On Contemplation at 50: SOPHE Presidential Address, November 1999

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I want to thank Fran Butterfoss for her kind introductory remarks and also thank Fran, Susan Levy, their committee members, and volunteers for organizing this wonderful conference. Dr. Koplan, thank you for being here as our keynote speaker to follow my remarks, and Dr. Fleming—thank you for welcoming Dr. Koplan and SOPHE to Chicago. Honored guests, SOPHE members, and other participants gathered here today, I thank all of you for attending the SOPHE annual conference on this auspicious occasion of our 50th-year anniversary.

I would like to begin my talk by briefly recounting some of SOPHE's accomplishments over the past year. The examples I am about to mention are just samples of SOPHE's accomplishments, and many members have been involved in making them a reality. These examples provide a flavor of how SOPHE has grown and how active our organization has become. First, this past spring, SOPHE moved its national office to the headquarters of the American Psychological Association's, which is in the hub of Washington, D.C. From our new location on First Street, we are situated to be an active advocacy group for public health and the professional issues in which we firmly believe. In addition, we continue to grow chapters—yesterday, the board approved three new chapters to join our SOPHE movement—so the organization is growing and developing: welcome, Colorado, Indiana, and Missouri.

In the past year, SOPHE was instrumental in developing and approving a unified code of ethics with several other prominent health promotion and education professional societies. Consequently, we now have, under one umbrella, organizations upholding a set of ethics that are unambiguous, dynamic, and cogent for the profession. Also, SOPHE has instituted an Advocacy Summit, this last year being our second summit during which we coordinated our efforts with nine other organizations. Participants attended a 2-day training in advocacy in Washington D.C., and then they went to Capitol Hill to meet with senators and congresspeople to advocate for increased funding for CDC so that its budget for the upcoming year would not remain flat, as Congress intended, for many areas crucial to public health. We advocated that the tobacco settlement monies be directed to health promotion activities, and we advocated for the Patient's Bill of Rights, which has gotten a lot

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of press recently. SOPHE has been the vanguard in promoting and supporting these and other important public health issues on the Hill. Much of the credit for these efforts goes to Elaine Auld, our executive director, and her staff, as well as to the other organizations that joined us in our efforts. We intend to continue the Advocacy Summit year after year.

Additionally, we contracted with the U.S. Health Resources and Services Administration (HRSA) to examine the effect of CHES (Certified Health Education Specialist) certification on health promotion practice. Former SOPHE President Bill Livingood is leading this initiative. I think it a very noble endeavor for a professional organization to conduct a self-study to see how we are doing so that we can do more and better.

We should all be aware that this is our 26th year of publishing *Health Education & Behavior*, formerly *Health Education Quarterly*, and before that *Health Education Monographs*—the journal has a long and illustrious history as SOPHE's flagship journal. Our current editor, Marc Zimmerman, is doing a wonderful job, and the journal certainly is a cornerstone of what we represent as an organization.

Coinciding with this conference, we are thrilled to inaugurate our first issue of a new journal entirely devoted to practice, *Health Promotion Practice*. Randy Schwartz, a consummate practitioner who also is the director of the Division of Community and Family Health for the state of Maine, is our editor-in-chief. He would be quick to tell you that the realization of *Health Promotion Practice* is an effort that resulted from the efforts of numerous individuals, many of whom are associate editors. They are an energetic group, already having held their editorial board meeting at 7:30 this morning prior to this opening plenary session. You can anticipate many good things coming from this board. I would be remiss not to thank Sage Publications for supporting the publication of the new journal. This being our inaugural issue, please make sure that you see a copy of it at the conference.

In the past year, SOPHE launched a fund-raising campaign called "50 for 50," which has been a huge success. At last count, we raised $67,000.00 to start an endowment to ensure SOPHE's legacy. Our immediate past president, John Allegrante, and the Resource Development Committee deserve a lot of credit for initiating the 50 for 50 campaign. By the way, they wanted me to tell you that it's not too late to give, even as we move into our 51st year!

We have also started a long-term giving campaign and received our first endowment of $100,000, bequeathed in the name of Vivian Drenckhahn. We envision the endowment as the first in a large-scale giving campaign that will support worthy efforts like SOPHE's strategic plan initiatives and student scholarships. The campaign will ensure SOPHE's viability well into the next millennium.

This year, our conference also received increased support from the Health Trac Foundation to sustain a Health Trac Plenary Session that is part of our program later today. Edward Rochella is this year's Health Trac Foundation award winner, and we thank the foundation for its support.

I must also mention the support we received from the California Endowment, which has generously provided scholarships for students who are attending the SOPHE annual conference, I imagine many, if not all, for the first time. I want to recognize them personally. As I mention your name, would you please stand: Maimai Cantos, Marcela Lopez, Marie Boman, Victoria Castellon, Kristin Davis, Wendy Hussey, Mary Cheryl Nacionales, France Nguyen, Julie Pickerel, Jennifer Rogers, Yumary Ruiz, Elvia Sobaranes, Matthew Staley. You represent the future of SOPHE, and we hope to see you become and remain active in the organization.

I also want to recognize our illustrious past presidents, many of whom are in the room. Would you mind standing if you are past president—please stand.

Looking at all these illustrious past presidents, contemplating SOPHE's 50 years, and knowing that I was going to give this talk, all have given me pause to think about what it means to be 50, which, by the way, also is my age. So, I think that this is a good time to talk about contemplating 50. One of the things that I thought about is that many of the notions that I firmly held at a younger age proved merely to be myths of my past. Let me share a couple of examples with you. What seems like not too long ago, but is actually 30 years removed, many of my cohort resonated to the slogan, "Never trust anyone over 30." From the vantage point of 50, I am left wondering, what were we thinking? A second example from my past: as a brash young person, when I observed a 50-year-old person stop to think, I wondered if and when they were going to start again. Now I realize that with a little more patience, if I listen a little more closely, and if I wait just a little longer, I generally will hear something worthwhile from those who have accumulated years of wisdom.

Using the lessons of increased wisdom with age as a guidepost and in thinking about the evolution of the field of public health education and promotion, I realized that SOPHE also has gained insight that is characterized in the way the organization and discipline have matured over many years. Given the limitations of time, I want to lead you on a quick journey regarding how the field developed over the years. Specifically, I want to focus on the importance of social psychology as a founding orientation for the profession and the evolution of the field today toward social ecology.[1] Then, I will end my talk with what I term the challenges of synergy to our profession and the need to incorporate synergistic approaches into our practice to move effectively into the next millennium. So, very quickly, here are some of the evolutionary trends that have braced our work over the past 50-plus years.

In the 1930s, the health education movement hit its full stride largely through official public health promotion campaigns, as exemplified by the efforts of Dorothy Nyswander and others who worked in larger cities implementing public information and educational campaigns for TB prevention and control. These mass public health campaigns focused around a limited number of health and social conditions like TB that continued well into the 1940s.[2] At the same time, a groundswell of professional change was imminent, as reflected in the work Mayhew Derryberry at the U.S. Public Health Service. Derryberry was one of the most instrumental people in our field. He epitomized a shift in direction for health education preparation and practice by advocating training for health education students in the classic public health disciplines of epidemiology, vital statistics, bacteriology, environmental sanitation, public health administration, and school and community health education, as well as adult education, public relations, and sociology.[3] Derryberry's influence on the professionalization and expansion of our field as a discipline cannot be overstated.

Simultaneous to Derryberry's push for professionalization in the 1930s and 1940s, public health education in the United States was influenced by the thinking of Kurt Lewin and his emphasis on the person-environment interaction.[4] By the 1950s, Lewin's influence permeated the dominant models that have since become standards in our field of practice, like the health belief model, which was first applied to TB campaigns,[5] and more generally to value-expectancy approaches such as social cognitive theory,[6] attribution theory,[7] the theory of reasoned action,[8] and others. These approaches became the mainstay of the health promotion movement so much so that, in looking back, Hochbaum, a social psychologist who was instrumental in developing the health belief model, pondered,

> What if it had been another scientific field, say, economics or sociology, instead of social psychology . . . that influenced the course of health education decisively? . . . It raises the question of whether today's and tomorrow's challenges may not require other scientific fields to complement what social psychology offers. (p. 72)[9]

Hochbaum's musings underscored the importance of social psychology to health promotion but also the challenges that remained in having one orientation predominate the field. The social movements of the 1960s stimulated a needed expansion in orientation that is reflected in a seminal article by Dorothy Nyswander, who asked, "Health for what?" What is the purpose of health; what social meaning does it have? She argued that we cannot ignore social climate in describing health education and "the continuing loss of creative manpower through social illness."[10] The notion of health education and promotion as a social movement was extended in the 1970s and 1980s through the integration of community approaches with models steeped in social psychology.[11] The synthesis of these forces is exemplified by the now-classic Stanford, Pawtucket, and Minnesota Heart Health studies that were based on social cognitive theory as well as community development strategies. These programs combined a potpourri of different types of interventions and program initiatives that were informed by social psychology and community models that included risk factor screening, media messages, worksite physical activity, menu labeling at restaurants, grocery labeling, school programs, work with health practitioners, community-wide contests, community task forces, and speakers bureaus.[12]

In the 1980s, and as a result of these initiatives, several important lessons surfaced that are reflected in the following quotes that come from the literature of that time:

> Community or large-scale programs . . . require a shift in perspective and the employment of the distinct set of analytic and programmatic tools from those used with patients, clients, or customers. (pp. 323-324)[13]

> Because community-based programs employ a variety of interventions, it is important to examine the effects of specific interventions on endpoint outcomes to account for variations in the magnitude and type of impact of each. . . . Without formal evaluation of these interventions, it is difficult to link their impact to the physiological endpoint outcomes or to differentiate the effects of one intervention from the others. (p. 483)[14]

The importance of altering the way that we understand and evaluate community programs is a major lesson that resulted from the groundbreaking initiatives of the 1970s and 1980s. That is, to intervene effectively on human problems that are knitted into the social fabric like substance abuse, AIDS, and violence, we must not view them solely from patient, client, and customer perspectives but from a larger perspective that takes into account complex societal mechanisms. Furthermore, we have to understand how to combine complex community interventions into a unified whole.

In essence, the community programs of the 1980s expanded the professional wisdom regarding health education and promotion approaches. Consequently, in the 1990s, interventions that previously were informed by social psychology models now became integrated into holistic approaches that were informed by social ecology principles.[15] The social ecology principle that I emphasize here I call the synergy of health promotion—planned strategies for connecting multiple interventions that address health and social problems so that their combined effects are much greater than their individual effects. Let me show you how this principle of synergy works and how these connections are made among interventions to produce the synergy of health promotion.

Let's take youth substance abuse as an example of a health concern that is embedded into our social fabric (Figure 1). If we respond by offering individually directed interventions—say, youth counseling and peer social support as program interventions—we know that these interventions alone are not likely to produce the optimum desired outcome of substance abatement among youth at a community or population level. Furthermore, those individuals who are positively influenced by counseling and support must continually guard against relapse, given pervasive social pressures. Consequently, social factors should be taken into account when developing interventions that address societal conditions and that these factors inform interventions that are directed at the ecology in which youth live their lives. These factors may be termed *modifying conditions* because they influence how successful individually focused interventions are likely to be. As illustrated in Figure 1, if youth at risk have a supportive family structure, the success of counseling and peer support may be greater. Yet, many families may be ill prepared to provide the necessary support. Therefore, family-focused interventions that provide training to parents and guardians become modifying factors at the next social level and can be instrumental in helping adults help youth in resisting substance abuse (Figure 1). But to provide family-focused interventions, a sufficient number of community agencies must be available that support family and youth substance abuse abatement training. The presence of an adequate number of supportive community agencies and programs is a modifying factor that influences how well communities may address family support of youth abatement. If there are an insufficient number of organizations, then a portion of our intervention strategies may best be directed toward developing and expanding services to meet the pressing need. As Figure 1 further illustrates, such strategies may require community support and political will that are modifying factors, which have an impact on the sufficiency of community programming. Therefore, interventions geared toward community awareness of the need for additional programming and mobilization to advocate for such programs are integral in producing an aware and active community. Such communities are vigorous in not tolerating crack houses in their locales; they influence the amount of resources directed toward youth and family programming; they influence community policies like policing, adjudication, and adequate street lighting in drug infested areas. Hence, it is when interventions are linked across social levels—from individuals to families and social networks to organizations, communities, and policies that govern communities—that the synergy of health promotion principle can work.

Let us take another moment to examine what synergy means traditionally in public health. As an example, let's say that in a given population, smoking results in 1 death out of 10,000 people who smoke. Let's further say that in the same population, individuals who live or work around asbestos also experience 1 death per 10,000 people who are regularly exposed. If these two elements are combined—people who smoke and live or work around asbestos—the result is not a twofold increase in mortality (that is, 2 people out of 10,000) but a geometric increase—say 5 people out of 10,000. This multiplier effect, when risks are combined, is the effect of synergy.

I suggest to you that we can use synergy not only to describe relative risk of illness as with smoking and asbestos but also as a positive metaphor that informs the way we practice health promotion. The synergy of health promotion is guided by the social ecology principle of linked interventions that is illustrated by my example of youth substance abuse (Figure 1). That is, we gain synergy by combining, in well-thought-out and intelligent ways, interventions at the individual level, the family and social level, the organizational level, the community level, and the policy level. The challenge that we as practitioners face is how to develop and link these interventions when we have enough money

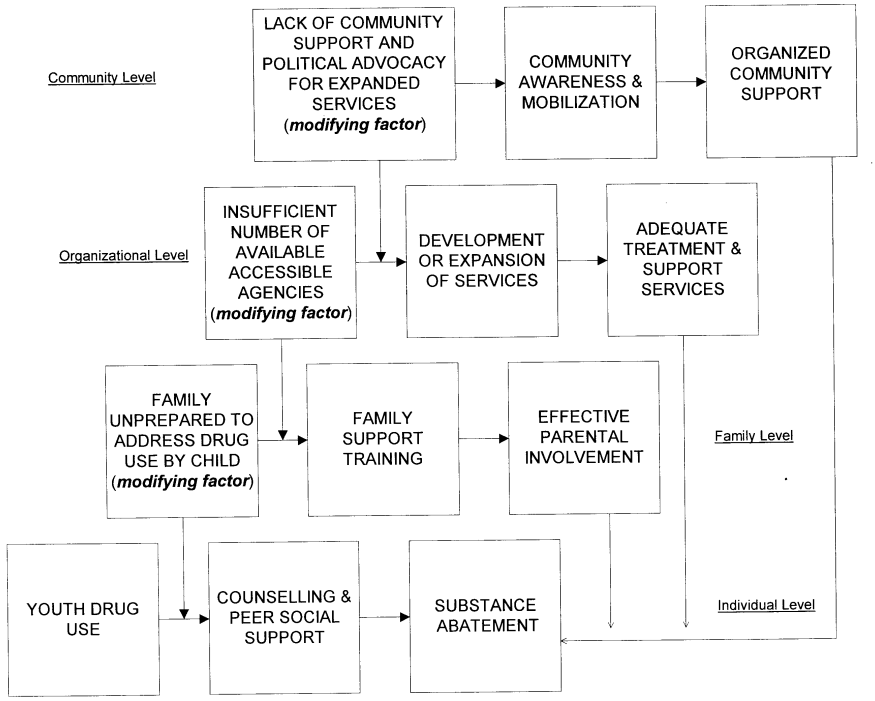

Figure 1. A social ecology model for designing program interventions in the 1990s and beyond.

only to do one. How can we do more when our organization has the expertise only to do one? How do we reach out to others in our community to link our efforts in ways that create synergy? Let me offer a few modest suggestions as a beginning step.

Those of us who train health educators should increase our emphasis on social ecology principles and health promotion synergy in the learning experience. Our students should be exposed to a wide range of social interventions at the policy, community, and organizational levels in addition to those interventions that focus on individual change. We should emphasize in our training creative ways that interventions may be combined, especially in the face of limited funding and other barriers. Similarly, those of us who do research should reduce parochialism and embrace a broad umbrella of disciplines under which we work together to build synergistic interventions. The list that Derryberry developed 50 years ago is a good start and can be expanded to include human ecology, anthropology, economics, political science, sociobiology, and communications. And for those of us in practice, we are challenged to fashion creative ways of garnering resources so that the whole of the program we produce is bigger than the sum of its parts. When educators, researchers, and practitioners institutionalize these principles as routine, we are more likely to produce health promotion synergistic effects in supporting the health and social well-being of populations at risk.

In closing, recently an article was brought to my attention that appeared earlier this year in *The Washington Post*. The article cited statistics supplied by CDC, highlighting the great public health successes that have been achieved over the last century in immuni-

zations, childbirth safety, family planning, fluoridation, occupational illness, motor vehicle safety, heart disease reduction, and tobacco control.[16] We who are present here today all know that the health promotion movement in general and SOPHE in particular have been vital forces in contributing to the reduction of the pernicious conditions associated with these successes. In the same *Washington Post* article, Dr. Jeffrey Koplan, the director of CDC and our honored guest sitting to my right, is quoted as saying, "What an incredible difference we've got in 100 years. Are we willing to make the same commitment in the next century?" Dr. Koplan, SOPHE's answer to your question is yes—you can count on SOPHE to work with you in the future as we have in the past.

It has been a pleasure for me to be SOPHE president this past year and at the onset of our 50th anniversary. I want to congratulate Kathleen Roe and wish her much success on her future year as our new president. Also, I want to thank all of you for your kind attention to my remarks. Have a wonderful time at our 50th-year celebration and thank you very much for your kind attention.

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