that healthy food was less tasty than unhealthy options.

Evidence statement 25: Motivation or resistance
25.a Nine study reports discuss people's motivations for, or resistance to, adopting risk reduction behaviours (DeBate et al, 2004 [+]; Goldberg et al, 1999 [-]; Kim et al, 2004 [+]; Khunti et al, 2008 [+]; Levy et al 2004 [+]; Mayer et al, 1998 [-]; Meillier et al, 1998 [-]; Netto et al, 2007 [++]; Peerbhoy et al, 2008 [-]). 25.b Two studies report that health concerns, sometimes serious, were motivating factors to participate (DeBate et al, 2004 & Goldberg et al 1999) and two that feedback of physiological test results was motivating (Mayer et al 1998; Peerbhoy et al, 2008). 25.c Women may be targeted to take heart health practices home, however, two studies report on difficulties initiating or maintaining family interest (Kim et al, 2004 & Levy et al 2004) and that resistance from family members was a barrier to adopting healthier behaviour (Kim et al, 2004) It is difficult to maintain behaviour changes amidst the usual business of family commitments (Peerbhoy et al, 2008). 25.d Netto et al (2007) suggest that there is a need for ongoing support in order for behavioural changes to be made and maintained. 25.e One study found that secondary school pupils enjoyed the freedom to make food choices no available at primary school - pupils' food choices, and those of the wider population, may reflect issues other than health (Goldberg et al, 1994; Khunti et al 2008).

5.8.3. Programme perceptions

Six studies report on participants' perceptions of programmes in which they were involved.

Participants reported improving heart health through weight loss, increased exercise, as well as increased awareness and use of services and programme activities, in one case this was mostly through referrals by primary care providers to programme activities (DeBate et al, 2004), whilst another identified use of media, signs and literature, together with the efforts of programme "champions" as effective in disseminating information about the programme (Goodman et al, 1995). The emergence of crucial networks which provided community support for heart health

changes was a benefit of the programme identified by participants (DeBate et al, 2004).

Rosecrans et al (2008) found that practical demonstrations, such as those for healthy eating, were much more successful than theoretical information, such as that provided in leaflets.

> *Pamphlets [involve] a lot of reading…but I find that the food sampling gives them the opportunity to feel comfortable, a little bit more relaxed, and they seem to think of questions to ask us as they're eating. (Edit in original. Community health representative. Rosecrans et al, 2008)*

Two studies suggest that the participants may doubt the credibility of health messages, with so many sources of, sometimes contradictory, information available (Moreno et al, 1997; Meillier et al, 1998). Goodman et al (1995) found among their African-American participants that the most credible source of health information was repeatedly found to be participants' mothers. However, physicians, nutritionists, and health professionals, especially if they were African-American and female, were also perceived by some to be credible sources of advice (Goodman et al, 1995). Matching the ethnicity of health educators to that of the target community may, therefore, be important.

Evidence statement 26: Programme perceptions
26.a Six studies report on participant perceptions of programmes in which they were involved (DeBate et al, 2004 [+]; Goodman et al, 1995 [-]; Meillier et al, 1998 [-]; Moreno et al, 1997 [-]; Rosecrans et al, 2008 [-]). 26.b In two studies participants reported improving heart health through weight loss, increased exercise, as well as increased awareness and use of services and programme activities (DeBate et al, 2004 & Goodman et al, 1995). One study also suggests that networks providing community support was a benefit (DeBate et al, 2004). 26.c Rosecrans et al (2008) found that practical demonstrations were much more successful than information provision alone. 26.d Two studies suggest that the participants may doubt the credibility of health

messages, with so many sources of, sometimes contradictory, information available (Moreno et al, 1997 & Meillier et al, 1998). Matching the characteristics of the community may be important.

6. Discussion

6.1. Limitations of the review

We only identified six programmes for which effectiveness data, as well as qualitative research, was available. This means that for the vast majority of the included papers, people's perceptions about the possible barriers and facilitators remain perceptions, and there is no way of comparing these perceptions with actual programme outcomes. While many observations may be valid, the does limit the synthesis outputs.

Due to the volume of material we initially retrieved, we excluded 36 qualitative study reports that were not related to a specific CVD programme. This material may have contained useful insights but there was insufficient time to review this collection of studies.

6.2. Methodological considerations

Despite a large and disparate evidence base, synthesis was possible using a framework of macro- meso- and micro-levels, with themes at each level developed through repeated readings of the studies' extracted findings. As the included study reports are largely descriptive, with little development of second order constructs, it was not possible to undertake meta-ethnography. In some cases, underlying porgramme theories were used to inform the conduct of the CVD projects, but the research fingings were not related back to this.

The synthesis is, necessarily, interpretive and the product of a particular two-person research team. Other teams may have developed alternative analysis frameworks or placed different emphasis on the findings included. The process of analysis and synthesis forces information to be cut and combined in particular ways, and we recognise that other ways of producing the review would be possible.

It remains unclear how to "weight" the synthesised findings. Findings reported in a single study may be found particularly insightful or pertinent, whilst findings common to several study reports may be less useful or applicable. These are matters of judgment on the part of both the reviewers and the review audience.

Quality appraisal for qualitative research remains a vexed issue. There are no universally accepted indicators of quality in qualitative research and different traditions and expectations of research are seen across and between disciplines. Given this lack of consensus, there are also no agreed protocols about the necessary nature and level of methodological detail reported. Limited word counts, especially in medical journals, may also mean that details of data collection and analysis procedures are left out in order to preserve space to report findings. A number of the papers we included reported on mixed methods research in a single publication, further restricting the amount of space to detail the qualitative methods or findings. Although we rated many papers as poor, it is often unclear whether deficiencies are in the reporting or the actual conduct of the research. It is particularly challenging to provide a single overarching quality "score".

Finally, it is not possible to identify all the interactions within and across study findings. In particular, there may be chains or combinations of factors that critically influence the success or failure of a programme, with the presence of absence of one factor acting to mediate, modify or mollify the action of others.

6.3. Further research

The 36 study reports about people's beliefs and behaviour related to heart health could be synthesised in the future.

Future work could assess how qualitative *evidence* (as opposed to qualitative *research*) might add to understandings of barriers to, and facilitators of, successful CVD programmes. By "qualitative evidence" we mean opinion pieces written by staff or researchers about a programme or the discussion sections of quantitative research, both of which may contain debate and possible explanations or theory about how and why a programme produced particular outcomes.

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Appendices

Appendix 1 Research protocol

1. Research Questions

What are the important factors associated with the successful (or unsuccessful) implementation of population programmes and interventions for the primary prevention of cardiovascular disease (CVD) within a given population?

What are the important factors influencing health or other intended outcomes associated with the primary prevention of CVD?

How do these factors interact, both with each other, or with other aspects of programme design, implementation processes or context to influence increased or reduced programme and intervention effectiveness?

2. Objectives

To conduct a systematic review of qualitative research into the processes of planning, implementation and evaluation of such programmes and interventions (or key components of them) as these aspects relate to their success or failure.

3. Rationale

We hope to gain a better understanding of how and why population programmes and interventions to prevent CVD are successfully (or unsuccessfully) implemented, and achieve (or fail to achieve) their intended outcomes, with a particular focus on identifying the factors which militate against or enhance effectiveness ("barriers" and "facilitators"). This will include identifying elements associated with key areas of programme and intervention success such as how the project evolved, acceptability, sustainability or cost-effectiveness.

By identifying such research we hope to be able to better explain the findings of the linked systematic reviews of quantitative research looking at effectiveness, which are being carried out by WMHTAC. While these will mainly address the question of "what works?" we hope to be able to generate firmer insights about why and how such programmes work, for whom and in what circumstances.

We also aim to identify any strategies that have been developed to address barriers to, or take advantage of facilitators of, the effective planning, delivery and evaluation of population level programmes and interventions to prevent the onset of CVD. This is a supplementary research question and will not inform the search strategy. Any relevant findings in the included study reports that address this question will be extracted and synthesised.

4. Methods

Given the necessarily iterative nature of much of this review, we anticipate that elements of this protocol may develop both in response to the identified studies and their findings, and in negotiation with the commissioner.

The research question focuses on CVD programmes and interventions. For the remainder of this protocol, we will only use the term "programmes" for conciseness and clarity, but we use this term to include to both programmes and interventions aimed at reducing CVD so long as they are population or community-focused and target multiple risk factors.

4.1 Relevant CVD programmes

Qualitative research included in this review will relate to population level programmes which aim to reduce multiple risk factors (two or more) for the primary prevention of CVD. In terms of the types of programmes to be included, our review will have the same definitions as the reviews of effectiveness prepared by WMHTAC. Qualitative research relating to programmes included in the effectiveness reviews will be our first priority. In these, sub-groups will be explored only where they remain aimed at a general population level. For example, information about programmes aimed generally at reaching South Asian men will be included, while those aimed at South Asian men already identified as at high risk (because they smoke, or have known high

cholesterol levels, for example) will not. Similarly, study reports related to programmes designed specifically to address those with known risk factors for CVD, or with existing CVD, will not be examined. Study reports related to programmes which focus on single risk factors (such as only smoking or only increasing physical activity) will not be examined.

4.2 Relevant research

Qualitative research included in this review will contain findings related to elements that facilitate, or militate against, successful CVD programmes that are aimed at general population(s). Study reports may include research with those involved in organising and delivering CVD prevention programmes (including funders, programme designers, implementers, managers etc.), those involved in evaluating programmes (researchers) or populations at whom such programmes are/were aimed.

We also anticipate that barriers and facilitators will operate at macro-, meso- and micro-levels and this will be used an organising principle for findings (see Supplement 1 for conceptual framework with illustrative possible concerns).

4.3 Search strategy

We want to identify all relevant qualitative research conducted alongside programs which are included in the systematic reviews of effectiveness of programmes and interventions for the reduction of cardiovascular disease (reviews 1 and 2) to be conducted by WMHTAC. This will be done through targeted searches related to the named interventions and programmes included in these reviews by WMHTAC (Stage1). Searches of electronic databases (Stage 2) will be used to supplement stage 1 and to identify study reports that are not associated with programmes and interventions included in reviews 1 and 2. Our third stage, also based on electronic database searches, will be used to investigate key elements associated with barriers and facilitators to programme success generally, and which may not relate to programmes that have been quantitatively evaluated. These can be thought of as moderating effects of programme success, and may relate to key programme features such as the feasibility of implementation, acceptability or fidelity of a programme to the original design. The findings from study reports identified in stages 1 and 2 will help to inform the search terms used at this stage.

Reference checking and citation searching of relevant study reports will be included at all stages of the search strategy.

Stage 1: We will use the list of programmes aimed at reducing CVD that have been identified in the effectiveness reviews and we will seek qualitative research associated with these programmes (i.e. searches undertaken in electronic databases and websites will be targeted on these programmes and interventions). Details of the search strategy will be developed in response to the results from the strategies used for Reviews 1 & 2, however it will use the following main elements to identify relevant study reports:

Programme name

Author names

Reference checking

Citation searching

Contact with experts in the field and personnel associated with particular programmes.

Stage 2: A search of electronic bibliographic databases will be undertaken at the same time as stage 1. This will use the same search terms (in terms of populations, programmes and comparators) as Programme Reviews 1 and 2, but apply qualitative research filters (see attached supplement).

Stage 3: We will then use a third search strategy to identify any other reports that explicitly focus on moderating effects for CVD programmes, including programme sustainability and feasibility. The extent to which this strategy is pursued will depend on the amount and nature of evidence identified using the first two stages, as it is envisaged that the most useful information from qualitative research will relate directly to programs that have specific documented health outcomes. Search terms for this stage are shown in the search supplement.

Specific questions or problems arising from the effectiveness reviews may also be used as the starting point for targeted searches if appropriate.

4.4 Study selection criteria and procedures

It is envisaged that the outcomes to be included will be guided at least in part by the literature identified and that inclusion criteria may be refined or expanded in response to identified study reports.

Study design

Study reports will be included if they use recognised qualitative research methods and present qualitative data analysed using qualitative methods. Studies may use solely qualitative research or mixed methods designs.

Study focus

Included studies will focus on processes associated with programme design, implementation and evaluation, and particularly, possible barriers to and facilitators of successful CVD programmes. "Success" may be considered in terms of programme delivery as well as in terms of health outcomes. In particular, study reports which address programmes for which no effectiveness data is available will be included only where they clearly address issues related to such intermediate success factors. This criterion may be re-visited in the course of the project in response to the quality and quantity of studies initially identified for inclusion.

Excluded studies

Study reports which do not explore factors contributing to the success or lack of success of a CVD programme will not be included.

Only study reports written in English will be included.

Study selection

The abstracts and titles of references retrieved by electronic searches will be screened for inclusion by one reviewer using the pre-specified inclusion/exclusion criteria. Full text copies of potentially relevant studies will be then be obtained and these will also be assessed by one reviewer against pre-specified criteria. At both stages a sample of 10% of the references will be checked by a second reviewer.

4.5 Methods of evidence synthesis

Quality assessment

The quality of individual studies will be assessed using the checklist methods shown in Supplement 2. The checklist will be supplemented by critical reading of each study. Studies will be independently quality assessed by two reviewers. Any disagreement will be resolved by consensus and if necessary a third reviewer will be consulted. We also anticipate, however, that the value of each study will be judged through its contribution to the synthesis (Noblit & Hare, 1988).

Data extraction

Key themes, concepts and quotes will be extracted from the included studies by one reviewer and checked by another reviewer. Findings from each study will be presented in an evidence table. Involvement of two reviewers in the extraction of qualitative research allows for alternative readings of the findings to be explored. Discrepancies will be resolved by discussion, with the involvement of a third reviewer if necessary.

Methods of analysis and synthesis

Preliminary analysis will involve reading and re-reading the study reports, and the extracted findings, in order to consolidate understandings of the themes and concepts and their relations within and between studies. A structured summary for each paper will also be produced. Key findings, quotes and concepts from each paper will listed and tabulated so that they could be explored, compared and juxtaposed based on the mechanisms of data manipulation and juxtaposition outlined by Popay et al (2006). We anticipate that meta-ethnography will be used as the main method of synthesis (Noblit & Hare 1988) The aim of meta-ethnography is to identify where similar themes and concepts from different study reports refer to the same thing (congruent synthesis) or identify opposing findings (refutational synthesis), this process is referred to as “translation”. Study concepts may also be linked to create a “line of argument”, developing ideas across more than one study. The context of the findings will also be considered in relation to the methods used to collect them and any

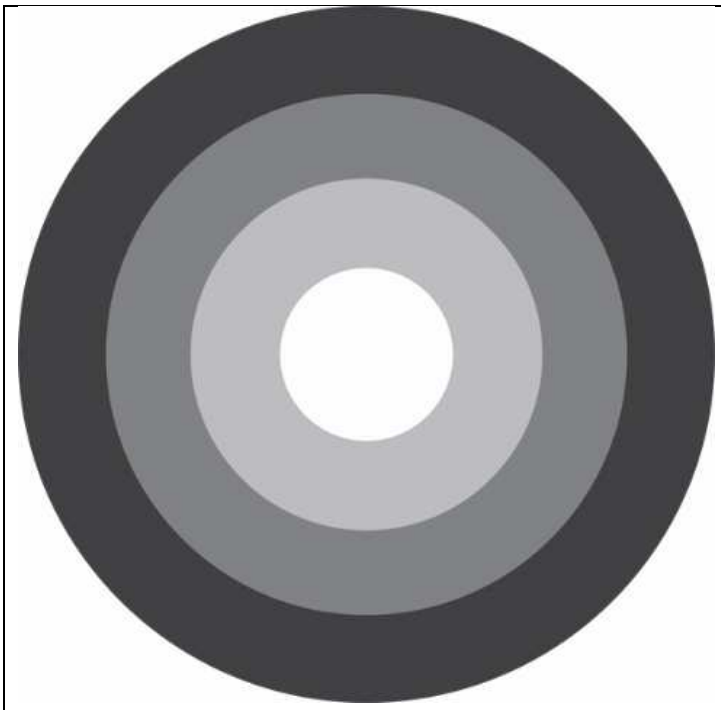
theories that either drive the research or are produced by it (Pound et al. 2005). Such elements may help to explain similarities and differences between study reports.

Depending on what we find, it may be appropriate to initially analyse and synthesise study reports within groups of similar types of programmes, participants or other organising factor. For example, we will be mindful of the needs of different populations and strive to identify any specific barriers and facilitators that apply only, or more strongly to specific groups (such as women, low income families, children etc.). We will also seek to identify those strategies relevant to reducing health inequalities. Such findings will be subsequently brought together if appropriate. The detail of this approach will be determined in response to identified study reports.

Expressing the synthesis

Details of each included study and the key findings will be tabulated (i.e. an evidence table will be produced). The product(s) of the synthesis may be presented in a number of forms. We will endeavour to use the methods that represent and clarify the evidence in ways that are of use to the Programme Development Group. For example, summary tables can be used to show the extent of congruence and refutation in findings between the studies. Where appropriate, links between findings and conceptual tools that explain them may be best represented diagrammatically. Written, descriptive summaries may also be useful. We are aware that the strength of the evidence may relate to factors beyond its aggregative contribution. That is, the quality of a theory may relate to its relevance or explanatory power, perhaps within a single study, rather than the frequency with which it occurs in the included study reports. Similarly, a single well conducted and analysed study may produce unique, but insightful findings, while a number of less well developed analyses may reach the same conclusion, but be less pertinent. In essence, we believe we will need some flexibility in deciding what studies or strands of theory or evidence justify being given extra effort in the process of synthesis, or extra weight in summarising the evidence.

Supplement 1: Macro-, meso- and micro- levels at which barriers and facilitators to adoption of behaviours likely to reduce CVD risk may operate



Macro-level factors

Environment

Prices

Wages

Legal factors

Meso-level factors

Community/ familial norms

Local access

Micro-level factors

Individual understandings of risk

Individual behaviours

Adoption of behaviours likely to reduce CVD

Adapted from Wallace et al (2004)

Supplement 2: Quality assessment criteria

All to be answered yes, no, can't tell or not applicable.

1	Question	Is the research question clear?
2	Theoretical perspective	Is the theoretical or ideological perspective of the author (or funder) explicit? Has this influenced the study design, methods, or research findings?
3	Study design	Is the study design appropriate to answer the question?
4	Context	Is the context or setting adequately described?
5	Sampling	Is the sample adequate to explore the range of subjects and settings? Has it been drawn from an appropriate population?
6	Data collection	Was the data collection adequately described? Was it rigorously conducted to ensure confidence in the findings?
7	Data analysis	Was there evidence that the data analysis was rigorously conducted to ensure confidence in the findings?
8	Reflexivity	Are the findings substantiated by the data and has consideration been given to any limitations of the methods or data that may have affected the results?
9	Generalisibility	Do any claims to generalisibility follow logically and theoretically from the data?
10	Ethics	Have ethical issues been addressed and confidentiality respected?

Source: Wallace et al 2004(Wallace et al. 2004)

Appendix 2 Search Strategy

This was based on the search strategy used by WMHTAC to address question 1, but with qualitative research filters applied, which were used to identify a broad range of qualitative studies. The section of the search strategy used was as follows, along with the qualitative research filters.

OVID Medline (R) 1950 to July Week 4 2008
Search Date: 26 July, 2008

1 cardiovascular disease$.mp. or exp Cardiovascular Diseases/
2 CVD.mp.
3 coronary disease$.mp.
4 heart disease$.mp.
5 atherosclerosis.mp.
6 arteriosclerosis.mp.
7 hypertension.mp.
8 blood pressure.mp.
9 exp Hyperlipidemias/ or hyperlipidaemia$.mp.
10 hyperlipidemia$.mp.
11 exp Cholesterol/ or cholesterol.mp.
12 exp Stroke/ or stroke$.mp.
13 peripheral vascular disease$.mp.
14 peripheral arterial disease$.mp.
15 hypercholesterol$.mp.
16 hyperlipid$.mp.
17 or/1-16
18 health education.mp. or exp Health Education/
19 health promotion.mp. or exp Health Promotion/
20 primary prevention.mp. or exp Primary Prevention/
21 campaign$.mp.
22 media.mp. or exp Mass Media/
23 exp Counseling/ or advice$.mp.
24 counsel$.mp.
25 program$.mp.
26 (policy or policies).mp. [mp=title, original title, abstract, name of substance word, subject heading word]
27 or/18-26
28 exp Smoking/ or smoking.mp.
29 exp Tobacco/ or tobacco.mp.
30 exp Diet/ or diet.mp.
31 exercise.mp. or exp Exercise/
32 obesity.mp. or exp Obesity/
33 diabetes.mp. or exp Diabetes Mellitus/
34 stress.mp. or exp Stress/
35 exp Cholesterol/ or cholesterol.mp.
36 exp Hypertension/ or hypertension.mp.
37 blood pressure.mp. or exp Blood Pressure/
38 alcohol$.mp.
39 drinking.mp. or exp Alcohol Drinking/

40 (cardiovascular adj3 risk$).mp. [mp=title, original title, abstract, name of substance word, subject heading word]
41 multiple risk$.mp.
42 or/28-41
43 17 and 27 and 42
44 limit 43 to (english language and humans and yr="1970 - 2008")

These are the qualitative research filter lines:
45 qualitative research/
46 ((focus or discussion) adj group).tw.
47 ((field or case) adj (stud$3 or research)).tw.
48 (interview$2 or qualitative).tw.
49 45 or 46 or 47 or 48
50 44 and 50

The filters for qualitative research from line 45 are based on work done by the McMaster Hedges team (see http://hirumcmaster.ca.hedges/Qualitative.htm) and at the department of health sciences, University of Leicester, with additions as requested by the CVD analyst team at NICE.

The above search strategy was then translated into the following Web-based databases. Where database dates begin pre-1970 a date restriction was applied (1970-current) all other databases were searched in their entirety;

MEDLINE(R) Version: OVID In-Process & Other Non-Indexed Citations. Search Date: 01 august 2008
EMBASE Version: OVID 1980 to 2008 Week 31. Search Date: 05 August 2008
CINAHL Version: DIALOG Datastar: CINAHL (R) - 1982 to date (NAHL). Search date: 28 July 2008
PsycINFO Version: OVID1806 to July Week 5 2008. Search Date: 01 August 2008
HMIC Version: National Library for Health Web 2.0 interface [underlying data is from OVID]. Search Date: 05 August 2008
ASSIA Version: CSA on-line. Search Date: 05 August 2008

Appendix 3 Evidence tables

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: Alberta Health **Year:** 1998 **Citation:** Evaluation Report: The Alberta Heart Health Project **Quality score:** (++, + or -) -	**What was/were the research questions:** Not clearly stated – general aim appears to have been to explore communities' and project staff's experience of the programme **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Focus groups (communities) Method not stated for research involving project staff **By whom:** Not stated **What setting(s):** Not stated **When:** 1997 **Programme description:** Local projects were developed in conjunction with community partners with the aim of not only modifying unhealthy behaviours, but also to make changes to the social environment so as to favour heart	**What population were the sample recruited from:** Communities in which the project was delivered **How were they recruited:** Not stated **How many participants were recruited:** Not stated (although 'between 5 and 9 in each group' (p51)) **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** Extent of documentation as follows: 'Project staff conducted focus groups with community participants at the conclusion of the project' (p51) **Key themes (with illustrative quotes if available) relevant to this review:** Findings from focus groups with community members (themes based upon 'project domains'): <u>Vision</u> Participants felt that community members who had responded positively to the project were largely already aware of heart health issues Planning for a 4-year time period was viewed as 'unwise' as it was perceived to limit the development of projects and possibly set goals that are not achievable (p52) <u>Resources</u> Participants felt that the project had made good use of available resources and stressed that whilst they saw themselves as vital resources, outside resources were also required Young people were identified as an 'untapped resource' (p53) <u>Knowledge and skills</u> Participants reported increasing confidence in their own skills as the project progressed, meaning that checking with project co-ordinators was not required so frequently	**Limitations identified by author:** None (for qualitative component) **Limitations identified by review team**: Extremely rudimentary documentation of entire research process (recruitment, conduct, analysis) Basic details such as the number of participants in focus groups not given No details given regarding how data was collected from project staff Reflection upon limitations of research process confined to summarising the role of qualitative research generally, but it is not at all clear how this actually informed the research process used No consideration of ethical issues documented **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** Not stated

	health. Local projects included: Comprehensive school heart health project (targeted students, teachers, school staff and parents; promoted community support for tobacco abstention, nutrition, physical activity and personal self-esteem) Workplace wellness project (targeted employees in local government departments; promoted CVD risk factor awareness, healthy lifestyles and reduction of work absenteeism Heart of the Land project (targeted adults in small rural communities; promoted CVD risk factor awareness and healthy lifestyles) Straight from the Heart project (targeted teens, young adults and families in two large rural cities; promoted CVD risk factor awareness, healthy lifestyles and tobacco-free environments) [this description taken from Dressendorfer et al (2005)]		<u>Decision-making</u> Mixed results regarding the extent to which community members contributed to decision-making, as some perceived that the same small core group was responsible for most of the decisions made "I still think that this was not a community development project. We were trying to mobilise people. They were not at that level yet – of making decisions on their own" (p54) <u>Leadership</u> Community facilitators were perceived by some as having supported the development of local leadership, whilst others disagreed One participant argued that the project had given the community the confidence to make changes in the social environment (e.g. stopping smoking in the community hall) Most participants felt that the project had provided leadership, but had not been successful in fostering the development of new leaders Challenges to project implementation identified from research (method unknown) conducted with project staff: (extracted directly from Table 2, p58) Breaking into established community networks and communication systems Involving community members in the creation and articulation of vision and goals Seasonal rhythms of rural communities Reaching young families (ages 20-40) Maintaining volunteer interest, commitment and support Expanding core volunteer groups Competing with other community events (e.g. weddings, hockey games) Getting people to read articles and newsletters once they are 'out there'	

			Building two-way communication with communities Changing attitudes Building physician support Building confidence in community members Overcoming the historical tradition of the Health Unit delivering programmes and services Time to build/ develop new leaders and shift the balance of power from project to community Learning to work with communities With regard to the Calgary Comprehensive School Heart Health Project (challenges to project implementation identified from research (method unknown) conducted with project staff) (p77): Achieving initial buy-in to the philosophy and goals of the project Maintaining consistent support at multiple levels, especially in the face of changing personnel Balancing project implementation with increased teacher workloads and diminishing resources Encouraging involvement from all grade levels Creating measures of success that are commonly valued (achievement scores/ improved health outcomes) Data management in long-term projects Timely feedback of knowledge, attitude, and behaviour data At the provincial level, maintaining a consistent project framework, philosophy, and priority focus	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** + **Extracted in conjunction with related paper drawing on the same research [paper 2]: Joffres, C., Heath, S., Farquharson, J., Barkhouse, K., Latter, C., and MacLean, D. (2004) Facilitators and challenges of organisational capacity building in heart health promotion. Qualitative Health Research 14 (1) 39-60**	**What was/were the research questions:** To present the outcomes of a capacity building exercise. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Participatory action research Description of the analysis references GT. **How were the data collected:** **What method (s):** 5-yr follow up using quantitative and qualitative methods. Participatory action research principles. Network mapping questionnaires, technical support logs, interviews, ongoing organisational reflection logs. **By whom:** Heart Health Nova Scotia research staff. **What setting(s):** NR **When:** Over the course of phase II. Interviews in 1999/2000. **Programme description:** Heart Health Nova Scotia, Western Health Region (part of the Canadian Heart Health Initiative) Launched 1989. Phase 1 1989-1995 – feasibility and impact of prototype interventions	**What population were the sample recruited from:** 20 organisations from health, education and recreation sectors involved in the project. **How were they recruited:** Self selection of organisations - those that volunteered to serve as case studies. Individuals were purposively sampled to ensure participants had required knowledge about their organisations, & from different organisational levels. **How many participants were recruited:** From 6 case organisations, & Heart Health Nova Scotia staff 14 members pf Regional coalition – network mapping questionnaire 4 Heart Health Nova Scotia staff – technical support logs. 12 organizational members (interviewed 5 times over 2 yrs) – capacity building 7 key informants in provincial health system (on role of health reform) 43 organizational members (final organizational interviews) 4 HH staff (organizational	**Brief description of method and process of analysis:** Research activities were intertwined with organisational change. Interview guides included two directional questions about capacity building and questions that facilitated spontaneous information generation. Organisational logs and interviews developed in collaboration. Logs took 15-60 minutes to complete. Interviews lasted approx. 1.5 hrs and were tape recorded and transcribed. Coding done “on an ongoing basis to allow maximum reflexivity”. Transcribed data were coded using open and axial coding. “Codes were grounded in themes that emerged form the data. Sub-nodes reflecting the properties of each node / category and illuminating the data in ways not provided by the main categories were created whenever necessary”. Transcripts reviewed several times. Theoretical memos further guided the analysis. Data displayed through matrices reflecting emergent themes, Draft reports reviewed by partner organisations. Credibility, transferability, dependability & confirmability (Lincoln & Guba) ensured by purposive sampling, audit trails, triangulation of time and methods. **Key themes (with illustrative quotes if available) relevant to this review:** Developing an organisational capacity profile seen as useful because they identified strengths and weaknesses, allowed communication with partners and helped determine future directions. See Figure 1 (reproduced below evidence table) regarding building capacity for heart health promotion [paper 3]	**Limitations identified by author:** Findings limited because drawn from only 6 organisations. Limited effectiveness data due to short-ish follow up. Concurrent political and financial changes may lead to an underestimate of possible impact. **Limitations identified by review team**: Recruitment not really clear. Very detailed analysis plan, but not clear if more than one person involved in analysis. Since the capacity building and research activities were interlinked and fed into each

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
(Quality score: ++) **Extracted in conjunction with related paper drawing on the same research [paper 3]:** **Joffres, C., Heath, S., Farquharson, J., Barkhouse, K., Hood, R., Latter, C., & Maclean, D.R. (2004) Defining and operationalizing capacity for heart health promotion in Nova Scotia, Canada. Health Promotion International 19 (1) 39-49** **(Quality score: ++)**	shown. 1996-2001 Phase II - lessons implemented with 20 partner organisations to form the Heart Health Partnership (HHP). Its aim was to build organisational capacity for heart health promotion.	reflection logs) (Total interviews = 62) **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	Organizational consultation was a key strategy in capacity building. Health Nova Scotia was the catalyst & played a leadership role. <u>Organisational change</u> All six organisations noted: - Creation of full time or part time positions related to heart health - Creation of new structures (e.g. committees) or reorientation of specific committees' activities to support an increased emphasis on heart health promotion. - Specific changes in organisational culture, including more decision making processes and increased interdepartmental communication in otherwise traditionally independent departments. - Policy changes (including broadening or updating members' roles to include more heart health promotion, integration of increased priority of heart health promotion in to mission or strategic planning. As a result, all noted increased reflection, knowledge, skills and understanding about heart health promotion among decision making bodies, staff and volunteers. - Increased reflection and knowledge and skill development reported in areas of advocacy, team building, group facilitation, evaluation, population health issues, strategies for heart health promotion and capacity building. This was due to technical support (such as training workshops and a clearing house), partnerships, community activation teams & research products. Technical supports allow a theoretical understanding of issues to be gained wh9le others give hands on experience on needs assessment and research/ evaluation tools. - Learning through partnerships was less formal, but also valued. "…….working together has really helped us enhance each others' capacity because we have been able to share skills,	other, it's not always clear where findings start and end. In addition, several potentially useful diagrams may be informing or the result of, research. Very few direct quotes supplied. **Evidence gaps and/or recommendations for future research:** **Source of funding:**

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			our knowledge and our experiences." [RG note – 1 of only 2 quotes. My edit.] Knowledge and skill transfer happened through: using activities from training and research as templates for new activities; using newly acquired skills in other activities; informally sharing acquired knowledge with colleagues. Baseline assessments of organisations' capacity for heart health promotion enabled reflective practice that further helped to organisations to determine the areas on which they were to focus their efforts and to provide a basis for the monitoring of capacity-building "It's made us look at ourselves, opened our eyes to a few truths we didn't think were there. It has made us more aware of our strengths and weaknesses and gave us a basis to act from" [paper 2] Technical support: Workshops facilitated members' theoretical understanding of advocacy, team building, health promotion practices, and capacity-building concepts Community Heart Health Action Teams 'fostered experiential learning [by] engaging partner organisations in small-scale community health interventions' (p47) Organisational partners communication and information needs were facilitated by a website and full-time co-ordinator (provincial, national and international health promotion resources were available) [paper 2] Networking benefits through allowing people to use time effectively and not duplicating programmes. Partnerships "had a synergistic effect" on projects – accelerating development, facilitating realistic goals and fostered a growing sense of efficacy among participants. <u>Further outcomes</u> Other benefits were:	

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			Network development & a regional vision was fostered. Visibility and credibility of partner organisations increased. Positive attitudes to collaborative work fostered. New understandings and appreciations of each others' work and skills. Growing sense of interdependency, shared vision and sense of collective efficacy. <u>Influencers</u> *Leadership* Importance of role played by Heart Health Nova Scotia in identifying organisations to participate in the programme, facilitating their involvement through presentations to top-level administrators and board members, and development and distribution of health promotion literature [paper 2] *Partnership* Facilitators of positive experiences - - Organisational culture that encouraged this. - Similar values about heart health between organisations. - Visibility/ credibility of potential partners. Hinderers of positive experiences – - Organisational turnover. - Long travelling distances - Role overload - Poor attitudes towards partnerships (us *vs.* we mentality) (which were based on poor prior experiences or organisational culture orientated towards independence.) - Terminology – some organisations' involvement was inhibited by the use of health promotion concepts and terminology "It's very hard to sell nebulous concepts such as collaborative partnerships and capacity building and advocacy. It's jargon and it's meaningless for some people" (p46) [paper 2] Some programme volunteers resistant to taking part in	

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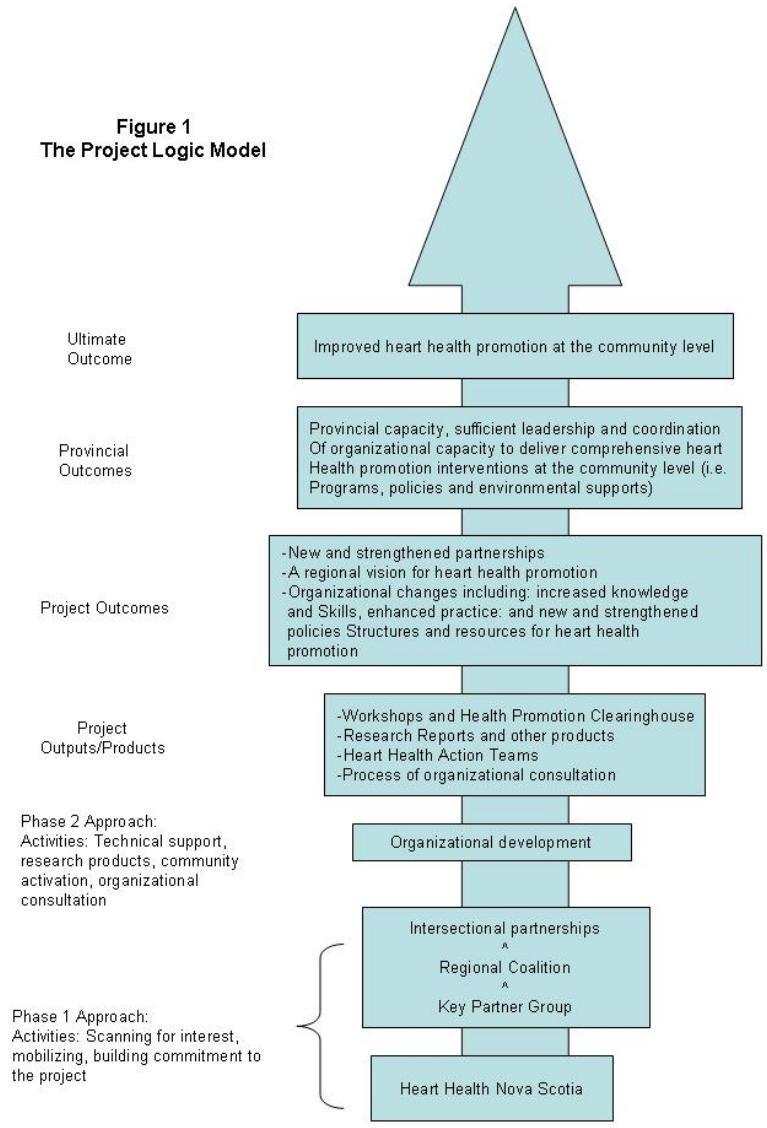
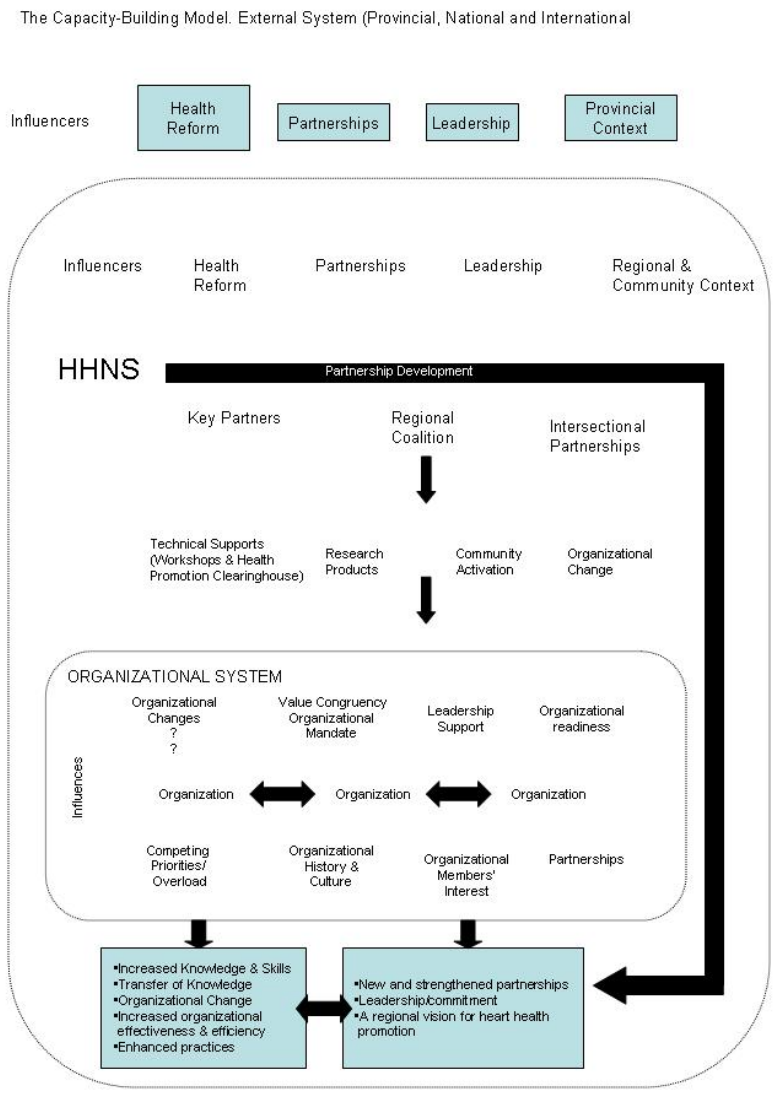
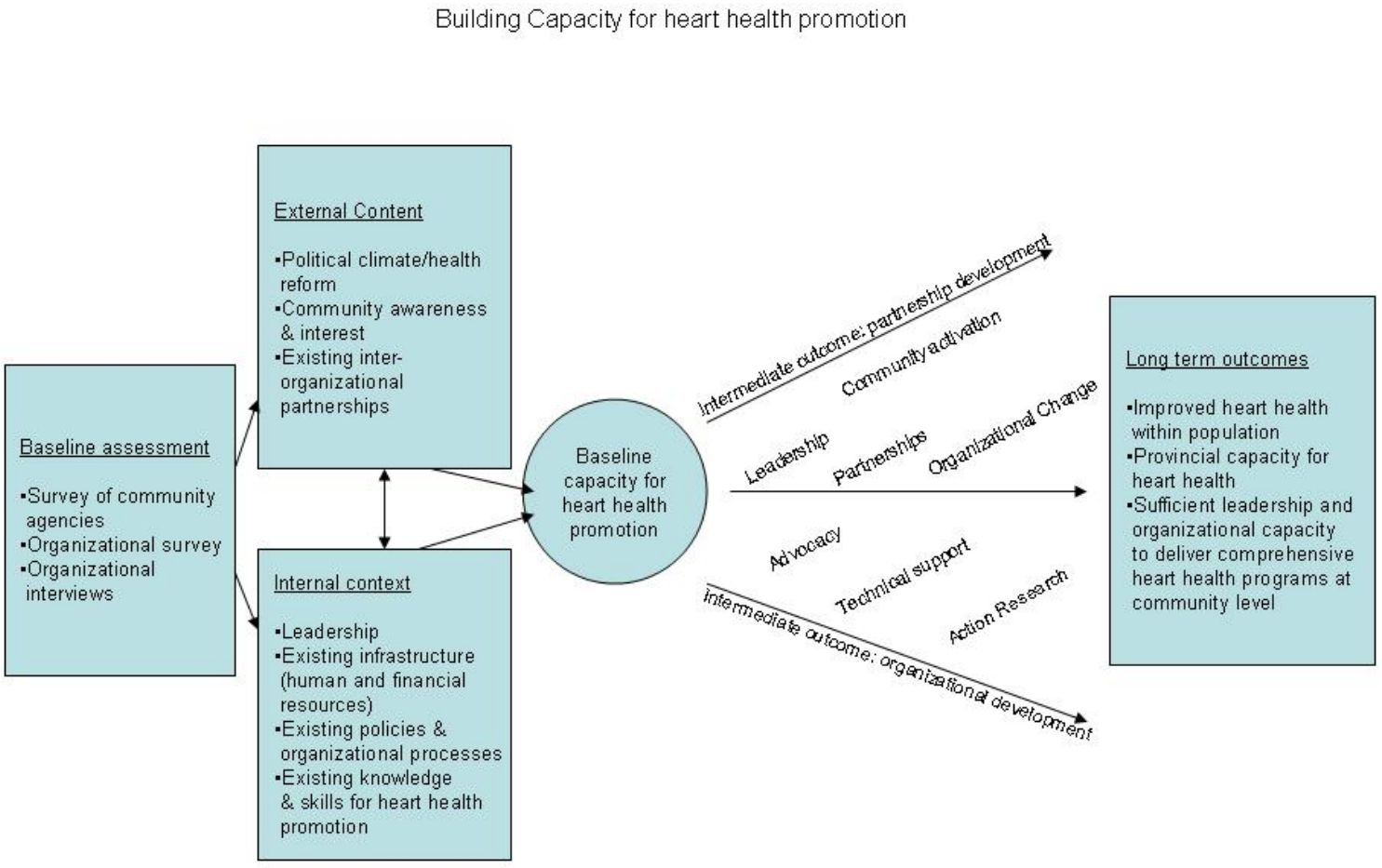
			health promotion activities, as a) preferred more traditional practices such as patient services, and b) the long-term, intangible outcomes of health promotion did not provide a source of satisfaction [paper 2] *Organisational development* Facilitators: - Values congruence re importance of heart health - Members' interest in heart health - Organisational readiness to embrace change - Leadership that embraced and promoted change Barriers: - Lack of interest in heart health promotion - Competing work priorities - Lack of funds for heart health promotion - "Loosely coupled organisational structures" - Lack of leadership Main external barrier was health care system reform due to freeze on creation of structures, budget cuts, re-evaluation of roles, lack of clear direction. Although stage/ change theory initially informed the project conceptualisation, it was clear form early in the project that "stages" might not best described the unfolding of organizational activities undertaken. Data emphasised the fluidity & evolutionary nature of organisational change, with some sequential and some overlapping activities and a range of engagements within and between organisations.	

Figure 1
The Project Logic Model






Building Capacity for heart health promotion
Baseline assessment
•Survey of community agencies
•Organizational survey
•Organizational interviews
External Content
•Political climate/health reform
•Community awareness & interest
•Existing inter-organizational partnerships
Internal context
•Leadership
•Existing infrastructure (human and financial resources)
•Existing policies & organizational processes
•Existing knowledge & skills for heart health promotion
Baseline capacity for heart health promotion
Intermediate outcome: partnership development
Community activation
Leadership
Partnerships
Organizational Change
Advocacy
Technical support
Action Research
Intermediate outcome: organizational development
Long term outcomes
•Improved heart health within population
•Provincial capacity for heart health
•Sufficient leadership and organizational capacity to deliver comprehensive heart health programs at community level

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Besculides, M., Zaveri, H., Hanson, C., Farris, R. and Gregory-Mercado, K.** Year: **2008** Citation: **Best practices in implementing lifestyle interventions in the WISEWOMAN program: Adaptable strategies for Public Health programs. American Journal of Health Promotion 22 (5) 322-328** Quality score: **(++, + or -)** **-** **Quality appraisal based upon**	**What was/were the research questions:** What were the best practices for implementing lifestyle interventions targeting CVD risk factors in WISEWOMAN programmes? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Preliminary telephone semi-structured interviews with federal, project, and local staff from the 2 highest- and 1 lowest-performing WISEWOMAN sites within a purposive sample of 5 WISEWOMAN projects Visits to these project sites, at which: 1) Semi-structured interviews with all staff involved in the development or administration of the lifestyle intervention 2) Observation of interventions 3) Focus groups with participants **By whom:** Not stated **What setting(s):** By phone (preliminary interviews) At the sites at which the programme was being delivered (interviews and focus groups)	**What population were the sample recruited from:** WISEWOMAN project staff Participants in the WISEWOMAN programme **How were they recruited:** Not stated **How many participants were recruited:** Not stated **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** Analytic themes were developed from the interviews and focus groups and were organised within the RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) framework in order to facilitate analysis across programmes **Key themes (with illustrative quotes if available) relevant to this review:** See extracted table below	**Limitations identified by author:** Participants at high- and low-performing sites may not be homogeneous **Limitations identified by review team**: Insufficient detail provided regarding participants'/ project's characteristics to allow generalisation Analytic themes framed within an external approach rather than the perspectives of participants Minimal details provided regarding analytic process, so not possible to assess its rigour **Evidence gaps and/or recommendations for future research:** None **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
methods paper: Besculides, M., Zaveri, H., Farris, R., & Will, J. (2006) Identifying best practices for WISEWOMAN programs using a mixed-methods evaluation. Preventing Chronic Disease 3 (1)	**When:** Not stated – programme was established in 1995 **Programme description:** Screening for CVD risk factors for uninsured women aged 40-64 (who were also ineligible for Medicaid) and provision of lifestyle intervention services to address these risk factors. (Note that programme was delivered as part of National Breast and Cervical Cancer Early Detection Programme, meaning that users also had to be participating in this)			

Best Practices Related to Each RE-AIM Dimension

	Practice	What High Performers Did
Reach		
1	Engage in active recruitment of new participants.	Used more than one active recruitment strategy (such as face to face outreach) and used strategies consistently over time.
2	Be an active member of the clinic or hospital in which your program operates to encourage other providers to refer women to the program.	Formed relationships with clinicians to promote referral to the program by attending clinician meetings to educate them about the program and by regularly participating in clinic activities.
3	Develop relationships with local health care providers external to the clinic or hospital in which you operate. Encourage them to refer women.	Met with provider offices on a regular basis to remind them about the services offered by the program. Educated all office staff, recognizing that administrative staff make women's appointments and record insurance information and that nurses may spend more time with women during encounters.

4	Target appropriate community organizations. Educate and encourage those organizations to refer women.	Formed relationships with organizations that served similar target populations.
Effectiveness		
5	Ensure that appropriate behavior change theory is understood and applied by staff during lifestyle interventions and that appropriate tools are used.	Hired staff with basic understanding of behavior change theory and built on this knowledge through training. Emphasized theory and its application during training, not just application of theory. Used tools in the intervention delivery that applied the theory in practice.
6	Train local staff on behavior change theories that guide lifestyle interventions.	Received training from professionals external to the program on behavior theory.
7	Deliver lifestyle interventions using appropriate adult learning techniques.	Used multiple techniques to deliver interventions (e.g., combination of auditory, visual and tactile techniques and experiential engagement activities). Although using language-and literacy-appropriate materials was essential, it was not enough.
8	Identify the individual needs of the women served and ensure that the lifestyle interventions target those needs.	Tailored counseling to the individual. Provided referrals and supported goals related to nutrition, physical activity and tobacco cessation.
9	Celebrate when women accomplish the goals they set for themselves.	Provided incentives for successful behavior change and taught women how to self-reward. Recording success stories of women helpful but not enough.
10	Incorporate experiential engagement into the lifestyle interventions with activities such as food tastings and grocery store tours.	Developed and conducted multiple types of experiential engagement activities.
11	Offer incentives that encourage women to self-monitor their behavior changes.	Gave clear, one on one instructions on how to use self-monitoring tools such as pedometers to ensure participants understood instructions.
12	Use incentives to encourage participation in program activities.	Explained the purpose of each incentive during a face to face encounter.
13	Link women to free or low-cost resources that support behavior change and address common barriers to adopting healthier lifestyles.	Linked women to several ongoing resources, such as smoking cessation counseling, nutrition education and passes to a gym, when appropriate.
14	Identify resources to address access to care barriers.	Identified resources that could be used for the long term and ensured that referrals were executed.
15	Recognize that staff serve as role models to women regarding healthy lifestyle choices.	Program staff modeled healthy behaviors that were directly related to program objectives.
16	Provide women with immediate feedback to capitalize on teachable moments created by the screening.	Discussed individual screening results before discussing behavior changes.
Adoption		
17	Develop an initial plan for implementation but revise this plan as needed.	Revised plans to add services to better meet the needs of women instead of revising plans because of program constraints.
18	Increase communication among local site staff to promote staff buy-in.	Used a team approach when delivering services. Holding staff meetings was not enough.
Implementation		
19	Reinforced training on program operations and lifestyle	Offered a variety of training for local staff from external trainers. Training offered on a

	intervention delivery on a regular basis.	regular basis for staff to stay current on issues. Conducted training on new topics and built on previous training.
20	Train and retrain staff to deliver lifestyle interventions.	Conducted training on new topics and built on previous training.
21	Partner with community organizations and health care providers.	Developed relationships with a greater number of organizations to offer women referrals for a variety of services. Used these partnerships more often.
22	Develop a proactive referral system to facilitate care for women.	Contracted with agencies or provider networks to simplify the referral process and ensure that women received needed services rather than simply giving a list of people or organizations that may be able to help. Developed strategies to address billing issues.
23	Develop a tracking system to identify women in need of rescreening.	Developed systems to alert clinic providers when women were due for program services so that women could visit the clinic for several services on the same day. Used computer databases to generate lists of women for staff to contact.
Maintenance		
24	Send multiple reminders to women about rescreening appointments.	Used indirect reminders of the program such as membership cards in addition to directly reminding women about the program through calls and letters. Also enlisted the help of clinic providers who were seeing women for other reasons to remind women about the program.
25	Expand program services to meet additional needs of women.	In addition to the lifestyle interventions, sites offered nutrition, physical activity and tobacco cessation services, which were readily available and ongoing.
26	Distribute newsletters and mailings to all enrolled women to reinforce behavior changes.	Distributed newsletters on an ongoing basis to inform women of community events, attract them to program services, educate them about specific topics and motivate them to maintain behavior changes.
27	Link women to free or low-cost resources that support behavior changes.	Linked women to multiple free or low-cost services.
28	Offer women opportunities for support from self and others.	Used peer support as part of interventions or to supplement them.
29	Identify resources to provide women access to needed medications.	Referred women to multiple programs that could provide medications at a reduced cost on an ongoing basis.
30	Compare screening results from one year to the next for a longer-term perspective.	Used past screening results to guide intervention discussion and goal-setting activities.
31	Develop partnerships for the purpose of program sustainability.	Developed multiple partnerships with other programs in the same organization with internal and external providers and with community organizations to increase long-term program sustainability.

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Authors: **Blamey, A., Ayana, M., Lawson,L., MacKinnon, J., Paterson, I., & Judge, K.** Year: **2004** Citation: **Final Report: The Independent Evaluation of Have a Heart Paisley. Glasgow: University of Glasgow** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** How did the context in which the Have a Heart Paisley programme was implemented impact upon its delivery? (this research question was just one aspect of a wider evaluation of the programme) **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Theory-driven evaluation ('stresses the importance of understanding and encouraging implementers to articulate the intervention plans and the underlying theories, rationales and logical links between activities, outputs and outcomes that support the plans' (p42)) **How were the data collected:** **What method (s):** Semi-structured interviews Focus groups Interviews and focus groups were recorded and transcribed (except in 3 cases where the interviewee did not want the interview recorded – in these instance, notes were taken by the interviewer) **By whom:** Not stated **What setting(s):**	**What population were the sample recruited from:** Personnel in involved with the programme and residents of Paisley **How were they recruited:** Not stated **How many participants were recruited:** Semi-structured interviews: Strategic & operational personnel (n=33, each interviewed at 3 different time points) Community stakeholders (n=16) Community representatives in strategy groups (n=5) GPs (n=14) Focus groups: Locality team (n=6) People running community projects (n=4) GPs and key informants (2 focus groups, each of n=12) Children/young people and parents of under-5s (n=35) **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:**	**Brief description of method and process of analysis:** For research conducted with health professionals: Interviews and focus groups were tape-recorded, transcribed and analysed according to pre-defined themes (contextual issues, process findings, outputs and outcomes) No details of method and analytic process available for interviews and focus groups conducted with community members **Key themes (with illustrative quotes if available) relevant to this review:** <u>GPs', nurses' and community staff's experiences</u> GPs predominantly felt that their role aligned more with secondary than primary prevention; nurses were far more active within the primary prevention activities GPs were largely 'unclear as to how primary care sat within the context of a community-based initiative' (p73-74) <u>Experiences with community-based groups</u> Some community-based groups were difficult to engage as these groups had previous negative experiences of initiatives, e.g. where their needs were not addressed or where facilities or venues for activities were lacking 'Territorialism and community politics were also reported as preventing people from participating in community activities and using facilities or venues in neighbouring areas' (p77) Tackling CVD was not viewed as an important issue by many in the community – issues such as housing and area regeneration, drug problems, safety issues , unemployment and poverty were	**Limitations identified by author:** None (relating to qualitative component) **Limitations identified by review team**: No rationale provided for purposive sample No quotations from participants provided Breadth of analysis presented has meant leaving out many key details that would facilitate understanding, e.g. Health on Wheels Project was problematic, but it is very unclear as to exactly why (p78) Limited details provided regarding analytic process **Evidence gaps and/or recommendations for future research:** None (relating to qualitative component) **Source of funding:** Evaluation was considered to be 'independent'; it was conducted by a research team at University of Glasgow, 'supported' by grantholders from University of Glasgow, NHS Greater Glasgow and University of Paisley (p3)

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	Not stated **When:** 2001-2004 **Programme description:** Have a Heart Paisley – project was a strategic partnership between local NHS organisations, the local council, and local community & voluntary organisations. It aimed to integrate the following programme strands in such a way as to maximise their effectiveness: Tobacco control and smoking cessation programme Healthy eating programme Physical activity programme Community locality network development Learning & development programme to increase 'good practice' in CVD prevention among community members and professional groups Marketing & publicity programme Secondary sector activities such as development of a CVD patient care pathway Council activities: Employee screening programme Facility and walking-based exercise programme Healthy eating and active living project Health promoting school project	None stated	viewed as more important Local project team were praised for their support of groups in applying for funding Community projects that developed were almost wholly physical activity based; smoking was not an issue that community activists or groups wanted to address (only one group addressed smoking) Involving community representatives at a strategic level was 'relatively unsuccessful', but it is unclear why (p78) <u>School-based projects – findings from pupil and parent focus groups</u> High level of awareness of importance of fruit and exercise for good health Many participants were aware of a wide range of health-related activities available in educational establishments All pupils were aware of the health messages relating to smoking through curriculum activities at school <u>Barriers to the effective delivery of the programme – findings from interviews with strategic & operational personnel</u> A lack of initial planning time Staff recruitment and retention problems A failure to free up enough time amongst existing senior agency staff with strategic support role in relation to the programme A need for a more conducive policy and legislative environment from local and national government with regard to key areas such as tobacco control (p98) A 'turbulent political and financial context' within local NHS bodies hindered the development of partnerships and hindered staff recruitment (p99)	

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			'The many existing statutory agendas and other short-term funded interventions limited the capacity of managers and operational staff to fully engage with the programme's agenda' (p99) Tensions between the NHS and local authority: - local authority staff viewed NHS staff's 'ambitious' goals for the project as 'naïve' given the inherent difficulties of delivering such a programme - wider remit (and accountability) of local authority members meant that CVD prevention was viewed as just one aspect of a wider field of intervention (i.e. housing, education, social work, etc.)	

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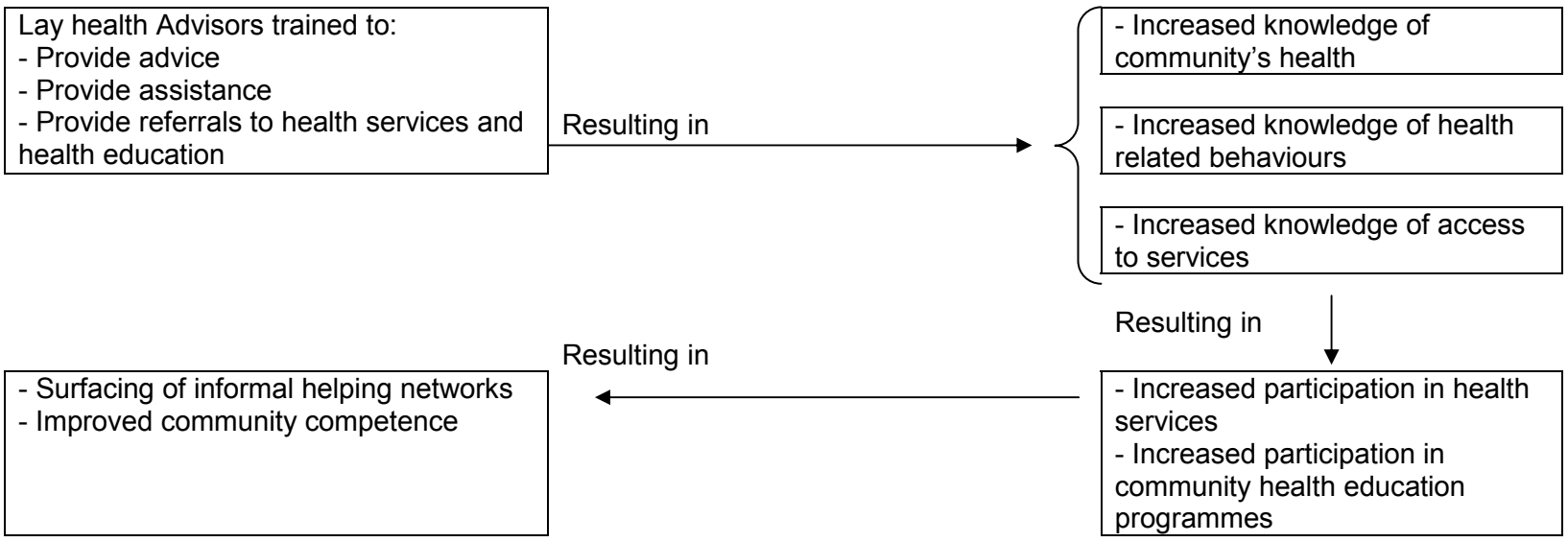
Authors: **Brännström, I., Emmelin, M., Dahlgren, L., Johansson, M. and Wall, S.** Year: **1994** Citation: **Co-operation, participation and conflicts faced in public health – lessons learned from a long-term prevention programme in Sweden. Health Education Research 9 (3) 317-329** Quality score: **(++, + or -)** -	**What was/were the research questions:** What promotes and constrains community participation in activities related to a programme to prevent CVD? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Unclear – mentions Bourdieu's 'cultural capital', but not clear how this has been utilised **How were the data collected:** **What method (s):** Semi-structured interviews (duration: 1.5 – 3 hours) Survey and analysis of health policy documents also conducted **By whom:** Member of research team who had not been involved with other aspects of evaluation of the project **What setting(s):** Not stated **When:** 1988-1989 **Programme description:** Norsjo (Sweden)	**What population were the sample recruited from:** Decision makers, planners, and medical staff involved with the programme **How were they recruited:** Not stated **How many participants were recruited:** 52 **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** Interviews were structured using a guide containing 46 questions regarding the perception health problems, community participation, conflicts and ideology in public health, and attitudes towards the programme. Interviews were audio-taped and transcribed. "The information from the interviews was systematically coded regarding the questions raised in the study [with a view to] describing both consensus and divergent opinions" (p321) **Key themes (with illustrative quotes if available) relevant to this review:** <u>Initiative, problem identification and interests</u> Provincial level actors perceived initiatives to have been taken by politicians, physicians, and researchers Local level actors perceived initiatives to have been taken by politicians at the provincial level or local health care service staff Citizens were uncertain about who had undertaken initiatives, although around half thought that medical staff at a local level, or researchers, were responsible. Some considered there to be greater health priorities than the prevention of CVD: "I still believe that the greatest health problems among the people are unemployment and uncertainty in everyday life" (Actor at the local level) (p322) <u>Participation</u> 'Community participation' as a concept was not widely agreed upon, but it was generally viewed that people would need to be involved in their personal health issues if lifestyle changes were to be made Most held the view that more active citizens' health behaviours would positively influence the lifestyles of less active citizens through passing on knowledge	**Limitations identified by author:** None **Limitations identified by review team**: Rationale for purposive sample not stated Analytic process and write-up is unclear and not sufficiently focused Rationale for the selection of quotations used is unclear Analysis is not integrated into a whole – mostly presented along the lines of 'some actors said this, some said something different' **Evidence gaps and/or recommendations for future research:** None stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			Views on the provision of health information were varied – whilst there was consensus that higher levels of general education facilitated healthier lifestyles, some identified the potential of 'forceful' health information to further exclude those who were not so educated Community participation as a goal "received little attention from the actors" (p323). One actor identified a lack of enthusiasm in Sweden for community participation: "We have no equivalent of tree-lovers as regards health – not like the people who love forests and the environment. There is no real public participation… It would be very exciting to have an eager participation and people who would almost fight for this concept" (Actor at national level) <u>Constraints and ideology</u> Co-operation in delivering the programme was "relatively friction-free" (p325), with conflicts (where they did arise) being resolved constructively Limitations identified regarding the programme: - "insensitive to peoples' habits and cultural patterns" (p325) - too 'professional', i.e not rooted in the local population - in some instances, the prioritisation of paperwork over practical delivery - differences in perception between local and regional actors/ organisations: "We have different frames of reference, we think differently. There is a small barrier between us and them" (p325) (Actor at the local level) - personal disagreements – "Sometimes these were seen as conflicts of interest, but more often as conflicts between strong personalities having different motives for their actions" (p325) – in the main, these motives were identified as being rooted in 'opposing' orientations towards either an individualist approach to health or one that stressed collective (community) action, e.g.: "Responsibility must lie on the personal side. We cannot	**Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			solve these problems by bringing in the community to take responsibility all the time" (Actor at the local level) "Naturally, the principal promoters of health are general political reforms and improvements" (Actor at the district level) (p326)	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **DeBate, R. & Plescia, M.** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** +	**What was/were the research questions:** To garner community perceptions of the Charlotte REACH 2010 lay health advisor programme as part of larger multi-levelled initiative. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** NR. **How were the data collected:** **What method (s):** 9 x1.5 hr Focus groups **By whom:** The principal evaluator conducted all FGDs **What setting(s):** "Various" community locations **When:** 2003 **Programme description:** REACH 2010 (Racial and Ethnic Approaches to Community Health.) 5-yr project. North-west Charlotte, NC, USA A multi-faceted, community driven intervention to reduce CVD and diabetes. Collaboratively developed between 19 community organisations and 12 neighbourhoods in predominately lower socio-economic status African American population. Engaged at multiple levels – personal, community & policy.	**What population were the sample recruited from:** 1 group lay health advisors. 3 groups residents attending a REACH programme. 3 groups with residents not attending a REACH programme. **How were they recruited:** Lay health advisors (LHAs) direct contact by letter. Residents via flyers posted at REACH programme sites and a local grocery store. **How many participants were recruited:** 78 (12 LHAs, 29 participating residents, 37 non-participating) **Were there specific exclusion criteria:** For different groups by participation in REACH. **Were there specific inclusion criteria:** Aged 18+ Living in NW Charlotte, NC.	**Brief description of method and process of analysis:** Questions developed following guidelines by Hawes, Degeling & Hall (1995) on *Evaluating Health Promotion* to "allow for a funnelling effect". FGDs taped and transcribed. 3 Independent coders hand coded following modified Spradley (1979) methods (*The Ethnographic Interview*). Coding compared and final codes agreed. Final codes entered onto NVivo, compared and contrasted into overarching themes and sub-themes. **Key themes (with illustrative quotes if available) relevant to this review:** 2 main themes: 1. Improved health practices 2. Community capacity. <u>1. Improved Health Practices</u> Reported by LHA & residents. Increased knowledge about healthy eating. Family members also adopting health-enhancing behaviours - "it's sort of filtering down to our children down to our grandchildren" Supporting changes and witnessing positive changes in the community were the greatest motivator for continuing to be a LHA. Non-participating residents did not indicate changes in health practice. Most believed they were healthy & defined healthy as being disease-free. <u>2. Community capacity</u>. Includes community commitment & collectiveness and social support networks. Commitment to improving the community was the main reason for becoming a LHA. LHAs motivated to continue due to increased	**Limitations identified by author:** None **Limitations identified by review team**: Inconsistencies are seen in the description of approach – 9 focus groups are mentioned, but only 7 listed. In addition, it is stated that focus groups "and interviews" were taped and transcribed. This is the only place interviews are mentioned. Despite referencing Spradley, there is little evidence of exploring relationships in the data. There appears to be overlap between the elements outlined under the different thematic headers. **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Centres for Disease Control and Prevention

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	14 residents were recruited as lay health advisors to provide outreach & education and link between peers and local health promotion programmes & services		awareness of health issues affecting their community. Non-participators also voiced sense of community commitment - “I like the fact that we are a community that cares”. Colletciveness was noted as the need to work together to make changes. Emergence of social networks noted by participating residents proving emotional, instrumental & informational support. Non residents were concerned about lack of neighbourhood fellowships.	



REACH Natural helper model (see paper also for ecological strategies for REACH overall)

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** +	**What was/were the research questions:** To explore changes that have occurred among and between levels of influence in this ecological model. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Not stated. Topic guide informed by Hawe, Degeling and Hall and analysis by Spradley. **How were the data collected:** **What method (s):** 10 focus groups **By whom:** All moderated one evaluator (RD) **What setting(s):** NR **When:** NR **Programme description:** REACH Ecological approach to community health – lasting changes in health behaviour require supportive changes in 5 levels of influence: intrapersonal factors, interpersonal processes and groups, institutional factors, community factors and public policy. Key characteristics of such models are multiple dimensions among these levels & the effects of environmental influences.	**What population were the sample recruited from:** Lay health advisors (LHAs), REACH program staff, participants and non-participants residents. **How were they recruited:** NR **How many participants were recruited:** 12 LHAs, 29 participating residents, 37 non participants and 6 program staff **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** 1) aged 18+ 2) Living in the NW Corridor of Charlotte, NC	**Brief description of method and process of analysis:** Questions developed following guidelines by Hawes, Degeling & Hall (1995) on *Evaluating Health Promotion* to "allow for a funnelling effect". FGDs taped and transcribed. 3 Independent coders hand coded following modified Spradley (1979) methods (*The Ethnographic Interview*). Coding compared and final codes agreed. Final codes entered onto NVivo, compared and contrasted into overarching themes and sub-themes **Key themes (with illustrative quotes if available) relevant to this review:** <u>Intrapersonal level changes</u> Majority of participants had learned a new skill, improved their health, lost weight & were regularly exercising. Improvement in social health through fellowship was a reason for continued participation, together with improvements in physical health. Non-participants identified lack of fellowship as the dominant theme in what they disliked about living in the area. They thought top issues affecting the community were health and lack of activities for children. LHAs, when asked how their perceptions of "health" had changed, suggested they had shifted from "disease free" perception to prevention based definition. <u>Interpersonal level changes</u> Participants promote positive health behaviours to their families.	**Limitations identified by author:** NR **Limitations identified by review team**: It is not always clear that items presented under each change level are appropriate – for example, knowledge about & use of services is a personal change, but presented under organizational level change? Explanations are not sought – does the lack of fellowship identified by non-participants lead to this non participation or *vice versa*? **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** NR

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			LHAs motivated to stay in their roles due to discovering health problems in their neighbourhood, witnessing positive changes, experiencing a sense of community connectiveness, and motivation from other LHAs. (RG note – some of these quotes relate to own family rather than community) <u>Organisation level changes</u> Participants noted changes in awareness and use of services provided due to referral by primary care providers to REACH activities. Current health concerns were motivating factors for referral & participation. Program staff perceived LHAs to be the link between the community and themselves – providing information both ways and giving them ideas and suggestions. Although it was seen as a collaboration, it was felt to need improvement. “It could be more, We don’t on a regular basis, see them and talk to them.” Stronger working relationships with the LHAs seen as a key way to enhance the probability of reaching programme goals. <u>Community level changes</u> Majority identified the implementation of a neighbourhood farmer’s market (as a meeting place and place to get food) as the biggest change, followed by better developed sense of helping neighbours.	

Identified themes among levels of influence			
Level	**Socio-Ecological Model and Reducing CVD and Diabetes**		
	Charlotte REACH Strategy	**Themes within Levels**	**Themes between levels**
Intrapersonal	Community programming to increase awareness of CVD, diabetes, and related risk factors; educational and skill programming for increasing positive health behaviors	*REACH programme participants residing in target area* Identified health issues as cue to action Improved knowledge regarding preventative health behaviours Expressed improved health status Developed health related skill *Non-program participants residing in target area* • Indicated lack of fellowship and activities for children were what they disliked about living in community • Perceived self as "healthy" because disease free	• REACH program participants supporting each others' continued behaviour change • REACH program participants diffusing health risk reduction activities to family • Primary care providers referring patients to REACH activities • LHAs changed perceptions of health to prevention oriented • Identified importance of program staff and LHA collaboration • Collaboration between LHA and program staff in the implement- ation of walking groups identified as a positive community change • Overcoming cultural barriers identified as a success • All levels identified farmers market as positive change in community
Interpersonal	Lay Health Advisor (LHA) Program	LHAs motivated by witnessing health issues of fellow residents and positive changes in community	
Organizational	PCP referral to REACH program activities, YMCA programming, diabetes support group, secondary prevention activities, working relationship between LHA and program staff	• Referral from primary care provider cue to action • Collaboration between staff and LHA exists	
Community	Winners Circle, farmers market	• Farmer's market and establishment of walking groups by LHAs identified as positive community changes	

Source: Table 3 of paper

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Dietz, W** Year: **2001** Citation: **Focus group data pertinent to the prevention of obesity in African Americans. American Journal of the Medical Sciences 322 (5) 286-289** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What are the needs and preferences of adolescents that can inform the design of a community-based communications campaign to promote more healthful lifestyles? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Focus groups **By whom:** Not stated **What setting(s):** Not stated **When:** Not stated **Programme description:** Linked to a community-based communications campaign to promote healthier lifestyles amongst African-American women ('Sisters Together')	**What population were the sample recruited from:** Unclear – simply states 'adolescents in Atlanta and San Antonio' **How were they recruited:** Not stated **How many participants were recruited:** Not stated, although 12 focus groups were held in total **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** None stated **Key themes (with illustrative quotes if available) relevant to this review:** <u>Terms used to describe weight</u> 'Underweight' was associated with adolescents who had eating disorders 'Overweight' was associated with eating too much rather than a physical state 'Obesity' was largely believed to apply only to people who were grossly and morbidly overweight African-American girls were notable for their not perceiving physical attractiveness to be linked with weight – their attractiveness to boys was a more important motivator to eat healthily than weight regulation or health <u>Healthy eating</u> All groups were able to describe a healthy diet Most participants understood the importance of a low-fat diet, but this understanding only extended as far as counting fat grams and calories Few participants reported following healthy eating guidelines Many participants reported that low-calorie alternatives were not provided in school cafeterias or vending machines <u>Physical activity</u> 'Physical activity' was mostly understood to be spontaneous, unregimented movement (and therefore enjoyable) 'Exercise' was mostly understood as being undertaken as a response to being overweight (and therefore not enjoyable)	**Limitations identified by author:** None **Limitations identified by review team**: Rudimentary or no details at all provided upon data collection and analytic procedures Very basic information only given regarding sample Rudimentary analysis **Evidence gaps and/or recommendations for future research:** None stated **Source of funding:** None stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Dressendorfer, D.H., Raine, K., Dyck, R.J., Plotnikoff, R.C., Collins-Nakai, R.L., McLaughlin, W.K. & Ness, K.** Year: **2005** Citation: **A conceptual model of community capacity development for health promotion in the Alberta Heart Health Project. Health Promotion Practice 6 (1) 31-36** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** How did local infrastructure and the resources that were mobilised for heart health promotion impact upon the effectiveness of interventions? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Participatory Action Research **How were the data collected:** **What method (s):** In-person and group interviews with site co-ordinators Focus groups Observation of staff meetings Documentary review (minutes of meetings, media clippings, correspondence, annual reports and background documents) **By whom:** Not stated **What setting(s):** Not stated **When:** Not stated **Programme description:** Local projects were developed in conjunction with community partners with the aim of not only modifying unhealthy behaviours, but also to	**What population were the sample recruited from:** Communities in which the project was delivered **How were they recruited:** Not stated **How many participants were recruited:** Not stated **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** Interviews and focus groups with project staff and community members were utilised. 'Identified factors and lessons were categorised thematically' and were 'driven by the commonalities in the data and informed by theoretical literature' (p33) **Key themes (with illustrative quotes if available) relevant to this review:** (Extracted directly from Table 2, p34): <u>Dimensions of community capacity development for health promotion</u> Leadership – the process of developing partnerships, collaborations and linkages within the community, including the mobilisation of volunteers and open communication with stakeholders Policy making – the process of developing vision, mission, and political will of the target community to implement and sustain a health initiative Infrastructure – the process of developing a supportive system and organisation in the health sector, the skills, knowledge and resources for health promotion, and the connectedness between individuals and agencies	**Limitations identified by author:** None **Limitations identified by review team**: The way in which Participatory Action Research actually informed the conduct of the research is not clear Basic details such as the number of interviewees and participants in focus groups is not given Although the analytic process is described, the jump from data to conclusions is undocumented and the theoretical basis for the analysis is unclear No actual data from the interviews or focus groups is presented No consideration of ethical issues documented **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	make changes to the social environment so as to favour heart health. Local projects included: Comprehensive school heart health project (targeted students, teachers, school staff and parents; promoted community support for tobacco abstention, nutrition, physical activity and personal self-esteem) Workplace wellness project (targeted employees in local government departments; promoted CVD risk factor awareness, healthy lifestyles and reduction of work absenteeism Heart of the Land project (targeted adults in small rural communities; promoted CVD risk factor awareness and healthy lifestyles) Straight from the Heart project (targeted teens, young adults and families in two large rural cities; promoted CVD risk factor awareness, healthy lifestyles and tobacco-free environments)			

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** ++	**What was/were the research questions:** - to describe changes in self-rated health during a 10-yr intervention period and analyse how these changes are related to changes in risk factor load, accounting for possible gender and educational differences. - to describe the health related norms and attitudes embedded in the social context and discuss their influence of attitudes and feelings towards the intervention programme and the observed development of self-rated health and risk factor load. (elsewhere it also states that understandings about changes over time were also sought) **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Grounded theory **How were the data collected:** **What method (s):** Mixed methods: some survey data plus semi-structured interviews. "the first 2 interviews formed the basis for the continued sampling of informants to capture the range and variation of experiences" **By whom:** **"**1 or 2 members of the research group"	**What population were the sample recruited from:** Participants to be approached for 10yr follow up health exam in 1996. **How were they recruited:** NR **How many participants were recruited:** 9 but interviewed men "brought their wives" **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** Those who had participated in the health examination in 1986. Variation in age and sex. "Able to reflect back" "expected to have had different experiences for the health examinations"	**Brief description of method and process of analysis:** All interviews transcribed, coded and sorted using OpenCode software. Analysis "followed the basic steps of grounded theory, where open coding resulted in a decision to focus on certain concepts capturing norm systems and attitudes." Interviews read and re-read, summarised, compared and re-coded in selective coding processes. Health related norms codes are mainly descriptive while, for attitudes, *in vivo* coding about feelings were generated and then more cognitive components of attitudes coded. These together guided towards more abstract categories of theoretical relevance. Guided by Weber's "ideal type" but grounded in the data. **Key themes (with illustrative quotes if available) relevant to this review:** <u>Norm systems related to health and illness</u> Intervention launch challenged the view that health is a gift from God – but rather the responsibility of individuals "You should not allow yourself to feel ill". Association of health and work – traditionally, health allows one to work so was a duty. Consulting the Dr seen as a last resort. These "internalised" [author quote] values still guided some health seeking behaviour, especially among older people, despite changes towards people today caring about their health – seen as an end in itself, with work an important way of maintaining and improving it. <u>Attitudes and feelings towards health and illness</u> Pride in self and others being strong, despite pain	**Limitations identified by author:** Trustworthiness discussed – recognised that saturation is the ideal stopping point & was not used here. More views, especially from men, could have been sought. Member checking was undertaken, but with members of the health care team, not participants. **Limitations identified by review team**: Based on 9 interviews and, despite using grounded theory, not sampled to saturation. **Evidence gaps and/or recommendations for future research:** Future community interventions may benefit from targeting more direcrtly those who in combination with high risk factor load perceive their health as bad, and to make all participants feel seen, confirmed and involved. **Source of funding:** Swedish Council for Planning and Coordination of Research, Swedish Council for Social

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	What setting(s): NR **When:** late1995/ early 1996. **Programme description:** Västerbotten Intervention programme (VIP) Norsjö, Sweden. A community intervention launched in 1985 to combine a population CVD strategy with efforts to meet, examine and give health advice to people at age 30, 40, 50 & 60 yrs – systematic risk factor screening & individual counselling.		or illness. Not being able to work induced shame (especially in those 50+). A shift had occurred to bring psychological aspects of health more to the fore – seen both negatively and positively. You are "allowed to "feel ill"" but "may not make enough effort and give up too easily". Clear distinction was made between disease and connected feelings. To be unhealthy included being both physiologically and psychologically ill. These were seen as linked. <u>Attitudes and feelings towards the intervention programme</u> Programme was well-established, accepted and able to start a dialogue with the population. CVD as a common problem was made understandable to the people during the process. Health examination screening and counselling was confirmed as having a central role. Typology of 6 "ideal types" of functional and dysfunctional attitude sets were developed: *The Blessing* Saw the intervention as something bigger, outside themselves that came to their rescue, for which they were grateful. Previously knew something was wrong, but not how to cope with it & had not attended primary care. *The Opportunity* Similar to above, but feeling of relief connected to pride and people's own choices/ behaviour rather than the implementers/doctors. Not hiding perceived illness, but tried to mobilise own resources. The intervention gave them the opportunity and they felt proud of themselves.	Research & Swedish National Public Health Institute

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			The Confirmation Influenced by internal and external forces. Feelings related to participation and empowerment. The intervention increased their self-control – rather than changing risk factors, felt recognised for being on the right track already. *The Watchman* viewed the intervention as a common good to be proud of. General concern for the community & created a feeling of trust. *The Disappointment* These people had unmet, high expectations, felt ignored by the programme, and in need of more help that it could offer. Some had problems that did not fit into the risk groups identified in the programme. *The Insult* Ambivalent about the programme (even if applauded at the start). Their participation was based more on feelings that heath problems. May have the targeted risk factors but could not meet the demands of the programme which they felt criticised about. In this group, suspicion about the collective ambition of the programme was seen. Hypothesise that there are more men in the "confirmation" and the "insult" types (related to pride/shame and empowerment/ insulted related to success or failure?). There is a complex interaction between feelings and willingness/possibility to adopt new health related norm systems for disease prevention.	

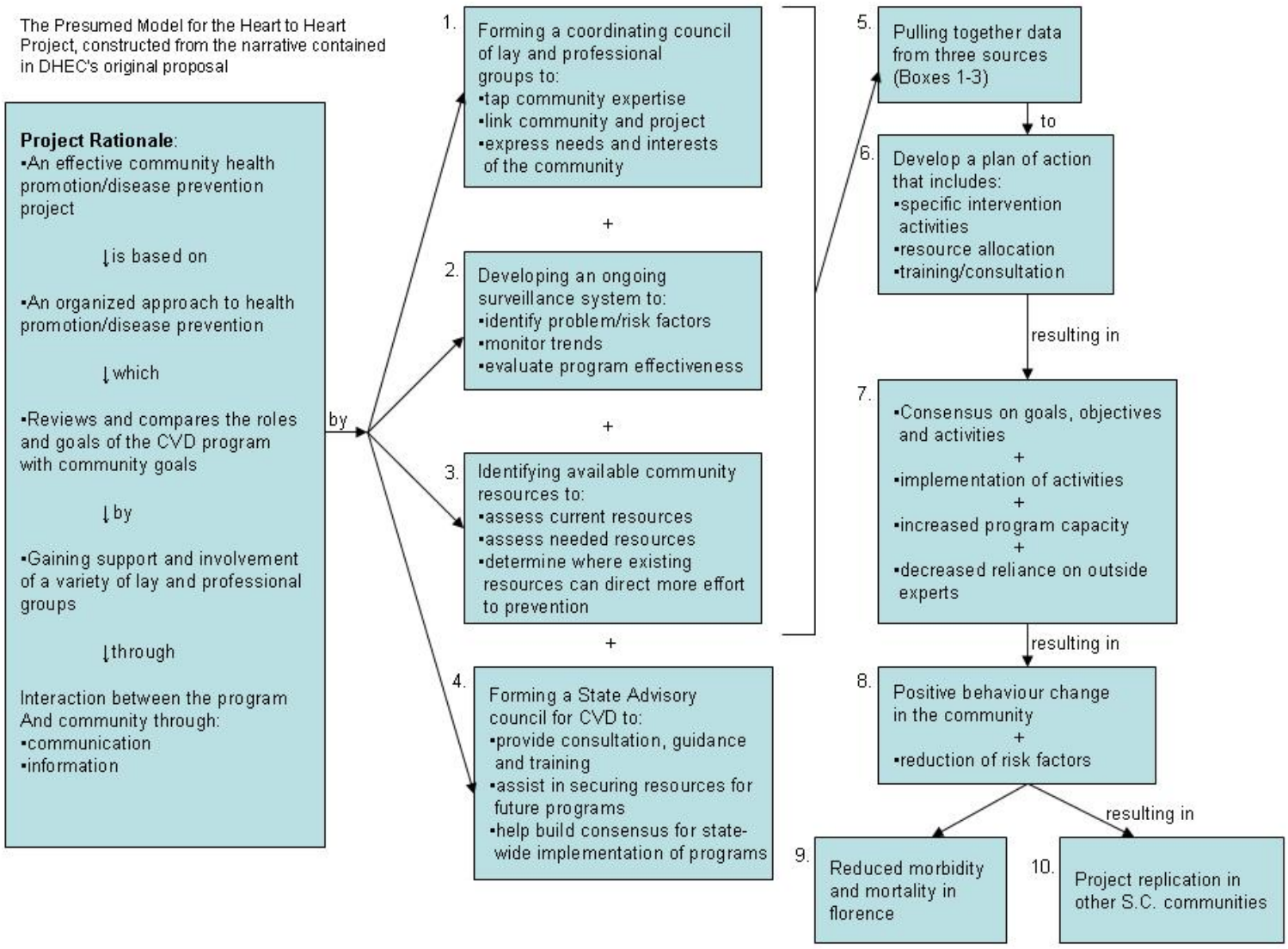
Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Goldberg, J., Rudd, R.E., and Dietz, W.** Year: **1999** Citation: **Using 3 data sources and methods to shape a nutrition campaign. Journal of the American Dietetic Association 99 (6) 717-722** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What are the needs and preferences of African-American women that can inform the design of a community-based communications campaign to promote more healthful lifestyles? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Semi-structured interviews with community nutritionists were used to design a discussion guide for use in 2 hour focus groups (6-9 women in each group) with African-American women **By whom:** Not stated **What setting(s):** Not stated **When:** Not stated **Programme description:** Community-based communications campaign to promote healthier lifestyles amongst African-American women in 3 communities in Boston, Mass. (US)	**What population were the sample recruited from:** Target communities in the Sisters Together: Move More, Eat Better programme **How were they recruited:** Staff recommendations at neighbourhood health centres and community organisations Posters **How many participants were recruited:** 47 (some did not take part in the focus groups but were instead interviewed individually, although it is not clear why this occurred) **Were there specific exclusion criteria:** Health professionals and/or 'nutrition experts' **Were there specific inclusion criteria:** Non-obese (no definition provided) Age 18-35 African-American Resident in one of the programme's targeted communities	**Brief description of method and process of analysis:** None provided **Key themes (with illustrative quotes if available) relevant to this review:** <u>Definition of healthful foods</u> Fresh fruit and vegetables (but not frozen or canned) were perceived as healthy Some women also mentioned beef, poultry, fish and seafood Many women described healthful eating as "3 meals a day from the basic four" Some women were confused about healthy eating as they perceived messages about what constituted healthy eating to be contradictory Some women observed that other family members had lived long lives whilst eating 'unhealthily' <u>Cooking preferences</u> Women largely preferred the taste of fried foods, but were aware of the need to fry less – but lack of time and family health problems mitigated against this Baking was perceived by some to be "lazy cooking" <u>Personal appearance</u> Healthier eating was perceived by many to benefit personal appearance ("your skin is better", "you look younger") and mood ("you feel better about yourself", "you feel energised") A minority of women did not believe in the benefits of healthier eating as they had concerns about the safety of food additives and pesticides on fruit and vegetables	**Limitations identified by author:** None **Limitations identified by review team**: Convenience sample used rather than a purposive sample Analytic process not reported Possible heterogeneity of sample not considered in analysis Simplistic understanding and utilisation of triangulation **Evidence gaps and/or recommendations for future research:** None **Source of funding:** National Institute of Diabetes and Digestive and Kidney Diseases of the National Institutes of Health

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			Attractiveness was not necessarily perceived as being associated with being thin – attitude, grooming and self-esteem were perceived of greater importance in making a woman attractive <u>Barriers to healthy eating</u> Cost, rapid spoilage, and the time taken to prepare fresh foods Participants perceived healthy food to be less tasty than those foods they described as 'unhealthy' Participants did not understand how to select low-fat foods for their diet <u>Motivators for healthy eating</u> Serious or life-threatening illness Lack of information on healthy ingredient substitutions and on selecting healthier and less expensive foodstuffs "Hard evidence" that healthy eating was really of benefit <u>Influence of participants' mothers</u> The most credible source of health-information was repeatedly found to be participants' mothers (other family members were a less important category of credible sources) Physicians, nutritionists, and health professionals, especially if they were African-American and female, were also perceived by some to be credible sources of advice	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** -	**What was/were the research questions:** To report the results of outcome and process evaluations of Heart to Heart Project. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** NR **How were the data collected:** **What method (s):** (quasi-experimental; case study) and interviews **By whom:** Carolina Dept of Health and Environment staff **What setting(s):** NR **When:** NR **Programme description:** Heart to Heart Project (Florence, South Carolina, 1986-1990) Based on the social learning theory programmes of Stanford, Minnesota and Pawtucket, but with less funding and time to achieve them. (see figure 1 for conceptual model)	**What population were the sample recruited from:** A list of 100 names supplied by the CDC (?who were involved in findings applications not clear) Representative sampling used. Stakeholders – advisors, administrators, coordinators, staff form local agencies, community members and a state advisory committee member were interviewed. Dept of Health and Environment. staff labelled each person as neutral, negative or supportive of the programme and people were recruited form each category. **How were they recruited:** NR **How many participants were recruited:** 40 **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	**Brief description of method and process of analysis:** Interviews lasted about 35 minutes (schedule provided) and were tape recorded and transcribed. Entered into *Ethnograph* software. 1 person coded transcript for text that completed the following types of sentences: "x is a method for participating in the programme" "Y is a benefit derived from it" "Z is a way the programme might have been improved". *Ethnograph* used to aggregate all similar codes into taxonomies. "Codes were counted to indicate which ones were repeated most often and therefore were most thematic for the evaluation." **Key themes (with illustrative quotes if available) relevant to this review:** <u>Specific benefits produced by Heart to Heart</u> Effective strategies identified as use of media, signs & literature; campaigns and other highly visible events and committed individuals who championed the project. Increased linkages among service providers and institutionalisation of programme activities next most frequently cited benefits. Increased community readiness to engage in large scale intervention projects. Increased capacity and skill in delivering community based projects. <u>Areas for improvement</u> *Confusion and conflict resulting from unclear and contradictory project goals* Project goals were not uniformly agreed or clear from the start. Goals were for research, development, dissemination of the community based model. People at different levels of	**Limitations identified by author:** NR **Limitations identified by review team**: Counting is limited use of qualitative data – the sense of the sentence relating to this is unclear. Counts are tabulated in the reporting of the findings. Quotes are provided in another report. **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Programme funded by CDC & S. Carolina Dept of Health and Environment.

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			engagement with the project also had different goals – for example, project staff wanted to gain acceptance & support for the project in the local community; agency staff wanted to deliver projects and council member wanted to shape policy. Lack of goal consensus may have contributed to lack of organisation during implementation. *Deficiencies in project implementation*. Some important community groups (such as African Americans, poorer communities, young people, men) were not reached as effectively as they could have been. "They may have had the feeling this was an upper class type program" "I still kind of figured it as a white middle class, white upper class type program with running and smoking cessation and that type of thing." The coordinating council, which was supposed to provide input for project planning, was not used effectively. Not clear to them how they were selected, or what their role was. *Time pressure* 3year time frame felt to lead to limited time to plan, use community survey data, gain community input, to develop interventions, orient staff, cultivate working relationships, to institutionalise the project and to achieve outcomes. *Inadequate staff qualifications* Necessary skills sometimes lacking. "there's a pretty string tendency for us to work within our comfort zone. We're talking about a predominately, upper middle class staff who functioned reasonably effectively in the white upper middle class of the community. We asked them to target the black community, or the poor community; [but that] was difficult for folks who hadn't had the training, or experience or knowledge of those portions of the communities." *Limits of project institutionalisation*.	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			Concerns about the durability of any impacts achieved – who would lead and carry in the work. “I’m afraid that the academic community is going to look at [it] and say because you didn’t make a change in cholesterol, smoking, and hypertension rates, you were not effective.” (note also a series of recommendation/ lessons learnt in the paper)	


The Presumed Model for the Heart to Heart Project, constructed from the narrative contained in DHEC's original proposal
Project Rationale:
•An effective community health promotion/disease prevention project
↓is based on
•An organized approach to health promotion/disease prevention
↓which
•Reviews and compares the roles and goals of the CVD program with community goals
↓by
•Gaining support and involvement of a variety of lay and professional groups
↓through
Interaction between the program And community through:
•communication
•information
by
1. Forming a coordinating council of lay and professional groups to:
•tap community expertise
•link community and project
•express needs and interests of the community
+
2. Developing an ongoing surveillance system to:
•identify problem/risk factors
•monitor trends
•evaluate program effectiveness
+
3. Identifying available community resources to:
•assess current resources
•assess needed resources
•determine where existing resources can direct more effort to prevention
+
4. Forming a State Advisory council for CVD to:
•provide consultation, guidance and training
•assist in securing resources for future programs
•help build consensus for state-wide implementation of programs
5. Pulling together data from three sources (Boxes 1-3)
to
6. Develop a plan of action that includes:
•specific intervention activities
•resource allocation
•training/consultation
resulting in
7. •Consensus on goals, objectives and activities
+
•implementation of activities
+
•increased program capacity
+
•decreased reliance on outside experts
resulting in
8. Positive behaviour change in the community
+
•reduction of risk factors
resulting in
9. Reduced morbidity and mortality in florence
10. Project replication in other S.C. communities

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Harralson, T.L., Emig, J.C., Polansky, M., Walker, R.E., Cruz, J.O. and Garcia-Leeds, C.** Year: **2007** Citation: **Un Corazón Saludable: Factors influencing outcomes of an exercise program designed to impact cardiac and metabolic risks among urban Latinas. Journal of Community Health 32 401-412** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What were the barriers and facilitators to exercise in Latinas who took part in the Un Corazón Saludable exercise and educational programme? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Focus groups of approximately 90 minutes each (2 focus groups of women who had completed the programme and 1 of women who had not) **By whom:** Unclear, but the facilitators were bilingual **What setting(s):** Private room at a Latino community-based organisation **When:** 2004-2005 **Programme description:** Exercise and educational classes (run over 2 years – 4 x 12 week sessions each year): Exercise component – 3 mornings each week of c.1hour salsa aerobics Education component (held immediately after aerobics classes) – c.30minutes covering CVD risk factors, diet modification, physical activity, depression and other factors	**What population were the sample recruited from:** Latinas enrolled in a bilingual exercise and educational programme in North Philadelphia **How were they recruited:** From existing programmes at a women's wellness centre of an urban community-based organisation serving low income Latinos **How many participants were recruited:** 24 recruited to focus groups (those who completed the programme n=19; those who did not complete the programme n=5) **Were there specific exclusion criteria:** No **Were there specific inclusion criteria:** Women who had participated in the exercise and educational programme	**Brief description of method and process of analysis:** Minimal details provided re: conduct of focus groups. No details provided re: process of analysis **Key themes (with illustrative quotes if available) relevant to this review:** <u>Facilitators to exercise</u> Desire to manage weight, improve mood, enhance appearance and well-being <u>Barriers to exercise</u> Family obligations, e.g. child care, accompanying parent (to translate) to Doctor's appointment Access to transport Authors state that domestic violence, poverty, housing and adolescent truancy "affect self care" (p408), but no data provided to support these claims Authors argue (based upon knowledge from outside of this study) that common cultural beliefs of Latinos of: a) 'Fatalismo' (accepting one's fate as God's will) b) 'Marianismo' (emulating the Virgin Mary by enduring suffering) can "impede preventive health practices" (p409) Authors also argue that the high level of "domestic violence and poverty in this population… can obstruct self care and exacerbate depressive symptoms" (p409)	**Limitations identified by author:** None identified with regard to the qualitative component **Limitations identified by review team**: No rationale given for purposive sampling strategy Only rudimentary details provided re: focus group design/ conduct and data analysis **Evidence gaps and/or recommendations for future research:** Effect of programmes that also address emotional support and the development of coping skills, and/or programmes that integrate into participants' families to a greater extent **Source of funding:** Edna Kynett Foundation Philadelphia Department of Health Cardiovascular Institute of Philadelphia

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Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** +	**What was/were the research questions:** Materials were piloted with the following aims: -To improve understandability of the tools. -To include advice salient to the priority population in the tip sheets. -To ensure the appropriateness of resources included in the guide. -To identify resources not found on the internet or in print resources. -To learn of barriers to the use of resources to be addressed ion the intervention tools. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** **How were the data collected:** **What method (s):** Semi-structured interviews **By whom:** **What setting(s):** **When:** **Programme description:** WISEWOMAN (Well-integrated Screening and Evaluation for Women across the Nation). CVD risk reduction programme for underserved, midlife women through improved nutrition, increased physical activity and smoking cessation.	**What population were the sample recruited from:** Women similar to WISEWOMAN participants from SE North Carolina. **How were they recruited:** A key informant in each of the 4 WISEWOMAN communities was contacted who helped to recruit people who used their centre. **How many participants were recruited:** 28 (16 used the first guide, 12 used the second) Black and white women aged 37-67. **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	**Brief description of method and process of analysis:** Interview guides elicited information about multilevel influences on behaviour. One guide also administered the neighbourhood assessment & asked about its understandability, & to provide advice to a hypothetical friend to overcome environmental barriers. In the other guide, feedback on the community resource guide was elicited. Consent obtained. $25 paid, ethics committee approval given. Interviews lasted 40-60 minutes, audiotaped and transcribed verbatim. A codebook listing codes was developed deductively from interview guide questions. Two coders independently coded interviews. Consensus on codes resolved by discussion. Transcripts were imported into NVIVO for data management. (Fuller details in Jilcott, 2006 – a doctoral thesis, unpublished) **Key themes (with illustrative quotes if available) relevant to this review:** Note that Table 2 reproduces barriers and facilitators identified by community advisory board members – not extracted here. See table below for key themes and their use.	**Limitations identified by author:** Intervention rather than research based: Difficult to identify the most appropriate resources for local communities if they are unfamiliar. Community resource guides need to be updated over time. Community interventions need to build in solutions to competing demands on participants time. The notion of environmental factors influencing health behaviours was abstract to some participants, so the introduction to the tools needs to be clear and understandable. **Limitations identified by review team**: The research

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	Federally funded in 15 states, operates in tandem with the National Breast and Cervical screening program through local health departments and community health centres. Part of this involved an RCT of enhanced (2 individual and 2 group counselling sessions with a WISEWOMAN health counsellor) and minimum (2x mailout only). A literature review, community exploration and the internet informed the first 3 steps of developing additional material – a community resource guide as a tool to increased awareness of local resources to address barriers identified in the neighbourhood assessment. Step four (feedback from community members to pilot) finalised them.			question is not entirely clear. Partly because there are project outcomes as well as research ones. This is one part of a broader programme of studies and it is sometimes difficult to work out where a piece of information has come from. The analysis is reported in a table and processes seem good but it is not totally clear how the participants were recruited. **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** NR

Using Qualitative Data to Inform Development of Community-Focused Intervention Tools

Nutrition Barrier Identified on the Neighborhood Assessment	Noted in the Literature? (Reference)	Present in Study Area? (Researcher Observation; Participant Quote)	Community Resources to Address Barrier	Participant's Advice or Encouragement to Hypothetical Friend	Advice or Encouragement as Worded on the Tip Sheets
Lack of supermarkets in rural and urban, downtown areas	Yes (Alwitt & Donley, 1997; Kaufman, 1999; Zenk et al., 2005)	Yes (Researcher observed no supermarkets in the downtown area; participant said, "Down where we stay it's a mile to get to a bank or a store…I mean a big supermarket. I'm not talking about a little store.")	Van rides to local discount superstore Produce market and food bank in downtown	"The cereals aren't as high…you can pay almost $5.00 for a box of cereal, where you can go in Store X and get that same box of cereal for $1.50, $1.98, maybe $2.98.	"Larger grocery stores have a wider selection of healthy foods that are cheaper than foods at smaller neighborhood grocery stores or convenience stores".
Fast food restaurants	Yes (Block, Scribner & DeSalvo, 2004; Cummins, Mckay & Macintyre, 2005)	Yes (Researcher observed many fast food restaurants; participant said, "There is always somebody selling something fast, like a hot dog or there's always an ice cream truck going around.")	None	"There are so many fast food restaurants…when you're shopping it's so much easier to grab this or grab that instead of taking it with you. I brought a big cooler to put in the van…so we can take our stuff with us."	"Take quick snacks like apples or carrot sticks when running errands so that you are not hungry when you pass a fast food place."
Lack of produce stands in urban, downtown areas	Yes (Moore & Diez-Roux, 2006)	Yes (Researcher observed few produce stands; participant said, "I prefer them [fruits and vegetables] off of the stand, but I just don't see them in my travels that much.")	Produce market and food bank in downtown Pick-your-own farm	"I think truly the farmer's market …the people there are so pleasant and nice."	"Farmer's markets and produce stands can give you the small-town feel in a larger city."
Neighborhood not "walkable"	Yes (Humpo et al., 2004; King et al., 2000)	Yes (Researcher observed heavy traffic, lack of pedestrian infrastructure; participant said, "I used to walk in this neighborhood and because of the traffic,	Local school tracks Mall walking program Two popular walking trails	"This town, the whole county is not a sidewalk county …with all the traffic in the neighborhoods it's not safe to walk. That's why your malls are so	"Think about other places to walk, such as school tracks or malls."

Nutrition Barrier Identified on the Neighborhood Assessment	Noted in the Literature? (Reference)	Present in Study Area? (Researcher Observation; Participant Quote)	Community Resources to Address Barrier	Participant's Advice or Encouragement to Hypothetical Friend	Advice or Encouragement as Worded on the Tip Sheets
		it was dangerous so that is one of the reasons I don't walk in this neighborhood anymore.")		popular.")	
Difficult to access school facilities	Yes (Evenson & McGinn, 2004)	Yes (Researcher observed that few schools allowed the public to use facilities; participant said that "you have to time when to go when it's not so congested – that's probably the most difficult thing.")	University and middle school tracks that allow public use	"I asked about it a couple of years ago and the principal said that he welcomed people to walk."	"Call schools near you to find out if they allow the public to use their facilities."
Cost of gyms and fitness centres	Yes (Eyler et al., 1998; Eyler, Matson-Koffman, et al., 2002)	Yes (Researcher found that most gyms had high membership fees; participant said, "I think some of the other stuff is too expensive so that's why people don't go …then they lock you into that contract.")	YMCA YWCA Senior center Community recreation center	"You can always go in and talk to them [private gyms] and they'll give you 3 months free or whatever."	"Ask about a trial membership so you can see if you'd really enjoy it. Take a friend with you and try it out!"

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Authors: **«Auth»** Year: **«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** +	**What was/were the research questions:** To describe and reflect on the action research process and present some findings regarding attitudes and barriers to promoting and adopting healthy lifestyles and the impact of the project. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Action research – involving the population in identifying interventions would increase the likelihood of achieving an impact. "Principles of grounded theory" used – I think only in the sense that themes were allowed to emerge from the data. **How were the data collected:** **What method (s):** Multiple methods including pre-project engagement, surveys, school identification. Also one observational visit, one baseline and one follow up focus group in each of the five schools. 18 baseline focus groups with pupils (2-4 per school, 5-8 pupils per group), one-tow follow up groups in each school (eight in total, 8-16 pupils per group) **By whom:** NR **What setting(s):** NR	**What population were the sample recruited from:** Staff and pupils in participating schools. **How were they recruited:** NR **How many participants were recruited:** Not clear – see previous group details. 5/6 eligible school took part. **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	**Brief description of method and process of analysis:** Combined qualitative data from focus groups and observational visits involved initial open coding using QSR N6 free nodes, "allowing ideas to emerge from the data". A progressive focusing was subsequently used to develop a thematic framework bearing in mind the aim of identifying barriers to healthy lifestyle promotion and adoption, also to allow scope for other emerging ideas. **Key themes (with illustrative quotes if available) relevant to this review:** Similar themes in baseline and follow up focus groups. Habits remain poor overall – limited changes seen. <u>Barriers to adopting and promoting healthy lifestyles in secondary schools: Pupil perspective</u> *Factors relating to Diet* Cost: healthy food perceived higher cost, unwillingness to "waste" money trying different foods. Control: enjoyment of freedom to make food choices in secondary school compared to primary school Motivation: some food choices based on taste, hunger satisfaction & peer pressure ("not cool" to eat an apple at school) not health Other food sources: local retail outlets seen as better value, choice and change of surroundings. Influence of process and presentation on choice: lack of clear pricing and labelling leads to "safe" choice like chips. *Factors relating to physical activity* Facilities: such as changing rooms, lack of safe storage for bikes & PE kit deter them from brings in kit for extra-curricular activities on non PE days. Ethnicity and gender: cultural commitments like attending	**Limitations identified by author:** 5/6 eligible schools participated. Only one class per school followed up. Surmised, but not confirmed that a representative sample was used. Parents views not incorporated. Limited time frame so not clear if this is sustainable. Media interest in obesity high at the time and no control group. **Limitations identified by review team**: Given space limitations the analysis is well presented, however, there is no room for descriptions about how participants were recruited, and very selected quotes are provided.

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	When: NR – pre and post intervention **Programme description:** SALAD (Schools acting in Leicester Against Diabetes) and heart disease.		mosque may limit time for physical activity. Interest in sport higher in boys (seen at break time when boys play football). Current provision: PE choices not appealing to all pupils. *Factors relating to diet and physical activity* Priorities: impact on lifestyle on health seen as more relevant to older people. <u>Barriers to adopting and promoting healthy lifestyles in secondary schools: staff perspective</u> *Factors relating to Diet* Cost: commercial bias of school meals provision. Control: lack of control over secondary school pupils meals (vs primary school) Motivation: difficulty changing behaviour in terms of influencing food choices though education. Other food sources: Competition from many near to schools. Influence of process and presentation on choice: Limited lunch time leads to rapid through put and rapid choices.. *Factors relating to physical activity* Facilities: limited sports hall space, inner city location limits green space. Ethnicity and gender: lack of "exercise culture", & reluctance to led children walk to school among S. Asians, resistance to physical activity among older girls Current provision: Good, but limited by availability of staff for extra curricular activities. *Factors relating to diet and physical activity* Priorities: Demands of curriculum and exam performance pressure limits time in schools to promote healthy lifestyles. Elements outside their control caused staff *frustration* – such as facilities, burger vans outside the gates. *Defensiveness* – reluctance to accept a need for change.	**Evidence gaps and/or recommendations for future research:** NR **Source of funding:** British Heart Foundation

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			Impact of action research awareness raising, focus. In addition, a number of suggested activities were discussed in the staff and pupil groups and adopted or rejected based on their discussion: Rejected – Motivational visit by sports personality (unrealistic as would only have an impact if someone huge came). "Walk to school" campaign (initial interested, but local campaign focussed on primary schools). More free water (practical barriers) Introduced - Dance option for PE (for girls, required extra staff member). "No chip" days (impact limited by alternatives outside school, and some replacements being higher in fat). Clearer food labelling (some attempts to do this). Incentive schemes with stamps collected and prize draw for fully stamped cards.	

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Authors: **Kim, S., Koniak-Griffin, D., Flaskerud, J.H. & Guarnero, P.A.** Year: **2004** Citation: **The impact of lay health advisors on cardiovascular health promotion: using a community-based participatory approach. Journal of Cardiovascular Nursing 19 (3) 192-199** Quality score: **(++, + or -)** **+**	**What was/were the research questions:** To identify the successes and challenges of implementing the programme. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated. **How were the data collected:** **What method (s):** Questionnaire – mostly closed questions, but including a number of relevant open-ended questions. **By whom:** Lay Health Advisors (from the same ethnic group as the participants) **What setting(s):** At community health education classes **When:** 2002 **Programme description:** Lay Health Advisors were trained in delivering health education in a variety of areas and also received training in research conduct (e.g. data collection, safety) as they were to administer the questionnaires. A participatory approach was adopted in order to allow the programme to	**What population were the sample recruited from:** 'Low-income Latino groups' in Pacoima, Los Angeles county (USA) **How were they recruited:** Through the Lay Health Advisors' social networks **How many participants were recruited:** 256 (98% female, 76% married, 71% did not work outside of the home, 51% lacked health insurance, 88% were Catholic) **Were there specific exclusion criteria:** None **Were there specific inclusion criteria:** Latino residents of Pacoima aged 18+	**Brief description of method and process of analysis:** "Written responses to the open-ended questions on successes and challenges of applying newly gained knowledge to their [the participants'] lives were analysed in Spanish line by line by a bilingual researcher with a background in qualitative research. Trends and response categories were identified, and response clusters were then grouped to identify underlying themes" (p196) **Key themes (with illustrative quotes if available) relevant to this review:** Authors' classified the analysis in 3 ways: 1) awareness and motivation issues 2) incorporating and maintaining specific practices into everyday life 3) cooperation or resistance (to changing behaviour) from family members <u>Diet</u> Increased knowledge of what constitutes a healthy diet – "we no longer purchase canned soup… and we are trying to eat 2 fruits and 3 vegetables each day" Difficulties experienced in maintaining family members' interest in healthier foods, e.g. husbands' disapproval of diet changes and adolescent childrens' fondness for fast food – "A challenge for me has been to convince my husband to use less oil and convince my children to eat less fried foods and sweets". <u>Physical activity</u> Integrating exercise into a daily routine was viewed as beneficial, e.g. "walking to pick up	**Limitations identified by author:** Sample was predominantly female, so the views and experiences of male members of the community were largely unidentified. **Limitations identified by review team**: Rationale for convenience sample is not provided. Study provided an opportunity for in-depth engagement with participants using e.g. semi-structured interviews rather than the more basic open-ended questionnaires – the reasons for not using methods that would have elicited richer data are not given. **Evidence gaps and/or recommendations for future research:** "Future research efforts may be enriched by including a controlled comparison group to further empirically test the effectiveness of Lay Health Advisors" (p198) **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	'evolve' in the manner most suitable for the community concerned. Lay Health Advisors delivered 3 health education classes (physical activity, smoking, diet - 2 hours duration each) in the community, utilising teaching aids such as: video on physical activity, audio tape of activity instructions with music, picture cards, plastic food models, a food pyramid poster, and measuring utensils.		children from school", "leaving the car a distance from the market". Family resistance to exercise was viewed as a barrier, e.g. "my husband does not want to get up and do exercise or make our children do it". <u>Smoking</u> Setting up a smoke-free home was reported as difficult when a number of (extended) family members smoked.	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Levy, S.R., Anderson, E.E., Issel, L.M., Willis, M.A. et al.** Year: **2004** Citation: **Using multilevel, multisource needs assessment data for planning community interventions. Health Promotion Practice 5 (1) 59-68** Quality score: **(++, + or -)** **+**	**What was/were the research questions:** 'To enhance understanding of the multitude of factors that influence CVD and diabetes in individuals living in the community area' (p61) **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Ecological Model of Health Behaviour (McElroy et al 1988) Study also informed by generic 'participatory' approaches **How were the data collected:** **What method (s):** Focus groups (either African-American or Latino participants; mostly single-sex, but some were mixed sex) Semi-structured interviews (both as part of a 'triangulation' approach that also included 'behavioural risk factor surveillance system' and 'community landscape asset mapping') **By whom:** Member of the research team of the same ethnicity as the participants **What setting(s):** Local community or social service agencies (focus groups) Community agencies or participants' own homes (interviews)	**What population were the sample recruited from:** Two contiguous communities (one predominantly African-American, one predominantly Latino) on west side of Chicago (US) – sample comprised both community members and health professionals working within those communities **How were they recruited:** Identified by planning council members (council had been formed for the purposes of the project – it consisted of health & evaluation professionals from different racial and ethnic backgrounds) **How many participants were recruited:** Focus groups (n=8, a total of 99 participants, all aged >25) Interviews (n=10) **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** "The evaluation team collectively generated five thematic areas" from the focus group and interview data (p62) – these were presented to the planning council for "discussion and refinement". The resulting themes were used in a triangulation process that drew upon survey and observational data as well as that from the focus groups and interviews **Key themes (with illustrative quotes if available) relevant to this review:** <u>Limited availability of accurate information on CVD</u> Community members lacked "basic knowledge" (p63) of CVD and diabetes risk factors, symptoms, or causes "Frustration" that health-related pamphlets & other educational materials were "overly technical and laden with medical jargon" (p63) Latino participants expressed difficulty at finding information written in Spanish <u>Desire for health programmes to be located within the community</u> Belief expressed that community would support health promotion programmes delivered within the community Community members wanted to make lifestyle changes, "but did not know where to go or how to begin" (p64) Information on nutrition, healthy cooking, and "changing family eating habits" was hard to find in the community (p64) African American participants wanted programmes that were "holistic and family-	**Limitations identified by author:** None **Limitations identified by review team**: No participant quotes provided Sampling strategy based upon the (unanalysed) expertise of planning council members **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	When: Not stated **Programme description:** REACH 2010 – Lawndale Health Promotion Project (Phase 1) – assessment of influences upon health at individual, family, community and public policy levels in order to inform the design of a 'comprehensive community action plan'		oriented" (p64) <u>Sociocultural barriers to health care</u> "Language compatibility with providers" could be an issue affecting access to health care/ prevention programmes, especially for non-English speakers but even for those who did speak English (no further details given) (p64) "Condescending and disrespectful attitudes from providers" was reported by African-American participants (p64) Women, particularly younger women, were more likely to access health services "because maternal and child health services are available in a cluster and therefore are more easily accessible" (p64), whereas adult men "dramatically underused available health care services" (p64) <u>Stress as a threat to health and well-being</u> Environment "frequently" mentioned as a source of stress, e.g. lack of employment, safety issues, "pervasiveness of liquor stores and illicit drugs" (p65)	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Mayer, J.P., Soweid, R., Dabney, S., Brownson, C., Goodman, RM., & Brownson, R.C.** Year: **1998** Citation: **Practices of successful community coalitions: A multiple case study. American Journal of Health Behavior 22 (5) 368-377** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What were the effective coalition practices in the Bootheel Heart Health Project? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Focus groups (each of 2 hours duration) **By whom:** A faculty member from the School of Public Health (St Louis University) **What setting(s):** At a 'routine coalition meeting' **When:** 1994 **Programme description:** Bootheel Heart Health Project – CVD health coalitions were established in six medically underserved rural counties in southeastern Missouri (including walking clubs, low-fat cooking demonstrations, health fairs, exercise classes, and bloody pressure screening)	**What population were the sample recruited from:** Bootheel Heart Health Project community coalitions **How were they recruited:** Not stated **How many participants were recruited:** 22 (12 from a coalition evaluated as successful, 10 from a coalition evaluated as unsuccessful) **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** Conduct of focus groups followed a semi-structured guide designed to address issues such as decision making, development and implementation of community interventions, and extent and type of participation Transcripts were analysed using Spradley's method of delineating domains and sub-domains **Key themes (with illustrative quotes if available) relevant to this review:** <u>Associated with *successful* coalitions</u> Community empowerment – view that coalition activity could strengthen representation of community's interests in the broader political and social system Programs for which the people and materials ar readily available Health behaviour or disease endpoints that are prevalent and easily observed in the local community Proactive dissemination of messages announcing coalition programmes Activities to detect early indicators of disease or risk factors Degree to which planned coalition activities encompass a range of population groups and health concerns Ability and confidence of the community to work together to influence broad political and social actions related to health Changes in the physical and political/ institutional environment Participation in training and education to expand skills of coalition members Efforts to develop interorganisational	**Limitations identified by author:** Identification of successful and unsuccessful coalitions was 'imperfect' as relied upon self-identified characteristics of the coalitions Small sample size (but argues that the richness of data obtained more than adequately compensates for this) **Limitations identified by review team**: Composition of focus groups unclear (were members from successful and unsuccessful coalitions in the same group or not?) Size of focus groups not stated Although the rationale for the purposive sample of the coalitions is clear, it is not clear for the sample of participants that comprised the focus groups **Evidence gaps and/or recommendations for future research:** None stated **Source of funding:** Not stated

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			relationships, in particular with new funding sources Efforts to expand the interests and activities of the coalition to new health concerns and new populations <u>Associated with *unsuccessful* coalitions</u> Fun and social programmes that community members could easily attend Setting programmes within established traditional/ seasonal community events (e.g. festivals, parades) Established programmes borrowed from manuals or other practice guidelines Provision of rewards to participants for attendance	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Mays, G.P., Hesketh, H.A., Ammerman, A.S., Stockmyer, C.K., Johnson, T.L., & Bayne-Smith, M.** Year: **2004** Citation: **Integrating preventive health services within community health centers: Lessons from WISEWOMAN. Journal of Women's Health 13 (5) 607-615** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What are the perspectives of health professionals and stakeholders (involved with the delivery and use of WISEWOMAN programmes) of the opportunities and challenges of integrating WISEWOMAN into community health centre settings? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** 'Facilitated discussion', initially for 2 hours in one large group (size not stated), and then in smaller groups (5-6 people) for a further 2 hours to discuss specific integration topics **By whom:** Not stated **What setting(s):** Not stated **When:** 2002 **Programme description:** Screening for CVD risk factors for uninsured women aged 40-64 (who were also ineligible for Medicaid) and provision of lifestyle intervention	**What population were the sample recruited from:** 'Stakeholders' involved with the WISEWOMAN programme (all were identified by the Health Resources & Services Administration's (HRSA) Bureau of Primary Health Care (BPHC)) **How were they recruited:** Panel was convened by HRSA's BPHC – no details provided regarding how participants were approached and recruited **How many participants were recruited:** 21 State co-ordinators n=4 Administrators from community health centres n=5 Representatives from state primary care associations n=5 CDC's Division of Nutrition & Physical Activity n=2 HRSA officials n=4 National Association of Community Health Centres n=1 **Were there specific exclusion criteria:** None stated	**Brief description of method and process of analysis:** 'Facilitated discussion', initially for 2 hours in one large group (size not stated), and then in smaller groups (5-6 people) for a further 2 hours to discuss specific integration topics No details given regarding analytic process **Key themes (with illustrative quotes if available) relevant to this review:** Challenges of integrating WISEWOMAN within health care centres: Excess demand for currently existing health care centre services; limited capacity to take on new activities Difficult to hire qualified staff to support new programmes Difficult to perform the administrative requirements of multiple programmes, i.e. data collection and reporting, patient tracking and follow-up care Need for participation in the National Breast and Cervical Cancer Early Detection Programme Difficult to pay for services not covered by WISEWOMAN but needed by participants	**Limitations identified by author:** None **Limitations identified by review team**: Insufficient details provided regarding the local programmes that participants were involved with Sample obtained by a government body's process about which transparency cannot be assessed given the lack of details in the paper Rationale for purposive sample not given Rudimentary reporting of research methods used Analytic procedures not reported at all **Evidence gaps and/or recommendations for future research:** None stated **Source of funding:** Health Resources and Services Administration and Centers for Disease Control & Prevention

Study details	Research parameters	Population and sample selection Results	Outcomes and methods of analysis	Notes
	services to address these risk factors. (Note that programme was delivered as part of National Breast and Cervical Cancer Early Detection Programme, meaning that users also had to be participating in this)	**Were there specific inclusion criteria:** None stated		

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **«Auth», Petersen & Sorrensen** Year: **1998«Year»** Citation: **«Ref»** Quality score: **(++, + or -)** -	**What was/were the research questions:** Not clear but seems to be to identify preferences and needs expressed by these men in order to design a workplace based communication strategy to address coronary heart disease **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Grounded Theory stated. Interpretations are strongly influenced by knowledge of health psychology and theories of health behaviour change. **How were the data collected:** **What method (s):** In depth interviews **By whom:** NR **What setting(s):** NR **When:** NR but 1992 or earlier **Programme description:** Denmark. This research informed the communication strategy for an intervention strategy in male-dominated work places in Vejle Denmark in 1992-95.	**What population were the sample recruited from:** 40-year old men **How were they recruited:** Randomly selected form the civil registry system. **How many participants were recruited:** 21 10 follow up interviews **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	**Brief description of method and process of analysis:** Interview topic guide is provided. Coding used 24 codes – 14 originated from the interview guide, 7 from themes in the data, 3 contained a single element intended for use in the counting up process. Codes then grouped at a higher level of main categories according to themes of the interview. Coded using TextBase Alpha software. In parallel, memos written on each new aspect of analysis, and collected under the codes form which they originated. All text codes that were the same were collected to gather regardless of the interview form which they originated – transverse coupling (Glaser, 1978). **Key themes (with illustrative quotes if available) relevant to this review:** Many men felt responsible for failures clearly rooted in environmental and social circumstances. <u>Credibility</u> Health education suffers from credibility issues, and tends to be contradictory. There is strong resistance to "being told what to do" – directed towards the communication form rather than the health issue. There are different perceptions of logic about health habits between recipients and health educators & they may be irritated if messages do not yet affect them. Their goals may be more about well-being, enjoyment or socialization rather than prevention. Anecdotes about young "healthy" deaths and older smokers are rated more highly than health education messages. <u>Knowledge types</u> Theoretical knowledge of risk is relatively extensive.	**Limitations identified by author:** NR **Limitations identified by review team**: States that grounded theory is used, but most codes used were pre-determined and counting was a mechanism of analysis. No sample details supplied No quotes are supplied, and there are a very limited number of obvious reported examples from the interview. A number of existing theories are discussed in the results section making verification of these interpretations difficult. Some meaning are slightly obtuse – possibly because of translation issues.

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			Practical knowledge of ideal diet is limited. Knowledge can be categorised as: Theoretical knowledge Practical knowledge Experiential knowledge Intuitive knowledge (after Shirriff (1990) knowledge = intuition + information + experience) Where there is discrepancy between theoretical and experiential knowledge, more stress is put on the latter, and this influences what they say and do. This knowledge appears well balanced and consistent, echoing elements of self efficacy and social influence in Social Cognitive Theory (Bandura, 1977; 1986) It is therefore difficult for health education to penetrate these consistent attitudes and experiences that men create for themselves. Elements may be categorised on three levels corresponding to PRECED-PROCED Models categories Predisposing, reinforcing and enabling factors (Green & Krueter, 1991) on personal, social and organisational levels. <u>Motivation for change</u> Under certain circumstances these links of experiences attitudes, knowledge and self-confidence are disturbed leading to openness towards new information. The disturbance might be among any of these elements and correspond to the Health Belief Model's Cues to Action: Changes relating to: Own illness The illness of others Breakdown of self image Overstepping of limits Social networks. Contrary to expectation, personal health habits did not change much due to heart disease of death among friends and family. Breakdown of self image or social network are	**Evidence gaps and/or recommendations for future research:** NR **Source of funding:** Danish research council, Dir E. Danielson and Wife Fund, the National Health Fund for Research and Development & Health Insurance Fund.

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
			far more significant (e.g. a man whose self image was as a strong man, being unable to move a dish washer up 4 flights of stairs, decided to start exercising). Motivation for change following such breaks in established rationale follow Festigers Cognitive Dissonance theory (1959). Type of advice needed depends on where the person is in the process of change. <u>Process of change</u> Can proceed rapidly or slowly, & may go through a number of stages: pre-contemplation to contemplation via basic changes in life circumstances to create new readiness to change. New cues need to be followed by practical support, easy accessibility or social support (Trans-theoretical model, Prochaska & Di Clemente, 1983), Changes based on what the person wishes are more permanent than those based on logical rational health considerations alone. <u>Health habits are interlinked</u> Health habits – diet, exercise, smoking, stress & weight loss are seen as interlinked. It is easier to start with exercise or stress, and then these can have an effect on the others. Communication strategy based on these interviews is described in details. Not extracted here.	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Moreno, C., Alvarado, M., Balcazar, H., Lane, C., Newman, E., Ortiz, G., & Forrest, M.** Year: **1997** Citation: **Heart disease education and prevention program targeting immigrant Latinos: Using focus group responses to develop effective interventions. Journal of Community Health 22 (6) 435-450** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What are immigrant Latinos' knowledge to and attitudes about heart disease and associated risk factors? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Focus groups (n=7) conducted in Spanish (duration: approximately 2 hours 30 minutes) **By whom:** 'A Latino health research professional' **What setting(s):** Not stated **When:** 1995 **Programme description:** Salud para su Corazón – part of the Latino Community Cardiovascular Disease Prevention and Outreach Initiative (Washington, D.C.) – no details given regarding programme, but its ethos was 'community-based'	**What population were the sample recruited from:** Latino people known to agencies that served the Latino population within the Washington, D.C. metropolitan area **How were they recruited:** Agencies provided lists of Latino people, from which participants were selected so as to reflect the demographic make-up of Washington, D.C. **How many participants were recruited:** 64 (2 focus groups were male only, 4 focus groups were female only, and 1 focus group was mixed) Age range 18-54 years (70% <40 years old) 61% monolingual Spanish speakers All were employed in labour-intensive jobs (e.g. gardening, construction, cleaning) 59% had family incomes of <$200/ week 'Acculturation level' measured using General Acculturation Index – for focus groups as a whole = 1.45 (i.e. low) **Were there specific exclusion criteria:**	**Brief description of method and process of analysis:** Focus groups were moderated by a bilingual, bicultural health professional 'with extensive experience in conducting Spanish-language focus groups with Latinos' (p438) and were tape-recorded After all focus groups were completed, recordings and written notes were 'analysed to determine trends and identify major themes' (p438) **Key themes (with illustrative quotes if available) relevant to this review:** <u>Heart disease</u> Heart disease was associated with: - poor diet (too much fat, an unbalanced diet, and/or eating too much food) - lack of exercise - being overweight - stress (job insecurities, family problems, financial concerns, and adjusting to life in the US) "It is the worries that we have in this country. There are worries about paying the rent at the end of the month. Not knowing if they are going to kick you out of your home. These worries go directly to your heart" (male) (p442) 'Participants could easily list behaviours one 'should not' do but could not list behaviours that a person 'should' do to be healthier' (p442) All groups identified cultural identity (expressed through the consumption of food) as important: "We go to the Latino grocery store to buy meat for frying… because there is always the temptation for things that are Latino. We like our little soups with their fat because they are tastier. And we do	**Limitations identified by author:** Despite sample matching demographic profile of metropolitan area, it is acknowledged that it may not be representative **Limitations identified by review team**: Precise inclusion criteria vague No evidence of ethical issues being considered in recruitment procedures or the conduct of the focus groups Analytic themes developed on the basis of focus group structure rather than the views of participants **Evidence gaps and/or recommendations for future research:** None stated **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
		None stated **Were there specific inclusion criteria:** Unspecified demographic criteria	not realise that we are hurting ourselves because we are determined to preserve our customs" (p442) <u>Cholesterol</u> >80% of participants had knowledge of cholesterol, although it was not always accurate No participants could identify high or normal blood cholesterol levels Participants argued that 'Latinos are often exposed to conflicting health information and need access to accurate information from credible sources' (p443) <u>High blood pressure</u> Few participants had knowledge about high blood pressure, although (for those who responded) it was associated with stress, a failure to keep calm, and being nervous Blood pressure was viewed as being controllable in a variety of ways, including: controlling anger, eating garlic, and drinking alcohol ("The doctors say it is good to drink… I think it is one shot every day, but only one… so that the heart functions better") (p443) <u>Eating habits</u> A change in eating habits upon immigrating to the US was identified by participants – rather than eating 3 times a day, meals tended to be taken just once or twice a day because of the time demands of employment. These meals tended to be 'fast food' because of the lack of time <u>Smoking</u> <33% of participants associated smoking with heart disease (it was primarily associated with cancer)	

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Authors: **Netto, G., McCloughan, L., & Bhatnagar, A.** Year: **2007** Citation: **Effective heart disease prevention: Lessons from a qualitative study of user perspectives in Bangladeshi, Indian and Pakistani communities. Public Health 121 177-186** Quality score: **(++, + or -)** **++**	**What was/were the research questions:** How can service user views and perspectives be used to enhance the effectiveness of targeted CVD prevention programmes? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** Grounded Theory Action Research Also utilised Roscinow et al's culturally sensitive health promotion framework (where the cultural, social, historical, environmental and psychological forces that influence health are considered) **How were the data collected:** **What method (s):** 'Longitudinal focus groups' – conducted on 2 occassions (6 months apart) with the same participants **By whom:** Community worker (fluent in Hindi, Punjabi, Urdu, and English), who was also involved with the research project, for focus groups with Pakistani and Indian participants 'Experienced health worker' (fluent in Sylheti and English) for focus groups with Bangladeshi participants **What setting(s):**	**What population were the sample recruited from:** Random sample from people using the Khush Dil clinic **How were they recruited:** Project staff approached potential participants, explained research and offered an information sheet translated (where necessary) into a relevant language **How many participants were recruited:** 55 (1st focus group) Indian men n=11 Indian women n=9 Pakistani men n=5 Pakistani women n=10 Bangladeshi men n=8 Bangladeshi women n=12 2nd focus group n=36; approximately similar distribution of participants **Were there specific exclusion criteria:** Age <16 **Were there specific inclusion criteria:** Users of Khush Dil clinic	**Brief description of method and process of analysis:** Focus groups conducted using a structure of topics – knowledge and understanding of heart disease, steps to address heart disease and barriers to taking these steps, and feedback on the Khush Dil programme Focus groups were observed by one of the study co-authors and recorded, transcribed, and translated (into English) by the facilitator Transcripts were analysed in conjunction with field notes; emerging themes were noted and independently coded by all 3 study co-authors **Key themes (with illustrative quotes if available) relevant to this review:** <u>Knowledge of heart disease and risk factors</u> Fatalistic views relating to the hereditary nature of heart disease and its incurable nature: "Only God knows why heart disease occurs. I feel that if anyone has heart disease, they will not be cured" (Bangladeshi woman) Perception of stress as a major contributory factor to heart disease, attributed to external factors over which individuals have limited or no control: "We have more worries because we are living in a country where the culture is different to ours. We continuously worry about our kids, about what kind of environment they are living in, and the type of people they are keeping company with. In this country, the society is very open and different to the one back home" (Pakistani woman) Men (in all three ethnic groups) reported that stress was caused by the pressures related to earning a living and honouring material obligations	**Limitations identified by author:** Fall in participation in 2nd focus group Those willing to participate in the 2nd focus group were possibly more likely to be more amenable to making lifestyle changes than those who dropped out Use of community worker to facilitate focus groups might have inhibited critical views of the project from being expressed **Limitations identified by review team**: None **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** British Heart Foundation

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	Varied according to participants; included local community premises, a mosque, and Primary Care NHS Trust premises **When:** 2002-2003 **Programme description:** Khush Dil ('happy heart') programme (established in the Leith area of Edinburgh to serve the local South Asian population) Consisted of 3 components: 1) Nurse-led community-based CVD risk clinic 2) Dietitian-led nutrition workshops to develop dietary adaptations 3) Work with local community organisations to establish healthy lifestyle initiatives, especially to increase activity levels		to members of the extended family living abroad (and for Indian Sikh men, the financial pressures related to the high cost of weddings for their daughters) Women (particularly from the Pakistani and Bangladeshi groups) attributed stress to isolation, lack of informal support, language barriers, and inability to access essential services and communicate with key professionals: "Our life is full of stress because there is nobody here to help us… I do not speak English… [and] cannot make any appointments to the doctor or talk to the teacher regarding my children. This makes me very upset. I feel my world is very dark" (Bangladeshi woman) Fear and experience of racism was a further stressor: "We live in fear, Especially when you go to the park and white children call you 'Paki'… if you go out onto the street, then you are at risk of being called racist names" (Pakistani man) <u>Barriers to adopting a healthier lifestyle</u> Lack of opportunities for physical activity due to fear of racial harassment, anti-social working hours (for many of the men who were involved with the retail or catering trade) and caring responsibilities: "Our husbands come home from work and they want food ready for them. When this is all finished, we get to bed by 3 o'clock in the morning and at 7 o'clock, we have to take our children to school. Then we come home and sleep again. When will I do exercise? I have no time" (Bangladeshi woman)	

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			Some participants described themselves as 'lazy' and a lacking the initiative to exercise on their own; in the 2nd round of focus groups, female participants were aware of the benefits of exercise, but made little time in their daily lives for it as work tended to dominate Food with a high fat content is considered socially desirable; existence of obligatory patterns of food intake in patterns of hospitality; women's cooking habits are often influenced by other members of the family: "We have approximately 10-12 weddings per year in the Sikh community. You have to attend most of them… and you end up drinking and eating too much. Then along come the parties as well – we had 3 parties last week" (Indian man) Association between obesity with health and prosperity, and of weight loss with poor health and unattractiveness: "We were told that fat children were healthy children. Now, there is this new concept of skinny children being healthy and all that" (Bangladeshi woman) "When I went to Pakistan, people remarked on the fact how thin I was and said 'Don't you eat in the UK? It is meant to be a prosperous country'" (Pakistani woman) <u>Impact of the Khush Dil programme</u> Difficulty of encouraging others to use the project; concerns by some participants about lack of access to full range of services Need for ongoing support to make and maintain behavioural changes related to CVD prevention	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Peerbhoy, D., Majumdar, A.J., Wightman, N.A. & Brand, V.L.** Year: **2008** Citation: **Success and challenges of a community healthy lifestyles intervention in Merseyside (UK) to target families at risk from coronary heart disease. Health Education Journal 67 (2) 134-147** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What were the successes and challenges of the Family Fit programme from the point of view of the officers delivering it and the participating families? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Semi-structured interviews with Family Fit Officers (sample size not stated) Focus groups with participating families (n=5) **By whom:** Study researchers **What setting(s):** Interviews – not stated Focus groups – at a local Healthy Living Centre **When:** 2004-2006 **Programme description:** "Family Fit programme aims to improve people's health through influencing dietary and physical activity habits… [through] providing	**What population were the sample recruited from:** Families who had completed the Family Fit programme **How were they recruited:** Via Family Fit Officers **How many participants were recruited:** 34 families (comprising 48 adults and 42 young people) **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** Each family had at least one member showing 1+ CVD risk factors	**Brief description of method and process of analysis:** Interviews – "key points were extracted from a digitally recorded interview" (p136) Focus groups – Open-ended questions were asked about different stages of the programme and the associated challenges in participating – themes "were noted on a flip chart and digital recordings were used to extract specific quotes to substantiate themes" **Key themes (with illustrative quotes if available) relevant to this review:** From interviews with project officers: <u>Barriers</u> Slow uptake from GPs regarding the project. Low motivation levels of some families, plus time and transport limitations. Prevalence of fast food within the area. Lack of education regarding healthy eating, exercise and health. Gyms not necessarily appealing places to exercise. <u>Facilitators</u> Substantial involvement of school nurses, dieticians and smoking cessation staff. Flexibility to spend significant periods of time with families if required. Feed back of participants' physiological results (e.g. blood pressure, weight/height) as an objective indicator (and motivator) regarding health. From focus groups with participating families: Re: physical activity – women only sessions, more dance classes, and more weekend activities were suggested as likely to increase participation in the	**Limitations identified by author:** None (with regard to qualitative component) **Limitations identified by review team**: Analysis of data did not utilise a theoretical framework and is subsequently quite basic. No rationale given for utilisation of a convenience sample. Representativeness of convenience sample is not considered. Minimal social and demographic details of participants is provided. **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** Big Lottery Fund

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	information and modifying behavioural, social, environmental and policy determinants" (p135) e.g. exercise programmes and integration of physical activity and dietary changes into family life, as part of a wider local regeneration initiative aimed at increasing access to healthy foods and exercise venues.		programme. Personal characteristics (friendliness, being upbeat) of project staff were viewed as very important for retaining participation (especially when mood was low) in the project. Work commitments could limit participation in the programme: "It's hard to do things when you get in from work…" (Mother) Difficulty of maintaining behaviour change amongst many other commitments: "Something silly like washing and drying the kids' hair after swimming is such a hassle…" (Mother); "I end up thinking 'oh, stuff it!' and just cooking them chips instead…" (Father) Lack of self-motivation to engage in physical activity – participants largely associated physical activity with scheduled classes rather than activities they could organise and partake in themselves.	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Pratt, C.A, Hurst, R., Williams, K.P. & Martin, J.** Year: **1999** Citation: **Evaluating cardiovascular disease prevention programs in African American communities. Journal of Public Health Management Practice 5 (6) 81-90** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** - What was the effect of the programme upon lifestyle behaviours? - What challenges were faced by participants in the programme? - Are participants willing to continue in the programme, and why? (or why not?) - What do participants suggest for modifying (improving) the programme? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** 8 focus groups (c.50 minutes each) **By whom:** 'a trained consultant' **What setting(s):** Not stated **When:** 1996-1997 **Programme description:** Sampled participants from 8 multi-risk factor programmes in Michigan – programmes involved varying degrees of screening, education and	**What population were the sample recruited from:** People who had taken part in one of the programmes **How were they recruited:** Convenience sample **How many participants were recruited:** 53 (64% male), aged 21-67. 84% of the participants in the programmes were African American. **Were there specific exclusion criteria:** Age <21 or >70 **Were there specific inclusion criteria:** Participation in one of the 8 stated Michigan multi-risk factor programmes.	**Brief description of method and process of analysis:** Utilised Krueger's methods for conducting and analysing focus groups. Focus group transcriptions were "read carefully and notes were made on key words, phrases, and quotations that described participants' feelings and attitudes". First author reviewed all transcripts and compared conclusions with those of the 'trained consultant' – consensus was sought regarding these conclusions. **Key themes (with illustrative quotes if available) relevant to this review:** The programmes were identified as "helping participants to make major changes in their lifestyle behaviours" (p88) – this took place through changing diet and physical activity habits, changing the lifestyle of family members, reading and using food labels, making healthy choices at fast food restaurants, and making the time to be physically active. Participants suggested that programmes could be improved by: providing more services for children, providing more physical activity programmes, involving church leaders, advertising programmes more extensively, and media campaigns. Participants identified the need for African-American communities to accept the reality of CVD as a major cause of death if they were to take action to prevent it. Economic development was perceived by some participants as being vital to improving health.	**Limitations identified by author:** Used convenience sample. Sample not linked to data concerning behavioural change. **Limitations identified by review team**: Sample size of participants from each of the programmes is not stated. Use of convenience sample severely limits generalisability of findings. Only rudimentary demographic details of participants provided. Analysis is rather basic – thematic categories appear to be 'common sense' rather than reflecting an in-depth engagement with the participants' views and experiences. Minimal use of quotations from focus groups – those which are given are basic, short and anecdotal. **Evidence gaps and/or recommendations for future research:** Quantitative data on behavioural changes linked to the programmes concerned is required to evaluate

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	counselling. Results were not disaggregated by programme or programme type.			effectiveness. **Source of funding:** Not stated

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: Puska et al **Year:** 1986 **Citation:** «Ref» **Quality score:** (++, + or -) **-**	**What was/were the research questions:** To describe the North Karelia intervention innovation-diffusion approach – the systematic use of lay opinion leaders to promote desired health innovations and the results of their use. **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** **How were the data collected:** **What method (s):** Survey 399 lay workers, interviews with 7. **By whom:** NR **What setting(s):** NR **When:** NR **Programme description:** Emphasis on middle aged men. Aimed at controlling known risk factors 1992-1977 extended due to success. Based on behaviour modification approach (psychological, social psychology), communication-behaviour change approach (sociology, communication), and the community organization approach (social policy, sociology). Innovation-diffusion approach used which focuses on risk-reducing lifestyles and that diffuse in the course of time through normal	**What population were the sample recruited from:** Lay opinions leaders still contactable. **How were they recruited:** "Selected" from those answering the survey – some low level involvement according to the survey and some high level involvement. **How many participants were recruited:** 7 **Were there specific exclusion criteria:** NR **Were there specific inclusion criteria:** NR	**Brief description of method and process of analysis:** Questions repeated some survey questions, verified answers or asked for suggestions for the future. **Key themes (with illustrative quotes if available) relevant to this review:** Interviews confirmed the degree of involvement in the programme – distributing leaflets form a variety of locations, encouraging people to stop smoking, creation of non-smoking areas in restaurants, giving vegetables to people as a way of opening up health topics. Even those not obviously engaged form the survey were effective in a modest way. Most didn't want more training, but wanted to share experiences with others. Some negative reactions ot their work "too much propaganda" were reported. Wanted advice on how to bring up CVD informally.	**Limitations identified by author:** None **Limitations identified by review team**: Most of article reports the survey results. Qualitative element used to a minimal level. No detail about how data was collected or analysed was given. **Evidence gaps and/or recommendations for future research:** NR **Source of funding:** NR

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	community networks to individuals. Diffusion leads to social change. Mass media makes innovations known, but interpersonal networks are the more effective in forming and changing attitudes and promoting behaviour change. Diffusion occurs through knowledge, persuasion, decision & confirmation. People act as innovators, early adopters, early or late majority, laggards. New ideas originate from mass media and are transmitted and modified by opinion leaders. Project worked with opinion leaders form the beginning (municipal leaders, voluntary organization leaders, health personnel, mass media, business leaders etc) and systematic use of lay opinion leaders started in 1975. Key contexts – N Karelia is traditional, rural areas, considered resistant to change & it was a large project area necessitating contact made with numerous villages. Full description of how opinion leaders were trained is provided.			

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Rosecrans, A.M Gittelsohn, J., Ho, S., Harris, S.B., Naqshbandi, M. & Sharma, S.** Year: **2008** Citation: **Process evaluation of a multi-institutional community-based program for diabetes prevention among First Nations.** ***Health Education Research* 23 272-286** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** - Was the programme implemented with high fidelity, reach and dose? - Is the programme a feasible, acceptable and sustainable model for this context? - How can the programme be improved for expansion to additional Native North American communities? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Semi-structured interviews (number not stated) **By whom:** Programme evaluators **What setting(s):** Not stated **When:** 2005-2006 **Programme description:** Programme preceeded by 'extensive formative community work' Simultaneous/overlapping phases of 6-10 weeks each: 1) School Grade 3 & 4 story-telling and participatory activities to teach and reinforce healthier eating & physical activity 2) Food store owners were asked to stock healthier food choices, identify promoted healthy foods with shelf labels and display educational	**What population were the sample recruited from:** Teachers, parents, store managers & employees, community health representatives and health & social service employees (at both sites) who had been involved with the delivery of the programme, or who had experienced it **How were they recruited:** Not stated **How many participants were recruited:** Parents – 16 Teachers/Principals – 9 Store managers/employees – 10 Community health representatives/health & social service employees - 5 **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** None stated	**Brief description of method and process of analysis:** 'Field guides' structured the conduct of interviews with questions and topics for probing. 'Most' interviews were taped and transcribed. First author of paper read transcripts 'several times until themes emerged' – from this, 'representative quotes were selected' **Key themes (with illustrative quotes if available) relevant to this review:** <u>School component</u> Time constraints limited the extent to which the programme could be delivered within the school curriculum. Schoolchildren were able to make the links between diet, physical activity and diabetes – also, to link this to the parents/grandparents (ill) health. Access to healthy foods could be difficult on the remote reserves. <u>Store component</u> Although shelf labels were perceived as useful and educational, this needed to be seen in the context of "every box of cereal [having] some marketing campaign on it… People are bombarded with so much health information and marketing that they don't know who to trust anymore" (store manager). On the whole, shops were willing to stock healthier foods, but would not continue if sales were poor. The price of healthier food was identified as a barrier – "… all the junk that they buy, it's no choice you know because it's cheaper, it's cost efficient for them" (store employee)	**Limitations identified by author:** Teacher interviews were retrospective and not based on direct observation. Availability of healthier foods in stores 'varied considerably'. 'Some' inconsistency between evaluators. **Limitations identified by review team**: No rationale provided for purposive sampling strategy. Process by which analytic themes were developed is unclear. Effect of the interviews being conducted by evaluators closely involved with the programme upon the responses obtained is not considered. **Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** American Diabetes Association and Canadian Institute of Health Research

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	posters 3) Cooking demonstration and 'taste tests' showcasing healthy foods 4) Community events and workshops to integrate community with ongoing Health & Social Services agencies 5) Promotion of programme and eating/activity advice by radio, cable TV, newsletters and bulletin boards		<u>Community events</u> Cooking demos/taste tests were perceived as successful because of their tangible nature – "… pamphlets [involve] a lot of reading… but I find that the food sampling gives them the opportunity to feel comfortable, a little bit more relaxed, and they seem to think of questions to ask as they're eating" (community health representative) Programme was well-received, culturally-acceptable and relevant to the communities. <u>Physical activity/pedometers/'walking challenge'</u> 'Walking challenge' component perceived to be 'too long' at one month – a shorter timescale with greater involvement of nurses (to screen for blood pressure and blood sugar) was perceived as being more likely to encourage people to participate. Environment (e.g. animals and unmetalled roads) could discourage people from taking part in 'walking challenge'/ walking as a form of exercise – "… get people out walking and get rid of the dogs… the only way to get rid of the dogs is to get something going like a walking group, and this way the chief and council can do action" (community health representative)	

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
Authors: **Viadro, C.I, Farris, R.P., & Will, J.C.** Year: **2004** Citation: **The WISEWOMAN projects: Lessons learned from three states. Journal of Women's Health 13 (5) 529-538** Quality score: **(++, + or -)** **-**	**What was/were the research questions:** What were the experiences of WISEWOMAN project staff in Arizona, North Carolina, and Massachusetts in the period of 1995-1998? **What theoretical approach (e.g. Grounded Theory, IPA) does the study take (if specified):** None stated **How were the data collected:** **What method (s):** Telephone interviews **By whom:** Study author **What setting(s):** Not applicable **When:** 2002 **Programme description:** Screening for CVD risk factors for uninsured women aged 40-64 (who were also ineligible for Medicaid) and provision of lifestyle intervention services to address these risk	**What population were the sample recruited from:** Project staff involved with the WISEWOMAN project in Arizona, North Carolina, and Massachusetts **How were they recruited:** Not stated **How many participants were recruited:** 9 **Were there specific exclusion criteria:** None stated **Were there specific inclusion criteria:** Project staff involved with the WISEWOMAN project in Arizona, North Carolina, and Massachusetts	**Brief description of method and process of analysis:** Convenience sample of WISEWOMAN project staff were interviewed by telephone and "extensive notes" taken. Responses were categorised into themes and "amplified" by referral to project documentation when considered necessary **Key themes (with illustrative quotes if available) relevant to this review:** <u>Planning & Start-up</u> Time constraints limited the extent to which planning could take place for each project Time constraints limited the accomplishment of initial tasks, e.g. developing materials and procedures, fostering communication between staff, clarifying roles <u>Outreach & Enrolment</u> Multiple approaches to engage participants in the programme (e.g. outreach programmes involving community leaders and individual providers) were considered to be the most effective <u>Screening & Intervention</u> Local health promoters were considered to be crucial to programme success – both in respect of recruiting participants (e.g. when of the same ethnic group) and in overcoming day-to-day issues (e.g. barriers to access, the completion of paperwork, and acting as informal counsellors)	**Limitations identified by author:** Staff turnover precluded recruitment of some key informants Some respondents had difficulty recalling project details in their responses **Limitations identified by review team**: No rationale given for convenience sample Recruitment dependent upon potential participants' interest in taking part No analytic framework utilised Interviews not recorded, therefore relied upon accuracy of interviewer's notes Some participant's responses were "amplified" by examining them in conjunction with project documentation – unclear how this analytic process took place Analysis unclear and contradictory in places, e.g. p533 reports that staff considered training to be 'essential', yet also found it overwhelming and not of use

Study details	Research parameters	Population and sample selection	Outcomes and methods of analysis Results	Notes
	factors. (Note that programme was delivered as part of National Breast and Cervical Cancer Early Detection Programme, meaning that users also had to be participating in this)		It was considered important to only try and implement the programme where there were adequate resources to do so Support for agencies implementing the programmes, and the women taking part in it, were perceived as needing to be individualised to be effective	**Evidence gaps and/or recommendations for future research:** None identified **Source of funding:** Centers of Disease Control & Prevention and University of North Carolina Center for Health Promotion & Disease Prevention

Appendix 4 Exclusions

Reasons for excluding studies at title abstract phase:

- Not addressing the primary prevention of cardiovascular disease
- Not addressing two or more risk factors
- Not targeting low or no risk groups (or focusing on groups at high risk of CVD)
- Not targeted at a population level
- Not set in an OECD country
- No qualitative research element
- Published prior to 1970
- Not in English

Additional reasons at full text phase:

- Findings do not relate to the barriers and facilitators of delivering a population level CVD prevention programme

Appendix 5 Studies excluded at full text stage

Study	Abstract	Reason for exclusion
(Aira et al. 2004)	BACKGROUND: Brief interventions by primary care physicians have been shown to be effective in reducing both smoking and excessive drinking. However, physicians seem to target smoking more often than drinking. We aimed to explore this difference in health promotion practises for finding ways to improve alcohol interventions in primary health centres. METHODS: Qualitative semistructured interviews of 35 physicians in four health centres in Finland, and triangulation by audit of notes made by these doctors concerning alcohol drinking and smoking in medical records (n = 1200) of randomly selected 20-60 years old patients, who had visited their physician at least once in a 12-month study period. RESULTS:On the basis of the interviews, there were five main differences in preventive work between issues of alcohol use and smoking: recognition, perceived importance as a health risk factor, intervention tools available, stigmatising label, and expectations about the effectiveness of counselling. In 106 (8.8%) of medical records, there was a mention of smoking, and in 82 (6.8%) of alcohol use (P < 0,0001). Quantity of alcohol consumption was described obscurely. When one of the visits was made for hypertension, diabetes, dyspepsia, general health check or heart arrhythmias, smoking was recorded more often than alcohol consumption. CONCLUSIONS: Tobacco use was mentioned more often in medical records than alcohol drinking. Physicians were more comfortable in undertaking a preventive approach for smoking than for alcohol use. The factors contributing to this difference must be considered in any attempts to improve implementation of secondary prevention of alcohol misuse	Not population level
(Albert et al. 2007)	Obesity, cardiovascular diseases, and diabetes are becoming leading causes of morbidity and mortality in the Eastern Caribbean countries of St. Vincent and the Grenadines, Saint Lucia, Grenada, and Dominica. To promote healthful diets and lifestyles and encourage behavioral changes, Food-Based Dietary Guidelines (FBDG) were developed for the general population in each of these countries. This paper reports on the comprehensive process of developing the guidelines through consensus building among stakeholders, technical assessments and priority setting, and use of qualitative methods to field test messages to ensure public understanding and motivation. Nutritionists in each country received training and support from the Food and Agriculture Organization and the Pan American Health Organization's nutritionists. [References: 16]	Not set in developed country
(Albrecht 1999)	- no abstract available -	not qualitative methods / analysis / findings
(Alderman 1996)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Allegrante 1984)	- no abstract available -	not qualitative methods / analysis / findings
(Allen & Szanton 2005)	Although the influence of gender and ethnicity on cardiovascular disease has been understudied, cardiovascular nurse researchers have contributed significantly to the existing body of knowledge. This article distinguishes between the constructs of 'gender versus sex" and 'ethnicity versus race," acknowledging that the terms are often used interchangeably in research. A sampling of the substantial contributions of cardiovascular nurse researchers related to gender and ethnicity in the areas of symptoms of cardiovascular disease; risk factors and prevention; delay in seeking care, diagnosis, and treatment; recovery and outcomes; and cardiac rehabilitation is highlighted. Recommendations for future research include publishing research data by gender and ethnicity subgroups even though statistical comparisons may not be feasible, and increasing cardiovascular disease research in minority populations such as Asian Americans, Pacific Islanders, Native Americans, and Hispanics. Finally, we challenge cardiovascular nurse researchers to shift from the documentation of disparities toward designing and testing of interventions to eliminate health disparities. [References: 28]	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Anders et al. 2006)	The existence of significant Hispanic health disparities requires the use of innovative community-based participatory research models to insure appropriate research questions are asked and dissemination of the findings to those affected occurs. When integrated into a community-based participatory model such as the one presented in this article, promotores de salud (PS) or community health workers (CHW) who are residents of local communities provide an opportunity to more effectively address health disparities associated with health outcomes of Hispanics. This article describes an application of how a PS model can integrate research into a community agenda for addressing health disparities for cardiovascular disease (CVD) and related risk factors within a complex border environment such as the one located in El Paso /Cd. Juarez, Chihuahua, Mexico	not qualitative methods / analysis / findings
(Anderson 571)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors

Study	Abstract	Reason for exclusion
(Angus et al. 2005)	The contribution of modifiable risk factors to the prevalence of coronary heart disease (CHD) has been well documented in the literature. A focus group component of a cardiovascular risk reduction project, The Community Outreach in Heart Health and Risk Reduction Trial was designed to explore issues that facilitate or constrain individual efforts to implement changes to health behaviours. Eight focus groups were conducted in urban, northern and rural sites in Ontario, Canada. In this article, we elaborate on the difficulties all group members experienced as they attempted to interpret their personal candidacy for CHD. For many participants, CHD was an undetectable or 'sneaky disease' in its earlier stages, thus coronary risk was to them an abstract concept that could not ordinarily be detected through sensory perception. Participants drew on three possible strategies to determine their candidacy for CHD: they cognitively engaged in weighing risks, they relied on the interpretive powers of medical hermeneutics, or they waited for 'the big event'. The findings suggest that lay understandings of the body and health differ from those of health professionals and educators, and that lay understandings differ according to SES and gender. This has implications for health literacy and must be considered in devising strategies for health education	Not targeting low/no risk groups / focusing on high risk groups
(Anhoj et al.)	Background: LinkMedica-Heart is a novel Internet based program intended to support people who seek to improve their life style by means of changes in diet and physical activity. The program is currently under evaluation in a clinical study and the present study is a feasibility test of the LinkMedica-Heart Internet based program. Objective: The aim of this study was to evaluate LinkMedica-Heart, an Internet based program we designed for support and maintenance of patient-led life style changes. Methods: The feasibility study of LinkMedica-Heart presented here is a qualitative study. Nine general practitioners were invited to participate. Each practitioner was asked to introduce LinkMedica-Heart to not less than two patients, with a maximum of five patients per practitioner. Patients and general practitioners were both asked to participate in testing the program for a period of 6 months. At the end of 6 months, evaluation meetings were held with the general practitioners, and separate interviews took place with some of the participating patients who were selected by the GPs. Results: Five general practitioners and 25 patients participated in the study. The general practitioners and the patients were enthusiastic about the prospect of an Internet based life style change program. However, the program was not able to sustain patient loyalty over an extended period. The doctors found that the program was much too complicated to navigate and that the results from the program could not be trusted. The patients in contrast had fewer complaints about the program design, but found that the advice given by the program was too elaborate and detailed and, in general, did not add to the patient's knowledge on life style change. Conclusion: Our study confirms that there is a need for, and a receptive attitude toward a Web-based program that supports people who want to improve their life style and health. LinkMedica-Heart in its present form does not satisfy these needs. We suggest a number of design changes and improvements to the program. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Findings do not relate to barriers/ facilitators
Anon. (1970)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
Anon. (1992)	- no abstract available -	not qualitative methods / analysis / findings
Anon. (2002)	- no abstract available -	Findings do not relate to barriers/ facilitators
Anon. (2003)	- no abstract available -	Findings do not relate to barriers/ facilitators
Anon. ((2006)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Arcury & Arcury 2001)	Knowing how an older adult interprets a specific health behavior can improve health education and medical compliance. This study analyzes the behaviors elders state are needed to stay healthy, and their meanings for these behaviors. 145 male and female rural adults, 70 yrs old and older are interviewed and the narratives are analyzed using systematic text analysis. The Ss' narratives include 7 health maintenance domains: (1) Eating Right, (2) Drinking Water, (3) Taking Exercise, (4) Staying Busy, (5) Being with People, (6) Trusting in God and Participating in Church, and (7) Taking Care of Yourself. There is overlap in the domains and 4 themes cross-cut them: balance and moderation, the holistic view of health, social integration, and personal responsibility. Elders in these rural communities hold a definition of health that overlaps with, but is not synonymous with a biomedical model. These elders' concept of health seamlessly integrates physical, mental, spiritual, and social aspects of health, reflecting how health is embedded in the everyday experience of these elders. Staying healthy is maintaining the ability to function in a community. The results indicate that providers cannot assume that older patients will share their interpretation of general health promotion advice.	Not directly linked to a programme
(Aronow 2007)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Arslanian 2007)	Understanding why women delay seeking treatment for symptoms suggestive of an acute myocardial infarction remains elusive. Thirty individual semistructured interviews were conducted to determine black (n=10), Hispanic (n=10), and white (n=10) women's perception of heart disease risk and whether differences	Not directly linked to a

Study	Abstract	Reason for exclusion
	existed based on participant's race or ethnicity. Narrative descriptions analyzed using the Morse and Field method revealed that women, regardless of race or ethnicity, associated heart disease and heart attacks with men who were obese, stressed, and smokers. Perceptions of heart disease risk were similar between groups, with women generally believing they were at risk for heart disease because of family history, diet, and obesity. Racial and ethnic differences were noted, however, in risk reduction and anticipated treatment-seeking behaviors. Continued efforts are needed to raise women's perception of their cardiac risks and the need for the engagement in health-promoting behaviors.	programme
(Assaf et al. 1987)	- no abstract available -	not qualitative methods / analysis / findings
(Backer & Rogers 1993)	(from the preface) [This book] is the second of two works that have resulted from a three-year study of health communication campaigns funded by the Center for Substance Abuse Prevention. /// The present book addresses the [impact on these campaigns of the various organizations that collaborated on them] through its examination of six highly successful health communication campaigns and the organizations that contributed to their success. /// The present results are intended to identify organizational factors of importance, to provide practical guidance for campaign designers, and to suggest research questions that might be asked in future investigations. (PsycINFO Database Record (c) 2007 APA, all rights reserved).	not qualitative methods / analysis / findings
(Backman et al. 2004)	- no abstract available -	Not directly linked to a programme
(Bagby 1987)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Balcazar et al. 2006)	This article describes results of year-1 implementation of the Salud Para Su Coraz¾n (Health For Your Heart)-National Council of la Raza (NCLR) promotora (lay health worker) program for promoting heart- healthy behaviors among Latinos. Findings of this community outreach initiative include data from promotora pledges and self-skill behaviors, cardiovascular disease risk factors of Latino families, family heart-health education delivery, and program costs associated with promotora time. Participation included 29 trained promotoras serving 188 families from three NCLR affiliates in Escondido, California; Chicago, Illinois; and Ojo Caliente, New Mexico. Using several evaluation tools, the results showed that the promotora approach worked based on evidence obtained from the following indicators: changes in promotora's pre-post knowledge and performance skills, progress toward their pledge goals following training, recruiting and teaching families, providing follow-up, and organizing or participating in community events. Strengths and limitations of the promotora model approach are also discussed. Grant information: Metropolitan Life Foundation	not qualitative methods / analysis / findings
(Baranowski et al. 1990)	A center-based cardiovascular disease prevention program was conducted as a feasibility study to lower sodium and saturated fat in the diets of Black-American families with fifth through seventh grade children in one southwest city. Ninety-six families were actively recruited and randomly assigned to experimental or control groups. The experimental group was encouraged to attend 14 consecutive weeks of education sessions at a central facility. Social learning, social support and adult education theories guided the design of sessions which emphasized active, participatory learning. A 2-week food frequency questionnaire and 24-h dietary recall were measures of the dependent variables. Behavioral capability and self-efficacy for dietary change were also assessed. A post-program, formative evaluation interview was conducted with one adult per family in the experimental group. Program participants reported less frequent consumption of high sodium foods (especially for boys). Low rates of attendance were recorded after the fourth week of the program. Participants reported that attendance was impeded by conflicts with work and school and a dislike for completing dietary self-monitoring forms. Future efforts to reach healthy Black-American adults should integrate such a program into other on-going community activities and avoid intensive diet self-monitoring procedures	not qualitative methods / analysis / findings
(Barthold et al. 1993)	Public understanding of cardiovascular disease (CVD) risk factors and primary prevention has increased, due in part to community prevention efforts. However, many segments of society are difficult to reach. Such groups still need public education to acquire the knowledge that can lead to behavior change. Community intervention programs in rural areas face the challenge of disseminating health information to widely scattered populations isolated by difficult terrain and weather, and restricted by the sparsity of channels for mass communication. School health promotion programs, because of the special role schools play in rural communities, can help reach rural populations. During a five-year period, the Otsego-Schoharie Healthy Heart Program, a state-funded community intervention program, provided presentations to 18% of the combined total population of two rural counties through its school-based component. It also helped promote other program initiatives by establishing linkages in the community. Schools provide an effective channel for health promotion efforts to reach rural populations	not qualitative methods / analysis / findings
(Basch & Sliepcevich 1983)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Basch et al. 1986)	- no abstract available -	Not addressing primary prevention of

Study	Abstract	Reason for exclusion
		cardiovascular disease / CVD risk factors
(Bauer & Austin)	This study aimed to identify factors in school physical and social environments that may facilitate or compete with programs and policies to improve student physical activity and nutrition. Focus groups and interviews were conducted with students, faculty, and staff of two public middle schools. Participants identified numerous aspects of the school environments as significant. Competition, teasing and bullying, time, and safety were described as major barriers for students to be physically active during physical education class, on sports teams, and before and after school. The quality of the food served, easy access to nonnutritious snacks, limited time for lunch period, and weight concerns emerged as significant reasons why students do not eat nutritious meals in school. When developing programs and policies to improve the health of students, environmental influences that undermine efforts to improve student health behaviors must be addressed. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not directly linked to a programme
(Behera et al. 2000)	- no abstract available -	Not directly linked to a programme
(Beune et al. 2006)	The aim of this study was to explore and compare explanatory models (EMs) of hypertension in native-Dutch, first-generation Ghanaian and African-Surinamese (Surinamese) hypertensives in Amsterdam, the Netherlands. Through semi-structured interviews, we elicited accounts of the nature, causes and consequences of hypertension in a purposive sample of 46 patients (aged 35-65 years, treated for hypertension in general practice > 1 year). All three groups had difficulty in describing hypertension. All groups mentioned culturally specific nutritional habits as possible causes of hypertension (Dutch liquorice; Ghanaians fufu; Surinamese salty diet). Most respondents, particularly those of Ghanaian and Surinamese background, perceived stress as the main cause of hypertension and experienced symptoms of hypertension. Many Ghanaian and Surinamese respondents attributed hypertension to migration-related factors: changes in diet or climate, stress owing to adaptation to the Dutch society or obligations towards family in their homelands. Many immigrants felt a return to their homeland could cure hypertension and were concerned about the consequences of hypertension. Half of the Dutch and almost all Ghanaian and Surinamese respondents believed uncontrolled hypertension could cause immediate damage. Some Ghanaians expressed reservations sharing their concerns with community members because it might cause social stigma. Few respondents associated hypertension with obesity, even though many were overweight. Confirming findings from UK and US studies, this study reveals that EMs of hypertension in patients from three ethnic groups differ from the common medical perspective. These differences are greater for patients from migrant groups. Our findings can be useful in developing patient-centred hypertension interventions, particularly in new migrant populations	Not targeting low/no risk groups / focusing on high risk groups
(Bhopal 1986)	- no abstract available -	not qualitative methods / analysis / findings
(Black & Kapoor)	Discusses preventive measures that are frequently performed in older people, involving primary (e.g., immunization, stress management, alcohol limitation), secondary, and tertiary prevention. A study is reported in which the attitudes and practices of 36 attending physicians and 38 housestaff were compared. 250 patients were interviewed and their charts reviewed for performance or recommendation. The housestaff had a significantly more positive attitude toward health promotion and disease prevention. Physicians' barriers included lack of compensation and an orientation toward diagnosis and treatment rather than prevention. Patients' barriers included an orientation toward treatment rather than prevention. Another barrier is posed by the health policy system, which is pluralistic and provides no mechanism for coordination of prevention efforts. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Bopp et al.)	This study examined factors influencing strength training (ST) in two convenience samples of older rural women. Focus group (FG) participants were 23 Caucasian and 16 African American women aged 67.5 9.2 years. Survey participants were 60 Caucasian and 42 African American women, aged 70.59 9.21 years. FG participants answered questions about the risks, benefits, and barriers to ST. Survey participants completed measures of demographics, physical activity (including ST), depression and stress, decisional balance for exercise (DBE), barriers to PA, and social support (SS). Regression modeling examined correlates of ST. FG participants identified physical health gains and improved appearance as ST benefits. African American women also included mental health benefits and 'feeling good.' Both Caucasian and African American groups named physical health problems as risks of ST. Caucasian women identified time constraints, lack of ST knowledge, physical health problems, lack of exercise facilities, and the cost of ST as barriers. African American women cited being 'too tired,' physical health problems, lack of support, and other family and work responsibilities. The linear regression model explained 23.2% of the variance in hours per week of ST; DBE and family SS were independent positive correlates. This study identified correlates to participation in ST in older rural women and provides a basis for developing ST interventions in this population. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not addressing 2+ risk factors
(Boutain 2001a)	PURPOSE: To explore how a sample of rural Louisiana residents constructed accounts about worry and stress in relationship to their high blood pressure. DESIGN: Qualitative study combining critical social theories, African American studies, and critical discourse concepts. Study participants consisted of a convenience sample (N = 30) of African American women (n = 15) and men (n = 15) with high blood pressure. METHODS: Over a 4-month period in 1999 a community- based population sample was interviewed twice. Field experiences in the community and the assistance of community consultants were critical to data analysis. Based on 60 interviews, 191 passages about worry and 58 passages about stress were analyzed using discourse analysis. FINDINGS: Participants not only distinguished between worry and stress in their everyday lives, but they also highlighted how those concepts were interrelated. Participants' concerns about themselves as well as their children, kin, and community were emphasized in passages about worry. Stress was primarily associated with doing multiple	Not targeting low/no risk groups / focusing on high risk groups

Study	Abstract	Reason for exclusion
	tasks and confronting multiple prejudices in the workplace and surrounding community. CONCLUSIONS: Participants perceived worry and stress as important health-related concepts that affected their high blood pressure. Nursing strategies designed to address these concerns may better facilitate holistic health. Grant information: Supported by the National Institute of Nursing Research (F31NR07249-01); Hoffman Endowed Fellowship Award; Magnuson Scholar Award; Nurses Educational Fund, Inc. ; University of Washington Retirement Association, Washington State Nursing Foundation; Washington State Credit Union; Centers for Disease Control and Prevention (U48/CCU009654-06); and Hester McLaws Award	
(Boutain 2001b)	Strategies to manage worry, stress and high blood pressure (HBP) are little understood from the perspective of African Americans. Using data from a qualitative research study in south Louisiana, this article outlines how participants with HBP managed worry and stress through the formation of family. In an exploration of 314 conversations about 'family,' African-American women were cited by both women and men as mediators of worry, stress, and HBP. Participants did not necessarily define 'family' by blood or marriage relations, unlike the way in which 'family' is presented in most HBP research. 'Family' was often discussed in terms of how relationships with others were utilized to share knowledge about HBP, to address situations that produced HBP elevation, and to marshal resources to manage HBP	Not targeting low/no risk groups / focusing on high risk groups
(Boutin-Foster et al. 2008)	Compared to white adults, blacks are less likely to be aware of their cardiovascular risk factors and are less likely to respond appropriately to signs and symptoms of a myocardial infarction or stroke. This fact highlights the need for better dissemination of health information about cardiovascular disease among communities of color. Community health workers (CHWs) are important resources for disseminating health information. Recognizing this important role of CHWs, the Greater Southern Brooklyn Health Coalition and its community and academic partners developed a workshop designed to educate CHWs about the risk factors, signs and symptoms of cardiovascular disease. The purpose of this workshop was to educate CHWs so that they themselves could be better informed and thus, be in a better position to educate their respective clients. The resulting workshop, Taking Action Against Cardiovascular Disease in Our Communities: A Training for Service Providers, was a half-day workshop attended by 70 CHWs from various community service organizations. Approximately 97% of attendees said that the workshop met their expectations. More than half said they learned the signs and symptoms of cardiovascular disease and about 90% said that they received clear and concrete information that they could use with their clients. These evaluations also provided critiques regarding aspects of the workshop that could be improved upon and other information which will be used as a formative tool in developing future educational initiatives. In conclusion, this workshop demonstrated that it was feasible to develop effective community programs targeted at educating CHWs about cardiovascular disease. copyright 2007 Springer Science+Business Media, LLC	Findings do not relate to barriers/ facilitators
Bowen et al. (2006)(Bowen et al. 2006)	Obesity is a risk factor for multiple disease outcomes, including cancer and cardiovascular disease. A healthy diet and physically active lifestyle can prevent obesity. Sexual orientation is an important demographic factor that has been suggested to affect engagement in health-related behaviors, and interventions developed for the general population of women are likely to be less effective in assisting sexual minority women to make healthy choices. We conducted seven focus groups with sexual minority women (i.e., lesbians and bisexual women) to explore issues, including barriers and motivations, regarding healthy eating, physical activity, and weight in this population. The participants reported a wide range of levels of engagement in health-related behaviors. While nearly all of the participants reported some awareness of the importance of good dietary choices, the majority reported some confusion about what constitutes a healthy diet. In contrast, the majority of participants seemed clearly aware that regular exercise was important for good health. These data can guide the design of effective intervention strategies to improve health behaviors in sexual minority women	Not directly linked to a programme
(Bracht 1988)	Successful implementation of large scale health intervention programs aimed at heart disease or cancer prevention require prior analysis and understanding of community structure, organization and influence networks. Systematic sociological analysis facilitates the health program entry process. Survey results are used to build acceptance, participation and to design educational programs. Specific methods used to assess the community's social configuration, organizational resources, and leadership patterns are described. Local leader identification process and participation in community advisory boards is presented. Approaches to the study of community are reviewed in the context of the Minnesota Heart Health Project, a ten year research and demonstration program to reduce risk of cardiovascular disease in three U.S.A. cities	not qualitative methods / analysis / findings
(Bracht)	(from the introduction) This book has been developed to assist a wide range of professional and lay leaders as they undertake efforts to mobilize community resources and citizen energy for communitywide health promotion, environmental protection, and disease prevention programs. The reported experiences from numerous community health demonstrations are intended to contribute to an understanding of what is required to implement community-based prevention programs successfully. One key message emanating from these demonstrations is that new cooperative partnerships that include representatives from government, industry, labor, education, religion, media, and medicine are necessary to realize community goals. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Bracht et al. 1994)	Community ownership and maintenance of heart health programs was a major study goal of the Minnesota Heart Health Program (MHHP), a community-based National Heart, Blood and Lung Institute (NIH)-funded demonstration project. A partnership between the University of Minnesota and three Upper Midwest intervention communities was initiated in 1981. Local citizen boards were instrumental in planning, implementing and incorporating programs. Through an 8 year process of community organization, training and volunteer involvement, MHHP educational program responsibility was transferred to existing community-based groups and organizations. In 1989, when federal funding was withdrawn, 70% of all heart health intervention programs initiated by MHHP were being continued by local sponsors and supported by local funds. By 1992, maintenance of programs had decreased to an average 60%. Differential results of program incorporation among the three intervention communities are presented including findings on community sectors that most frequently sponsored programs. Factors that facilitate	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	or impede local ownership are discussed. Research on longer-term maintenance of heart health programs in the three communities continues	
(Brannstrom et al. 1988)	This article attempts to illustrate the process from community diagnosis to community involvement by a case study from the north of Sweden. The case of Norsjo is one of few documented Swedish examples of a preventive program with a broad participation from the community. The results up to now are promising and further illustrate the importance of decentralized health planning and local data	not qualitative methods / analysis / findings
(Brown)	Examined the California Drug, Alcohol, and Tobacco Education program, the methods of influence used in drug education to prevent student substance use, and the effects students perceived regarding overall influence, affect, and locus of control. Analysis of 143 field interviews with educators and administrators, and 40 student focus groups (approximately 240 students in grades 5-12) showed that educators attempted to prevent student substance use by providing a 'no-substance-use' message through high fear appeal, offering rewards, and attempting to improve students' self-esteem by teaching refusal skills. Results from student interviews show program dissatisfaction and service-related cognitive dissonance. Findings also suggest that drug, alcohol, and tobacco education programs had no positive influence on a majority of students' substance-use decisions, and had other effects counter to those intended, especially among students in grades 7th-12th. The need for a conceptual shift in how students are viewed and educated about substances are discussed. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Brownson et al. 1997)	Describes the development of and baseline data from the Ozark Heart Health Project, a community-based intervention to reduce cardiovascular disease (CVD) in rural Missouri. Preliminary data on mortality, health, economics, and other selected CVD risk factors are given. The theoretical basis for the project is a composite of the social learning theory and the stage theory of innovation. A comprehensive evaluation strategy is being used to document potential changes in risk factors and community norms. Components of the evaluation strategy include outcome evaluation using a risk factor survey; intermediate evaluation through community monitoring; and process evaluation through case studies, network analysis, formative and implementation assessment. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Brownson et al. 1998)	- no abstract available -	not qualitative methods / analysis / findings
(Brownson et al. 2003)	Purpose. Coalitions can be a successful way to promote healthy initiatives throughout a community. To properly measure the success of coalition-based interventions, it is important to conduct a process evaluation of coalition activities and establish a system for evaluating outcomes. This article describes a process evaluation of a monitoring and feedback system for community coalitions targeting chronic disease risk reduction. Methods. Community coalitions in six rural, southeast Missouri counties collaborated with the Missouri Department of Health and Saint Louis University to track coalition events using the process described in the Centers for Disease Control and Prevention manual Evaluating Community Efforts to Prevent Cardiovascular Diseases. Summary. First, we describe the methodology used to monitor monthly activities and to evaluate satisfaction with the process. Next, we discuss the data that resulted from the monitoring system and interviews with recorders. Third, we discuss changes made to the monitoring system and lessons learned along the way. Finally, we end with recommendations for incorporating this monitoring system in community practice. Conclusions. When used properly, this system is an effective way of evaluating and promoting sustainability of community interventions. (Original abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Caine 1993)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Capewell et al. 1999)	- no abstract available -	not qualitative methods / analysis / findings
(Caraher & Dowler 2007)	Background and Objective: Successive governments have promoted local action to address food components of public health. This article presents findings from research commissioned by the (then) London NHS Office, scoping the range of food projects in the London area, and the potential challenges to public health practice. Methods: Research followed four overlapping phases with a London focus: (1) a systemized review of the literature, (2) analysis of health authority Health Improvement Plans (HImPs) and Coronary Heart Disease (CHD) local implementation plans and Health Action Zone reports, (3) a scoping exercise of'food projects' and community-based participatory projects with a food focus using food databases and directories, and (4) 29 in-depth interviews with individuals responsible for commissioning and running projects. Results: There were, in 2001/2, a variety of food projects in the London area, ranging from small-scale social enterprises to those whose turnover marked them out as small businesses. There was a significant human resource cost in maintaining and setting up such projects both from NHS staff and in terms of volunteer and paid labour. The lack of an overall or area-based approach to food policy development in London was apparent, and little thought seemed to have been given to creating a supportive policy environment. Food projects often existed as isolated entities in a borough or health authority area, with short-term funding and little systemic long-term support. The majority employed what might best be called health education approaches. This is now partially addressed by the draft London Food Strategy. Conclusions: Food projects run by local professionals and/or volunteers operated within an isolated policy and suffered from a lack of support both from financial and human resources perspectives. The potential for long-term delivery of improved health was unrealized, as was their potential contribution to a London-wide food economy and to London food policy. copyright copyright SAGE 2007	Not addressing 2+ risk factors

Study	Abstract	Reason for exclusion
(Carlaw et al. 1984)	The World Health Organization has emphasized the importance of community participation as a keystone of primary health care and in meeting their goal of health for all. This article reports on the first three years of experience in a community-based approach to cardiovascular health. The project involves three communities totaling almost a quarter of a million inhabitants with matched comparison communities. An extensive volunteer structure provides a dynamic partnership with the education research group in bringing learning opportunities and enabling situations for the practice of heart healthy life styles in the total community. The project goal is to demonstrate reduced mortality and morbidity from educational interventions. The participative intervention model suggests a feasible alternative for future public health practice	not qualitative methods / analysis / findings
(Carleton et al. 1987)	- no abstract available -	not qualitative methods / analysis / findings
(Carleton et al. 1991)	The Pawtucket Heart Health Program, a research effort testing a process of community activation for cardiovascular risk factor behavior change, risk factor change, and coronary heart disease event rate change, utilizes risk factor behavior change programs for the entire population of a northeastern city. A diversity of nutrition programs designed to teach new skills and to alter the nutrition environment have been delivered. These include group programs, highlighting restaurant menus, labeling grocery shelf items, screening for blood cholesterol levels accompanied by nutritional counseling, and provision of programs in schools. In addition to standard curricula, the Heart Healthy Cook-Off for both junior high school and high school students has been developed. Students select recipes, make substitutions to lower fat, saturated fat, and cholesterol content, analyze original and substitution recipe nutrient content using a microcomputer and nutrient analysis software, and prepare the food. A panel of judges assesses presentation, taste, and health-promoting characteristics. In one junior high school class, cholesterol measure before and after the cook-off decreased by 10.7% among those with elevated cholesterol. The Heart Healthy Cook-Off is an education program that influences the culinary practices of children in an enjoyable, challenging format	not qualitative methods / analysis / findings
(Carleton et al. 1995)	- no abstract available -	not qualitative methods / analysis / findings
(Carroll et al. 2002)	- no abstract available -	Not addressing 2+ risk factors
(Carter et al. 2005)	The primary purpose of this study was to determine employees' perceptions of a wellness program resulting from collaboration between a small rural industry and a College of Nursing. Focus group methods were used to elicit evaluative data from 27 employees. A semi-structured interview guide of open-ended questions was used to elicit information. The employees readily identified the screenings and information they had received related to hypertension, blood sugar, and cholesterol to be helpful. Health behavior changes the employees identified based on the health promotion activities and screenings included diet changes, different food preparations, and exercise. The screenings were found to be beneficial because they helped them to understand the significance of the results and how they could alter them with health behaviors. The repeated screenings provided an opportunity for them to see how health behavior changes had affected their results	Study linked to a school or workplace programme
(Carver 2002)	- no abstract available -	not qualitative methods / analysis / findings
(Centers for Disease Control and Prevention (CDC) 2003)	- no abstract available -	not qualitative methods / analysis / findings
(Charlie et al. 1991)	This paper is concerned with the appropriateness of current attempts to prevent chronic disease through behavioural change. Based on extensive ethnographic research in South Wales, the paper suggests that, within contemporary British health culture, there exists a well developed lay epidemiology which has a significant bearing on the public plausibility of modern health promotion messages. The paper describes the notion of the coronary candidate (the 'kind of person who gets heart trouble') and discusses the operation of the idea in everyday life. The manner by which lay epidemiology and the population approach to health promotion construct the 'prevention paradox' within the social world is outlined. In conclusion it is suggested that lay epidemiology readily accommodates official messages concerning behavioural risks within the important cultural fields of luck, fate and destiny. This simultaneously constitutes a rational way of incorporating potentially troublesome information, and a potential barrier to the aims of health education	Not targeting low/no risk groups / focusing on high risk groups
(Clayton & Ruston 2003)	Objective: The aim of this study was to explore women's beliefs about exercise in relation to key messages about physical inactivity and coronary heart disease. Design: This was a qualitative study using semi-structured interviews. Setting: Cardiac and gynaecological units of three hospitals in different locations. Method Open-ended, semi-structured interviews were conducted with 50 women admitted with a cardiac related event or suspected cardiac event, and 33 women without manifest coronary heart disease who had been admitted to the same hospitals for routine elective surgery/procedures. Results: Women related to exercise primarily in terms of losing weight, looking good, staying mobile and keeping fit generally. Moderate physical activity was considered best and there was a perception that activity inherent in women's domestic lives provided this. Women believed overexercise could be potentially harmful. Conclusion: Key messages about physical activity and its importance in preventing coronary heart disease need to take into account women's ideas about the benefits and hazards of exercise	Not directly linked to a programme

Study	Abstract	Reason for exclusion
(Collie-Akers et al. 2007)	BACKGROUND: Although it is well known that racial and ethnic minorities in the United States have a higher prevalence of chronic diseases and a higher rate of related deaths than the overall U.S. population, less is understood about how to create conditions that will reduce these disparities. CONTEXT: We examined the effectiveness of a collaborative community initiative--the Kansas City-Chronic Disease Coalition--as a catalyst for community changes designed to reduce the risk for cardiovascular diseases and diabetes among African Americans and Hispanics in Kansas City, Missouri. METHODS: Using an empirical case study design, we documented and analyzed community changes (i.e., new or modified programs, policies, or practices) facilitated by the coalition, information that may be useful later in determining the extent to which these changes may contribute to a reduced risk for adverse health outcomes among members of the target population. We also used interviews with key partners to identify factors that may be critical to the coalition's success. RESULTS: We found that the coalition facilitated 321 community changes from October 2001 through December 2004. Of these changes, 75% were designed to reduce residents' risk for both cardiovascular disease and diabetes, 56% targeted primarily African Americans, and 56% were ongoing. The most common of several strategies was to provide health-related information to or enhance the health-related skills of residents (38%). CONCLUSION: Results suggest that the coalition's actions were responsible for numerous community changes and that certain factors such as hiring community mobilizers and providing financial support to nontraditional partners may have accelerated the rate at which these changes were made. In addition, our analysis of the distribution of changes by various parameters (e.g., by goal, target population, and duration) may be useful in predicting future population-level health improvement	Findings do not relate to barriers/ facilitators
(Collins et al. 1993)	The Kilkenny Health Project (KHP) was established in 1985 as a community-based research and demonstration programme for cardiovascular disease in County Kilkenny, Ireland, and as a pilot programme for future national initiatives. This article examines the penetration of the Project into the community, the extent of knowledge of, contact with, or participation in its activities	not qualitative methods / analysis / findings
(Collis 1977)	New Perspectives on the Health of Canadians described the self-inflicted nature of many of the major medical problems facing Canada. Given this understanding it might have been anticipated that a carefully mounted large scale health education programme would lead to a reversal of behaviour-related complaints. However, such programmes have not had a strong record of success, with the possible exception of the recently reported Stanford Three Communities study, which is concerned with decreasing cardiac risk factors by a process of mass persuasion, aimed at teaching specific behavioural skills. In the past, living conditions have changed slowly and appropriate lifestyles have evolved along with changing conditions. Only recently has environmental change occurred so dramatically that liviing patterns could no longer mutate and develop gradually to keep pace. Hence the demand for behavioural science to assist people to develop new lifestyles which are in synchrony with a rapidly changing world. Examination of the literature concerning the application of behaviour modification techniques to specific problems clearly demonstrates the difficulties involved in changing behaviours such as smoking and overeating. Behaviour change related to increasing physical activity shows more promise in that it can be presented positively as a pleasant addition to people's lives. If lifestyle modification and environmental control are going to assume a larger part of the health care system, methods have to be devised to translate the experimental successes with relatively small numbers into powerful programmes for press action	not qualitative methods / analysis / findings
(Conn et al. 1994)	- no abstract available -	Not directly linked to a programme
(Constantine et al. 2008)	BACKGROUND: In Georgia an estimated 32% of blacks and 28% of whites have high blood pressure. In 2004 the rate of death from stroke in Georgia was 12% higher than the national average, and blacks in the state have a 1.4 times greater rate of death from stroke than that of whites. CONTEXT: The Georgia legislature funds the Stroke and Heart Attack Prevention Program (SHAPP) to provide treatment and medications for indigent Georgians. The median rate of blood pressure (BP) control among SHAPP enrollees is approximately 60%, compared with the national average of 35%. METHODS: SHAPP was evaluated through interviews with key health care and administrative staff and through focus groups of patients in two clinics. CONSEQUENCES: Outcomes for patients were increased knowledge of their BP and improved compliance with taking medication and keeping clinic appointments. INTERPRETATION: Successful components of SHAPP include an easy enrollment process; affordable medication; use of evidence-based, documented protocols and patient tracking systems; routine follow-up of patients; and effective communication between staff and patients. Challenges and recommendations for improvement are identified	Not targeting low/no risk groups / focusing on high risk groups
(Corson 1990)	- no abstract available -	No qualitative research element
(Covington & Grisso 2001)	BACKGROUND: Cardiovascular disease among American women is affected by a number of high-risk lifestyle factors, but little is known about the perceptions of high-risk behavior among women in an inner-city population. The two purposes of this study were to identify the perceptions of an inner-city, predominantly African-American community as they pertain to a high-risk lifestyle for cardiovascular disease as well as to develop a culturally sensitive survey instrument for women. METHODS: There were two components to the study. In the first, four focus groups were conducted to obtain qualitative data on women's attitudes and lifestyles regarding cardiovascular disease risk. In the second, focus group data were used to construct a survey on women's attitudes and lifestyles regarding cardiovascular disease risk that was modified using a fifth focus group and then pilot-tested with a sample of 27 women. RESULTS: Focus group and pilot-testing data suggest interesting differences between the behaviors and perceptions of inner-city women and the general population. OBESITY: Obesity was more loosely defined by this community than by guidelines based on standard height and weight measures. Being heavy was not necessarily equated with being fat and was felt at least partially to reflect muscle tone and muscle mass. STRESS: It was volunteered almost unanimously as a distinct risk factor for cardiovascular disease among women, although it rarely is listed on risk factor questionnaires. EXERCISE: Standard aerobic exercise participation was low, but participation in daily	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	physical activity such as casual walking and housework was high. CONCLUSIONS: Health care providers, in attempting to reduce a patient's risk for cardiovascular disease, should be aware of the cultural and socioeconomic factors that might influence that patient's perceptions of cardiovascular disease risk. These perceptions should shape a provider's approach to lifestyle modification advice	
(Crockett et al. 1990)	We used the focus group interview technique as a preliminary research step in developing a nutrition education intervention for rural seniors who, because of less than optimal eating habits and changing demographics, are an important target audience. Sixty-eight well, active, rural North Dakota seniors, 60 years or older, from communities of 2,500 or fewer people, participated in five focus groups conducted in late summer 1988. As a qualitative research approach, focus group interviews offer a means of obtaining in-depth information on a specific topic from representatives of a target audience in a discussion group atmosphere. Focus groups require careful preparation and structuring and should include a capable moderator, a prepared discussion guide, carefully recruited participants, and a comfortable setting. The process generated ideas that we are using to develop a health promotion nutrition intervention that will be a mailed-home approach, including use of incentives, social role models, cholesterol screening, and learning activities. The intervention relies on the interest and ability of seniors to make positive health changes. We conclude that the focus group approach is useful in developing nutrition education interventions	Not addressing 2+ risk factors
(Crow et al. 1986)	A population-wide, community-based program in cardiovascular disease prevention, the Minnesota Heart Health Program (MHHP), has been designed to promote more frequent and vigorous physical activity in North American communities, along with improved eating and smoking patterns. The physical activity component of this broad-based education strategy is based on the facilitation which physical activity provides to lowering of other risk characteristics for heart disease and its enhancement of other healthy behaviors and on the potential for prevention of elevated risk in the first place. The rationale for a population strategy to complement medical approaches to prevention is that exercise patterns are largely socially learned and culturally determined. The MHHP Physical Activity Program is implemented through three major education strategies: direct education, community organization, and mass communications. Early results from this 10-year project indicate that it is feasible to enter U.S. communities and to involve their leadership actively in MHHP activities of health promotion. Moreover, attitudes, knowledge, awareness, participation, and behaviors related to exercise and eating patterns appear to be changed by the program. Nevertheless, there are problems in the design, implementation, analysis and interpretation of population changes in physical activity and other health behaviors in community demonstration programs. These issues, along with their solutions, should provide useful information for medical science and for the public health about population strategies of disease prevention and health promotion	not qualitative methods / analysis / findings
(Daly & Lumley 2002)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Daly et al. 1991)	The Kilkenny Health Project, started in 1985, aims to reduce the level of risk factors in the community for coronary heart disease through health promotion. Dental disease and coronary heart disease share risk factors of tobacco use, alcohol consumption and poor dietary patterns. A baseline oral health survey demonstrated significant levels of dental disease in Kilkenny in the 429 adults and 523 children who were examined there in 1987. Seventy one per cent of adults required treatment for periodontal disease and 49% of children surveyed required treatment for dental decay. The Kilkenny Oral Health Project was developed as a community participation project aiming to reduce the level of common risk factors in the community for coronary heart disease and dental disease. It has run parallel with the main Kilkenny Health Project and is one of the first health promotion projects which has an integrated health message preventing dental disease and coronary heart disease	not qualitative methods / analysis / findings
(deKoven & deKoven)	This research examines the importance of trust in the classroom, and answers the following questions: 1) Is trust important to create and maintain in the classroom? 2) What is the significance of trust between a teacher and a student? and 3) Do students trust their drug and alcohol educators? In-depth interviews were conducted with 38 middle school students. Analysis of the transcripts reveals the importance of trust in the classroom environment. Trust is important not only between teachers and students, but also between students and their peers. In addition, hurdles to the effective transmission of important information about alcohol, tobacco, and other drugs (ATOD) were discovered. Chief among these revelations was the discovery that students perceive that asking questions about ATOD is tantamount to a tacit admission of guilt for having used or for contemplating using controlled substances. Implications for designers of curricula, drug and alcohol educators, and teachers of other sensitive subjects are discussed. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not directly linked to a programme
Donohew(Donohew et al.)	A theoretic model of attention to messages has been used to guide an extensive series of laboratory and field experiments involving the mass media and, more recently, classroom instruction and health interventions. The model draws on individual differences in need for novelty as a basis both for identifying target audiences most likely to engage in a number of health-risk behaviors, such as drug and alcohol abuse and risky sex, and as a guide for designing messages to attract and hold the attention of these same individuals, who make up the prime target audience for many campaigns. These strategies have been successful in bringing about changes in attitudes and behavioral intentions in experimental studies, and in reaching at-risk audience segments in field studies through novel televised public service announcements placed in appropriate television programming. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	not qualitative methods / analysis / findings
Dugdill (2003)(Dugdill 2003)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors

Study	Abstract	Reason for exclusion
(Duncan & Simmons 1996)	Since 1990, due to political and legislative changes, immigration from the former Soviet Union to the United States has increased significantly. Population reports from 1988 indicate that there were approximately 406,000 Soviet immigrants in the United States at that time. This number is expected to increase due to the Immigration Reform Act of 1990, which raised the Soviet refugee ceiling to 50,000 per year. Currently, very little is known about the health status and health practices of this population, although some published data indicate that life expectancy and infant mortality rates compare poorly with those of the general population in the United States. Although the former Soviet republics experienced universal health care coverage, there was little emphasis on promoting a healthy lifestyle. Heavy cigarette use, high alcohol intake, poor dietary intake, little attention to physical fitness, and crowded living conditions have been described. Environmental pollution and poor occupational safety are common and have contributed to the health problems of the population. As the influx of immigrants continues, the consequences of these health conditions will impose a burden on health care services in this country. As with any immigrant group, an understanding of the potential health conditions and cultural values can facilitate appropriate medical care. This research was conducted to explore these issues. Interviews and a physical assessment were conducted with 30 adults from the former Soviet Union. The major health problems identified included various dental conditions requiring treatment, obesity, and the absence of basic health screening measures such as cholesterol testing, high blood pressure screening, Pap smears, and mammograms. The authors also identified a need for translators and for education regarding preventative self-care, such as breast self-examinations	not qualitative methods / analysis / findings
(Durack-Brown et al. 2003)	Background: A better understanding of patients' and physicians' perceptions and experience of hypercholesterolaemia will help to improve cardiovascular disease prevention and aid the development of appropriate educational strategies. Aim: To identify perceptions, experience, educational needs, and barriers to learning in hypercholesterolaemic patients at high risk of cardiovascular disease. Design of study: A qualitative study involving interviews with 27 hypercholesterolaemic outpatients and 21 physicians. Setting: 21 centres in Paris, Bordeaux and Lille. Methods: Semi-structured interviews were conducted by a sociologist with the aid of two interview guides focusing on hypercholesterolaemia. Interviews were recorded and subsequently transcribed, and qualitative analysis was performed to identify emerging themes. Results: Six main themes emerged: understanding hypercholesterolaemia - a 'virtual' disease; understanding cardiovascular risk - a vague concept; lifestyle measures; long-term effects of medication; medical language difficulties; and patients' expectations and needs. Patients and physicians disagreed over the terms used to describe hypercholesterolaemia and cardiovascular risk, and the complexities of medical language. In contrast, patients and physicians agreed on the difficulties associated with implementing lifestyle changes and adhering to long-term treatment. Conclusions: The differences in perception and experience between physicians and patients indicate that physician-patient communication is sub-optimal and highlights the need to improve educational material for cardiovascular disease prevention. This analysis helps to identify appropriate educational objectives and methods for patients at risk of cardiovascular disease, and develop a structured educational programme	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Dye & Wilcox 2006)	This study elicited perceptions about physical activity in 28 older rural and low-income women (27 were Caucasian) in four focus groups to identify factors that affected their physical activity levels. This population is greatly understudied and underserved. Overall, themes that surfaced across the groups were consistent with social cognitive theory. Prominent themes included outcome expectations about both physical and mental benefits; beliefs about the sources of motivation to be physically active, including both internal sources and external sources; barriers to being active; and the types of social environments important for physical activity. These findings provide useful information regarding the types of physical activity programs preferred by rural, low-income older women and ways to build self-efficacy and social support among members of this population group with regard to increasing physical activity. Copyright copyright by The Haworth Press, Inc. All rights reserved	Not addressing 2+ risk factors
(Ebbesen et al. 2004)	Significant international progress has been made researching and addressing the economic and social burden of cardiovascular disease, advanced particularly by international conferences and subsequent declarations, and the Canadian Heart Health Initiative (CHHI). The implementation focus of the CHHI on building capacity for heart health promotion is paralleled by efforts to measure capacity. Through the collective experience of Heart Health Programs in Nova Scotia, Saskatchewan, Alberta and British Columbia, critical issues in measuring health promotion capacity are identified and strategies for addressing them are presented. The provincial contexts for the programs vary, as do the conceptualizations of capacity and intervention strategies to build capacity. Yet, despite such differences across provinces, shared issues influencing measuring capacity number many. These include: multiple understandings of terms; evolving understanding of capacity; invisibility of capacity building; detecting change within a dynamic system; staff turnover; time course required for change; attribution for change in capacity; understanding a process through 'snap-shot' measurements; lack of existing 'gold standard' measurement tools; validity and credibility of instruments; evolving nature of measurement tools; gathering perspectives from multiple levels within organizations; dealing with conflicting perspectives; and managing and disseminating sensitive data. A number of strategies have been devised or adopted to address measurement issues, ranging from adopting participatory processes to the development of monitoring systems. Understanding and addressing issues in measuring capacity deserve attention as they may be potent influences in the dynamic interplay between research and intervention in the process of capacity building in the context of health promotion generally, and/or heart health specifically	not qualitative methods / analysis / findings
(Ebrahim & Davey 1998)	- no abstract available -	not qualitative methods / analysis / findings
(Ebrahim & Smith 1998)	- no abstract available -	not qualitative methods / analysis / findings
(Edmundson et al. 1994)	The purpose of this paper is to describe the process evaluation model for the classroom curricula of the Child and Adolescent Trial for Cardiovascular Health	not qualitative methods /

Study	Abstract	Reason for exclusion
	(CATCH) Project. The process evaluation plan specifically targets how much each curriculum was implemented, to what degree it was implemented as designed, and the barriers to implementation. Additionally, the rationale for each of the process evaluation measures and the instrument development process are presented. Data resulting from these measures will be essential in order to answer questions regarding the internal validity of the main outcomes of the project. Specific examples and sample results are provided from the CATCH third-grade classroom curriculum, which was implemented the first year of CATCH. A discussion also is presented of how the findings from a sample of these measures were used to gain additional insight on the salient features of the curriculum, and how those features may be related to student outcomes	analysis / findings
(Elder et al. 1986)	The Pawtucket Heart Health program (PHHP) is a federally funded research and demonstration project for the primary prevention of coronary heart disease (CHD) in a community. This article presents a discussion of the first 26 months of this intervention, divided into its three phases. PHHP staff initially approached the intervention city through local organizations to accomplish risk-factor behavior change in the population. After 11 months, PHHP complemented its programs in organizations with activities open to all city residents, in order to accelerate participation by the population. Seven months into this phase, it was decided that community activities should be the major focus of the intervention approach to assure a level of participation adequate to make a measurable impact. The third has shown the greatest percentage of public participation, demonstrating the complementary nature of organization and community interventions and of the translation of social learning theory into principles for primary prevention in a community	not qualitative methods / analysis / findings
(Elder et al. 1988)	(from the chapter) this chapter deals with issues relevant to community-level interventions for the primary prevention of heart disease, building on individual, group, and organizational strategies described previously (Abrams et al., 1983) /// we will begin with an integration of Social Learning Theory as it applies to community interventions, followed by a description of more traditional medical interventions in community settings, and proposed alternatives to this model . . . social work models . . . public health [models] /// finally, the community-level interventions of the Pawtucket Heart Health Program, integrating aspects of all these approaches into a behavioral community psychology framework, will be described /// Pawtucket Heart Health Program (PHHP) / promotion / exercising with 'ExerCity' / 'Heart Check': a volunteer-led screening approach / linkages with the health-related professions / food vendor intervention / community-level weight loss efforts / smoking cessation lotteries (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Elliott et al. 2000)	Community-based heart health promotion is viewed as an effective means of reducing cardiovascular disease risk. Although public health agencies have a central role in the implementation and dissemination of heart health programmes, their effectiveness is being challenged by major structural changes to Provincial public health systems across Canada, although the impacts of the changes have received relatively little attention in the research literature. As part of the Canadian Heart Health Initiative--Ontario Project (CHHIOP), this study used a qualitative approach to address the perceived implications of these changes to Ontario's public health system for heart health promotion. Interviews (n = 38) were conducted in eight public health units with staff most familiar with managing and/or delivering heart health activities. The results are mixed; that is, while many see the future of heart health promotion programming in Ontario as being at risk, others see recent changes as a step forward toward their institutionalization, particularly in light of recent funding decisions made by the Ministry of Health's Health Promotion Branch	Not directly linked to a programme
(Emslie et al. 2001)	Current public health policy emphasizes the importance of primary and secondary prevention of coronary heart disease (CHD). However, evidence on the effectiveness of health advice to modify behavioural risk factors to date is discouraging. This lends urgency to understanding more about the public's perceptions of the causes and consequences of heart disease, and particularly any barriers to adopting less coronary prone behaviours. Using data from a qualitative study of heart disease amongst 61 men and women living in the west of Scotland, we draw attention to a powerful image that recurred when people were weighing up their decisions about health-related behaviours and appeared to undermine people's preparedness to change their lifestyle. This is the image of CHD as a 'good way to go', typically described in contrast to a painful and lingering death, usually from cancer. Two elements of this characterization of CHD as a 'more desirable' way to die were apparent: in some deaths (particularly those occurring prematurely) its 'quickness' was emphasized; and in deaths amongst older people a heart attack was often portrayed as an inevitable and 'natural' way of dying from 'old age'.	Not directly linked to a programme
(Fahrenwald & Fahrenwald)	This descriptive-correlational study examined the Transtheoretical Model (TTM) of behavior change in relationship to the physical activity behavior of mothers receiving assistance from the Women, Infants, and Children (WIC) nutrition program. A purposive sample of 30 women, 6 each at the five stages of readiness for behavior change, was used. Relationships between stage of behavior change (measured using the Stage of Exercise Adoption tool) and other TTM constructs were examined. The constructs and corresponding instruments included physical activity behavior (Seven-Day Physical Activity Recall), pros, cons, decisional balance (Exercise Benefits/Barriers Scale and two open-ended questions), self-efficacy (Self-efficacy for Exercise scale), and processes of behavior change (Processes of Exercise Adoption tool and the Social Support for Exercise scale). Use of the 10 processes of change differed by stage of change. Physical activity pros included a sense of accomplishment, increased strength, stress relief, and getting in shape after pregnancy. Cons included fatigue, childcare, and cold weather. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Falk et al. 2000a)	Grant information: Partially supported by a Kappa Omicron Nu Research Fellowship and funding from the Division of Nutritional Sciences, Cornell University	Not targeting low/no risk groups / focusing on high risk groups
(Falk et al. 2000b)	Grant information: Partially supported by Kappa Omicron Nu Research Fellowship and funding from the Division of Nutritional Sciences, Cornell University	Not addressing 2+ risk factors

Study	Abstract	Reason for exclusion
(Fanning 2004)	Cardiovascular disease remains the most pressing healthcare problem in the United States. Traditional risk factors--hypertension, obesity, and diabetes-are still unresolved issues; and new risk factors--pre-diabetes, insulin resistance, and pediatric and adolescent diabetes-have emerged. There is an urgent need to identify the risk factors for cardiovascular disease, and address risk reduction with disease management and treatment for each factor, based on qualitative and quantitative approaches for developing the evidence base for public health action. The objectives of this paper are to review (i) the burden of cardiovascular illness-morbidity, mortality, and cost; (ii) risk factors and the emerging epidemic of adolescent obesity; (iii) the challenges of attaining target endpoints; and (iv) the attributes of a successful programmatic healthcare initiative for potential impact on cardiovascular care and, eventually, public health. [References: 29]	not qualitative methods / analysis / findings
(Farnkvist & Weinehall 2006)	AIMS: To study the context of an intervention programme, including possible competing demands between an intervention and other health service assignments, and to develop a measure of intervention intensity. METHODS: Data used include questionnaires and interviews with intervention staff, protocols, and reports from the intervention programme, and cross-sectional health surveys. A new Intervention Intensity Score (IIS) is used as an indicator of the intensity of the intervention. RESULTS: Initially the intensity of support and activity of the programme was high and some cardiovascular risk factors such as cholesterol and daily smoking declined. There were favourable allocations of resources in the setting and enthusiasm. Later, disturbing changes in the organisation, competing demands within Primary Health Care (PHC), and an incipient decline of the intervention intensity occurred. These changes accelerated and finally the intervention intensity faded out, parallel to unfavourable risk factor changes. The Intervention Intensity Score (IIS) is useful as an indicator in the interpretation of programme effectiveness. CONCLUSIONS: The amount and quality of support, the intervention process itself, and the intervention intensity were determining factors of the achievements of this intervention programme. The IIS measure used in this study provides a feasible way to interpret and understand achievements and shortcomings of the intervention programme	not qualitative methods / analysis / findings
(Farooqi et al. 2000)	South Asians have a significantly higher risk of mortality from coronary heart disease (CHD) compared with the general population in the UK. There is a lack of evidence on attitudes to and knowledge of risk factors for CHD amongst South Asians. Such information is important for the provision of effective health promotion services. OBJECTIVES: The aim of the study was to identify key issues relating to knowledge of and attitudes to lifestyle risk factors for CHD amongst South Asians aged over 40 years in Leicester, UK. METHOD: A qualitative focus group analysis was carried out using randomly selected South Asians from GP lists and South Asians attending community centres. Group discussions were taped, translated and transcribed. The transcripts were analysed using qualitative methodology to identify key issues and themes. RESULTS: Participants expressed a range of attitudes to and different levels of knowledge of lifestyle risk factors for CHD. Barriers to improving lifestyle with respect to diet and exercise were identified; these included lack of information (e.g. of how to cook traditional Indian food more healthily) and cultural barriers, such as lack of women-only exercise facilities. Participants perceived stress as an important cause of CHD, and stress directly related to ethnic minority status was described frequently. Language was identified as a key barrier to accessing health services. CONCLUSION: Health professionals need to provide individually tailored health promotion for South Asians which avoids stereotyping, but recognizes potential cultural obstacles to change. The issue of stress amongst South Asians requires more research and needs to be recognized as an important issue by health professionals. South Asians still face problems accessing health and leisure services due to language and cultural issues	Not directly linked to a programme
(Farquhar 525)	(from the chapter) determine whether community health education can reduce the risk of cardiovascular disease / [consider] the powerful cultural forces which reinforce and maintain the health habits that we [wish] to change / use an untested combination of an extensive mass-media campaign plus a considerable amount of face-to-face instruction / [include] 3 elements often ignored in health campaigns / the mass-media materials were devised to teach specific behavioural skills, as well as offering information and affecting attitude and motivation / both the mass-media approaches and, in particular, the face-to-face instruction used established methods of achieving changes in behaviour and self-control training principles / the campaign was designed after analysis of the knowledge deficits and the media-consumption patterns of the intended audience / develop and evaluate methods for achieving changes in smoking, exercise, and diet that would be both cost-effective and applicable to large population groups /// data were gathered from a random . . . sample of 35-59-yr-old men and women through interviews conducted in a survey centre set up in . . . 3 communities (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Farris et al. 2004)	Implementing effective programs to prevent chronic disease holds the promise of reducing morbidity and mortality, reducing health disparities, and promoting health. Yet many programs have demonstrated success only in highly controlled research settings and few address the needs of low-income, uninsured, minority women. Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN), a demonstration program funded by the Centers for Disease Control and Prevention (CDC), that provides chronic disease risk factor screening and lifestyle interventions for low-income, 40-64-year-old women is learning from our own successful programs but is also charting new territory. As the CDC, state health departments, tribal organizations, and other WISEWOMAN partners approach the end of the first decade of WISEWOMAN demonstration projects, we are seeking to understand what has worked and what has not. This paper describes the rationale and proposed methodology for assessing best practices in the WISEWOMAN program through a participatory process that will examine scientific evidence and quantitative and qualitative program data. By emphasizing practicality in addition to scientific rigor, we are expanding the base of evidence considered to identify effective approaches for reducing cardiovascular disease (CVD) risk in financially disadvantaged, ethnically diverse women. Results of the 3-year project will be disseminated in a format intended to encourage programs to select and adapt those strategies best suited to their particular contexts	not qualitative methods / analysis / findings
(Finkelstein et al. 2004)	BACKGROUND: In today's healthcare environment, public health resources are scarce. Thus, interventions to improve the public's health must be rigorously evaluated to ensure that they make the best use of available resources. METHODS: The Centers for Disease Control and Prevention (CDC) provides a general framework for program evaluation. This paper presents additional details on several key evaluation areas within CDC's framework. RESULTS: Successful evaluations will be built into the program design; will be multifaceted, incorporating both quantitative and qualitative methods; will assess both process and	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	outcome measures; and will engage stakeholders to ensure utility of results. CONCLUSIONS: Well-planned evaluations can lead to less burdensome yet more effective assessment and better program performance and can increase the knowledge base for health promotion practice	
(Finnegan, Jr. et al. 1989)	In an overall framework uniting program planning and evaluation, process evaluation can assist community-based health promotion programs in establishing participation objectives, monitoring their achievement and the quality of interventions used, and translating these into useful information for managing and developing programs. This research reports on efforts by the Minnesota Heart Health Program to develop a system that permitted tracking educational program contacts, its implementation, and its use to make management decisions about program activities. The system was developed as part of a planning and evaluation framework with specific criteria for developing and tracking educational programs drawn from the social-learning literature. Overall, the system helped to make participation objectives more concrete, aided decision making about allocation of personnel and material resources, and encouraged the development of innovative programs	not qualitative methods / analysis / findings
(Flay & Cook 1981)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Flay 1987)	Many mass media health promotion programs seem to fail because of inadequate attention to several levels of evaluation research, possibly during product development. A rational sequence of evaluation research is suggested and described. Pre-production research includes planning research, concept testing, and pretesting of rough forms of the product. Audience testing research is suggested post-production but prior to dissemination - it includes small-scale assessments of message/product acceptability and efficacy. Post-dissemination research includes implementation, effectiveness, and process evaluation. It is argued that greater emphasis be placed on formative (pre-production) research and audience testing (particularly efficacy testing) than is usually the case	not qualitative methods / analysis / findings
(Fleury 2002)	- no abstract available -	Not addressing 2+ risk factors
(Flora & Farquhar 1988)	The Stanford Five City Project (FCP) is a long-term field experiment designed to investigate the impact of a comprehensive community-wide educational effort on cardiovascular disease risk factors and on cardiovascular disease, morbidity and mortality. Five theoretical models of individual, organization and community change guide the design, development, implementation and evaluation of educational programs. Data from formative research aid in the selection of target audiences and in development of messages and programs for these audiences. These data also give feedback about the extent to which these educational products accomplished their information and behavior-change goals. Formative research data collection methods include surveys, focus groups, interviews and unobtrusive measures. This paper describes how change theories and formative research are used to the comprehensive community-wide change effort for the Stanford FCP and how examples from the FCP can be used as a model for the successful development of other social change programs	not qualitative methods / analysis / findings
(Flora et al. 1989)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Flora et al. 1993)	Understanding the process of behavior change interventions is critical to achieving campaign effectiveness and successful program replication. The present article presents a community education monitoring system (CEMS) using data from the Stanford Five-City Project (FCP), the Minnesota Heart Health Program (MHHP) and the Pawtucket Heart Health Program (PHHP). CEMS records the number and type of intervention activities, outcome objectives, targets of change (individual, organizational or environmental), channel(s) of dissemination and proportion of programs funded by the community. These data illustrate (1) the application of theory for each project, (2) data-based program administration, (3) feedback for revising programs and (4) type of reach or 'dose' information obtained from intervention monitoring. Process evaluations such as CEMS provide critical links between field realities and evaluation outcomes. This type of evaluation develops standards for measuring program reach and allows comparisons with other programs. CEMS also illustrates how programs enact theory. Validation studies are critical to the continued successful use of CEMS. The first step, however, is to develop a uniform way of describing complex multichannel behavior change programs. CEMS in a refined form should prove invaluable to health promotion program planners whether in research or service settings	not qualitative methods / analysis / findings
(Folta et al. 2008)	INTRODUCTION: Cardiovascular disease (CVD) is the leading cause of death for women in the United States. A healthy diet and appropriate physical activity can help reduce the risk for CVD. However, many women do not follow recommendations for these behaviors. In this study, we used qualitative methods to better understand knowledge and awareness about CVD in women, perceived threat of CVD, barriers to heart-healthy eating and physical activity, and intervention strategies for behavior change. METHODS: We conducted four focus groups with 38 white women aged 40 years or older in Kansas and Arkansas. We also interviewed 25 Cooperative State Research, Education, and Extension Service agents in those states. Environmental audits of grocery stores and the physical environment were done in three communities. RESULTS: Most women were aware of the modifiable risk factors for CVD. Although they realized they were susceptible, they thought CVD was something they could overcome. Common barriers to achieving a heart-healthy diet included time and concern about wasting food. Most women had positive attitudes toward physical activity and reported exercising in the past, but found it difficult to resume when their routine was	Not directly linked to a programme

Study	Abstract	Reason for exclusion
	disrupted. The environmental audits suggested that there are opportunities to be physically active and that with the exception of fresh fish in Kansas, healthful foods are readily available in local food stores. CONCLUSION: Interventions to change behavior should be hands-on, have a goal-setting component, and include opportunities for social interaction. It is especially important to offer interventions as awareness increases and women seek opportunities to build skills to change behavior	
(Franck et al.)	Use of the internet to provide health information to young people is a relatively recent development. Few studies have explored young people's views on how they use internet health websites. This study investigated the navigation, design and content preferences of young people using the Children First for Health (CFfH) website. Young people from five secondary schools completed an internet site navigation exercise, website evaluation questionnaire and participated in informal discussions. Of the participants, 45 percent visited the website section aimed at older adolescents within their first two clicks, regardless of their age. There were conflicting preferences for design and strong preference for gender-specific information on topics such as appearance, relationships, fitness and sexual health. The findings indicate the importance of gaining young people's views to ensure that health information websites meet the needs of their intended audience. Cooperation from schools can facilitate the process of gaining young people's views on internet website navigation, design and content. (PsycINFO Database Record (c) 2008 APA, all rights reserved) (journal abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Gabhainn et al. 1999)	Coronary heart disease (CHD) rates in Ireland are very high but little is known about attitudes to the disease. Qualitative attitudinal data were collected in focus group settings from 74 individuals across socio-demographic categories in order to assess knowledge of and attitudes to CHD and associated risk factors. Focus group questions were derived from group deconstruction of constructs from the Health Belief Model, Theory of Planned Behaviour, Protection Motivation Theory and Social Learning Theory. Participants were drawn from the personnel lists of local government and a health authority hospital. Eight types of groups were constructed according to the various permutations of the three variables: age, gender and occupational group. Analyses revealed good knowledge levels about risk factors among participants. However, participants exhibited mixed loci of control and low motivation to change behaviours. Men generally were less motivated to change than women; older men thought it too late and younger ones too soon. Though white and blue collar groups' views were similar, the discussion in white collar groups was more varied. Participants were sceptical about apparently contradictory medical advice which undermined motivation to change. The data complement earlier work and suggest preventative initiatives should be more focused.	Not directly linked to a programme
(Gans et al. 1989)	- no abstract available -	not qualitative methods / analysis / findings
(Gans et al. 1999)	Grant information: Grant RO1-HL47624 Minimal Contact Education for Cholesterol Change from the National Institutes of Health	Not addressing 2+ risk factors
(Garcia & Johnson 2003)	For healthy and successful aging, remaining active and eating well appear to be very important. These two behaviors need to be supported and maintained through educational interventions. This paper describes the development of teaching modules for nutrition education and physical activity, based on needs assessment and identified barriers, facilitators and motivational factors among four groups of immigrant older adults. Seven modules on nutrition education and six modules on physical activity are described, including textual content and educational goals. Modifying behaviors related to nutrition and physical activity can have profound effects on the health status of the older population. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	not qualitative methods / analysis / findings
(Ghebremeskel & Crawford 1994)	Intensive animal rearing, manipulation of crop production and food processing have altered the qualitative and quantitative balance of nutrients of foods consumed by Western society. This change, to which the physiology and biochemistry of man may not be presently adapted to, is thought to be responsible for the chronic diseases that are rampant in the Industrialised Western Countries. Agriculture production and food processing practices, dietary habits and lifestyle of the West is being fostered without any appraisal of the health implications by most developing countries. Consequently, a rising trend in the incidences of obesity, diabetes, high blood pressure, cardiovascular diseases, dental decay and appendicitis is apparent. Mediterranean countries are adopting the agriculture and food practices of northern Europe as the result of the harmonisation of European food and agriculture policy. It is predicted that the low incidence of morbidity and mortality from coronary heart disease, stroke, diabetes and breast and colon cancer of the Mediterranean countries would rise to the high northern European level in the foreseeable future. Most of these chronic diseases are lifestyle related and are preventable. This can be realised by tackling the root problem which is food production and processing practices and not by dispensing designer drugs or opening more hospital beds. [References: 88]	not qualitative methods / analysis / findings
(Glanz & Mullis 1988)	Reviews the rationale, conceptual models, program examples, and recent empirical evidence regarding the extent and effects of environmental interventions to promote healthy eating. The state of the art is described for 5 types of interventions: (1) changes in the food supply, (2) point of choice nutrition information, (3) collaboration with private sector food vendors, (4) worksite nutrition policies and incentives, and (5) changes in the strucure of health and medical care related to nutrition. A case example is presented of several environmental interventions in the community-wide cardiovascular risk reduction efforts of the Minnesota Heart Health Program. Environmental approaches to dietary behavior change can reach large segments of the population through increased availability of nutritious foods, provision of quality nutrition services in workplace and health care settings, and accessible information about healthful food choices. Nutrition intervention can also serve as a model for other types of health promotion initiatives using multidimensional environmental and educational technologies. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing 2+ risk factors
(Glanz et al. 1992)	This article describes an evaluation of the implementation of a cholesterol management program in family physicians' offices as part of the Physician-Based Nutrition Program to Lower Coronary Heart Disease Risk (PBNP). The evaluation, conducted through a partnership evaluation model, used multiple case study	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	methodology and combined the use of quantitative and qualitative methods. Data sources included office staff reports and interviews, records of contacts with study personnel, patient care data, and patient telephone interviews. Data from these sources revealed gradual program implementation and considerable variation in practitioner and clinic involvement in cholesterol management. Clinic staff reported that the support provided by PBNP in the form of training, operations materials, patient education materials and ongoing assistance was very useful. This formative evaluation has implications for refinement of the PBNP and for other prevention programs in primary care settings. It demonstrates the feasibility and acceptability of a systems approach to physicians, cholesterol/nutrition educators and clinic support staff. It also suggests ways in which researchers and clinicians can implement and evaluate health care innovations	
(Glinsky 1981)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Goldman et al. 2006)	PURPOSE: Despite some recent improvement in knowledge about cholesterol in the United States, patient adherence to cholesterol treatment recommendations remains suboptimal. We undertook a qualitative study that explored patients' perceptions of cholesterol and cardiovascular disease (CVD) risk and their reactions to 3 strategies for communicating CVD risk. METHODS: We conducted 7 focus groups in New England using open-ended questions and visual risk communication prompts. The multidisciplinary study team performed qualitative content analysis through immersion/crystallization processes and analyzing coded reports using NVivo qualitative coding software. RESULTS: All participants were aware that "high cholesterol" levels adversely affect health. Many had, however, inadequate knowledge about hypercholesterolemia and CVD risk, and few knew their cholesterol numbers. Many assumed they had been tested and their cholesterol concentrations were healthy, even if their physicians had not mentioned it. Standard visual representations showing statistical probabilities of risk were assessed as confusing and uninspiring. A strategy that provides a cardiovascular risk-adjusted age was evaluated as clear, memorable, relevant, and potentially capable of motivating people to make healthful changes. A few participants in each focus group were concerned that a cardiovascular risk-adjusted age that was greater than chronological age would frighten patients. CONCLUSIONS: Complex explanations about cholesterol and CVD risk appear to be insufficient for motivating behavior change. A cardiovascular risk-adjusted age calculator is one strategy that may engage patients in recognizing their CVD risk and, when accompanied by information about risk reduction, may be helpful in communicating risk to patients	Not directly linked to a programme
(Gombeski, Jr. et al. 1982)	Data from a six-week hypertension campaign aimed at urban Mexican Americans were analyzed to document how they receive their health information and to identify the communication channels most likely to reach different segments of the Mexican-American community. The nine sources of information examined were doctor, nurse, pharmacist, family, friends, radio, newspaper, television, and magazine. The most common source of health information reported was doctor, followed by television, newspapers, magazines, family, and radio. Interview language (Spanish or English) was a significant predictor of the amount of health information received from all nine sources. Sex, family income, education, and age also were shown to affect the amount of health information received from various sources. Profiles of respondents most likely to use each source of health information are presented and implications for health educators are discussed	not qualitative methods / analysis / findings
(Goodhart et al. 1953)	To complement National College Health Assessment data and to further assess student lives and health needs, staff at the Rutgers University Health Services' Department of Health Education used a participatory research method called photovoice. Using this methodology, health care professionals provided a discrete and tangible way for students to feel empowered, as the students conducted the project themselves, collecting data using photography, analyzing the results qualitatively, and meeting with policy makers to discuss their photos and offer recommendations for change. Policy recommendations addressed issues of safety, nutrition, sexual health information, alcohol and drugs, and campus parking. In this article, the authors offer a description of this process as another tool for assessment and advocacy. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Graham et al. 2007)	- no abstract available -	Not population level
(Grant 1993)	Two hundred and forty female clients attending primary health care centers in Montego Bay and the Kingston Metropolitan Area were interviewed to obtain information about their beliefs with regard to hypertension. This study revealed that the variables-perceived susceptibility, perceived severity and 'cue to action'-identified in the Health Belief Model need to be strengthened if patient compliance and adoption of health-promoting behaviours are to be realized. This study also pointed out the pressing need for health care providers to enhance health promotion programmes relative to hypertension. These programmes should be aimed at increasing clients' knowledge base and self-care abilities in order to to help prevent and/or control this disorder	not qualitative methods / analysis / findings
(Green et al. 2002)	To support program planning for a local health foundation whose mission is health promotion, a survey consistent with the Behavioral Risk Factor Surveillance System (BRFSS) was conducted in El Paso County, Texas. A total of 1,010 adult participants were interviewed in either English or Spanish. Age-adjusted prevalence estimates of several health indicators were compared to statewide and national BRFSS estimates. Data were presented to the community in an open forum, and community groups were invited to propose interventions to improve the health of El Pasoans. Several differences in risk factors were noted in El Paso as compared to the state of Texas. These local data were useful in the development of intervention programs, which are now being evaluated. This survey identified opportunities for public health interventions and was useful for raising community awareness of health behavior issues. It proved affordable both for surveillance and program building	not qualitative methods / analysis / findings
(gstrup & Hollins 2007)	- no abstract available -	No qualitative research

Study	Abstract	Reason for exclusion
		element
(Guest 1978)	- no abstract available -	not qualitative methods / analysis / findings
(Hall 1979)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Hanna 1998)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Hanusaik et al. 2003)	This study examined the context and processes in which health promotion policy and program decisions are made to ensure that an Internet-based information system on heart health promotion programs provides appropriate information for decision makers' needs and is compatible with their decision-making processes. Five focus groups and six individual interviews were conducted with potential users of and contributors to the G8 Heart Health Projects Database. Results suggest that Internet-based systems such as this are seen as useful tools, but will only be used at certain critical points in program development and then, only when they meet several rigorous criteria. Systems must be completely credible and up-to-date, providing instant answers to complex questions about program design, implementation, and effectiveness, with adequate qualitative information for assessing contextual applicability. Participants also provided information about the conditions required if they were to submit project information to the system	Findings do not relate to barriers/ facilitators
(Haq et al. 1995)	- no abstract available -	not qualitative methods / analysis / findings
(Hart & Hart)	Investigated the psychosocial barriers and benefits perceived by parents to the provision of a healthy diet and adequate exercise for their primary school age children children. A qualitative methodology was employed and 41 parents of 7-12 yr olds took part in 7 focus groups separated by SES. Results show that across the groups, a combination of reported external barriers and unconscious internal barriers, stemming from high optimistic bias, low perceived control and unrealistic health expectations, were observed. SES differences were suggested in restrictive feeding practices, the responsibility attributed to the school and in the level and format of desired nutrition education. Overall a demand for interventions focusing on behavioral techniques rather than fact transmission was uncovered, in particular the promotion of parental self-awareness to reduce negative influences within the family food environment. Providing realistic definitions of appropriate behavior and empowering parents to tackle children's weight issues were indicated as important targets for future education programs.	Not directly linked to a programme
(Harvey 1998)	- no abstract available -	not qualitative methods / analysis / findings
(Hautman & Bomar 1992)	This descriptive exploratory study was undertaken in an attempt to describe how hypertension as a disease and illness is conceptualized from the point of view and experience of black couples. Twenty-one black couples were interviewed and the data content was analyzed. Explanatory models constructed from the taped interviews revealed that the differences in knowing about hypertension were primarily due to gender. Differences were identified in the structure and content of the explanatory models. Content differences between women and men were primarily in the areas of stress and diet. The significance of this research is that it identified gender differences in ways of learning about illness that need further exploration	Not targeting low/no risk groups / focusing on high risk groups
(Heitman 2001)	The purpose of this study was to identify the health beliefs and behaviors that influenced cardiovascular health in multigenerational families already at risk for cardiovascular disease (CVD). Guided by the concepts from the Health Belief Model, the concept of Social Support, and health behavior efficacy, and the concepts of the Transtheoretical Model of Change, this study provides insights into how these family members reinforce each others beliefs and behaviors. The literature review established the importance of the perception of vulnerability, risk, and efficacy in effecting behavior change at the individual and family levels. No studies were identified that had examined intergenerational influence on cardiac risk behavior and how health behaviors in families may be subject to change. Using a case study method, semi-structured individual and family group interviews were conducted of 3 members of 10 families (n = 30) with known cardiovascular risk. Each family member represented a different generation. The index member was a senior or middle family member who had undergone coronary bypass surgery. A convenience sample was recruited from individuals having had coronary bypass surgery at a regional hospital in a rural area. Prior to group family interviews, each subject completed a Behavior Risk Questionnaire (BRQ) to determine high or low risk of CVD. A sub-sample of 6 subjects received individual interviews. A subject with high behavioral CVD risk and one with low behavioral CVD risk represented each generation. Themes generated from the family interviews formed the basis for the individual interview questions. All interviews were audio taped, transcribed, and interviewer reflections were documented. Analysis consisted of coding, naming and categorizing data according to conceptual patterns. The findings reveal family members' perceptions of health, personal and family cardiovascular risk, and family experiences shared across generations that influence health behaviors. Opportunities were identified as to when family members may be open to change and what vehicles might influence family health behaviors that promote sustained change in cardiovascular	Not targeting low/no risk groups / focusing on high risk groups

Study	Abstract	Reason for exclusion
	health. Incorporation of this eclectic approach to understanding the health beliefs and health behaviors of families at risk for CVD can reveal opportunities for the nurse to create an individualized approach to behavior change that may result in a reduction of cardiovascular risk and hope for improved health and quality of life for families	
Herrick et al. (1978)(Herrick et al. 1978)	- no abstract available -	not qualitative methods / analysis / findings
Higginbotham et al. (1999)(Higginbotham et al. 1999)	Coronary heart disease is a leading cause of death in Australia with the Coalfields district of New South Wales having one of the country's highest rates. Identification of the Coalfields epidemic in the 1970's led to the formation of a community awareness program in the late 1980's (the healthy heart support group) followed by a more intense community action program in 1990, the Coalfields Healthy Heartbeat (CHHB). CHHB is a coalition of community members, local government officers, health workers and University researchers. We evaluate the CHHB program, examining both the nature and sustainability of heart health activities undertaken, as well as trends in risk factor levels and rates of coronary events in the Coalfields in comparison with nearby local government areas. Process data reveal difficulties mobilising the community as a whole; activities had to be selected for interested subgroups such as families of heart disease patients, school children, retired people and women concerned with family nutrition and body maintenance. Outcome data show a significantly larger reduction in case fatality for Coalfields men (although nonfatal heart attacks did not decline) while changes in risk factors levels were comparable with surrounding areas. We explain positive responses to the CHHB by schools, heart attack survivors and women interested in body maintenance in terms of the meaning these subgroups find in health promotion discourses based on their embodied experiences. When faced with a threat to one's identity, health discourse suddenly becomes meaningful along with the regimens for health improvement. General public disinterest in heart health promotion is examined in the context of historical patterns of outsiders criticising the lifestyle of miners, an orientation toward communal lather than individual responsibility for health (i.e, community 'owned' emergency services and hospitals) and anger about risks from environmental hazards imposed by industrialists. (C) 1999 Elsevier Science Ltd. All rights reserved	not qualitative methods / analysis / findings
(Higgins et al. 2006)	Cardiovascular disease remains a health issue in North America, particularly for marginalized citizens. Although lifestyle issues and behavioral risk reduction continue to dominate prevention initiatives, an emerging literature suggests that contextual factors such as poverty and social exclusion also influence health. Using group and personal interviews (N = 38), this research explored the social and economic contexts shaping heart health-related experiences from the perspectives of low-income, lone mothers. The transcripts were analyzed using McKinlay and Marceau's upstream-midstream-downstream framework. The overriding pattern characterizing lone mothers' discussions was that the women felt out of the mainstream of everyday life. They lacked the resources and power to effect change, particularly regarding heart health behaviors that were not perceived to be a priority compared to more pressing survival issues. Results are discussed in terms of concepts from the population health and social determinants literature, concluding with policy implications for enhancing health while living in poverty	Not directly linked to a programme
(Hine et al. 1995)	This paper discusses some of the findings of the Bristol Black and Ethnic Minority Health Survey, especially in relation to local plans to improve opportunities for South Asian women to become more physically active. Low levels of participation in exercise sessions were reported in the survey, particularly among Pakistani women. Many of the South Asian women whom we interviewed have poor self-assessed health and limited knowledge of English; they are also economically disadvantaged. It seems likely that exercise sessions outside the home will not reach many of these women. A project has been funded to discuss the research with local women, to identify exercise facilities and improve opportunities for South Asian women to become more active. In what follows we discuss findings relating to all South Asian women but subsequently with particular regard to Pakistani women, the largest single group. Grant information: Supported by grants from King's Hospital Fund, London, the South Western Regional Health Authority and Bristol and District Health Authority	Not addressing 2+ risk factors
(Hoelscher et al. 2001)	The total impact of a health promotion program can be measured by the efficacy of the intervention multiplied by the extent of its implementation across the target population. The Child and Adolescent Trial for Cardiovascular Health (CATCH) was a school-based health promotion project designed to decrease fat, saturated fat, and sodium in children's diets, increase physical activity, and prevent tobacco use. This article describes the dissemination of CATCH in Texas, including the theoretical framework, strategies used, and lessons learned. To date (Fall 2000), CATCH materials have been adopted by more than 728 elementary schools in Texas	Findings do not relate to barriers/ facilitators
(Hood et al. 1997)	The increasing prevalence of obesity and diabetes in the Mohawk Community of Akwesasne led to the formation of an advisory group who's mission was to increase community awareness and strengthen the infrastructure necessary to create a community coalition to promote healthy lifestyles. The methodology used to reach these goals included: obtaining an understanding of the community's knowledge, attitudes and behaviors about diabetes, diet and exercise using semi-structured interviews and focus groups; analyzing data from a case control study of diabetes and it complications using a medical record review; exploring methods for evaluating energy expenditure in children; and identifying influential community members and organizations. In the last 50 years people had become less physically active and high fat, high caloric foods were more available. Community members were concerned about health and the well-being of their children, had knowledge about healthy lifestyles but lacked confidence and social support for bringing about desired changes. A strong association was documented between diabetes, smoking cigarettes, high blood cholesterol and vascular disease in this community. Approximately 100 persons participated, several hundred received the results in presentations to 17 community organizations, two public fora, letters to participants and articles in local newspapers. Fifty persons and 29 businesses or organizations regarded as strong advocates of healthy lifestyles were identified. From these a community coalition was formed and has initiated	Not directly linked to a programme

Study	Abstract	Reason for exclusion
	programs to reduce dietary fat and increase physical activity in young children	
(Hopman-Rock & Westhoff)	Examined the effects of the Aging Well and Healthily (AWH) health-education and exercise program for community-living older adults. Following a control trial of the AWH program by 25 older adults (aged 75-80 yrs), 269 older adults (aged 59-89 yrs) residing in the Netherlands participated in a community intervention trial of the AWH, which consisted of health education by peers and low-intensity exercise. Subjects (Ss) completed interviews following completion of the program and at 4-6 mo follow-up concerning general health, physical performance, physical activity, and health-related knowledge. Results show that reasons given for participating in the program included: (1) exercising; (2) acquiring information about health; and (3) social interaction. The program was rated highly, and mean physical activity scores improving significantly during its course for the least inactive Ss compared to controls not enrolled in AWH. 25% of Ss joined exercise groups after completion of the program, and 28% intended to do so. At followup, 60% of Ss reported continuing to exercise regularly at home. It is concluded that AWH is a potentially effective program for older adults. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Horowitz et al. 2004)	Uncontrolled hypertension and its complications continue to be major health problems that disproportionately affect poor minority communities. Although dietary modification is an effective treatment for hypertension, it is not clear how hypertensive minority patients view diet as part of their treatment, and what barriers affect their abilities to eat healthy diets. We conducted nine focus groups with 88 African American and Latino patients treated for hypertension to assess their knowledge, attitudes, behaviors, and beliefs concerning hypertension. Participants generally agreed that certain foods and food additives play an important role in the cause and treatment of hypertension. However, they found clinician-recommended diets difficult to follow in the context of their family lives, social situations, and cultures. These diets were often considered expensive, an unwelcome departure from traditional and preferred diets, socially isolating, and not effective enough to obviate the need for medications. These findings suggest the importance of culturally sensitive approaches to dietary improvements. Grant information: US Agency for Health Care Research and Quality (PO1 HS 10859) and the Commonwealth Fund (20030088)	Not targeting low/no risk groups / focusing on high risk groups
(Howarth & Imich 2003)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Hsu-Hage et al. 2001)	Understanding health service utilisation by community groups can be used to enhance cost-effective service delivery planning. In an inquiry into general health needs, and experiences with health service utilisation by Chinese living in Melbourne, we conducted a series of focus group discussions to explore community health-seeking behaviour. Seven focus groups were drawn from community groups and bilingual health workers in the period September-October 1999. Discussions were carried out in dialect familiar to the participants, facilitated by trained multilingual researchers, tape recorded and transcribed in Chinese and then translated into English. Cross validation was carried out by an independent researcher. Themes that emerged from these discussions included common pathways to care seeking, barriers to the use of health care services, general health concerns, and perceived validity of health information sources. Participants opt for self care when feeling unwell if the condition is perceived as 'not severe'. Use of over-the-counter medication is usually the first course of action. There is a tendency to 'wait and see' when feeling unwell. The use of Traditional Chinese Medicine Practitioners (TCMP) is common, while continuing to see Orthodox Western Medicine practitioners. There are, however, common concerns about the quality of care provided by TCM practitioners and their qualifications. Language, transport, and cost are among other barriers that undermine the use of health care services. Participants reported diabetes, heart disease risk factors, peptic ulcer, hay fever and asthma, poor vision, dental problems, social isolation, and gambling among the most common health concerns. Participants accepted health information from a wide range of sources and placed trust in material disseminated by SBS Chinese Radio Programs and the Chinese Health Foundation; an established community organisation run by voluntary health professionals. In conclusion, the study confirmed a number of patterns by which the Chinese community sought and utilised health services and associated factors	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Hugentobler 1992)	Describes the implementation of a longitudinal multimethodological research and intervention project aimed at (1) examining the relationship between occupational stress and psychosocial moderating factors (e.g., social support, participation, and influence over decision-making) and health outcomes and (2) reducing work stress and improving employee health. Combining qualitative and quantitative research techniques (semi-structured individual and focus group interviews, field notes and survey data) increases confidence in research findings and strengthens the process and outcomes of needs assessment, program planning, implementation, and evaluation. Examples illustrate the usefulness of this approach in identifying and understanding problem areas and in developing and evaluating appropriate health education interventions. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing 2+ risk factors
(Hunt et al. 1990)	Point-of-purchase nutrition education in supermarkets is one intervention strategy of the Pawtucket Heart Health Program, a community cardiovascular disease prevention program in Pawtucket, Rhode Island. Using consumer intercept interviews, awareness of shelf labels and their effect on purchase behavior have been continuously evaluated. Between 1984 and 1988, the percent of shoppers who could identify correct labels increased from 11 percent to 24 percent (95% confidence intervals of difference: 7.17). The percent who reported they were encouraged to purchase the identified foods increased from 36 percent to 54 percent (95% CI of difference: 5.41)	not qualitative methods / analysis / findings
(Ingram et al. 2005)	BACKGROUND: Diabetes is reaching epidemic proportions on the U.S.-Mexico Border, and culturally competent diabetes education is not available in many communities. CONTEXT: People with diabetes often do not have access to regular medical care, cannot afford medication, and lack the community infrastructure that supports self-management practices. Self-management education and support have great potential to impact diabetes control in this environment.	Not targeting low/no risk groups / focusing on high risk groups

Study	Abstract	Reason for exclusion
	METHODS: To address this need, partners of the Border Health Strategic Initiative (Border Health iSI!) collaboratively developed a culturally relevant diabetes outreach and education program. The model included a five-week series of free diabetes education classes that assisted participants in gaining the knowledge and skills necessary to be physically active, control diet, monitor blood sugar, take medications, and be aware of complications. Central to the model was the use of community health workers - or promotores de salud - to conduct outreach, participate in patient education, and provide individual support. CONSEQUENCES: Program participants achieved significant improvements in self-management behaviors and HbA1c, random blood glucose, and blood pressure levels. INTERPRETATION: Quantitative and qualitative evaluation helped to identify the essential elements of a successful program, including partnership of providers, community diabetes classes, promotores outreach and support, linkage between diabetes education and clinical care, and program evaluation	
(Jackson et al. 1994)	Increasingly, agencies supporting community health promotion interventions require participating communities and evaluators to specify how the intervention will be maintained once agency funding ends. The Stanford Five-City Project (FCP) implemented two different strategies to maintain its heart disease education program, with the second strategy designed to overcome the barriers to implementation that were encountered by the first. This paper provides a practice-oriented description of the initial 'community network' maintenance strategy of the FCP, the barriers that were encountered as this network strategy was implemented, the alternative 'capacity-building' strategy directed at local health educators and the successful implementation of this alternative. Also discussed are the community organization issues underlying the shift in intervention maintenance strategies and the specific components of the capacity-building strategy, including its focus on health educators, and its application of a training of trainers model and cooperative learning methods to provide professional development, technical assistance and other resources to a target group of community health educators. Our experience indicates that capacity-building is a viable method for intervention maintenance and that it may also facilitate efforts to disseminate model health promotion programs to communities lacking experience in community health promotion intervention	not qualitative methods / analysis / findings
(Jackson et al. 2006)	Objective To explore women's views on being referred to and attending a specialist antenatal hypertension clinic. Design Qualitative interview study. Setting A pregnancy hypertension clinic in a large teaching hospital in the East Midlands. Population Twenty-one women (aged 18 years and above) attending the pregnancy hypertension clinic for the first time during their current pregnancy. Methods Women who had been referred to and attended a specialist antenatal clinic participated in semi-structured interviews. Data analysis was based on the constant comparative method. Main outcome measures Women's experiences and perceptions of being referred to and attending a specialist antenatal clinic. Results Being referred to the clinic conferred an 'at risk' status on women. Some women welcomed the referral but others experienced it as unsettling. Many were unclear about why they had been identified as being at risk or had difficulties in accepting the legitimacy of the reason for referral. Women were often inadequately informed about why they were referred to the clinic, what they could expect and the benefits of attending the clinic over management in the community. Although attendance at the clinic was cited as a source of reassurance, the reassurance was often made necessary by concern raised by the initial referral. Conclusions Women's accounts suggest that the interface between community and secondary antenatal services needs improvement to minimise possible adverse effects from identifying women as being 'at risk' during pregnancy. Grant information: NHS Modernisation Agency; partly funded, Primary Care Trusts, Leicester, Leicestershire and Rutland	Not targeting low/no risk groups / focusing on high risk groups
(Jilcott et al. 2004)	BACKGROUND: Although most health departments recognize the need for programs to reduce the risk of cardiovascular disease (CVD) among older, low-income women, they face numerous barriers to successfully implementing such programs. This paper explores counselors' attitudes and beliefs about patients and perceived barriers to implementing the North Carolina Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program. METHODS: Health departments were assigned to provide patients with either an enhanced intervention (EI) or a minimum intervention (MI). Cross-sectional baseline and 12-month follow-up surveys were completed by health department counselors designated to deliver the MI or EI. Both surveys addressed counselors' beliefs about patients' motivation and attitudes, their counseling practices, and their personal diet and physical activity behaviors and attitudes. The follow-up survey also addressed opinions about the feasibility of long-term WISEWOMAN implementation. RESULTS: Counselors were skeptical about patients' motivation to improve their lifestyle, citing high perceived cost and burden. At follow-up, EI counselors reported having higher self-efficacy for counseling, incorporating more behavioral change strategies, and spending more time counseling than did counselors at MI sites. They were also more likely to report making healthful personal lifestyle choices. All counselors identified lack of time as a major barrier to counseling, and most cited obtaining low-cost medications for patients, ensuring that patients made follow-up visits, and implementing the program with existing staff as key challenges to the long-term sustainability of WISEWOMAN. CONCLUSIONS: Our findings provide insight into the organizational challenges of implementing a CVD risk-reduction program for low-income women. We discuss ways in which intervention and training programs can be improved	Not targeting low/no risk groups / focusing on high risk groups
(Johnson & Garcia 2003)	In Canada, the population of older adults is becoming ethnically diverse. However, our understanding of the health behaviors including diet and physical activity among this group is limited. The purpose of this study is to examine the dietary and physical activity profiles, and the factors that influence these behaviors, among older immigrants. The sample included 54 participants (mean age = 68 +/- 6 years) from Cambodian, Latin-American, Vietnamese and Polish groups. Measures included background questionnaire, nutrition screening tool, 24-hour dietary recall, and physical activity assessment. Results showed that 72.5% were at moderate to high risk for poor nutrition. Identified dietary issues were related to food preparation, nutrition management for diseases, and nutritional needs of the elderly. Although 83.3% reported to be physically active, the level was less than optimal, and barriers to physical activity were identified. The results are further discussed in light of health promotion and nutrition education among immigrant older adults	not qualitative methods / analysis / findings
(Johnson 1983)	- no abstract available -	Not targeting low/no risk groups / focusing on

Study	Abstract	Reason for exclusion
		high risk groups
(Johnson 2005)	African Americans die earlier than other US. subpopulations. This phenomenon is demonstrated by lower projected life expectancies than Caucasian Americans. Health disparities exist among African Americans for many of the diseases that can be altered by health promotion. For example, obesity results in cardiovascular diseases, diabetes, and cerebrovascular accidents. The literature documents that increasing physical activity and eating more nutritiously will reduce obesity and thereby minimize the development of these disorders. This is not new in ormation, but the problem of disparity remains. Is it possible that the conceptualization o health promotion for African Americans may be different from historically accepted definitions, thereby creating dissonance when prescribing and implementing health care strategies? The purposes of this qualitative study were to a) present an historical overview of health promotion, and b) explore heath promotion and disease prevention from an African American perspective. A theoretical model of the subjects' perceptions is also included. Grant information: Funded by a National Institute of Nursing Research Mentored Scientist Award	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Jones et al. 2005)	Deaf persons' access to health-related information is limited by barriers to spoken or written language: they cannot overhear information; they have limited access to television, radio, and other channels for public information; and the average reading level of Deaf adults is at a 3(rd) to 4(th) grade level. However, literature searches revealed no published reports of community analysis focusing specifically on health education priorities for Deaf communities. A seven-step community analysis was conducted to learn the health education priorities in Arizona Deaf communities and to inform development of culturally relevant health education interventions in Deaf communities. The word 'Deaf rdquo; is capitalized to reflect the cultural perspective of the Deaf community. A 14-member Deaf Health Committee collected data using multimethods that included review of state census data, review of national health priorities, key informant interviews, discussions with key community groups, a mail survey (n = 20), and semistructured interviews conducted in sign language with 111 Deaf adults. The community diagnosis with highest priority for health education was vulnerability to cardiovascular disease (CVD). Following completion of the community analysis, a heart-health education intervention (The Deaf Heart Health Intervention) was developed using a train-the-trainer, community health worker model. If this model proves to be effective in addressing vulnerability to CVD, then a similar protocol could be employed to address other health concerns identified in the Deaf community analysis. Grant information: Funded by the Arizona Disease Control Research Commission (Contract 5005)	not qualitative methods / analysis / findings
(Juarbe 1998)	In this study, I describe the cardiovascular-related diet and exercise experiences of 24 married immigrant Mexican women (21 to 40 years-old) who have children. I used semistructured taped interviews in Spanish to elicit qualitative data concerning the diet and exercise experiences of this sample. The data were analyzed in Spanish using grounded theory procedures. A major finding in this study is a core process of realizing a covert overweight image. Women described an ongoing process of coming to terms with diet and exercise decisions in a sociocultural disempowering environment that limited their options to promote their health. Despite these limitations, some of the women assessed and formulated options that developed into transcending strategies for engaging in diet and exercise behaviors. Such sociocultural factors as women's roles and their social support structures were found to be critical in describing those behaviors.	Not directly linked to a programme
(Kalra et al. 2004)	OBJECTIVE: The focus groups were utilized to gather information on the perceptions of cardiovascular risk within the Asian Indian community, and to identify opportunities to design health promotion and intervention programs for Asian Indian communities. DESIGN: Qualitative methods were utilized to obtain perceptions of cardiovascular risk within 3 Asian Indian communities. Eight focus groups were conducted in either English or Punjabi. SETTING: These focus groups were conducted as part of a 3-year community-based participatory research project examining cardiovascular risk factors among the Asian Indian population in Northern California. PARTICIPANTS: Focus group participants were selected through referrals from community-based organizations, postings in local community centers, and businesses. Fifty-seven men and women were recruited using snowball sampling. RESULTS: Six themes emerged from the focus groups: knowledge of cardiovascular disease, health and cultural concerns regarding diet, physical activity levels, stress as a factor for cardiovascular disease, acculturation concerns, and cardiovascular prevention ideas. CONCLUSIONS: The use of focus groups was an effective method for gathering information on perceptions of cardiovascular risk, and collecting information on risk behaviors within these Asian Indian communities. In this study, we found that psychosocial and cultural factors, especially cultural issues concerning stress and acculturation, surfaced as key elements across all 8 focus groups	Not directly linked to a programme
(Kedward & Dakin 2003)	BACKGROUND: Statin prescribing to prevent coronary heart disease is well below recommended levels. Studies suggest that the prescribing behaviour of doctors may be the biggest factor in the wide variation in statin prescribing in general practice. Understanding doctors' perceptions offers some insight into why variation occurs. AIM: To understand general practitioners' (GPs') views about barriers to statin prescribing, statin prescribing guidelines, and the successes and barriers to coronary prevention in primary care. DESIGN OF STUDY: Qualitative analysis of semi-structured interviews. SETTING: General practices in mid and south Bedfordshire. METHOD: Interviews with 26 GPs. RESULTS: GPs spoke of a variety of barriers to initiating statin treatment specifically, and coronary heart disease prevention generally. Barriers to statin prescribing included: concerns about cost; increased workload and adherence to treatment; variation in treatment targets for lowering cholesterol; and concerns about medicalisation, lifestyle, and health behaviour. GPs found it difficult to prioritize patients for statin treatment, their statin treatment targets varied, and many found primary prevention risk assessment tools difficult to interpret. Coronary prevention was limited by practice space and organisational issues, by problems with recording and retrieval of electronic data, and by limited doctor and nurse time. GPs suggested that funded nurse time, nurse-led heart disease clinics, and better use of electronic data would improve primary care coronary prevention. CONCLUSION: There are complex barriers to statin prescribing and coronary prevention in general practice, which may explain some of the variation that exists. Further studies of patients' views of statins may provide more information. More resources, improved guidance, and better dissemination of guidance may only address some of the issues	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Keith & Doyle 358)	This study's objective was to provide a theory-based framework to address non-insulin dependent diabetes mellitus (NIDDM) among American Indians of the Choctaw Nation. Rapid assessment procedures were used for interviews of the 17 Choctaw health professionals and tribal members in the study. Observations in	Findings do not relate to

Study	Abstract	Reason for exclusion
	Choctaw health care facilities were also conducted. Tribal newspapers and documents were studied to further identify health needs. A PRECEDE/PROCEED description emerged of NIDDM and influencing factors (including behavioral diagnosis) within the Choctaw Nation. Also provided are a suggested program design, specific objectives, and evaluation procedures. By incorporating cultural values into health education programs for American Indians, the programs should have a better chance to succeed. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	barriers/ facilitators
(Kelder 1993)	- no abstract available -	not qualitative methods / analysis / findings
(Kelder et al. 2003)	To test the effectiveness of the Child and Adolescent Trial for Cardiovascular Health (CATCH) program, a randomized trial was conducted in 96 elementary schools in four regions of the United States. Results from the original trial indicated a significant positive effect on the delivery of physical education (PE). All 56 former intervention schools (FI), 20 randomly selected former control schools (FC), and 12 newly selected unexposed control schools (UC) were assessed 5 years postintervention. Results indicate a strong secular trend of increasing moderate to vigorous physical activity (MVPA) in PE classes among both FC and UC schools. The FI schools surpassed the Healthy People 2010 goal for MVPA during PE lesson time (i.e., 50%), whereas the FC and UC schools came close to it. Barriers to implementing CATCH PE included insufficient training and lower importance of PE compared to other academic areas and indicate the need for in-service training	Study linked to a school or workplace programme
(King et al. 2006)	Gender and ethnocultural affiliation can influence people's health beliefs and their ability to make behavioural changes associated with risk reduction. The authors undertook a series of grounded theory studies aimed at describing and explaining how gender and ethnocultural affiliation influence the process that people undergo when faced with the need to make behavioural changes to reduce the risk of coronary artery disease (CAD). Here, they describe the gender- based influences associated with managing CAD risk in a small sample of older Sikh immigrants to Canada. Data were collected through semi- structured interviews, using an interpreter when necessary. Interviews were audiotaped to enable verification of interpretation and transcription. Data were analyzed using constant comparative methods. The core variable that emerged in the series of studies was "meeting the challenge." The process of managing CAD risk included pre-diagnosis or event, liminal or changing self, and living with CAD. Intra-, inter-, and extrapersonal factors as well as sociodemographic characteristics influenced the participants' ability to meet the challenge of managing CAD risk. Health-care providers and policy- makers have a responsibility to work with ethnocultural communities in order to (1) enhance the ability of health-care providers to provide ethnoculturally sensitive care, and (2) develop ethnoculturally relevant resources to enable health promotion and disease prevention. The ultimate aim is to improve health outcomes for Sikh immigrants as vulnerable members of society.	Not directly linked to a programme
(Klein)	Conducted focus-group interviews with 19 graduate and undergraduate students (aged 17-34 yrs) to determine why these Ss had volunteered to be peer health educators. Constructs from social learning theory were used to contribute to an understanding of Ss' motivations. Many Ss specified experiences with family members or friends (such as alcoholism or other illnesses) that influenced their decisions. Ss' motivations for volunteering were altruistic, such as wanting to help others, or egoistic, such as wanting job training. Ss' motivations were also related to self-efficacy beliefs; these Ss believed they could be successful in meeting the needs of their peers. Personal experiences and positive reinforcement to join also influenced Ss' decision to volunteer. Based on these findings, recommendations for creating more effective peer education programs are described. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Kline & Kline)	In the wake of growing concerns about a 'globesity' epidemic, this article explores the panic surrounding sedentary lifestyles and fast food culture, which have underscored calls for the cultural regulation of children's marketing. Avoiding the tired debate between those who see children as either manipulated or savvy consumers, this article resituates the controversy over children's consumerism in the broader context of our 'risk society'. Based on an approach that sets out to reduce media as risk factors in socialization, this article provides an overview of a media-risk education strategy, which acknowledges both the importance of media in children's leisure as well as the need to educate young consumers to make informed choices about their consumer lifestyles. The strategy provides the framework for a successful media education programme developed and tested in North Vancouver, which offers a complementary approach to marketing regulation. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Klos & Rosenstock 1982)	- no abstract available -	not qualitative methods / analysis / findings
Kohli (1998)(Kohli 1998)	- no abstract available -	not qualitative methods / analysis / findings
(Koopman & Koopman)	In this study 158 children, 80 children with diabetes mellitus and 78 healthy classmates, were interviewed about their concept of different types of illness (a cold, diabetes, infection, the most and least serious disease) and illness-related concepts (pain, becoming ill and going to the doctor or hospital). Special attention was given to the relationship between development of thinking and the variables anxiety, locus of control and family- and school functioning. The results show that the ideas of the children about the causes of illness follow a sequence of developmental stages, described as Through the Eyes of the Child' (TEC) model. Perception seems to be the child's central auto regulative system of cognitive development. The findings suggest that thinking about illness develops relatively independently of other influences. The practical relevance of knowing how children's thinking about illness develops is elaborated in terms of their implications for health education. Immature thoughts of children about illness can be detected and accepted and not dismissed as irrational. With the help of this model, health education of the child can be facilitated (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors

Study	Abstract	Reason for exclusion
(Kreps)	(from the chapter) four important levels of health communication inquiry are selectively reviewed here: interpersonal, group, organizational, and mediated communication in health care / the chapter also identifies future directions for conducting applied health communication research that can help increase the effectiveness of health-care delivery /// interpersonal health communication research / therapeutic communication / social support / health-care interviewing strategies / provider-consumer health-care relationships / health education / development of health communication competencies /// group communication in health and health care / health-care teams / support networks /// organization communication in health and health care / coordinating communication channels to direct organizational adaptation / communication and stress in health-care organizations /// mediated communication in health and health care / print media / telephonic health communication / radio and television as public health communication media / mediated health education campaigns / communication technologies as health-care media (PsycINFO Database Record (c) 2007 APA, all rights reserved)	No qualitative research element
(Kreuter & Green 1978)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Krummel et al. 2002)	- no abstract available -	Not directly linked to a programme
(Kuller 2008)	- no abstract available -	not qualitative methods / analysis / findings
(Lancaster et al. 1983)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Lando et al. 1994)	- no abstract available -	not qualitative methods / analysis / findings
(Lando et al. 1991)	We conducted a survey of 875 smokers in a Minnesota Heart Health Program community who were nonparticipants in screening and intervention. We found particular levels of interest in quitting and in formal cessation topics and programs among these smokers. Also, we collected information on smoking history, social environment, and anticipated barriers to quitting. Most noteworthy was the finding that more than half of the respondents indicated a desire to be contacted by telephone to receive information on materials on, classes on and ways of quitting smoking. Topics of particular interest to smokers included physical addiction, stress reduction, and (for women) methods of avoiding weight gain after quitting. Only 7% of respondents reported that they definitely did not want to quit, and approximately one-third of those interested in quitting indicated that they would seek outside help in doing so. The findings support the viability of 'reverse' helpline procedures in which smokers are contacted directly and offered assistance in quitting	not qualitative methods / analysis / findings
(Lane et al. 2005)	Being overweight is regarded as the most common nutritional disorder of children and adolescents in the United States. The escalating problem of being overweight or being obese in our society indicates the need for treatment strategies that encompass an all-inclusive approach. Moreover, these strategies need to be comprehensively evaluated for their effectiveness. Nurses are in an excellent position to ensure that this occurs. The purpose of this study was to determine whether using a mixed-methods approach was an efficacious way to provide a comprehensive evaluation of the behavior modification benefits of a weight loss/weight management nursing intervention in African-American adolescent girls (13-17 years of age). The overall effectiveness of the intervention was evaluated by analyzing pre- and post-program measures of weight, body mass index, cholesterol, blood pressure, self-esteem, depression, and body image (quantitative data); conducting focus groups with mothers of the participants; and administering open-ended, written questionnaires to the participants (qualitative data). Findings from the quantitative data indicated favorable outcomes in weight, blood pressure, cholesterol, body mass index, self-esteem, and body image, indicating that progress had been made over the course of the program. Furthermore, qualitative data indicated that mothers of the participants observed positive behavioral changes related to eating and exercise patterns and participants demonstrated perception of these changes as well. Grant information: National Center on Minority Health and Health Disparities Grant No. 5 R24 MD000192-03 and the National Institute of Nursing Research/National Center on Minority Health and Health Disparities Grant P20 NR 008389-03	Not targeting low/no risk groups / focusing on high risk groups
(Lasater et al. 1988a)	- no abstract available -	not qualitative methods / analysis / findings
(Lasater et al. 1988b)	- no abstract available -	not qualitative methods / analysis / findings
(Lasater et al. 1988c)	(from the chapter) an historical research evolution has led to community-wide cardiovascular disease prevention research efforts such as the Pawtucket Heart Health Program [PHHP, Rhode Island] /// [in this research program] behavior and risk factors are impacted by educational intervention, the frequency of new heart	No qualitative research element

Study	Abstract	Reason for exclusion
	attacks and stroke is measured by hospital record abstraction, and specific causes of death are recorded /// primary prevention efforts offer the most promise for major reductions in cardiovascular mortality and morbidity /// PHHP / program evaluation / risk factor surveys / morbidity and mortality surveillance /// theoretical model /// program delivery / organizational approach / community linkages / volunteers (PsycINFO Database Record (c) 2007 APA, all rights reserved)	
(Lasater et al. 1991)	The Pawtucket Heart Health Program (PHHP), in its attempt to treat obesity in the community, has delivered many traditional group and self-help weight loss programs. However, in order to reach a sufficient number of people to produce a public health impact in Pawtucket, PHHP devised a monthly city-wide 'weigh-in.' This program, designed to be delivered by volunteers, allowed individuals to set a weight loss goal and pledge a monetary incentive toward this goal. Self-help materials and the opportunity to join weight loss groups were provided. In the pilot study, 129 (61%) of 213 enrollees completed the 10-week program with a mean weight loss of 8.2 lb (p less than .001). A large decrease in total serum cholesterol was also observed. Nonpersonnel costs, including the total costs of the cholesterol measurement, were $1.30 per pound lost. Moreover, success is also evident by continued availability of the program and the increasing number of new participants 'referred' to the weigh-in by members	not qualitative methods / analysis / findings
(LEFEBVRE 1987)	The Pawtucket Heart Health Program is one of the community studies examining whether population-based efforts to lower cardiovascular risk factors will reduce cardiovascular morbidity or mortality. The Pawtucket Heart Health Program intervention is based on a blend of social learning theory, community psychology tenets, and diffusion research. This model allows for multi-faceted programmes that target individuals, groups, organisations, and the entire community to alter their cardiovascular risk through managing blood pressure, lowering blood cholesterol, quitting smoking, increasing fitness and maintaining desirable weight levels. A dominant feature of the intervention is the emphasis that it places on volunteers for programme delivery. The role of volunteers in providing direct services to help citizens lower their blood pressure and lose weight is highlighted to demonstrate the feasibility and effectiveness of these services. In addition church-based programming which utilises volunteers to manage and direct programmes is also presented as an example of community-based health promotion efforts that promote collective efficacy. Cites 24 references. [Journal abstract]	not qualitative methods / analysis / findings
(LEFEBVRE 1990)	(from the introduction) reviews strategies to maintain [health promotion] programs / builds on the Pawtucket Heart Health Project in Rhode Island, which comprises special efforts to reach low-income and minority populations that reside there (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Lefebvre et al. 1987)	Four years of participant tracking data (N = 24,995) for community-based programs targeting cardiovascular disease risk factors are presented. Over two-thirds of contacts were female; age segment representation in these programs was comparable to the city's demography. However, the data show that programs of varying formats which target specific risk factors attract different types of participants. Implications for marketing strategy are discussed	not qualitative methods / analysis / findings
(Lefebvre et al. 1988b)	The Pawtucket Heart Health Program (PHHP) is a community-based research and demonstration project in cardiovascular disease (CVD) prevention located in the United States. Targeted risk factors include high blood pressure, elevated blood cholesterol, cigarette smoking, obesity and sedentary living. Evaluation methods included biennial household risk factor surveys in the education and comparison communities, morbidity and mortality surveillance in hospitals serving each community, and both formative evaluation and process tracking. Intervention methods are theoretically derived from social learning theory and seek to motivate, enable and maintain individual behavior change; modify social networks; and introduce environmental change in organizations and normative shifts in the community in ways that reduce the prevalence of CVD risk factors. The intervention strategy began as an organization-based model, and has evolved into a community-wide effort in which marketing research tools and techniques are employed. In the past 4 years, over 40,000 individual contacts have been made with PHHP programs, including 1,260 persons who have volunteered their time to deliver risk factor programs	not qualitative methods / analysis / findings
(Lefebvre et al. 1988a)	- no abstract available -	not qualitative methods / analysis / findings
(Lefebvre et al. 1990)	Although the number of smokers has declined in recent years, many people remain resistant to traditional smoking cessation programs. Therefore, new and innovative approaches have been attempted. This study describes the application and effects of a community-wide smoking cessation program over three successive years. Smoking cessation rates ranged from 10.6% (CO verified) to 30.1% (self-report) at 1 month, and 17.3% to 24.5% at 1 year follow-up. Analyses revealed that successful quitters were more likely to have heart about the program at work and to have used materials contained in the self-help kit; and were more likely to be married and have a higher average income than either people who attempted to quit or made no attempt. Twelve-month follow-up data were used to classify participants into four new, distinct groups: maintainers, new quitters, relapsers, and nonquitters. Maintainers were more likely to have heard about the program at work and less likely to have become involved at Octoberfest. These programs do reach representative samples of the community. Their results compare favorably to other minimal contact intervention and physician-mediated efforts	not qualitative methods / analysis / findings
(Lefebvre et al. 1991)	Adherence to referral recommendations given to participants at blood cholesterol screening programs is a critical aspect of these efforts to help detect and control high blood cholesterol in the US adult population. In this study, 386 participants who had received two consecutive blood cholesterol measurements above 240 mg/dl (6.21 mmol/l) were interviewed by telephone 3 months after their second measurement (May 1987 - May 1988). Approximately 40% of respondents had seen a physician by the time of the interview; another 30% reported having scheduled an appointment. There was no significant difference in adherence behavior between participants who received a letter reiterating the referral and those who did not. However, participants who received the letter reported greater physician attention to the evaluation and treatment of their high blood cholesterol, primarily because these participants stated that they visited their physician for their high blood cholesterol. Significantly higher rates of further blood tests, cholesterol education material distribution, cholesterol-lowering medication prescription and patient-physician discussions about cholesterol were the result. These findings suggest that consumers can be effective in stimulating and reinforcing physician	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	practice behaviors related to cholesterol control. However, strategies must be crafted so that consumers are aware of, and appreciate, the necessity of seeking physician care when they become aware of a high blood cholesterol level	
(Leventhal)	Because of its important implications for policy decisions and research funding in the preventive health area, the objectives, methods, results, and conclusions of the Stanford 3-community study (A. J. Meyer et al; see record 1980-12441-001) are critically examined. Both incorrect and inappropriate conclusions have been drawn about the effectiveness of mass media in reducing risk factors and changing life-style. The high-risk Ss in the media-only condition showed virtually no reduction in cardiovascular risk, although they did show increased knowledge about cardiovascular risk factors and did report a reduction in the consumption of cholesterol and fats. Ss in the media plus face-to-face instruction condition did reduce cardiovascular risk, primarily through smoking reduction, but because of a high drop-out rate and the absence of a face-to-face-instruction-only condition, it is impossible to evaluate the media's role in producing or maintaining the observed reduction in risk. The Stanford study was not a 'community study,' but a quasi-experimental study of individuals conducted in a community setting, and as such provides an incomplete and probably inappropriate model for changing unhealthy life-styles. (18 ref) (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Levin et al. 1998)	Describes the process of developing the community-based Pawtucket Heart Health Program moderate-intensity physical activity campaign, Imagine Action, from its pilot, Get Fit. The study took place in Rhode Island, and targeted sedentary individuals. 161 employees (mean age 36.5 yrs) from 2 worksites participated in the competitive Get Fit pilot. 80% percent of Get Fit participants reached the campaign goal of 600 min aerobic activity during the 6-wk competition, but results showed that men and those over 50 were not adequately reached, and few sedentary individuals participated, suggesting it was not the best approach for reducing cardiovascular disease. After Get Fit and nonexerciser focus groups met to evaluate the pilot and contribute suggestions for the new campaign, Imagine Action was developed and implemented as a 6-wk community-wide campaign targeting sedentary adults and focusing on leisure time activities. There were 648 participants with a mean age of 40.8 yrs. Observational results and a telephone survey of randomly selected participants showed that the campaign was largely successful. It is concluded that moderate physical activity was widely accepted in a community setting, but that the Get Fit approach had limited potential to reach inactive populations. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Lewis et al. 2004)	BACKGROUND: Compelling success stories, rich with details about real-life events and people, are a tool that health agencies can use to convey how their health promotion programs work, why they are successful, what lessons they have learned, and how others can launch similar programs. Success stories describe project accomplishments that are not easily captured by quantitative evaluation methods, such as surveys. METHODS: Although success stories have not been widely used in public health, the North Carolina Department of Health and Human Services developed a series of stories, the Community Change Chronicles, to highlight environmental and policy changes that promote cardiovascular health. In 2003, the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program used the Community Change Chronicles as a model to develop success stories about WISEWOMAN projects. RESULTS: WISEWOMAN Works: A Collection of Success Stories from Program Inception Through 2002 includes 12 stories and offers advice on how to create and use success stories in public health. This paper reviews the rationale for developing the stories, presents one success story as an example, and describes the process used to gather information, write the stories, and produce a resource for others interested in developing success stories. We also discuss how the WISEWOMAN success stories are being used to promote women's health and cardiovascular health. CONCLUSIONS: As the WISEWOMAN experience suggests, healthcare providers and organizations can use success stories to gain support for successful activities, inform the public about program benefits, complement other quantitative and qualitative evaluation methods, and publicly acknowledge the contributions of staff and organizational partners	not qualitative methods / analysis / findings
(Liewer et al. 2008)	Cardiovascular disease (CVD) is the leading cause of death for women in the United States, resulting in a greater emphasis on research and methods for addressing issues relating to this health problem both nationally and worldwide. The authors' purpose was to identify barriers to women's cardiovascular risk knowledge, both personal and organizational, through key informant interviews of health leaders at 10 community health organizations. Analysis showed an overall lack of awareness of CVD risk for women. Culture, finance, and lack of awareness and easily accessible programs implicated the importance of physicians as health care providers and educators for women patients	not qualitative methods / analysis / findings
(Lindholm et al. 1997)	Prevention can reduce the risk of disease, but has other consequences as well. Willingness-to-pay (WTP) is one method to analyse these multi-dimensional consequences, if the stated WTP is assumed to be a function of all the expected positive and negative effects perceived. An interview study of a community-based cardiovascular disease prevention programme in northern Sweden shows that expectations regarding reduced mortality in the community and future savings in public health care spending increase the perceived value of the programme. Among personal benefits, decreased disease risk was not positively associated with WTP, while a low level of anxiety was	not qualitative methods / analysis / findings
(Linnan et al. 1990)	The workplace offers a unique setting in which to offer CVD risk reduction programs. Marketing these programs involves at least two distinct processes. First, a corporation must agree to accept and support workplace health programming. Second, workplace programs must be effectively marketed to eligible employees, dependents, and retirees. After identifying critical barriers to the effective marketing of workplace programs, a stepwise approach used by the Pawtucket Heart Health Program to successfully overcome these obstacles is used. Using real world examples and practical tips, a discussion of implications for marketing future programs to the corporate and employee audience is shared	not qualitative methods / analysis / findings
(Logstrup & Hollins 2007)	- no abstract available -	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
(Loken et al. 1990)	(from the chapter) social influence processes have played and important role in the conceptual underpinnings, development, and implementation of the Minnesota Heart Health Program (MHHP) / MHHP is a communitywide program developed to prevent illness and disability by helping people reduce their own risk factors associated with heart disease / this chapter describes the program as a way of illustrating how social influence processes have been used in a primary prevention program /// program evaluation / Lewin's action approach social learning theory / attitude change theories (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Love & Thurman 1991)	Since the release of the Surgeon General's report, Healthy People, the general public has been barraged with health information and advice by the popular media. Accordingly, this article introduces a method for examining the public's beliefs about the importance of behavioral risk factors associated with health and longevity. The factorial survey approach--a technique appropriate for studying normative beliefs--seems uniquely suited to measuring the degree of public consensus regarding complex social phenomena. Data collected using this experimental vignette methodology suggest that there is much public agreement about the sources of good health. Information described in hypothetical vignettes about smoking, body weight and alcohol consumption are judged most important in promoting health and longevity even when controlling for other behavioral factors such as exercise activity, diet, amount of rest, stress, personality type, and coping strategies. The implications of these findings are briefly discussed	not qualitative methods / analysis / findings
(Ludescher et al. 1993)	Qualitative research was used to determine what young black male college students do and believe in the hypertension related areas of nutrition, stress and exercise. Black female college students also were asked about their perception of the men's beliefs and behaviors in regard to the above mentioned areas. The study identified stress, especially the stress of being a black male in the US, as the most important concern of both male and female students. There was also agreement in both gender groups that relatives and close friends, especially females, had more influence on men's health behavior than professionals or celebrities. The study discusses the implications of these findings for hypertension prevention programs targeted at young black male college students	Not directly linked to a programme
(Luepker & Perry 1991)	Within the Minnesota Heart Health Program, all schools have participated in these programs and most have been incorporated as part of the regular school curriculum. The involvement of parents in youth programs has been challenging, but we view it as essential to making significant changes. Further, a program with appropriate underlying behavioral theory and community involvement can be successful. Such efforts seem critical to primary prevention of cardiovascular disease risk and subsequent disease in a culture where these diseases are common	not qualitative methods / analysis / findings
(Lukoschek 2003)	Since low adherence rates contribute to morbidity and mortality among hypertensive African Americans, health beliefs known to influence nonadherence must be explored. Hypertensive African Americans were recruited from an urban, public hospital and divided into two categories: adherent, well-controlled versus nonadherent, poorly controlled participants. Separate focus group sessions were held for each category. Participants proved similar with respect to sociodemographic variables but varied in the duration of hypertension. Some beliefs were mentioned more often among nonadherent participants than among adherent participants when describing medical treatments and physicians' encounters. Some participants perceived medication to be harmful and noneffective, and some expressed distrust of pharmaceutical companies and physicians, believing them to use patients for experimentation to test medications. Their descriptions of dialogues with physicians suggested authoritarian and ethnicity-inappropriate communication patterns. To reduce the nonadherence rate among African Americans, it may be necessary to integrate health beliefs into educational interventions and physician-patient communication	Not targeting low/no risk groups / focusing on high risk groups
(Lytle et al. 2003)	To better understand the institutionalization process in Child and Adolescent Trial for Cardiovascular Health (CATCH) intervention and control schools, 199 key informant interviews were conducted with school food service staff, physical education teachers, classroom teachers, and administrators at the four CATCH-ON field centers. School personnel were asked to talk about the degree of CATCH program implementation, who at the school or school district was instrumental in promoting CATCH, and the conditions that facilitated or impeded the institutionalization of CATCH activities and philosophies. The CATCH Physical Education (PE) component appeared to have the highest level of institutionalization, and the CATCH classroom curriculum and family components appeared to have the lowest levels of institutionalization. The primary barriers expressed included the low priority for health promotion activities and time constraints of schools: lack of mechanisms for training of school staff; and lack of sufficient funds for materials, equipment, and lower fat vendor products	Study linked to a school or workplace programme
(Ma'at et al. 2002)	- no abstract available -	not qualitative methods / analysis / findings
(Macallan & Narayan 1994)	In the Grampian Region of Scotland, a new 10 year heart health initiative, 'Keeping the heart Beat in Grampian' was launched in October 1991. Although this programme is based on a number of well-tested health promotion principles it is unique in a number of aspects. The concepts of community ownership, corporate identity and people empowerment have been extended to a much greater degree. The programme is registered as a private company with charitable status so that management, decision-making and budgetary control are vested totally in the community	not qualitative methods / analysis / findings
(Maccoby & Altman 1988)	(from the chapter) central theme of the community organization and development efforts was that collaboration between community organizations and SHDPP [Stanford Heart Disease Prevention Program] research would enhance the adoption of healthful behaviors and ultimately lead to the long-term institutionalization of health promotion programs in the community /// Stanford Three Community Study / Stanford Five City Project (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Maccoby & Farquhar 1975)	- no abstract available -	not qualitative methods / analysis / findings
(Mack et al. 1997)	Knowledge, attitudes, and activities in cardiovascular disease (CVD) control among local health departments in Missouri were surveyed in 1990 and in 1994,	not qualitative methods /

Study	Abstract	Reason for exclusion
	following four years of a community-based CVD risk-reduction project. Hypertension screening was rated as the most frequently performed CVD-related activity in 1990 and in 1994. Differences in mean scores between baseline and follow-up surveys showed no significant changes except for cholesterol screening. Respondents preferred individual patient education rather than community-wide approaches to risk reduction. Our findings highlight the need for more emphasis on coalition building and community-based programs for preventing and controlling CVD at the local health department level	analysis / findings
(Makrides et al. 1997)	Primary care physicians have an important role in coronary heart disease prevention. This paper discusses the results of a qualitative study conducted with Nova Scotian physicians to explore the following: physicians' expectations about their role in prevention; obstacles to providing preventive care; and, mechanisms by which preventive care occurs. The second part of the paper presents a practice model which is intended as a framework by which physicians may more effectively educate and counsel their patients about health issues, such as coronary heart disease	Not directly linked to a programme
(Makrides et al. 1998)	The purpose of this study was to determine the cardiovascular health needs of university students living in residence. A survey was administered to students living in residences at a university in Nova Scotia, Canada to identify eating patterns, physical activity, smoking behaviours and perceived stress. Data were analyzed using descriptive statistics and chi-square tests of association. Qualitative data were collected using focus group interviews. Results showed that fewer than half of the students participated in exercise three or more times per week, and 82% ate less than the recommended amount of fruits and vegetables. As perceived knowledge of CVD increased so did level of physical activity and consumption of fruits and vegetables. Fifty-six percent of students rated their stress as high or very high; exams and course assignments are a major cause of this stress. Fifteen percent of the university students surveyed were daily smokers. Barriers to a healthy lifestyle include time constraints and limited food choices in the residence cafeteria	Not directly linked to a programme
(Mann et al. 1996)	Ongoing professional learning is essential for all health professionals. This need is increased as community-based, multidisciplinary approaches to the delivery of health care and to health promotion and disease prevention emerge. A pilot educational program was developed to test a model of multidisciplinary learning in heart health. A multidisciplinary professional education committee jointly developed a case-based educational program to include physicians, nurses, dietitians, pharmacists, social workers, and recreation professionals or health educators. The program was developed in the context of primary health care; specific objectives were developed using a health promotion framework. Problem-based learning was selected as the educational approach, and the cases were developed to incorporate program objectives. Three communities participated. Ten to 12 participants met for 2 hours weekly across 4 weeks to discuss problems concerning individuals at high and low risk for cardiovascular diseases and heart health in their community. The project evaluation involved direct observation, review of documentation, pre- and postprogram questionnaires, and individual interviews. In each site, the project met its goals; however, goal achievement varied across communities. The sessions provided an opportunity to learn about the roles and contributions of other health professionals; they created the basis for future collaboration, and they stimulated extensive discussion about heart health resources in each of the communities involved. We conclude that a multidisciplinary approach to planning and development of such a project is feasible, and that multidisciplinary case-based learning is an effective means of acquiring new understandings and promoting health professionals' collaboration in addressing heart health in their communities	Findings do not relate to barriers/ facilitators
(Marcus et al. 1992)	PURPOSE. This study examined the use of the stages of change model to design an exercise intervention for community volunteers. DESIGN. The 'Imagine Action' campaign was a community-wide event incorporating the involvement of local worksites and community agencies. Community members registering for the campaign were enrolled in a six-week intervention program designed to encourage participation in physical activity. SUBJECTS. Six hundred and ten adults aged 18 to 82 years old enrolled in the program. Seventy-seven percent of the participants were female and the average age was 41.8 years (SD = 13.8). SETTING. The campaign was conducted in a city with a population of approximately 72,000 and was promoted throughout community worksites, area schools, organizations, and local media channels. MEASURES. One question designed to assess current stage of exercise adoption was included on the campaign registration form as were questions about subject name, address, telephone number, birthdate, and gender. INTERVENTION. The intervention included written materials designed to encourage participants to initiate or increase physical activity, a resource manual describing activity options in the community, and weekly 'fun walks' and 'activity nights.' RESULTS. A Stuart-Maxwell test for correlated proportions revealed that subjects were significantly more active after the six-week intervention. Sixty-two percent of participants in Contemplation became more active while 61% in Preparation became more active. CONCLUSIONS. Most participants increased their stage of exercise adoption during the six-week intervention. This study provides preliminary support for use of the stages of change model in designing exercise interventions	not qualitative methods / analysis / findings
(Marder et al. 2005)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Marmot 2006)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Martin & Woolf-May 1999)	Aim: The purpose of this retrospective evaluation was to examine the characteristics of men and women who embarked upon a 10-week general practitioner (GP) referral exercise prescription programme and to compare those who completed a 10-week programme of exercise (Finishers) with those who failed to complete (Non-finishers). Methods: Forty-two Finishers (16 males and 26 females) and 35 Non-finishers (12 males and 23 females) were followed up with a semistructured telephone interview. Clinical data were also collected from the patients' GPs' case notes and the data were analysed using both quantitative and qualitative methods. Results: Baseline results using one way ANOVA showed no statistical difference between the groups for age (P > 0.3), BMI (P > 0.9), Systolic BP (P > 0.9), Diastolic BP (P > 0.9), total cholesterol (P > 0.1). number of coronary heart disease (CHD) risk factors (P > 0.4]. number of subjects with CHD family history	Not addressing 2+ risk factors

Study	Abstract	Reason for exclusion
	(P > 0.7] or for number of smokers (P > 0.9); However, generally the females were younger than the males (males 57.9 +/- 12.1 years, females 50.7 +/- 13.3 years). Analysis of the available data from the case notes showed that [CHD)/coronary vascular disease (CVD) risk factors were not generally taken into account by the primary health care team to make appropriate referrals. Finishers attended the gym significantly (P < 0.0001) more times per week than the Non-finishers (F 2.5 +/- 0.9, NF 1.7 +/- 0.6 sessions/week). Results from the semistructured interviews revealed that Finishers were less reliant on social support and more likely to report tangible health benefits whereas Non-finishers relied on support of others when attending the gym. Conclusions: Results from this evaluation suggest, that the methodology used was too crude to accurately measure the complex characteristics which determine the differences between Finishers and Non-finishers	
(Maschewsky-Schneider & Greiser 1989)	The German Cardiovascular Prevention Study is a multicentre community-based intervention study with the primary goal of reducing cardiovascular mortality by primary prevention measures. The intervention strategy comprises improving people's life styles as well as health promotion so as to modify cardiovascular risk factors (hypercholesterolemia, cigarette smoking, arterial hypertension, physical inactivity and over-weight). Design elements of the German Cardiovascular Prevention Study, now in its fifth year, were adopted from well known community intervention studies, including monitoring of mortality and morbidity, health examination surveys to assess distribution of cardiovascular risk factors, health attitudes and health behaviour in the community and use of formative and process evaluation to monitor the effects of intervention policies in the community. To identify risk factor profiles a cluster analysis was carried out from survey data. Four clusters were identified: a) people with none or few risk factors; b) those with high prevalence of smoking; c) those with high prevalence of hypercholesterolemia and hypertension; d) high risk factor exposure individuals. The clusters are different along social indicators like age, sex and social status. Process evaluation data show that special strategies like interventive blood pressure screenings reached a relatively high proportion of people from lower socioeconomic status. But they also indicate that there is a long way to go from publicity of intervention programs to lasting changes in behaviour	not qualitative methods / analysis / findings
(Mason 2006)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Mauriello)	This article describes the development and pilot testing of a computer-based, multiple- behavior obesity prevention program for adolescents. Using the Transtheoretical Model as a framework, this intervention offers individualized feedback based on readiness to engage in physical activity, to consume fruits and vegetables, and to limit television viewing. Focus groups and interviews with students, teachers, school administrators, and experts guided the development. Forty-five students participated in a baseline intervention session and completed a 16-item acceptability measure. Ratings were positive, with item means ranging from 3.60-4.75 on a 5-point scale. Student responses to open-ended questions aided in the enhancement of the intervention, for which an effectiveness trial begins in September 2006. This formative work demonstrated the acceptability of this school-based intervention approach, which can be promoted and prescribed by school nurses. Further, if found effective, it can be disseminated as an efficient, low-cost, population- based approach designed to address the epidemic of obesity. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	not qualitative methods / analysis / findings
(McAlister et al. 1992)	BACKGROUDd. Smoking-related disease and injury is prominent among the numerous health problems on the U.S.-Mexico border, but little is known about the methods that might help promote smoking cessation among the low-income populations in this region. METHOD. Media campaigns were combined with different forms of intensive and community-wide interpersonal communication to encourage smoking cessation in a border U.S. city and in a Mexican city. Panels of moderate to heavy smokers were followed in four groups to allow quasi-experimental comparison of smoking cessation rates. RESULTS. Over a five-year study period smoking cessation rates of 17% (self-reported) and 8% (verified) were observed in panels in the program community (N = 160). In the comparison community (N = 135) corresponding rates of smoking cessation were 7% (self-reported) and 1.5% (verified). Within the program community, no differences were observed in smoking cessation among smokers exposed to a community-wide program and those assigned to receive personal counseling. DISCUSSION. Although the observed changes in smoking were unexpectedly small in the treatment and comparison groups, the approximately 8% effect size for the community-wide program was close to what was predicted. Results indicate that such programs may yield effects similar to those of more intensive approaches, but further research with greater statistical power will be necessary to confirm that point	not qualitative methods / analysis / findings
(McCarthy et al. 1992)	Focus group discussions are an effective way to determine the needs and interests of a target population. In August 1989, eight focus group discussions were conducted with municipal employees in Phoenix, Ariz, to determine the needs and interests of potential participants in a worksite cholesterol education program. Employees were selected for the focus groups on the basis of an initial screening that determined their motivation to change customary eating habits. Individuals categorized as "somewhat motivated" were invited to participate in the focus groups because researchers thought they would best represent the motivation level of the majority of potential participants in the cholesterol education program. The focus group participants indicated that they preferred educational formats and approaches that appealed to diverse learning styles and recognized individual differences. Several of the program features identified by the focus groups are consistent with principles of adult education, especially active participation in the learning activity. The focus group participants wanted information presented in a simple, easy-to-understand manner, and they asked for behavioral directives rather than background information or medical jargon. Release time from work and employer commitment to the program were viewed as important to the success of the program. We conclude that employees respond best to worksite wellness programs that are simple, practical, and relevant and that allow them to participate actively in the learning activity during work time	Study linked to a school or workplace programme
(McGraw et al. 1996)	The purpose of this article is to illustrate the use of process evaluation for understanding study outcomes. Data from the Child and Adolescent Trial for Cardiovascular Health (CATCH), a large school-based field trial, are used. Teacher characteristics, measures of classroom curriculum implementation, and competing influences are linked to changes in dietary knowledge, intentions, and self-efficacy of students in the intervention schools. Multiple regression analyses	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	indicate that teacher characteristics did not predict program implementation. Teacher characteristics and program fidelity, or the number of modifications made to the classroom curriculum during implementation, had direct and independent effects on student outcomes	
(McGraw)	The measurement of program implementation and policy adoption is an essential evaluation component of any health intervention program. This paper reviews approaches to measuring the implementation of school-based programs and policies to promote physical activity and healthful eating among youth in elementary through high schools. Areas examined include classroom instruction/curricula, food service, physical activity classes, and school policies. Operational definitions of implementation and methods of collecting data are described and compared. Most implementation measures are focused on 2 dimensions: quantity (dose or completeness) and quality (fidelity). Data collection methods include the use of teacher self-report recorded through checklists, questionnaires, and interviews. Classroom observations by a trained observer are also used. Studies of policy development have used archival records and semi-structured interviews. Considerable variability exists across studies in how program of implementation is defined and measured. This is in part due to the need to tie measures closely to the content and format of the intervention. More work is needed to assess and compare the reliability and validity of various approaches to measuring implementation. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(McMichael 1989)	Epidemic diseases move in grand cycles, accompanying changes in culture, social organization, and environment. Coronary heart disease (CHD), a mass disease of twentieth century industrialized society, has a predominantly environmental aetiology. Although the major biomedical risk factors appear to have been identified over the past 40 years of epidemiological research, we are not certain why CHD is now on the wane in most Western nations. In Australia, CHD death rates have, since 1968, declined much more in professional and white-collar men than in blue-collar men. Any substantial reduction in CHD rates will require a generalized population shift towards a lower CHD risk profile. Numerically, the greatest gains should come from reducing the CHD risk of the bulk of the population, who are currently at medium risk of CHD. Notions of risk need, in the first instance, to be based on up-to-date knowledge of biomedical risk factors and mechanisms in order to develop optimal intervention strategies. A population-based strategy can be achieved via community education and structural modification of the social environment. The latter approach will require public health research into broader questions of the social-environmental influences on population cardiovascular health: for example, research into the social, political, and economic determinants of national food and nutrition policies; and into the various environmental (including workplace) changes that will facilitate risk-lowering behaviour. Hopefully, intervention strategies in such areas, set within a community development context, will be developed within the incipient National Program for Better Health.(ABSTRACT TRUNCATED AT 250 WORDS) [References: 42]	not qualitative methods / analysis / findings
(Messner 1993)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Miller et al. 2004)	To gain an understanding of health-related practices and perceptions, Nashville REACH 2010 conducted focus studies among 5 community groups. Attitudes about health, personal risk behaviors, quality of health care, and models of personal behavior change were assessed. All focus-group sessions were transcribed and analyzed using a consensus panel methodology. A combined analysis of the focus groups revealed 3 categories of barriers to healthier living: 1) personal, 2) environmental, and 3) systemic. Personal barriers included lack of adequate finances, physical limitations, lack of knowledge, and stress. Environmental barriers were related to the unavailability of healthy food choices and adequate places to exercise in the community. The accessibility and quality of health care were the most pervasive systemic barriers identified. Though these findings are not novel to urban African-American communities, they will serve as the framework by which Nashville REACH 2010 will implement strategies to reduce and, ultimately, eliminate cardiovascular disease and diabetes disparities	Not directly linked to a programme
(Mohan et al. 2006)	Despite the high prevalence rate and significant mortality and morbidity from coronary heart disease in Asian Indians (irrespective of their religious background), very few studies have reported on family members' experiences of caring for a person with coronary heart disease. This paper reports on family members' experiences of coronary heart disease in Asian Indians residing in Australia, and is part of a larger study that explored the experiences and/or understanding of coronary heart disease in Asian Indians from the perspective of patients, family members and 'healthy' participants. Using a constructivist approach semi-structured in-depth interviews were conducted with five family members. Findings are represented under the following main categories: 1. A period of complexity for family members; 2. Indian Culture: Its influence on health/health behaviour & illness experience; 3. Impact of migration and societal discrimination; 4. Disappointment with health care services and the health system; and 5. Strategies to prevent cardiac illness and attain optimal health. Cultural factors had both positive and negative influences not only on the illness experience but also on health behaviour and attitude. The impact of Indian culture in relation to coronary heart disease needs to be understood not only at the cultural level by providing culturally sensitive health care, but also by educating Asian Indians to change their health attitude and behaviour and improve their lifestyle. Asian Indians need education and advice to become more resilient and adaptable to a Western society and also to become aware of the acculturative effects of a Western lifestyle	Not directly linked to a programme
(Moon)	Outlines a 3-yr evaluation study of the effectiveness of the Wessex Healthy Schools Award scheme (WHSA) intervention in changing health promotion policy and practice in school, and in influencing health-related knowledge, attitudes and behavior of pupils. The study was conducted in 11 secondary and 5 control schools. Changes in school health promotion were assessed by audit; pupils' health-related knowledge, attitudes and behavior through self-administered questionnaires; and attitudes and perceptions of support staff, parents and governors from semi-structured interviews. The results showed that audit scores for all areas, except	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	physical activity and taking responsibility for health, increased in intervention schools. There was little improvement in healthy food choices, smoke-free environment and developing community links. Pupils' knowledge, high at the baseline, remained unchanged. Positive effects on smoking uptake and drug use were seen, but little change in healthy eating and physical activity. Older girls made greater progress in all areas. Parents and non-teaching staff strongly supported school health promotion, perceived many benefits of the Award, and wished to be more actively involved. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	
(Morris & Welsh 1996)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Mosca & Hayes 2001)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Most et al. 2003)	A thorough quality assurance (QA) program upholds the integrity of nutrition research studies by yielding reliable data and results. Continually evaluating the implementation of a procedure against a goal and making adjustments when needed enhance the quality of a study's conduct and outcomes. Controlled diet studies require QA processes at various steps beginning with the screening of study participants, through diet preparation and delivery to data collection. Staff training and observations with monitoring activities, are important so tasks are completed according to protocol. When several clinical sites participate as partners in a controlled diet study, uniform procedures must be followed and a formal standardized QA program will assist. The Dietary Approaches to Stop Hypertension (DASH)-Sodium study employed such a program, described in this article, that included training staff, observing procedures, monitoring data for completeness and accuracy, evaluating processes, giving feedback, and documenting that tasks were done according to protocol. Furthermore, QA processes were used in the areas of participant screening, orientation, diet adherence, food procurement and preparation, and exit interviews. Other researchers may implement similar activities to ensure quality in their nutrition research programs	not qualitative methods / analysis / findings
(Mshana et al. 2008)	Stroke is an emerging problem in sub-Saharan Africa, about which little is known since most research to date has been based on retrospective, hospital-based studies. This anthropological work, designed to complement a large community-based project on stroke incidence, focuses on local understandings and treatment-seeking behaviours in urban (Dar-es-Salaam) and rural (Hai) areas of Tanzania. Semi-structured interviews (n=80) were conducted with 20 stroke patients, 20 relatives of stroke patients, ten traditional healers, and 30 other local residents. In contrast to common expectations, and literature that finds witchcraft beliefs to be most common in rural areas, stroke in urban Dar was widely believed to emanate from supernatural causes (demons and witchcraft), while in rural Hai, explanations drew mostly on 'natural' causes (hypertension, fatty foods, stress). These different beliefs and explanatory models fed into treatment-seeking behaviours. The first option in Hai was hospital treatment, while in Dar-es-Salaam, where belief in demons led to hospital avoidance, it was traditional healers. In both sites, multiple treatment options (serially or simultaneously) were the norm. Analysis of patient and carer narratives suggested that causation beliefs outweighed other factors, such as cost and distance, in shaping effective treatment. Three policy implications are drawn. First, as other studies have also shown, it is important to engage with, rather than dismiss, local explanations and interpretations of stroke. Stroke awareness messages need to take into account the geographical and belief systems differences. Developing an understanding of explanatory models that recognizes that local beliefs arise from dynamic processes of social interaction will be critical to designing effective interventions. Second, there is a clear role for multiple healing systems with possibility of cross-reference in the case of a chronic, disabling condition like stroke, since biomedical treatment cannot offer a 'quick fix' while traditional healers can help people come to terms with their condition. Third, issues of communication between health services and their patients are particularly critical	Not set in developed country
(Mumm 1975)	- no abstract available -	not qualitative methods / analysis / findings
(Muntoni 1992)	- no abstract available -	not qualitative methods / analysis / findings
(Murphy et al. 1994)	An assessment of nutrition education needs and learning preferences of students in grades 5, 8, and 11 was conducted to target instruction toward areas of highest need and strongest interest of students using teaching methods they prefer. This research evaluated students' knowledge, attitudes, and practices related to the Dietary Guidelines for Americans, including knowledge of the new Food Guide Pyramid; attitudes about school lunches and learning about nutrition; nutrition topics of interest; and preferred methods for learning about nutrition. Although results varied across grade level, generally students need to learn about the Food Guide Pyramid; the relationship between dietary fat, weight status, and health; and food sources of fat, salt, and fiber. They want to learn about personal health--how to control weight, improve diet, and prevent disease--using instructional methods that actively involve them. Results provide information relative to students' interest, understanding, and application of the Dietary Guidelines	not qualitative methods / analysis / findings
(Nader et al. 1982)	- no abstract available -	not qualitative methods / analysis / findings
(Nagy 2007)	- no abstract available -	not qualitative methods /

Study	Abstract	Reason for exclusion
		analysis / findings
(Nakajima et al. 2007)	We conducted a health promotion programme using mobile videophones and examined changes in the participants' health conditions, health practices and their subjective sense of health. The subjects were volunteers (mean age, 59 years) recruited from a community-based health promotion group. A focus group interview was conducted to evaluate the quality of the programme. All subjects expressed concerns about lifestyle-related diseases. The subjects participated in group activities at least twice a month under the supervision of public health professionals. Six of them participated in mobile care in addition to group activities (mobile care group) and the other eight subjects (control group) participated in the regular group activities. Three consecutive health examinations were carried out at intervals of 12 weeks. There were significant reductions in low-density lipoprotein cholesterol (P = 0.01) and health locus of control internal score (P = 0.05) in the mobile care group. The subjects who used mobile phones were highly accepting of the use of the device for further health consultations. There is potential for wider application of mobile videophones in health promotion programmes for people who have concerns about lifestyle-related diseases and are seeking healthier lifestyles	Findings do not relate to barriers/ facilitators
(Nakkash et al. 2003)	Triangulation of methods, sources, and investigators can lead to a multidimensional understanding of a particular issue. In this study, the combination of qualitative and quantitative data collection methods, and information from community and coalition members resulted in the development of a tailored community-specific intervention. Three components were triangulated after analyzing each separately. A household survey of community members between the ages of 25 and 64 years was conducted to identify knowledge, attitudes, and behaviors related to cardiovascular disease and to assess risk factor levels. Focus group discussions were conducted with community members to describe facilitators and barriers to healthy lifestyles, as well as possible interventions. Natural group discussions with coalition members analyzed the relevance, feasibility, affordability, acceptability, and sustainability of specific intervention activities. Results from the different components were compared and contrasted. Areas of added information, validation, and contradiction were analyzed and guided the development of intervention activities	Not set in developed country
(Naylor et al. 2002)	This paper presents the evaluation of a participatory research process used in a community-based heart health project, the British Columbia Heart Health Demonstration Project. The project utilized both a population heart health approach and a community mobilization model for taking action on heart health. A participatory evaluation plan was selected to: allow for participation in decision-making, incorporate the community perspective, enhance utilization of data, increase skills and capacities at the community level and enhance the responsiveness of the project team to emerging issues. Six elements common to participatory research were synthesized from the literature and rating scales were developed. Project participants across three project levels (investigative team, community project management committee members, community and provincial project coordinators) were asked to rate each of the elements and then explain their ratings during a focus group interview. Ratings were averaged and plotted on a 'sextagram' to illustrate the extent of participation in the research project. Patterns and themes that emerged from the transcripts and fieldnotes, regarding issues that influenced each rating, were categorized according to the framework of participatory research. Ratings and descriptions of participation on each element varied across project levels. The ratings of participation for the elements of sustainability and resource mobilization were uniformly low reflecting the large dependence on external funds. Participants involved at the community level perceived a greater level of participation in the identification of need and definition of goals and activities. Critical issues identified were related to the predominance of the external funding source, the imposition of funding agency guidelines on the communities, the amount of guidance by experts and the data collection methods. The analysis highlighted the responsiveness of the project to feedback over time and increases in the capacity of communities over time. Critical issues in the evaluation of participation were: differentiating stakeholder participation in program activities from research activities, variations in the meaning of community and participation among interviewees, the complexity of evaluating the extent of participation in a multi-level project and the evolution of participation over a 5 year time span. A definitive conclusion about the level of participation was elusive, however, the methodology afforded a contextual understanding of the assessments of participation and of participation itself and provides a foundation for evaluating and improving future participatory research initiatives	Findings do not relate to barriers/ facilitators
(Neittaanmaki et al. 1980)	The role of natural community leaders in serving as lay health workers in a comprehensive community health programme has been explored. In rural Finland, nearly 300 persons were trained to detect cardiovascular risk factors (smoking, high-cholesterol diet, high blood pressure) in their communities, and to advise community members of the desirability of lowering these risk factors. Initial data from studies of the lay health workers and their intervention work support the concept that carefully select community health workers who are to varying degrees representative of their local populations, can well act as intermediaries in preventive health care strategies	not qualitative methods / analysis / findings
(Nissinen et al. 1981)	- no abstract available -	not qualitative methods / analysis / findings
(Nix 1977)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(North Carolina Department of Health	- no abstract available -	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
and Human Services 1111)		
(Nutbeam et al. 1993)	Study objective - To examine the difficulties of developing and maintaining outcome evaluation designs in long term, community based health promotion programmes. Design - Semistructured interviews of health promotion managers. Setting - Wales and two reference health regions in England. Participants - Nine health promotion managers in Wales and 18 in England. Measurements and main results - Information on selected heart health promotion activity undertaken or coordinated by health authorities from 1985-90 was collected. The Heartbeat Wales coronary heart disease prevention programme was set up in 1985, and a research and evaluation strategy was established to complement the intervention. A substantial increase in the budget occurred over the period. In the reference health regions in England this initiative was noted and rapidly taken up, thus compromising their use as control areas. Conclusion - Information on large scale, community based health promotion programmes can disseminate quickly and interfere with classic intervention/evaluation control designs through contamination. Alternative experimental designs for assessing the effectiveness of long term intervention programmes need to be considered. These should not rely solely on the use of reference populations, but should balance the measurement of outcome with an assessment of the process of change in communities. The development and use of intervention exposure measures together with well structured and comprehensive process evaluation in both the intervention and reference areas is recommended	not qualitative methods / analysis / findings
(Oliver 1987)	- no abstract available -	not qualitative methods / analysis / findings
(Osganian et al. 2003)	Research is lacking on how to make effective programs available on a large scale and how to maintain levels of implementation. CATCH: A Study of Institutionalization (CATCH-ON) was designed to help us understand the conditions under which such programs are institutionalized after the trial has ended. The Child and Adolescent Trial for Cardiovascular Health (CATCH) was the largest field trial of school-based health promotion in the United States conducted in 96 schools in four geographic areas of the United States: California, Louisiana, Minnesota. and Texas. The intervention was multicomponent, targeting school policy and practices in nutrition, physical activity, health education, and smoking. This report provides background on the CATCH study design, the conceptual framework for research on institutionalization of the CATCH program, and an overview of the seven original reports that present results from the CATCH-ON study in this theme issue	not qualitative methods / analysis / findings
(Park et al. 2001)	Grant information: Supported by grants MCH-480612 and MCH-480747 from the Maternal and Child Health Program (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services, Washington, DC	not qualitative methods / analysis / findings
(Parker & Assaf 2005)	Review of the community-based CVD intervention programs suggests that a number of components have been successful using varying methods and materials for CVD risk reduction [46]. It should be noted, however, that in multi-intervention programs it is often difficult to determine which components of the intervention were responsible for the overall success of the study. The community-based approach to CVD prevention is generalizable, cost-effective (because of the use of mass communication methods), and has the potential for modifying the environment and influencing health policies [46,53]. Based on the experiences and successes of a number of community projects, recommendations have been proposed for developing future programs [49,51,52]. Although they are not totally comprehensive, it has been suggested that a community-based intervention program should consider the following recommendations: 1) An understanding of the community: the needs and priorities of the community should be assessed, and close collaboration with individuals from the community, including community leaders, opinion leaders, community health care providers, and community organizations from various sectors of the community, should be consulted. Efforts should be focused on underserved and vulnerable populations. 2) Inclusion of community activities: these activities should be integrated within the context of the community environment, including primary health care services, voluntary organizations, grocery stores, restaurants, work sites, schools, and local media. 3) Inclusion mass media messages: the mass media can provide information and reinforcement of the behavior change. 4) Develop cost-effective interventions to assure that the community is exposed to an effective dose of the intervention. 5) Work with community organizations to help change social and physical environments to make them more conducive to health and healthy lifestyles changes. 6) Develop a reliable monitoring and evaluation system: monitor the change process and conduct summary evaluations. 7) Disseminate the results to ensure that the benefits from the community program reach all communities. 8) For national implementation, the intervention program should work closely with national policy makers throughout the project. copyright 2005 Elsevier Inc. All rights reserved	not qualitative methods / analysis / findings
(Parra-Medina et al. 2004)	BACKGROUND: To serve the populations targeted by Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) effectively, healthcare providers need educational materials that are evidence based and ethnically relevant and can be easily incorporated into busy clinic settings. We describe a replicable process used to redesign and tailor physical activity and diet education materials for African American women in the southeastern United States. METHODS: The process consists of seven phases. Quantitative and qualitative analyses were used on data gathered in 2000 from two expert panels and eight focus groups. RESULTS: Expert panelists preferred materials perceived to be high quality, easy to understand, organized to facilitate use by healthcare providers, and with content relevant to African American women. Focus group participants were mostly concerned with the visual appeal and content of educational materials. They liked high-quality materials that are brief; avoid jargon and use simple language, bright colors, and photographs; and provide useful information that acknowledges the context of their lives, including their family roles. CONCLUSIONS: The redesign process can produce ethnically and culturally appropriate educational materials for use by WISEWOMAN providers and other healthcare providers in conjunction with cardiovascular (CVD) risk reduction and	Not directly linked to a programme

Study	Abstract	Reason for exclusion
	behavioral counseling. To be effective, materials must address the needs and concerns of both providers and patients	
(Pasternak 1997)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Perry et al. 1985)	Children and adolescents recently have become a group targeted for health promotion efforts. It is argued that early behavioral intervention will alter patterns of behavior that might place young people at increased risk for chronic diseases later in life. The Minnesota Heart Health Program is a longitudinal, community-based research and demonstration project to improve cardiovascular health in three north central communities. Reductions in cigarette smoking, improved eating and exercise patterns, and hypertension management are targeted objectives. To design educational interventions for children and adolescents in these areas as part of this program, a behavioral needs assessment was conducted in the communities prior to program implementation. This needs assessment focused on existing behavior patterns, skills related to the targeted behaviors, and environmental influences. This article describes that needs assessment, the results from two of the communities, differences due to gender and age of student, and the implications of the results for designing intervention activities for children and adolescents	not qualitative methods / analysis / findings
Perry et al. (2008)(Perry et al. 2008)	The purpose of this qualitative study is to describe rural women's barriers and motivators for participation in a walking program. Twenty rural women, ages 22 to 65, participated in a 12-week walking program. Data from field notes and focus groups were analyzed using qualitative content analysis. Data were inductively coded, codes were categorized into themes, and themes were classified as barriers or motivators to adopting a walking program. Three main barriers are identified: balancing family and self, chronic illness gets in the way of routine, and illness or injury breaks routine. Seven motivators are identified: being part of a group, group camaraderie, learning, pacesetter, seeing progress, energizing, and I am a walker. Women report that family responsibilities are a powerful and pervasive barrier. Motivators center on the importance of group interaction. This qualitative study increases our understanding of rural women's barriers and motivators to embarking on and sustaining a regular walking routine. Grant information: Supported by NIH, Office of Research on Women's Health, and the National Institute of Nursing Research (NINR) Postdoctoral Fellowship (F31 NR08656); NINR Predoctoral Fellowship (T32 NR07061); Oregon Health & Science University School of Nursing Dean's Dissertation Award; Northwest Health Foundation; and Sigma Theta Tau International, Beta Psi Chapter	Not addressing 2+ risk factors
(Peters et al. 2006)	A qualitative study was done to explore attitudes and beliefs of African Americans regarding hypertension-preventive self-care behaviors. Five focus groups, with 34 participants, were held using interview questions loosely based on the Theory of Planned Behavior (TPB). Analysis revealed themes broadly consistent with the TPB and also identified an overarching theme labeled "circle of culture." The circle is a metaphor for ties that bind individuals within the larger African American community and provides boundaries for culturally acceptable behaviors. Three subthemes were identified: One describes how health behaviors are "passed from generation to generation, " another reflects a sense of being "accountable" to others within the culture, and the third reflects negative views toward people who are "acting different, " moving outside the circle of culture. Findings provide an expanded perspective of the TPB by demonstrating the influence of culture and collective identity on attitude formation and health-related behaviors among African Americans.	Not directly linked to a programme
(Peterson et al. 2008)	- no abstract available -	not qualitative methods / analysis / findings
(Pham et al. 1999)	BACKGROUND AND OBJECTIVES: Prior studies have shown low awareness of hypertension and cardiovascular disease and low health care utilization in the US Vietnamese community. This study assessed awareness and understanding of these chronic conditions, health care barriers, and cultural beliefs in the Philadelphia Vietnamese community. METHODS: This qualitative study analyzed data collected from focus groups, family interviews, and individual interviews of community members and health care providers during 1996 and 1997. RESULTS: Awareness of hypertension was higher than expected but low for heart disease. Understanding of the cause and primary prevention of these illnesses was low, as was health care utilization. Major barriers to receiving health care included problems with language, medical insurance, and transportation. Desired resources were interpreter services, increased medical insurance, translated educational materials, health education classes, and community health fairs. The community widely held the belief that Western medicine is 'stronger, faster, and curative' while folk medicine is 'weaker, slower, but preventive.' CONCLUSIONS: The Vietnamese community appreciates the importance of hypertension and cardiovascular disease and believes that traditional, Western medicine is necessary for care but perceives significant barriers. Providing needed services and specific intervention programs could improve access and understanding, as well as enable health promotion, disease prevention, and appropriate care	Findings do not relate to barriers/ facilitators
(Pine et al. 1988)	The medical care program (MCP) concept emerged from a conviction that it would be possible to combine biomedical knowledge about a certain disease, principles of care and an efficient organization into a holistic approach to care. The purpose of the present review of nine MCPs was to: (1) provide an overview of MCP development and an evaluation in the Stockholm County; (2) present different perspectives regarding the current status of the MCP policy and future developments; and (3) contribute to a discussion of factors which enhance or block the effectiveness of MCPs. Information was gathered during interviews with 32 representatives of professionals and interest groups. The majority of MCPs were initiated by medical professionals while two, the program for alcohol disorders and that for rheumatoid diseases, were initiated by politicians or the rheumatoid patients. Three central problems were identified: (1) the original desire for standardization and the emergent demand for local variation; (2) ambiguities about specific roles of the newly developing general practitioners; and (3) lack of resources to develop, implement and evaluate MCPs to the standards of the original concept. The experience of the MCPs certainly has increased understanding of the policy-program-implementation-outcome process and inevitable gaps that materialize as policy struggles towards implementation	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Plescia & Groblewski	BACKGROUND: We describe a community-oriented primary care project that implemented all 5 steps of the formal model. Data are presented on cardiac risk	not qualitative methods /

Study	Abstract	Reason for exclusion
2004)	factors, protective behaviors, health locus of control, and stage of readiness for change in an African American community. We discuss the use of these data to refine our health promotion interventions. METHODS: We undertook a cross-sectional study of self-reported health behaviors from a door-to-door household survey of a geographically-defined community. Trained community members administered the survey questionnaire, which was completed in 386 of 557 randomly sampled households (response rate 69.4%). Qualitative discussions of survey results with 2 community groups were taped, transcribed, and analyzed for common themes. RESULTS: Compared with their counterparts, respondents who were older than 65 years (P = .0006), who had hypertension (P	analysis / findings
(Pransky 386)	(from the book) My intent [is] to provide the field of 'prevention' with a book that could serve as a guide for its effective practice. /// This book attempts to cover much of what is known about the prevention field as the 1990s begin. /// The information comes from 3 sources: my personal experience, the research, and interviews with top Vermont prevention people who are reflective of the top prevention work being conducted across the country. /// The book focuses largely on 'primary prevention' and emphasizes strategies that affect children and young people. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Puska 1973)	- no abstract available -	not qualitative methods / analysis / findings
(Puska 1992)	- no abstract available -	not qualitative methods / analysis / findings
(Puska 1995)	- no abstract available -	not qualitative methods / analysis / findings
(Puska et al. 1979b)	- no abstract available -	not qualitative methods / analysis / findings
(Puska et al. 1979a)	- no abstract available -	No qualitative research element
(Puska et al. 1982)	- no abstract available -	not qualitative methods / analysis / findings
(Puska et al. 1983)	- no abstract available -	not qualitative methods / analysis / findings
(Puska et al. 1985)	- no abstract available -	not qualitative methods / analysis / findings
(Puska et al. 1993)	The North Karelia Project, a community-based demonstration project for prevention of cardiovascular diseases since 1972 in Finland, was successful in reducing the population levels of the major cardiovascular risk factors. A net decline in risk factors and coronary heart disease mortality was observed in North Karelia in the 1970s. Thereafter, the mortality from coronary heart disease has declined markedly in all of Finland. The aim of the study was to find out how the cancer mortality has changed in North Karelia during this longer follow-up period. Age-adjusted mortality trends were calculated for the male population aged between 35 and 64 years in the province of North Karelia, and in all of Finland for the period 1969-91, using the official mortality data. The trends and the changes were calculated using general linear model procedures. During the 20-year period, cancer mortality declined in North Karelia by 45.4% and in all of Finland by 32.7% (P = 0.006 for difference). The greater decline in North Karelia occurred particularly in the second decade of the follow up, and lung cancer. The results support the hypothesis that reduction in the population levels of the cardiovascular risk factors lead to beneficial changes in cancer mortality rates, but such changes take longer time to manifest than for coronary heart disease	not qualitative methods / analysis / findings
(Putnam 2002)	- no abstract available -	not qualitative methods / analysis / findings
(Quelch 1980)	Whether preventive programs are advanced as complementary to therapy or as partial substitutes to lower costs, public resistance makes the cost effectiveness of these programs questionable. 'Marketing' may be helpful in differentiating among the nature of products, services, and ideas of prevention, on the one hand, and heterogeneous consumer needs, attitudes, and responsibilities on the other. Making policy for marketing will involve new strategies and use of leverage: the 'message' is not the only medium	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Ramey et al. 2008)	The purpose of this study was to use data triangulation to inform interventions targeted at reducing morbidity from cardiovascular disease (CVD) and associated risk factors among law enforcement officers. Using the Precede-Proceed Health Promotion Planning Model, survey data (n = 672) and focus group data (n = 8 groups) from the Milwaukee Police Department were analyzed. Narrative transcripts disclosed that law enforcement officers encounter potential barriers and motivators to a healthy lifestyle. Survey results indicated rates of overweight (71.1% vs. 60.8%) and hypertension (27.4% vs. 17.6%) were significantly (p < or = .001) higher among Milwaukee Police Department law enforcement officers than the general population of Wisconsin (n = 2,855). The best predictor of CVD was diabetes (p = .030). Occupational health nurses are uniquely positioned to identify health risks, design appropriate interventions, and advocate for policy changes	Study linked to a school or workplace programme

Study	Abstract	Reason for exclusion
	that improve the health of those employed in law enforcement and other high-risk professions	
(Ramirez & McAlister 1988)	A mass media health promotion program directed toward reducing future cancer trends among Mexican Americans, the largest subgroup of Hispanics in the United States, by decreasing smoking and encouraging smoking prevention and other health practices is described. Included is an outline of the program design and its significant features and a discussion of social modeling, the theoretical approach which provides a framework for the program. The development of the program, including the role focus groups played in the identification of areas to be targeted by the program, and the production and implementation of the mass media campaign based upon the targeted program areas are also discussed	Not addressing 2+ risk factors
(Ramirez 554)	(from the chapter) Describes a case study presenting program methods, implementation evaluation results, and preliminary outcomes for a study called A Su Salud En Accion (To Your Health in Action; ASSA), demonstrating the application of the ASSA health promotion model to diabetes. The objective of this study was to conduct a community education demonstration project in a Hispanic community to (a) learn about the community's knowledge, attitudes, and practices regarding diabetes; (b) develop an educational community intervention based on the ASSA model; (c) enhance the community's knowledge, attitudes, and protective behaviors about diabetes; and (d) promote screening for diabetes. A total of 800 baseline telephone interviews were completed. Survey questions included background variables and outcome variables. Several forms were designated to facilitate data collection and to monitor the conceptual and applied development of ASSA. Preliminary results from the baseline telephone survey found that many persons from the target community were in need of diabetes information to help them understand the nature of the disease, its cause, and its early warning signs. Preliminary data from the reported screening outcomes showed a positive impact of ASSA intervention efforts. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Ramirez et al. 2008)	- no abstract available -	not qualitative methods / analysis / findings
(Ray 2001)	Does health behaviour change after people receive the results of screening tests? A cohort from rural central Queensland were contacted through telephone interview at 6-month intervals following heart risk screening. Participants self-reported their health behaviour and identified aspects of their lifestyles that supported or inhibited positive health behaviour. Qualitative analysis revealed the types of changes made and the contextual issues that affected health behaviour. The majority of participants did change their behaviour or maintained existing positive behaviours. Some participants were unsuccessful in making health changes. Health enablers included physical ability to undertake activities, appearance and support. The cost and availability of nutritious food in rural areas and the need for more socially supportive environments at a community level were issues raised by participants. Resources need to be made available so that mobile health services can augment local health initiatives, supporting positive health behaviour in rural areas	not qualitative methods / analysis / findings
(Reid et al. 2003)	Background. Health promotion is an established part of the general practice consultation. It is widely acknowledged that risk-behaviours are strongly affected by socio-economic status and the structural constraints of the individual, but little is known about the possible negative effects of lifestyle advice. Objectives. To examine the extent to which self-responsibility, blame for ill health and risk behaviours feature in accounts of respondents with chest pain, and to ascertain whether perceived victim-blaming influences lay interpretations and responses to chest pain, and to ill health in general. Methods. Qualitative interviews were carried out in two socio-economically contrasting areas of Glasgow, with 30 respondents (15 men and 15 women) from a socio-economically deprived area, and 30 respondents (15 men and 15 women) from an affluent area. Results. Respondents recognized the causative links between well-established cardiac risk factors and heart disease. Individuals blamed themselves for their heart disease and general ill health and many also believed that they would be blamed for their behaviour and health problems by doctors. For some respondents, self-blame and fear of blame appeared to contribute to a reluctance to seek care. Self-blame, experience of blame and fear of blame were more common in respondents from the deprived area. Conclusion. Emphasis by doctors on 'unhealthy' behaviours may deter patients from seeking medical care. Lifestyle advice should be given taking into account the health beliefs and the socio-economic context of individuals. Future studies should focus on the theme of blame in order to explore further the possible negative effects of lifestyle advice given by health professionals. (Original abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Reinli et al. 1996)	- no abstract available -	not qualitative methods / analysis / findings
(Richmond)	Evaluated the effects of a brief intervention to reduce excessive drinking, smoking and stress among police. Researchers conducted pre- and post-intervention assessments approximately 8 mo apart and focus groups to identify relevant factors. Five focus groups were carried out with 43 police officers (17-62 yrs old) in Australia. Weekly alcohol consumption and binge drinking, smoking and symptoms of stress were measured by a self-administered health and fitness questionnaire. Alcohol consumption, particularly among men, was high at both baseline and follow-up assessments. Excessive drinkers and those reporting moderate to severe stress levels used more sick leave. An increase in awareness of alcohol policies in the work-place was found in both groups over time. The percentage of smokers declined in both groups. Women had more symptoms of stress than men. Only 20% of Ss thought they would seek advice from work-place staff about alcohol consumption, 14% for smoking and 61% for stress. Ss generally distrusted their organization's involvement in health unless work performance was affected. Seeking professional assistance for life-style issues was viewed as a sign of weakness. Alcohol use was seen as a way of obtaining information or group membership, self-medication and socializing. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not targeting low/no risk groups / focusing on high risk groups
(Richter et al. 2000)	Children's diet and exercise patterns are affected by numerous environmental factors, including the availability of healthful foods and exercise opportunities in the community, media messages about foods, and family practices regarding physical activity and food choices. Efforts to measure these environmental factors are	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	relatively new. The present paper describes an ecobehavioral perspective on factors influencing health behavior. The authors review the reliability and validity of 16 environmental measures relevant to physical activity and nutrition among youth. To illustrate the use of environmental measures, a case study is provided of how one was used to evaluate two partnerships whose missions were to decrease risk of cardiovascular disease and some cancers among children. The paper closes with recommendations for research and practice. (C) 2000 American Health Foundation and Academic Press	
(Ridker & Moyad 2005)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Ritchie et al. 1994)	Focus group discussions were employed to gain insights into the perceptions and beliefs of blue collar workers regarding coronary risk behaviours, in order to reveal factors which might increase receptivity to change for better health. A total of 116 manual workers from three categories, as defined by the Australian Standard Classification of Occupations, participated in group discussions at 10 worksites in metropolitan Sydney. The discussions yielded a rich array of beliefs and perceptions regarding heart disease, risk factors, personal risks, motivations and perceived barriers to change. The most powerful influencing factors in the lives of participants were considerations of ongoing personal well-being rather than end-stage health. Well-being was distinguished by being tied primarily to social affiliation and achieving wellbeing was seen as a positive, ongoing process over which the individual had a degree of control. This contrasted sharply with achieving health, which was perceived as a negative process of avoidance and determined by chance rather than individual action. Recommendations include the development of initiatives in heart health promotion that enhance the association of healthy behaviours with perceived well-being, rather than the conventional approach of admonishing individuals to instigate changes that are perceived by them as diminishing well-being	Not directly linked to a programme
(Robertson et al.)	Nutrition PathfindersCopyright is an interactive school-based nutrition education program developed by the Dairy Council of California for third, fourth, and fifth grade students. It is designed to reinforce the Food Guide Pyramid and to help students learn how to make healthful food and physical activity choices that minimize the risk of overweight and obesity, as suggested by the Surgeon General. It aims to increase their knowledge and help them differentiate between healthful and unhealthful behaviors and then change their behavior accordingly to improve snack and meal selections and increase active play. Individual lessons include hands-on activities in which students track what they know about nutrition, what new information they have learned, and what they want to learn. To determine the program's effectiveness and identify areas for improvement, an evaluation was conducted in the spring of 2003. The evaluation investigated teacher and student satisfaction with the program, instructional and logistical factors affecting implementation, and observable changes in student knowledge, attitudes, and self-reported food consumption behavior after using the program. The results suggest that an interactive school-based nutrition education program can successfully influence student knowledge and attitudes toward nutrition. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Findings do not relate to barriers/ facilitators
(Roncarati et al. 1989)	- no abstract available -	not qualitative methods / analysis / findings
(Ronda et al. 2004)	In 1998, a regional cardiovascular diseases prevention program was started in The Netherlands. This paper presents the design and results of a process study on the community intervention. The main purpose of the study was to gain insight into the reasons why expected effects were or were not achieved. Data was collected using multiple data sources and/or methods to measure indicators of intervention implementation. The results indicate that the community analysis and the subsequent organization of nine local Health Committees had been satisfactory. However, some factors that might influence the actual functioning of the Health Committees could be improved. Furthermore, the expert training for the members of these Committees had not yet been carried out as planned and there were doubts about the added value of collaboration with experts thus far. Environmental strategies were felt to need more attention and ensuring long-term continuation requires continuous effort. Most of the 293 intervention activities had focused on nutrition, while smoking cessation activities had been given lowest priority. It is concluded that the process evaluation has provided information about successful and less successful elements of the community intervention	not qualitative methods / analysis / findings
(Ross 2008)	- no abstract available -	not qualitative methods / analysis / findings
(Salonen 1982)	- no abstract available -	not qualitative methods / analysis / findings
(Sanders et al.)	In this study, the authors sought to examine how risk information is articulated in relation to health problems that people identify as personally important and relevant. The respondents were receptive to health education messages, using different types of information in relation to its personal relevance and as a resource for managing and exercising control over perceived risk. People were not fatalistic about disease risk, as reported in previous research. Instead, they were responsive to complex public health messages and actively engaged in rationalizing their health risks, although this did not necessarily result in behavioral change. Consequently, a theoretical distinction exists between taking responsibility for evaluating complex public health messages and taking responsibility for behavioral change. The authors conclude that people's rationalizations about health risks often mirror the medical model of disease, suggesting that they are responsive to, and not fatalistic toward, such public health information. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not directly linked to a programme
(Schechter et al. 1982)	- no abstract available -	Findings do not relate to barriers/ facilitators
(Schneiderman 663)	(from the chapter) examines the biobehavioral and psychosocial aspects of cardiovascular disease in terms of pathogenesis, treatment, prevention, and	not qualitative methods /

Study	Abstract	Reason for exclusion
	rehabilitation /// hypertension / coronary heart disease / cardiomyopathies / other circulatory disorders [migraine, Raynaud's disease] / prevention of atherosclerotic CHD [coronary heart disease] [Stanford Heart Disease Prevention Program, North Karelia project, Oslo study, Multiple Risk Factor Intervention Trial] / coronary rehabilitation [prehospital behavior, acute care phase, posthospital phase] (PsycINFO Database Record (c) 2007 APA, all rights reserved)	analysis / findings
(Scott 1987)	- no abstract available -	not qualitative methods / analysis / findings
(Scott 2001)	Grant information: Funded in part by Kappa Epsilon Chapter-At-Large, Sigma Theta Tau International, Grand Valley State University; Kirkhof School of Nursing, Grand Valley State University; and a Student Award Program grant from Blue Cross Blue Shield of Michigan Foundation	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Segnan et al. 1992)	Health care reforms introduced in Italy in the late 1970s triggered a profound rethinking of the role of general practitioners (GPs) in prevention. We interviewed 209 GPs registered in the Torino area to delineate their beliefs, attitudes, and practice patterns in relation to prevention. We examined an array of primary and secondary preventive interventions, including influenza vaccination of the elderly; counseling activities related to smoking, alcohol consumption, accidents, contraception, safety helmets, and seat belts; and early detection of hypertension and lung, cervical, and breast cancers. Improvement can still be made in the full implementation of preventive practices. We examine features of the organization of medical practices in Italy that impede the integration of preventive interventions in primary care	not qualitative methods / analysis / findings
(Shaw-Perry et al.)	Objective: To conduct formative assessment and preliminary biological impact of a school-based diabetes risk prevention program for African-American children during a 14-week study. Methods: NEEMA is a school-based diabetes prevention program tailored for African-American children. The NEEMA is implemented via four social networks--classroom (Health and Physical Education Class), after school (Health Club), home (Family Fun Fair) and school cafeteria (Food Service Program). Formative assessment data were collected through semistructured interviews with physical education (PE) teachers and a pre-to-post design was used to measure biological impact. Fasting capillary glucose, height, weight, body mass index, percent body fat and fitness data were collected from a sample of 58 fourth-grade students. The six elementary schools had >40% African-American enrollment and were located in low-income neighborhoods. Results: Face-to-face interview data revealed diabetes, obesity and food insufficiency as major health concerns among PE teachers. Teachers also cited large classes and short PE periods as major challenges for implementing the program. From baseline to follow-up, fitness laps increased from 16.40 (SD = 9.98) to 23.72 (SD = 14.79) ($p < .000$), fasting capillary glucose decreased from 89.17 mg/dl (SD = 10.05) to 83.50 mg/dl (SD = 11.26) ($p < .000$), and percent body fat decreased from 27.26 (SD = 12.89) to 26.68 (SD = 11.67) ($p < 0.537$). Conclusion: The NEEMA pilot study provided teacher feedback useful for revising the NEEMA health curricula and positive preliminary impact of the NEEMA PE class on children's fitness and blood glucose levels. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	not qualitative methods / analysis / findings
(Shea et al. 1992)	The Washington Heights-Inwood Healthy Heart Program (WHIHHP) is part of the New York State Healthy Heart Program, which comprises eight community-based programs in different areas of the state. WHIHHP is directed at a population of approximately 200,000 people, predominantly Hispanic and of low socioeconomic status, living in northern Manhattan in New York City. The initial 3 years of experience are presented. Six potential barriers to diffusion of the community-based disease prevention model in disadvantaged inner city communities are discussed: (a) issues of scale and complexity; (b) adaptation of this model to a 'community' without geopolitical boundaries or infrastructure; (c) linguistic and cultural diversity; (d) competing problems; (e) the role of evaluation; and (f) sustainability of the program in a poor community. Strategies for addressing obstacles to model adoption are also described, including program legitimization, building program infrastructure, setting realistic expectations, focusing on one risk factor at a time, defining target population segments, and emphasizing a small number of communication channels. Finally, research issues related to the diffusion of the community-based model are discussed, specifically: (a) Does the model work in disadvantaged urban settings? (b) What are the program effects on social class gradients for risk factors? (c) What are the barriers to program adoption in such settings? (d) What changes in the model will facilitate adoption in such settings? (e) What are the best methods for conducting formative evaluation in such programs? (f) What is the best way to select communities that may be ready to adopt the model? Our initial experience implementing this model in a disadvantaged urban setting supports the feasibility of model adoption. Unanswered questions about efficacy in such settings and regarding research issues related to model diffusion will require additional research investment	not qualitative methods / analysis / findings
(Shelley 1994)	Community research and demonstration programs for cardiovascular disease prevention have been developed and implemented to test the feasibility of increasing health-promoting behaviors over and above changes that occur in similar communities without specific interventions. The Kilkenny Health Project is described to illustrate such a community program effort. Involvement of whole communities recognizes that communication leads to learning flows through natural social networks. Principles of social marketing are applied, recognizing the needs of different consumer groups and planning campaigns accordingly. Effective communication considers attitudes, knowledge, and skills of the target audience. Messages are designed to move the group forward in the behavior change process. Communication channels include mass media, education materials, and community-based classes as appropriate to the messages that the sender wishes to convey.	not qualitative methods / analysis / findings
(Shelley et al. 1991)	Ireland has one of the highest death rates in the world from coronary heart disease (CHD) and has not shared in the rapid decline in mortality which has occurred in other countries. The Kilkenny Health Project was established as a community-based research and demonstration programme for cardiovascular disease	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	prevention in County Kilkenny and as a pilot project for future national initiatives. The first phase of the health promotion programme in Kilkenny is being carried out between 1985 and 1990. Changes in behaviour and in factors associated with CHD will be estimated by the difference in changes over time between Kilkenny and the reference area, as measured by independent random sample surveys of men and women aged 35 to 64 years. CHD and stroke events, fatal and non-fatal, will be registered in both areas from 1987-1992. The Project has studied attitudes to CHD and its prevention. Health behaviours have been studied in adults and in post-primary school pupils. Risk factors for CHD have been measured in adults in accordance with the methods of the international MONICA Project. It has been demonstrated that health and education professionals can incorporate preventive activities and health education into everyday practice	
Shelley(Shelley 1994)	Community research and demonstration programs for cardiovascular disease prevention have been developed and implemented to test the feasibility of increasing health-promoting behaviors over and above changes that occur in similar communities without specific interventions. The Kilkenny Health Project is described to illustrate such a community program effort. Involvement of whole communities recognizes that communication leads to learning flows through natural social networks. Principles of social marketing are applied, recognizing the needs of different consumer groups and planning campaigns accordingly. Effective communication considers attitudes, knowledge, and skills of the target audience. Messages are designed to move the group forward in the behavior change process. Communication channels include mass media, education materials, and community-based classes as appropriate to the messages that the sender wishes to convey. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings
(Sherman 1986)	- no abstract available -	not qualitative methods / analysis / findings
(Sibilski & Wucherer 1995)	- no abstract available -	not qualitative methods / analysis / findings
(Silvestri 1978)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Simmons & Voyle 2003)	Maori and other indigenous peoples experience a high prevalence of type 2 diabetes. A pivotal question is how primary and secondary preventative initiatives might be more effectively targeted to embrace those who are at highest risk of developing diabetes and its complications. This paper proposes that, in the case of Maori, as a high-risk population, conventional approaches are insufficient, and that increased consideration needs to be given to how the settings in which health education and services are offered may influence diabetes prevention and earlier diagnosis. Traditionally, the hub of Maori culture and everyday life is the marae, a place where Maori identity, values and cultural practices are affirmed within an over-arching spiritual dimension. We have investigated the potential utility of an urban marae and its member network as a setting for a lifestyle programme focused around diabetes prevention. The research included a cross sectional survey of behavioural and metabolic risk factors for type 2 diabetes and qualitative data collection as part of a formative and process evaluation of a lifestyle programme established at the marae and connected venues. The programme attracted 436 participants. The majority knew little about diabetes, had low levels of vigorous activity and high intakes of fatty foods. A family history of diabetes was present in >40% of participants. Undiagnosed diabetes, high blood pressure, hypercholesterolaemia, obesity, smoking and self-reported excessive alcohol consumption were common. The advent of diabetes education, a healthy lifestyle support programme, and exercise sessions at the marae and connected venues served as the impetus for the marae community to take over the running of their own health promotion programme, including a declaration of their marae as a 'smoke-free' venue. It is proposed that marae can be useful settings for lifestyle programmes aimed at controlling the diabetes and obesity epidemic in New Zealand	Findings do not relate to barriers/ facilitators
(Simmons 1975)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Smail & Parish 346)	Heartbeat Wales is a broadly based initiative designed to decrease the incidence of cardiovascular disease. After three years there are encouraging signs that the people of the Principality are adopting a healthier lifestyle	not qualitative methods / analysis / findings
(Small 1981)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Smith & Nutbeam 1990)	Interviewed a sample of non-responders to the mail-return questionnaire used in the 1985 Survey. The aim was to obtain information about a number of key health behaviours and risk factors for heart disease, so that comparisons could be made with responders to the survey. (Abstract amended)	not qualitative methods / analysis / findings
(SMITH 1989)	The UK has one of the highest coronary heart disease mortality rates in the world. However over the last decade there has been a growing impetus in coronary	not qualitative methods /

Study	Abstract	Reason for exclusion
	prevention. In 1988 the Faculty of Community Medicine carried out a survey of all health authorities in the UK to assess the progress and problems with coronary prevention. This survey received a 92 per cent response rate and shows some interesting findings. The picture at present reveals a growing momentum in the last couple of years with half the authorites at present claiming to have a programme. The main hinderances reported are lack of funding rather than lack of interest. The development and difficulties with nutrition and smoking policies, and with blood pressure screening are also described. The regional pattern of development of these programmes and policies is complex. Many authorities favour a general health promotion approach rather than a negative, diesase oriented one; this conflict in approach requires further debate. Cites 4 references. [Journal abstract]	analysis / findings
(Solomon 1984)	- no abstract available -	not qualitative methods / analysis / findings
(Spangler et al. 2005)	To identify whether perceptions about the physical activity environment were related to the prevalence of sedentary lifestyle, residents from high-risk (n = 153) or low-risk (n = 100) counties were interviewed. County risk status was determined by the prevalence of cardiovascular mortality, overweight, and sedentary lifestyle. Key public officials in the same counties were also interviewed. Residents in the low-risk county were more likely to report having sidewalks in their community and that these sidewalks were safe and well lit than residents living in the high-risk counties. Low-risk county residents also reported more indoor recreation facilities being available than the residents in the high-risk counties. Residents supported allocating tax dollars toward improving sidewalks, lighting, and so on. Thus a more conducive environment for physical activity was found in the low-risk county. Improving physical environments and individual perceptions could help increase physical activity behavior. Grant information: West Virginia bureau for Public Health Cardiovascular Health Program	not qualitative methods / analysis / findings
(Spearman 2006)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Springett 2003)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Stamler 2004)	- no abstract available -	not qualitative methods / analysis / findings
(States & Godwin)	To address disparities in access to health care information, we developed a model program of community-based, health education workshops to be delivered in English and Spanish to older urban adults from diverse ethnic, cultural, and language backgrounds. The workshops were created through an interdisciplinary collaboration among faculty from seven health care professions and focused on three healthcare topics identified in Healthy People 2010: dementia and depression, stress reduction, and physical activity. The development of workshop content and structure, including didactic and interactive components, an approach to interdisciplinary student involvement, and program evaluation by clients and community center staff, are presented as a model for other educators. The workshops presented at five senior centers were attended by 1110 mostly female clients with an average age of 74 yrs and with a large proportion self-identified as of minority background. One hundred seven students from seven healthcare programs helped deliver the workshops. Interviews and surveys of the clients demonstrated that most had a positive learning experience, whereas the evidence of intent to take action on health care issues was less definitive. Analysis of student essays demonstrated increased student understanding of older adults and of community services. A website, Geriatric Educational Resources for Instructors and Elders (www.GERIE.org), was created to provide access to the instructional and resource materials used for the workshops, including presentation materials in Spanish. This model program may help address the substantial health education needs of a growing population of older adults from diverse ethnic, cultural, and language minorities. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	not qualitative methods / analysis / findings
(Talbert et al.)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Taler & Ofili 2002)	- no abstract available -	not qualitative methods / analysis / findings
(Then 2000)	Cardiovascular disease (CVD) is the leading cause of death in Canada. Information is available regarding the understandings of risk factors in adults, but there is little information about the understanding of risks by adolescents. Two risk factors that lead CVD often found in the adolescent population are: smoking and physical inactivity. What is also unknown is the possible impact of stress/anxiety in adolescents on other behaviors such as smoking and physical activity. The purpose of this exploratory study was to gain more information regarding smoking and physical inactivity in adolescents, and the influence that stress/anxiety	Not directly linked to a programme

Study	Abstract	Reason for exclusion
	might have on these risks. Study methods included the administration of a risk factor questionnaire and the participation of adolescents in focus group sessions. A total of 57 adolescents completed the questionnaire and a sub-sample of these adolescents participated in focus groups. The findings of this study were categorized into the areas of knowledge, influencing factors, and effects of stress/anxiety on the cardiovascular (CV) risk factors of smoking and physical inactivity. Approximately 35% of males and 58% of females had tried smoking by Grade 9. The majority of adolescents reported being very active (64.9%), while 29.8% were moderately active, and 5.3% were inactive. Factors identified that influenced both smoking and physical activity/inactivity levels included: peers, media, family and general social pressure. Focus group data were organized in relation to influences on behavior which included cognitive abilities and developmental roles and responsibilities. Developmental roles and responsibilities included: identity (self) and relationships (intimate, peer, authority and society/cultural). Sub-categories developed from the focus group data included: need for acceptance, body image, peer pressure, rebellion, stressors, vulnerability and media influence. Gender differences were identified in relation to the themes of image and peer pressure. This dissertation addresses the questionnaire and focus group results in relation to gender differences, risk factor participation, and presents conclusions and recommendations for practice. Understanding these risk-taking behaviors and the influence of stress/anxiety from the adolescent's perspective will help nurses in developing CV programs specifically aimed at this population	
(Torjesen 2007)	- no abstract available -	not qualitative methods / analysis / findings
(Tuomilehto et al. 1979)	- no abstract available -	not qualitative methods / analysis / findings
(Turner et al. 2008)	PURPOSE: This study evaluated the consistency of cardiovascular health information in popular women's magazines against the American Heart Association's (AHA) guidelines for nutrition, physical activity, weight management, and smoking. DESIGN: Six issues of four publications, Cosmopolitan, Glamour, Vogue, and Shape (24 total) were reviewed for inclusion. SETTING: Content analysis was performed by two independent raters on 162 articles (283 instances of priority-related information). MEASURES: Articles were rated using a questionnaire developed from the AHA-recommended priorities. ANALYSIS: Results are presented primarily in qualitative form, supplemented by analyses of variance and correlation significance tests when appropriate. RESULTS: Physical activity was the most common topic, followed by nutrition, weight management, and cigarette smoking. Information about weight management was less consistent than other areas. Although publications varied widely in the frequency of coverage, there was no significant difference among them in overall consistency of the information. No articles gave information directly contrary to the AHA recommendations. Limitations include the subjective nature of the content analysis and the limited number of publications and time period for review. CONCLUSION: Women are receiving information related to diet, exercise, weight management, and cigarette smoking in popular magazines. However, the information is variable to the extent that it is consistent with evidence-based prevention guidelines	not qualitative methods / analysis / findings
(US Centers for Disease Control and Prevention 2000)	- no abstract available -	Not directly linked to a programme
(van et al. 2004b)	The application of cardiovascular guidelines and risk tables may be impeded by many barriers. In the present paper, we explored the role of patients in the feasibility of cardiovascular preventive care in general practice. Patient-related barriers were examined by means of a qualitative study. Fifteen GPs audio-taped one or two consultations on primary cardiovascular preventive care. The tapes were used to guide the subsequent semi-structured in-depth interviews with patients. Twenty-two patients were interviewed. Patients' understanding of prevention of cardiovascular disease (CVD) was often insufficient. The risk table and the multi-factorial approach were difficult to understand. Risk perception was often unrealistic and dichotomous, and mainly based on personal experiences. There was a demand for more information and cholesterol tests. At the patient level, many barriers impede effective prevention of cardiovascular diseases. In particular, the highly individualized high-risk approach needs to be explained to patients. Educational patient materials, intended to support both the GP and the patient, should take into account the ideas, fears and expectations of patients	Not population level
(van et al. 2004a)	DESIGN: Qualitative study. GPs were interviewed after analysing two audiotaped cardiovascular consultations. SETTING: Primary health care. SUBJECTS: A sample of 15 GPs who audiotaped 22 consultations. MAIN OUTCOME MEASURES: Barriers hampering GPs from following the guideline. RESULTS: Data saturation was reached after about 13 interviews. The 25 identified barriers were related to the risk table, the GP or to environmental factors. Lack of knowledge and poor communication skills of the GP, along with pressure of work and demanding patients, cause GPs to deviate from the guideline. GPs regard barriers external to themselves as most important. CONCLUSION: Using the risk table as a key element of the high-risk approach in primary prevention encounters many barriers. Merely incorporating risk tables in guidelines is not sufficient for implementation of the guidelines. Time-efficient implementation strategies dealing in particular with the communication and presentation of cardiovascular risk are needed	Not population level
(Vaskilampi 1981)	The article considers the sociological aspects of community based health intervention programmes using the North Karelia Project as an example. Health programmes are still in the process of institutionalisation. This means that unlike long established disciplines they do not yet have a well-established methodology, clear research evaluation criteria, or known laws or invariances. The social characteristics of health intervention programmes are considered. They may be regarded as action research. A basic dilemma in the aims of health intervention programmes is emphasized; on the one hand to produce a change in the behavior and health status of the population, and on the other hand to discover the laws or invariances, governing them. The solution of this conflict affects the goals,	not qualitative methods / analysis / findings

Study	Abstract	Reason for exclusion
	methods and organisation of the programme and is also important in the evaluation of the outcome. The North Karelia Project, like other health intervention programme was launched and given legal force for medical reasons based on epidemiological research into risk factors. However, behaviour affecting health involves many other dimensions than the medical one. The social determinants and functions of health behaviours, and the role of health intervention as an agent of social control are discussed. Finally, the results and evaluation of this community level health intervention programmes are discussed and their practical implications are considered	
(Viadro & Will 2004)	- no abstract available -	not qualitative methods / analysis / findings
(Viinamaki 201)	Studied dimensions of personal interaction as they relate to changes in health behavior of the population, based on a psychodynamic view of personality development. Health risk data, including serum cholesterol levels, blood pressure, and reported amount of smoking, were collected from 90 Ss in 1972 and 1982. Ss were interviewed to determine intrapsychic and unconscious factors, focusing on Ss' interactive mode in relation to the researcher and the possible health educator. Results stress the significance of health professionals for successful health education and emphasize the importance of a positive relationship between the client and the health educator. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not population level
(Wagner 1982)	- no abstract available -	not qualitative methods / analysis / findings
(Waldmeier 2002)	An exploration to identify the impact of traditional health education on embedded cultural beliefs of the Cajun population in Cameron Parish Louisiana was performed. The largest parish in the state also has a much higher incidence of coronary heart disease (CHD) than the national average. Ten residents in western Cameron Parish of Cajun heritage were interviewed to obtain views of health as it relates to their culture and CHD. In general, although the participants had acquired knowledge pertaining to the cause of CHD, they valued their culturally prepared foods and way of life above their health. As a unique and isolated group, they continue to have many beliefs and health practices different than the mainstream. The challenge for health care professionals is to use innovative social and health education that will break through cultural barriers to promote health prevention	not qualitative methods / analysis / findings
(Wallace et al. 1985)	- no abstract available -	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Wallerstein & Sanchez-Merki)	Illustrates how P. Freire's social change theory can be integrated with a cognitive and behavior change theory to develop a comprehensive health education program directed at both individual- and community-level change. Through discussion of the Alcohol and Substance Abuse Prevention Program, for youth from high-risk communities in New Mexico, this article presents an interweaving of Freirian theory and protection-motivation cognitive change theory. Qualitative research data are provided on the processes of change, the interplay of personal and societal factors, and the potential outcomes as a result of using this integrated approach. Programmatic and evaluation implications for health education programs are discussed. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Findings do not relate to barriers/ facilitators
(Warren 2006)	Researchers have suggested that lifelong chronic and cumulative exposure to social and economic stressors is associated with early onset of chronic illness in African American women. Recent literature has demonstrated that socioeconomic aspects of neighborhoods contribute to health disparities in heart disease morbidity and mortality. In this article, the author analyzes the stories of older African American women concerning stress and other events related to heart disease, triangulated with individual- and neighborhood-level socioeconomic and environmental data, from the perspective of the weathering conceptual framework. She conducted in-depth qualitative interviews with urban, older Black women with early-stage heart disease. Women described lifelong and recent incidents of stress that they perceived as contributing to their 'bad heart.' The episodes described were a mixture of chronic social, environmental, and family-related challenges. Findings reveal substantial evidence supporting the weathering conceptual framework and the Sojourner syndrome in this sample of older, chronically ill Black women. Grant information: American Association of University Women Educational Foundation	Not targeting low/no risk groups / focusing on high risk groups
(Webb & Gonzalez 2006)	A qualitative study using focus groups to explore African American women's mental representations of hypertension was conducted with 47 participants. The ability of participants to select and perform rational procedures for threat management also was explored. Leventhal's Self-Regulation Process Model was used to guide the development of the study. African American women (mean age 50.11 years) were recruited from community settings to participate in focus groups. Transcripts from the focus groups were coded and analyzed using comparative analysis. Four themes were generated from the women's mental representations: (1) Vulnerability and Inevitability, (2) Biobehavioral Assaults, (3) Barriers to Effective Management, and (4) Culturally Relevant Remedies. Hypertension was perceived as a significant disease threat; causality was associated with risk factors interacting within the context of psychological stress. Acquiring a clear perspective of how African American women perceive hypertension and their ability to reduce risk factors can assist in developing a model for stimulating the use of health promotive behavior	Not directly linked to a programme
(Welham 2006)	The present paper reports on a study of the efficacy of drugs education delivered to children aged 7 to 11 years through a carefully sequenced high-fidelity programme of classroom based curriculum enrichment activities supported by visiting drug education specialist educators. The programme was designed to map onto the national curriculum requirements of British primary schools and was framed within the conceptual boundaries provided by a 'healthy lifestyles approach'.	Not addressing primary prevention of

Study	Abstract	Reason for exclusion
	The programme operated through a spiral curriculum with each year of the programme building on the aims and objectives of preceding years. The overarching aim was to enable children to develop an increasingly sophisticated cognitive framework through which they would be empowered to make informed choices about being safe, healthy and drug-free. 240 children between 3+ and 10+ years of age, were assessed for knowledge and understanding of targeted healthy lifestyles issues prior to and at two points subsequent to the interventions. Children were drawn in approximately equal numbers from nursery classes through to year 6 across 14 schools in one large urban Authority in the North of England. The Authority had adopted a drugs prevention and education programme delivered by a National Charity and supported by teachers and parents. This paper reports on the data from a defined age segment of the total sample. Outcomes indicated that the intervention with subsequent teacher support in-class affected positively children's knowledge of how stay healthy and the likely impact of drugs, alcohol and smoking on the maintenance of health and well-being. However, it became clear that yr6 pupils in particular were overtly conscious of the likely future impact of older pupils on their ability to stay drug free on transferring to Secondary school. This study indicates that whilst interventions at primary school level can achieve valued objectives at the level of knowledge and understanding, the maintenance of these acquired dispositions into adolescence is unlikely in the absence of continuing programmes of education and support on a long-term basis. Interpreting what 10 year olds say, such programmes should enable individual children to acquire strategies of personal empowerment and support their intention to adopt a healthy lifestyle. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	cardiovascular disease / CVD risk factors
(Westerstahl et al. 2002)	OBJECTIVE: To understand the experience of being at risk and of participating in health interventions. How is information about risk factors handled on an individual level with respect to feeling, thinking and doing? DESIGN: Tape-recorded, open interviews, written out and analysed using a descriptive/analytical method. SETTING: Selected women who had participated in a lifestyle intervention programme aimed at reducing risk factors for cardiovascular disease in Stromstad, a community of 10 000 inhabitants on the west coast of Sweden. SUBJECTS: Eight women in the most active group who had had some contact with the project during the whole period 1985-94. MAIN OUTCOME MEASURES: The creation of core concepts as a result of close text reading through codes and categories. RESULTS: Three core concepts in relation to the handling of risk factors were identified: there is no one but yourself to rely on, resisting invasion, and living with incompatibility, based respectively on the subjects' self-efficacy and self-awareness, their ways of maintaining a good life and their trying to understand the risk-factor concept. CONCLUSION: Risk-factor-oriented health interventions focus on disease and create uncertainty as to the relationship between the concepts of risk and disease. The powerful health resources demonstrated by the women in this study to counterbalance the risk pre-occupation suggest changing to health-oriented interventions that focus on individual health resources	Not targeting low/no risk groups / focusing on high risk groups
(Westhoff)	Examined the dissemination and implementation of the Aging Well and Healthily (AWH) program in the Netherlands. 263 program participants (aged 51-89 yrs), 28 peer educators (mean age 58 yrs), and 13 organizers completed interviews concerning: (1) life satisfaction; (2) perceived general health; (3) prevalence of chronic diseases; (4) loneliness; (5) activities; (6) satisfaction with program delivery; and (7) whether they had enrolled in related local activities, such as gymnastics or education. Results show that subjects (Ss) expressed overall satisfaction with the content and delivery of the AWE program. 13% of Ss enrolled in related local sports activities. The AWH program was run 57 times over two years, which did not meet the target of 50 times annually. Factors possibly negatively influencing dissemination included: (1) the perception that the organization of the program was complex and incompatible with the values of the organizations implementing AWH; and (2) 3 national implementation partners exhibited organizational problems independent of AWH. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(White et al. 2001)	This paper provides an overview of the Prince Edward Island Heart Health Program (PEIHHP) Dissemination Research Project. Prince Edward Island (PEI) is a small province in the Atlantic region of Canada with a population of 137,980. The Island's economy is dependent on the fishery, agriculture, and tourism industries. Although unemployment rates are high (14.4%), Prince Edward Island has the lowest poverty rate in the country at 15.2%, high levels of social support (86%), and the second lowest rate of high chronic stress (Report on the Health of Canadians, 1996, 1999)	not qualitative methods / analysis / findings
(Whitelaw et al.)	In 1996 the Health Education Board for Scotland (now NHS Health Scotland) began a process of developing a 'settings'-based framework that would inform health promotion work across Scottish health services--the Health Promoting Health Service Framework (HPHS). It took the form of a flexible guidance document, attending to the foundations of integrated and sustainable health promotion practice via specific areas like partnership work, policy development and staff health. The project has subsequently been progressed over an extended period, comprising three phases: an initial development of the resource; piloting of the framework; and a wider assessment of implementation and initial impact. This paper reports on the latter phase. Within the context of various issues pertaining to the evaluation of a 'settings' approach and based on the use of case study methodology in nine HPHS pilot sites, this paper reports on the latter 2 year phase. This involved ongoing concern for understanding intervention processes and a growing interest in intervention outcomes and the paper reports on findings in each of these domains. In relation to outcomes, some positive gains in various indicators were detected though significant problems were experienced in this aspect. More significantly, the work was able to gain insights into what we call 'necessary conditions' of implementation. We theorize a range of 'contextual' factors (e.g. responsiveness to health improvement policy agendas) and project specific 'mechanisms' (e.g. providing skilled support) and present these as a nexus of conditions required for effective implementation of health promotion practice within explanatory models. Most significantly, we stress the relative frailty of any settings implementation strategy based simply on the uncoordinated dissemination of a tool or resource. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Whitelaw et al.)	This paper reports on a review undertaken for the Health Education Board for Scotland on 'health events'. On the basis of a literature review and interviews with 20 professionals in the UK, it appraised the effectiveness of such activities, assessed their current extent and status, and ultimately considered whether they are	Findings do not relate to barriers/ facilitators

Study	Abstract	Reason for exclusion
	useful and relevant within emergent contexts. It suggests that the evidence base for health events is relatively weak, particularly given the scale of such work. At best, all that can be said is that there is some evidence that some of these events have some use within very specific assumptions and values. Consideration is given to possible ways forward. The paper also considers a series of related issues that impinge on the assessment of complex health promotion interventions. From our field interviews, health events are perceived by most to be labour intensive and ineffective. Rather, they are undertaken for a range of pragmatic 'public relations' reasons that exist independent of knowledge, attitudinal or behavioural outcomes. This ambiguity of expectation coupled with a paucity of published high-quality literature led to the use of a judicial approach to evidence appraisal. It considers the ways in which this exercise could be undertaken, ultimately being sceptical of systematic meta-reviews. (PsycINFO Database Record (c) 2007 APA, all rights reserved) (journal abstract)	
(Wilbur et al. 2003)	Background: Latinas (Latino women) are at higher risk than non-Latina white women of cardiovascular disease and stroke, primarily because of higher rates of obesity and type-2 diabetes mellitus. Increases in physical activity help control these cardiovascular risk factors, but a higher percentage of Latinas than white women are inactive. The study goals were to identify personal, social environmental, and physical environmental correlates of physical activity of urban-dwelling, Midwestern Latinas and to obtain their recommendations for increasing exercise in their communities. Methods: A face-to-face interview (Women and Physical Activity Survey) that covered personal, social environmental, and physical environmental correlates of physical activity was performed with 300 volunteer Latinas (242 in Spanish, 58 in English), aged 20 to 50 years, living in Chicago. Physical activity was measured with questions on lifestyle and planned leisure activity (exercise) from the Behavioral Risk Factor Surveillance System survey. Results: The sample consisted of urban-dwelling Latinas who were primarily from Mexico and who spoke predominantly Spanish. The breakdown was as follows: 36% met current recommendations for moderate or vigorous physical activity, 52.3% were insufficiently active, and 11.7% were inactive. Physical activity was higher among younger women, married women, and women with the following characteristics: had some confidence about becoming more active, saw people exercising in the neighborhood, attended religious services, or lived in areas with heavy traffic. Conclusions: Interventions need to focus on encouraging Latinas, especially those who are older, to reach the level of physical activity recommended to benefit health. The church may be a suitable community setting for initiating programs that provide women with the knowledge, skills, and motivation to become more active so that they can bring back to the larger Latina community. copyright 2003 American Journal of Preventive Medicine	not qualitative methods / analysis / findings
(Will & Loo 2008)	The WISEWOMAN program targets low-income under- and uninsured women aged 40-64 years for screening and interventions aimed at reducing the risk of heart disease, stroke, and other chronic diseases. The program enters its third phase on June 30, 2008. Design issues and results from Phase I and Phase II have been published in a series of papers. We summarize remaining challenges, which were identified through systematic research and evaluation. Phase III will address these challenges through a number of new initiatives such as allowing interventions of different intensities, taking advantage of resources for promoting community health, and providing evidence-based interventions through the program's Center of Excellence. Finally, we provide a framework and vision so that organizational, community, and other partners can make the case for the importance of the program to their communities and for what is needed to make it work	not qualitative methods / analysis / findings
(Williams et al.)	INTRODUCTION: Rates of overweight among US children have been rising over the past three decades. Changes in lifestyle behaviors, including dietary and physical activity habits, have been examined thoroughly to identify correlates of weight status in children. Youth in rural US Appalachia are at a disproportionately greater risk for obesity and related health complications. Inadequate physical activity and poor dietary habits are two primary causes of obesity that have been noted in West Virginia adolescents. Few existing data describes the decisional balance in performing lifestyle behaviors, nor the perceptions of these youth regarding their beliefs about weight. The purpose of this study was to identify the perceptions of a healthy weight in rural Appalachian adolescents. METHODS: Ninth grade students were recruited from classroom presentations in four high schools throughout West Virginia. Interested parent-caregiver pairs returned forms to indicate interest in participation. Separate focus group interviews were conducted concurrently with adolescent and parents or caregivers to identify the cultural perceptions of a healthy weight. Questions were developed using grounded theory to explore how a healthy weight was defined, what factors dictate body weight, the perceived severity of the obesity issue, and the social or health ramifications of the condition. Verbatim transcripts were analyzed to identify dominant themes, and content analysis provided text segments to describe the themes. This article describes the data obtained from the adolescent focus groups. RESULTS: When asked what defined a healthy weight, the adolescents who participated in the focus groups placed great value on physical appearance and social acceptability. Students believed there was a particular number, either an absolute weight or body mass index value that determined a healthy weight. These numbers were usually conveyed by a physician; however, there was also a general acceptance of being 'thick' or a reliance on 'feeling healthy' as a determinant of maintaining a healthy weight. Despite these beliefs, many teens had unrealistic and unhealthy perceptions of weight. Female participants were more concerned with weight than males, some to the point of obsession. Both males and females expressed a social stigma associated with overweight. Issues of guilt and diminished self-esteem were prevalent. When asked about the extensiveness of the problem of childhood overweight, the students indicated that a degree of familiarity with being overweight has developed and 'you just get used to [seeing] it.' Because of the rising rates of chronic disease in this region, a fear was evident in these youth about the increased risk of developing these conditions in those who are overweight. Experiences with family members with diabetes and cardiovascular disease fueled these concerns, which instilled a fear of becoming overweight in many of the students. Many perceptions of healthy weight and appropriate body size were shaped by the media and entertainment industry. Additionally, some participants admitted to performing unsafe practices to reduce body mass, such as very low calorie diets or fasting. CONCLUSIONS: Youth in rural Appalachia present similar perceptions about weight as other children; however, differences in perceived healthy lifestyle habits and a general acceptance of a higher average body weight present additional challenges to addressing the increasing problem of child overweight. Despite the relative isolation of many of these communities, the media has a profound impact on weight valuation that has been intertwined with school-based health education and cultural values of health. These data will provide valuable information for the development of obesity prevention programs in	Not directly linked to a programme

Study	Abstract	Reason for exclusion
	rural Appalachia	
(Yancey 2004)	- no abstract available -	not qualitative methods / analysis / findings
(Yoon et al. 1065)	Conducted focus group discussions to gain insight into people's thoughts on stroke and to inform the development of educational strategies in the community in New South Wales, Australia. 35 people participated: 11 from the general public (mean age 64.0 yrs), 14 people (mean age 70.1 yrs) who had had a stroke, and 10 carers or partners. The main outcome measures were: views on risk factors, symptoms, treatment, information resources, and prevention. All groups reported similar knowledge of risk factors. People generally mentioned stress, diet, high BP, age, and smoking as causes of stroke. Participants in the community group gave little attention to symptoms. Some participants who had had a stroke did not initially identify their experience as stroke because the symptoms were not the same as those they had read about. There were mixed feelings about the extent of involvement in management decisions during hospital admission. Some felt sufficiently involved, some wanted to be more involved, and others felt incapable of being actively involved. The authors suggest that presentation of information about stroke by hospital and community health services should be improved. Simple and understandable educational materials should be developed and their effectiveness monitored. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	Not addressing primary prevention of cardiovascular disease / CVD risk factors
(Young et al. 2007)	BACKGROUND: People with learning disabilities have become increasingly exposed to health risk with the move to community living. Yet, health promotion is poorly developed with a heavy reliance on primary care. OBJECTIVES: To elicit the perceptions of people with learning disabilities, carers and care workers regarding risk factors associated with cardiac disease. METHODS: A qualitative approach was adopted incorporating semi-structured interviews based on vignettes. Twenty people with mild learning disabilities, 10 carers and 10 care workers were recruited. Data were analysed using Miles and Huberman's five-fold process. RESULTS: In total, 29 women and 11 men were interviewed. A range of health risks was identified with different patterns across groups. There were common concerns around diet. Approximately 50% of participants also had worries regarding 'excessive computer usage', often related to physical inactivity, and a similar proportion identified social isolation as a risk. The importance of safeguarding personal autonomy was stressed in all three groups. CONCLUSION: We demonstrated the feasibility of engaging with people with mild learning disabilities regarding health improvement. Participants recognized not only risks but also the subtle interplay of different factors, reflecting a grasp of the complexity of health promotion. Approaches within primary care to health improvement need to acknowledge this level of awareness	Not directly linked to a programme
(Zint)	Assessed goals for health and environmental risk education and examined current risk education practices, future interests, and perceived barriers to risk education of Michigan, Ohio, and Wisconsin grade 6-12 science teachers. Data were collected through a mail questionnaire and in-depth telephone interviews. Results for 45 teachers show that many teachers had covered some aspect of risk education and were interested in enhancing their efforts. Results also suggest that teachers need to be made aware of risk education resources and provided with training, particularly regarding psychological influences on risk decisions. (PsycINFO Database Record (c) 2007 APA, all rights reserved)	not qualitative methods / analysis / findings

Studies not received by cut-off date

Study	Abstract	Reason for exclusion
(Botvin 2001)	Froedtert Hospital promoted its cardiovascular center through an extensive educational effort. By inviting people to join its 'Heart-to-Heart' and '10,000 Steps' programs, the Milwaukee hospital put important cardiac care advice into thousands of hands and raise awareness of its cardiovascular services	Unobtainable
(Brody 2009)	- no abstract available -	Unobtainable
(Fuquay 1983)	- no abstract available -	Unobtainable
(Goodman & Prince 1991)	- no abstract available -	Unobtainable
(Juarbe 1994)	This study describes the factors that influence the cardiovascular (CVD)-related diet and exercise experiences.of married immigrant Mexican women (IMW) with children. Semi-structured taped interviews elicited qualitative data on the diet and exercise experiences of this sample, which were analyzed using grounded theory procedures. The structured interview elicited cardiovascular disease (CVD) related diet and exercise knowledge, behaviors, beliefs, and risk factors, which were analyzed statistically. The body mass index was used for defining weight status and the waist-to-hip ratio (WHR) to determine the distribution of body fat and, therefore, the increased risk to develop heart disease. The physical fitness status was determined by the National Council of Young Men's Christian Association (YMCA) three-minute step-test. This study was guided by a feminist perspective that considered roles, social support, and environment- related concepts as relevant for the health of IMW. This perspective valued health promotion behaviors from the perceptions and lived experiences of women, and underscored issues of ethnicity, age, education, employment, and class. The nonprobability and purposive sample consisted of 51 IMW aged 21 to 40 years and who lived in Santa Clara county. All interviews were conducted and analyzed in Spanish. The mean age of the participants was 28 years (SD 5). Participants had very limited knowledge regarding saturated fat and cholesterol, and very good knowledge regarding exercise. However, the majority (76%) did not exercise regularly and were not physically fit. According to the WHR, 41% (21) of the women were at an increased risk of developing heart disease. Fifty-six percent of the sample had a BMI greater than 26.0. Qualitative data suggest that IMW diet and exercise practices were hampered by a socio-cultural disempowering process that limits the women's options to promote their own health. Women described a process of assessing and developing strategies that unfolded in transcending strategies to engage in diet and exercise behaviors. This study found that in addition to cognitive-behavioral variables, there are other socio-cultural factors, such as women's roles and social support structures, that are critical in describing the diet and exercise behaviors of IMW	Unobtainable
(Levine & Kolbe 1983)	- no abstract available -	Unobtainable

Study	Abstract	Reason for exclusion
(Maxwell 1997)	Cardiovascular disease, the major cause of death, disease, and illness in Canada, is costly in terms of health, quality of life, and dollars spent on health care. Three decades of trend analysis and evaluation of community-based heart-health interventions indicate that these interventions have been moderately successful most notably with more affluent segments of Western societies. Future success depends on creating supportive environments and policies that make healthful choices easier for all Canadians. Family is one environment not well understood for its influence on individual health-related decisions in response to heart-health initiatives. The objective of this study was to explore social processes in families that influence individual health-related decisions in response to heart-health initiatives. Grounded theory, informed by critical and feminist perspectives, is the methodology of this study. Twenty-eight families participated, representing considerable diversity with regards to family type, socioeconomic status, age, and geographic location. Participants' accounts are rich and, when analyzed, generate a theory of family influence on individual health-related decisions. Participants were consistent in their view that health decisions made in response to heart-health initiatives are conceived within a broad definition of health of which heart health is a part. Family climate was developed in the analysis as important for health decisions--a climate of comfort enhances self-worth and strengthens the will lo be healthy, while a family climate of stress consumes this will. Family climate of stress or comfort is not a binary opposite but rather like the weather, ever-present and changing, Further, family climate may not be perceived similarly by family members. A family climate of comfort and stress has both relational and contextual dimensions. Family stress has an additional dimension--perpetrated stress, occurring when actions taken by one family member are unwholesome thereby affecting the perceived stress and health of others. Two family processes, talking (either productive, unproductive, or dismissive), and modelling are family action strategies that interact with relational and contextual factors and family climate to determine the ultimate family influence on individual health-related decisions. Productive talking and modelling provide inspiration and rationale for individual health-related decisions. On the other hand, the lack of co-operation characteristic of unproductive and dismissive talking may lead to inaction. Family exerts its influence on individual health-related decisions in response to a heart-health initiative by shaping self- worth and agency with regard to heart health-related responses. In light of the scholarly literature on families and health, participants' accounts suggest that theory development in health promotion should attend to the family as a unit of concern. Moreover, health promotion practice and research concerned with heart health that considers the everyday lived reality of family life has potential to be effective in working with clients toward healthful change	Unobtainable
(Wallace 1981)	- no abstract available -	Unobtainable