Educational and Community-Based Programs

7

Co-Lead Agencies: **Centers for Disease Control and Prevention**
Health Resources and Services Administration

Contents

Goal

Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Overview

Educational and community-based programs have played an integral role in the attainment of Healthy People 2000 objectives and will continue to contribute to the improvement of health outcomes in the United States by the year 2010. These programs, developed to reach people outside traditional health care settings, are fundamental for health promotion and quality of life.

Issues and Trends

People working together can improve individual health and create healthier communities. Although more research is needed in community health improvement, clearly, the health of communities not only depends on the health of individuals, but also on whether the physical and social aspects of communities enable people to live healthy lives.[1] Health and quality of life rely on many community systems and factors, not simply on a well-functioning health and medical care system. Making changes within existing systems, such as the school system, can effectively and efficiently improve the health of a large segment of the community.

Communities experiencing the most success in addressing health and quality-of-life issues have involved many components of their community: public health, health care, business, local governments, schools, civic organizations, voluntary health organizations, faith organizations, park and recreation departments, and other interested groups and private citizens. Communities that are eager to improve the health of specific at-risk groups have found that they are more likely to be successful if they work collaboratively within their community and if the social and physical environments also are conducive to supporting healthy changes.

Because many health problems relate to more than one behavioral risk factor, as well as to social and environmental factors, communities with effective programs also work to improve health by addressing the multiple determinants of a health problem. Among the more effective community health promotion programs are those that implement comprehensive intervention plans with multiple intervention strategies, such as educational, policy, and environmental, within various settings, such as the community, health care facilities, schools (including colleges and universities), and worksites.[1, 2, 3, 4]

Educational strategies may include efforts to increase health awareness, communication, and skill building. Policy strategies are those laws, regulations, formal and informal rules, and understandings adopted on a collective basis to guide individual and collective behavior.[5, 6, 7, 8]

These educational and policy strategies are effective when used in as many settings as appropriate.[3] Settings—schools, worksites, health care facilities, and the community—serve as channels to reach desired audiences as well as apply strategies in as wide a population as possible. These settings also provide major social structures for intervening at the policy level to facilitate healthful choices.[9]

The school setting. The importance of including health instruction in education curricula has been recognized since the early 1900s.[10] In 1997, the Institute of Medicine advised that students should receive the health-related education and services necessary for them to derive maximum benefit from their education and enable them to become healthy, productive adults.[11]

The school setting, ranging from preschool to university, is an important avenue to reach the entire population and specifically to educate children and youth. Schools have more influence on the lives of youth than any other social institution except the family, and provide a setting in which friendship networks develop, socialization occurs, and norms that govern behavior are developed and reinforced.

More than 12 million students currently are enrolled in the Nation's 3,600 colleges and universities.[12] Thus, colleges and universities are important settings for reducing health-risk behaviors among many young adults. Health clinics at the postsecondary level can help empower students to take responsibility for their own health through education, prevention, early detection, and treatment. In addition, colleges and universities can play an important role in eliminating racial and ethnic disparities and other inequalities in health outcomes by influencing how people think about these issues and providing a place where opinions and behaviors contributing to these factors can be addressed.

The health care setting. The health care setting is critical to the delivery of health education and health promotion. In health care facilities providers often see their patients at a teachable moment. Individualized education and counseling by health care providers at such moments in these settings have been shown to have positive and clinically significant effects on behavior in persons with chronic and acute conditions.[9] Providers must be cognizant of these opportunities and prepared to provide appropriate patient education. Institutions that employ providers also must be cognizant and allow sufficient time and training for patient education and counseling to occur.

The community setting. While health promotion in schools, health care centers, and worksites provides targeted interventions for specific population groups, community-based programs can reach the entire population. Broad public concern and support are vital to the functioning of a healthy community and to ensure the conditions in which people can be healthy.[13] Included in the community setting are public facilities; local government and agencies; and social service, faith, and civic organizations that provide channels to reach people where they live, work, and play. These groups and organizations also can be strong advocates for educational, policy, and environmental changes throughout the community. Places of worship may be a particularly important setting for health promotion initiatives, and they may effectively reach some undeserved populations. Valuable and effective health benefits of community-based approaches have been demonstrated by community interventions that have served a variety of ethnic and socioeconomic population groups.[6, 14, 15] Community-based approaches in conjunction with targeted approaches in schools, health care, and worksites increase the likelihood for success to improve personal and community health.

A community health promotion program should include:

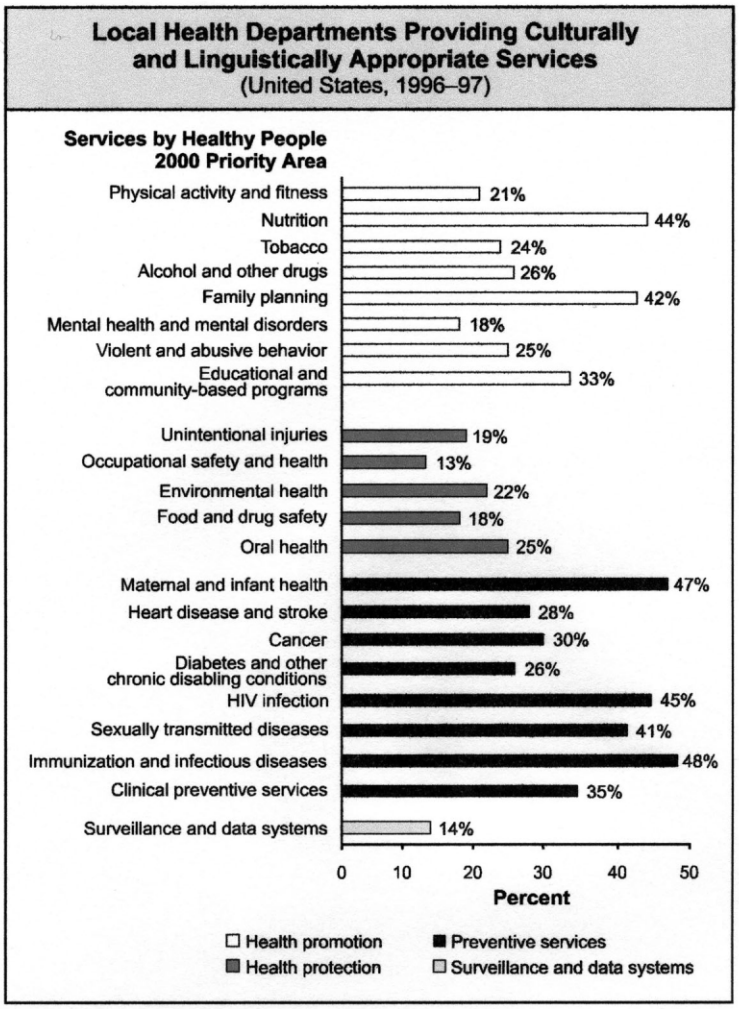
- Community participation with representation from at least three of the following community sectors: government, education, business, faith organizations, health care, media, voluntary agencies, and the public.
- Community assessment to determine community health problems, resources, and perceptions and priorities for action.
- Measurable objectives that address at least one of the following: health outcomes, risk factors, public awareness, or services and protection.
- Monitoring and evaluation processes to determine whether the objectives are reached.
- Comprehensive, multifaceted, culturally relevant interventions that have multiple targets for change—individuals (for example, racial and ethnic, age, and socioeconomic

groups), organizations (for example, worksites, schools, faith communities), and environments (for example, local policies and regulations)—and multiple approaches to change, including education, community organization, and regulatory and environmental reforms.

Schools are natural settings for reaching children and youth whereas worksites can reach the majority of adults. Efforts to reach older adults necessarily must involve the community at large.

Disparities

The U.S. population is composed of many diverse groups. Evidence indicates a persistent disparity in the health status of racially and culturally diverse populations as compared with the overall health status of the U.S. population. Over the next decade, the composition of the Nation will become more racially and ethnically diverse, thereby increasing the need for effective prevention programs tailored to specific community needs. Poverty, lack of adequate access to quality health services, lack of culturally and linguistically competent health services, and lack of preventive health care also are underlying factors that must be addressed. Given these disparities, the need for appropriate interventions is clear.



Source: National Association of County and City Health Officials, National Profile of Local Health Departments, 1996–97.

Effective prevention programs in diverse communities must be tailored to community needs and take into consideration factors concerning individuals, such as disability status, sexual orientation, and gender appropriateness. For example, women often are the health care decision makers and caregivers in their families and in their communities. When provided with enabling services and health promotion and prevention information, they can make better health choices and better navigate the health care system to get the information and services they and their families need.

Opportunities

Health promotion programs need to be sensitive to the diverse cultural norms and beliefs of the people for whom the programs are intended. This is a continuing challenge as the Nation's population becomes increasingly diverse. To ensure that interventions are culturally appropriate, linguistically competent, and appropriate for the needs of racial, ethnic, gender, sexual orientation, disability status, and age groups within the community, members of the populations served and their gatekeepers must be involved in the community assessment and planning process.

Community assessment helps to identify the cultural traditions and beliefs of the community and the education, literacy level, and language preferences necessary for the development of appropriate materials and programs. In addition, a community assessment can help identify levels of social capital and community capacity. Such assessments help identify the skills, resources, and abilities needed to manage health improvement programs in communities.[3,16]

Educational and community-based programs must be supported by accurate, appropriate, and accessible information derived from a science base. Increasing evidence supports the efficacy and effectiveness of health education and health promotion in schools, worksites, health care facilities, and community-based programming.[7] Gaps in research include the dissemination and diffusion of effective programs, new technologies, policies, relationships between settings, and approaches to disadvantaged and special populations.[9]

Communities need to be involved as partners in conducting research ensuring that the content of the prevention efforts developed are tailored to meet the needs of the communities and populations being served. Communities also need to be involved as equal partners in research, to enhance the appropriateness and sustainability of science-based interventions and prevention programs and ensure that the lessons of research are transferred back to the community.

Interim Progress Toward Year 2000 Objectives

New information from the National College Health Risk Behavior Survey shows that college students are receiving information on health topics such as human immunodeficiency virus (HIV) and sexually transmitted disease prevention.

REPRODUCTIVE HEALTH–RELATED OBJECTIVES

Educational and Community-Based Programs

Goal:

Increase the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life.

Number Objective Short Title

School Setting

7-2. School health education

7-3. Health-risk behavior information for college and university students

Health Care Setting

7-9. Health care organization sponsorship of community health promotion activities

Community Setting and Select Populations

7-11. Culturally appropriate community health promotion programs

HEALTHY PEOPLE 2010 OBJECTIVES

School Setting

7-2. Increase the proportion of middle, junior high, and senior high schools that provide comprehensive school health education to prevent health problems in the following areas: unintentional injury; violence; suicide; tobacco use and addiction; alcohol and other drug use; unintended pregnancy, HIV/AIDS, and STD infection; unhealthy dietary patterns; inadequate physical activity; and environmental health.

Target and baseline:

Objective	Schools Providing School Health Education in Priority Areas	1994 Baseline	2010 Target
		Percent	
7-2a.	All components	28	70
	Individual components to prevent health problems in the following areas		
7-2f.	Alcohol and other drug use	90	95
7-2g.	Unintended pregnancy, HIV/AIDS, and STD infection	65	90

Target setting method: 150 percent improvement for 7-2a; percentage improve varies for individual components 7-2f and 7-2g.

Data source: School Health Policies and Programs Study (SHPPS), CDC, NCCDPHP.

7-3. Increase the proportion of college and university students who receive information from their institution on each of the six priority health-risk behavior areas.

Target: 25 percent.

Baseline: 6 percent of undergraduate students received information from their college or university on all six topics in 1995: injuries (intentional and unintentional), tobacco use, alcohol and illicit drug use, sexual behaviors that cause unintended pregnancies and sexually transmitted diseases, dietary patterns that cause disease, and inadequate physical activity.

Target setting method: Better than the best.

Data source: National College Health Risk Behavior Survey, CDC, NCCDPHP.

Note: The table below may continue to the following page.

Undergraduates, 1995	Received Information on Six Priority Health-Risk Behavior Areas Percent
TOTAL	6
Race and ethnicity	
American Indian or Alaska Native	DSU
Asian or Pacific Islander	DSU
Asian	DSU
Native Hawaiian and other Pacific Islander	DSU
Black or African American	8
White	6
Hispanic or Latino	5
Not Hispanic or Latino	DNA
Black or African American	8
White	6
Gender	
Female	6
Male	6
Family income level	
Poor	DNC
Near poor	DNC
Middle/high income	DNC

Undergraduates, 1995	Received Information on Six Priority Health-Risk Behavior Areas Percent
Disability status	
Persons with disabilities	DNC
Persons without disabilities	DNC
Sexual orientation	DNC

DNA = Data have not been analyzed. DNC = Data are not collected. DSU = Data are statistically unreliable.

Note: The table above may have continued from the previous page.

The School Health Education Study[17] conducted during the 1960s identified 10 conceptual areas that have traditionally served as the basis of health education curricula. Subsequently, six categories of behaviors have been identified as responsible for more than 70 percent of illness, disability, and death among adolescents and young adults. These categories, which should be the primary focus of school health education, are injuries (unintentional and intentional); tobacco use; alcohol and illicit drug use; sexual behaviors that cause unintended pregnancies and sexually transmitted diseases; dietary patterns that cause disease; and inadequate physical activity.[18] In addition to the 6 behavior categories, environmental health (recognized influence on personal and community health), mental and emotional health, personal health, and consumer health are among the 10 conceptual areas being added to track the influence of these factors over the next 10 years.

The overall goal of the National Health Education Standards[19] for youth is to achieve health literacy—the capacity to obtain, interpret, and understand basic health information and services and the competence to use such information and services to enhance health. Research has shown that for health education curricula to affect priority health-risk behaviors among adolescents, effective strategies, considerable instructional time, and well-prepared teachers are required. To attain this objective, States and school districts need to support effective health education with appropriate policies, teacher training, effective curricula, and regular progress assessment. In addition, the support of families, peers, and the community at large is critical to long-term behavior change among adolescents.

Health education and health promotion activities also can be conducted in postsecondary settings and reach the Nation's future leaders, teachers, corporate executives, health professionals, and public health personnel. Personal involvement in a health promotion program can educate future leaders about the importance of health and engender a commitment to prevention.

In 1995, 49 percent of undergraduate students reported receiving informationon alcohol and other drug use, and 55 percent on unintended pregnancy, HIV/AIDS, and STD infection.[20]

Health Care Setting

7-9. (Developmental) Increase the proportion of hospitals and managed care organizations that provide community disease prevention and health promotion activities that address the priority health needs identified by their community.

Potential data source: Annual Survey, American Hospital Association.

The concept of increased consumer protection in the health care industry, particularly in the form of a Consumers' Bill of Rights and Responsibilities, is gaining support. These protections include consumers' rights to accurate, easily understood information related to choice of a health plan, its benefits, availability of specialty care, and confidentiality of medical records. However, the right to comprehensive patient and family education is missing from this list. Two distinctive characteristics of health care settings underscore their importance to promote patient and family education: improved health is a primary objective; and health care providers generally are considered credible sources of information.[9] The interaction between these two factors helps create an environment conducive to effective patient and family education programs and activities. The positive and clinically significant effects of patient education and counseling of persons with chronic and acute conditions are well-documented; however, the amount and types of health promotion and disease prevention activities offered by managed care organizations (MCOs) to their participating employers vary widely.[21]

Community health promotion services provided by hospitals and MCOs are growing. This growth is illustrated by the expansion of Federal and State managed care reform legislation directed at the creation of a core set of prevention activities across MCOs.[21] Despite the different motivations and strategic objectives of public health and managed care organizations, they share a mutual interest to improve the health of communities and specific populations within communities. Collaboration between managed care plans and public health agencies is a logical consequence of the health promotion objectives shared by these organizations.[22] Additionally, a number of Federal public health agencies are developing collaborative relationships with the managed care community on issues of clinical preventive services and prevention surveillance and research.[23]

7-11. Increase the proportion of local health departments that have estabLished culturally appropriate and linguistically competent community health promotion and disease prevention programs.

Target and baseline:

Objective	Increase in Local Health Departments That are Culturally Appropriate and Linguistically Competent Community Health Promotion and Disease Prevention Programs	1996-97 Baseline	2010 Target
		Percent	
7-11a.	Access to quality health services	Developmental	
	Clinical preventive services	35	*
7-11c.	Cancer	30	50

7-11g.	Educational and community-based programs	33	50
7-11i.	Family planning	42	50
7-11l.	Health communication	Developmental	
7-11n.	HIV	45	50
7-11o.	Immunizations and infectious diseases	48	50
7-11p.	Injury and violence prevention	Developmental	
	Violent and abusive behavior	25	*
7-11q.	Maternal, infant (and child) health	47	50
7-11y.	Sexually transmitted diseases	41	50
7-11z.	Substance abuse (alcohol and other drugs)	26	50

*These are Healthy People 2000 priority areas that are not applicable to Healthy People 2010.

Target setting method: Percentage improvement varies by program.

Data source: National Profile of Local Health Departments, National Association of County and City Officials (NACCO).

Over the next decade, the Nation's population will become even more diverse. Mainstream health education activities often fail to reach select populations.[24] This may contribute to select and disadvantaged communities lagging behind the overall U.S. population on virtually all health status indicators. In 1991, an estimated 78,643 excess deaths occurred among African Americans and an additional 4,485 among Hispanics or Latinos.[25] Approximately 75 percent of these excess deaths occurred in seven categories, all of which had contributing factors that can be controlled or prevented: cancer, cardiovascular disease, cirrhosis, diabetes, HIV or AIDS, homicide, and unintentional injuries. Special efforts are needed to develop and disseminate culturally and linguistically appropriate health information to overcome the cultural differences and meet the special language needs of these population groups.

Terminology

Community: A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and who are arranged in a social structure according to relationships the community has developed over a period of time.[26]

Community-based program: A planned, coordinated, ongoing effort operated by a community that characteristically includes multiple interventions intended to improve the health status of members of the community.

Community capacity: The characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.[27,28]

Culturally appropriate: Refers to an unbiased attitude and organizational policy that values cultural diversity in the population served. Reflects an understanding of diverse attitudes, beliefs, behaviors, practices, and communication patterns that could be attributed to race, ethnicity, religion, socioeconomic status, historical and social context, physical or mental ability, age, gender, sexual orientation, or generational and acculturation status. Includes an awareness that cultural differences may affect health and the effectiveness of health care delivery. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, disability, or habits.

Excess deaths: The statistically significant difference between the number of deaths expected and the number that actually occurred.

Health: A state of physical, mental, and social well-being and not merely the absence of disease and infirmity.

Health care organizations: Included are hospitals, managed care organizations, home health organizations, long-term care facilities, and community-based health care providers.

Health education: Any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities.[29]

Health literacy: The capacity to obtain, interpret, and understand basic health information and services and the competence to use such information and services to enhance health.[30]

Health promotion: Any planned combination of educational, political, regulatory, and organizational supports for actions and conditions of living conducive to the health of individuals, groups, or communities.[29]

Health promotion activity: Broadly defined to include any activity that is part of a planned health promotion program, such as implementing a policy to create a smoke-free workplace, developing walking trails in communities, or teaching the skills needed to prepare healthy meals and snacks.

Healthy community: A community that is continuously creating and improving those physical and social environments and expanding those community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[31]

Healthy public policy: Characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible and easier for citizens. It makes social and physical environments health enhancing.[26]

Linguistically competent: Refers to skills for communicating effectively in the native language or dialect of the targeted population, taking into account general educational levels, literacy, and language preferences.

Managed care organizations (MCOs): Refers to systems that integrate the financing and delivery of health care services to covered individuals by means of arrangements with selected providers to furnish health care services to members. Managed care includes health maintenance organizations, preferred provider organizations, and point-of-service plans.

Patient and family education: Refers to a planned learning experience using a combination of methods, such as teaching, counseling, skill building, and behavior modification, to promote patient self-management and patient and family empowerment regarding their health.

Postsecondary institutions: Includes 2- and 4-year community colleges, private colleges, and universities.

Quality of life: An expression that, in general, connotes an overall sense of well-being when applied to an individual and a pleasant and supportive environment when applied to a community. On the individual level, health-related quality of life (HRQOL) has a strong relationship to a person's health perceptions and ability to function. On the community level, HRQOL can be viewed as including all aspects of community life that have a direct and quantifiable influence on the physical and mental health of its members.[32]

School health education: Any combination of learning experiences organized in the school setting to predispose, enable, and reinforce behavior conducive to health or to prepare school-aged children to be able to cope with the challenges to their health in the years ahead.[29]

Settings (worksites, schools, health care sites, and the community): Major social structures that provide channels and mechanisms of influence for reaching defined populations and for intervening at the policy level to facilitate healthful choices and address quality of life issues. Conceptually, the overall community, worksites, schools, and health care sites are contained under the broad umbrella of "community." Health promotion and health education may occur within these individual settings or across settings in a comprehensive, communitywide approach.[9]

Social capital: The process and conditions among people and organizations that lead to accomplishing a goal of mutual social benefit, usually characterized by four interrelated constructs: trust, cooperation, civic engagement, and reciprocity.[29]

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