



# Community Health Advisors: Models, Research, and Practice

Selected Annotations—United States

Volume I

*September 1994*

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Public Health Service  
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion  
Division of Chronic Disease Control and Community Intervention  
Atlanta, GA 30333

**CDC**  
CENTERS FOR DISEASE CONTROL  
AND PREVENTION

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## About Community Health Advisors

" If increased community competence is an outcome that is just as important as health improvements, then planners and practitioners need to build upon the naturally existing care and organizing skills of community health advisors who are uniquely linked to people and places and in ways that no health professional could begin to acquire."

*Eugenia Eng, DrPH  
Associate Professor  
Department of Health Behavior and Health Education  
School of Public Health  
University of North Carolina*

" Lay health workers, who so effectively bridge gaps between the haves and have nots of our society, play a significant role in creating a democracy of knowledge and a democracy of health."

*Joel Meister  
Director of Prevention Research  
Primary Care  
Mariposa Community Health Center  
Nogales, Arizona*

" Community health advisors bring a special expertise to their work. They understand the threads that form the cloth that is their community. When health and human service workers seek to serve communities, they may join with community health advisors to discover the weak points in the fabric of the community. They may then work hand-in-hand to weave the broken threads back to whole cloth. As a team, their efforts will be wisely and effectively carried out."

*E. Lee Rosenthal, MPH  
Director  
State Office of Rural Health Program  
Arizona Rural Health Office  
University of Arizona*





## Preface

The mission of the Centers for Disease Control and Prevention (CDC) is to promote health and quality of life by preventing and controlling disease, injury, and disability. As the nation's prevention agency, CDC accomplishes its mission by working with partners throughout the nation and the world to monitor health, detect and investigate health problems, conduct research to enhance prevention, develop and advocate sound public health policies, implement prevention strategies, promote healthy behaviors, foster safe and healthful environments, and provide leadership and training.

In the United States, community health advisors\* foster these goals by conducting community-level activities and interventions that promote health and prevent diseases. These advisors are trusted, respected members of the community who serve as a bridge between their peers and health professionals. Their informal, but direct, involvement enhances the delivery of health-related services to diverse populations, including minority, rural, and underserved populations. They provide a vital service by establishing and maintaining relationships with health care professionals in local public health departments and laypersons in the community. As health advocates, community health advisors promote and encourage positive, healthful behaviors among their peers.

In recent years, community health advisors have experienced a resurgence in their role in the community. They are currently involved in a variety of CDC-funded projects in such areas as HIV/AIDS, breast and cervical cancer, cardiovascular disease, diabetes, maternal and child health, and nutrition.

To emphasize the important work being done by indigenous health workers at the community and neighborhood levels, we have prepared an extensive bibliography by searching bibliographic databases and by contacting organizations, programs, and individuals engaged in community-based activities and interventions. During our search, we may have overlooked some excellent source materials. If you find that your program or article is not listed, we invite you to furnish information about your project by filling out the program data sheet located at the back of Volume II. We will include your program or research when we update the bibliography.

\*The term community health advisor denotes trusted and respected community members who provide informal community-based health-related services and who establish vital links between health care professionals in local public health departments and persons in the community. In the following list, we have tried to include some of the different terms that may be used to identify these lay-health community members:

Community health advisor	Informal helper
Community health advocate	Lay community health worker
Community health aide	Lay health worker
Community health representative	Lay volunteer
Community health worker	Natural caregiver
Community helper	Natural helper
Family health promoter	Paraprofessional
Health facilitator	Parent befriender
Health promoter	Peer counselor
Health visitor	Peer health advisor
Health liaison	Peer health educator
Home visitor	Promotora
Indigenous health aide	Resource mother
Indigenous paraprofessional	Volunteer health educator





# Introduction

## *What does this publication contain?*

*Community Health Advisors: Models, Research, and Practice, Selected Annotations—United States, Volume 1* contains bibliographic abstracts of journal articles, reports, literature, and resource materials, from the 1960s through the present. These entries were selected to provide information to community health advisors with models, research, and practice information on subjects such as breast and cervical cancer, heart disease, hypertension, nutrition, physical activity, pregnancy and prenatal care, and smoking prevention. Items were obtained by searching computerized bibliographic databases and by contacting organizations currently conducting programs. Items are also listed in the Health Promotion and Education Database, the Comprehensive School Health Database, and the Cancer Prevention and Control Database, subfiles of the Combined Health Information Database (CHID).

## *What is CHID?*

CHID is a computerized bibliographic database of health information and health promotion resources developed and managed by several Federal agencies. This unique reference is for all health professionals who need to locate health information for themselves or their clients. Current CHID producers include the Centers for Disease Control and Prevention, the National Institutes of Health, the Office of Disease Prevention and Health Promotion, the Department of Veterans Affairs, and the Health Resources and Services Administration.

## *How can I access the databases?*

CHID and its subfiles, the Health Promotion and Education Database, the Comprehensive School Health Database, and the Cancer Prevention and Control Database are available for online searching through CDP Online, CDP Technologies, 333 Seventh Avenue, New York, NY 10001 (800) 289-4277 and may be accessed using a telecommunicating computer or through libraries and information centers that subscribe to CDP Online. The databases are also available through *CDP File*, a CD-ROM produced by CDC's National Center for Chronic Disease Prevention and Health Promotion.

## *Where can I get more information?*

Should you need more information on the databases, *CDP File*, or CHID; wish to submit materials for possible inclusion in the databases; or need additional copies of this publication, contact:

Technical Information Services Branch  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE, Mailstop K-13  
Atlanta, GA 30341-3724  
(404) 488-5080

*Questions on programmatic issues may be directed to:*

Division of Chronic Disease Control and Community Intervention  
National Center for Chronic Disease Prevention and Health Promotion  
Centers for Disease Control and Prevention  
4770 Buford Hwy, NE, Mailstop K-56  
Atlanta, GA 30341-3724  
(404) 488-5440

# How to Use This Publication

## *Arrangement of Items*

Items in this publication are arranged in eight sections: (1) Foundations of community health advisors; (2) Health promotion and disease prevention programs; (3) Chronic diseases and risk factors; (4) Issues of aging; (5) School health; (6) Maternal and child health; (7) Sexual behavior; and (8) Injury and violence. Within sections there are several parts. Items in each part are listed in alphabetical order by title. The items are numbered sequentially, beginning with 001.

## *Indexes*

This publication contains three indexes. The *Title Index* lists document titles. The *Author Index* lists personal and corporate authors. The *Subject Index* lists selected key words describing the content of publications. If you know the title of a publication, use the *Title Index*. If you are looking for a publication produced by a particular person or agency, use the *Author Index*. If you want to identify items in a specific subject area, such as breastfeeding peer counselors, use the *Subject Index*.

## *Data Elements*

A citation and abstract are listed for each item in this publication. Data elements include the item number, title, form, author or corporate author, source and availability when noted, abstract, and CHID accession number.

### **Sample Description:**

<i>Item Number</i>	139
<i>Title</i>	<b>Use of Lay Persons as Patient Educators.</b>
<i>Form</i>	Journal Article.
<i>Author</i>	Lorig, K.
<i>Source</i>	Patient Education Newsletter. 5(3):29-30, June 1982.

<i>Abstract</i>	The Stanford (California) Arthritis Center offers patients a self-management course taught by lay leaders. This type of course was planned and developed in response to a nationwide need for education programs for arthritis patients. This particular format was designed by a team of health professionals, including nurses, physicians, physical therapists, occupational therapists, nutritionists, social workers, and health educators. Described in this article are (1) methods used for recruiting and compensating lay leaders, (2) course structure and training of leaders, (3) acceptance of lay leaders by course participants, and (4) acceptance of the course by physicians and other health professionals. After 3 years of experience, during which 125 such courses have been taught, it was concluded that lay persons can effectively teach complex disease-oriented courses. Evaluation of the program's success was based on a randomized, controlled study showing that course participants became more active, experienced less pain, and made fewer physician visits than nonparticipants. The Arthritis Foundation is now testing this course in 25 U.S. cities. 4 references.
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*CHID Accession Number* (HE8302306)

## *Obtaining Additional Information*

This publication provides source and availability information for each item when noted. For more information about a program or publication, contact the agencies or persons listed.





# Foundations of Community Health Advisors

## Conceptual Models

001

### **Aides: Pain or Panacea?**

**Form:** Journal article.

**Author:** D'Onofrio, C.N.

**Source:** Public Health Reports. 85(9):788-801, September 1970.

**Abstract:** Health aides can be seen as a miraculous new cure-all for insufficient health manpower (panacea), or as workers who are overrated and who cause more problems than they solve (pain). There is no one definition of a health aide; they are called indigenous health workers, subprofessionals, neighborhood health workers, health guides, health hostesses, or community representatives. Three concepts of health aides include the (1) routine aide (traditional, lower-echelon assistant who performs routine functions); (2) program aide (one who performs a group of functions not essential to minimum operation but helpful in delivering agency services); and (3) policy aide (related to an agency's overall direction; performs functions such as defining agency goals and setting its priorities, and planning and evaluating agency programs). Often misunderstandings arise when different parties are confused about the type of aides they are discussing. There can be confusion over terminology and over qualifications considered in recruitment, or differing expectations for the role and status of aides. The recruitment of aides can force an agency to reconsider its concern with health and its purposes and goals; to reexamine its relationships with the community it serves; and to reconsider its understanding of the educational process. Some persons believe that the aide concept itself is theoretically invalid. The deepest root

of the conflict over aides is resistance to change. Sources of resistance include inadequate agency planning for the incorporation of aides, individual differences in readiness for change, and agency resistance to societal change. Resistance to change adds to the compounding of conflict. Planning for aides, especially program and policy aides, requires an agency to go through an often-painful self-analysis. Therefore, the greatest potential contribution of health aides lies in stimulating a process of education that enables the agency to better serve the community over time, helps aides and staff to grow in ability, and helps the community residents to achieve physical and emotional well-being.

(HE9401204)

002

### **Community-Based Family Support and Education Programs: Something Old or Something New?**

**Form:** Report.

**Author:** Weiss, H.; Halpern, R.

**Availability:** National Center for Children in Poverty, 154 Haven Avenue, New York, NY 10032. (212) 927-8793.

**Abstract:** Researchers provide a historical framework for better understanding the emergence of community-based family support programs, their place within the larger service delivery system, and their potential for meeting the needs of children and families living in poverty. In chapter one, they provide a working definition and identify premises underlying community-based family support and education (CBFSE). They enumerate the core characteristics of CBFSE and list what

these programs provide and how they provide it. Chapter two provides a historical review of CBFSE. Chapter three addresses the question: What can evaluation contribute? Topics include (1) lessons from past evaluation practice, (2) the effects of family support and education programs, (3) studies of implementation and the collection of practice knowledge, and (4) planning future evaluations. Chapter four presents emerging patterns of organization and institutionalization. Topics in this chapter include (1) basic characteristics of State CBFSE initiatives, (2) promoting new services, (3) pilot programs and slow growth, (4) decisions about program location and community responsiveness, (5) differentiation of universal services, (6) funding variability, and (7) issues related to the growth of State initiatives. Chapter five addresses policy, program, and research issues for the future. Among the important questions that need to be explored are (1) Which approaches and emphases are likely to be most effective for which populations of families?; (2) What is the minimum set of services needed to constitute a program that is likely to be effective?; (3) What are the advantages and disadvantages of different staffing patterns?; (4) What contextual conditions are critical?; (5) In what family and community situations are direct services to children a critical element of family support programs?; and (6) What are the advantages and disadvantages of universal versus more selective targeting approaches? (HE9401385)

003

### Community Groups and Mutual Aid.

**Form:** Book chapter.

**Author:** Levin, L.S.; Idler, E.L.

**Source:** IN: Hidden Health Care System: Mediating Structures and Medicine. Levin, L.S.; Idler, E.L. New York, NY, Ballinger Publishing Company pp. 159-229, 1981.

**Availability:** Ballinger Publishing Company, Harper Business, 10 East 53rd Street, New York, NY 10022.

**Abstract:** Community Groups and Mutual Aid is a chapter in The Hidden Health Care System: Mediating Structures and Medicine. The chapter describes three general categories of community groups organized around health issues: (1) The lay referral and help-giving resources of the local neighborhood, which may have certain ethnic or cultural characteristics; (2) the mutual aid or self-help group, whose numbers are growing; and (3) volunteer organizations, especially those that use some form of peer counseling. An example of the latter is examined in more detail (the rape crisis center, a volunteer organization). Provided are an overview and background information on the history of mutual aid in the United States. Section headings include (1) kinship and friendship networks; (2) the lay volunteer in community health; and (3) a closer look: rape crisis centers. Mutual aid groups are formed largely out of lay initiatives, and they function under their members' control. Active participation is the key. Members of these groups benefit as they contribute both in personal health management and adaptive skills and in affecting social factors that inhibit or enhance the health status of the membership. Strengthening the lay sector in health is the most reasonable and generous way of making more efficacious the role of professional care. The argument for a reappraisal of the health care resource to include the social resource of



mediating structures is profoundly conservationist: To conserve and nurture the health care functions of individuals, the family, the neighborhood, and the community. 138 references. (HE9401228)

004

**Community Research: Partnership in Black Communities.**

**Form:** Journal article.

**Author:** Hatch, J.; Moss, N.; Saran, A.; Presley-Cantrell, L.; Mallory, C.

**Source:** American Journal of Preventive Medicine. 9(6, Supplement):27-31, November-December 1993.

**Abstract:** In the 1990's, research is expected to increase on United States populations that experience a disproportionate burden of disease, disability, and premature death. Community collaboration with the scientific community provides the opportunity for creative problem-solving. Researchers explore four potential models for collaborative research in African-American communities in the United States. They also explore the challenges to the African-American and scientific communities when such research partnerships are formed, and the research and potential partnerships in the community of African-American women. In the first model for community collaboration, the persons the researchers consult for advice and consent are at the periphery of community cultural systems. In the second model, researchers identify influential people within community cultural systems to whom they explain the research design and from whom they request endorsement and cooperation. In the third model, researchers contact influential community leaders to explain the research and to ask for support, advice, and guidance in hiring community people as interviewers, outreach workers, and screeners. One

example of this model is a community-based intervention program designed and conducted in 1985 in East Baltimore by the Johns Hopkins medical institution and community leaders. The program was designed to control hypertension and related cardiovascular risk factors in a predominantly black inner-city population. Much of the success of the model was attributed to the recruitment and training of community residents as certified health workers skilled in community outreach, counseling, and monitoring blood pressure. Another example of the third model is a study begun in 1978 by health educators at the University of North Carolina. The intervention, which was designed to increase the use of health care resources in the control of hypertension and diabetes, called for training community-selected volunteers as health advocates who would share information with others in their social networks and play a facilitating role in linking individuals with resources. In the fourth model, the researcher seeks community assistance in setting the direction and focus of the research. This is the model best suited for research in African-American communities because it both involves and enables the community. Challenges to the African-American community when forming a research partnership include (1) selecting a research problem that has social significance for the community, (2) assuring the physical safety of community participants, (3) preventing socially damaging uses of scientific data, and (4) assuring long-term social benefit to the community by establishing a community-based infrastructure to continue interventions. 22 references. (HE9401374)

005

**Dimensions and Characteristics of Lay Helping.**

**Form:** Journal article.

**Author:** Ayers, T.D.

**Source:** American Journal of Orthopsychiatry. 59(2):215-225, April 1989.

**Abstract:** A researcher conducts a literature review and presents a conceptual framework for research on lay helping strategies, differentiating the strategies along two dimensions: (1) Their focus (individual or interpersonal) and (2) their source (natural or supplemental). Examined are the ways people help themselves in the absence of formal (professional) assistance. The four common lay helping strategies are described as (1) support from informal social support networks, comprising family, friends, and coworkers; (2) organized peer support (people who gather in response to a shared problem); (3) individual self-improvement materials available through the popular media (television, books, magazines, cassette and videotapes, and newspapers); and (4) individual self-reliance (self-care and use of personal coping skills). The strategies may interact, and the use of each may lead to positive, negative, or neutral results. Presented is a typology of major characteristics derived from this review of attributes of group-based and individually-based lay help. The typology provides a conceptual tool for categorizing lay strategies, and a set of empirically testable hypotheses about them. The dimensions of source of assistance and focus of strategy are important to understand, as they describe commonalities observed across diverse helping methods. Structural elements described include magnitude of problem, characteristic emphases, commonly used techniques, opportunity for use, resource base, and intervention design. Of all the strategies, research on peer support organizations may

offer the greatest promise for understanding lay helping. More data are needed to delineate better which strategies (or combinations of them) are appropriate for which situations and for what reasons. 2 tables, 52 references. (HE9401215)

006

**Expanding Roles for Health Assistants in a Model Cities Health Program.**

**Form:** Journal article.

**Author:** Gonzalez, J.L.; Woodward, L.H.

**Source:** Health Services Reports. 89(2):145-151, March-April 1974.

**Abstract:** The model cities health component of the Laredo-Webb County (Texas) Health Department was planned basically as an outreach program using health assistants. Health assistants play major roles in the two main components of the Community Health Assistance Project: Community health education and an information and referral system. Eight health assistants work in the model cities health component and another 10 in other parts of the health department. All are women between age 18-50, most with high school degrees or equivalencies. The program's first health assistants were trained by Project Hope in its first domestic project. The health assistants take part in a number of projects to promote community health education, including a campaign to increase immunizations among preschool children in the model cities area, a program to teach mothers infant care, and programs to detect carbon monoxide and lead paint poisoning. With appropriate training and inservice education, health assistants are able to broaden their outreach and be of service to the entire health department. Health assistants also are instrumental in information and referral programs. They go into the target neighborhood with letters of referral to



respective agencies from which residents seek assistance, and refer residents to health department clinics for various health services and other services such as environmental sanitation. Other outreach activities include promotion of attendance at clinics for tuberculosis skin tests and promotion of the department's migrant clinic. Experience shows that health assistants are often the best available persons to communicate with poverty groups and motivate them to use services, and that they are well-suited to conduct certain types of educational programs. Selection, training, supervision, and how assistants are utilized are equally important factors for successful use of assistants. Good morale of the assistants is also important; program planning responsibilities foster this. 2 tables, 13 references. (HE9401206)

007

**Help Is Where You Find It: Four Informal Helping Groups.**

**Form:** Journal article.

**Author:** Cowen, E.L.

**Source:** American Psychologist. 37(4):385-395, April 1982.

**Abstract:** Researchers studied four groups known or suspected to be involved in interpersonal help-giving: Hairdressers, divorce lawyers, bartenders, and industrial supervisors. The purposes of the study included (1) documenting the basic facts and descriptive profiles of interpersonal help-giving in each of the four groups; (2) identifying cross-group differences and the corresponding behaviors and ecological factors that prompt such differences; and (3) developing training and consultation models for interested help-givers to buttress and support their roles. All four studies were built around a detailed, structured interview or questionnaire that evolved from early, extensive pilot-testing.

Questions were divided into the following seven clusters: (1) Information about the backgrounds, employment histories, and work patterns of respondents; (2) descriptions of respondents' clientele and the frequency and nature of their contacts with them; (3) summaries of verbal interactions with clients, particularly time spent dealing with their personal problems; (4) reports of the nature and frequency of specific personal problems raised by clients; (5) descriptions of respondents' strategies for handling clients' personal problems; (6) feelings about being called on to engage themselves with clients' personal problems and the satisfaction they felt in that role; and (7) perceptions of help-givers' effectiveness and need for help in dealing with the personal problems of clients. Researchers gathered data from 325 people representing the four different groups. Moderate to serious personal problems were encountered in all groups, but more so with hairdressers and divorce lawyers than with supervisors or bartenders. Although the problems mentioned were similar to those often brought to mental health professionals, somewhat different problems came up within the different groups. Only a small fraction of the psychological problems discussed reached the formal mental health establishment; informal sources of help, for many reasons, are preferred by most individuals. 4 tables, 39 references. (HE9401496)

008

**Important Variables Influencing Successful Use of Aides.**

**Form:** Journal article.

**Author:** Moore, F.I.; Stewart, J.C.

**Source:** Health Services Reports. 87(6):555-561, June-July 1972.

**Abstract:** A clear understanding of the relevant and essential variables pertaining to

the use and evaluation of aides in health services delivery is vital. There is a lack of consensus on what role aides should play. Some research since the 1960's suggests that persons randomly selected from low-income areas can be trained to be effective workers, but other studies are ambiguous about this matter. Similarly, various researchers have said that training is most important for aides on one hand and for the professionals on the other. Two important variables not yet explored are (1) quantified job descriptions and (2) careful selection. Limited data and experience indicate that these variables are crucial in the successful use of aides. In one study in 1965, indigenous persons were trained for 8 days to raise levels of immunization in hard-core areas. Study results showed that these aides met that goal, became more effective with experience, and should be permanently employed. The data and experience of the study proved the importance of the selection process, and that long-term training and traditional supervision were not necessary. Researchers designed a conceptual model to simplify the relative importance of the many variables affecting new health employees. They emphasized interrelatedness of variables and suggested the contributions and products that can be developed from a through task analysis. The model highlights the necessity of considering individual phases in the context of the total process. The training phase of the manpower development process is bracketed by antecedent and modifier events. Considered are manpower planning decisions, recruitment decisions, and selection of applicants. One study suggests that three clusters of variables affect most worker performance measures: Health care delivery systems variables, patient variables, and worker variables. 1 figure, 1 table, 26 references. (HE9401205)

009

### **Institutionalizing Social Support Through the Church and Into the Community.**

**Form:** Journal article.

**Author:** Eng, E.; Hatch, J.; Callan, A.

**Source:** Health Education Quarterly. 12(1):81-92, Spring 1985.

**Abstract:** A conceptual framework that has been used to institutionalize health-related activities through the role and function of the black church, as a social unit of identity and solution for rural black communities in North Carolina, is considered. The positive influence of social support on such health-related outcomes as patient adherence to medical regimens and stress reduction at the worksite has captured the attention of public health researchers and practitioners alike. Yet, the broader social outcome of building community competency to undertake and sustain health-related solutions without constant intervention from professionals still remains elusive. The difficulty may lie with the need to uncover on each occasion the various roles and functions of social support structures that may or may not exist in a given community. The intent would then be to graft an intervention onto these existing roles and functions to mirror the naturally occurring social support structures. Specific problems that have been addressed in the North Carolina program include reducing risks for diabetes, maternal and child health issues, and controlling blood pressure levels among hypertensives. The experience in applying this framework has covered 14 years (from 1970 until the present). The uniqueness of the black church as both a unit of identity and solution makes it a potentially effective unit of practice for health professionals. However, this kind of program has shown that the transfer of services from the health center to the local church only addresses the problems of accessibility and not those of long-term



behavior change. The usefulness of this conceptual framework to health professionals is twofold. First, it can allow professionals to determine the most effective unit of practice that exists in the complex networks of social support and influence in community life. Second, it provides a useful foundation for initiating the process of eliciting participation and mobilizing resources from within the community. 35 references. (HE9401227)

010

**Introduction.**

**Form:** Journal article.

**Author:** Israel, B.A.; McLeroy, K.R.

**Source:** Health Education Quarterly. 12(1):1-4, Spring 1985.

**Abstract:** The editors of Health Education Quarterly present an introduction to the thematic issue devoted to the topic: Social Networks and Social Support: Implications for Health Education. Reasons that the concepts of social networks and social support have become increasingly important to health education theory, research, and practice include (1) the nature and extent of supportive relationships in which an individual is involved may have important health consequences, and can affect quality of life and the ability to function effectively in society; (2) social support and social network concepts provide health educators with strategies for strengthening and reinforcing interventions directed at primary, secondary, or tertiary prevention; and (3) the application of social support and social network concepts provides an alternative to more traditional health education strategies that have focused almost exclusively on interventions directed at individual behavior change. Social networks are defined according to the functions they provide: (1) New information, (2) emotional support, (3) instrumental assistance in dealing

with routine daily affairs and with life crises, (4) access to new social contacts, and (5) a sense of social identity. Types of network interventions include those designed to (1) strengthen existing networks, (2) develop new social networks, (3) improve network functioning through natural helpers, and (4) develop cooperative problem solving through overlapping networks. In network therapy, which is designed to strengthen existing networks, a therapeutic team works as a group with the family, friends, neighbors, and kin of an emotionally troubled client to establish a stronger support network for the individual, reduce dysfunctional communication patterns, and alter the life patterns of the client. Mutual aid or self-help groups are traditional examples of new social network linkages. A brief description of each article in the journal issue is presented. 7 references. (HE9401426)

011

**Lay Advisor as a Community Health Resource.**

**Form:** Journal article.

**Author:** Salber, E.J.

**Source:** Journal of Health Politics, Policy and Law. 3(4):469-478, Winter 1979.

**Abstract:** The lay advisor is a community health resource who can act as a liaison between the public and professional spheres, and thus reduce the general malaise currently existing between doctor and patient. The lay referral network would strengthen the professionals' ties with the community; channel knowledge to and from the community; educate the community about medicine's role and function and the professional about the lay referral and lay consultation system; acquaint the community with available human resources; improve the helper's role; lessen the dependency and passivity of the patient in relation to the

professional; and help the patient cope more effectively with his problem. The health facilitator concept can raise the level of health consciousness in the community. The health facilitator would be identified by the community and selected by his willingness to participate in the program. Education and training of the health facilitator would consist of both group and individual sessions. The health facilitators would provide social support to the community, which could then protect people in crisis from a wide range of pathological states. Examples of lay advisor programs throughout the world are described. 23 references. (HE7900523)

012

### **Lay Health Advisors as Community Change Agents.**

**Form:** Journal article.

**Author:** Eng, E.; Young, R.

**Source:** Family and Community Health. 15(1):24-40, April 1992.

**Abstract:** Researchers reviewed a range of Lay Health Advisor (LHA) programs and research to synthesize determinants of and outcomes from lay helping and organized them into a conceptual model, diagramming possible intervention effects of lay helping on individuals' behaviors, social network functions, service agency collaboration, and community capacity in problem solving. The conceptual model includes (1) the individual health behavior change process, involving perceived risk and benefits, behavioral intent, health seeking behaviors, sustained health behaviors, and health outcomes; (2) the social network (i.e., collaborative helping process), involving social support and social interaction with external structures; and (3) the community (i.e., collective transformation), involving social control, community participation, community competence, and

development outcome. Researchers also devised a lay health advisor program planning model for practitioners to use in conjunction with the conceptual model. The planning model requires consideration of four major questions: (1) In what level is outcome desired (individual health behavior change, social network collaborative helping, or community collective transformation); (2) which network strategy will be used (strengthening of already existing network ties, enhancing mediating capacity of total network, or organizing cooperative problem solving); (3) what existing structure will be targeted for initiating change (family and friends and/or religious and social organizations, civic and/or service organizations, or neighborhoods and/or businesses); and (4) how will LHA's carry out social support functions (emotional support, instrumental support, informational support, or appraisal support). Once this information is analyzed, the planner can determine the level of program outcomes desired and can formulate corresponding outcome objectives. The development of the models is grounded in field-based demonstration research experiences; the models are currently being used in five separate projects in the southern United States and in Appalachia. 1 table, 3 figures, 70 references. (HE9201343)

013

### **Lay Participation in Health Care Decision Making: A Conceptual Framework.**

**Form:** Journal article.

**Author:** Charles, C.; DeMaio, S.

**Source:** Journal of Health Politics, Policy and Law. 18(4):881-904, Winter 1993.

**Abstract:** Lay participation in health care decision making, although not a new concept in Canadian health policy, has gained increasing and broader interest in Canada in recent years. Since there is still confusion



over what lay participation really means, researchers define lay participation and discuss its historical and current context.

Additionally, since little consideration has been given to whether and how lay participation can lead to better decision making and the criteria by which it should be judged, the authors present a framework for lay participation based on decision-making domains, role perspectives, and levels of participation. To help clarify different health care decision-making domains within which lay individuals can participate, three subdomains are distinguished: (1) Treatment, (2) service delivery, and (3) broad macro or system level decision-making. Lay individuals can adopt different roles when they become involved in health care decision making. These roles include those of patient, advocate, tax payer, fund raiser, volunteer, or policymaker. Two fundamentally different role perspectives can also be distinguished, that from a user of health services, or that from a public policy perspective. The level of participation in health care decision making is the extent to which individuals have control over the decision-making process. There is a significant difference between listening to the views of lay individuals on the one hand, and shifting full decision-making authority to them on the other. Feingold's ladder of increasing citizen participation to describe different levels of citizen participation has been collapsed here into three categories: (1) Consultation, (2) partnership, and (3) lay control. This framework is an analytic tool for conceptualizing key dimensions of lay involvement in health care decision making. As an analytic tool, it has certain limitations. First, it provides a static picture of dimensions of lay participation in health care decision making, while actual decision making is a dynamic process encompassing a number of different phases. Second, the three framework variables are not the only important analytic variables for describing dimensions of lay

participation. 1 figure, 69 references.  
(HE9401392)

014

### Mediating Structures and Health Policy.

**Form:** Book chapter.

**Author:** Levin, L.S.; Idler, E.L.

**Source:** IN: Hidden Health Care System: Mediating Structures and Medicine. Levin, L.S.; Idler, E.L. New York, NY, Ballinger Publishing Company, pp. 231-265, 1981.

**Availability:** Ballinger Publishing Company, Harper Business, 10 East 53rd Street, New York, NY 10022.

**Abstract:** Mediating Structures and Health Policy is a chapter in The Hidden Health Care System: Mediating Structures and Medicine. Mediating structures are culturally determined, highly variable in form and function, and often are obscured by their primary identification as family, church, or friend. Policy formed in response to such resources cannot rely on traditional methods of calculating costs or benefits or negotiating trade-offs among competing political interests. Topics discussed include (1) aspects of mediating structures of special relevance to health policy (a broader definition of health care; health benefits of pluralism; political effectiveness; response to need; benefits for traditional care); (2) the vulnerability of mediating structures in health; (3) implications for health policy (preserving existing structures; restructuring health care; encouraging self care); (4) research on mediating structures for policy development; and (5) a future perspective (caring for the chronically ill; holistic health; beyond medicine; altering the doctor-patient relationship; public empowerment). Public policy should be sensitive to the vital private role of people in their health and health care, and should arrive at collective actions that

accept people as resources as well as recipients. 35 references. (HE9401229)

015

### **Natural Support Systems, Minority Groups, and the Late Life Dementias: Implications for Service Delivery, Research, and Policy.**

**Form:** Book chapter.

**Author:** Valle, R.

**Source:** IN: Clinical Aspects of Alzheimer's Disease and Senile Dementia. Miller, N.E.; Cohen, G.D.; eds. New York, NY, Raven Press, Aging, Volume 15, pp. 277-299, 1981.

**Availability:** Raven Press, 1185 Avenue of the Americas, New York, NY 10036.

**Abstract:** There is a need to focus more attention on the presence and impact of later-life dementias among the minority elderly, but there is little preparation for such a focus within the aging research and caregiving establishment. The author focuses on four groups of minorities in the United States: Asian Americans, African Americans, Latinos/Hispanics, and Native Americans. Because many minority populations have greater exposure to high-risk, illness-producing occupations than majority groups, they may have differential symptoms of dementia incidence and/or accompanying sensory losses. Being poor, part of a minority group, or elderly may also affect health-related coping behaviors and access to formal caregiving systems. The author describes the concept of informal health support networks for minorities, discussing three distinct operational formats or levels: Aggregate, linkperson, and kinship networks. Collectively, these three types of natural networks embody a number of properties vital to future planning and decision-making in the care of minority elderly with dementias. Natural, or endogenous, support networks can be combined with more formal health services to develop a joint

system of interaction and support. To be part of a successful joint approach, endogenous support networks must be (1) informed about the availability and accessibility of services; (2) accepted as partners in the intervention; and (3) used to their maximum potential within each of the four stages of the dementia continuum, including data collection and reporting activities. The formal, or exogenous, aspect of a holistic support system must (1) maintain cross-cultural interventive and communicative capabilities, whether internally and/or through use of community brokers and resources; (2) allow the patient's cultural help-accepting values and outlooks to remain as intact as possible; and (3) maintain the interface relationships between formal services and natural networks over time. The development of working ties between formal health services and natural support systems would not only assist in the incorporation of cultural values into intervention approaches, but it would also permit agencies to overcome the often sporadic relationship between minority elderly populations and formal health services. 3 figures, 5 tables, 106 references. (HE9401252)

016

### **Networking Between Agencies and Black Churches: The Lay Health Advisor Model.**

**Form:** Journal article.

**Author:** Eng, E.; Hatch, J.W.

**Source:** Prevention in Human Services. 10(1):123-146, 1991.

**Abstract:** Researchers explore possible, proper, or desirable relationships of churches to health and human service agencies. Identifying, recruiting, and training important members of natural helping networks in the black church, who can serve as lay health advisors (LHA's) linking and negotiating between people at risk and agency services, is



one health intervention strategy for establishing a relationship between formal and informal support systems. As lay people to whom others turn for advice, emotional support, and tangible aid, LHA's provide informal and spontaneous assistance. Found at many levels of the community, these persons are already helping people by virtue of their community roles, occupations, or personality traits. An LHA intervention model conceptualizes the relationships between the social support functions of networks within black congregations and their expected effects on the (1) behaviors of persons at risk; (2) service delivery structures of agencies; and (3) problem-solving capacities of communities. Based on this model, three types of LHA interventions are categorized in accordance with the aim of network member involvement: (1) Enhancing the total network within a church; (2) cooperative problem-solving linking networks between churches; and (3) coalition building connecting networks beyond the church. Authors provide an intervention example for each of these categories, including a description of the target population, support provider(s), purpose, problems addressed, network characteristics emphasized, activities used, and role of the professional. In planning a church-based program, the LHA model can provide a useful conceptual rationale for (1) determining expected levels of outcome; (2) selecting network intervention strategies; (3) identifying formal and informal structures to be linked; and (4) defining LHA characteristics, roles, and activities that contribute to the above. 1 figure, 50 references. (HE9401221)

017

**Peer Health Education Community Based Programs: Mobilizing Resources for Practice, Policy and Research: Conference Summary, February 7-8, 1993, Tucson, AZ.**

**Form:** Proceedings.

**Corporate Author:** Arizona Disease Prevention Center. Southwest Border Rural Health Research Center.

**Availability:** Arizona Disease Prevention Center, 2501 East Lee Street, Tucson, AZ 85716. (602) 626-5576.

**Abstract:** Peer Health Education Community Based Programs: Mobilizing Resources For Practice, Policy and Research summarizes the results of a conference held February 7-8, 1993, in Tucson, Arizona. The conference incorporated formal presentations with a workshop format consisting of four simultaneous working groups comprised of an interdisciplinary team of policy-makers, researchers, and program staff who focused on aspects of peer health educator programs and policy development issues. Working group focus area one, Cultural Contexts, addressed (1) how peer health advisors can contribute to a program's cultural competence, (2) how programs can integrate cultural competence into their implementation and evaluation approaches, and (3) how the culture of bureaucracy impacts program direction. Working group focus area two, Intervention Approaches, discusses (1) the appropriate roles and functions of peer health advisors, (2) the kinds and amount of training that are necessary and desirable, and (3) whether peer health advisors should be paid. Working group focus area three, Program and Research, addresses (1) the desirable and appropriate outcomes of peer health advisor projects, (2) goal determination, (3) how research and policy relate to goal setting and attainment, and (4) whether empowerment is an appropriate goal. Working group focus area four, Policy and

Funding, discusses (1) the options for sustaining peer health advisor projects, (2) the role evaluation plays in these projects, (3) who advocates for the project, and (4) how advocacy for the project is managed.

Community-based interventions using peer health advisors can be an effective way of reaching underserved and minority populations and assisting them in responding to their own health needs. (HE9401417)

018

### **Population Behavior Change: A Theory-Based Approach.**

**Form:** Journal article.

**Author:** McAlister, A.L.

**Source:** Journal of Public Health Policy. 12(3):345-361, Autumn 1991.

**Abstract:** A researcher presents a theory on how to change population behavior by combining mass media education and personal interactions. Behavioral science provides useful ideas about how programs of mass communication and community participation can produce synergistic influences on the lifestyles and policy decisions of populations and their representatives. Media campaigns featuring real-life behavior models and community networks mobilized to promote behavior change provide a theoretically sound paradigm for community-level activities to accelerate the diffusion of innovation in health. Mass media communications can present cognitive/behavioral modeling while interpersonal networks can offer reinforcement and distribution. Presented are illustrative case studies that demonstrate how behavioral science concepts can be applied to preventing human immunodeficiency virus (HIV) infections and to promoting citizen lobbying against selected nuclear weapon systems. The basic approach outlined here has been applied to other forms of social change, such as

product sales and agrarian reform. The direction of change can be determined by the behavioral models that are selected. Communication networks may thus become sources of community self-determination and foster internal leadership to set new goals and policies. Behavioral objectives must be selected according to their impact on health. Mechanisms that select goals for the social-behavioral technology described here may include political processes, citizens' panels, or the informed decision of a public health authority. 42 references. (HE9401223)

019

### **Professionalizing Volunteer Work in a Black Neighborhood.**

**Form:** Journal article.

**Author:** Wolf, J.H.

**Source:** Social Service Review. 59(3):423-434, September 1985.

**Abstract:** A researcher highlights the shortcomings of grafting a model of professional service onto a voluntary program for the elderly, using as an example the Elderly Neighbors project. The risks of professionalizing social relations with neighbors is demonstrated. The project, designed for African-American urban residents aged 60 or older, was intended to stimulate and build on traditional helping networks of family and friends to aid elderly residents in an inner-city, residential area of a large midwestern city. The goal of promoting the health and social well-being of elderly in the neighborhood was to be accomplished by using trained volunteers as block workers who would routinely visit their neighbors. The workers then identified emerging social and health problems and aided their neighbors in securing help for these problems. After 1 year of service, Elderly Neighbors had enrolled 227 households on ten blocks. In 35 households,



more than one resident was enrolled, for a total of 303 individuals served by the program. An analysis of the program's block worker activity focuses on (1) penetration (the number of residents enrolled on a particular block), (2) home visits, (3) phone contacts, and (4) services. Overall totals derived from this data are deceptive, however, because they mask a distinction that developed among workers involved in the program. Some of the workers conformed to the professionalizing demands made as the program developed (professionalized block workers), while others resisted the professionalizing demands (nonprofessionalized block workers). Overall, the 3 professionalized workers contributed 32 services, while the 3 nonprofessionalized workers contributed 91 services. Not only did the nonprofessionalized workers contribute more services, but those services were more likely to include the personal attention normally expected of a neighbor/friend. 21 references. (HE9401492)

020

**Role of the Black Church in Community Medicine.**

**Form:** Journal article.

**Author:** Levin, J.S.

**Source:** Journal of the National Medical Association. 76(5):477-483, 1984.

**Abstract:** Historically, the African-American church has been the preserver and perpetuator of African-American culture, the center from which its defining values and norms have come, and the independent social institution that has provided order and meaning to the African-American experience in the United States. The traditional ethic of community-oriented service within the African-American culture is highly compatible with the communitarian ethic of community medicine. The author concludes that, given this similarity

and the fact that African Americans are an at-risk and underserved group regarding health-status indicators, the African-American church is in an excellent position to enhance the practice of community medicine among African Americans. Focusing on four areas of community medicine (primary care delivery, community mental health, health promotion and disease prevention, and health policy), the article describes several health programs based in or affiliated with the African-American church that have operated throughout the United States, and examines the body of literature comprising articles that are favorable toward a community health role for the black church. 66 references. (HE9401253)

021

**Self Care in Health.**

**Form:** Journal article.

**Author:** Levin, L.S.; Idler, E.L.

**Source:** Annual Review of Public Health. 4:181-201, 1983.

**Abstract:** Purposes for this review of the professional literature on self care in health were (1) to assess the current state of the art and (2) to identify promising directions for future research and public health policies and programs. Although lay self care is the dominant form of health care in Western Europe and North America, it has been of only marginal interest to researchers and health planners. Individual and family self care is but one element in a complex of nonprofessional health resources that have evolved in response to a shortage of professional health services. Recognition of these resources raises difficult ethical and strategic political issues. There seems to be a reasonable basis for such misgivings, considering the nature of some expert-originated self care education materials and programs. Health professionals should remove

barriers to public access to information, materials, and health technology so as to render lay participation in health care more effective. 129 references. (HE8400136)

022

### **Self Care: New Challenge to Individual Health.**

**Form:** Journal article.

**Author:** Levin, L.S.

**Source:** Journal of the American College Health Association. 28(2):117-120, October 1979.

**Abstract:** Professionals and the public are beginning to recognize that further improvements in health care are best achieved through the development of lay resources in health in contrast to professional resources. Recent research has shown that most health care still remains in the hands of lay people and that efforts to improve this resource can have a powerful effect on health and the health care industry. Health professionals should recognize that the new public interest is demystifying medicine and deprofessionalizing health care. With this increased knowledge the populace can begin to establish a health-competent society less dependent upon unnecessary professional intrusion. Such a view will lead to a broader based perspective on health and health care which may involve new concepts of health that are at variance with present professional views and practices. In addition, society can expect to achieve a new level of equity in responsibility for the production and consumption of health care. 19 references. (HE8001134)

023

### **Social and Cultural Factors in Health Promotion.**

**Form:** Book chapter.

**Author:** Levine, S.; Sorenson, J.R.

**Source:** IN: Behavioral Health: A Handbook of Health Enhancement and Disease Prevention. Matarazzo, J.D.; Weiss, S.M.; Herd, J.A.; Miller, N.E.; Weiss, S.M., eds. New York, Wiley, p. 222-229, 1984.

**Abstract:** The values, practices, and beliefs held by the members of a society affect their health status and behavior and influence the effectiveness and efficiency of professional health promotion efforts. Professional health workers must know and respect the culture of the population with which they are working, must be aware of their own values and beliefs, and must make recommendations that are compatible with the values and beliefs of the recipient culture. Social and cultural factors that influence health promotion efforts include (1) cultural diversity among subcultures, (2) differences in the conceptions of health between the lay population and health professionals, (3) the lay health network, and (4) variation among different segments of the population in health-enhancing behaviors. In promoting health, we are seeking to modify normal, everyday practices that are deeply embedded in the social life of people and are reinforced by powerful mechanisms. Planned change strategies can be categorized into three basic types: (1) empirical-rational, (2) normative-reeducative, and (3) power-coercive. The role of social and cultural factors in health promotion is illustrated by an examination of elements contributing to the relative success of a recent national campaign to discourage cigarette smoking. 16 references. (HE8501098)



024

**Social Networks and Health Status: Linking Theory, Research, and Practice.****Form:** Journal article.**Author:** Israel, B.A.**Source:** Patient Counselling and Health Education. 4(2):65-79, 1982.

**Abstract:** A researcher examined the literature on social networks and health status, focusing on (1) social networks and social support definitions and distinctions; (2) a conceptual framework of social network characteristics, relevant theoretical base, and research findings; and (3) implications for practice and the role of the professional. Social networks are one of numerous psychosocial factors that are related to physical and psychological well-being. Social networks have structural, interactional, and functional characteristics; of these, 14 attributes are frequently referred to in the literature: (1) Range, (2) density, (3) content, (4) directedness, (5) durability, (6) intensity, (7) frequency, (8) dispersion, (9) homogeneity, (10) affective support, (11) instrumental support, (12) cognitive support, (13) maintenance of social identity, and (14) social outreach. A summary of theory and research findings demonstrated that (1) the examination of social networks is a viable approach for investigating the association between social interactions and health status; (2) quantitative structural and interactional characteristics of networks have been found to have conflicting associations with well-being and warrant further study; (3) qualitative structural and interactional characteristics of networks have been consistently found to have a positive relationship to well-being and are considered more significant than quantitative characteristics; (4) the functional dimension of networks includes at least two characteristics associated with well-being: Affective support and instrumental support; (5) the quality or

affective component of social support is more strongly related to health status than are instrumental and cognitive support; (6) networks consisting of certain structural and interactional characteristics may be more or less effective at providing certain functions; and (7) there are other factors that influence both the types of social networks and their influence on well-being (e.g., socioeconomic status, coping styles, social competence, stressful life events). Program examples illustrating how key social network concepts have been integrated into practice are presented. 1 figure, 1 table, 111 references. (HE9401423)

025

**Social Networks and Social Support: An Overview of Research, Practice, and Policy Implications.****Form:** Journal article.**Author:** Gottlieb, B.H.**Source:** Health Education Quarterly. 12(1):5-22, Spring 1985.

**Abstract:** A researcher presents a brief overview of the stressful life events/illness model and its implications for intervention, then highlights the role of social support as a resource for resisting stress-induced illness and disability. Studies show an association between the number and intensity of life events and subsequent illness episodes. Social support can be conceived of as the feedback provided via contact with similar and valued peers. Three different connotative meanings that have been assigned to the social support construct are identified and their empirical operationalizations in several recent studies are described. Specifically, the social integration/participation formulation, the social network approach, and the social intimacy measurement strategy are described and contrasted. Within the latter approach, one

study that illuminated types of informal helping behaviors is discussed in more detail. A review of possible mechanisms whereby social support accomplishes its health-protective impact is offered, and two types of planned interventions involving the mobilization or optimization of social support are spotlighted. The first type aims to envelop people in a social fabric composed of similar peers who exist in their social network or can be grafted onto it; the second type aims to optimize the quality of support that people give and get in the natural environment. The researcher concludes with ideas about ways that professionals can safeguard the natural helping skills of citizens and achieve an appropriate balance between formal and informal systems of service delivery in the health and human services fields. 1 table, 42 references. (HE9401226)

026

**Task Force Report: Social Networks as Mediators of Social Support: An Analysis of the Effects and Determinants of Social Networks.**

**Form:** Journal article.

**Author:** Mitchell, R.E.; Trickett, E.J.

**Source:** Community Mental Health Journal. 16(1):27-44, Spring 1980.

**Abstract:** Researchers present an overview of current literature on social networks that emphasized research linking social networks to psychological adaptation. The analysis includes (1) a review of social network concepts, (2) an analysis of the multiple determinants of social networks, (3) an analysis of the varied effects of social networks, and (4) implications for the policies and practices of community mental health centers. The review of social network concepts provides operational definitions of criteria for social network membership. It also

defines the characteristics of social networks. The authors address the functions served by social networks and support systems, which include emotional support, task-oriented assistance, communication of expectations, and access to new and diverse information and social contacts. In the section on multiple determinants of social networks, the authors discuss what factors influence or determine an individual's social network and what effects these networks have on individuals in terms of help-seeking and general psychological adjustment. They expand the discussion on social networks and help seeking and social networks and psychological adaptation in the section on the effects of social networks. The final section, which covers implications for community mental health policy and practice, discusses (1) individual and family-focused treatment interventions, (2) training for mental health paraprofessionals, (3) network analysis as an evaluative and planning tool, (4) community needs and resources assessment, and (5) the strengthening of natural caregiving networks. 3 tables, 63 references. (HE9401494)

# Foundations of Community Health Advisors

## Applications and Methods

027

### **Aged Blacks' Choices for an Informal Helper Network.**

**Form:** Journal article.

**Author:** Chatters, L.M.; Taylor, R.J.; Jackson, J.S.

**Source:** Journal of Gerontology. 41(1):94-100, January 1986.

**Abstract:** Using data obtained from the National Survey of Black Americans, researchers explored the relationships of sociodemographic, health, and family factors to informal helper choice among a nationally representative sample (n = 581) of African Americans over age 55. Previous research on the support networks of impaired elderly adults suggests that membership in sociodemographic subgroups influences use of specific informal helpers. Researchers examined nine categories of helpers: (1) Spouse, (2) son, (3) daughter, (4) father, (5) mother, (6) brother, (7) sister, (8) friend, and (9) neighbor. Nominations for the helper network were elicited by presenting to the respondent a list of categories of individuals and asking who would help in the event of sickness or disability. Logistic regression analyses were used to assess the effects of the demographic, health, and family factors on nominations to the helper network. Results revealed that (1) the category of daughter (41.5 percent) was most frequently chosen as helper, followed by son (37.2 percent), and spouse (32.8 percent); (2) marital status was important in selecting the categories of sister, friend, and neighbor; (3) presence of children decreased the likelihood that siblings and friends would be chosen; (4) perceived family closeness facilitated the selection of siblings but inhibited the choice of

friends; and (5) regional differences suggest a greater likelihood of selecting the categories of sister, friend, and neighbor among southern residents. 1 table, 24 references.

(HE9401425)

028

### **Alaskan Community Aide Scheme: A Successful Rural Health Program.**

**Form:** Journal article.

**Author:** Haraldson, S.

**Source:** New York State Journal of Medicine. 90(2):61-63, February 1990.

**Abstract:** There has been a dramatic decline in morbidity and mortality rates among Alaskan natives, especially for tuberculosis, otitis media, and other infectious diseases over the last two decades. This is partly due to general socioeconomic development, and partly due to efficient rural health programs. The author describes the history and development of Community Health Aides (CHA's) in Alaska. Since 1968, CHA's have undergone standardized training which is designed by the Alaska Area Native Health Board in Anchorage, and carried out in each of 7 service units. The village council for each of about 200 native villages chooses a local woman (only a few men are aides) for training. Training focuses on primary health care and on health problems that consume the major part of rural health services. Prevention, immunizations, and health education are important ingredients in the curriculum and in the practice of CHA's. In her daily work, the CHA is supported by a manual, Guidelines for Primary Health Care in Rural Areas, and by daily radio and



telecommunication via satellite with doctors at a regional hospital. Difficult cases (5-15 percent) are transported by air to the hospital for more qualified diagnosis and treatment. There are several keys to the success of Alaska's health care program. First, trainees are chosen by their own fellow villagers, and after training the CHA's live and work among their own people. Selecting trainees in this way seems to be of great psychological importance, as it tends to create a foundation of mutual confidence. Also, training is concentrated on a relatively small number of leading rural health problems. Other essential elements include team work, frequent consolidation courses, a comprehensive working manual, and daily use of telecommunication networks. 12 references. (HE9401365)

029

### **Alaskan Health Aide: A Successful Model of Family and Community Health.**

**Form:** Journal article.

**Author:** O'Hara-Devereaux, M.; Reeves, W.; Curtis, E.

**Source:** Family and Community Health. 3(2):71-84, August 1980.

**Abstract:** Researchers provide a historical overview of the health care system in Alaska, list legislation that has influenced Alaskan health care, and describe the Alaskan Community Health Aide Program (CHAP). In 1968, the Indian Health Service (IHS) obtained funds from Congress to pay for training and minimal salaries for health aides. A centralized training program for the State was established in Anchorage at the Native Alaskan Medical Center. There are now 215 community health aides (CHA's), one for each isolated village and one per 300 people in larger villages. These and 171 alternate CHA's are the only primary care providers

available to 90 percent of the native population in remote, rural areas of the State. Health Aides are responsible for 200,000 outpatient encounters a year. Health services provided include acute care, emergency care, health surveillance, and preventive services. A small full-time staff at each of three training sites (Anchorage, Bethel, and Nome) conducts a standardized CHA curriculum which consists of basic and advanced training. The curricula are competency-based and clinically oriented. Annual patient visits by CHA's (200,000 per year) account for a significant portion of all ambulatory care for Alaskan natives. Through the program, basic primary care services are available, accessible, continuous, acceptable to the population, and cost effective. Tables presented include (1) a comprehensive list of subjects taught at the Anchorage training center, (2) rating of five best teaching methods by Alaskan CHA's, (3) length of away from home training preferred by Alaskan CHA's, (4) frequency of training preferred by Alaskan CHA's, and (5) concerns of Alaskan CHA's when away from home for training. 5 tables, 23 references. (HE9401362)

030

### **Catalyst Who Inspires Self-help: The Community Health Worker in Deprived Areas.**

**Form:** Journal article.

**Author:** Moore, G.F.

**Source:** Professional Nurse. 5(7):342-344, April 1990.

**Abstract:** A researcher highlights the role of the community health worker (CHW) and discusses the methods used by CHW's to address community health problems. Community development approaches to health inequalities attempt to address negative social conditions while enabling members of a community to raise their awareness of the



issues affecting their health. Success in community development requires that CHW's be known and trusted by community members, who may be confused about the role of the CHW. CHW's must therefore define their role as catalysts and supporters, enabling members of the community to gain the confidence and ability to take control over their own lives. Nurses are rarely part of a community health project team because managers often do not wish to involve people they feel might adopt a medical approach to health when a social model is deemed more appropriate. Many studies suggest that a multidisciplinary approach to community health promotion might be more successful. The use of CHW's might have the following possibilities: (1) They would network with the primary healthcare team and others in the health service, (2) they would be aware of many of the issues affecting the community, (3) they would be highly skilled and trained, and (4) they would adopt a holistic approach to healthcare. The initial reaction towards CHW's from nurses and other health workers may one of suspicion; CHW's may not be viewed by other health workers as having the necessary skills and training to perform in a health role. Such potential suspicion could be prevented by consultation with workers during the planning process of a community health project. (HE9401410)

031

### Churches Health Resources Center.

**Form:** Program.

**Corporate Author:** University of North Carolina at Chapel Hill, School of Public Health.

**Author:** Hatch, J.

**Availability:** CB 7400, Rosenau Hall, Chapel Hill, NC 27599-7400. 1988-continuing.

**Abstract:** The Churches Health Resource Center of the University of North Carolina School of Public Health provides technical assistance to emerging networks of church-based health promotion and risk reduction programs in North Carolina and South Carolina. At present, there are seven such projects in operation. Most are sponsored by conferences, conventions, and clusters of churches associated with traditionally black denominations. Consequently, they have focused on addressing health conditions that affect blacks disproportionately, including (1) cardiovascular risk reduction through exercise, diet, and smoking cessation; (2) educating church laypersons to lead support groups for stress management, arthritis, and hypertension; (3) knowledge and attitude change about cancer control; and (4) organizing female church members to do outreach among young women and infants. Other church organizations are also encouraged to include health promotion in their missions of service in the Carolinas and are provided with planning assistance. The Health Resources Center serves as a clearinghouse by providing health statistics and culturally appropriate print and audiovisual media. The Center produces other educational materials, edits a newsletter, and sponsors annual conferences and workshops. An oversight board including church leaders, health services providers and administrators, and persons from the academic community is being formed to guide activity development. (HE89P0580)

032

### Community Health Advocacy.

**Form:** Book chapter.

**Author:** Kohn, S.

**Source:** IN: Handbook of Health Education. Second Edition. Lazer, P.M.; Kaplan, L.H.; Gordon, K.A.; eds. Rockville, MD, Aspen Publishers, pp. 261-278, 1987.

**Availability:** Aspen Publishers, 200 Orchard Ridge Drive, Gaithersburg, MD 20878.

**Abstract:** Community health advocacy is a process which involves the members of a community in identifying symptoms, diagnosing causes, and developing strategies to prevent unnecessary illness at the community level. Community Health Advocacy, a book chapter in Handbook of Health Education, (1) presents two projects which illustrate the types of programs that aim to promote social change while simultaneously offering health services, (2) identifies factors that can facilitate or prevent an advocacy approach, and (3) examines the roles that health professionals play in making an advocacy approach work. The health advocacy programs presented as case studies are the Montefiore Medical Center Community Health Participation Program (CHPP) and The Hub, A Center for Change for South Bronx Teens. The CHPP staff and volunteer coordinators have been responding to the needs of a changing community for over 10 years. The program offers Health Coordinators, educational forums for the community at large, and the neighbor-to-neighbor provision of health information and services. Through the CHPP, people of diverse ages and cultural backgrounds work closely together to promote the health of their community. The Hub, a much younger program, has also developed a role for adolescent community residents in the delivery of services. Peer teachers and youth service workers have become advocates for all of the adolescents served by the Hub. The Hub has

also been instrumental in creating new legislation designed to improve services for adolescents at the State and Federal levels. Both the CHPP and The Hub involve community residents in the improvement of the health and medical care of their neighbors and use an advocacy approach to promote the rights and future well-being of high risk adolescents. Factors that can facilitate or prevent an advocacy approach include type of agency, funding, political climate, and support of other organizations. Health professionals can choose from several approaches when working toward health advocacy. These approaches include (1) documentation (inadequate services or prevalent health problems should be reported either within the agency or externally); (2) education and training (clients, staff, and community officials can be educated about the need for addressing problems more effectively); (3) research (research into a problem may shed new light on a long-standing situation and thereby lead to a new solution); (4) networking (forming a coalition can be one of the most effective means of attracting attention and marshaling resources to attack a health problem); and (5) working with elected officials and legal strategies (elected officials will be motivated to support a project if it can be demonstrated that their constituents support the project or its goals). The potential benefits of community health advocacy include (1) better service delivery; (2) new legislation; (3) additional funding for existing services, or new funding for new services; and (4) strengthened community organizations. 2 figures, 2 tables, 13 references. (HE9401373)

033

**Community Health Advocacy Training Project.****Form:** Program.**Corporate Author:** Women's Health Exchange, University of Illinois at Chicago.**Author:** McElmurry, B.J.; Swider, S.M.**Availability:** College of Nursing, University of Illinois at Chicago, 845 South Damen Avenue, Chicago, IL 60612. (312) 996-3035 or (312) 996-7393. April 1, 1987-continuing.

**Abstract:** The Community Health Advocacy Training Project of the University of Illinois at Chicago is a program to foster trust and collaboration between health care professionals and community residents by educating women to work with a public health nurse to: (1) provide health information and referrals and (2) collect information about health issues in their neighborhoods. The health advocacy training program selects young women from poor urban neighborhoods to receive 160 hours of education, half in the classroom and half in the neighborhood. Goals are to provide women's health education, to teach advocacy skills, and to foster career awareness. The health education component focuses on issues relevant to urban women. Formal presentations cover topics such as health care, child care, violence against women, life cycle changes, nutrition, health promotion issues, and sexuality. Nurse practitioners give each trainee a health history and physical examination, with referral as appropriate. Trainees then work with nurses to respond to community health concerns in coordination with other programs, networking with local health services and cooperating with the University. Collaborative activity of the first group resulted in a community health assessment and development of an interview guide to survey the health concerns of neighborhood residents. Evaluation of the first

demonstration project indicated the effectiveness of the education programs. (HE89P0021)

034

**Community Health Advocate.****Form:** Journal article.**Author:** Callen, W.B.; McClurken, S.**Source:** Journal of Allied Health. 267-274, November 1981.

**Abstract:** Researchers review the development of an academic training program for rural and urban community health workers (CHW's) in Washington State and describe a needs assessment and job task inventory. The organizational and cost factors involved in the design of a decentralized training model are presented along with an outline of the formal curriculum established after pilot testing. The 1-year curriculum includes 3-4 days per month of classroom work with equal attention paid to assessment of common medical problems and to health education and counseling. The training model consists of 300 hours of instruction, 300 hours of one-on-one clinical instruction, and 1,000 hours of directed practicum over a 1-year period. Integrated with the didactic work is a full year of practical community health training under the guidance of a licensed practitioner (physician, physician assistant, or nurse practitioner). Three program goals are identified: (1) Establishment of health career entry-level training, (2) service to minority populations, and (3) certification for career mobility. Researchers discuss and evaluate these goals in relation to current progress of the program. Of the 60 students who entered the training, 80 percent completed it or are expected to complete it after pregnancy. The student body is almost exclusively from minority groups, especially Native American. Most are female (85 percent), between 21-45 years old. In the



first 2 years, classes were small and student applications were few, but this picked up, which indicates the demand for this training program. 2 tables, 5 references. (HE9401233)

035

### **Community Health Education: The Lay Advisor Approach.**

**Author:** Service, C.; Salber, E.J.; eds.  
**Source:** Durham, N.C., Duke University, Department of Community and Family Medicine, Community Health Education Program. 112 p., 1977.

**Abstract:** Guidelines for implementation of the lay advisor approach to health education and counseling are provided for those interested in the health facilitator concept. Topics include staffing of the facilitator program, hiring and training community coordinators, making the program known to the community, identifying, recruiting, and training facilitators, applying the health facilitator concept in four New Mexico communities, using videotape techniques in the facilitator program, evaluating the facilitator program, and using resource personnel. A profile of a health facilitator and forms for use in programming are appended. (HE7900126)

036

### **Community Health Representative: A Changing Philosophy of Indian Involvement.**

**Form:** Report.

**Corporate Author:** US Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Indian Health Service, Office of Program Development.

**Source:** Tucson, AZ, US Department of Health, Education, and Welfare, Public Health Service, Health Services and Mental Health Administration, Indian Health Service, Office of Program Development, 12 p., 1969.

**Availability:** Out of Print.

**Abstract:** The Indian Health Service (IHS) of the U.S. Public Health Service initiated a Community Health Representative Program which emphasizes Native-American involvement in community health. A major goal of this program is to satisfy two recognized needs: (1) The need for greater involvement of Native Americans in their own health programs and greater participation by Native Americans in the identification and solving of their health problems, and (2) the need for greater understanding between Native Americans and the IHS staff. The Community Health Representative Program is designed to provide Native-American communities with a representative who is capable of using his or her knowledge of the community, combined with the sound principles of community development and outside resources, to assist the community in the solution of health problems. This program is unique in the history of IHS relationships with Native-American tribes because of its elements of coordination and financial control. Although funded by the IHS in a contractual agreement with the tribes, each tribe develops a program which is the most responsive to specific needs, selects the individuals to serve as representatives, and selects tribal members to

administer and coordinate the program. The IHS provides training for the Community Health Representative Program in cooperation with the individual tribes. Curriculum content for the 4 week intensive training period focuses on (1) communications skills and techniques, (2) socio-cultural concepts, (3) concepts of health and disease, and (4) technical skills. IHS officials initiated a study to elicit attitudes toward and expectations of the program from both Native-American and IHS participants. The study focused on three important areas in the development of the Community Health Representative Program: (1) Objectives of the program, (2) areas of expected impact, and (3) possible problem areas. After 1 year of operation, researchers reviewed the program with respect to the attitudes and expectations addressed in the study. (HE9401378)

037

**Community Outreach Guidance: A Strategy for Reaching Migrant and Seasonal Farmworkers. Final Draft.**

**Form:** Report.

**Corporate Author:** National Outreach Advisory Committee.

**Availability:** National Clearinghouse for Primary Care Information, 8201 Greensboro Drive, Suite 600, McLean, VA 22102. (703) 821-8955.

**Abstract:** A report from The Office of Migrant Health provides Migrant Health Centers and Migrant Health Programs with assistance in implementing necessary systems for effective community outreach programs. The five chapters describe (1) Community Outreach, (2) Components of Community Outreach, (3) Planning a Community Outreach Strategy, (4) Orientation for Community Outreach Workers, and (5) Effective Models of Community Outreach. The last chapter

presents examples of four types of community programs: (1) Peer counselor models, (2) statewide models, (3) multidisciplinary models, and (4) paraprofessional models. The programs described are (1) Camp Health Aide Program (CHA) in Detroit, Michigan; (2) Migrant Lay Health Advisor Program (LHA) in Chapel Hill, North Carolina; (3) El Nino Sano in Hood River, Oregon; (4) Un Comienzo Sano/Health Start in Tucson, Arizona; (5) Consolidated Outreach Program (COP) in Indianapolis, Indiana; (6) East Coast Migrant Health Project (ECMHP) in the District of Columbia; and (7) Colorado Migrant Health Program (CMHP) in Denver, Colorado. Eight appendixes include (1) a job description for an Outreach Coordinator, (2) a job description for a community outreach worker and a health promotor, (3) an outreach screening form, (4) an outreach encounter form, (5) a grower profile, (6) a camp profile, (7) a referral form, and (8) an outreach medical kit. 21 references. (HE9401376)

038

**Development of a Community Health Worker Outreach and Health Promotion Program.**

**Form:** Paper.

**Author:** Fedder, D.O.; Monsanto, H.A.; Curry, S.; Nichols, G.; Chang, R.

**Availability:** Dr. Donald O. Fedder, Project Director, Community Health Worker Outreach Program, School of Pharmacy, University of Maryland at Baltimore, Allied Health Building, Suite 240, 100 Penn Street, Baltimore, MD 21201. (410) 706-5044.

**Abstract:** Health professionals describe the development and implementation of the Community Health Worker (CHW) Outreach Program, a service program in Baltimore, Maryland, aimed at identifying and training volunteers to use secondary prevention



techniques to help medical assistance patients with diabetes mellitus or high blood pressure (1) reduce morbidity and mortality, (2) maintain better control of their illnesses, and (3) improve their therapeutic outcomes. The CHW outreach program was developed by a 24-member advisory committee consisting of physicians, health educators, community leaders, and government officials. A practitioner panel determined the appropriate patient inclusion/exclusion criteria. A training subcommittee formulates the training goals and objectives, develops the training manual, identifies the speakers, and reviews training materials. A community outreach subcommittee informs community residents and professionals about the program, identifies appropriate sources for volunteer and patient recruitment, and identifies resources within the community to assist patients in need. Indigenous volunteers who were literate, willing to make a commitment to help people, and residing within nine zip code areas in West Baltimore were recruited. Following a structured screening process, volunteers complete a 40-hour training program that focuses primarily on the management of diabetes mellitus. Volunteers are then assigned patients to begin their initial field training (approximately 4-6 months). As trained CHW's, the volunteers contacted patients weekly, alternating a brief telephone consultation with an indepth home visit. The CHW's reinforced physician instructions to adhere to all aspects of the therapeutic regimen, monitored for therapeutic effects and signs and symptoms of complications, and assisted the patient in keeping scheduled medical appointments. As of July 1993, the program had held four training classes and 38 CHW's were actively monitoring 195 patients. Preliminary data suggest that CHW's were successful in promoting healthy behaviors. It is anticipated that this will result in a decrease in the use of costly emergency care and

unnecessary, preventable hospitalizations. 3 tables, 14 references. (HE9401415)

039

### Family Health Worker.

**Form:** Journal article.

**Author:** Wise, H.B.; Torrey, E.F.; McDade, A.; Perry, G.; Bograd, H.

**Source:** American Journal of Public Health. 58(10):1828-1838, October 1968.

**Abstract:** Researchers describe the philosophy behind the creation of the family health worker, the methods of selection, the training program, and their functioning as part of a family-care team. The Neighborhood Medical Care Demonstration was developed by the Division of Social Medicine of Montefiore Hospital in the Bronx, New York in the late 1960's. The two primary goals of the project were to provide a facility which coordinated all outpatient services in areas where poor patients predominated, and to encourage intensive participation of neighborhood residents in the operation of the health center. The family health worker was created as part of the effort to achieve these goals. In selecting family health workers, preference was given to unemployed heads of households and to trainees who, during an 8-week core training program, showed maturity, warmth, and interest in social advocacy and demonstrated the ability to function as a team member. The first 8 weeks of training consisted of a core curriculum, which covered basic health skills, a survey of health careers, community resources, and remedial training in English and mathematics. In the remaining 16 weeks of training, two-thirds of the time was allotted to health skills and one-third to community resources. Anecdotal material from the health center's records is provided to give an idea of the functions of the family health worker. Problems which developed



during the creation of the health worker program included (1) the difficulty of envisioning a job where no model existed, (2) the varying perceptions of what the health workers' job should be, (3) the difficulty that health professionals had of accepting the health workers as equals, and (4) the difficulty of balancing the training curriculum between the desire for clarity and the need for flexibility. The curriculum outline for the training program is provided in an appendix. 9 tables, 4 references. (HE9401493)

040

**Guidelines for Training Community Health Workers in Nutrition. Second Edition.**

**Form:** Manual.

**Corporate Author:** World Health Organization.

**Availability:** World Health Organization, Publications Center USA, 49 Sheridan Avenue, Albany, NY 12210.

**Abstract:** Guidelines for Training Community Health Workers in Nutrition is divided into two parts. Chapter one introduces the guidelines, and chapter two discusses teaching skills. Chapter three presents basic facts about foods to help trainers focus on the basic nutritional knowledge that community health workers need in order to work effectively. The guidelines are designed to train a community health worker to improve nutrition in his or her area by learning in a practical way the most important things he or she will need to know and do. The guidelines are based on the following considerations: (1) Training should be directed to the performance of specific tasks, (2) the community health worker should be trained to perform a limited number of practical tasks, (3) training requires maximum participation by the trainees, (4) trainees should have a strong motivation to learn their job and to serve the community, (5)

training should be given near the community in which a trainee will be working later, (6) the whole community must participate as much as possible in solving their own problems, (7) duration of training depends upon the educational background of the trainees, and (8) training is not necessarily completed in a set period of time. The second part of the book presents nine training modules: (1) Getting to know the community; (2) measuring and monitoring growth and nutrition; (3) promotion of breast feeding; (4) nutritional advice on feeding young children; (5) nutritional care of mothers; (6) identification, management, and prevention of common nutritional deficiencies; (7) nutritional care during diarrhea and other common infections; (8) conveying nutrition messages to the community; and (9) solving nutritional problems in the community. Each module presents learning objectives, training content, training methods, and exercises. (HE9401404)

041

**Health and Human Services Project (1983 Secretary's Community Health Promotion Award for Excellence).**

**Form:** Program.

**Corporate Author:** North Carolina General Baptist State Convention.

**Author:** Jackson, C.

**Availability:** 603 South Wilmington Street, Raleigh, NC 27601. Continuing. Verification requested, 1988; no response received.

**Abstract:** Outstanding Characteristics: Uses Baptist churches throughout the State as basis for health promotion; reaches underserved black communities; provides training to lay church members who act as health advisors to the congregations; builds on communication networks already established in the community. I. Target Audience: The black population in North Carolina; congregations of

churches belonging to the North Carolina General Baptist State Convention; especially persons at risk to develop hypertension, maternal and child problems, and diabetes. II. Specific Objectives for the Nation: High Blood Pressure Control, Pregnancy and Infant Health, Nutrition. III. Setting: Churches and other meetings places and health service facilities in North Carolina. IV. Goals and Methods: Recognizing the disparity between North Carolina blacks and whites in terms of health status and acknowledging the church's traditional supportive and guiding role for black Americans, the North Carolina General Baptist State Convention established the Health and Human Services Project. This innovative program is designed to strengthen and formalize the church's role in health promotion and disease prevention by linking the resources of health services with the network of community persons who, identified as natural helpers, directly assist members of the black community. The program's goals are (1) to train local community helpers and (2) to provide an institutional support base for health promotion, working at congregational, regional, and State levels. The lay advisors are chosen at the local congregational level, nominated by church members. The project staff provides for their orientation. In 10 weekly training sessions, the lay advisors learn to recognize risk factors associated with the targeted health problems: Hypertension, diabetes, and pregnancy-related problems. They also learn to make appropriate referrals, to conduct health information sessions for their congregations, and to teach simple self-care techniques. All sessions are designed and conducted by local health and human service providers, with guidance from the project staff. One objective of the program is to demystify the provider-consumer relationship, thus bringing together the unique resources of each. The second major goal, to provide an institutional base for health promotion activities within the church, is accomplished

through working with the church leadership at regional and State levels. The approach is modeled on other successful and enduring activities such as the Sunday School and the Ladies Missionary Society. Health and Human Services staff members are headquartered in the Convention's State offices. They take every opportunity to meet with church pastors and moderators and with lay leaders, and they assist with focusing on health within the church. They also coordinate the input of providers in the local communities who serve as resource persons for training sessions. The lay advisors are viewed as perhaps the most important people in the program. They are an invaluable natural resource, and they give their help voluntarily. A technical advisory board of university, health department, and other expert members assists the project with training, program design, and evaluation. V. Evaluation: An illustrative case history of a lay health advisor is described as an example of the project's results. Formal evaluation adapted to the church environment used three different assessment instruments: (1) the Profile Questionnaire, (2) Knowledge Tests, and (3) the Helping Behavior Questionnaire. Detailed analysis of these can be summarized by concluding that the project (1) has attracted stable and mature lay advisors, (2) has presented training programs that are successful regardless of education differences, and (3) appears to be changing patterns in the black community of both self-care practices and utilization of information and services. VI. Continuation Plans: The Health and Human Services Project has received enthusiastic support from churches, the academic community, and others interested in improving the health of black people. The structures developed by the church will further develop and will continue to enable the community to provide new and innovative ways to meet its needs. (HE84P0551)



042

**Health Care Delivery in Rural Alaska.****Form:** Journal article.**Author:** McCracken, H.**Source:** Hospital Forum. 21(5):13-15, November-December 1978.

**Abstract:** This overview of health care delivery in rural Alaska includes discussions of (1) community health aides (CHA's), (2) the five satellites that serve Alaska, and (3) Project Media. In order to meet the health care needs of rural Alaska, the Indian Health Service (IHS) developed health delivery systems that employ CHA's. The CHA's are local people who undergo formal training for approximately 10 weeks. In addition to providing acute and emergency care, CHA's provide health surveillance and other preventive health care services. An extensive community health aide manual directs CHA's in general care and is especially helpful when they are unable to contact their medical supervisors for advice. Satellite telecommunications have helped to solve the geographic and meteorological barriers to rural health care in Alaska. With project funds received from the National Library of Medicine (NLM), 26 villages were connected with the Tanana Region Hospital and Anchorage via the ATS-1 (application technology satellite). In this program, medical aides in the villages could contact the hospitals for medical information and advice. Subsequently, the Governor's Office of Telecommunications conducted an experiment in which video transmissions via the ATS-6 satellite enabled physicians to provide supervision, guidance and consultative and diagnostic support to paramedical personnel in remote villages. The video system was supported by biomedical telemetry and a comprehensive patient data system. Alaska is served by three other satellites: SatCom I, SatCom II, and Westar II. Project Media began in 1978 and ran for 3 years. The

project was funded under the Nurse Training Act, and sought to extend continuing education to all registered and licensed practical nurses through the use of satellite TV, radio, and other media. At the conclusion of the project, instructional methods and materials that had been developed were integrated into the existing continuing education structure. (HE9401398)

043

**Health Education Training Model.****Form:** Teaching guide.**Corporate Author:** Hesperian Foundation, Palo Alto, CA.**Availability:** Available from ERIC. Order No. ED-254 659.

**Abstract:** A manual has been prepared for preservice and inservice training of Peace Corps community health volunteers. The purpose of the training manual is to help community health workers become better facilitators and educators as they help motivate people toward a healthier and more self-reliant life. The introduction provides suggestions for preparing for and carrying out the training program. The 12 training sessions cover the following topics: (1) defining expectations and clarifying objectives of health education training; (2) identifying group needs and resources and setting up committees; (3) Project Piactla, an example of community health and education; (4) exchanging ideas about health education; (5) group dynamics and facilitation skills; (6) how people learn; (7) the role of the Peace Corps volunteer as a community health worker; (8) identifying community needs and resources; (9) teaching about important health issues; (10) developing and using storytelling as a teaching aid; (11) creating low-cost materials and equipment; and (12) the health fair. Each session includes objectives, an overview, lists of resources and



materials, preparation needs, activities, and handouts. Appendixes include information on working with a group, evaluation ideas, a calendar for a 10-day training program, and a listing of selected resources and references. (HE8600339)

044

### **Home Visiting: A Promising Early Intervention Service Delivery Strategy.**

**Form:** Report.

**Corporate Author:** US General Accounting Office.

**Availability:** US General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20884.

**Abstract:** Home Visiting: A Promising Early Intervention Service Delivery Strategy is a report to the Subcommittee on Government Activities and Transportation, Committee on Government Operations, House of Representatives. The report discusses home visiting as a method for delivering preventive health and social services to women and their families. The remarks come from a July 1990 report that reviewed literature and interviewed experts to assess the nature, scope, and effectiveness of home visiting. Through case studies of eight home visiting programs in Great Britain, Denmark, and five American States, researchers identified design traits important to the development and operation of effective home visiting programs. Home visiting is a promising strategy for delivering early intervention services, especially for vulnerable populations. In addition to working with families in their homes, home visitors can help them access other center-based services. Such services can improve the health and well-being of pregnant and parenting women and their children, particularly those at risk for poor outcomes. Home visiting involves coaching, counseling, teaching, referrals to other providers, and hands-on health care,

focusing on the establishment of trust and support that motivates a woman and her family to seek and remain in care. After describing several aspects of the different home visiting programs studied, the report identifies characteristics that strengthen the design and implementation of home visiting services and explains the need for more research on five areas of effective home visiting service designs. (HE9401262)

045

### **Home Visiting: A Promising Early Intervention Strategy for At-Risk Families.**

**Form:** Report.

**Corporate Author:** US General Accounting Office.

**Availability:** US General Accounting Office, P.O. Box 6015, Gaithersburg, MD 20884.

**Abstract:** Home Visiting: A Promising Early Intervention Strategy for At-risk Families is a report to the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate. The report reviews home visiting as an early intervention strategy to provide health, social, educational, and other services to improve maternal and child health and well-being. Families that are poor, uneducated, or headed by teenage parents often face barriers to obtaining health care or the social support services they need. Home visiting may be an effective way to reduce these barriers. Researchers believe that using home visiting to deliver or improve access to early intervention services such as prenatal counseling, parenting instruction for young mothers, and preschool education can address problems before they become irreversible or extremely costly. The report describes (1) the nature and scope of existing home visiting programs in the United States and Europe, (2) the effectiveness of home visiting, (3) strategies critical to the

design of programs that use home visiting, and (4) Federal options for the use of home visiting. The report indicates that home visiting can be an effective service delivery strategy, and it notes characteristics that can strengthen program design and implementation. These characteristics include clear objectives, a well-defined target population, a plan of structured services, trained home visitors, sufficient linkages to other community services, systematic evaluation methods, and long-term funding. The report suggests that Federal commitment could be better coordinated and focused. Five appendixes offer (1) a description of the eight home visiting programs examined by the General Accounting Office, (2) a description of what happens on a home visit, (3) comments from the Department of Education, (4) comments from the Department of Health and Human Services, and (5) a list of major contributors to the report. (HE9401261)

046

**Implementation of the Indigenous Model for Health Education Programming Among Asian Minorities: Beyond Theory and Into Practice.**

**Form:** Journal article.

**Author:** Chen, M.S.; Zaharlick, A.; Kunn, P.; Li, W.L.; Guthrie, R.

**Source:** Journal of Health Education. 23(7):400-403, November-December 1992.

**Abstract:** The authors (1) describe the setting for the first Office of Minority Health (OMH)-funded Minority Community Health Demonstration Grant Project (MCHDGP) targeted at Southeast Asian minorities (Cambodians, Laotians, and Vietnamese); (2) explain how the theoretical basis of the Indigenous Model (IM) was implemented; and (3) offer lessons learned and suggestions for future minority health programs. Researchers

received funding from OMH for a 2-year project, Heart Health for Southeast Asians in Franklin County, Ohio. At the core of the IM is the belief that hypertension control is best achieved through (1) individuals most accessible to the target population; and (2) using a nationally standardized, technically correct protocol frequently, conveniently, and in multiple ways. The project hired 18 bilingual cadre the first year and 13 more the second year, using this ethnic staff to implement the IM. The authors provide three examples of how the model was applied. Suggestions based on lessons learned include that (1) decision making on what works should be deferred to the leadership of the targeted minority population; (2) planners should consider the use of nontraditional means of evaluating and tracking minority health project interventions and project penetration, such as through gifts of a calendar with health messages or the use of health messages spliced into entertainment videos; and (3) program staff should be willing to adapt to the lifestyles of targeted minority groups and to direct efforts that leave a positive, lasting change after the project ends. 1 figure, 6 references. (HE9300618)

047

**Indigenous Community Health Workers in the 1960s and Beyond.**

**Form:** Book chapter.

**Author:** Wilkinson, D.Y.

**Source:** IN: Health Issues in the Black Community. Braithwaite, R.L.; Taylor, S.E.; eds. San Francisco, CA, Jossey-Bass, Inc., pp. 255-266, 1992.

**Availability:** Jossey-Bass Inc., Publishers, 350 Sansome Street, San Francisco, CA 94104.

**Abstract:** Indigenous Community Health Workers in the 1960s and Beyond is a chapter



from a book on health issues in African-American communities. The chapter reviews selected studies that offer insights into how community health workers have functioned in the United States and suggests future roles and culturally sensitive models. Also assessed are training programs and the diversity of tasks that paraprofessional health aides have performed, despite similarities in expectations and in their responsibilities. The author describes a 1960's tuberculosis program in New York that employed community paraprofessionals for the first time in the history of the Department of Health. The success of the unique experiment and the subsequent assessments of its effectiveness indicated that neighborhood workers could make meaningful contributions to efforts to control a highly infectious disease like tuberculosis. Since the 1960's, a principle emphasis of health education has been on devising techniques for appraising the usefulness of indigenous workers. In an exemplary infant immunization surveillance program, the impact of referrals on additional service contacts was assessed. The results demonstrated that local helpers influenced a significant number of the referrals reporting immunization. The author notes that current community health workers are the products of the social consciousness and political activity that characterized the civil rights movement and the Peace Corps era. A principal concern of that time period was how to reach African Americans in inner cities and whites in rural areas to provide needed health services. Earlier tasks of community health workers depended on the goals of local or State programs, research project plans, and client needs. Over the past 25 years health aide responsibilities have changed, but two dimensions have remained constant: Acting as a resource to provide health information and assisting with patient education. The author describes an urban high blood pressure control project conducted in Baltimore in 1985.

Researchers interviewed one worker to examine the role obligations, activities, and social placement of health aides within the professional status class structure, centering on the neighborhood worker. Coinciding with the notion of the advantages of shared cultural backgrounds for effective blood pressure control with African-American populations, the lay health worker believed she was in a better position than physicians or nurses to respond to questions from patients. She perceived herself as better able to interpret their reluctance to comply with formal and impersonal medical care regimens. Research indicates that despite variations in their assigned roles, lay health workers have had a significant impact on health education and promotion. 47 references. (HE9401260)

048

### **Involving the Urban Poor in Health Services Through Accommodation: The Employment of Neighborhood Representatives.**

**Form:** Journal article.

**Author:** Kent, J.A.; Smith, C.H.

**Source:** American Journal of Public Health. 57(6):997-1003, June 1967.

**Abstract:** The culturally and socially disadvantaged patient is not really hard to reach if programs accommodate his or her motivational orientation. Researchers examine (1) patient accommodation as a way to recruit disadvantaged persons to health care; (2) the urban neighborhood as the basic unit for organizing health care programs; and (3) employment of indigenous workers to involve disadvantaged patients in the accommodation process. Programs for this population need to include social action; immediate problems need immediate solutions before health care is a priority. Programs can be designed to accomplish particular goals unique to each neighborhood. Neighborhood representatives,



hired to represent their own disadvantaged neighborhood, provide a link between health professionals and low-income clients. Selection criteria for such representatives include that they be identified with the subculture being served; possess subculturally oriented communication skills; live in the neighborhood, preferably for some time; have a value for work; be accepted as a member of the neighborhood; be socially mobile; have an identifiable value for health care; not be a member of a group identifiably middle-class; and be a female over age 35. Training of representatives is not a formal, classroom-oriented affair but rather a continuous process. After a 2-day orientation concerned with project goals and philosophy, representatives are immediately involved in unstructured, problem-oriented training within their neighborhoods. Trainees then go out on their own to discuss a new health clinic with neighbors. Traditional supervision is minimal. As a somewhat independent worker, the representative has three functions: That of service expediter, neighborhood organizer, and patient representative. A measure of progress is that use of clinic services increased 42 percent during the same period of time in neighborhoods served by representatives when compared with those without representatives. 5 references. (HE9401202)

049

**Learning to Teach: Training of Trainers for Community Development.**

**Form:** Manual.

**Author:** Vella, J.

**Availability:** OEF International, 1815 H Street, NW., 11th Floor, Washington, DC 20006. Save the Children Federation, P.O. Box 950, Westport, CT 06881.

**Abstract:** The manual Learning to Teach facilitates training workshops for Save the

Children Federation field staff and their partners in development around the world. Training of Trainers (TOT) is an effort to change the teaching model from formal to informal education. Nonformal adult education (NFE) is a structured system of teaching and training based on the needs of learners and their experiences. NFE differs from formal education in (1) the relationship between learner and teacher, (2) the goals and objectives of the learning experience, and (3) the methods of teaching and evaluation. In TOT, both the learner and the facilitator expect to be able to use new skills and knowledge at the end of training. The manual describes the structure of TOT, offering guidelines for 25 sessions to the trainer who is designing and leading a TOT. Sessions include (1) Introductions and Warm Up; (2) Setting Objectives and Describing the Program; (3) Expectations of the Learners; (4) How Adults Learn; (5) Respect, The Most Important Factor; (6) Adult to Adult Relationships for Communication; (7) Safety; (8) Seven Steps of Planning; (9) What is To Know?; (10) Banking versus Problem Posing Education; (11) Using Pictures, Sociodrama, Stories, Found Objects; (12) Open Questions; (13) Why Small Groups; (14) How Groups Work; (15) Setting Tasks; (16) Meeting Resistance; (17) Learning Needs Analysis; (18) A Framework for a Session; (19) Feedback; (20) Accountability; (21) Engagement; (22) Evaluation of Learning; (23) Practice Teaching; (24) Second Practice Teaching; (25) Summary and Closure. Appendixes include warm up activities and more books for nonformal education. TOT, as presented by the manual, has been performed with over 500 Save the Children staff in the United States, Africa, Asia, Latin American and the Middle East. (HE9401497)

050

**Migrant Lay Health Advisors: A Strategy for Health Promotion. Volume I.**

**Form:** Manual.

**Corporate Author:** Department of Maternal and Child Health.

**Availability:** Department of Maternal and Child Health, C.B. no. 7400, School of Public Health, University of North Carolina, Chapel Hill, NC 27599-7400. (919) 966-5979.

**Abstract:** Migrant Lay Health Advisors: A Strategy for Health Promotion (Volume I) is a resource guide for those interested in developing peer counselor health education programs. Lay health advisors in the Maternal and Child Health Migrant Project are members of the migrant community and share a number of important factors: Language, social class, education, and life situation. Women are recruited based on their perceived natural ability to be caring and empathetic helpers. Program content focuses on issues important to maternal and child health as well as leadership and accessing of service skills. The project is based at the Tri-County Community Health Center (TCCHC) in Newton Grove, North Carolina, a federally funded health facility serving North American, Hispanic American, and Haitian migrant and seasonal farmworkers. Project goals were to (1) improve pregnancy outcomes of migrant farmworker women and the health status of children between ages 0-5 who receive care at TCCHC and (2) demonstrate the effectiveness of lay health advisors in disseminating accurate, culturally appropriate health information to this population and linking them with health and social services. The report has four main sections. Part I is a review of the literature (self-care literature review; who are lay health advisors and why are they important to health intervention; and community health for migrants: The uses of community health workers). Part II consists of a strategy for

health promotion using migrant lay health advisors; a section on collaboration of students; reflections from the fields; and feedback from trainers. Part III includes resources (session plans, resource list, and bibliography), and Part IV is an appendix that includes relevant charts and forms. (HE9401212)

051

**Migrant Lay Health Advisors: A Strategy for Health Promotion. A Program Evaluation, Volume II.**

**Form:** Manual.

**Corporate Author:** Department of Maternal and Child Health.

**Availability:** Department of Maternal and Child Health, School of Public Health CB no. 7400, University of North Carolina, Chapel Hill, NC 27599.

**Abstract:** Migrant Lay Health Advisors: A Strategy for Health Promotion, A Program Evaluation (Volume II) is a resource guide for those interested in developing peer counselor health education programs. Lay health advisors (LHA's) in the Maternal and Child Health Migrant Project are members of the migrant community and share a number of important factors: Language, social class, education, and life situation. Women are recruited based on their perceived natural ability to be caring and empathetic helpers. Program content focuses on issues important to maternal and child health as well as leadership and accessing of service skills. The project goal is to improve the perinatal and infant outcomes among migrant women and infants receiving care in North Carolina between October 1, 1987 and September 30, 1990. Most project participants were Hispanic American, although women and infants of all ethnic groups were included in the study. Chapter 1, A Health Promotion Strategy for



Farmworker Women and Children, describes the project background and setting. Chapter 2, The Application of a Network Approach, presents the concept of social support and social networks applied to the LHA program as an intervention in improving the health status of migrant farmworker families. Chapter 3, Evaluation and Preliminary Findings, reports on the methodology and preliminary data analysis. An appendix includes consent forms, recruiting leaflet, session plans, resource list, hypotheses and research questions, and evaluation tools (prenatal and child data collection forms, LHA profile, pretest/posttest of knowledge and attitudes, exposure questionnaire, and helping contacts questionnaire). 26 references. (HE9401213)

052

**Model to Nationally Replicate a Locally Successful Rural Family Caregiver Program: The Volunteer Information Provider Program.**

**Form:** Journal article.

**Author:** Halpert, B.P.; Sharp, T.S.

**Source:** *Gerontologist*. 29(4):561-563, August 1989.

**Abstract:** Successful human service programs are often confined to their place of origination. Researchers discuss the strategy and key elements that worked to take the Volunteer Information Provider Program (VIP) from its origination site in Missouri to national replication. The VIP, an information sharing program to assist rural family caregivers of older adults, was successfully transplanted from Missouri to 20 additional States within one year. The VIP contained the seeds for its own dissemination at its inception. The original pilot in Missouri involved national organizations, the National Extension Homemakers Council (NEHC), and

Cooperative Extension Services (CES), which could span State boundaries. NEHC and CES provided the volunteers and professionals at both the State and local levels. To disseminate the VIP program, State teams received training; these teams then trained county teams in the same manner. The county teams then recruited and trained 10 to 15 Volunteer Information Providers (VIP's). Volunteers were drawn from local service organizations. They were asked to assist a minimum of 2 caregivers each over a 3-month period. The national success of transplanting the local VIP rested upon six key elements: (1) The VIP demonstrated that the existence of a need for rural family caregiver programs was crucial to its dissemination and replication; (2) while need was a generating factor, the efficiency of the VIP provided an economic solution for communities to help caregivers; (3) the national dissemination and replication of the VIP was made possible by the availability of effective community-based networks; (4) the program's success depended on carefully developed and tested educational materials; (5) a well-designed training model worked to instill confidence at the State level; and (6) the success of the program's dissemination depended on the continuing nurturance of the trainers and volunteers in each State. 3 references. (HE9401381)

053

**Natural Helpers as Street Health Workers Among the Black Urban Elderly.**

**Form:** Journal article.

**Author:** Milligan, S.; Maryland, P.; Ziegler, H.; Ward, A.

**Source:** *Gerontologist*. 27(6):712-715, December 1987.

**Abstract:** Researchers describe Project GOH (Golden Age Outreach for Health), a neighborhood-based, volunteer geriatric health



outreach program developed by a consortium of health and social agencies. Project GOh was established in 1979 to enhance the network of natural helpers in an African-American, urban, low socioeconomic community in Cleveland, Ohio. The goal of the project was to promote the health and social well-being of persons 60 and older in the neighborhood by using natural helpers as Street Health Workers (SHW's). SHW's routinely visited neighbors, identified emerging social and health problems, and helped neighbors to locate community resources. Local, philanthropic, and public organizations provided funding for the project. Men and women ranging from 45 to 70 years old were selected as SHW's. The predominance of elderly females requiring service resulted in a preference for females to provide services. A training program was held over an 8-week period, integrating social and physical health knowledge and skills with field practice. By 1985, 45 SHW's provided services to 1,568 residents living on 42 streets in the neighborhood. Evaluation of SHW's training sessions through pretests and posttests provided feedback on the training process and training methods. Content was modified as a result of the evaluations. In 1986, a neighborhood survey was conducted to assess the level of awareness, perceived quality of service, and service utilization of Project GOh. The neighborhood residents were generally aware of Project GOh's services and location (83.6 percent), knew how to contact the office by phone (65.1 percent), and were generally satisfied with the quality of the service (as rated excellent to good by 69 percent). 12 references. (HE9401357)

054

### **Provision of Health Care in a Frontier Setting: An Alaskan Perspective.**

**Form:** Journal article.

**Author:** Berner, B.J.

**Source:** Journal of the American Academy of Nurse Practitioners. 4(3):89-94, July-September 1992.

**Abstract:** An instructor with the Alaska Area Native Health Service (AANHS) provides an overview of the Community Health Aide Program (CHAP) and assesses its implications as a health care delivery model for other underserved areas of the United States. Health care problems in Alaska are significant and unique. Long distances and high travel costs restrict patient use of regional hospitals. As a result, many people must stay in their villages and obtain care from Community Health Aides (CHA's). CHA's receive 10 weeks of intensive, hands-on didactic and clinical experience. All CHA's are expected to become certified. Certification includes (1) the completion of basic training, (2) 600 hours of field experience, (3) the completion of a list of 140 necessary skills, (4) 30 hours of direct patient care under supervision, and (5) a three-part certification examination. Most CHA's finish training and become certified within 2 to 3 years. Since CHA training and employment began, there have been significant improvements in life expectancy and reductions in infant mortality, number of persons hospitalized, and length of days hospitalized. Complications of acute diseases such as rheumatic fever have decreased dramatically, probably because of early treatment of presumptive streptococcal pharyngitis. In 1972, there were 69 cases of rheumatic fever in Alaska, while in 1989, only two cases were reported. There are many isolated communities in the United States that could benefit from a program such as CHAP. This program could also function well in urban

settings where there are isolated populations of minority groups who could best be served by people of their own race and background. 17 references. (HE9401363)

055

### **Role of the Health Facilitator in Community Health Education.**

**Form:** Journal article.

**Author:** Salber, E.J.; Beery, W.L.; Jackson, E.J.R.

**Source:** Journal of Community Health. 2(1):5-20, Fall 1976.

**Abstract:** The Department of Community Health Sciences at Duke University Medical Center established a community health education program in two target areas of Durham County, North Carolina. The program trains unpaid lay persons (health facilitators) to whom others already turn for help, to increase their competency for advising and referring community residents to appropriate community resources. In the first training program conducted, middle-aged black women predominated. The training program was given over 3 months and consisted of seven biweekly group meetings as well as regular one-to-one meetings between coordinators and facilitators. Material covered included self-diagnosis, knowledge of specific diseases, self-treatment, use of health facilitators, use of the health care system, the consumer/provider partnership, and health maintenance. Several methods for identifying health facilitators have been developed. Evaluation of the role of health facilitators hinges on designing measures to demonstrate their existence in the community and the impact they make. To be successful, the training of health facilitators should result in improving the quality of the advice they give their fellows. It is also important to assess the cultural acceptability of the facilitators' advice

and to ensure that their helping role in the community is not disturbed by the possible professionalization of their role due to the training program. The health facilitator concept appears to be feasible and to have considerable potential for improvement of the delivery of health services. 4 tables, 29 references. (HE9401234)

056

### **Rural Community Leaders Learn to Provide Health Education.**

**Form:** Journal article.

**Author:** Vail-Smith, K.

**Source:** Health Aims. 4(1):15-16, Spring 1988.

**Abstract:** The Community Health Advocacy Program (CHAP) of Eastern North Carolina uses the natural support system to provide community health education. In this area, as in many communities where health and social services are lacking or inaccessible, residents consistently seek out certain individuals for help with problems. Through CHAP, such natural care givers undergo comprehensive training in health advocacy. The group training program includes topics such as first aid, cardiopulmonary resuscitation, environmental safety and health, nutrition, aging, and maternal and child health. Participants also learn about appropriate utilization of existing services. Upon graduation, the health advocates return to their communities to work singly or in groups, helping to determine their communities' needs and organizing programs to meet these needs. CHAP originated at the Center for Health Services Research and Development at the East Carolina University School of Medicine. It was started as a pilot program in one North Carolina county but has since been replicated in 16 other communities and is in the developmental stages in 25 communities in



North Carolina and Mississippi. The program's success has resulted in the establishment of the National Training Program for Community Health Advocacy. (HE8800644)

057

**Salud Popular: An Ethnographic Study of the Lay Health Beliefs and Health Seeking Behaviors of Hispanic Elderly.**

**Form:** Dissertation.

**Author:** Sanchez, A.L.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 8319453.

**Abstract:** A researcher conducted an ethnographic study exploring the relationship between the utilization of health services by older Hispanics and the degree to which the lay health network, consisting of families and social networks, influenced the type of health care sought and the beliefs and actions associated with the health seeking process. The author explored the lay health care system of elderly Hispanics using multiple anthropological research techniques and minority researchers studying members of their own community. The dissertation has six chapters. Chapter one provides a review of Hispanic health research and discusses major theoretical and methodological trends in the study of the Hispanic health care system. Chapter two addresses the conceptual framework of Hispanic health care, focusing on understanding medical roles in culture using a health systems approach. The author used Kleinman's health systems approach and Chrisman's health seeking process model as a basis for a Hispanic Lay Health Referral System and a Hispanic Lay Health Seeking model. Chapter three discusses the selection of informants/facilitators from the elderly

Hispanic community in Seattle, Washington, for conducting interviews and participating in information gathering. Chapter four gives ethnographic data on the Hispanic elderly, their community, and the details of their daily lives. Data showed that most Hispanic Americans surveyed were foreign born and spent early childhood outside of the United States. Mexico was the most common country of origin. Many subjects reported a history of low wages and discrimination due to ethnicity. Chapter five, Health Beliefs and Health Seeking Behaviors, examines data concerning health beliefs, perceptions, and health seeking behaviors among the Hispanic elderly. The lay health sector was the most relied-upon source of health care for nonacute health problems. The social network of elderly persons played a major role in determining utilization of the different health sectors. Chapter six includes a summary of the major findings, conclusions and implications. The elderly Hispanic person's limited ability to gain adequate access to the modern health care system included the following barriers: (1) Lack of bilingual/bicultural health care providers; (2) lack of awareness of lay health beliefs and behaviors, which have traditional qualities; and (3) limitations brought on by poor health, financial limitations, transportation problems, and conflicting cultural values. The lay health network, with the family at the center, is an important connection between the modern health care system and the Hispanic elderly. (HE9401405)



058

**Seniors Helping Seniors: Training Older Adults as New Personnel Resources in Home Health Care.****Form:** Journal article.**Author:** Heller, B.R.; Walsh, F.J.; Wilson, K.M.**Source:** Journal of Gerontological Nursing. 7(9):552-555, September 1981.

**Abstract:** The Seniors Helping Seniors demonstration training project was conducted by the Department of Nursing of the State University of New York at Farmingdale over a period of 5 years, in cooperation with the Nassau County Department of Senior Citizen Affairs and the Suffolk County Office for the Aging. Federal funds made available under Title III of the Older Americans Act of 1965 partially supported the project. The project tested the feasibility of developing older adult, non-professional volunteers as new personnel resources in home health care. Enrollment in the training program was restricted to residents of Nassau and Suffolk counties 60 years of age or older; a total of 250 seniors enrolled in the training programs. Specific objectives of the training program were (1) to develop participants' abilities to identify the basic health needs of elderly persons; (2) to provide participants with understanding about the common health problems associated with aging; (3) to familiarize participants with common age-related barriers to communication; (4) to develop participants' skills in providing home health support services; and (5) to prepare participants to administer basic first aid in home health emergencies. To evaluate the program, questionnaires which assessed program outcomes in terms of stated objectives were mailed to each of the participants 6 months after completion of training. Compiled surveys indicated that program participants believed that (1) they had a better

understanding of aging and the health needs of older people, (2) they felt confident about their ability to advise and assist their elderly peers, (3) they were better able to care for their own health needs, (4) they had enhanced their feelings about their value to society, and (5) they would like additional training. 7 references. (HE9401354)

059

**Training of Persons for the Delivery of the Staying Healthy After Fifty Program.****Form:** Journal article.**Author:** Kane-Williams, E.; Salisbury, Z.T.; Benson, L.**Source:** Health Education Quarterly. 16(4):473-483, Winter 1989.

**Abstract:** Researchers discuss the process by which volunteers were selected and trained to conduct a national health promotion program for older Americans. The program, Staying Healthy After Fifty (SHAF), was part of a 3-year national project in which the American Association of Retired Persons (AARP), the American Red Cross, and the Dartmouth Institute for Better Health (DIBH) all collaborated. The content and teaching strategies of SHAF were developed and tested during a community study by DIBH for the program Self-Care for Senior Citizens. Modifications of the materials were made by staff of AARP and the Red Cross. Volunteers to be selected as educational team members needed to have skills and interests consistent with job descriptions established by the three participating organizations at the national level. Therefore, teams with the following characteristics were recruited: (1) A registered nurse, licensed practical nurse, nurse practitioner, medical doctor, or physician's assistant; (2) background in social services, education, or lifestyle-related areas; (3) previous work or teaching experience with

adult groups; (4) good communication and group-process skills; (5) interest in self-care and lifestyle issues. Once recruited, potential educational team members (1) participated in educational team workshops; (2) learned clinical health skills; and (3) participated in two structured practica. These practica simulated what the workshop participants would experience in conducting SHAF and provided an opportunity for them to become acquainted with the content and processes contained in the SHAF program. Researchers used a variety of mechanisms to determine the effectiveness and quality of the training: (1) Workshop participants completed pre- and postworkshop questionnaires; (2) core staff made site visits to observe course implementation; and (3) educational team members completed an after-course survey. The training of persons for the delivery of SHAF was successful in preparing persons with competence and commitment to effectively provide older adults with a quality health promotion program. 1 table, 11 references. (HE9401360)

060

### **Using Paraprofessionals in the Arkansas Health Education Programs.**

**Form:** Journal article.

**Author:** Fox, E.L.; Lammers, J.W.; Deere, R.E.

**Source:** Health Education. 9(2):12-13, March-April 1978.

**Abstract:** Use of indigenous homemakers as community health education aides was examined. The paraprofessionals underwent an intensive 3-week, 120-hour training program on specific diseases, basic first aid, and basic home sanitation with an underlying theme of personal responsibility for health care. Aides also received instruction in proper referral measures to direct clients to outlets of

the local health delivery system. Upon being dispatched to a program family, an aide would teach the homemaker one prepared mini-lesson on: (1) effects of living habits on health; (2) use of preventive health practices; (3) determining the proper occasion to practice self-care as opposed to resorting to professional care; (4) effects of a clean home environment on health; and (5) understanding of the local health care delivery system. The outreach program used aides with educational and socioeconomic statuses congruent to those of the client population to ease the atmosphere in which information was presented.

Assessment by means of a family review form, filled out at 6-month intervals by the 121 participating households, showed significant improvement in all categories of health knowledge and maintenance behavior, except dental care and weight loss. This program, which has grown out of the aide concept of Alabama Extension Service's Expanded Food and Nutrition Education program of 1969 and undertaken by the Cooperative Extension Service of the University of Arkansas, seems successful. (HE7900635)

061

### **Where Does Primary Care Begin? The Health Facilitator as a Central Figure in Primary Care.**

**Form:** Journal article.

**Author:** Salber, E.J.

**Source:** Israel Journal of Medical Sciences. 17(2-3):100-111, February-March 1981.

**Abstract:** The majority of illnesses reported by patients are never presented to a doctor. Health facilitators are people to whom others naturally turn for advice, counsel, and support. A pilot program in North Carolina is described in which 39 health facilitators were identified and given training in the recognition of common illnesses, disease prevention, health



promotion, and community resources. For the health facilitator program, researchers chose the rural population of Rougemont/Bahama in Durham County, North Carolina which they had studied since 1973. They also studied an additional target population, that of Bragtown, in the adjoining urban fringe of Durham County. Researchers found few demographic differences between the health facilitators they recruited and the community residents they were to serve. Staff designed a simple contact form and asked facilitators to use it for recording problems brought to them by clients. Types of problems recorded included (1) head colds, (2) excessive drinking, (3) attempted suicide, (4) vaginitis and venereal disease, (5) diabetes, (6) arthritis, (7) hypertension, (8) child rearing problems, (9) marital problems, (10) job and unemployment problems, (11) housing problems, and (12) problems surrounding nutrition. Tables presented include (1) types of care sought, by illness conditions and race; (2) methods used in the selection of the 39 facilitators for the training programs; (3) a profile of 31 health facilitators who participated in training programs; (4) the type and distribution of problems reported by facilitators; and (5) fact sheet topics prepared for facilitators. The health facilitator model also needs to be tested in urban areas (as well as other rural areas), middle class neighborhoods, low income communities, and other ethnic groups in different areas of the United States and in other countries. While the health facilitator model is applicable to all groups, the concept is particularly suited to ethnically mixed populations, especially when the health professionals are not of the same culture and do not speak the language of the people they are treating. 5 tables, 43 references. (HE9401366)

062

**Women's Health Perspective in Primary Health Care: A Nursing and Community Health Worker Demonstration Project in Urban America.**

**Form:** Journal article.

**Author:** Swider, S.M.; McElmurry, B.J.

**Source:** Family and Community Health. 13(3):1-17, November 1990.

**Abstract:** The Primary Health Care in Urban Communities (PHCUC) demonstration project trains community residents as community health workers to work in two low-income neighborhoods in Chicago, Illinois. The PHCUC project, developed by the Women's Health Group at the College of Nursing, University of Illinois at Chicago (UIC), seeks to implement the primary health strategy in two neighborhoods by training local women as community health workers in these communities. The perspective at UIC on women's health focuses on learning about multiple aspects of women's life experiences: Historical, political, cultural, developmental, and socioeconomic; women's health is concerned with women as both consumers and providers of health care and with empowering women to increase their self reliance and self care in health concerns. The PHCUC project works with women at the community level to help them address community health concerns; the emphasis is on collaboration, essential health services, and community self reliance. Of the two communities involved, one community is primarily black, with a large concentration of families in poverty, living in public housing, and with female single heads of household; the other is a low-income, multiethnic community in which most residents are Hispanic, primarily Mexican-American. Community health workers are community residents who receive special training to bring health services and education to their communities and to mobilize other residents to



## Foundations of Community Health Advisors

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improve health and living conditions. The community determines whether the community health worker is to be a part of the health care system or a change agent who critiques the system. The role of the community health worker is to serve as a bridge between the community and the formal health care system. This role has three components: Translating the communities concerns to the health care system and vice versa; providing linkages between the community and the health care system; and enabling the communities' action to influence their own health and development. The PHCUC effort shares many of the same ideas and problems of similar programs in developing countries. 4 figures, 16 references. (HE9100636)

## Foundations of Community Health Advisors

### Volunteers as Community Health Advisors

063

**AIDS Community Demonstration Projects: Implementation of Volunteer Networks for HIV-Prevention Programs. Selected Sites, 1991-1992.**

**Form:** Journal article.

**Corporate Author:** US Department of Health and Human Services, Public Health Service, Centers for Disease Control.

**Source:** Morbidity and Mortality Weekly Report (MMWR). 41(46):868-869, 875-876, November 20, 1992.

**Abstract:** Many States and cities have introduced the use of community-level intervention projects to prevent human immunodeficiency virus (HIV) infection among hard-to-reach persons. Researchers summarized the methods used by demonstration projects in five cities (Dallas, Denver, Long Beach, New York City, and Seattle) to recruit and retain volunteer networks during 1991 and 1992. Outreach workers from local health departments recruited volunteers during the first year of the intervention. The intervention's objective was to increase condom use and bleach use (for disinfecting needles) among persons at risk by changing the attitudes, perceived risk, self-efficacy, and social norms of the at-risk groups. Volunteers included peers and interactors (members of the community who had frequent contact with persons in the target groups). Project staff at each site conducted interviews and focus groups with volunteers to determine reasons for volunteering and methods for maintaining and improving the networks. Based on data from these efforts, each site developed methods for maintaining and improving the volunteer networks that included (1) offering incentives to provide

volunteers recognition (prizes and media coverage); (2) increasing team-building opportunities for volunteers; (3) informing volunteers of the progress of the project and reinforcing their role; (4) maintaining frequent contact between outreach workers and volunteers; and (5) providing skills during volunteer training sessions for coping with rejection. 9 references. (HE9401372)

064

**Barefoot Doctors in Rural Georgia: The Effect of Peer Selection on the Performance of Trained Volunteers.**

**Form:** Journal article.

**Author:** Kay, B.J.

**Source:** Social Science and Medicine. 19(8):873-878, 1984.

**Abstract:** In order to discover whether the selection of volunteers by their peers has a measurable effect on the volunteers' performance, researchers conducted a field experiment which used community organizations as a means to select people to serve as Emergency Medical Coordinators (EMC's). The project used 36 communities in north-central Georgia as field sites. Populations ranged from 150 to 1850 persons. The project identified local organizations in each community which were willing to serve as sponsors and to organize the selection of two residents who would serve as EMC's. Organizations used the following guidelines to aid in their selection of EMC's: (1) Access to a private telephone, (2) access to a car, (3) good physical condition, (4) positive attitude about being an EMC, (5) residence in the community, (6) work location in the community, (7) competency to learn skills, and

(8) respected by community residents. Project staff trained the EMC's as a group in a 40 hour program modeled after the U.S. Department of Transportation's Crash Injury Management course. Project staff measured the EMC's performance using two composite variables; a first aid performance index, and an activity index. The performance measures were analyzed according to the process of EMC selection and a related set of independent variables. The researchers found that the selection process is significantly correlated with both performance measures. Peer selection was a statistically significant predictor of EMC performance as a first responder, but not as a response system organizer. While education is positively related to first aid performance, it is negatively associated with the activity score. Length of residence in the community is negatively correlated with both performance measures. Results from this project demonstrate that, in contrast with simply putting out a call for volunteers to serve as EMC's, the additional time invested in organizing a local selection process may be well worthwhile. 3 tables, 7 references. (HE9401368)

065

**Fostering Volunteer Programs in the Public Sector: Planning, Initiating, and Managing Voluntary Activities.**

**Form:** Monograph.

**Author:** Brudney, J.L.

**Availability:** Jossey-Bass Inc., Publishers, 350 Sansome Street, San Francisco, CA 94104.

**Abstract:** Fostering Volunteer Programs in the Public Sector: Planning, Initiating, and Managing Voluntary Activities examines how volunteers are involved in the delivery of government services and how volunteer programs can be initiated, bolstered, and

sustained in the public sector. It evaluates competing claims regarding volunteers based on original survey research, extensive fieldwork, and literature from several disciplines. To show how volunteer involvement can be a coherent approach for providing and enhancing services and for aiding government organizations in achieving policy goals, the book explores methods for planning and designing the volunteer program, coordinating the efforts of paid staff and volunteers, and managing the program and strengthening accountability. Chapters include (1) Growth of Volunteerism in the Public Sector; (2) Evaluating the Cost-Effectiveness of Volunteer Programs; (3) How Volunteers Can Improve Service Quality and Impact; (4) Sharing Power and Authority with Volunteers: Issues of Volunteer Accountability; (5) A Framework for Designing and Organizing Volunteer Programs; (6) Planning and Managing Volunteer Programs to Overcome Staff Resistance; (7) Attracting and Retaining Able Volunteers; (8) Encouraging Volunteer Involvement in the Public Sector; and (9) Guidelines for Successful Public Sector Volunteer Programs. (HE9401420)

066

**Good Neighbor Rescue Program: Utilizing Volunteers to Perform Cardiopulmonary Resuscitation in a Rural Community.**

**Form:** Journal article.

**Author:** Bachman, J.W.

**Source:** Journal of Family Practice. 16(3):561-566, 1983.

**Abstract:** The Good Neighbor Rescue Program in Zumbrota, Minnesota (a small, rural community of about 2,000 people) uses volunteers who pay \$10 for their basic life support training. Program staff recruited nurses, hospital employees, volunteer firemen, teachers, and National Guardsmen. Recruiting



primarily occurred by cardiopulmonary resuscitation (CPR) instructors and through a speakers bureau. Each Good Neighbor received two metallic stickers to display at home and at work, and was to inform neighbors of their status. Acting as first responders during cardiac emergencies, Good Neighbors became involved in the emergency care of seriously ill patients. In the town's hospital, a map was set up with the location of all Good Neighbors, so that a dispatcher could decide rapidly which volunteer had the highest probability of being nearest an emergency. A book with pin numbers, names, and telephone numbers of each volunteer was placed near the map. Sixty victims of cardiac emergency were encountered in the 2-year period, with those having cardiac arrest seen most commonly. Volunteers participated in saving two lives during the first 2 years of the program. They reduced the time for trained help to arrive at the scene in 90 percent of the emergencies by arriving before the ambulance. Aside from performing CPR in witnessed cardiac arrest, the volunteers provided assistance by directing the ambulance driver to the scene and calming onlookers. The program requires coordination of existing resources within the rural community, is inexpensive, and is heavily dependent on volunteerism. It complements the goals of providing basic life support to cardiac victims before the ambulance arrives and of providing advanced life support at the scene. 3 figures, 2 tables, 10 references. (HE9401219)

067

**Peer Counseling in Health Care: A Collaboration of Social Work and Voluntarism.**

**Form:** Journal article.

**Author:** Simonson, S.K.

**Source:** Social Work in Health Care. 12(4):1-19, Summer 1987.

**Abstract:** The Social Service Department in an acute care urban hospital explored the implications of social work collaboration with volunteers to augment agency services. In 1981, the department developed a demonstration parent support program to provide perinatal, pediatric and hospice services for a regional perinatal center. In 1982, other hospital units requested services, resulting in an expansion to The Patient Support Program. This program provides comprehensive peer support services for all patients and families coping with serious illness or disability. Program services are available during and after hospitalization for a three-county population of 221,000 in South Central Washington. The Yakima Volunteer Bureau screens and refers suitable community applicants for the program. Community agencies, support groups, and hospital staff also refer persons for screening. The volunteers undergo 20 hours of initial training for 10 specialized disease and disability categories. Teaching methods include lectures, group discussions, and simulated case presentations to stimulate role-playing. Volunteers assess the training programs and educational materials through written and oral evaluations. After successful completion of the initial training program, the program coordinator assigns volunteers to clients. The program coordinator, social workers, other health care team members, clients and volunteers jointly develop individualized care and followup support plans for each client. A program evaluation database provides (1) the

number of clients referred and number of clients served; (2) percentage of clients characterized by medical category target groups to define the type of service provided; and (3) performance outcome, measured by client satisfaction surveys. Researchers studied a sample of 949 clients. Quantitative research using sample survey methods documents an outcome satisfaction ratio of 100 percent for positive responses to interview questions regarding program process and outcome. This program model is replicable in other primary health care settings where collaboration between social workers and volunteers can be developed or expanded. 33 references. (HE9401384)

068

### **Program of Friendly Visitors as Network Builders.**

**Form:** Journal article.

**Author:** Korte, C.; Gupta, V.

**Source:** *Gerontologist*. 31(3):404-407, June 1991.

**Abstract:** The Sunshine Visitors program is an experimental, friendly visitor program that trains volunteers to function as network builders for isolated elderly adults. The local Council on Aging in a large North Carolina city conducted the program with a population of clients who were widowed, divorced or separated, retired, 60 or more years of age, and noninstitutionalized. The program was based on the premise that friendly visitors can expand and strengthen the social support networks of isolated elderly, and that these efforts should be guided by a careful analysis of the specific deficits that are present in the elder's network. Volunteer visitors for the program were recruited from the community. They were randomly assigned to one of two versions of the program, either the network-building version or the friendly visitor version.

Twenty-one volunteers completed the training program, and fifteen of these were successfully matched and carried out weekly visits with their visitee. Eleven of these were network-building volunteers, and four were friendly visitor volunteers. Researchers conducted a formal evaluation at the 6-month point of the program. Both clients and volunteers gave a very favorable response to their experiences as participants in the Sunshine Visitor program. Comparisons of clients in the two versions of the program showed that gains in the relational needs fulfillment scores were greater for the clients visited by network-building volunteers. Gains on the morale and happiness measures were greater for the clients visited by the friendly visitor volunteers. (HE9401361)

069

### **Reach to Recovery International Interactive Volunteer Training: A Guidebook for Organisers of Volunteer Training Programmes.**

**Form:** Manual.

**Author:** Mahak, C.T.; ed.

**Availability:** International Union Against Cancer, 3, rue du Conseil-General, 1205 Geneva, Switzerland.

**Abstract:** Developed at a workshop held by the International Union of Cancer (UICC), Geneva, Switzerland, *Reach to Recovery International Interactive Volunteer Training: A Guidebook for Organisers of Volunteer Training Programmes* is a reference for the development of training skills and methods adapted to *Reach to Recovery* programs. *Reach to Recovery International* is a comprehensive, nonmedical program created to help women with breast cancer by (1) providing them with practical and emotional support and (2) enabling them to make relevant personal decisions and find the motivation for recovery with optimal quality of life. The



program utilizes carefully chosen, well-trained volunteers. Guidebook objectives include (1) providing general guidelines for training; (2) helping each Reach to Recovery and affiliated organization to format a training program best suited to its circumstances; (3) conveying a spirit of open, enjoyable, and supportive learning during the skills-practice sessions; (4) promoting good practice in volunteer support services; and (5) stimulating assessment and development of training techniques. Sections include (1) a training approach with an interactive format to bring out the volunteers' resources; (2) an explanation of the benefits of interactive training (e.g., volunteers discover and formulate important principles themselves and process concepts through open discussion); (3) general guidelines for giving supportive feedback; (4) tips for effective interactive training (e.g., facilitating volunteers learning instead of teaching them and modeling effective listening skills and nonverbal behavior); (5) tips for running a group training session (e.g., plan the session, manage time effectively, and keep the group alert and happy); (6) a description of the training approach in action; and (7) key principles for effective patient visits (e.g., begin by establishing positive contact, listen and support, and avoid commiserating with the patient). (HE9401418)

070

### **Rural Volunteer Ombudsman Programs.**

**Form:** Journal article.

**Author:** Netting, F.E.; Hinds, H.N.

**Source:** Journal of Applied Gerontology. 8(4):419-431, December 1989.

**Abstract:** The long-term care ombudsman program in the United States began in seven demonstration projects established through the Department of Health, Education, and Welfare in 1972 and 1973. An ombudsman is

generally one who investigates reported complaints, reports on findings, and helps to achieve fair settlements. The rural ombudsman can serve as the liaison between a local county office on aging and the long-term care facility, providing feedback on how facility residents are doing. Ideally, a trained volunteer in the rural county can serve as the actual communication link between the resident's home community and the long-term care facility. This paper discusses the benefits and difficulties surrounding the effective development and implementation of a long-term care volunteer ombudsman program, focusing on the East Tennessee Advocates for Elders ombudsman program as a rural case example. The authors note that, since most literature does not address the advantages and difficulties of implementing an ombudsman program in a mainly rural community, and because each rural setting is unique, it is unwise to expect that one community will be similar to another simply because it is rural. The ombudsman must have a developed network upon which to build. Paid ombudsmen must approach each rural community to ask for assistance in publicizing the ombudsman program and in recruiting volunteers. Ombudsman programs can link rural communities to outside organizations. Some rural communities may be large enough to have their own long-term care facilities. It is necessary to train volunteers to use strategies appropriate to each individual community. A combination of models is important to rural program development. Beginning with a locality development model, the ombudsman may be able to organize a group of trusted volunteers who are powerful community leaders. Once organized, the volunteers may become the initiators of change as they identify the needs of older persons in their communities. 9 references. (HE9401251)



071

**Senior-to-Senior Mediation Service Project.**

**Form:** Journal article.

**Author:** Cox, E.O.; Parsons, R.J.

**Source:** Gerontologist. 32(3):420-422, June 1992.

**Abstract:** The University of Denver Institute of Gerontology sponsored the senior-to-senior mediation service project (SSMS). The overall goals of the project included (1) training elderly volunteers as mediators; (2) exploring the use of senior volunteers in providing conflict resolution services to other elderly persons; and (3) locating auspices for the establishment of a permanent senior-to-senior mediation service in the Denver metropolitan area. The Institute received a small grant from United Way to initiate the project. The Denver Commission on Aging (DCOA) agreed to be the primary source of referral. The program recruited SSMS volunteers from a group of seniors who had completed 30 hours of mediation training. The volunteers were predominately college graduates. Average age was 72. Acceptance for the program training was limited to 50 persons due to space and training capacity limitations. During the first 9 months of operation, SSMS received over 70 referrals. Thirty-nine of these cases were determined to be amenable to conflict resolution strategies and were accepted by SSMS. Over 80 percent of the clients were poor or low income and approximately 25 percent of the clients served were of ethnic minority status. A social work graduate student collected program evaluation data. Data sources included (1) interviews with all volunteer mediators and program clients; (2) interviews with the DCOA staff and staff of other referral sources; and (3) project records and process notes of volunteer administrators and project officers. A jointly agreed-upon resolution was achieved in 27 cases, temporary agreement was made in 5 cases, and 7 cases

remained unresolved. 1 table, 9 references. (HE9401353)

072

**Use of Volunteerism in Indigent Health Care.**

**Form:** Journal article.

**Author:** Beardain, R.P.; Grantham, J.B.

**Source:** Journal of Health and Social Policy. 5(1):1-7, 1993.

**Abstract:** Researchers report on several volunteer efforts of Northwest Public Health District I of the Mississippi State Department of Health. District I includes Coahoma, DeSoto, Grenada, Quitman, Panola, Tate, Tallahatchie, Tunica, and Yalobusha Counties. Seven of the nine counties in District I report percentages of poverty greater than the State percentage. District I uses volunteers to perform a variety of services including (1) transporting patients to medical care facilities; (2) helping to solve child care problems so that patients can get to their medical appointments; (3) assisting the chronically ill or elderly with household chores; (4) serving as companions to the elderly; and (5) providing financial assistance for expensive items such as medications, medical equipment and special diets. Good Neighbors is a nonprofit organization established by a group of civic minded citizens for the purpose of addressing the needs of the working poor. Through the Good Neighbor Organization, assistance is available for utilities, rent, mortgage payments, and food. Another grass roots effort functioning in District I is Q-TIP. This is a Quitman County effort to reduce teen pregnancy. The purpose of the program is to work with teens to provide support, instruction, career planning, goal setting and communication skills. Volunteers are selected from the young adult population who have experienced similar pregnancy situations.

Another volunteer initiative in District I is Hold Out the Lifeline. This project, sponsored by the Southern Governor's Association and Southern Legislative Conference through the Southern Regional Project of Infant Mortality, is aimed at gaining clergy involvement in the fight against infant mortality. Local clergy attended meetings to learn about initiatives taken by clergy in other States. Local church groups then enlisted volunteers to provide transportation to prenatal and child health clinics and to make appointment reminder calls. When initiating volunteer programs, important issues to be addressed include (1) confidentiality, (2) relationships between employed staff and volunteers, (3) training, (4) supervision, (5) space, and (6) quality of services expected from volunteers. 8 references. (HE9401383)

073

### **Volunteer Advocates in Long-Term Care: Local Implementation of a Federal Mandate.**

**Form:** Journal article.

**Author:** Netting, F.E.; Hinds, H.N.

**Source:** Gerontologist. 24(1):13-15, February 1984.

**Abstract:** The Comprehensive Older Americans Act Amendments of 1978 required the establishment of ombudsman services for elderly residents of long term care facilities. Researchers describe the East Tennessee Advocacy Assistance Program, which was developed in response to this mandate. The volunteer program was created in 1978 to assist the ombudsman/director in resolving problems and complaints made by residents in long-term care facilities. The goals of the program are (1) to develop a corps of volunteer advocates in a 16 county area; (2) to train volunteers to assist in the identification of instances of abuse, neglect, or other problems

of older persons in the facilities; (3) to help volunteers distinguish between complaints and problems and make appropriate referrals to the ombudsman; and (4) to provide ongoing training, evaluation, and supervision of new and certified volunteer advocates. Volunteers who participate in the program are a diverse group of 23 women and 15 men, representing 13 of the area's 16 counties. Occupational experience ranges from retired lawyers to homemakers. The majority of volunteers are over 60. Volunteers must complete a six-step process to become a fully certified advocate: (1) The individual must attend training sessions; (2) the potential advocate fills out a request for certification and sends it to the ombudsman; (3) the ombudsman and a screening committee schedule an interview; (4) if the interview is successful, the advocate is certified and placed on 3 month probation; (5) the advocate is assigned to a facility in his county; and (6) after a successful 3 months, the advocate is fully certified. An area that is being explored by the program is that of volunteer liability insurance. Some persons are reluctant to become advocates because they fear being sued. Training sessions therefore stress the importance of thinking before acting. The program has developed five role plays that demonstrate potential liability problems. 4 references. (HE9401382)

074

### **Volunteer Community Representatives as Ombudsmen for the Elderly in Long-Term Care Facilities.**

**Form:** Journal article.

**Author:** Zischka, P.C.; Jones, I.

**Source:** Gerontologist. 24(1):9-12, February 1984.

**Abstract:** In 1979, the Director of the Office for the Aging in Rockland County, New York, implemented a program for the training of



volunteer ombudsmen to act as advocates on behalf of the residents of long-term care facilities. The design of the program assigned all ombudsmen to a particular facility and gave each ombudsman responsibility for 50 residents, some alert and some not alert. Ombudsmen were expected to volunteer a minimum of 6 hours of service weekly. After screening, 25 candidates were selected for the training program. The group selected included both men and women ranging in age from 20 to 80, with a wide diversity of educational, vocational, cultural and ethnic backgrounds. This group received an intensive 30-hour training program. Means of attracting volunteers included coverage in the media, personal contacts, and appeals at meetings of organizations. Retention of volunteers can be complicated by the pressures of recession and inflation, which have led some volunteers to return to gainful employment. Sometimes, ombudsmen are forced to leave the program because of personal illness or illness within their family. In other cases, burnout occurs. The authors stress that institutional back-up and support are needed. To be effective, any ombudsman program must have the clout to achieve its aim. For the Rockland County program, this clout derives from (1) The Older Americans Act of 1965 which mandates long-term care ombudsman programs nationwide; (2) The New York State Long Term Care Ombudsman Program which represents the State-level implementation of the national mandate; and (3) the New York State legislature mandate which guarantees access of ombudsmen as well as immediate reporting of any suspected incidents of abuse, neglect, or mistreatment of long-term care residents. (HE9401369)

075

### **Volunteers.**

**Form:** Manual.

**Author:** Breitrose, P.

**Availability:** Stanford University, School of Medicine, Stanford Center for Research in Disease Prevention, Health Promotion Resource Center, 1000 Welch Road, Palo Alto, CA 94304-1885. (415) 723-1000. No. HTP 1.

**Abstract:** Volunteers provides information designed to help program organizers assess the benefits or disadvantages of using volunteers in a community health promotion program. The manual presents suggestions for writing job descriptions, and recruiting, training, supervising, evaluating, and maximizing personnel. Other topics include the history of voluntary service, the task of appointing a Director of Volunteers, the preparation before recruiting, marketing methods, and suggestions on the interviewing process. The manual makes six recommendations to improve the chances of success at all stages of the volunteer process: (1) Know what role the volunteers will play before recruiting; (2) recruit from populations most likely to yield the people you want; (3) arrange for necessary skills training in addition to orientation; (4) encourage ample communication among volunteers, staff, and administrators; (5) evaluate performance of individual volunteers and the volunteer program as a whole; and (6) make volunteers feel that they are a vital, well-informed part of the organization. 5 references. (HE9200091)



076

**Volunteers in Patient Education: Is There a Role.**

**Form:** Journal article.

**Author:** Lemons, W.L.

**Source:** Family and Community Health.  
7(4):66-76, February 1985.

**Abstract:** The role of volunteers in patient education is explored. While accrediting bodies and consumers have been demanding more patient education, hospital resources available to meet those demands have shrunk alarmingly. However, with proper training and supervision, volunteers can be involved in patient education activities, thereby assuring that education is available to all at minimal cost. Volunteers can play support roles in patient education activities or serve as patient educators. Volunteers can perform a wide variety of support tasks in specific projects, long-term or ongoing activities, and fundraising activities. Many volunteers can be used as patient educators in a variety of teaching situations, such as (1) one-to-one structured teaching, (2) medication instruction, and (3) family counseling. The key to success in using volunteers as patient educators appears to be (1) limiting the scope of teaching, (2) providing extensive training, and (3) emphasizing the patient-layperson relationship. To assure adequate patient care and to avoid legal consequences, patient education programs involving volunteers must be carefully planned and monitored. Guidelines for program planning are provided. 7 references. (HE8500200)



# Foundations of Community Health Advisors

## Evaluation

077

### **Assessing the Effectiveness of Lay Health Advisors With Migrant Farmworkers.**

**Form:** Journal article.

**Author:** Watkins, E.L.; Harlan, C.; Eng, E.; Gansky, S.A.; Gehan, D.; Larson, K.

**Source:** Family and Community Health. 16(4):72-87, January 1994.

**Abstract:** Researchers report on an analysis of data from a major study of five health care agencies at four North Carolina sites serving migrant and seasonal farmworkers. The study involved the application of a social network intervention model using Lay Health Advisors (LHA's). The study population included migrant women receiving prenatal care, their newborns, and infants one year of age or less whose mothers received care elsewhere. A program involving the recruitment, training, and implementation of LHA's was undertaken at two of the intervention sites, and the other two sites served as controls. The study was funded for 3 years (1987-1990) and was staffed by a full-time project coordinator, a training coordinator, and a data manager. In 1988 and 1989 the program recruited a total of 78 women for LHA training. A subsample profile was completed on 31 LHA's to develop an understanding of the group's demographics. A Knowledge Test and Helping Contacts Questionnaire were developed to assess the training program's effectiveness and the extent to which the LHA's assisted the target population after the program was completed. The Knowledge Test and an Exposure Questionnaire assessed the effect of interaction with LHA's on the target population. The study demonstrated that the LHA model is a valid one for migrant farmworker families and

that implementation of an LHA program with Latina migrant farmworker women is feasible. Mothers with exposure to LHA's were more likely to bring their children for sick child care and have greater knowledge about health practices. There was an indication that at sites where LHA's have been active for more than 1 year, a higher proportion of pregnant women who encountered LHA's made the recommended number of prenatal visits. 18 references. (HE9401339)

078

### **Community Health Aides: How Effective Are They?**

**Form:** Journal article.

**Author:** Cauffman, J.G.; Wingert, W.A.; Friedman, D.B.; Warburton, E.A.; Hanes, B.

**Source:** American Journal of Public Health. 60(10):1904-1909, October 1970.

**Abstract:** A study conducted in the Pediatric Emergency Room (PER) of the Los Angeles County-University of Southern California Medical Center measured the ability of community health aides to perform in an educational capacity related to patient care. Researchers hypothesized that mothers instructed by community health aides would be as likely to comply with Physicians' Upper Respiratory Infection (URI) Order Lists as would mothers who were instructed by public health nurses or by physicians. Project staff recruited and trained community health aides to teach mothers how to care for their children when they had an upper respiratory infection (URI). The aides were of either African-American or Spanish surname backgrounds, representing the dominant ethnic groups



attending the PER. They had a high school education, and ranged in age from 18 to 35. Two pediatricians, two public health nurses, and a health educator trained the aides for their work in the PER. The training period was four weeks. Mothers were randomly assigned to the aides, to nurses, or to physicians to receive instruction about their children's URI. After identifying a child's illness as a URI, the physician asked the mother to follow from 1 to 11 recommendations on the Physicians' URI Order List. A mother was classified as having followed the Physicians' Order List only if she followed all of the URI orders that were assigned to her at the PER. When a mother performed anything less than all applicable items, she was classified as not having followed the physicians's orders. An analysis of the data indicated that there was no difference in the level of compliance among mothers who were instructed by community health aides, by public health nurses, or by physicians. This project demonstrated that with leadership from a health care team, aides can be trained to assume important responsibilities in maternal education. With appropriate supervision, they can be expected to assist mothers in a low-income area to comply with the physician's orders when their child's health problem is an URI. 1 table, 14 references. (HE9401371)

079

### **Effect of Outreach Workers' Educational Efforts on Disadvantaged Preschool Children's Use of Preventive Services.**

**Form:** Journal article.

**Author:** Colombo, T.J.; Freeborn, D.K.; Mullooly, J.P.; Burnham, V.R.

**Source:** American Journal of Public Health. 69(5):465-468, May 1979.

**Abstract:** A special program of outreach services was implemented to assist a poor

population to use health services appropriately in the Kaiser-Permanente Medical Care Program. A study was conducted to determine the effect of outreach workers' intervention on the use of preventive services by this population. Initially, families were divided into two groups, one with and one without outreach workers. Outreach workers (neighborhood health coordinators) were trained in prevention and health education. They were then assigned to specific subgroups of the population to teach the importance of preventive services and to motivate persons to use these services. Preschool children in families with coordinator services had higher use rates for preventive care. The subgroup for which outreach workers were specially trained to focus on preventive procedures for the preschool group had markedly higher use rates for preventive care. The findings suggest that special intervention programs, using indigenous and nonprofessional outreach workers, can increase preventive service utilization by poverty groups. 9 references. (HE7900514)

080

### **Effective Utilization and Evaluation of Indigenous Health Care Workers.**

**Form:** Journal article.

**Author:** Giblin, P.T.

**Source:** Public Health Reports. 104(4):361-368, July-August 1989.

**Abstract:** The use of indigenous health care workers (IHCW's), who were key elements in community health care programs in the United States in the 1980's, has gone in and out of fashion in subsequent years. Researchers recently established a service program at Wayne State University's Institute of Maternal and Child Health (in Michigan) that employs IHCW's. Developers reviewed characterizations of IHCW's in previous health

care programs in the process of developing criteria and guidelines for the recruitment, selection, training, employment, and evaluation of these workers in the Institute's program. Researchers address the unique applicability of indigenoussness to the delivery of health care services in terms of the rationale for the use of IHCW's as well as criteria for their success, benefits and problems encountered in the use of these workers, and deficiencies in evaluations of IHCW's. Researchers propose a model of program evaluation (action research) that assesses the processes and outcomes of providing health services by indigenous paraprofessionals. Within program evaluation, additional aspects of the model are specific to IHCW's and these are explored here. They include discussions of community characteristics, indigenoussness, health services characteristics, and continuation criteria. Program evaluation of this type would likely enhance the program's services as well as provide a basis for recognizing the value of indigenous health care workers to their communities. 1 figure, 35 references. (HE9401222)

081

**Friendly Visiting as a Means of Informing Homebound Senior Citizens of Health-Related Community Services.**

**Form:** Journal article.

**Author:** Keller, K.L.; Flatten, E.K.; Wilhite, B.C.

**Source:** Journal of Community Health. 13(4):231-240, Winter 1988.

**Abstract:** The purpose of this study was to investigate the effectiveness of friendly visiting programs as a way of informing homebound senior citizens about health-related community services. One group of homebound seniors received visitors from an ongoing friendly visiting program (VISITING AS IS) and a

second group of seniors received visitors who were specifically trained to convey community referral information (REACH). A control group received no visits. Visited seniors were compared with homebound controls on pretest and posttest measures of knowledge of eight community services: (1) Visiting nurses, (2) congregate meals, (3) home delivered meals, (4) the Retired Senior Volunteer Program, (5) homemaker health aides, (6) telephone reassurance, (7) adult day care, and (8) letter carrier alert. The postinterview mean knowledge scores of the visited groups differed significantly from those of unvisited seniors. Those visited by REACH visitors increased their knowledge of services significantly more than those visited by VISITING AS IS visitors. Friendly visitors can effectively transmit information about community services to the homebound, especially if the visitors receive specific training. 8 references. (HE8900612)

082

**Home Visitors and Child Health: Analysis of Selected Programs.**

**Form:** Journal article.

**Author:** Chapman, J.; Siegel, E.; Cross, A.  
**Source:** Pediatrics. 85(6):1059-1068, June 1990.

**Abstract:** To determine the state-of-the-art of programs in the field, to stimulate interest and awareness among pediatricians, and to consider the place of the programs within the health care system, a review focused on seven home-visitor, child-health programs: Helping Mothers (North Carolina); Parent-Infant Project (Colorado); Rural Alabama Pregnancy and Infant Health (Alabama); Healthy Start (Kansas); Resource Mothers (South Carolina); Resource Mothers (Virginia); and Prenatal-Early Infancy Project (New York). The study describes each program according to the following features: Program characteristics;



description of the home visitors; program objectives, sample size, and research design; outcome measures; and reported data. The study reviewed each program's funding and long-term viability, use of professional or paraprofessional visitors, visitor selection and supervision, and evaluation. The review's findings suggest that home visitor programs can contribute to child health outcomes such as increased birth weight, improved prenatal care, improved maternal-infant interaction, and improved use of community resources. Pediatricians can be supportive of such programs at many levels: Becoming aware of the existence and range of services of home visitor programs in their area that serve families with children and referring families to those programs; being available to advise programs that are in the planning stages; providing advocacy at the local, State, and national level for the funding and development of such programs; and taking the initiative to join multidisciplinary efforts to develop new programs. 4 tables, 30 references. (HE9001298)

083

### **Lay Health Care: The Hidden Resource in Health Promotion.**

**Author:** Levin, L.S.

**Source:** New York, NY, Columbia Univ., Teachers College, Center for Health Promotion, (Health Promotion Monographs No. 3), 26 p., July 1983.

**Abstract:** The lay health care movement is considered with respect to precipitating factors, components, and policy issues. Social trends that have contributed to growing interest in and demand for lay participation in health care include changes from centralization to decentralization, from single to multiple options, and from a technical approach to management of disease by a professional.

Other factors contributing to the popularization of health and medical care include (1) increasing recognition of structural and behavioral factors in disease prevention, (2) the shift in disease patterns from acute to chronic, (3) the shift from a professional medical care model to an economic and bureaucratic model, (4) increased availability of health information and growing public awareness, (5) greater availability of technology for lay use, (6) the upgrading of over-the-counter medications, and (7) people's reaction to a general feeling of loss of control. From available evidence, it can be estimated that 85 to 90 percent of all health care activity is undertaken by lay people. Lay health resources that act as mediating structures between the individual and public institutions include (1) family and friends, (2) mutual aid and self-help groups, (3) lay volunteer groups, and (4) organized religion. Critical issues in lay health phenomena are (1) its safety and effectiveness, (2) trust in the health professional, (3) access to professional resources, (4) relevance to different socioeconomic groups, (5) effect on women as major resources, (6) self-care efforts and political action, (7) commercial interests, and (8) medicalization of social life. 20 references. (HE8400801)

084

### **Role of the Community Health Aide in Public Health Programs.**

**Form:** Journal article.

**Author:** Hoff, W.

**Source:** Public Health Reports. 84(11):998-1002, November 1969.

**Abstract:** In the 1950's and 1960's the use of auxiliary personnel in public health programs increased rapidly in the United States. Community health aides were employed to perform a wide range of duties in health



programs such as health education, communicable disease control, maternal and child health, dental health, family planning, and environmental health. A literature review provides evidence from a variety of health programs and projects that demonstrates the value of using community aides, often from the indigenous population being served. Increasing communication, bridging the cultural gap, and improving the delivery of health services to low-income, ethnic, and other neighborhood groups are values that have been demonstrated. The need for more and new types of health care personnel will only increase as the nation demands comprehensive health care for all citizens. The creation of entry-level jobs for persons with low levels of education and experience and the development of meaningful health career opportunities for low-income persons are ways to meet these demands. Adequate education and training programs for both health aides and professional workers are needed to ensure effective functioning of the new health manpower systems. 21 references. (HE9401203)



## Health Promotion and Disease Prevention Programs

085

### **Boston's Codman Square Community Partnership for Health Promotion.**

**Form:** Journal article.

**Author:** Schlaff, A.L.

**Source:** Public Health Reports. 106(2):186-191, March-April 1991.

**Abstract:** A proposed project in Boston, Massachusetts, promotes changes in individual behavior and community relationships to reduce the morbidity and mortality associated with the many problems affecting poor, minority communities in the United States. Specific project objectives include (1) making services offered by the health center more responsive to community needs and concerns; (2) increasing the organizational capacity of community residents and voluntary agencies to work on health issues; (3) increasing residents' control over and satisfaction with life in the community; (4) creating an ongoing community-health professional partnership to plan and implement community health initiatives; (5) recruiting and training 10 community residents as lay health workers to supply home-based health education and referral services to every household in Codman Square; and (6) developing an ongoing health data collection system in the community for use in program planning and evaluation, surveillance, and research. The project addresses problems including violence, injuries, substance abuse, acquired immunodeficiency syndrome (AIDS), infant mortality, child abuse and neglect, and cardiovascular disease through a variety of community-based health promotion models (community participation, community organization, empowerment education, and community-oriented primary care) and encourages new coalitions that can ameliorate the social isolation and health-averse social

norms linked to poverty and poor health. The program uses local residents trained as lay health workers to deliver home-based health services and to help create the necessary partnerships, linkages, and communication networks to foster the reorganization of the community to better address its health problems. Project evaluators will measure community involvement and satisfaction with the program through counting numbers of people at meetings and in roles such as block coordinators, and through annual surveys administered by the health workers as they conduct home visits. 80 references. (HE9101501)

086

### **Church Community Health Awareness and Monitoring Program.**

**Form:** Program.

**Corporate Author:** Liberty Medical Center.

**Author:** Charleston, J.

**Availability:** Liberty Medical Center, 2600 Liberty Heights Avenue, Baltimore, MD 21215. (301) 383-4435. July 1979-continuing.

**Abstract:** The Church Community Health Awareness and Monitoring Program provides health screening services, delivered through trained church members, for blood pressure monitoring, diabetic assessment and referral, and cardiovascular risk reduction programs consisting of weight control and exercise. Members of the congregation receive training as church health advocates to increase congregational health awareness and to screen, refer, monitor, and provide a built-in support system to those members identified as having risk factors. Monthly clinics offer screening services, provide discussions about the myths and the risk factors to cardiovascular disease,



and examine individuals' diet and behavioral lifestyle changes needed to prevent and/or reduce these risk factors. Volunteers also refer at-risk members to the Cardiovascular Risk Reduction Intervention Program (CRIP), an 8-week intense program whose main objective is to help church and community members reduce at least one cardiovascular risk factor. The awareness and monitoring program rests on the belief that the church affords an effective means to reach and educate those individuals with the greatest risk for cardiovascular disease. (HE91P1313)

087

### **Community Health Advisors.**

**Form:** Journal article.

**Author:** Kaplowitz, J.A.

**Source:** Journal of Christian Nursing.  
8(4):12-15, Fall 1991.

**Abstract:** Volunteer Community Health Advisors are part of the answer to bringing needed health care to millions of Americans. Officials estimate that over 37 million Americans lack health insurance coverage, but earn too much to qualify for government assistance. As a result, 17 percent of the United States population is unable to obtain adequate medical care when needed. Christian nurses and educators of The Luke Society in Mississippi train Community Health Advisors (CHA's). The Luke Society is particularly concerned about the needs of young pregnant women. Over 37 percent of pregnancies in Mississippi are among teens. Three women in five have no insurance for maternity care during their prime childbearing years. Through the Luke Society, Health Advisor Programs have been established in two other States: Arkansas and Michigan. In 1989, Carol Powers, a registered nurse, spent a week at the Cary Christian Center in Mississippi learning how to implement a CHA program.

Supported by local churches, she trained ten volunteers. During a 30-week course, the Michigan CHA's learn creative ways to (1) present nutrition talks to children, (2) teach Bible-based sex education to teens, (3) make home visits to elderly people and new mothers, (4) provide hypertension counseling and blood-pressure monitoring, and (5) share their faith in Christ. The effectiveness of this church-based concept has been recognized by two secular sources. The Federal office of Maternal and Child Health awarded The Luke Society one of ten national grants designed to help community-level health programs. Entitled Healthy Tomorrows Partnership for Children, the program is administered through the Cary Christian Center. Dr. Claude Lenfant, director of the National Heart, Lung, and Blood Institute, has stated that a large part of health care must be done at the community level, not from a doctor's office. (HE9401364)

088

### **Community Health Aide.**

**Form:** Journal article.

**Author:** Potts, D.; Miller, C.W.

**Source:** Nursing Outlook. (12):33-35,  
December 1964.

**Abstract:** A California county health department carried out a pilot health education project to extend its services to seasonal farm workers in the area. The project hired and trained community health aides from within the farm worker community. Suggested names of these workers came from public health nurses and from other community sources. Training efforts focused on very basic public health concepts, with formal training occurring over 1 full month. Learning continued on the job, through the workers' close contact with local public health nurses and sanitarians. Weekly staff meetings also provided inservice training.

Community aides conducted surveys to ascertain community residents' level of health, education, living conditions, residency, and mobility; they visited new families in the community to tell them about available health services and assess their need for services; Spanish-speaking workers interpreted for health nurses when necessary (at the health center or in the home); they assisted with arranging for health education programs and demonstrations in the community; and they performed many other functions. Health hostesses visited new families in their homes to find cases who needed health care. In 1963, these hostesses visited 150 families. Seventy-six needed health services, of which 54 followed through and received some care. Cooperative relationships were necessary as some nurses were hesitant about accepting the aides. It is necessary to foster smooth working relationships for such a program to work well. The project helped members of the health department staff in their communication and work with each other and the community, and it helped seasonal farm workers with some of the problems they face regarding accessibility to health care. (HE9401231)

089

### **Community Helpers Project: A Description of a Prevention Strategy for Rural Communities.**

**Form:** Journal article.

**Author:** D'Augelli, A.R.; Vallance, T.R.; Danish, S.J.; Young, C.E.; Gerdes, J.L.

**Source:** Journal of Prevention. 1(4):209-223, Summer 1981.

**Abstract:** Prevention programs are especially important for rural communities because of the prevalence of psychosocial distress and the difficulties involved in delivering services to rural areas. Program planners designed the Community Helpers Project as a model

prevention program for rural communities since it builds on informal local helpers. Through a system of community-based training, local helpers' skills are enhanced using three training packages: Basic helping skills (16 hours of training), life development skills (16 hours), and crisis resolution skills (12 hours). Professionals (community psychologists and advanced graduate students) train local trainers (e.g., ministers, housewives, local agency personnel) who then provide increased skills to small groups of natural caregivers. The project is situated in two areas in central Pennsylvania: Bloomsburg, a county seat (population 12,000), and the western part of Snyder County (population 3,200). One is a small town and the other is a predominantly rural area. Two advisory boards were formally designated by the catchment area's administrator of the Mental Health/Mental Retardation (MHMR) program, with day-to-day activities carried out by a half-time person employed by the MHMR program. The project has been operating since July 1977. Thirteen trainers were trained in western Snyder County and 19 in Bloomsburg. Basic helping skills groups conducted in each area had attendance of 37 and 28 local helpers, respectively. One problem with the program, despite its success to date, is that far fewer helpers have been trained than originally planned and much effort has gone into designing ways to attract local helpers to the project. In both areas, broad public recognition of the program has yet to be achieved. The program is successful as primary prevention, giving the average person skills to use in dealing better with common problems brought to them by friends, acquaintances, and family. 31 references. (HE9401210)



## Health Promotion and Disease Prevention Programs

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090

### **Familia Sana. (Healthy Family).**

**Form:** Program.

**Corporate Author:** Clinica del Carino.

**Author:** Wiggins, N.

**Availability:** Clinica Del Carino, P.O. Box 1217, Hood River, OR 97031.

(503) 386-4880. October 1991-continuing.

**Abstract:** La Familia Sana (Healthy Family) from Oregon's Clinica Del Carino improves the mental and physical health status of Hispanic migrant and seasonal farm workers and trains new lay health promoters in Wasco and Hood River Counties, Oregon and in Klickitat County, Washington. Services include health education classes, home visits, social support groups, and workshops to train trainers. Evaluation includes preintervention and postintervention clinical chart audits, cooperative evaluation of classes and courses, and preintervention and postintervention surveys regarding the level of health knowledge and the level of perceived social support. Collaborating organizations include the Salud Medical Center, Woodburn, Oregon, the Valley Family Health Care Center, Nyssa, Oregon, and the Migrant and Indian Coalition. (HE92P1207)

091

### **Second Look at Substance Abuse: Peer Prevention and Education.**

**Form:** Journal article.

**Author:** Holley, S.J.

**Source:** Alcohol, Drugs, and Driving. 8(3-4):265-276, July-December 1992.

**Abstract:** A researcher discusses the evolution of a railroad company's efforts to institutionalize peer intervention as a means of reducing alcohol and drug use in the workplace. The project, Operation RedBlock,

was initiated on the Union Pacific Railroad began in 1983 with two primary objectives: To prevent railroad personnel from reporting to work while intoxicated, and to deter workers from using alcohol and drugs while on the job. The structure of Operation RedBlock included steering committees, coordinators, and employee assistance. The crux of the Operation RedBlock concept was that coworkers would not tolerate fellow employees drinking or using illicit drugs while working. By forming Volunteer Prevention Committees, the Railroad organized a chairperson and volunteer employees who served as a resource for other employees and managers. Almost from the outset, it became apparent that the role of confrontation by fellow employees was difficult to achieve. Breaking the code of silence that has existed for decades was a formidable task, and one that has been a problem since the program began in 1983. Program volunteers have since focused on peer prevention and education efforts, preferring to engage in positive events such as softball tournaments, golf outings, and display booths at various Railroad functions which promote Operation RedBlock. One difficulty confronted in the program has been the ability to recruit and develop new participants. For the first two years, enthusiasm for Operation RedBlock was strong and more than 3,300 persons were trained in the program. Committees have since dwindled in size and function, however, and each has begun operating independently. In spite of difficulties, Operation RedBlock has been successful in several areas. There has been a substantial reduction in the number of problem drinkers (previously 23 percent in the industry), coupled with a change in social culture where consumption and the use of drugs is generally not condoned. There has also been substantial development of various information and education sessions for employees on drug and alcohol use as well as other health behaviors. Continuation of the



project is dependent upon the development of projects to enhance participation, improve methods for confrontation, and increase referrals. 23 references. (HE9401411)

092

**Weight Reduction at the Work Site: A Promise Partially Fulfilled.**

**Form:** Journal article.

**Author:** Brownell, K.D.; Stunkard, A.J.; McKeon, P.E.

**Source:** American Journal of Psychiatry. 142(1):47-52, January 1985.

**Abstract:** Three consecutive studies of weight reduction at the worksite were conducted to develop the most effective program. A total of 172 female union members participated in three 16-week behavioral group programs; the programs were similar in methods used for weight reduction. The first study was used to gain information on how to improve program performance. This information was then incorporated into the next two studies.

Program variables investigated included the (1) relative effectiveness of lay and professional leaders, (2) effects of meeting frequency, and (3) effects of program location. Results indicated no significant difference in weight loss in the three studies, but attrition decreased from 57.5 percent in the first study to 33.8 percent in the third study and weight loss maintenance improved. Groups that met three to four times a week had less attrition than groups that met once a week. These behavioral weight reduction programs were as effective as self-help and commercial groups, and lay leaders produced (at one-third the cost) results equivalent to those produced by professional therapists. 31 references. (HE8500850)



## Chronic Diseases and Risk Factors

### Cancer

093

**Breast and Cervical Cancer Education Program: Witnessing in the Delta.**

**Form:** Program.

**Corporate Author:** Arkansas Cancer Research Center, University of Arkansas for Medical Sciences.

**Author:** Erwin, D.O.

**Availability:** Arkansas Cancer Research Center, 4301 West Markham, Slot 623, Little Rock, AR 72205. (501) 686-6000. 1989-continuing.

**Abstract:** Breast and Cervical Cancer Education Program: Witnessing in the Delta is the title of a program targeted toward African American and low-income women in the Mississippi River delta region of Arkansas. The program develops community and organizational structures to help rural black women participate in breast and cervical cancer education programs. Participants learn breast self-examination (BSE), about mammograms and Papanicolaou (Pap) smear tests, and the value of early diagnosis and treatment. The program seeks to provide continuing medical education to local physicians, nurses, and technologists to improve their diagnostic techniques and appropriate referral of symptomatic breast and cervical cancer patients. A final goal is to evaluate the influence of the breast and cervical cancer education and services intervention. Black women who have breast and cervical cancer act as lay health advisors by sharing their experiences, or witnessing, to program participants. Participants are recruited through local churches. After listening to the role models witness, participants learn BSE. Local health

professionals are provided with medical education through the University of Arkansas for Medical Sciences to improve diagnostic techniques and referral of patients. Limited funding for mammography services is provided. The program was pilot tested from 1989 to 1992. Eighty-two percent of the participants responded to a followup survey at 3 months. Comparison of responses given at baseline to those at followup showed a significant increase in frequency and confidence in performing BSE. Among the 63 respondents at 3 months, 12 reported that they obtained a mammogram following the program. (CP93P0178)

094

**Breast and Cervical Cancer Screening in Minority Populations: A Model for Using Lay Health Educators.**

**Form:** Journal article.

**Author:** Brownstein, J.N.; Cheal, N.; Ackermann, S.P.; Bassford, T.L.; Campos-Outcalt, D.

**Source:** Journal of Cancer Education. 7(4):321-326, Winter 1992.

**Abstract:** Screening prevalence and survival rates for breast and cervical cancers are disproportionately lower among minority women than among other women. A model program outlines techniques for recruiting and training minority women who can effectively deliver preventive health care information to their peers to serve as lay health educators. The intervention model has numerous advantages for reaching minority, underserved, and hard-to-reach populations (older, low-income, or undereducated persons). Lay



health educators have three primary functions: (1) To serve as mediators between minority women and health agencies; (2) to establish a social network; and (3) to offer social support. The goal of lay health education is to increase the detection, prevention, and treatment of breast and cervical cancers in minority communities and thus decrease related deaths. An ongoing intervention by the Arizona Disease Prevention Center, targeting Yaqui Indian and Mexican American women over age 35, illustrates specific elements of the model. Prospective lay health educators and their social networks should be assessed before any decisions about interventions are made. Steps involved in establishing lay health educators in an intervention include (1) program development, (2) recruitment, (3) training and curriculum development, and (4) program evaluation of the training process and its outcomes. Program development involves considering whether (1) lay health educators will be appropriate for carrying out discrete aspects of the program, (2) the community will support the program and the use of lay health educators, (3) the type and amount of supervision needed, (4) funding, (5) reimbursement and work schedules of lay health educators, (6) lay health educators' desired educational backgrounds, and (7) if lay health educators will act as an extension of an existing health agency or be more independent. 32 references. (CP9300199)

095

### **Breast Cancer Screening in Older African-American Women: Qualitative Research Findings.**

**Form:** Journal article.

**Author:** Tessaro, I.; Eng, E.; Smith, J.

**Source:** American Journal of Health Promotion. 8(4):286-293, March-April 1994.

**Abstract:** Researchers examined qualitative research findings to evaluate the cultural and social variables that shape the breast cancer screening behavior of older African-American women. Researchers conducted focus group interviews in natural settings (e.g., churches) for older African-American women. The study sample included 132 members from 14 social networks of older African-American women. A focus group guide facilitated discussion about (1) perceived risk of breast cancer, (2) behavioral intentions about breast cancer screening, (3) health-seeking behavior, and (4) social support. Results revealed that for older African-American women, other health concerns were of more concern than breast cancer and that age was generally not recognized as a risk factor for breast cancer. Fear of finding breast cancer and its social consequences were barriers to screening. The women tended to rely on breast self-examination rather than mammography to detect breast problems. Competing priorities may be more of an issue than cost, because people have traditionally visited the doctor for health problems rather than prevention. Results indicated that social networks are a naturally existing source of support for designing interventions to increase breast cancer screening. 1 figure, 3 tables, 22 references. (CP9400653)

096

### **Cancer Screening Intervention Among Black Women in Inner-city Atlanta: Design of a Study.**

**Form:** Journal article.

**Author:** Sung, J.; Coates, R.J.;

Williams, J.E.; Liff, J.M.; Greenberg, R.S.;

McGrady, G.A.; Avery, B.Y.;

Blumenthal, D.S.

**Source:** Public Health Reports. 107(4):381-388, July-August 1992.

**Abstract:** Researchers structured a study design to explore whether a culturally sensitive, in-home educational intervention conducted by lay health workers (LHW) could increase the adherence of low-income, inner-city black women to screening schedules for breast cancer and cervical cancer and could increase the women's knowledge and change their attitudes about these cancers. The LHW's were specially trained, black female residents of the same communities in Atlanta, Georgia, as the interviewees. Starting in March 1989, the LHW's recruited and interviewed 321 women from a variety of locations, including (1) patients seen in a community health center, (2) women referred by the National Black Women's Health Project (NBWHP), and (3) residents of public and senior citizen housing projects. Overall, about half of the volunteer subjects self-reported at least one Papanicolaou (Pap) smear and one breast examination within a year before enrollment in the study. Referrals from NBWHP were more likely to have had a Pap test and breast self-examination, whereas residents of public housing projects were somewhat less likely to have done so. About 35 percent of participants over age 35 had a mammogram within an appropriate interval. Researchers randomly assigned participants to intervention and control groups. LHW's visited women in the intervention group in their homes on three occasions. The intervention consisted of (1) demonstration and teaching of breast self-examination (BSE); (2) print and video presentation of BSE, Pap smear, pelvic examination, and reproductive health; (3) print and oral health educational materials on risk factors for breast and cervical cancers; (4) print and oral educational materials on mammography; (5) review and evaluation of materials previously presented; (6) interpretation, referral, and followup of the subjects concerning any abnormal Pap smear or breast examination results; (7) facilitation to promote the use of cancer screening services,

transportation, and scheduling for other referral processes; and (8) encouragement to participate in NBWHP's self-help groups. The educational materials on cancer and reproductive health showed black models and actors; the materials were designed according to black cultural norms and an empowerment philosophy. Postintervention interviews were completed in April 1992. The investigators plan to conduct an evaluation of the outcomes of both study and control groups to determine whether there are differences in the women's screening compliance, knowledge, attitudes, and practices. The process and its ability to reach target women and to transfer information will also be evaluated. 1 figure, 2 tables, 22 references. (CP9200569)

097

#### **Development and Implementation of an Intervention to Increase Cervical Cancer Screening in Inner-city Women.**

**Form:** Journal article.

**Author:** Mamon, J.A.; Shediak, M.C.; Crosby, C.B.; Celentano, D.D.; Sanders, B.; Matanoski, G.M.

**Source:** International Quarterly of Community Health Education. 12(1):21-34, 1991-1992.

**Abstract:** Researchers describe developing and implementing an intervention to increase cervical cancer screening among inadequately served women in inner-city Baltimore, Maryland. Researchers implemented the intervention over a 3-year period (1987-1990), involving the target community and a similar control community; both communities had high rates of cancer mortality compared to city-wide and national averages. Researchers recruited 144 community volunteers from 17 church and community organizations and trained them as lay peer educators. The peer educators learned (1) to approach women in need of screening and educate them about the need for



## Chronic Diseases and Risk Factors

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screening; (2) to identify and work through knowledge, attitudinal, and practical barriers to screening; (3) to assist in selecting appropriate screening facilities; and (4) to motivate women to make and keep Pap smear test appointments. Implementation involved volunteers canvassing listed telephone numbers within several sub-areas to survey and identify women who had received fewer than three Pap smear tests in the last 4 years. The survey included questions on (1) whether the respondent had been to a doctor for a check up in the last year, (2) the respondent's recent history of Pap smear testing behavior, hysterectomy status, and age; (3) the respondent's organizational membership; and (4) whether the respondent would be interested in receiving more health information. Peer educators later taught the interested women and motivated them to seek Pap smear tests. Each peer educator counseled an average of eight women. Approximately 43 percent of the counseled women made and kept an appointment for a Pap smear test and indicated an intention to get a repeat test the following year. 15 references. (CP9200216)

098

### **Increasing Pap Smear Compliance Among Young, Underserved Women in Northern Manhattan.**

**Form:** Program.

**Corporate Author:** Columbia University Comprehensive Cancer Center.

**Author:** Bloch, S.

**Availability:** Columbia University, Comprehensive Cancer Center, 701 West 168 Street, Room 1424, New York, NY 10032. January 1991-continuing.

**Abstract:** Increasing Pap Smear Compliance Among Young, Underserved Women in Northern Manhattan helps increase the compliance with cervical cancer screening

guidelines of underserved young women 15-35 years of age. It provides a community-based, culturally sensitive outreach and education program in Northern Manhattan, a neighborhood with the highest concentration of immigrants from the Dominican Republic in New York City. Its working committee consists of 18 bilingual individuals with extensive experience in health education or health care delivery. In 1991, the program sponsored focus groups with community women and developed a model educational workshop program and educational materials. There were over 40 workshops in churches, adult education centers, women's groups, social clubs, and schools, and over 1,000 young women received information about cervical cancer and screening services in the community. The project also held four low-cost Papanicolaou (Pap) smear test screening sessions in the evenings at a conveniently located community clinic. A total of 14 community women received training as lay health educators to lead future workshops in schools, churches, and other community settings. The project developed brochures in Spanish and English for distribution to local women. Pretesting and posttesting of the workshop participants revealed an average 40-50 percent increase in knowledge about cervical cancer. (CP92P0348)



099

**Increasing Pap Test Screening: A State Health Department Approach to Community and Provider Interventions.**

**Form:** Manual.

**Author:** Steiner, C.B.; Bussey, J.; Schultz, R.; Harris, S.; Liff, J.M.; Brockman, J.E.; Parker, R.M.; Dickson-Smith, V.J.

**Availability:** Georgia Department of Human Resources, Cancer Control Program, 878 Peachtree Street, NE., Room 102, Atlanta, GA 30309. (404) 894-6428.

**Abstract:** The Georgia Department of Human Resources has published a resource guide, *Increasing Pap Test Screening: A State Health Department Approach to Community and Provider Interventions*, for public health professionals who are integrating a cervical cancer intervention program with their existing multiservice adult health activities system. The department developed the guide as a result of their 5-year cooperative agreement with the Centers for Disease Control to implement the Cervical Cancer Demonstration Project designed to reach a community's high risk women in need of Pap test screening. Five sections of the guide describe the process of implementation for each component of the demonstration project. Section one covers the management plan, including the objectives, project staff, organizational support, and responsibilities; state staffing; funding levels; and the lessons learned. Section two describes a case-control study in two Georgia counties designed to identify differences in behavior between cervical cancer cases and controls, as well as direct intervention activities from these observed differences. The third section presents community-based woman-to-woman intervention targeting four low income, minority communities. Nonthreatening, positive approaches are used to educate women and motivate them to seek preventive health

care. Program staff conducted focus groups to identify barriers and motivating factors for obtaining Pap smear; developed community coalitions; designed patient education and promotional materials; and distributed provider referral lists. Section four explains a physician awareness campaign that includes a survey of physician knowledge, attitudes, and practices regarding cervical cancer screening. A videotape and patient education packet demonstrates the professionals' role in cancer prevention and presents up-to-date patient education materials. The final section examines a teaching program for medical housestaff designed to enhance breast and cervical cancer screening in clinic settings. (CP9300050)

100

**Involvement of Low Literate Elderly Women in the Development and Distribution of Cancer Screening Materials.**

**Form:** Journal article.

**Author:** List, M.A.; Lacey, L.; Hopkins, E.; Burton, D.

**Source:** *Family and Community Health*. 17(1):42-55, April 1994.

**Abstract:** Researchers used a peer participant model to develop and distribute a new breast and cervical cancer screening brochure to low-literate older women. Older women are at increased risk for both breast and cervical cancer, yet they are less likely to undergo routine screening procedures and possess accurate information about cancer. Traditional messages and educational approaches may not be as effective in changing attitudes or behavior in this group because of low reading skills. The peer participant approach used in this study incorporated both focus groups and peer helpers known as senior health advocates (SHA). All participants were recruited from the target population. Each SHA was a focus

group participant who assumed the additional role of auxiliary project staff member and distributed materials, assisted in project evaluation, and conveyed audience feedback. Of the 147 screening interviews conducted, 44 women met the eligibility criteria of being over the age of 65 and having less than 8 years of formal education. The final sample consisted of 37 women ranging in age from 65 to 81. Five focus groups were conducted over a 5-month period. Each group included 5 to 10 participants and lasted about 2 hours. The project staff recruited 8 SHA's from the 37 focus group members, based on their personal characteristics and the ethnic diversity of their area of residence. The following outcome and process variables were examined: (1) Knowledge and attitude change in SHA's as a function of project participation, (2) brochure readability and appeal, (3) practical issues involving the target audience, and (4) investigators' overall approach. Findings strongly supported the feasibility and acceptability of employing the peer helper approach to impart early cancer detection messages to low literate older women. 1 figure, 1 table, 27 references. (CP9400652)

101

### **North Carolina Breast Cancer Screening Program (NC-BCSP).**

**Form:** Program.

**Corporate Author:** University of North Carolina, Chapel Hill, Lineberger Comprehensive Cancer Center of the School of Medicine and the Department of Health Behavior and Health Education of the School of Public Health.

**Author:** Earp, J.

**Availability:** University of North Carolina Lineberger Comprehensive Cancer Center, CB no. 7295, Department of Health Behavior and Health Education, CB no. 7400, Rosenau Hall, the University of North Carolina at Chapel Hill, Chapel Hill, NC 27599-7900. (919) 966-3903. October 1992-continuing.

**Abstract:** The NC Breast Cancer Screening Program (NC BCSP) is a consortium of State and local public health agencies and universities directed by a research team at the University of North Carolina (UNC) Lineberger Comprehensive Cancer Center (LCCC) in Chapel Hill. The project's primary purpose is to increase initial and repeat breast cancer screening rates among black women over age 50 in 11 rural, eastern North Carolina counties. The project will include three complementary interventions: (1) An OutReach intervention involving a lay health advisor program; (2) an InReach intervention that helps local health departments and community health centers to expand and organize screening services for older, low-income women; and (3) an Access intervention to lower health care system barriers, particularly cost and inadequate transportation. In the OutReach intervention, lay health advisor programs in each county will recruit and train 25-50 women from the community to provide support for women in obtaining breast cancer screening. This program will also include a community education campaign and



the organization of community resources for screening weeks. The InReach intervention will include training, consultation, and materials to help health departments and community health centers organize and support breast cancer screening and followup.

Consortium members include the UNC LCCC, East Carolina University, Duke University, the Division of Adult Health, the NC Office of Rural Health, the NC Primary Care Association, and the NC Division of the American Cancer Society. (CP93P0427)

102

### **Prevention of Cervical Cancer in Native American Women.**

**Form:** Program.

**Corporate Author:** Bowman Gray School of Medicine, Department of Family/Community Medicine.

**Author:** Dignan, M.B.

**Availability:** Bowman Gray School of Medicine, Department of Family/Community Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1084.

(919) 716-4565. July 1990-continuing.

**Abstract:** Prevention of Cervical Cancer in Native American Women, part of the North Carolina Native American Cervical Cancer Project, is a 5-year community health education project in which researchers at the Bowman Gray School of Medicine are collaborating with the National Cancer Institute and three other Avoidable Mortality From Cancers in Native American Populations projects. Primary objectives are to prevent cervical cancer mortality by increasing the proportion of women over age 18 who receive Papanicolaou (Pap) smears at appropriate intervals and by increasing the number of women who return for followup care when necessary. The project will develop and implement a focused, culturally sensitive

community health education intervention, which will be presented to women individually by trained Native American lay health educators. The target population includes women who are enrolled members of the Cherokee and Lumbee tribes. The Cherokee study population includes all women over age 18 living on the reservation. The Lumbee study population was selected at random from female tribe members who are residents of Robeson County (the traditional homeland of the tribe). The intervention will include home visits, and followup by mail and telephone. A total of 1,000 women were recruited in each tribal population and assigned to one of four groups. Two groups (500 women) in each population received the pretest knowledge, attitudes, and beliefs interview. One of these groups is receiving the intervention. One of the two groups that was not interviewed will also receive the intervention. This design allows for estimation of the effect of the pretest interview as an intervention. All women will be interviewed after the intervention. Outcome measures include changes in knowledge, attitudes, and behaviors with regard to cervical cancer, early detection, and importance of followup care; data on Pap smears is also being collected from medical providers serving each population.

Intervention materials include an information brochure and a potholder and refrigerator magnets with cancer prevention messages. (CP93P0428)

103

### **Small Group Training in Breast Screening Using Volunteer Leaders.**

**Form:** Journal article.

**Author:** McVety, D.; Geller, B.; Haisman, P.; Anthony, B.; Solomon, L.; Worden, J.K.

**Source:** Florida Nurse. 41(3):10-11, March 1993.



**Abstract:** The Lee County Breast Screening Program (LCBSP) was established in 1991 in Lee County, Florida, as a community-wide education and research demonstration project. The program's goal is to encourage 80 percent of the 94,000 women in Lee County over age 40 to participate in breast screening. The program is designed to inform women about the importance of (1) regular breast screening, (2) monthly breast self-exams (BSE), (3) a yearly clinical breast exam (CBE), and (4) mammograms every 1 to 2 years for women over 40. In the first 8 months, 1,905 women participated in the program. The program recruited 89 volunteer trainers who conducted the small group programs. Volunteer trainers completed a 6-hour facilitator's course and committed to teach program sessions one or two times per month. Each of the Small Group Education (SGE) programs (8-15 women per group) feature a 5-minute video tape of local women who have had an experience with breast cancer. Another video presentation shows the actual breast self-exam. Following the visual demonstration, every woman is given an opportunity to practice skills on a silicone breast model embedded with lumps. Trainers observe and give feedback to each participant on her technique. Participants assess each session at the end of the educational programs by filling out anonymous evaluation surveys. Participants found the sessions highly informative; 91 percent found the volunteer leaders well informed and prepared. Women reported that they enjoyed the comfort and intimacy of the small group and benefitted from the group dynamics. Wider utilization of the small group process is encouraged because of its success in the training model. 1 reference. (CP9400651)

104

### Using Elderly Educators to Increase Colorectal Cancer Screening.

**Form:** Journal article.

**Author:** Weinrich, S.P.; Weinrich, M.C.; Stromborg, M.F.; Boyd, M.D.; Weiss, H.L.

**Source:** *Gerontologist*. 33(4):491-496, August 1993.

**Abstract:** The authors examined the effectiveness of using elderly educators to increase colorectal cancer screening among low-income individuals. The study tested the effects of four educational methods on participation in fecal occult blood screening: The Traditional Method, the Elderly Educator Method (EE), the Adaptation for Aging Changes (AAC) Method, and a Combination Method (EE and AAC). The Traditional Method presented standard American Cancer Society slide tape presentations and handouts on colorectal cancer. The EE Method was identical to the Traditional Method except that elderly persons were the teachers and demonstrators in the colorectal cancer presentation. The AAC Method modified the American Cancer Society's slide-tape presentation to accommodate normal aging changes (e.g., increased time needed for learning and changes in sensory abilities). The Combination (CC) Method used both the EE and the AAC at the same time. Researchers chose the 12 study sites from 173 of South Carolina's Council on Aging's Congregate Meal Sites. Between 1990 and 1991, educators presented colorectal cancer educational programs at the 12 sites using the four methods; sites randomly received one of the four methods. Each participant completed interviews on demographics and colorectal screening status prior to the educational program. During the program, each participant was given a screening kit and asked to return it in 6 days. Researchers analyzed data for a total of 171 subjects. Return rates

for fecal occult blood screening kits were as follows: (1) 56 percent for the Traditional Method, (2) 61 percent for the EE Method, (3) 43 percent for the AAC Method, and (4) 93 percent for the Combination (CC) Method. There was a statistically significant difference between the two methods that used elderly educators (the EE and CC Methods) and the two that did not. This study documents the effective use of elderly peer educators at senior centers for increasing colorectal screening. 1 figure, 3 tables, 35 references. (HE9401259)

105

### **Using Informal Caregivers to Communicate With Women About Mammography.**

**Form:** Journal article.

**Author:** Howze, E.H.; Broyden, R.R.; Impara, J.C.

**Source:** Health Communication. 4(3):227-244, 1992.

**Abstract:** Researchers attempted to increase the intentions to obtain a mammogram among their clients over age 34 using hair stylists as lay health educators. Theories of informal network communications, social support, and planned behavior provided the conceptual frameworks for the study. Researchers trained eight hair stylists at a local salon to give clients in the experimental group information about breast cancer, including the benefits risks of mammography, and to encourage them to schedule an appointment for a mammogram if they had not had one recently. Over a 3-week period in 1989, 102 eligible women who entered the hair salon for their styling appointments were invited to participate in a women's health project but were not informed about the specific focus of the study. As an incentive, researchers told women that if they entered the study they would become eligible to win a day of beauty package at the hair salon. The hairstylists provided the 98 clients

in the control group with a health message and a pamphlet on nutrition. At 2-week followup, the study found significant differences between the two groups of clients in knowledge of breast cancer risk, in belief about the value of mammography for early detection of breast cancer, in perceived behavioral control, and in intention to obtain a mammogram. At 1-year followup, the study showed that women in the experimental group who responded were twice as likely (44 percent) to report having had a mammogram during the previous year compared to controls (21 percent). This low-cost intervention shows potential for activating an informal social support system to reach women at risk with messages designed to increase their utilization of mammography. 7 tables, 47 references. (CP9300037)

106

### **Waianae Coast Cancer Control Project.**

**Form:** Program.

**Corporate Author:** Waianae Coast Comprehensive Health Center.

**Author:** Banner, R.

**Availability:** Waianae Coast Comprehensive Health Center, 86-260 Farrington Highway, Waianae, HI 96792-3199. (808) 696-7081. 1990-continuing.

**Abstract:** Through a joint effort of the Waianae community and the Waianae Coast Comprehensive Health Center, a research project was developed to test the effectiveness of a culturally-sensitive intervention to promote breast and cervical cancer screening in Native Hawaiian women. The intervention uses Kokua Groups (kokua means help) to educate women in socially supportive groups that emphasize traditional Hawaiian values and assist participants to overcome barriers to screening. Laywomen from the community are trained to work with groups of friends, neighbors, and family to encourage early

## Chronic Diseases and Risk Factors

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detection through screening for breast and cervical cancer. Women participants are recruited through informal communication networks formed by project staff with women from the community. The Cancer Information Service (CIS)-Hawaii program provides ongoing training and cancer education updates to project staff. The research goal is to evaluate the effectiveness of the community-based intervention in producing change in community knowledge, attitudes, and behaviors. (CP92P0550)



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### Cardiovascular Disease

107

#### **Black Church Blood Pressure Management Program.**

**Form:** Program.

**Corporate Author:** American Heart Association, Rhode Island Affiliate.

**Author:** Mattea, E.J.

**Availability:** 40 Broad Street, Pawtucket, RI 02860. (401) 728-5300. 1986-continuing. Verification requested, 1990; no response received.

**Abstract:** The Rhode Island affiliate of the American Heart Association has developed a hypertension screening and management program targeted to the black community in Providence. The Black Church Blood Pressure Management Program is a response to statistics indicating that black Americans are at far greater risk than white Americans for morbidity and mortality associated with hypertension. Because the church plays a unique supportive role for black and other minority populations, it provides an ideal setting for addressing a serious threat to the health of these groups. Program components include: (1) a hypertension screening and education program tailored for the churches; (2) training for program coordinators in each church (including training in the 6-hour American Heart Association blood pressure measurement course); (3) annual blood pressure screenings and followup; and (4) health education via health sermons, posters, guest speakers, and church bulletins. The program's effectiveness will be monitored through a computerized reporting system. Volunteer coordinator training classes began in October 1987, and annual blood pressure screenings are scheduled to begin in February

1988. To date, 14 individuals have been trained and certified as coordinators in six churches. (HE88P0246)

108

#### **Community Based Program: Risk Reduction-Health Education.**

**Form:** Program.

**Corporate Author:** Middletown Department of Health.

**Author:** Vinci, L.F.; Hewitt, R.D.

**Availability:** P.O. Box 1300, DeKoven Drive, Middletown, CT 06457-1300. (203) 344-3474. June 1985-continuing. Verification requested, 1988; record revised.

**Abstract:** The Middletown Department of Health in Middletown, Connecticut, has devised a program to educate residents regarding the interrelationships between high blood pressure, excess dietary fats, excess sodium, and cardiovascular illness. Programs and activities in 1985 were aimed at women in church groups having primarily a black congregation. The program seeks to teach selected participants to conduct blood pressure screenings and counseling, and to conduct an education nutrition program on fats and sodium in the diet. Women from three predominately black churches currently take part in a highly structured educational programs consisting of lectures, cooking demonstrations, taste testing, recipes, and a church supper in which participants prepare a full-course dinner using special recipes. The project evaluations using preprogram and postprogram forms indicate the respondents have decreased consumption of 13 of 15 indicator foods. The participating churches

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continue to screen blood pressures and offer referral and followup services. The Middletown Health Department Risk Reduction Program acts as consultant to the church groups ongoing efforts and works with other groups to replicate this program. The program has since been expanded to include other segments of the community. The primary purpose of the program is to decrease risks of premature death and disability from heart disease, stroke, and certain cancers by reducing the risk factors of high blood pressure, excess dietary fats and sodium, and smoking for these diseases among adults and young people generally. Program staff members train blood pressure monitors, and conduct nutrition education programs, smoking cessation programs, and blood pressure screenings and followup. Methods employed include classroom demonstrations and lectures, one-on-one counseling, films, and the media. Evaluation includes pretests and posttests and monitoring changes in morbidity and mortality rates for cancer, heart disease, and stroke. (HE85P1371)

109

### **Community Health Worker: A Resource for Improved Health Care Delivery.**

**Form:** Journal article.

**Author:** Richter, R.W.; Bengen, B.; Alsup, P.A.; Bruun, B.; Kilcoyne, M.M.; Challenor, B.D.

**Source:** American Journal of Public Health. 64(11):1056-1061, November 1974.

**Abstract:** The Community Health Worker Training Program represents a major component of the Harlem (New York) Region Stroke Program, established in 1970 to screen for, treat, and follow up persons with hypertension, stroke, and related diseases. The training program, which graduated its first class in August 1971, is designed to create a

new entry-level health position for inner-city residents who show potential for contributing to health care delivery but have not be able to use their abilities within a traditional health structure. The program developed a 2-phase recruitment process, working closely with community agencies participating in the Stroke Program. Twenty-one trainees (13 males and 8 females between ages 18-35) were chosen for the 6-month training program, which integrated didactic and clinical teaching, emphasizing pathogenesis and treatment of stroke, hypertension, and related diseases. Most of the trainees had completed high school, had reading levels of 10th grade and above, and had scores of 9th grade or above in problem-solving and math skills; most had little previous exposure to the health field; and a large percentage had records of past social, personal, or family problems. Fourteen trainees successfully completed the 6-month program and were placed in health worker positions in specialties ranging from hypertension unit assistant and stroke unit followup workers to social service casework assistant and EEG technician trainee. Training programs and job roles for community health workers need to be legitimized and standardized to overcome present fragmentation of programs and to ensure career mobility among allied health workers. Academic accreditation of training programs and their sponsorship by municipal, regional, or statewide health agencies are two critical prerequisites for these goals. 1 table, 18 references. (HE9401207)

110

**Emergency Department Detection and Follow-up of High Blood Pressure.****Form:** Journal article.**Author:** Bone, L.R.; Mamon, J.; Levine, D.M.; Walrath, J.M.; Nanda, J.; Gurley, H.; Noji, E.K.; Ward, E.**Source:** American Journal of Emergency Medicine. 7(1):16-20, January 1989.

**Abstract:** Increasing numbers of people live in medically underserved urban areas and are using hospital emergency departments (ED's) for their medical care. ED's have begun to reexamine their role to be more responsive to the prevalent health-care problems of the populations they serve. Chronic high blood pressure was used to measure the expanded role of the ED because of its prevalence and cost to poor urban communities. A study was conducted at the Adult Emergency Department of The Johns Hopkins Hospital over a 2-year period. Community health workers provided three services to supplement health providers' routine efforts in high blood pressure detection, treatment, and followup: (1) Blood pressure and pulse measurements and risk reduction counseling; (2) telephone preappointment reminders; and (3) recontact of patients failing to show for their ED followup visits. Results indicate that community health workers are a useful resource for enhancing detection, referral, and followup of high blood pressure. These paraprofessionals can improve appointment keeping as well as be useful in assisting in screening and counseling for chronic conditions within the ED. 1 figure, 21 references. (HE9000013)

111

**Heart, Body, and Soul Program.****Form:** Program.**Corporate Author:** Clergy United for Renewal of East Baltimore. Johns Hopkins Center for Health Promotion.**Author:** Tuggle, M.B.**Availability:** Clergy United for Renewal of East Baltimore, 1830 East Monument Street, no. 8037, Baltimore, MD 21205. (301) 955-7781. January 1990-continuing.

**Abstract:** The Heart, Body, and Soul Program is developing and implementing a community-based, community-owned, health program to reduce the burden of heart disease, stroke, vascular disease, diabetes, cancer, and pulmonary disease in the African American community of east Baltimore, Maryland. The program offers screenings in cholesterol, blood pressure, diabetes, smoking, and other general risk factors. The program trains community health workers to monitor these health problems and to provide counseling, health education services, and referral services to individuals with high risk health status identified in the screening settings. Also, the program trains lay health workers to perform health education interventions in churches and the community. The program uses traditional outreach methods along with behavioral and cognitive approaches to health problems in their sociocultural context. Program staff use randomized quasiexperimental designs to evaluate all aspects of the current project. Evaluation results are not yet available. (HE91P1359)



112

**Heart Healthy Bridgeport Program.**

**Form:** Program.

**Corporate Author:** Bridgeport Health Department.

**Author:** Von Euler, N.

**Availability:** Bridgeport Health Department, 752 East Main Street, Bridgeport, CT 06608. (203) 576-7680. July 1, 1988-continuing.

**Abstract:** The Bridgeport Health Department in Bridgeport, Connecticut, began the Heart Healthy Bridgeport Program to decrease the risk of premature death and disability from heart disease and stroke by reducing the risk factor of high blood pressure. The program offers blood pressure screenings at churches, worksites, and the general community; education; compliance programs; and followup. The program uses church members trained to monitor high blood pressure under health department supervision. Followup, education, referral, and compliance procedures have been established for aiding identified, uncontrolled, and multi-risk factor hypertensives. Target populations for the program include the elderly, minorities, working-age males, and the poor. (HE91P0123)

113

**Lose Weight and Win: A Church-based Weight Loss Program for Blood Pressure Control Among Black Women.**

**Form:** Journal article.

**Author:** Kumanyika, S.K.; Charleston, J.B.

**Source:** Patient Education and Counseling. 19(1):19-32, February 1992.

**Abstract:** Researchers describe and evaluate the 8-week, core component of a behaviorally oriented weight control program offered by the Baltimore (Maryland) Church High Blood

Pressure Program (CHBPP). Researchers established the CHBPP in 1979 to organize black churches as high blood pressure control centers by teaching lay volunteers how to offer (1) blood pressure, (2) screening, (3) referral, (4) followup, and (5) monitoring services. The nutrition education and behavioral counseling component of the weight loss program were based on a State health department program. Adaptations designed to promote effectiveness in the population served by the church program included (1) adding an exercise component, (2) using individual and team competitions as incentives, and (3) using teams to facilitate mutual support for weight control efforts. The core intervention program consisted of eight weekly classes at individual churches. Moderately overweight adults who were willing to commit to practicing the necessary skills and making the necessary changes for permanent weight loss were eligible. The program offered diet counseling, exercise, social support, and adherence monitoring. Researchers analyzed preprogram and postprogram weight and blood pressure measurements for 184 black and 3 white women who participated between 1984 and 1986. Results indicated the participants received the program very well. The improved or maintained weight status of most women in the followup sample suggests the program had lasting effects. The study indicates weight loss and related dietary and behavioral changes resulting from participation in a weight control program can enhance blood pressure control among black women. 31 references, 4 tables. (HE9201072)

114

**Por la Vida (For Life).****Form:** Teaching guide.**Corporate Author:** San Diego State University, Center for Behavioral and Community Health Studies. University of California, San Diego, Child and Family Health Studies. Logan Heights Family Health Center.**Availability:** Stanford Center for Research in Disease Prevention, Health Promotion Resource Center, Distribution Center, 1000 Welch Road, Palo Alto, CA 94304-1885. (415) 723-1000.

**Abstract:** Por la Vida (For Life) is a Spanish/English facilitator's guide to a community health improvement program; the guide shows Hispanic women how to lead groups of their friends and neighbors in the Por la Vida community health promotion program. The pre-session guide chapter helps a woman chosen to be a group facilitator to understand her skills regarding the project; provides suggestions on preparing, organizing, and recruiting of the group; and provides masters for duplication of printed flyers and information sheets. The recommended regime includes 16 meetings during which the facilitator leads the group of women in discussing nutrition, exercise, communication in the family, and other matters that affect their personal and their families' well-being. The meeting topics include physical fitness; fat, salt, and sugar intake; family communication; special interest sessions on community resources; and a grocery store shopping tour that highlights nutrition sources. The guide contains instructions for each week's activities, materials for educational games, and master copies of all participants' worksheets and handouts. The guide is bilingual: English on the left hand page and Spanish on the right hand page. (HE9101020)

115

**Role of Churches in Disease Prevention Research Studies.****Form:** Journal article.**Author:** Lasater, T.M.; Wells, B.L.; Carleton, R.A.; Elder, J.P.**Source:** Public Health Reports. 101(2):125-131, March-April 1986.

**Abstract:** The Health and Religion Project is a large-scale research project in which church volunteers deliver behavior change programming on the following major cardiovascular risk factors: Smoking, elevated blood pressure, elevated serum cholesterol, excess weight, and physical inactivity. A total of 20 churches of various denominations throughout Rhode Island were recruited and assigned randomly to five experimental conditions. These conditions were designed to test the necessity of training special task forces to coordinate efforts within each church and to test the relative efficacy of high or low levels of professional (paid staff) involvement. The churches' receptivity to participation in this type of project was tested through mail and telephone surveys. Those that met several eligibility criteria were selected for recruitment into the study. The enthusiastic response of churches to this particular research project bodes well for the receptivity of churches to participating in other research. The positive responses, both initially and during the first 30 months of programming, seem to indicate that churches may have strong potential as sites for major health promotion activities. 19 references. (HE8600549)



116

**Role of Lay Volunteers in a Community Hypertension Control Program.**

**Form:** Journal article.

**Author:** Caraway, J.; van Gilder, J.

**Source:** Journal of Voluntary Action Research. 14(2-3):133-141, April-September 1985.

**Abstract:** Researchers report on the effectiveness of a community hypertension control program run by the Red Cross in Greater New York and present a review of related literature that demonstrates the changing role of nonprofessionals in hospital and community-based health programs. The Red Cross in Greater New York Hypertension Services use non-medical volunteers trained for blood pressure screening and referral services. Since the program began in September 1977, over 150,000 screenings have been provided. Volunteers are recruited through (1) press releases to local newspapers and radio stations, (2) flyers and bookmarks distributed at the screening sites and throughout the community, (3) mass mailings to churches and other organizations, and (4) the friends and relatives of present volunteers. The screening sessions are held weekly in community locations such as post offices, libraries, banks and stores. In each community a hospital works with the Red Cross as medical back-up for any individuals found with hypertension who do not have their own doctors or clinics. Followup consists of postcards and phone counseling provided by volunteer nurses. A random sample of the 7,708 screenings provided during a 1-year period in one of the communities (Harlem) resulted in 2,054 screening forms being selected and coded for computer analysis. There were a total of 32 volunteers who provided screening and referral during the study period. The cost per screening and referral was compared to programs that use paid professional nurses. Cost per screening

and counseling ranged from \$1.44 for the Red Cross Program to \$17.07 to other programs. 1 table, 23 references. (HE9401340)

117

**Selection, Training, and Utilization of Health Counselors in the Management of High Blood Pressure.**

**Form:** Journal article.

**Author:** Frate, D.A.; Whitehead, T.; Johnson, S.A.

**Source:** Urban Health. 12(5):52-54, May 1983.

**Abstract:** Researchers describe the use of community members as hypertension health counselors in a five-county rural area in central Mississippi. This area comprises a bi-racial population of over 86,000, with equal proportions of African Americans and whites. The resident population is poor, and the region is medically underserved. Hypertension counselors are trained by a 3-week curriculum of lecture topics. Counselors are then evaluated by written examinations, blood pressure measurement certification, and cardiopulmonary resuscitation certification. The hypertension health counselors function in three ways: (1) They perform the traditional role of managing individual hypertensive clients; (2) they develop and monitor high blood pressure management self-help groups; and (3) they perform community activities such as blood pressure screenings and dissemination of health education materials. The following evaluation data are based on a 12-month formative evaluation. After 12 months in operation, 5 hypertension health counselors are currently managing 222 hypertensive clients, 92 percent of whom have achieved a controlled blood pressure. Currently, 16 self-help groups are operating. Of the 211 hypertensive participants, over 90 percent have achieved a controlled blood pressure. The data on access



to the medical care system indicate that during the 12 month period, over 1300 individuals were identified who were either recently or previously diagnosed hypertensives and who subsequently entered the medical care system for treatment of their hypertensive condition. 9 references. (HE9401355)

118  
**Senior Citizens' Wellness Program-Growing Younger.**

**Form:** Program.  
**Corporate Author:** Bi-County Health Department.  
**Author:** Gates, E.  
**Availability:** Butler County Court House, El Dorado, KS 67042. (316) 321-3400. 1983-continuing. Verification requested, 1988; no response received.

**Abstract:** The Bi-County Health Department of Butler and Greenwood Counties, Kansas, established the Senior Citizens' Wellness Program-Growing Younger in response to assessment and surveys indicating several health-related problems in the aging population. These problems include inadequate access to health care facilities, hypertension, smoking, special diets, obesity, lack of physical recreation or light activity, loneliness, and a high incidence of cardiovascular and respiratory disease. Program objectives focus on addressing these identified health problems through ongoing health promotion activities and education for persons over the age of 60 years. The program consists of four parts: (1) recruitment, (2) workshops, (3) neighborhood group development, and (4) evaluation. The workshops are a series of six weekly 2-hour classes that include educational presentations, group activities, skits, fitness and relaxation exercises, and height, weight, and blood pressure assessments. Participants select

personal objectives to work on for 6-months. Booster sessions are provided every 6 months. The program also includes recruitment and training of neighborhood health group leaders. Eleven neighborhood health groups have been formed and have held a total of 932 meetings with a total attendance of 6,876. Participants have demonstrated improved blood pressure levels, weight reduction, and improved cardiac risk reduction scores. The program will be continued and replicated in other communities. (HE85P1414)

119  
**Training Volunteers to Conduct Heart Health Programs in Churches.**

**Form:** Journal article.  
**Author:** DePue, J.D.; Wells, B.L.; Lasater, T.M.; Carleton, R.A.  
**Source:** American Journal of Preventive Medicine. 3(1):51-57, 1987.

**Abstract:** The Health and Religion Project (HARP) is an ongoing heart disease prevention program. HARP uses volunteers to act as discussion group leaders and information sources in cardiovascular risk factor change programs for members of their church congregations. The authors describe the rationale for the use of volunteers in this setting and the design and initial response to the HARP volunteer training program. Two hundred and twenty two volunteers from 16 Rhode Island churches were trained and certified to conduct risk factor change programs. Their certification exam performance demonstrated that they had mastered the knowledge and skills deemed necessary for their jobs. Overall, the trainees were very enthusiastic about their new roles. Considering the urgent need for economically feasible prevention methods, initial data from HARP suggest that partnerships with churches

for health promotion appear worthy of further development. 30 references. (HE8700456)

120

### **Volunteers as Providers of Heart Health Programs in Churches: A Report on Implementation.**

**Form:** Journal article.

**Author:** DePue, J.D.; Wells, B.L.; Lasater, T.M.; Carleton, R.A.

**Source:** American Journal of Health Promotion. 4(5):361-366, May-June 1990.

**Abstract:** Twenty randomly selected churches participated in the Health and Religion Project (HARP) to study the use of church volunteers to reduce cardiovascular disease risk factors among their fellow church members.

Researchers randomly divided the churches into five groups: Four treatment groups and one control group with four churches per group. Researchers conducted a baseline survey among a random sample of church members in each of the 20 churches. Two treatment groups involved the presence or absence of a task force. In churches with task forces, pastors recruited volunteers to be part of a committee charged with managing the project within their own church. Task force members received 6 hours of training on the project's purpose, program planning, and volunteer recruitment. They in turn recruited other volunteers as Risk Factor Leaders. Each Risk Factor Leader specialized in one of five risk factor programs: Exercise, heart healthy nutrition, smoking cessation, weight loss, or blood pressure. The churches without task forces used Risk Factor Leaders recruited directly by their pastor, both to conduct their programs and coordinate their offerings with one another. Researchers assessed results from the first 12 months to determine (1) if volunteers can implement these plans without professional staff, (2) if volunteer efforts could

be facilitated by a local volunteer task force, and (3) if readily available professional staff involvement aids implementation efforts. In the intervention churches, 220 certified Risk Factor Leaders conducted 82 group programs with 740 registrants and 104 blood pressure screenings with 1,834 contacts. The results of the first 12 months show that (1) volunteers are effective implementers of heart health programs in churches, (2) task force involvement seemed to facilitate volunteer recruitment, and (3) churches with a lower level of professional involvement had more blood pressure screenings. Consequently, churches have excellent potential as sites of heart disease risk factor reduction programs, and the use of volunteers as providers of such programs appears feasible. 1 figure, 1 table, 20 references. (HE9001137)

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### Diabetes

121

#### **Community Health Representatives: The Vital Link in Native American Health Care.**

**Form:** Journal article.

**Author:** Landen, J.B.

**Source:** IHS Primary Care Provider. 17(7):101-102, July 1992.

**Abstract:** Community health representatives (CHR's) are a necessary link for optimal health care in remote areas, including Native American communities. Among the southwestern tribes, there is a high prevalence of diabetes, and CHR's play an important part in diabetes prevention and management efforts. On one southern Arizona reservation, two women act as designated diabetes counselors. Their backgrounds include a high school education and basic CHR training. Their duties include diabetes counseling and education, home visits, and assisting in diabetes clinics. Under the supervision of a family nurse practitioner, the women perform weekly chart reviews on diabetics scheduled to visit the clinic. The two women have expanded their education methods by offering not only individual and group counseling but also low fat and low sugar food preparation demonstrations and chair exercise classes during diabetes clinics. They also assist with patient flow, perform foot checks, and act as interpreters between the client and practitioner. The two CHR's coordinate diabetes field clinics with the assistance of a physician and a nurse, and are responsible for organizing transportation, equipment, and supplies. Following group teaching sessions or food demonstrations, the CHR's do intake and organize treatment. The two CHR's were instrumental in starting a diabetes registry and

acting as patient/tribal representatives on the hospital diabetes committee. Other major activities of the CHR's include home visits and involvement with community agencies. It is possible to greatly enhance health care in remote areas using the talents and experiences of role model CHR's. (HE9401257)

122

#### **Community Health Worker Outreach Program.**

**Form:** Program.

**Corporate Author:** University of Maryland at Baltimore School of Pharmacy.

**Author:** Fedder, D.O.

**Availability:** University of Maryland at Baltimore School of Pharmacy, Allied Health Building, Room 234, 100 Penn Street, Baltimore, MD 21201. (410) 328-5044. October 1991-continuing.

**Abstract:** The University of Maryland at Baltimore School of Pharmacy developed Community Health Worker Outreach Program, a community-based program that uses trained community health workers as outreach workers. The target population consists of medical assistance patients with diabetes mellitus and/or high blood pressure and with a hospitalization in the preceding 12 months. Community health volunteers are recruited from the same communities that produce the patients. After an orientation and personal interview, volunteers complete 20 hours of classroom and practical education in diabetes. They begin their field work following 4 patients, and gradually increase their patient assignments to up to 10 patients. After 2 to 3 months of field work, they receive an



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additional 40 hours of training in blood pressure measurement and other related topics. Outreach workers allow targeted patients to maintain better control of their illnesses, helping them keep regular appointments, follow their doctor's treatment advice (including recommended diets), monitor their glucose, and recognize early warning signs of serious illness. Outreach health workers visit each patient assigned to them twice a month, call the patient during the weeks they do not visit, help patients deal with Medical Assistance (if necessary), and provide information about other resources that may be available to them. (HE93P0060)

123

### **Frybread Five and Dime Run, Walk, Bike for Diabetes.**

**Form:** Program.

**Corporate Author:** Devils Lake Sioux Tribe, Health Education Program. Indian Health Service, Diabetes Project.

**Author:** Garcia, L.

**Availability:** Devils Lake Sioux Tribe, Tribal Health Programs, Fort Totten, ND 58335. (701) 766-4236. 1985-continuing.

**Abstract:** Frybread Five and Dime Run, Walk, Bike for Diabetes is a yearly event aimed at increasing the awareness of health and fitness in preventing and controlling diabetes. Tribal Health Education, in cooperation with the Indian Health Service Diabetes Project, developed the program for Native Americans and any other interested in and around the Fort Totten, North Dakota area. Each year, the project establishes a planning committee whose members plan that year's events. Each member receives specific tasks such as soliciting contributions from local businesses, appointing volunteer duties, etc. The committee (1) invites an honorary chairman, such as a famous sports figure, (2)

gathers awards, and (3) disseminates promotional material. The 2-day event takes place at a local park. The first day begins with a spaghetti supper, registration, blood sugar screenings, and educational presentations with featured speakers and honored guests. The second day starts the races: (1) Three foot races (1 mile, 5 kilometer, and 10 kilometer) start simultaneously from different distances from the finish line; (2) a Tiny-Tot Race involves a 50-yard dash for children under the age of 7; and (3) the bike event and the walking event, which are noncompetitive. The awards ceremony for runners and incentive awards presentations are made later in the day at a picnic. Event participants receive pledge sheets with incentive awards (T-shirts, visors, headbands) given for obtaining high pledges. The program has been highly successful in fund-raising for diabetes and in pursuing the original goal of offering health education on diabetes. (HE91P1159)

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### Nutrition

124

#### **Black Churches United for Better Health.**

**Form:** Program.

**Corporate Author:** North Carolina Department of Environment, Health, and Natural Resources, Division of Adult Health Promotion.

**Author:** Simmons, J.D.

**Availability:** North Carolina Department of Environment, Health, and Natural Resources, Division of Adult Health Promotion, P.O. Box 27687, Raleigh, NC 27611-7687. June 1993-continuing.

**Abstract:** Black Churches United for Better Health is a 4-year research project that encourages rural African-American North Carolinians to eat five servings of fruits and vegetables each day for better health. The purpose of the project is to develop, implement, and evaluate interventions in specific community channels and/or for specific target populations to increase the eating of fruits and vegetables using the 5-A-Day message. The 5-A-Day message is to eat five servings of fruits and vegetables a day for better health. The African-American church is the main site for activities to promote the 5-A-Day message. The project uses a lay health advisor approach. The advisors make up the Nutrition Action Team and serve as liaisons between project staff and church congregants. Specific project goals are to develop interventions that will (1) increase awareness and beliefs of rural African Americans regarding the importance of fruits and vegetables in their diet as a means of primary prevention; (2) increase fruit and vegetable consumption among rural African-American adults; (3) increase social support for dietary

change among rural African Americans by using lay health advisors in churches; and (4) increase the availability of fruits and vegetables in the environment of rural African Americans by promoting the development of church programs such as food cooperatives, gardens, and food-related activities and enhancing the marketing of fruits and vegetables by local markets, vendors, and producers. For evaluation, the project will use a before and after quasi-experimental design, with the church group as the unit of analysis. Approximately five churches in each of 10 counties will be part of the evaluation. (HE94P1263)

125

#### **Effectiveness and Feasibility of Delivering Nutrition Education Programs Through Religious Organizations.**

**Form:** Journal article.

**Author:** Lasater, T.M.; DePue, J.; Wells, B.L.; Gans, K.M.; Bellis, J.; Carleton, R.A.

**Source:** Health Promotion International. 5(4):253-258, 1990.

**Abstract:** A study examined the feasibility and effectiveness of small group behavior change programming through religious organizations to achieve changes in eating patterns. The study used data from a 5-year study, the Health and Religion Project (HARP), that tested the feasibility and effectiveness of religious organizations and volunteers within their congregations in delivering cardiovascular disease risk factor reduction behavior change programming. HARP included separate programs in smoking

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cessation, blood pressure control, weight loss, and physical activity; 20 religious organizations, randomly selected from Catholic, Episcopal, and Baptist denominations scattered throughout Rhode Island participated in the project. During the first year of HARP, health professionals recruited, trained, and certified 41 lay volunteers from 16 religious organizations over a 4-week period in all the principles and materials to be used in teaching a heart-healthy nutrition class; the training also included techniques in group management. The volunteers received a manual with structured outlines for each session of the 7-week (1 hour per week) nutrition education program designed to help the participants decrease their daily intake of saturated fats, dietary cholesterol, and sodium. One year after the completion of the first class, 64 graduates provided retrospective and current self reported behavior data in areas specifically targeted by the classes. A comparison group from the same religious organizations completed the same questionnaire. Comparisons between the two groups on the retrospective reports yielded no statistically significant differences in the reported preintervention nutrition behaviors. The comparisons of reports of current nutrition behaviors, however, did yield statistically significant differences with those who had attended the classes indicating more heart-healthy eating patterns. 1 table, 33 references. (HE9101031)

126

### **Effectiveness of Nutrition Aides in a Migrant Population.**

**Form:** Journal article.

**Author:** Chase, H.P.; Larson, L.B.; Massoth, D.M.; Martin, D.L.; Niernberg, M.M.

**Source:** American Journal of Clinical Nutrition. 26(8):849-857, August 1973.

**Abstract:** Researchers conducted a study to evaluate changes in dietary intake, medical problems, and biochemical measures of nutritional status in a group of Mexican-American migrant children after nutrition aides taught the families. Five mature, bilingual Mexican-American mothers were trained as aides in a Texas county. Each aide worked with 15-20 families during the year after her last training period, backed up as needed by the nutritionist and home economist who trained her. Aides visited project families and presented practical nutrition concepts to homemakers. Children in the project, all under age 6, were brought voluntarily by parents to temporary clinics set up in churches, homes, or community centers. One community had no aides and acted as a control group. Comparative data was obtained from 60 experimental and 30 control families. Researchers obtained socioeconomic, dietary, and medical histories, and blood samples from about 200 Mexican-American preschool children in during the project, and performed physical examinations. Dietary data included a 24-hour food recall on the children in 1971 and 1972, and frequency of foods selected from each food group in 1970 and 1972. Family socioeconomic data were available from about 90 families throughout the project; medical history information was available on 205 children. Although there was suggestive evidence that the aides' influence helped families improve their nutritional status, the effectiveness of the aides in this study was not shown to be statistically significant. A major limitation of the study was the short time period to bring about and measure nutritional improvement (1 year). 6 tables, 10 references. (HE9401232)



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**Expanded Food and Nutrition Education Program (EFNEP) in Oklahoma.****Form:** Program.**Corporate Author:** Oklahoma State University, Cooperative Extension Service.**Author:** Morgan-Luddeke, J.**Availability:** 411 HEW, OSU, Stillwater, OK 74078. 1969-continuing. Verification requested, 1988; record revised.

**Abstract:** The Expanded Food and Nutrition Education Program (EFNEP) in Oklahoma was implemented by the Oklahoma Cooperative Extension Service to provide education in nutrition and related areas to homemakers from limited income families with young children. Homemakers enrolled in EFNEP learn how to (1) provide for their families' nutritional needs, (2) stretch their food dollars, (3) plan and prepare nutritious meals, (4) grow and preserve foods, and (5) store food properly to prevent waste and food-borne illness. EFNEP has both adult and youth phases. In the adult program, paraprofessional Nutrition Education Assistants teach homemakers, in their homes or in small-group settings, how to meet each family member's nutritional needs within their limited resources. The Nutrition Education Assistants are hired from the community in which they work and are trained and supervised by County Extension home economists. In the youth program, EFNEP Nutrition Education Assistants teach 6- to 19-year-olds from limited income families how to meet their nutritional needs and make wise food choices. (HE84P0620)

128

**Mount Sinai Medical Community Health Education Cholesterol Screening Program.****Form:** Program.**Corporate Author:** Mount Sinai Medical Center.**Author:** Lee, J.A.**Availability:** Mount Sinai Medical Center, 1 Mount Sinai Drive, Cleveland, OH 44106. (216) 421-3634. 1988-continuing.

**Abstract:** Many Disadvantaged minorities do not access medical care routinely and therefore are unable to take advantage of primary illness prevention programs. The churches in the black community have proven to be a vital link to those individuals who are not part of the traditional health care system. Therefore, the Mt. Sinai Medical Center Community Health Education Cholesterol Screening Program, in cooperation with churches in Cuyahoga County, Ohio, targets predominantly black communities that are at high risk for hypertension with greater severity of complications and increased morbidity rates of coronary heart disease. The screening program takes place in churches participating in the high blood pressure program. The program staff provides health education regarding cholesterol to church volunteers and ensures followup of all individuals identified as having elevated blood cholesterol levels. The volunteers educate the congregation, identify members with elevated cholesterol levels and encourage followup. Training of the church volunteers takes 3 weeks, meeting once a week for 2 hours. The volunteers receive time during the training session to practice usage of the Reflotron Analyzer. The expected outcome of the training is that church volunteers will increase their awareness of the importance of cholesterol, educate the congregation, and encourage seeking medical care from their health care providers. Evaluation of the program includes

identification of (1) the total number of participants, (2) those individuals with elevated blood cholesterol, (3) clients that had their blood cholesterol rechecked by a health care provider, and (4) health care providers who responded to a contact letter informing them of their patient's participation in the program. The program has expanded to shopping malls, health fairs, and small businesses. To date, 1,935 individuals have participated in the program. (HE90P1379)

129

### **Peer Educator Nutrition Program for Seniors in a Community Development Context.**

**Form:** Journal article.

**Author:** Ness, K.; Elliott, P.; Wilbur, V.

**Source:** Journal of Nutrition Education. 24(2): 91-94, March-April 1992.

**Abstract:** Researchers describe the development, implementation and evaluation of Food for Life; Seniors Helping Seniors, a community-based health promotion program launched in 1985 to improve the nutritional health of local seniors. Senior volunteer peer educators provided basic nutrition information for men and women over age 55 living in their own homes. A nutritionist developed the resources for training. These included a Nutritionist's Teaching Manual, a Peer Educator Training Manual, a Community Directory of Food and Nutrition Information, and Nutrition Fact Sheets. Project developers recruited 18 peer educators from local community and senior organizations through personal contact and media advertising. Once trained, the 18 peer educators shared their nutrition knowledge and skills with other seniors in the community. In the first 5 months of the program, 130 seniors contacted the nutritionist or were referred through community agencies. Program evaluators

administered a questionnaire during the training period to evaluate the peer educators' increase in knowledge and conducted telephone interviews with seniors receiving home visits to evaluate the usefulness of the information and resources received and the acceptability of using peer educators. Findings included that (1) the use of home visits provides a supportive environment for nutrition education; (2) community development principles are fundamental to the success of this type of program (i.e., the community must accept ownership of the program's implementation, support it, and be committed to it); and (3) seniors must have as much control as possible to direct programs that will benefit them personally and the community as a whole. 7 references. (HE9201473)

130

### **Peer Nutrition Education for Seniors: October 1, 1984-October 1, 1985. Final Report.**

**Form:** Report.

**Corporate Author:** St. Paul-Ramsey County Nutrition Program.

**Availability:** St. Paul-Ramsey County Nutrition Program, 1954 University, Suite 12, St. Paul, MN 55104. (612) 292-7000.

**Abstract:** A final program report provides an overview of the Peer Nutrition Education for Seniors project, and presents the results of the program's evaluation. Tables summarize project output and project outcomes. Plans for the project's continuation are also discussed. During November and December of 1984, six seniors were trained to help others stay on low sodium, low cholesterol, diabetic, or weight control diets, and to help the frail elderly to gain weight. The initial training program, and the continuing training meetings were conducted by a registered dietitian who also supervised the peer counselors, screened



referrals, and individualized the help provided to each client. Home visits by the senior nutrition advisors began in January 1985. Over 9 months, they made 246 visits to 90 seniors. Project experience showed that (1) the health of the peer counselors was the most important of the criteria in assuring the levels of help and followup desired by the clients; (2) no difference in productivity, commitment, or acceptability to clients was noted between peer counselors from professional and non-professional backgrounds; (3) the signing of a contract assured increased commitment and eliminated costly retraining during the first year of service; and (4) a stipend for volunteer expenses is essential for low income peers assisting other seniors. To assess the effectiveness of the program, researchers used a pre and post assessment of clients' dietary knowledge and behavior six months after visits were initiated. Seventy-five percent of the clients showed increased dietary knowledge, compliance, or continued diet compliance over the six month evaluation period. The peer counselors showed special strengths in encouraging the frail elderly to gain weight. Seventy-five percent of the underweight clients had gained weight and improved their nutritional status at the 6 month reevaluation. A grocery store project provided additional help for low-income seniors on special diets. Registered dietitians were present in selected stores to offer samples of low-cost foods and to assist seniors in finding foods appropriate for special diets. Program experience showed that senior nutrition advisors are providing special diet assistance at a lower cost than other existing providers in the area. (HE9401402)

131

### **Training Health Professionals and Lay Volunteers to Deliver Cholesterol Screening and Education Programs.**

**Form:** Journal article.

**Author:** Linnan, L.A.; Gans, K.M.; Hixson, M.L.; Mendes, E.; Longpre, H.; Carleton, R.A.

**Source:** Public Health Reports. 105(6):589-598, November-December 1990.

**Abstract:** The Pawtucket Heart Health Program (PHHP) volunteer training and certification program for blood cholesterol Screening, Counseling, and Referral Events (SCORE's) provides models for training lay volunteers and health professionals to deliver quality public screening programs for high blood cholesterol. The PHHP, a community intervention research and demonstration trial aimed at reducing cardiovascular disease morbidity and mortality, has actively participated in the development and implementation of model cholesterol screening and education programs since 1984. All SCORE volunteers must complete a 1-hour training session for the registration and intake station. The training for the cholesterol measurement station includes a description of the factors that influence blood cholesterol levels and instruction and skill development on fingerstick blood collecting and on using a portable desktop analyzer. From August 1984 through August 1989, 369 people received training to work in one or more stations of a cholesterol SCORE. The Cholesterol Training Center, established in 1988, modified and adapted many of the training protocols established by PHHP for a nationwide audience of health professionals. The Design and Management of Cholesterol Control Programs workshop serves program managers, administrators, and other professionals responsible for planning, delivering, and evaluating cholesterol control programs. An



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overview of high blood cholesterol levels as a public health threat provides an update on Federal initiatives and presents data that support the need for high-quality cholesterol screening and education programs. An interactive, strategy-building session on working with the medical community is followed by general sessions on management issues, marketing strategies, logistics, and medicolegal issues. Workshop registrants rate individual trainers, program content, teaching methods, and audiovisuals on a standardized evaluation form. The Cholesterol Training Center begins each workshop with a 30-item multiple choice pretest. Between May 1988 and August 1989, the Cholesterol Training Center conducted 23 workshops for 359 registrants in 15 States across the country. 2 tables, 35 references. (HE9100666)

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### Tobacco Control

132

#### **Heart, Body, and Soul: A Church-based Smoking-cessation Program for Urban African Americans.**

**Form:** Journal article.

**Author:** Stillman, F.A.; Bone, L.R.; Rand, C.; Levine, D.M.; Becker, D.M.

**Source:** Preventive Medicine. 22(3):335-349, May 1993.

**Abstract:** The authors conducted a randomized intervention trial to reduce cigarette smoking in African-American churchgoers in East Baltimore, Maryland. The objective of the Heart, Body, and Soul program was to test strategies for reducing the total number of smokers. The writers conducted a random-digit-dialed survey to establish baseline levels of self-reported cigarette smoking, examine attendant attitudes, and determine the presence of known cardiovascular risk factors among community residents. A similar survey was conducted among churchgoers to establish baseline data. The study involved 22 churches that participated in either intensive or minimal (self-help) intervention strategies. Researchers held baseline health screenings at all participating churches. The study then conducted innovative, culturally specific smoking cessation strategies in the intervention churches, mediated through lay volunteers from participating churches. Materials for the intervention reflected the spiritual nature of the church culture. A total of 29 volunteer lay smoking cessation specialists received training and successfully implemented the intensive interventions at the churches. An additional 272 church members received training to conduct their church's health screenings. The

intervention efforts included (1) churchwide mobilization events, (2) volunteer cessation specialist training, (3) a Sunday kick-off service, (4) weekly spiritual support groups, and (5) reinforcement and acknowledgment of successful cessation efforts. The churches held followup health fairs 1 year after the study. Of the 374 original smokers, the authors reinterviewed 91 percent during the followup. The study indicated that the essential components of the implementation process included building trust and acceptance and providing the technical support to encourage smoking cessation strategies. 3 figures, 1 table, 19 references. (HE9401258)

133

#### **Smoking Cessation Initiatives for Black Americans: Recommendations for Research and Intervention.**

**Form:** Journal article.

**Author:** Orleans, C.T.; Strecher, V.J.; Schoenbach, V.J.; Salmon, M.A.; Blackmon, C.

**Source:** Health Education Research: Theory and Practice (Oxford). 4(1):13-25, March 1989.

**Abstract:** This paper summarizes research about the smoking and quitting patterns of black Americans to define needed smoking-cessation initiatives. The sociodemographic correlates of smoking among blacks are similar to those of society as a whole, although there is a distinctive low-rate, high-nicotine pattern. Determinants of quitting motivation and success are also similar to those of the population as a whole, but opportunities and access to services are lower among blacks.

Community education is among the most needed interventions for blacks. A multichannel approach, combining mass media and interpersonal communication is likely to be more effective than any single channel approach. Any campaign should take advantage of the existing media focusing on blacks, such as newspapers, magazines, and radio stations aimed at a black audience. Antismoking education programs in churches, schools, workplaces, and fraternal and mutual aid organizations can shape behaviors in families and social networks. Educating lay counselors in the black community seems worthy of special attention from government and voluntary health organizations. It is important that both delivery modes and educational messages be tailored to the black target audience and responsive to the barriers to quitting disproportionately faced by black smokers. 63 references. (HE8900558)

134

### **Use of Lay Health Educators for Smoking Cessation in a Hard-to-reach Urban Community.**

**Form:** Journal article.

**Author:** Lacey, L.; Tukes, S.; Manfredi, C.; Warnecke, R.B.

**Source:** Journal of Community Health. 16(5):269-282, October 1991.

**Abstract:** Researchers describe the use of indigenous lay health educators in a supplemental intervention to stimulate the interest of young black women (between ages 18 and 39) in participating in a televised smoking cessation program and to provide interpersonal support to those who might choose to participate at four randomly selected Chicago (Illinois) Housing Authority public housing developments. Researchers recruited nonsmoking candidates for the lay health educator positions from this population; they

were expected to be knowledgeable about the community and to demonstrate good communication skills and the ability to establish rapport with the target population as reflected in a genuine interest and experience in working with individuals and groups in the community. Lay health educators were responsible for establishing contact and rapport with local community organizations to inform them about the smoking cessation program, to seek their involvement, and, when necessary, to negotiate use of space for the classroom component of the supplemental intervention. With the cooperation and assistance of the Chicago Housing Authority, the Chicago Department of Health, and local tenant councils in the targeted developments, researchers selected and hired 15 lay health educators. The supplemental intervention consisted of community lay health educators either conducting smoking cessation class sessions or making reminder visits with target group members. The lay health educators were successful in organizing this population, often viewed as difficult to reach, to become more aware of the dangers of smoking and to become more interested in participating in a structured smoking cessation program. They motivated 235 individuals to sign up for the program; of these, 141 attended at least one class session or accepted at least an initial reminder visit. None of the participants quit smoking immediately after the intervention. The results suggested that lay health educators may be able to mobilize this population to participate in health promotion programs; however, due to differences in this population related to smoking, the findings indicate that new methods must be developed for sustaining their involvement after they have been contacted. 1 table, 27 references. (HE9200669)



## Chronic Diseases and Risk Factors

### Sickle Cell Anemia

135

#### **Lay Educator Approach to Sickle Cell Disease Education.**

**Form:** Journal article.

**Author:** Holmes, A.P.; Hatch, J.; Robinson, G.A.

**Source:** Journal of National Black Nurses' Association. 5(2):26-36, 1992.

**Abstract:** Researchers assess the activities of the Education Division of the Duke University Comprehensive Sickle Cell Center, one of ten federally funded comprehensive sickle cell centers in the United States. The project's goals include (1) assessing the effectiveness of providing community genetic education with a focus on sickle cell disease by training lay community volunteers as information providers able to educate their peers through contact within formal and informal social networks; (2) increasing the level of self-sufficiency in selected communities by enabling at-risk populations to increase their responsibility for health issues; and (3) raising the level of appropriate technical knowledge of sickle cell disease and related disorders by ten percent within trainee groups. Four major project components include (1) orientation and training of project staff, (2) recruitment and training of volunteers, (3) sickle cell education campaigns by volunteers, and (4) project evaluation. Project organizers looked for the following characteristics in the volunteers they recruited: (1) Previous demonstration of willingness to help others, (2) plans to remain in the community for at least 2 years after training, (3) ability to follow through on assigned tasks, (4) trust and respect for other individuals, and (5) a personality conducive to effective communication with neighbors and

professionals. Volunteers must master basic knowledge and skills to earn certification as a lay educator. Upon completion of training, volunteers are tested on mastery of technical content. Those passing the examination are certified. Researchers observed a decrease from 37.2 percent incorrect responses on the pretest to 8.2 percent incorrect responses on the posttest. Depending on available resources, project officials will conduct both process and outcome evaluations. The lay volunteer model presents an opportunity to empower community representatives to serve as proactive constituents. Through the information disseminated by these volunteer educators, knowledge of available health care resources and effective methods of accessing these resources are enhanced. 1 table, 38 references. (HE9401358)

136

#### **Sickle Cell Trait Counseling: Evaluation of Counselors and Couselees.**

**Form:** Journal article.

**Author:** Whitten, C.F.; Thomas, J.F.; Nishiura, E.N.

**Source:** American Journal of Human Genetics. 33(5):802-816, September 1981.

**Abstract:** Information on counselee and counselor performance was obtained from 193 tape-recorded counseling sessions with adults identified as carriers of sickle-cell or parents of a child with sickle-cell trait. Counselors were specially trained lay persons. Approximately two tapes per month from each of eight counselors were selected at random for transcription, coding, and analysis. Overall, 78.8 percent of the answers were

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satisfactory, 19 percent of the counselees answered all questions satisfactorily, and almost 80 percent answered seven or more questions (out of a total of ten) satisfactorily. Of the counselee characteristics studied, only education and age were related to successful learning. The data indicate that lay persons can understand essential sickle-cell information and that trained lay persons using a structured format can transmit this information successfully. The findings suggest that (1) the evaluation of information transfer in counseling programs should consider variables such as counselor performance and curriculum content, in addition to counselee comprehension; (2) a reduction in negative feelings connected with the diagnosis of sickle-cell trait is an immediate effect of counseling; and (3) audio-taping of counseling sessions is acceptable to clients and is useful for evaluation, quality control, and counselor training. 11 references. (HE8301586)

## Issues of Aging

### Arthritis

137

#### **Beneficial Outcomes of the Arthritis Self-Management Course Are Not Adequately Explained by Behavior Change.**

**Form:** Journal article.

**Author:** Lorig, K.; Seleznick, M.; Lubeck, D.; Ung, E.; Chastain, R.L.; Holman, H.R.

**Source:** *Arthritis and Rheumatism*. 32(1):91-95, January 1989.

**Abstract:** The authors describe the results of an investigation into the mechanisms of the effects of an Arthritis Self-Management Course (ASMC) conducted in the San Francisco Bay area of California. The author used public service announcements in the mass media to recruit volunteers with arthritis to either attend a 12-hour ASMC or to participate as controls receiving no intervention. The course consisted of six weekly 2-hour sessions taught by two trained lay leaders who followed a standardized protocol. Course content included (1) the pathophysiology of osteoarthritis and rheumatoid arthritis, (2) individual relaxation and exercise programs, (3) medication effects, (4) joint protection methods, (5) nutrition practices, (6) decision making about remedies, (7) physician-patient communication, and (8) techniques for solving arthritis-related problems. The course used experiential and interactive teaching methods. Participants (n=501) and controls (n=206) completed self-administered questionnaires before the start of the course and again 4 months later. Respondents, who represented 83 percent of the original study group, reported on changes in knowledge, health behaviors, and health status. Patients in the ASMC group had statistically significant increases in

knowledge about arthritis as compared with controls. The authors analyzed the changes in reported behaviors (exercise, relaxation, and self-management activities) to determine whether they were associated with improvement in health status. Though the study indicated significant positive changes in the practice of health behaviors and in health outcomes, associations between knowledge increase and adoption of taught behaviors and between adoption of taught behaviors and health outcomes were weak. These weaknesses suggest that there are mediating factors in the effects of behavioral changes on health status. Patient education can bring about changes in behavior and in health status but assumptions that behavior change is sufficient in itself or that a particular behavior will result in a desired outcome may be erroneous or insufficient. 12 references. (HE8900962)

138

#### **Comparison of Lay-Taught and Professional-Taught Arthritis Self-Management Courses.**

**Form:** Journal article.

**Author:** Lorig, K.; Feigenbaum, P.; Regan, C.; Ung, E.; Chastain, R.L.; Holman, H.R.

**Source:** *Journal of Rheumatology*. 13(4):763-767, 1986.

**Abstract:** To evaluate the safety and effectiveness of lay instructors, researchers randomized 100 subjects with arthritis into lay-taught or professional-taught arthritis self-management (ASM) courses, or a control group. The Stanford Arthritis Center



(California) developed a 12 hour patient education ASM course. Using a standardized protocol, the course is taught by pairs of trained lay leaders, about 50 percent of whom have arthritis. Course content includes 12 hours of arthritis related content and 6 hours of teaching methods and practice. In addition, each participant receives a copy of the Arthritis Helpbook which covers all course content. For this study, the professional teachers included a rheumatologist and a physical therapist. They attended the 18 hour ASM Leader's Training Program and taught the course according to the protocol specified in the ASM Leader's Manual. Lay leaders were instructed to call Stanford to secure information about questions they could not answer. The health professionals were instructed to answer all questions as they saw appropriate. Over a period of 4 months, a total of 4 courses were offered, 2 lay-led and 2 professional-led. There was no crossover of subjects from one set of courses to the other. At the end of 4 months, the controls were offered the ASM course. Outcomes, knowledge, exercise, relaxation, disability, pain, and number of physician visits were measured at baseline and at 4 months. Knowledge was measured using a multiple choice quiz. The frequency of practicing the recommended health behaviors was reported at times per week for the week preceding completion of the questionnaire. A double anchored visual analogue scale was used to measure pain. Number of doctor visits was self-reported. Professional-taught groups demonstrated greater knowledge gain while lay-taught groups had greater changes in relaxation and a tendency toward less disability. This study suggests that lay leaders can teach ASM courses with results similar to those achieved by professionals. 3 tables, 20 references. (HE9401389)

139

**Use of Lay Persons as Patient Educators.**

**Form:** Journal article.

**Author:** Lorig, K.

**Source:** Patient Education Newsletter. 5(3):29-30, June 1982.

**Abstract:** The Stanford (California) Arthritis Center offers patients a self-management course taught by lay leaders. This type of course was planned and developed in response to a nationwide need for education programs for arthritis patients. This particular format was designed by a team of health professionals, including nurses, physicians, physical therapists, occupational therapists, nutritionists, social workers, and health educators. Described in this article are (1) methods used for recruiting and compensating lay leaders, (2) course structure and training of leaders, (3) acceptance of lay leaders by course participants, and (4) acceptance of the course by physicians and other health professionals. After 3 years of experience, during which 125 such courses have been taught, it was concluded that lay persons can effectively teach complex disease-oriented courses. Evaluation of the program's success was based on a randomized, controlled study showing that course participants became more active, experienced less pain, and made fewer physician visits than nonparticipants. The Arthritis Foundation is now testing this course in 25 U.S. cities. 4 references. (HE8302306)

## Issues of Aging

### Alzheimer's Disease

140

#### **Model for Alzheimer's Disease Support Group Development in African-American and Hispanic Populations.**

**Form:** Journal article.

**Author:** Henderson, J.N.;

Gutierrez-Mayka, M.; Garcia, J.; Boyd, S.

**Source:** *Gerontologist*. 33(3):409-414, 1993.

**Abstract:** Ethnic minority caregivers seldom attend Alzheimer's disease (AD) support groups commonly offered in large cities. Researchers developed a process to extend AD support group options to these communities. Active AD support groups were operating in both test sites (two large Florida cities) before project start-up. A targeted ethnographic survey of the minority communities revealed detailed information about those communities relative to issues of late life, health and well-being, and dementia. The survey process involved (1) developing a community demographic profile; (2) developing a list of ethnic minority organizations; (3) identifying ethnic minority media; (4) identifying key community members; (5) interviewing those who were identified as key community members; and (6) maintaining vigilance in ongoing learning processes. Planners developed a curriculum to train interested ethnic minority persons to be indigenous support leaders. The minority media were responsive, offering publicity at no charge through articles about dementia and caregiver and on radio talk shows. Educational presentations were given at meetings of ethnic minority professional, social, and civic organizations. AD support group meetings began 5 months into the project; evening meetings were more attended than day

meetings. One ethnic minority support group per city was sufficient. Location of meetings was a crucial factor. The successful location in the black community was a culturally neutral site, such as a library. For the Hispanic American community, meetings were successful at a hospital and a private health care clinic. No minorities attended the AD support groups before the project; 24 months later, 114 primary caregivers (77 black and 37 Hispanic American) were identified. The project showed that ethnic minorities will respond to AD support group intervention when it is implemented in a culturally sensitive manner. 1 figure, 40 references. (HE9401225)

141

#### **Power of Support: Alzheimer's Disease Support Groups for Minority Families.**

**Form:** Journal article.

**Author:** Henderson, J.N.

**Source:** *Aging*. No. 363-364:24-28, 1992.

**Abstract:** An ethnic minority specialist discusses the development and utilization of Alzheimer's disease support groups for minority families, noting that when the emotional strain of dealing with Alzheimer's disease and feelings of physical exhaustion are shared with a support group, caregivers seem to find more strength to cope and gain practical help by learning from the support group about community services. However, this help is not reaching caregivers from minority groups. A 1987 survey conducted in several States with large populations found that minority individuals made up only 6 percent of a sample of 2,300 caregivers who were using

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community services to assist relatives with Alzheimer's or other types of dementia. The National Resource Center on Alzheimer's Disease at the University of South Florida's Suncoast Gerontology Center developed a project to organize support groups specifically tailored to the needs of African American and Hispanic families in the Florida cities of Jacksonville and Tampa. The project entailed an intensive effort to understand each group's culture, especially its attitudes toward illness, caregiving, and the other issues raised by the presence of Alzheimer's in a family; it was particularly concerned about providing services in a manner that would not conflict with the culture's values regarding acceptance of help. Lessons learned in the project include (1) the importance of getting out from behind the desk and into the community to identify key members of ethnic minority communities through social, civic, educational, health, and other organizations who are willing to serve as liaison or coaches to the support group and (2) the need to test out the intervention models espoused in the literature. A neutral site for holding group support meetings is preferable, but a site that a health professional perceives as neutral may not be neutral in the eyes of the target group. For example, the loyalty of African-American members to their own church prevented them from attending group support meetings at another church in the community. Liaison with ethnic communities is necessary for effective program startup and maintenance. Constant personal contact by support group staff with caregivers and their families is needed to counter the impersonal nature of most service programs. Compared with support groups dominated by whites, minority support groups generally were much less formal, with frequent, loud, and animated interactions and much more interpersonal contact. Developing a support group is a long, labor-intensive process, in which it is essential to understand ethnic minority cultures. Older persons frequently are

especially resistant to attending the support groups and often only become involved through their children's or grandchildren's influence. (HE9401416)



## Issues of Aging

### Quality of Life

142

#### **Community Organizations: A Resource for Rural Volunteer Programs.**

**Form:** Journal article.

**Author:** Young, C.L.

**Source:** Volunteer Leader. 26(1):10-13, Spring 1985.

**Abstract:** Volunteer programs in rural areas face special problems. Volunteers may live in scattered communities, making it hard to attend meetings and training sessions. The volunteer organizer's understanding and involvement regarding individual communities may not be broad. Even very strong volunteer programs may need to reassess their longstanding programs and methods of operation. One way to resolve problems is to change the focus from recruiting individual volunteers to recruiting organizational volunteers. Community organizations are good sources of volunteers, especially in rural areas. The author describes a project by the Southwestern Pennsylvania Area Agency on Aging to show the feasibility of community organizations as volunteer resources for homebound elderly. A social worker acted as the program supervisor, and two long-time residents of the county were the community organizers. The supervisor identified over 300 organizations in the area, and the community organizers made introductory contacts and frequent visits with local organizations whose members were potential volunteers. Whenever several organizations expressed interest, project staff arranged a community meeting to explain the project, identify specific problems, and enlist the support of leaders in identifying homebound elderly. A total of 50 organizations agreed to participate and

completed a series of training sessions for organizational volunteers. After receiving training, volunteers inventoried their communities and identified homebound elderly. They conducted home visits to screen the elderly person's independent functioning skills, filling out needs assessment forms. If the volunteers could assist, they were assigned a caseload of local residents. Over 3 years, the project identified 472 frail elderly, most of whom lived alone. The author concludes that the program was successful because the organizational volunteers were allowed to choose their projects, and because volunteers participated in ongoing staff meetings in their communities. (HE9401255)

143

#### **Geriatric Peer-Counseling: Pilot Project Provides Support for the Homebound Elderly.**

**Form:** Journal article.

**Author:** Grossman, E.H.; Rizzolo, P.J.; Atkinson, V.

**Source:** North Carolina Medical Journal. 53(6):296-298, June 1992.

**Abstract:** The Geriatric Peer Counseling Project is part of the Geriatric Assessment and Continuity Care Clinic (GACC) at the University of North Carolina. Volunteer peer counselors make weekly visits to the homebound elderly to provide an extra support system for this population. Project goals are to relieve patient depression, to keep the frail elderly at home for a longer period of time than would be possible without visits by volunteers, and to encourage an overall higher level of patient function. The project hired a

program coordinator and recruited senior volunteers from several counties. Applicants were screened by first sending them a 10 page questionnaire listing hypothetical counseling situations, each of which was accompanied by a list of five responses. Applicants were asked to rate the responses from very poor to very good. Personal interviews were held during which applicants were rated for personal warmth, for being non judgmental, and for good listening ability. Fifteen applicants, ranging from ages 53 to 83, were accepted. The training curriculum was based on an adaptation of materials used in the University of Minnesota Peer Counseling Training Project. The coordinator, a clinical social worker, and a student from the UNC School of Social Work developed a 10-week curriculum that included both listening skills training and didactic lectures by UNC staff. Topics included (1) aging and mental health, (2) organic brain disorders, (3) aging and depression, (4) normal physical aging, (5) communicating with the demented elderly, (6) chemical dependency, and (7) caregiver stress. As soon as the peer counselors began weekly visits to their clients, the program coordinator began meeting once a week with them for supervision. Monthly group meetings are also held and afford the counselors the opportunity to talk about their visits. The program is too young to see long term results, but based on observation so far, enlisting retired volunteers and training them for this kind of service is a very workable idea. 5 references.  
(HE9401390)

144

### **Helping Network Approach: Community Promotion of Mental Health.**

**Form:** Journal article.

**Author:** Pilisuk, M.; Parks, S.H.; Kelly, J.; Turner, E.

**Source:** Journal of Primary Prevention. 3(2):116-132, Winter 1982.

**Abstract:** The Galt Helping Network Project was a 2-year program designed to augment mental health and community services in a rural California community through the use of natural or informal resources. The experiment made use of a preventive intervention model which identified important needs of local youth and families, board and care residents, and the entire community for recreation and for mental health services, and of the Mexican-American community for recognition and participation. It involved a number of volunteers in the provision of direct services, and it created institutional forms by which continued services and enlarged voluntary participation in community affairs are continuing beyond the official end of the project. The five major components of the project are (1) a project staff that coordinates the needs of all the various interest groups involved; (2) the umbrella group, a group of community leaders who advise the project staff on community matters and support the project through lobbying efforts and sponsoring community forums; (3) constituency-based problem-solving forums in which community problems and concerns could be discussed; (4) natural helpers, a group of people providing assistance to the community but not involved in human services, who have information about what kinds of support groups and agencies already exist within the community; and (5) natural helping teams, a group of people who are involved in helping a person seeking help from the project, including the person's family and friends. The results of the project indicate that

the Galt Helping Network Model can provide a major contribution to mental health maintenance and community involvement through recognition of natural helpers and the involvement of the community in an active form of problem-solving. Using these methods, a community with limited fiscal resources can take a major step toward providing a caring and helping environment for its members. 22 references. (HE8300010)

145

### **Intergenerational Neighborhood Networks: A Basis for Aiding the Frail Elderly.**

**Form:** Journal article.

**Author:** Pynoos, J.; Hade-Kaplan, B.; Fleisher, D.

**Source:** *Gerontologist*. 24(3):233-237, 1984.

**Abstract:** Researchers discuss the development and implementation of Project LINC (Living Independently through Neighborhood Cooperation), a research and demonstration project that served the needs of frail elderly persons in North Hollywood, California, by organizing residents of all ages into neighborhood-based helping networks and linking those networks to community agencies for access to additional resources as needed. Elderly residents acted as both service donors and recipients in the LINC intergenerational helping networks. LINC's program design components included (1) cosponsorship with a senior center, (2) neighborhood-based intergenerational helping networks, (3) an exchange bank of services and skills, and (4) involvement of community-based volunteers. In the first phase of implementation, community-based volunteers contacted 2,000 residents to present information about Project LINC and ask them to register. Monthly meetings were held using films, lecturers, and public leaders to address relevant issues. As membership increased, small networks were

organized along intergenerational lines. Three support groups were organized in response to older persons' desires to expand their peer relationships: (1) Men's Rap Group, which was composed of 12 members age 60-90 and met weekly to discuss national issues and personal concerns; (2) Women's Advocacy Group, which brought together 13 members for bimonthly meetings to work on community projects; and (3) Social Club of Peers, which organized its activities around social events that were attended by as many as 40 elderly participants. During the 2-year implementation phase, more than 450 participants, ranging in age from 20-93, were served by LINC. Program developers documented 2,045 service exchanges among neighbors, with an additional 641 services requiring professional intervention provided by LINC staff. Neighbor-provided services included (1) transportation with an escort; (2) telephone reassurance; (3) home visits; and (4) assistance when participants were ill, homebound, or during an emergency. A pretest-posttest evaluation conducted to measure program impact on participants revealed that the program reached the intended population of persons whose health problems threatened their ability to function independently and that their support system was expanded. Based on the success of this program and the positive impact on participants, the San Fernando Valley Interfaith Council decided to continue and replicate Project LINC at the conclusion of its 3-year demonstration period. 11 references. (HE9401422)

146

### **Maturing of Peer Counseling.**

**Form:** Journal article.

**Author:** Bratter, B.; Freeman, E.

**Source:** *Generations*. 14(1):49-52, Winter 1990.



**Abstract:** Researchers examine the growing trend of using peer counselors among aging populations and describe the Santa Monica-based Senior Health Peer Counseling Center (SHPCC) peer training model. The proliferation of peer counseling is easily understood in the context of a rapidly increasing older population that is at high risk for mental illness and emotional disorders. Professionals are often not able to meet the growing mental health needs of older adults for the following reasons: (1) Professional resistance to treating the elderly, (2) high costs of professional services, (3) low Medicare reimbursement for mental health, (4) resistance from older people to the use of mental health services, and (5) an increasingly underfunded mental health care system. The SHPCC peer training model is an in-depth, 12-week program that presents a full range of interventions suited to the aging population and emphasizes the significance of personal growth. The SHPCC model trains counselors to view the goal of the client as the primary goal of counseling. Counselors are taught that clients are more likely to achieve goals they themselves have initiated, and that just being with the client is often more beneficial than doing something for the client. Researchers sent an evaluation questionnaire to 80 agencies that had purchased the SHPCC training package. Forty-two agencies responded; of these, 19 were conducting peer counseling programs and 18 were using the SHPCC trainer's guide. A summary of responses showed the following: (1) 38 training events were reported conducted from 1983 to 1989; (2) the mean age of the counselors ranged from 49 to 65, with a median age range of 55 to 78; (3) peer counselors were trained to address both mental and physical conditions; (4) the most common reasons that clients sought counseling included illness, loss, and emotional difficulties; (5) 33 percent of the patients were seen at home; (6) when asked if clients differed because of ethnicity, education,

or socioeconomic factors, the answer most cited was socioeconomic differences (45 percent); and (7) the most commonly-used methods of evaluating the effectiveness of counseling were with evaluation forms (24 percent), through supervision (33 percent), and through client self-report (14 percent). 14 references. (HE9401412)

147

### **Mobilizing Community Outreach to the High-Risk Elderly: The Gatekeepers Approach.**

**Form:** Manual.

**Author:** Lidoff, L.

**Availability:** National Council on the Aging, Inc., West Wing 100, 600 Maryland Avenue, SW., Washington, DC 20024.

**Abstract:** Mobilizing Community Outreach to the High-Risk Elderly: The Gatekeepers Approach is the tenth volume in Program Innovations in Aging, a series that includes (1) how-to program models designed to provide detailed guidance for replicating or adapting innovative program ideas, (2) syntheses of program-relevant research findings, and (3) descriptive summaries of successful practices used in demonstrations and other innovative projects. The gatekeepers approach, which has as its goal the identification of older people who are extremely isolated and in need of help to maintain their independence, is an access vehicle for a community service system, not a freestanding program. The approach is based on an outreach component of the Spokane (Washington) Community Mental Health Center's Elderly Services program, which works by mobilizing and involving those individuals who, in the course of their regular activities, are in contact with the high-risk elderly (e.g., apartment managers, local grocers, police, pharmacists, ministers, meter readers, and delivery people). These

individuals are asked not to be counselors, but to be alert to signs that an older person may be ill or in trouble and to contact the appropriate agency in such instances. Steps in planning and organizing a gatekeeper outreach program include (1) defining the target population, (2) gaining commitment from the service system to focus on them, (3) identifying potential gatekeepers, and (4) involving gatekeepers. The high-risk elderly target population include persons that (1) are very old; (2) often have dementia, depression, or both; (3) have minimal family support; (4) have significant biomedical problems; and (5) are the most resistant to receiving help. Many of the people identified by the gatekeepers have such serious problems and so few personal coping resources that they would be likely candidates for institutionalization if the community service system were not prepared to assist them. Preparing gatekeepers for their role may take any form from a brief presentation to a formal training course. The actions in a gatekeeping scenario include (1) the gatekeeper identifying an elderly person in trouble or potential trouble and contacting the lead agency and (2) the lead agency investigating the situation quickly and providing the gatekeeper with prompt feedback and recognition for his/her efforts. (HE9401419)

148

### **Organizational Volunteers for the Rural Frail Elderly: Outreach, Casefinding, and Service Delivery.**

**Form:** Journal article.

**Author:** Young, C.L.; Goughler, D.H.; Larson, P.J.

**Source:** *Gerontologist*. 26(4):342-344, 1986.

**Abstract:** Community organizations can be used as the foci of volunteer services for homebound, frail elderly persons and can be particularly effective in rural areas where the

population at risk is dispersed. An Administration on Aging (AoA) model project took place in Fayette County, Pennsylvania, a large rural county located in the Appalachian Mountain foothills. Project goals were to (1) enlist and activate existing community organizations as service providers for frail elderly residents of the area; (2) match community organizations with older persons through client identification, needs assessment strategies, and organizing and training activities; (3) coordinate these organizational volunteers; and (4) amalgamate the service agencies and volunteers through a client-focused planning and management approach. Of 373 organizations contacted in 3 years, 50 agreed to participate and 41 of these provided ongoing volunteer services. After initial training, the organizations undertook a service delivery role such as friendly visiting, recreational activities, or shopping for the homebound elderly. During the 3-year period, organizational volunteers identified 472 frail elderly persons. Of these, 277 (58.7 percent) had no previous contact with the AoA. Of the 41 organizations, youth and school groups (12) and churches (11) were most likely to participate in the model project. Most services performed were those directly related to interpersonal contact (friendly visiting and telephone reassurance). The characteristics of the volunteers themselves influenced the services performed; for instance, older volunteers were not likely to do manual labor or chores. The project demonstrated the effectiveness of using community groups in casefinding and providing adjunctive in-home service for older persons. 1 table, 9 references. (HE9401218)



149

**Peer Support for Renal Patients: the Patient Visitor Program.**

**Form:** Journal article.

**Author:** Roy, C.A.; Atcherson, E.

**Source:** Health and Social Work. 8(1):52-56, Winter 1983.

**Abstract:** The Patient Visitor Program enables newly diagnosed renal patients facing dialysis or transplantation to meet with someone who has experienced similar stress and dealt with it constructively. The program is available to all newly diagnosed renal patients in Iowa and is a low-cost method of augmenting the personalized services available to these patients at various Iowa hospitals. Although the program was designed specifically to serve patients, the volunteer visitors report that meetings with the patients have been positive experiences for them, too. Training of the volunteer visitors, a crucial aspect of the program's success, features workshop training sessions that include communication exercises, rehearsal of sample questions and answers, and discussion of guidelines for the volunteers. Similar programs could be designed for patients with other chronic illnesses. 5 references. (HE8300356)

150

**Preventive Interventions Involving Social Networks and Social Support.**

**Form:** Book chapter.

**Author:** Gottlieb, B.H.

**Source:** IN: Social Networks and Social Support. Gottlieb, B.H. Newbury Park, CA, Sage Publications, Sage Studies in Community Mental Health, Volume 4, pp. 201-232, 1981.

**Availability:** Sage Publications, P.O. Box 5084, Newbury Park, CA 91359,.

**Abstract:** Recent research has reframed the question surrounding the nature and consequences of social support. The question of whether social support promotes and protects health has been replaced by a more specific query: Which people, with what skills, should be mobilized to address the issue of social support? The chapter reviews several research studies, evaluates existing knowledge of social support, and proposes directions for future research and interventions involving the mobilization of social support for health protection. The author identifies two major types of preventive health intervention strategies. The first type focuses on improving the supportive quality of network contacts: Recognizing that people undergoing stressful experiences typically initiate their help-seeking strategies by unburdening themselves to sympathetic figures, researchers have tried to find ways of optimizing the quality of help that these associates provide. The second type of preventive intervention focuses on efforts to bring people into contact with similar peers who are either already in their network of social ties or who can be added to their network. Since network analysis is a relatively new approach to the study of social support, the author briefly reviews it and points out its advantages over other approaches that have been used. The author concludes that social network analysis represents the most useful and ecologically valid approach to the study of social support, and that preventive programs have suffered because they have not given sufficient attention to the social structure and social norms surrounding the populations they serve. Future action research should be directed toward exploring how social networks arise and take shape in the community, and how their influence on matters of health, both positive and negative, can be modified. 57 references. (HE9401379)



151

**Service Delivery for the Community Elderly:  
The Mutual Help Model.**

**Form:** Journal article.

**Author:** Ehrlich, P.

**Source:** Journal of Gerontological Social Work. 2(2):125-135, Winter 1979.

**Abstract:** The Mutual Help for the Community Elderly research and demonstration project created an innovative service delivery model and operational plan for elderly community service delivery based on the interpretation of social research theories. The project's Mutual Help model was based on a service delivery method intended for incorporation into a more comprehensive agency program. Its sponsor could be a multi-purpose senior center, social agency, or mental health department. The structure of the model consisted of small social groups organized within natural neighborhood boundaries. The model was implemented in the Benton Neighborhood Program for the Elderly in rural Illinois. Researchers developed 10 neighborhood groups; the organization of the groups provided an outreach medium with an immediate neighborhood backup structure through which the needs of elderly residents could be identified to the community. The neighborhood groups attempted to meet social role losses through involvement of elderly residents as individuals, as group members of the neighborhood, and as participants in the total community. The evaluation of the model included an extensive research component designed to test, on the individual level, the development of informal supports, increased social role involvement, and maintenance of well-being. According to the author, social service delivery is too often measured by participant satisfaction levels and frequency of attendance. An analysis of the data, including causal modeling of criterion variables of morale, mutual help, and social participation,

suggested support for the project rationale. 3 figures, 17 references. (HE9401254)

152

**Size and Composition of the Informal  
Helper Networks of Elderly Blacks.**

**Form:** Journal article.

**Author:** Chatters, L.M.; Taylor, R.J.; Jackson, J.S.

**Source:** Journal of Gerontology. 40(5):605-614, 1985.

**Abstract:** Using data taken from the National Survey of Black Americans, researchers examined the relationship of a group of health, family, sociodemographic, and availability factors to the size and composition of the informal support network of elderly African Americans. One of the most critical support relationships occurring between elderly adults and their significant others centers around support during an illness. Research findings indicate that the most frequent contacts between impaired elderly adults and their kin involve either a spouse or child. Subjects constituted a nationally representative sample ( $n = 581$ ) of older African Americans over age 55. Least squares regression was used in the analysis of network size and logistic regression was used in the analysis of network composition. A topology of helper networks was developed by grouping them into three categories: (1) Immediate family only (spouse/partner, children, siblings, and parents); (2) mixed networks (comprised of distant relatives and nonkin associates, but that also had at least one immediate family member); and (3) nonimmediate family (distant relatives and nonkin associates only). Among this sample of older African Americans, 49 percent reported experiencing low levels of disability and 51 percent had relatively higher disability. Of those persons who had a life problem within the past month, 38.8 percent

reported that a health condition was the most serious problem they had encountered. Of the total sample, 3 percent indicated that they had no potential helper who would be of assistance to them in the event of illness, 18 percent identified one potential helper only, 22 percent reported two potential helpers, and 56 percent indicated that there were three people who would help them if they were ill. None of the health factors emerged as significant predictors of helper network size. Family closeness was the only family variable that emerged as a significant predictor of network size. These findings emphasize the importance of availability and family factors in support relationships and the relative ineffectiveness of health factors as predictors of network size and composition. 2 tables, 31 references. (HE9401424)

153

### **SMILE Program.**

**Form:** Program.

**Corporate Author:** Green River District Health Department.

**Author:** Green, T.

**Availability:** P.O. Box 1243, Henderson, KY 42420. (502) 827-2649. 1985-continuing. Verification requested, 1988; no response received.

**Abstract:** Seniors Moving Independently, Living Energetically (SMILE) is a self-care program to teach adults health promotion so that loss of strength, flexibility, and reduced circulatory and respiratory functioning can be prevented through increased activity levels. Community leaders who have frequent contact with senior citizens are trained in physical fitness, health, and recreational programs. The project is organized to develop wellness centers, stimulate healthy behaviors and attitudes, distribute pretests and posttests to evaluate the program, and coordinate senior

games competition. Media coverage informs local residents of the program and networking is done throughout local agencies. Senior volunteers act as group leaders of the program. Evaluations are conducted through use of testing, communications, and monitoring participation at the wellness centers. Results show that participation has dramatically increased in the Green River area (Kentucky); in part this has been attributed to the positive communications regarding the SMILE program from one group to another. Many senior citizen groups have incorporated SMILE group activities into their meetings. The creation of permanent wellness centers will assure ongoing continuation of these activities. (HE85P1418)

154

### **Strength of Weak Ties.**

**Form:** Journal article.

**Author:** Granovetter, M.S.

**Source:** American Journal of Sociology. 78(6):1360-1380, 1973.

**Abstract:** A researcher suggests analysis of social (or interpersonal) networks as a tool for linking micro and macro levels of sociological theory. He illustrates the procedure by elaborating on the macro implications of one aspect of small-scale interaction: The strength of dyadic ties. The strength of a tie is a (probably linear) combination of the amount of time, the emotional intensity, the intimacy (mutual confiding), and the reciprocal services that characterize the tie. The degree of overlap of two individuals' friendship networks varies directly with the strength of their tie to one another. Studies show that weak ties, often denounced as generative of alienation, are indispensable to individuals' opportunities and to their integration into communities; strong ties, breeding local cohesion, lead to overall fragmentation. This principle has an impact on diffusion of influence and



information, mobility opportunity, and community organization. Weak ties can have a cohesive power. Most network models deal, implicitly, with strong ties, thus confining their applicability to small, well-defined groups. Emphasis on weak ties lends itself to discussion of relations between groups and to analysis of segments of social structure not easily defined in terms of primary groups. The researcher presents this theory (with mathematical modeling) under section heads that include (1) the strength of ties; (2) weak ties in diffusion processes; (3) weak ties in egocentric networks; (4) weak ties and community organization; and (5) micro and macro network models. 2 figures, 61 references. (HE9401209)

155

**Utilization of Peer Counselors for the Provision of Mental Health Services to the Aged.**

**Form:** Journal article.

**Author:** Kirkpatrick, R.V.; Patchner, M.A.

**Source:** *Clinical Gerontologist*. 6(4):3-14, Summer 1987.

**Abstract:** Researchers examine the use of peer counseling in an agency. They focus on (1) the agency's preparation for peer counselors, (2) recruitment and retention of peer counselors, (3) training of the volunteers, and (4) services which they can provide to the elderly. The first step in the decision to use older persons as peer counselors requires that agency staff in charge of setting up volunteer programs be acquainted with basic knowledge about older people. Thinking of the aged as a uniform and homogeneous group, for example, could lead to serious mistakes during program development. Determining whether peer counselors are appropriate for a proposed program also requires that agency staff be familiar with the volunteers' capabilities.

Once the characteristics and potential of the volunteers are understood, it is necessary to understand the role of a peer counselor. Further, it is necessary to determine whether the agency has the resources required for the volunteer program. Peer counselors can be recruited from a variety of sources. Traditional sources of older volunteers are retired senior volunteer programs and community service centers for the aged. Volunteer loss or turnover can become problematic if the peer counselors' needs are unmet. Sainer and Zander identified eight broad guidelines that are listed for attracting and retaining volunteers. There are several specific factors to consider when training older individuals. Because a large proportion of the elderly are female, some specific training should be provided concerning counseling women. Wolleat developed ten guidelines to be considered when dealing with elderly women. These have been condensed to five guidelines which are presented. Peer counselors are competent in many areas and can provide a variety of services to the elderly. Eight functions of peer counselors are listed. 29 references. (HE9401395)

156

**Volunteer Information Provider Program: A Strategy to Reach and Help Rural Family Caregivers.**

**Form:** Journal article.

**Author:** Halpert, B.P.

**Source:** *Gerontologist*. 28(2):256-259, 1988.

**Abstract:** Over a 17-month period, planners developed a Volunteer Information Provider Program (VIPPP) in five rural Missouri counties to help families deal with the strain of caregiving. The project capitalized on two major community-based organizations in rural areas: The Missouri Cooperative Extension Services (MCES) and the Missouri



Homemakers Extension Association (MHEC). MCES Home Economist Advisors recruited volunteers. VIP training occurred over 3 days (7 hours/day) spread over 3 weeks. After completing training, each VIP was expected to share information with at least two caregivers who could be a family member, friend, neighbor, or someone referred by the community's aging network. VIP training was focused on how to work with adult learners; normal and abnormal physical and psychological changes that occur in later years; communication skills; stress management; personal care for activities of daily living (bathing, dressing, incontinence, etc.); identifying, accessing, and interfacing with community resources; being a more informed health care consumer; and assessing the needs of the caregiver. Sixty-three volunteers were recruited as VIP's, ranging in age from 24-80 (mean = 56.3 years). About 95 percent had completed 4 years or less of high school. These VIP's shared information with more than 1,100 caregivers in a 14-month period. Caregivers were found to be assisting elderly persons with a wide range of problems including Alzheimer's disease, Parkinson's disease, alcoholism, heart disease, cancer, severe arthritis, stroke, hearing loss, hip fractures, and paralyzing injuries. The VIP's helped caregivers deal with stress, communication problems with elderly persons and doctors, misinformation about aging, identifying and accessing appropriate community resources, medicine use, and personal care. The VIPP was documented as a successful strategy in reaching and helping rural caregivers and has been replicated in 21 States. 21 references. (HE9401217)

## School Health

### Elementary

157

#### **Peer Education Program to Promote the Use of Conflict Resolution Skills Among At-Risk School Age Males.**

**Form:** Journal article.

**Author:** Giuliano, J.D.

**Source:** Public Health Reports. 109(2):158-161, March-April 1994.

**Abstract:** A researcher describes and evaluates a program targeting violence prevention in elementary school boys through creative educational techniques and community partnerships. The problem of violence is particularly acute among disadvantaged young urban males. The primary goal of the program is to decrease the incidence of violent episodes in schools by teaching conflict resolution skills. In the program, conflict resolution is included in the health education component of the school health program; skills are taught using a peer education model supervised by the school health nurse and planned in partnership with a Violence Advisory Board. A 4-phase development process provides nurses with a general framework for implementing the peer education aspect of the program. Phase one consists of a violence assessment that focuses on objective data and provides guidelines for the development of a Violence Advisory Board. Phase two involves student recruitment and the formation of peer education groups from the older boys in the fifth and sixth grades. Phase three involves the training of peer education teams (PET's) by the school nurse on communication skills, problem solving skills, identification of feelings, methods of safe early intervention, and refusal skills. Phase four implements the peer

education model in grades kindergarten through four using the PET's. The program suggests ways to promote school and community involvement using an advisory board comprised of student, community, and school members. The peer education program is cost effective and demonstrates how existing resources can be used creatively within the school setting. 10 references. (SA9401030)

158

#### **Use of Community Health Aides in a School Health Program.**

**Form:** Journal article.

**Author:** Russo, R.M.; Harvey, B.; Kukafka, R.; Supino, P.; Freis, P.C.; Hamilton, P.

**Source:** Journal of School Health. 52(7):425-427, September 1982.

**Abstract:** In 1978, the New Brunswick, New Jersey, Public School System inaugurated a pilot project with the primary objective of exploring the feasibility of using community health aides to improve health care services for its elementary school children. The New Brunswick Public School System, in conjunction with representatives of Rutgers Medical School and its primary affiliate, Middlesex General Hospital, planned a curriculum and assembled a faculty of health educators, nurses, and physicians to train two community health aides. The health aides were termed family liaison workers (FLW) to emphasize their important role in providing an effective bridge between school staff and the families of enrolled children. The program established the following duties for the FLW's: (1) To provide a means of communication

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between the school and the families of enrolled children, (2) to assist in explaining the school's health goals and obtaining parental consent for the children's participation in a comprehensive health assessment program called Reach for Health, (3) to visit homes, (4) to assist parents in completing a medical/psychosocial history on their children, (5) to implement health staff-generated referrals, and (6) to be present at scheduled sessions to assist parents and children in relating to and understanding the process of comprehensive health assessments and their results. A training period presented (1) medical interviewing, (2) the use of medical/psychosocial histories, (3) the role of the school in providing health services, (4) the use of resources, and (5) the elements of comprehensive health screening. Each FLW was then assigned to a third grade class in one of two elementary schools. An independent group of program evaluators who did not participate in operational aspects of the program evaluated the FLW's effectiveness. Their findings included (1) 86 percent of parents of third graders at both project schools gave signed permission for their children's participation in the voluntary health assessments; (2) parents of 100 percent of participating third graders completed medical/psychosocial history forms with the assistance of the FLW's; and (3) parental participation in the children's health assessments, which had previously been negligible, rose dramatically to 55 percent of participating families. The success rate observed in this study promises future improved performance and achievement of higher quality school health care services. 2 tables, 9 references. (SA9401025)



## School Health

### High School

159

#### **Case Study Analysis of the Process Evaluation of a Peer-based Primary Prevention Program.**

**Form:** Dissertation.

**Author:** Fraser, R.W.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 9022786.

**Abstract:** A researcher applied a qualitative case study method to analyze and describe the process evaluation of a primary prevention program which used peer counselors to provide sexuality information to high school students. This method allowed a case description of the program and a case description of the evaluation of the program. Evaluation components included site visits and the development of program-specific evaluation instruments. The author traced the development of these evaluation instruments from initial qualitative open-ended instruments through revision into a more quantifiable form. The program evaluated was a Planned Parenthood Peer Education program that employed 12 high school students at three high schools as peer educators. These peer educators provided factual information about human sexuality in both a one-to-one setting and in classroom and group settings. A questionnaire was distributed in 1986 to a sample of students ( $n = 278$ ) from each grade level in the three schools to determine level of awareness of the program in the schools. Results of the case study indicated that this evaluation method is a useful form of naturalistic inquiry for examination of an event or process. Data from the 278 student

questionnaires revealed demographic and grade-level characteristics as well as the percentage of students aware of the program. Questionnaire data and interviews with the peer educators, school administrators, and parents indicated that the peer educators felt privileged to have been part of the program. 3 figures, 167 references. (SA9401028)

160

#### **Case Study of a Peer Health Education Project in an Urban High School.**

**Form:** Dissertation.

**Author:** Carter, B.; Frances, S.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 8602617.

**Abstract:** Researchers documented the development and evaluation of a peer health education project for adolescents in low-income neighborhoods in Worcester, Massachusetts. The project implemented youth-helping-youth concepts within the school environment using the health curriculum and peer support. Researchers devised and field-tested a peer support plan using low-cost resources such as existing role models, peer pressure, self-assessment tools, and training manuals. The outcome of the plan was a health education project with, for, and by young people. The use of student support encouraged relevance and credibility and allowed the program design to meet local needs and strengths. The study included approximately 100 elementary school participants, 10 high school student peer facilitators, 4 administrators, and guidance

staff. The high school peer facilitators were all health education students who expressed an interest in the project. Researchers collected data from elementary school participants, teachers, high school student facilitators, and adult leaders about the effectiveness of the training. Coopersmith's Self Esteem Inventories (SEI), pretests, and posttests were used to measure attitudes toward self in social, academic, and personal contexts for the high school facilitators. The elementary students completed a Peer Facilitator Effectiveness Inventory (PFEI). A total of 60 to 90 percent of the elementary students believed that the facilitator changed their attitudes, helped them enjoy school more and get to know others better, and increased their understanding of peer relationships. Only 30 to 40 percent believed that their behavior changed as a result of their experience in the group. The teachers also completed an evaluation form. All teachers agreed or strongly agreed that they were glad to have a facilitator work with their students. The primary health topic discussed with the peer facilitators was smoking prevention; other topics included youth problems, exploring self, and group approaches to problem solving. (SA9401026)

161

### **Cognitive and Affective Results of Participation in a Risk Reduction Peer Education Program on Tobacco.**

**Form:** Dissertation.

**Author:** Simpson, P.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 8219624.

**Abstract:** A researcher evaluated changes in attitudes and knowledge of teenagers who were trained as peer tutors in the Risk Reduction Health Education Program on Smoking. The

program was planned and implemented by the Dallas Independent School District in Texas. The author compared the knowledge and attitudes of 87 high school students who received peer education training in the Risk Reduction Health Education Program on Smoking with a control group of 29 students who did not participate. All of the 87 students in the program received information on tobacco, alcohol, and other drugs. Twenty-nine of the students trained as peer educators subsequently taught information on the use of tobacco only, 29 taught tobacco and alcohol education, and 29 taught only alcohol education. The peer tutors and the control group were administered a knowledge and attitude pretest and posttest in the spring of 1981. Peer tutors taught elementary and junior high school students in the district. Both the peer tutors and the control groups were administered a knowledge and attitude pretest and posttest in the spring of 1981. The peer tutors completed the pretest prior to the teaching sessions, and the posttest following the tutoring sessions. The control group was pretested and posttested at approximately the same time as the tutors. All students in the study were asked questions about their own smoking behavior. Six students identified themselves as smokers and 110 students indicated that they were nonsmokers. The number of days spent tutoring varied, but 72 percent of the tutors taught for 2 days. Approximately 75 percent of the tutors indicated that tutoring was helpful in teaching about smoking, and 85 percent indicated that they enjoyed the tutoring experience. There were no significant differences, however, in knowledge and attitudes about alcohol and tobacco use between the tutors and the students who were not trained as part of the program. 15 tables, 40 references. (SA9401029)

162

**Facilitator's Handbook: Reflections in a Glass - A Course for Women.****Corporate Author:** National Center for Alcohol Education, Arlington, VA.**Source:** Rockville, Md., National Institute on Alcohol Abuse and Alcoholism (DHEW Publication No. (ADM)77-452), 79 p., 1977.

**Abstract:** Guidelines for the implementation of an eight-session primary alcohol prevention course designed to help women confront their use and abuse of alcohol are offered for use by lay persons interested in acting as course facilitators. The sessions address the effects of alcohol on bodily functions, drinking and driving, the influence of family and peers, reasons for drinking, the effects of alcohol in combination with other drugs, the influences of American history and popular media, the relationship between American history and women's use of alcohol, and personal standards for drinking. Notes for the facilitator include awareness of drinking attitudes, group norms on drinking, group participation, course assumptions, organization of course materials, and methods and media for presenting course content. A glossary and a list of resources are appended. (HE8101471)

163

**Peer Counseling for Teenage Victims: A Student Proposal.****Form:** Journal article.**Author:** Williams, M.B.**Source:** Response to the Victimization of Women and Children. 9(2):22-23, 1986.

**Abstract:** The author discusses a student proposal for a peer counseling model targeting teenage victims of sexual abuse. Five students at George Mason High School in Falls

Church, Virginia, produced a television series on sexual abuse for a sociology course. Two of the students were invited to attend the Fourth National Conference on Victimization; they also testified before the Senate Caucus on Children, and received a positive response to their testimony by health professionals and educators. The students believed that a peer counseling model could be adopted to the middle school and high school setting and that groups, led by trained peer counselors, could offer support, information, and assistance to victims of crime and abuse. In the student model, the peer counseling groups would be publicized through advertisements and referrals from counselors, psychologists, teachers, school social workers, and peers. Each group would consist of two teenage leaders who have been trained in peer counseling techniques, have been involved in group counseling themselves, and, if they were victimized, have resolved their own personal experiences in a healthy manner. Peer leaders need 8-10 hours of training in the development of communication skills, as well as training about reaction patterns and issues related to victimization and sexual abuse. The group should have a maximum of 10-12 members and should meet on a weekly basis. In addition, the group members must be aware of the legal requirements for reporting abuse and, if an unreported case is uncovered, they must inform the group leader. The leader or a group advisor should then meet with the student to gather information and make the necessary report. The students who have proposed the peer counseling model intend to present a detailed training program in a video tape format. 6 references. (SA9401031)



164

**Peer Education: A Case Study in County-Wide Networking of School-Based Peer Helping Programs and Community Service Agencies.**

**Form:** Dissertation.

**Author:** Bianconi, A.M.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 9026522.

**Abstract:** A researcher investigated participant perceptions of networking between school-based peer-helping programs and community service agencies. Study subjects included 10 community service providers from 8 different service agencies in Schuylkill County, Pennsylvania. Nine of 10 participants acted as trainers of peer helpers while one acted as an administrator. Prior to implementation of the countywide networking approach, the author interviewed the 10 service providers on their perceptions of the relationships between community service agencies and school district personnel as well as other service providers. The author reviewed respondents' observations, field analysis, and historical data, and then categorized this data on the basis of similarities and discrepancies to identify recurring themes. Results indicated that countywide networking of school-based peer helping programs and community service agencies generated unintended community change because of new linkages established by key agency staff outside schools. Specific developments included: (1) The evolution of a countywide Peer Education Association; (2) the establishment of an annual countywide peer helper training program; (3) the development of a school and community agency representative planning group to meet quarterly throughout the school calendar year, evaluate program policy, and plan program events; (4)

improved agency services to adolescents throughout the county; and (5) the establishment of a Teenline telephone information and referral system. Findings indicated that the countywide peer-helping and agency networking approach improved agency services to adolescents throughout the county. (SA9401027)

## School Health

### College

165

#### **Athletes as Rape-Awareness Educators: Athletes for Sexual Responsibility.**

**Form:** Journal article.

**Author:** Caron, S.L.

**Source:** Journal of American College Health.  
41(6):275-276, May 1993.

**Abstract:** The University of Maine developed its peer education program, Athletes for Sexual Responsibility, to address the problem of sexual assault on campus. Founded in 1990, the program addresses both date rape and gang rape. Athletes for Sexual Responsibility includes approximately 25 male and female student athletes representing all intercollegiate sports at the University of Maine. Athletes are recruited during the year through a human sexuality class, coaches, fliers posted in the gym, and recommendations from current members of the program. The athletes are accepted as peer educators after a favorable review of their application and an interview with the director. Peer athlete educators attend biweekly training meetings. Each meeting contains a business, educational, and practice session component. The program attempts to dispel myths about gender expectations that are believed to contribute to rape, particularly myths about what constitutes normal male behavior. A series of three brief skits portray how better communication might make a positive difference in tough sexual dilemmas and decisions. A unique problem for this program is that, because athletes have in-season and out-of-season schedules, they are often unable to commit themselves to a regular schedule of meetings for an entire semester or year. This is one of the biggest differences between this program and other peer education

programs. Recognizing that all peer athlete educators should have the same foundation of knowledge, the program requires each athlete to take a human sexuality course and requires specific readings. The program uses athletes as role models, not only for their physical strength, agility, and stamina; but also for their appropriate social and sexual behavior. 5 references. (HE9401348)

166

#### **Case Study of a Successful Health Advocate Program.**

**Form:** Journal article.

**Author:** Allen, N.J.

**Source:** Journal of American College Health.  
41(6):293-295, May 1993.

**Abstract:** A health educator describes the health advocate program of Olin Health Center at Michigan State University. The health advocates are the peer branch of the university's health education/public health service. Since initiation of the program in January 1986, more than 125 students have participated in the training and service, for which they receive academic credit. Although initiated as a cooperative effort between Olin Health Center and the MSU Department of Student Affairs and Services, the health center assumed total responsibility for the program in September 1988. Training consists of a 2-credit course that meets 3 hours per week for 1 term during the academic year. The 30-hour training includes both general and specific components: Approximately 20 hours of activities designed to enhance general health promotion knowledge and an additional 10 hours of skill development related to team

participation and service responsibilities. The health advocates participate in one of three focus teams: (1) Exerstart for LIFE, (2) a speakers bureau, or (3) special projects. The Exerstart For Life team promotes lifestyle changes related to exercise and fitness. The speaker's bureau offers programs to promote healthy lifestyles through small-group presentations. The special projects team promotes four to six events per term: (1) A World AIDS Day, (2) Eating Disorders Awareness Week, (3) the Great American Smokeout, and (4) Sexual Health Awareness and Stress Release Weeks. In addition, all health advocates are involved in staffing the health education resource center, helping with MSU's health fair, and promoting health-related events. The health center evaluates the health advocacy program both quantitatively and qualitatively. Forms are used to record the numbers and types of students involved in outreach activities, and team members complete their own evaluations. This assists them in analyzing their performance, assessing programs in terms of goals and objectives, and sharing recommendations for future events. In conclusion, the author offers specific recommendations to those considering creating a peer education program. 1 reference. (HE9401351)

167

### **Comparison Study of Peer Teaching and Traditional Instruction in Venereal Disease Education.**

**Form:** Journal article.

**Author:** Jordheim, A.

**Source:** Journal of the American College Health Association. 24(5):286-289, June 1976.

**Abstract:** A study addressed the question of whether peer teaching in venereal disease (VD) education is more effective than traditional

instruction in imparting knowledge, changing attitudes, and influencing behavior. For this study, VD is defined as syphilis and gonorrhea. Researchers randomly selected 100 community college students from 3 health education classes in Brooklyn, New York. They assigned 50 students to the E-Group (experimental group, to be taught by the peer teachers), and 50 to the C-Group (control group, to be taught by 3 health education instructors). All students received pretests on the following instruments: (1) The Venereal Disease Knowledge Inventory and Attitude toward VD Prevention and Control, (2) the Attitude toward VD Tests, and (3) the Behavioral Intentions Survey. Twenty peer teachers, all student volunteers from a public health class, were trained to teach VD education; they then taught the E-Group about VD. The C-Group was taught about VD by their regular health education instructors. All students received posttests using the same instruments used for pretest. An analysis of variance was done on all pre- and posttests for the two groups of students. T-tests were included. Pretest and posttest findings are presented in 12 tables. Significant differences were found between the two groups on the VD Knowledge Inventory and the Attitude toward VD Test. In both cases, the experimental group had higher scores. No difference was found between groups on the Attitude toward VD Prevention and Control Test and the Behavioral Intentions Survey. According to this study and under these experimental conditions, peer teaching was shown to be more effective than traditional VD education in the areas of knowledge and attitude toward VD. A comparison study of peer teaching and traditional classroom teaching in VD education may be worth duplicating under more rigorous experimental conditions. 12 tables, 1 reference. (HE9401399)



168

**Evaluative Study of the Peer Education Component of the Total Alcohol Awareness Program (TAAP).**

**Form:** Dissertation.

**Author:** Eakin, J.T.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 8419588.

**Abstract:** A researcher evaluated the success of the peer education component of Pennsylvania State University's Total Alcohol Awareness Program (TAAP), a voluntary alcohol education program focusing on freshman at the University Park Campus during the 1978-79 academic year. The objectives of the peer education component of TAAP included increasing knowledge about alcohol and its effects, helping students evaluate current drinking practices, and encouraging the responsible use of alcohol by those who choose to use it. Students in the sample resided in selected university residence halls. All students, both program participants and nonparticipants, completed pretests to ascertain initial differences between students and posttests to measure changes in use, behavior, and attitudes. Testing was accomplished using established alcohol survey instruments including Engs' Student Alcohol Questionnaire and Gonzalez's Student Drinking Questionnaire. Analysis of data comparing program participants and nonparticipants was conducted using Statistical Package for the Social Sciences. One concern about voluntary alcohol education programs is the general belief that the individuals who most need alcohol education will not choose to attend, but results suggest that this may not be true. Initial differences on pretests showed that participating males had the least responsible attitudes about alcohol, used the most alcohol, and experienced the largest number of alcohol-

related consequences. These factors indicated that such a group would make suitable candidates for alcohol education programming. Findings of the study with regard to program effects indicated no significant relationship between participation in the TAAP program and change in knowledge scores or pattern scores. The effects of the program on responsible attitudes were different between men and women. The program achieved the desired effect for women, with female participants showing more responsible attitudes after the program and males reflecting a deterioration in responsible attitude scores. Males are generally more knowledgeable about alcohol, use the substance to a greater degree, and experience a higher number of negative consequences as a result of their alcohol use. 14 tables, 63 references. (HE9401406)

169

**Evolution of Peer Education: Where Do We Go From Here?**

**Form:** Journal article.

**Author:** Gould, J.M.; Lomax, A.R.

**Source:** Journal of American College Health. 41(6):235-240, May 1993.

**Abstract:** In a guest editorial for a special issue of the Journal of American College Health, the authors present a discussion of the evolution of peer education. They place its origin at the University of Nebraska in 1957 and discuss the reasons for the recent proliferation of peer education programs. The authors present a detailed table entitled Starting a Peer Education Program From Scratch, which identifies key components and key groups involved in peer education programs. Eight program notes provide profiles of individual programs as they currently exist and are being implemented on campuses around the country. Another group of program notes points out how crucial it is to provide tailor-

made interventions to meet the needs of specific groups within the general student population. A final set of program notes turns to issues to be considered when training peer educators in specific content areas. A training model is introduced as a sample model for preparing peer educators on how to respond to a highly focused issue. Specifically, the model is designed to enhance the capabilities of already-trained sexuality peer educators in responding effectively to fellow students' needs for information about HIV infection. The authors caution that peer education should never serve as a substitute for the work that can be performed effectively only by professionals whose training and experience necessarily exceed that of students trained as peer educators. 1 figure, 2 references. (HE9401341)

170

### **Generalized Effects of a Peer-Delivered First Aid Program for Students With Moderate Intellectual Disabilities.**

**Form:** Journal article.

**Author:** Marchand-Martella, N.E.; Martella, R.C.; Agran, M.; Salzberg, C.L.; Young, K.R.; Morgan, D.

**Source:** Journal of Applied Behavior Analysis. 25(4):841-851, Winter 1992.

**Abstract:** Peers with mild intellectual disabilities taught first aid skills to four students with moderate intellectual disabilities. Researchers assessed the students' acquisition of three first aid skills (treating abrasions, second-degree burns, and severe cuts) and the generalization of these skills to their homes. Four students with moderate intellectual disabilities who were enrolled in a self-contained classroom in a regular public school were participants in the study. None had previously received first aid training. Two students with mild intellectual disabilities

served as peer tutors. Each peer tutor taught two participants. All students were elementary school age. For training, the study used simulated injuries attached to the skin with two-way tape. Simulated blood was used on severe cuts, dirt was placed on abrasions, and embalmer's wax was applied to burns to simulate blisters. The investigators supplied participants with a first aid kit for their homes. The kit was also used in all baseline and training sessions. Researchers used a multiple probe design across participants to examine the effects of the peer teaching program during an acquisition and a partial sequential withdrawal phase. They conducted generalization assessments in the participants' homes using novel, randomized simulated injuries. Results suggest that the peer teaching program results in acquisition of first aid skills, and the participants' skills generalized to the home, to novel simulated injury locations, and to new trainers. Additional findings are discussed with respect to training issues, generalization, maintenance of acquired skills, and the use of peer tutors with disabilities. 2 figures, 3 tables, 14 references. (HE9401393)

171

### **Longitudinal Analysis of a Peer Health Aide Program.**

**Form:** Paper.

**Author:** Martin, G.L.; Newman, I.M.; Carlson, M.

**Availability:** ERIC Document Reproduction Services, 7402 Fulleton Road, Suite 110, Springfield, VA 22153. (800) 443-3742. ERIC document no. ED 177 132.

**Abstract:** Researchers describe the Health Aide Program at the University of Nebraska-Lincoln, an important component of the campus health program. In this program, approximately 140 students are trained as paraprofessional health aides and serve in their



respective dormitories in exchange for a small weekly salary (\$5 per week). They provide over-the-counter medication for various health problems, first aid care, and advice and referral for health needs and health education programs. The majority of visits to health aides were for physical complaints such as upper respiratory infections, injuries, headaches, abdominal complaints, and genitourinary complaints. From its inception in 1958 until 1978 the program experienced stable administrative support and followed a consistent pattern of activities. Researchers compiled a record of the number of visits reported by aides and of the types of student complaints. During a 3-year period, the magnitude of the helping effort has remained relatively constant despite large turnovers in both staff (health aides) and consumer population. Student evaluations of the program were completed by individuals who were consumers of the health aide services and probably did not represent the entire student population served by the program. The evaluations reflected favorably upon the acceptance of services received but did not necessarily provide an indication of the merits of the total program. It was unclear if the majority of students were aware of the program or if they still had unmet health needs. A more rigorous sampling method, coupled with provisions for assuring a better return rate, should provide a much more complete view of the student population's evaluation of the program. (HE9401413)

172

### **Model Approach to Peer-Based Alcohol and Other Drug Prevention in a College Population.**

**Form:** Journal article.

**Author:** Grossman, S.; Canterbury, R.J.; Lloyd, E.; McDowell, M.

**Source:** Journal of Alcohol and Drug Education. 39(2):50-61, Winter 1994.

**Abstract:** Researchers provide a description of the background, development, implementation, and followup evaluation of the Virginia Intervention Education Weekend (VIEW) program. VIEW was designed to implement effective peer-based alcohol and other drug prevention programs in colleges and universities in Virginia. The overall goal of the VIEW project was to make every student participant a prevention specialist who would return to his or her college as part of a peer network of student leaders to institute alcohol and other drug (AOD) prevention programs on their respective campuses. Twenty-eight Virginia colleges and universities sent a total of 201 participants to VIEW. Seventy-four percent of the participants were students or student facilitators, 19 percent were administration/staff members, and 6 percent were faculty members. Sixty-seven percent of the VIEW Participants surveyed (n = 136) perceived alcohol abuse to be a serious problem on campus. Fifty-four percent perceived drinking and driving to be a serious campus problem as well. Marijuana use was also perceived by many VIEW participants (41 percent) as a major problem, while cocaine use (7 percent) was perceived as a much less serious problem. Evaluations of the program were completed during the workshop and again later during the year. The evaluation revealed positive outcomes relating to increased awareness of alcohol and other drug abuse and prevention activities in 89 percent (23 of 28) of the participating colleges and universities.



Results of the evaluation also indicated that (1) revisions were needed in the original program plan to increase involvement of other students or administrators when the participant returned to his or her respective college; (2) administration support and involvement was inadequate; (3) funding for substance abuse prevention programs, sometimes as a result of budget cuts, was inadequate; and (4) students involved in the project were often overextended with other campus activities, chose to transfer to other schools, or needed followup support to maintain their focus and enthusiasm. 15 references. (HE9401408)

173

### **Peer Education and the Deaf Community.**

**Form:** Journal article.

**Author:** Joseph, J.M.

**Source:** Journal of American College Health. 41(6):264-266, May 1993.

**Abstract:** Gallaudet University, the world's only liberal arts university for deaf students, has recently established a peer health education program. This program is unique because of the population it is designed to serve and the rich culture within which the program exists. The program began in spring 1991 when a health educator was hired who assumed primary responsibility for its establishment. Peer health educators (PHE's) were recruited in the spring to begin training for presenting workshops the following fall on HIV infection and other sexually transmitted diseases (STD's), safer sex, contraception, and rape. The pilot PHE program at Gallaudet accepted 4 of 15 applicants who were recruited through mailings to their post office boxes, personal contacts, and the campus computer mail and conference system. PHE's are not paid, but they do receive academic credit for their 2-semester experience in the program. The week before the beginning of the semester, the

PHE's participated in approximately 24 hours of training. Training then continued for 2 hours every week. Training topics included basic health education principles, including (1) the differences between knowledge, attitudes, and behaviors of students; (2) sexuality issues, such as basic reproductive anatomy and physiology, homosexuality, and societal influences on sexuality; (3) group facilitation skills; (4) professionalism, ethics, and referral; and (5) detailed information on the specific topics for the PHE workshops. Although the program is still in its early stages, it has provided insights for improvement in the future. Plans are in place to include more students in the program and to have smaller groups of PHE's specialize and receive in-depth training on only one or two health issues. Plans are also in place to increase collaboration with residence hall staff, other student paraprofessionals, and student organizations to increase the demand for and the number of workshops presented on campus. (HE9401347)

174

### **Peer Education in the Residential Context.**

**Form:** Journal article.

**Author:** Bauman, D.W.

**Source:** Journal of American College Health. 41(6):271-272, May 1993.

**Abstract:** The division of campus residences at the State University of New York (SUNY) at Stony Brook began an HIV peer education program in 1989 which focuses the energy and attention of peer educators on one-to-one interaction with their fellow students. The program relies primarily on resident assistants (RA's) who maintain contact with a wide range of individuals. All RA's at Stony Brook must participate in training on AIDS and HIV transmission. At these training sessions, the peer educator program is described and

interested students are encouraged to apply. The choice of peer educators focuses on identifying those individuals who have superior skills and heightened sensitivity to the impact of HIV infection. Training focuses on orienting peer educators to identify opportunities for raising the topic of risk reduction. The professional staff uses video and role playing to help peer educators learn to recognize statements and behavior that indicate that an individual may be at risk for exposure to HIV. Peer educators also receive extensive training about routes of HIV transmission; sexuality and sexual orientation; sexually transmitted diseases; and the demographics of HIV infection. Peer educators at Stony Brook have available to them a mentor who provides them with consistent, high-quality, one-on-one interaction. Professional staff members who serve as mentors must agree to devote a great deal of time and energy to the program. To evaluate the effectiveness of the program, peer educators keep journals that describe their interactions with the students with whom they are working. Journal entries and discussions between the peer educators and professional staff members offer clear evidence that the peer educators often succeed in encouraging fellow students to change the behaviors that put them at risk of exposure to HIV infection. 3 references. (SA9401024)

175

**Peer Educator Programs as Self-education: Effects on Self-concept, Motivation and Sexual and Exercise Behaviors.**

**Form:** Dissertation.

**Author:** Leibowitz, B.G.

**Availability:** University Microfilms Inc., 300 North Zeeb Road, P.O. Box 1346, Ann Arbor, MI 48106. (800) 521-3042. (313) 761-4700. Order No. 9000817.

**Abstract:** A researcher conducted a study to examine the effects of a peer health educator program on the helpers themselves, specifically in terms of their exercise and acquired immunodeficiency syndrome (AIDS)-preventive behaviors and the effects of certain psychosocial variables on these behaviors. Variables studied included (1) health locus of control, (2) health value, (3) self-efficacy, (4) self-motivation, and (5) current and future self-conceptions. A longitudinal study was conducted at the University of California at Los Angeles (UCLA) to assess behavioral and psychosocial changes in students participating in the peer educator program. The sample included students who were accepted into the UCLA peer educator program and students who applied to the program but were not accepted. The Student Health Service of UCLA sponsors two helper programs: A peer health educator program and a student health advocate program. Peer health counselors and student health advocates are undergraduate students who provide education, counseling, and referrals for UCLA students. The basic goal of both programs is to narrow the gap between the health needs of students and the available services designed to meet their needs. On two occasions, four months apart, 168 program participants and nonparticipants completed a questionnaire which included behavioral and psychosocial measures. Results showed that self-conceptions and efficacy beliefs were important influences on the



continued practice of these health behaviors. More specifically, self-fears such as becoming a person with AIDS were shown to be a potent influence on the maintenance of AIDS-preventive behaviors. The effects of the helper program on the health behaviors of program recruits were not clear cut. No significant differences between recruits and nonrecruits emerged for measures of behavior; however, a trend toward more positive sexual health behaviors among the active recruits was suggested by descriptive data. Program recruits also reported greater efficacy beliefs and more positive self-conceptions than did nonrecruits. 37 tables, 159 references. (HE9401407)

176

### **Planning for the Future of Peer Education.**

**Form:** Journal article.

**Author:** Edelstein, M.E.; Gonyer, P.

**Source:** Journal of American College Health. 41(6):255-257, May 1993.

**Abstract:** The University of Massachusetts began a pioneering program in 1970 using student peer educators in the fields of alcohol and other drug use and sexuality. These student educators were valued agents of change because they could communicate effectively with their contemporaries in ways that professional staff members could not. Over time, it became clear that peer education was also valuable for its ability to respond, adapt, and remain flexible in times of change. This article focuses on one school's response to necessary changes in its peer education program, demonstrating that although the program evolves over time, evolution can be both natural and beneficial. Since July 1974, the university staff has trained more than 1,300 peer educators who have guided more than 3,500 peer education outreach projects that have reached approximately 43,250

participants. Recently, in response to critical personnel problems and harsh economic realities, the University reorganized its peer education programs. They achieved their primary goals by collapsing three academic courses into one. In preparing peer educators to work on campus, the University employs three different models: (1) Training through academic course work, (2) community development/volunteer educators, and (3) employed peer educators. About 90 percent of the current peer educators are trained in academic courses. The restructured training combines individual peer programs into one 2-semester class. The authors offer their recommendations for university peer programs: (1) Plan a rigorous training model and a viable supervision strategy; (2) allow the peers to express their creativity; (3) when making changes in the program, seek active involvement from the primary staff who are responsible for program coordination; (4) anticipate and expect the typical discomfort, instability, and doubt that change often invokes; (5) involve current peer educators and other students on campus in designing or changing the program; and (6) collaborate with and look to other campus organizations for support. 6 references. (HE9401345)

177

### **Power of Peer Health Education.**

**Form:** Journal article.

**Author:** Sloane, B.C.; Zimmer, C.G.

**Source:** Journal of American College Health. 41(6):241-245, May 1993.

**Abstract:** Peer education on college and university campuses has grown from self-educated students responding to campus health issues to state-of-the-art health education and motivational models designed to empower students to help each other promote positive health beliefs and behaviors. The authors



provide a brief history of college peer educators, citing student health aides who were organized in response to a 1957 Asian flu epidemic as one of the earliest recorded instances. Reasons for acceptance of peer education include the 1979 publication of *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. This report called upon individuals, families, schools, businesses, communities, and consumers to join health professionals in creating environments and educational opportunities to help Americans change unhealthy living patterns. Over time, relationships among health-care professionals and patients changed. People increasingly sought to be partners who participated in their own health and lifestyle decisions, and a new array of allied health providers and alternative therapies evolved. Current model peer education efforts are based on carefully trained and closely supervised programs that ensure continuing quality improvement. Health educators are now exploring more comprehensive training and delivery models that encompass the complex nature and relationship among risk behaviors, life skills, and the social pressures that have an impact on students' lives. *Healthy People 2000, National Health Promotion Disease Prevention Objectives* has charged colleges and universities with the responsibility of providing strategies, including HIV education and reducing episodes of heavy drinking among university students. This can be accomplished by creating roles for students in the assessment, design, development, and implementation of programs that speak to others like themselves. 26 references. (HE9401342)

178

**Professionals' Experiences of Peer Education.****Form:** Journal article.**Author:** Devera, C.; Haines, M.; Kelley, S.; Wessel, L.**Source:** *Journal of American College Health*. 41(6):300-301, May 1993.

**Abstract:** Four experts in the field of peer education shared their views, ideas, and experiences. They responded to three questions: (1) Who benefits from peer education?; (2) how is peer education abused?; and (3) what have you learned from your involvement in peer education? Three of the experts agreed that peer educators themselves were among the chief recipients of benefits from peer education programs. One expert believed that institutions also benefit from peer education programs in that difficult topics, such as human sexuality, alcohol and other drug use, and date rape, are addressed by individuals who are highly accessible to their audiences and have credibility with them. The experts felt that peer education is abused (1) when professionals engage in peer indoctrination rather than peer education; (2) when peer educators become imbalanced in their commitment to the program; (3) when campus units request programs not out of any real interest in the topic, but to fill a quota or to meet a demand from an external person or supervisor; and (4) when facing crippling fiscal crises, institutions may implement so-called cost effective peer outreach programs without providing adequate professional staff supervision of the peer educators. Insights into peer education provided by the experts include: (1) Peer educators often have a high degree of sensitivity to the problems they are being trained to face; (2) it is important to establish ongoing recruitment of students so that an adequate pool of peer educators is available to meet the demand for programs; (3)

for peer education programs to work best, they must be indigenous, generated from the population that they intend to serve; and (4) peer educators can become a potent force in effecting change in campus environments and modeling health-enhancing behavior as the norm rather than as the exception. (HE9401352)

179

### **Refining Your Peer Education Program.**

**Form:** Journal article.

**Author:** Keeling, R.P.; Engstrom, E.L.

**Source:** Journal of American College Health. 41(6):259-263, May 1993.

**Abstract:** There are 10 closely-related characteristics that are common features of enhanced peer education programs. Taken together, these characteristics define programs that effectively assess and respond to the needs of the campus community in an inclusive, flexible way; their presence is evidence of the strength and effectiveness of the program itself. The authors identify and discuss these ten features: (1) The ability to sense, monitor, and react to change; (2) the frequent and careful evaluation of the program in the context of an ongoing appraisal of campus needs in health education and health promotion; (3) the ability to match the talents, skills, and preparation of peer educators to the most appropriate tasks, activities, and programs; (4) the recruitment of people with specific talents that match the program's needs; (5) the recruitment of students who are broadly representative of the diversity of students on campus; (6) the development of highly targeted, carefully designed, frequently evaluated training activities, which are specifically tailored to the needs of each group of trainees; (7) the awareness of and responsiveness to the diversity of learning styles among students and their focus on visual

learning; (8) the commitment to inclusive programming; (9) flexibility; and (10) a focus on effective marketing. (HE9401346)

180

### **Review of Evaluations of Peer Education Programs.**

**Form:** Journal article.

**Author:** Fennell, R.

**Source:** Journal of American College Health. 41(6):251-253, May 1993.

**Abstract:** The author presents a review of the literature on process and outcome evaluations of peer education programs and offers suggestions to encourage evaluations that will yield more accurate and useful information in the future. Because only five of the articles reviewed provided outcome data, the author also suggests how health educators can increase evaluation outcome data and why it is critical to collect this information. The absence of evaluations may help explain why there is so little research literature on the effectiveness of paraprofessionals. Unless administrators demand that evaluation be part of a peer education program, such evaluations will not increase because those who are responsible for the programs often do not have the skills to do the studies. The author suggests that health professionals in charge of peer education programs (1) develop relationships with other faculty members; (2) discuss the possibility of having graduate students conduct evaluations of the peer programs as independent study projects or as the basis for a research thesis; and (3) work with academic departments to develop evaluation methodologies for peer education programs. Existing literature gives little indication of how successful peer education programs have been in encouraging positive behavioral change on the part of students. Until these programs can provide evidence of



their effectiveness, questions about their impact on the health choices students make will continue. 18 references. (HE9401344)

181

### **Social Marketing Campaign to Promote Low-fat Milk Consumption in an Inner-city Latino Community.**

**Form:** Journal article.

**Author:** Wechsler, H.; Wernick, S.M.

**Source:** Public Health Reports. 107(2):202-207, March-April 1992.

**Abstract:** Researchers describe a multifaceted, social marketing program to promote the use of low-fat milk in the Washington Heights-Inwood neighborhood of New York City, a low-income, inner-city Latino community. Healthy Heart Program, a community-based cardiovascular disease prevention agency, implemented the program. Changing the milk-consumption preference of the study population from whole milk to low-fat milk may significantly reduce their fat consumption, particularly among the children. The primary target audience is Latina mothers of children between the ages of 2 and 12, because the mothers buy the groceries for the families and children those ages drink the most milk. For Phase I of the program, the campaign provided nutritional counseling activities and educational presentations at which the mothers could ask questions and participate in informal discussions. Using insights gained from these events, the study produced an Spanish and English language versions of an easy-to-read, 1-page flyer and a poster. After pretesting the materials, investigators widely distributed them (and a refrigerator magnet with the campaign slogan) across the community. They placed posters at 62 key locations including churches, schools, and stores, and distributed about 25,000 low-fat milk flyers. The campaign strategy also

features (1) presentations to organizations, (2) taste tests on busy streets, (3) local media publicity, (4) distribution of discount coupons, and (5) a contest among community organizations to collect the most low-fat milk labels. Phase II of this program began in December 1990 and continues to build on these efforts; it also will try to persuade local institutions that currently serve whole milk to begin offering low-fat milk. 4 figures, 21 references. (HE9201396)

182

### **Student Competition to Develop an Innovative Alcohol Education Strategy.**

**Form:** Journal article.

**Author:** Morritz, T.; Seehafer, R.W.; Maatz-Majestic, E.

**Source:** Journal of American College Health. 41(6):283-286, May 1993.

**Abstract:** Researchers report on a competition that emphasized peer health education and alternative activities to encourage alcohol-free student behavior during a weekend traditionally associated with the abuse of alcohol. Staff at Purdue University conceived of the competition and received a grant from the Fund for the Improvement of Post-Secondary Education (FIPSE) in 1989. The Purdue University Alcohol Education Innovation Award: Student Competition had the goal of discouraging the abuse and illegal use of alcohol and other drugs. Organizers set award guidelines that were designed to encourage activities that would (1) be consistent with behavior change theories; (2) generate student ownership, energy and participation; (3) use the creativity and resourcefulness of students; and (4) involve as many university staff members, departments, and community resources as possible. Organizers publicized the competition through promotional materials sent to all residence hall



floors, cooperative houses, sororities, fraternities, and student organizations that participated in a spring health resource fair. In addition, the press releases from the university news service resulted in three articles in student and local newspapers promoting attendance at the introductory workshops. Students participated in three phases of the innovation award competition: Orientation workshops, proposal development, and project implementation. Sixteen students, representing eleven student organizations with total memberships of approximately 400, attended the workshops. Three student organizations completed proposals, and two of these were selected for funding of \$1,000 each. The two funded proposals resulted in activities that involved approximately 1,200 students as planners, participants, and supporters. 17 references. (HE9401349)

183

### **Total Quality Assurance and Peer Education.**

**Form:** Journal article.

**Author:** Croll, N.; Jurs, E.; Kennedy, S.

**Source:** Journal of American College Health. 41(6):247-249, May 1993.

**Abstract:** To promote program quality assurance, the Office of Health Promotion and Education at Penn State University evaluated peer health educators' presentation skills in three areas: Knowledge, delivery, and sensitivity. To ensure quality in their peer education programs, Penn State conducts intensive training programs during the fall semester. The amount of academic credit given varies from program to program. Nutrition peer educators must complete five credits of academic coursework; sexual health peer educators, four credits; and drug and alcohol, wellness, and self-care peer educators, two credits. Experienced peer educators or

professional staff, all of whom received specific written and oral instruction, conducted evaluations of the peer educator training program during the 1991 spring and fall semesters. As part of the evaluation, workshops were observed and reviewed. The reviews included the participant evaluation form, the contact person's evaluation form, the peer educator's self-evaluation form, and the instrument developed for peer review. Each peer educator received a score recorded as a percentage on the peer review form. A score of 85 percent on the instrument was set as the minimum level of acceptable performance. Results showed that the educators were competent in most areas. Of the 24 evaluated, only 4 scored below 85 percent and most scored above 90 percent in competency. Researchers used the results to identify training needs and to plan in-service programs in the areas of delivery and sensitivity. 6 references. (HE9401343)

## Maternal and Child Health

184

### **Comienzo Sano. (Health Start).**

**Form:** Program.

**Corporate Author:** Arizona Department of Health Services Office of Women's and Children's Health.

**Author:** Helms, S.

**Availability:** Arizona Department of Health Services Office of Women's and Children's Health, 411 North 24th Street, Phoenix, AZ 85008. (602) 220-6533. September 1987-continuing.

**Abstract:** Comienzo Sano (Health Start, or Healthy Beginning) targets low-income, minority, adolescent, migrant, Hispanic American, Native American, and African American women. The target populations are located in 5 sites designated as Federal Health Professional Shortage Areas in Yuma, Pinal, and Maricopa counties, Arizona. The outreach and intervention program increases the adequacy of prenatal care, provides prenatal education, improves birth outcomes and infant health, and empowers local residents to improve access to health care. Services offered include (1) casefinding, (2) education, (3) referral, (4) advocacy, and (5) social support, using such methods as lay health worker outreach, prenatal classes, and home visiting. The program works to remove such barriers to prenatal care as (1) lack of consistent medical providers, (2) inability to pay for care, (3) lack of transportation, (4) language barriers, (5) lack of community-based education resources, and (6) inadequate knowledge about self care during the childbearing period. Health Start offers three components: (1) A Spanish-language prenatal curriculum, (2) a group of mature Hispanic

American women recruited from the target communities and trained as Comienzo Sano Promotoras (health promoters) who make home visits, and (3) the organization of a support network of local health professionals. Includes two curriculum guides, one in Spanish and one in English. (HE92P1450)

185

### **Community Health Worker Program.**

**Form:** Journal article.

**Corporate Author:** New York Department of Health, Division of Epidemiology.

**Source:** New York State Journal of Medicine. 90(10):519-520, October 1990.

**Abstract:** The New York State Prenatal Care Act of 1987, which mandated public education, outreach, and referral services for low-income pregnant women, led to the establishment of the Community Health Worker Program. The program is a community-focused outreach program that directs women to early and continuous prenatal care services. Through Community Health Worker Program contracts, the Department of Health hires and trains indigenous residents of high risk areas to be community health workers (CHW's). The CHW (1) works with pregnant women and their families to assist the women to overcome barriers to health care and support services, (2) develops a highly individualized approach to each family, and (3) maintains a relationship with the family through repeated home visits. The content of the CHW training program focuses on (1) prenatal care, (2) parenting, (3) child growth and development, (4) nutrition, (5) family planning, (6) HIV prevention, and (7) loss and



bereavement. CHW's also learn to assess and describe family high risk situations such as child abuse, domestic violence, substance abuse, environmental, and housing problems. The CHW program has been implemented in 14 locations across New York State in both urban and rural settings. The department developed contracts with community-based organizations and local health units to establish the programs. Evaluation of program effectiveness examines both process and outcome measures: (1) The number and types of referrals that CHW's make and that are completed; (2) the number of women who actually enter care and receive services as a result of recruitment and referral; (3) the pregnancy outcomes for prenatal clients relative to birth weight, gestational age, and health status of the infant; and (4) other problems that are resolved as a result of CHW intervention. 4 references. (HE9401380)

186

### **Community-Based Perinatal Care for Disadvantaged Adolescents: Evaluation of the Resource Mothers Program.**

**Form:** Journal article.

**Author:** Julnes, G.; Konefal, M.; Pindur, W.; Kim, P.

**Source:** Journal of Community Health. 19(1):41-53, February 1994.

**Abstract:** Researchers compared the effects of a community-based lay home visiting initiative for pregnant adolescents, the Norfolk Resource Mothers Program (RMP), with the effects of a more traditional clinic-based, multi-disciplinary program (MDP) containing a public health component. An additional comparison group was composed of adolescents who received no prenatal medical care during pregnancy. The RMP supports disadvantaged teens through the use of mature para-professional home visitors who are similar to the teens in race and

socioeconomic status. The RMP recruits teens into the program, encourages early prenatal care, provides teen mothers and their families with practical help, and increases community awareness regarding infant mortality and adolescent pregnancy. The study used several sources of quantitative data: (1) A database comprised of the monthly reports of Norfolk births, (2) information concerning prenatal intervention program participation which was obtained from RMP and MDP client lists, and (3) perinatal statistics from State and national sources comparing them with outcomes from the evaluation study. The effectiveness of the RMP lay home visitor program was evaluated in terms of outreach objectives, behavioral objectives, and health objectives. The RMP reached a higher percentage of high-risk adolescents (75.5 percent RMP versus 45.6 percent MDP clients ages 17 years or under), promoted a higher level of prenatal care (53.1 percent RMP versus 32.6 percent MDP clients beginning prenatal care before the fourth month of pregnancy), and resulted in pregnancy outcomes that favored the MDP but were comparable (89.8 percent RMP versus 93.5 percent MDP client babies were over 2500 grams at birth). 4 tables, 17 references. (HE9401387)

187

### **Counseling the Nursing Mother: A Reference Handbook for Health Care Providers and Lay Counselors. Second Edition.**

**Form:** Manual.

**Author:** Lauwers, J.; Woessner, C.

**Source:** Garden City Park, NY, Avery Publishing Group Inc., 507 p., 1989.

**Abstract:** Counseling the Nursing Mother: A Reference Handbook for Health Care Providers and Lay Counselors, is a complete reference and training manual designed to meet



the special needs of the breastfeeding counselor. Eleven sections include (1) learning to help mothers, (2) understanding breast structure and function, (3) relating nutrition to health, (4) examining human breast milk, (5) guiding a couple through pregnancy, (6) counseling the mother through the learning period, (7) assisting with family adjustments, (8) encouraging breastfeeding as a baby grows, (9) counseling the mother through special situations, (10) breastfeeding problems, and (11) guiding the mother in the use of special aids and techniques. Nine appendixes provide further important information. These include (1) a glossary, (2) drugs excreted in breast milk (substantiated data), (3) drugs excreted in breast milk (unsubstantiated data), (4) brand name index of drugs, (5) recommended reading for counselors and mothers, (6) resources for counselors and mothers, (7) milk bank directory, (8) sources for breastfeeding aids and devices, and (9) a bibliography. (HE9401375)

188

**Dar a Luz: A Perinatal Care Program for Hispanic Women on the U.S.-Mexico Border.**

**Form:** Journal article.

**Author:** Carrillo, J.M.; Pust, R.E.; Borbon, J.

**Source:** American Journal of Preventive Medicine. 2(1):26-29, 1986.

**Abstract:** In Arizona, undocumented pregnant Hispanic American women without private health care have no recourse but to enter an emergency room after labor begins. One survey showed over 150 such emergency births annually in Tucson. Program planners developed a prenatal care program called Dar a Luz specifically targeted at this population. It includes prenatal obstetrical care and anticipatory birthing education that is culturally

sensitive to Mexican-American traditions; community consciousness-raising; and a cooperative obstetrical agreement with Tucson hospitals. Bilingual community volunteers (usually from the same cultural background) act as patient advocates. After receiving special training in basic communication skills, patient rights, lab tests and procedures, and childbirth education, each advocate is matched with a prenatal patient. She follows the patient through pregnancy and accompanies her to the emergency room for a hospital delivery. Volunteer advocates include nurses, housewives, and college and health professional students. An important aspect of the program is the childbirth education series taught in Spanish in the waiting room at each clinic session. The prenatal clinic is held once a week and is staffed by a physician and an nurse-midwife. In its first 3 years the program served 274 clients (mean age, 25 years). Family incomes of all the clients were below the national poverty level; most (85 percent) did not work outside the home; 35 percent did not complete 6th grade. The continued need for this kind of program is demonstrated by the number of women who registered. In communities with willing health professionals and a large undocumented population, a program like Dar a Luz can meet the needs of this underserved population. 1 table, 6 references. (HE9401220)

189

**De Madres a Madres. (From Mothers to Mothers).**

**Form:** Program.

**Corporate Author:** Texas Woman's University.

**Author:** McFarlane, J.

**Availability:** Texas Woman's University, 1130 M.D. Anderson Boulevard, Houston, TX 77030. (713) 794-2138. February 1989-continuing.

**Abstract:** De Madres a Madres (From Mothers to Mothers) is a Houston, Texas, community partnership for health designed to increase the number of inner-city pregnant Hispanic women who begin early prenatal care. The program is a collaborative effort among the general public, businesses, and volunteer mothers. Volunteer mothers living in the targeted community learn (1) how to identify Hispanic women at risk for not starting early prenatal care and (2) how to provide social support and community resource information within a culturally acceptable milieu. The program also offers information and support to help high-risk pregnant women gain access to prenatal care. Requirements for the volunteer mothers include (1) residence in the community, (2) over age 18, and (3) completion of an 8-hour training program offered by a community health nurse. The curriculum includes (1) role as advocate, (2) resources in the community, (3) communication/support techniques, (4) aspects of quality prenatal care, (5) detailed description of health resources, (6) known causes of low-birthweight infants, (7) family dynamics and interpersonal relationships, and (8) the importance of social support and the effects of stress on pregnancy. The program methods include home visits and community outreach by the trained volunteers. (HE92P0912)

190

### **De Madres a Madres: A Community Partnership for Health.**

**Form:** Journal article.

**Author:** Mahon, J.; McFarlane, J.; Golden, K.

**Source:** Public Health Nursing. 8(1):15-19, March 1991.

**Abstract:** Low birth weight, infant mortality, and pregnancy complications are clearly

associated with inadequate prenatal care. Hispanic American women are substantially less likely than non-Hispanic white mothers to begin prenatal care early, and three times as likely to obtain late or no care. The Houston, Texas, program De Madres a Madres (From Mothers to Mothers) encourages Hispanic women to begin early prenatal care. The program is the result of a community partnership for health initiated among the general public, businesses, 14 volunteer mothers, and one community health nurse. Volunteer mothers living in the targeted community learn (1) how to identify Hispanic women at risk for not starting early prenatal care and (2) how to provide social support and community resource information within a culturally acceptable milieu. The training curriculum contains (1) the role of the advocate; (2) awareness of available community resources; (3) communication and support techniques; (4) the use of effective supportive communication skills; (5) aspects of quality prenatal care; (6) available health resources; (7) known causes of low birthweight; (8) family dynamics and interpersonal relationships; and (9) the importance of social support and the effects of stress on pregnancy. At the end of its first year, volunteer mothers contacted over 2,000 women considered to be at risk for not starting early prenatal care. 16 references. (HE9101202)

191

### **De Madres a Madres: A Community Partnership to Increase Access to Prenatal Care.**

**Form:** Journal article.

**Author:** Rodriguez, R.; McFarlane, J.; Mahon, J.; Fehir, J.

**Source:** Bulletin of the Pan American Health Organization. 27(4):403-408, 1993.



**Abstract:** De Madres a Madres is a community coalition effort initiated in 1989 to increase access to prenatal care for Hispanic women in Houston, Texas. It operates in Houston's Northside community, an inner-city neighborhood with high-density housing in which the median family income is \$12,782. All the women of childbearing age, who make up 34 percent of the community's population of 13,555, are considered to be at-risk for insufficient early prenatal care. De Madres a Madres features a group of volunteer mothers who work in partnership with community services, including schools, businesses, churches, health and social service agencies, and the media. The volunteer mothers live and work in the community, providing pregnant women with information and support and assisting them in beginning and continuing prenatal care. A community health nurse performed a community assessment in which a total of 31 community leaders were asked for their viewpoint on the proposed program. The community assessment and a trust-building period were the longest phases of coalition development; by the end of 2 years, de Madres a Madres had become an active community organization. Important aspects of the program include (1) a structured orientation for volunteers; (2) outreach to pregnant women at grocery stores and schools; and (3) the Madres a Madres center, located within walking distance of most of the target population. The center was funded in 1991 for 3 years by the W.K. Kellogg Foundation. Evaluation of the program includes gathering feedback from staff, volunteers, and pregnant mothers and tracking quantifiable measures such as the number of at-risk mothers contacted and the number of volunteer visits to at-risk mothers. 6 references. (HE9401337)

192

**De Madres a Madres: A Community, Primary Health Care Program Based on Empowerment.**

**Form:** Paper.

**Author:** McFarlane, J.; Fehir, J.

**Availability:** Dr. Judith McFarlane, Texas Women's University, 1130 M.D. Anderson Boulevard, Houston, TX 77030. (713) 794-2138. In Press: Health Education Quarterly, Vol. 21, No. 2, Summer 1994.

**Abstract:** Early prenatal care is essential for maternal and infant health yet only 58 percent of Mexican-American women receive early prenatal care compared to 79 percent for Caucasian women and 61 percent for African American women. The De Madres a Madres program's director and evaluator describe a 5-year community empowerment process undertaken by the program and the subsequent collective enhancement of community health. Based on the concepts of volunteerism and empowerment of indigenous women through unity, validation of women as key health promoters, and the acceptance of a community's ability to identify and redress its own health needs, the De Madres a Madres Program began in a Houston, Texas, inner-city Hispanic community, with the goal of decreasing barriers and increasing access to prenatal care. The community's population of 13,555 was 34 percent women of childbearing age; median family income was \$12,782 and 19 percent of the households received public assistance. A community health nurse trained 14 indigenous volunteer mothers to provide culturally relevant information to pregnant women to increase their access to health care. Mothers then formed community coalitions with health clinics, social service agencies, local businesses, schools, churches, elected officials, and the media to provide information. Outcome data showed that the De Madres a Madres Program enhanced



individual women's self-esteem and power, and collectively enhanced community self-esteem, power, and economy. Program evaluation results revealed that since the beginning of the De Madres a Madres Program, no low birthweight baby has been born to a woman who was followed by a volunteer mother. The rate of infant mortality also decreased from 16.5 per 1,000 live births in 1989 to the rate of 11.4 in 1993. The concept of community economy and a theoretical basis of empowerment of women are discussed in terms of community empowerment for community health. 1 table, 23 references. (HE9401414)

193

### **Development of a Paraprofessional Home Visiting Program for Low-income Mothers and Infants.**

**Form:** Journal article.

**Author:** Poland, M.L.; Giblin, P.T.; Waller, J.B.; Bayer, I.S.

**Source:** American Journal of Preventive Medicine. 7(4):204-207, July-August 1991.

**Abstract:** Researchers describe the development of a paraprofessional home visiting program that (1) provides services based on empirically documented client needs, (2) uses indigenous paraprofessional maternal and child health advocates, and (3) emphasizes maintaining and enriching the sharing of beliefs, values, and attitudes. To determine client needs, researchers conducted preliminary studies involving (1) telephone interviews with women who received prenatal care in publicly funded clinics and (2) in-hospital interviews with low-income postpartum mothers. The studies addressed (1) how women evaluate services provided by publicly funded prenatal care clinics in Detroit, Michigan; (2) how to encourage more pregnant women to remain in prenatal care and receive more appointments;

and (3) whether prenatal behavior predicts deficits in parenting and therefore makes urgent the continuation of program efforts through infancy. Findings indicate a need for program emphasis in (1) a continuity of services from pregnancy through infancy, (2) the development of needs assessment procedures sensitive to a broad range of health and social problems, (3) an ongoing personal relationship with an indigenous paraprofessional, and (4) a reduction of barriers to prenatal care inherent in the health care system itself (waiting time, lack of transportation, lack of insurance, lack of available services, and need for a babysitter). In implementing the program, developers required that applicants to become paraprofessional maternal and child health advocates (1) receive public assistance, (2) possess a high school diploma or equivalent, (3) reside in Detroit, (4) have private transportation, (5) possess personal warmth, (6) be able to accept full-time employment, and (7) be knowledgeable about the maternal and child health and social systems. The paraprofessional training program fostered mutuality and cooperation and included supporting and modeling (1) assertive, caring, and problem-solving behaviors and (2) positive self-esteem. Paraprofessional case management included promoting and assisting in the attainment of health care services through the establishment of a personal and caring one-on-one relationship of the advocate with her client based on home visits and frequent telephone contacts. 1 table, 6 references. (HE9200877)

194

**Effect of Peer Counselors on Breastfeeding Initiation, Exclusivity, and Duration Among Low-Income Urban Women.**

**Form:** Journal article.

**Author:** Kistin, N.; Abramson, R.; Dublin, P.

**Source:** Journal of Human Lactation. 10(1):11-15, March 1994.

**Abstract:** A study examined the effect of support from trained peer counselors on breastfeeding initiation, duration, and exclusivity among low-income urban women. The study compared infant feeding practices of 59 women who planned to breastfeed and received support from counselors (counselor group) to 43 women who requested counselors, but owing to inadequate numbers of trained counselors, did not have a counselor (no counselor group). In 1987, the Chicago Breastfeeding Task Force established a breastfeeding peer counselor program within the Perinatal Center at Cook County Hospital in Chicago. Task force members, hospital personnel, and community groups recruited the peer counselors. Criteria for acceptance as a counselor included being from the same racial or socioeconomic background as the hospital patient population, having breastfed, and desiring to help other women. Counselors graduated from the training program if they attended six of the eight two-hour training sessions. Methods of training included group discussion, role-playing, and use of speakers who served as role models as well as information sources. Women in the patient population delivered infants at Cook County Hospital, where 90 percent of patient family incomes are at or below poverty level. Counselors were instructed to talk with clients before delivery if possible, to telephone at least twice a week after delivery until breastfeeding was established, to telephone every 1 to 2 weeks for the next 2 months, and

as needed after that. The project director formally supervised and reviewed counselors' caseloads every 2 weeks. Women were interviewed at the time they entered the project, and also received followup phone contact. Women in the counselor group had significantly greater breastfeeding initiation (93 percent vs. 70 percent), exclusivity (77 percent vs. 40 percent), and duration than women in the no-counselor group (mean of 15 weeks vs. 8 weeks). Peer counselors, well trained, and with on-going supervision, can have a positive effect on breastfeeding practices among low-income, urban women who intend to breastfeed. (HE9401386)

195

**Effects of a Home Visiting Program on Prenatal Care and Birthweight: A Case Comparison Study.**

**Form:** Journal article.

**Author:** Poland, M.L.; Giblin, P.T.; Waller, J.B.; Hankin, J.

**Source:** Journal of Community Health. 17(4):221-229, August 1992.

**Abstract:** Researchers conducted a study to determine the impact of paraprofessional support services on the amount of prenatal care received and on birthweight in a sample of 111 low-income women in Detroit, Michigan. Researchers randomly selected women attending a publicly funded prenatal clinic to receive in-home supportive services by a Maternal Child Health Advocate. Of patients who remained with an advocate at least through delivery, 92 percent were black with a mean age of 24.1. The study trained as paraprofessional advocates women who had been on public assistance and had successfully attained health and human services for themselves and their infants. The 6-week advocate training program taught interviewing and counseling skills, how to assess growth



and development and client needs, and how to refer to needed services. Advocates assisted pregnant women with health and social services, housing, food, transportation, and other basic necessities. They followed their clients over pregnancy and for the first year of the infant's life under the supervision of a nurse or social worker, recording services provided on activity logs. A comparison group matched for ethnicity, parity, and trimester entering prenatal care also participated in the study. Researchers conducted a medical chart review on all participants to identify medical risk indicators, amount of prenatal care received, and pregnancy outcomes (including length of gestation and birthweight). Findings showed that, compared with the comparison group, women followed by a paraprofessional had significantly more prenatal appointments (8 versus 6.5 visits) and infants with average higher birthweight (3,273 grams versus 3,125 grams). 4 tables, 12 references.  
(HE9300301)

196

### **Enhancing Prenatal Care: Community Health Workers Speak Out.**

**Form:** Report.

**Corporate Author:** March of Dimes Birth Defects Foundation, National Office.

**Availability:** March of Dimes Birth Defects Foundation, National Office, 1275 Mamaroneck Avenue, White Plains, New York, NY 10605. (914) 428-7100.

**Abstract:** Enhancing Prenatal Care: Community Health Workers Speak Out reports on the 1990 March of Dimes Speak-Out Conference in which professionals and paraprofessionals who worked with priority, high risk populations discussed how to support pregnant women at greatest risk of delivering low birth weight infants. The report describes

the challenges panelists faced and approaches they found effective in meeting the challenges. After a message from the March of Dimes President, an introduction to the conference, and profiles on each of the panelists, the report examines several major topics of discussion: (1) Identifying Pregnant Women and Getting Them Into Prenatal Care: Strategies for Overcoming Obstacles to Prenatal Care; (2) Encouraging Pregnant Women to Take the Lead in Caring for Themselves: Helping to Build Self-Esteem; (3) The Substance Abuse Barrier: Approaches to Substance Abuse Among Pregnant Women; and (4) Providing Effective Audiovisual and Print Media. A section entitled Where Do We Go From Here? examines lessons learned in seven diverse programs to reach and educate pregnant women and condenses the most significant observations into 10 points. A final section describes March of Dimes activities.  
(HE9401264)

197

### **Healthy Families and Young Children: A Lay Home Visitor Program.**

**Form:** Program.

**Corporate Author:** Kansas Department of Health and Environment, Bureau of Family Health.

**Author:** Kenney, L.; Neff, J.

**Availability:** Kansas Department of Health and Environment, Bureau of Family Health, Landon State Office Building, 900 Southwest Jackson, 10th Floor, Topeka, KS 66612-1290. (913) 296-1303. October 1988-continuing.

**Abstract:** Healthy Families and Young Children: A Lay Home Visitor Program targets families with preschool children living in Kansas to reduce the three leading causes of morbidity/mortality in infants and young children: Preventable diseases, abuse/neglect, and home/auto accidents. Home visitors



provide support education and referral services to families regarding immunizations, well-children checks, parenting skills, community resources, and safety education. The lay visitors also provide guidance on prevention of child injury that emphasizes home and auto safety and coordinate support groups through county health departments. The visitors' group consists of emotionally mature and experienced parents who receive ongoing training from nurse supervisors in local health departments. Areas of training include parenting skills, use of community resources, home and auto safety, child development, recognizing signs of potential child maltreatment, and recognizing family needs. Public health nurses supervise the visitors. Evaluation results from comparison studies of counties using the health visitors with control counties is not yet available. (HE92P0295)

198

**Home Visiting: Opening Doors for America's Pregnant Women and Children.**

**Form:** Report.

**Corporate Author:** National Commission to Prevent Infant Mortality.

**Availability:** International Medical Services for Health (INMED), 45449 Severn Way, Suite 161, Sterling, VA 20166. (703) 444-4477.

**Abstract:** The report of the National Commission to Prevent Infant Mortality discusses the rationale for home visiting, the cost savings, the key components of such programs, and a series of international and domestic examples of successful programs. Home visiting sends trained workers into the home to provide pregnant women and children with access to the health care system. The main function of home visiting is to assess a family's health and social needs and provide the link between the family and the existing

community health and social services that meet these needs. Home visiting programs targeted to reducing infant mortality and morbidity assist in linking pregnant women, new mothers, and children to the cost-effective health care they need. The four key components of any successful home visiting effort are as follows: (1) The selection of clearly defined goals, objectives, and target populations; (2) the selection of workers with strong people skills; (3) the emphasis on ongoing training for home visitors; and (4) the consideration of a community focus. Home visiting can be effectively used as a part of a comprehensive effort to link mothers and children to medical and social supports. (HE9000128)

199

**Home Visiting: Procedures for Helping Families.**

**Form:** Monograph.

**Author:** Wasik, B.H.; Bryant, D.M.; Lyons, C.M.

**Availability:** Sage Publications, Inc., 2455 Teller Road, Newbury, CA 91320.

**Abstract:** Home Visiting: Procedures for Helping Families presents broad information about procedures and issues related to home visiting with families. The book provides a sense of the history and philosophy of home visiting, defines models of best practice for the use of home visiting, and raises a number of serious issues that are important to home visitors, trainers, program directors, and policymakers. It also provides practical information on home visiting issues (training, supervision, services) and procedures for both beginning and experienced home visitors from a variety of backgrounds. There are 10 chapters: (1) A Historical Overview, (2) Philosophy of Home Visiting, (3) Illustrative Home Visiting Programs, (4) Personnel Issues

Related to Home Visiting, (5) Helping Skills and Techniques, (6) Managing and Maintaining Home Visits, (7) Visiting Families in Stressful Situations, (8) Professional Issues Facing Home Visitors, (9) Assessment and Documentation in Home Visiting, and (10) Future Directions of Home Visiting. An appendix presents home visit report forms from the Infant Health and Development Program, a national collaborative study from the 1980s that focused on low birth weight infants. (HE9401250)

200

### **Hospitalized Cases of Nonorganic Failure to Thrive: The Scope of the Problem and Short-Term Lay Health Visitor Intervention.**

**Form:** Journal article.

**Author:** Haynes, C.F.; Cutler, C.; Gray, J.; Kempe, R.S.

**Source:** Child Abuse and Neglect. 8(2):229-242, 1984.

**Abstract:** Researchers describe the characteristics of thriving and failure to thrive (FTT) children and their mothers and examine the effect of short-term lay health visitor intervention in cases of nonorganic failure to thrive (NOFTT). Twenty-five FTT children and mothers received lay health visitor (LHV) intervention in addition to other community and medical treatment. Twenty-five other FTT children and mothers did not receive the LHV intervention but did receive all other medical and community treatment. A comparison group of 25 thriving non-hospitalized children and their mothers were matched with the LHV FTT pairs. The pairs were matched on the child's age at intake, sex, birth weight, and the mother's age, ethnicity, and number of living children. The assessment process involved a videotape of mother-child interactions and an informal interview with the mother while she was

attending to the child. Interviews also assessed a mother's experience with her child, her perception of the child, her own upbringing, and her current life situation. The Bayley Scales of Infant Development were administered to the child. At initial assessment, the FTT and thriving groups were found to be comparable on demographic factors, infant birth weight percentiles, Apgar scores, complications of pregnancy or delivery, and separations in the newborn period. A majority of mothers in the FTT groups had negative memories of childhood in contrast to more positive memories in the thriving group. There were clear differences in mother-child interaction patterns in the thriving and FTT groups. Three patterns of interaction were identified in the FTT group: (1) Benign neglect (attending to the infant's needs only when the infant would cry or give other cues), (2) incoordination (not matching appropriate action with infant's cues), and (3) overt hostility. Intervention had no measurable effect on the child's weight, development, or interaction patterns. 5 tables, 9 references. (HE9401397)

201

### **Lay Home Visiting: An Integrated Approach to Prenatal and Postpartum Care.**

**Form:** Program.

**Corporate Author:** Health Federation of Philadelphia.

**Author:** Levkovich, N.

**Availability:** Health Federation of Philadelphia, 1211 Chestnut Street, Suite 801, Philadelphia, PA 19107. (215) 567-8001. April 1988-continuing.

**Abstract:** Researchers designed Lay Home Visiting: An Integrated Approach to Prenatal and Postpartum Care to improve birth outcome and overall health status of children and to encourage positive parenting in at-risk families



in the Philadelphia, Pennsylvania, area by offering utilization and continuity of prenatal and postpartum/pediatric care and related services. The program began as a 2-year project using indigenous lay community workers (1) to establish trusting relationships, (2) to provide nonjudgemental support, and (3) to communicate culturally appropriate information to the target population. The pilot project demonstrated that the lay home visitor model could deliver health and social services to a population of residentially, socially, and economically unstable women and it facilitated continuity of care for a population commonly regarded as hard to reach and difficult to retain. The home visiting intervention enhances clinical services available at community health centers (CHC) and extends services into the community and the homes of vulnerable young families. Each of four participating CHC's employ a home visiting project team consisting of three home visitors and one nurse supervisor. The home visitors (1) reside in the target communities, (2) have children, and (3) are culturally similar to the client population. They receive extensive training by the Health Federation of Philadelphia, Inc. Each client works with a home visitor who becomes her primary advocate and link to services. The home visitors provide (1) individualized health education, (2) psychosocial support, (3) needs assessment, (4) role modeling, and (5) linkage to the CHC and other services. The nurse supervisor acts as the (1) case manager, (2) consultant, (3) teacher, and (4) project site manager. (HE92P1043)

202

**Maternal Care Coordination for Migrant Farmworker Women: Program Structure and Evaluation of Effects on Use of Prenatal Care and Birth Outcome.**

**Form:** Journal article.

**Author:** Larson, K.; McGuire, J.; Watkins, E.; Mountain, K.

**Source:** Journal of Rural Health. 8(2):128-133, Spring 1992.

**Abstract:** Cultural and social barriers, along with constant travel, make coordination of care difficult for migrant health centers providing perinatal services to female farmworkers. Almost three-fourths of these farmworkers are Hispanic American. As part of a demonstration project, researchers developed a migrant-specific maternal care coordination program that used bilingual staff, outreach services, lay health advisors, and a multistate tracking system. The project was based at the Tri-County Community Health Center (TCCHC) in North Carolina, a federally funded health facility serving North American, Hispanic American, and Haitian migrant and seasonal farmworkers. Specific program objectives were to (1) increase first-trimester enrollment into prenatal care; (2) improve continuity of care, including frequency of visits; and (3) improve perinatal outcomes. The number of bilingual staff was increased from only one (the medical director) to four more persons (registered nurses). Outreach included seeking out pregnant women, offering them transportation to the clinic, and documenting where mothers of Head Start children were receiving care for current pregnancies. Project staff trained migrant women as maternal lay health advisors so they could teach other migrant women as they traveled. Because this population moves from State to State, planners developed a multistate tracking system to follow a client from her first prenatal visit to the center until the



postpartum visit, obtaining a permanent address and expected location of delivery. A total of 599 migrant farmworker women participated between 1985-1989. Hispanic American representation at this migrant health center increased significantly from 55 percent in 1985 to 80 percent in 1989, and over the 5 years, staff noted a younger prenatal population having fewer pregnancies. First-trimester entry into prenatal care increased from 35 percent to 51 percent in the 5 years. Results suggest that the elimination of barriers to care, particularly language and transportation barriers, combined with close tracking and followup can have a positive effect on prenatal care and pregnancy outcome for a traditionally hard-to-reach migrant maternity population. 3 tables, 13 references. (HE9401216)

203

### **Maternal Infant Health Outreach Worker (MIHOW) Project.**

**Form:** Program.

**Corporate Author:** Vanderbilt University Medical Center, Center for Health Services.

**Author:** Skaggs, K.

**Availability:** Vanderbilt University Medical Center, Center for Health Services, Station 17, Box 567, Nashville, TN 37232. (615) 322-4184. 1982-continuing.

**Abstract:** The Center for Health Services at Vanderbilt University developed an outreach program, the Maternal Infant Health Outreach Worker (MIHOW) Project, targeting pregnant women and mothers of young children in rural, low-income communities in central Appalachia and the Mississippi Delta. The project represents a network of grassroots organizations working in partnership with the Center for Health Services. The Center for Health Services provides training and technical assistance at each site, and the local

organization gradually takes on responsibility for maintaining the project. Using local women as the primary staff, the program provides a community-based, low-cost intervention to improve family health and child development for low-income, rural families. Trained community mothers visit pregnant women and parents of small children at home, providing health and child development education, support for healthy lifestyles and positive parenting practices, and advocacy of health and social service systems. Parenting group meetings led by trained community workers give parents a chance to share experiences and learn from each other. Other services offered include peer support, education on prenatal health and self-care, and information on local services including health care, financial assistance, and educational programs. Projects have included adult literacy efforts, dealing with environmental and toxic waste problems, legal assistance for rural black farmers, recreation and education for children, and nutrition efforts for the elderly. (HE93P0315)

204

### **Maternity and Infant Outreach Project.**

**Form:** Program.

**Corporate Author:** Hartford Health Department.

**Author:** McKane, S.U.

**Availability:** 80 Coventry Street, Hartford, CT 06112. (203) 722-6715. May 19, 1985-continuing.

**Abstract:** The Maternity and Infant Outreach Project of the Hartford Action Plan on Infant Health (HAP), in Connecticut, targets pregnant women and girls living in seven designated high-risk neighborhoods for its interventions. The purpose of the project is to decrease low birthweight and infant mortality and morbidity and to increase registration in its programs in

the first trimester of pregnancy. The project oversees a team of three professional community health educators, who work mainly with groups, and a team of neighborhood health workers, trained by HAP, who educate pregnant women in the home. Community health educators reach neighborhood residents through community-based organizations, schools, and churches. At group meetings, these educators talk about preventing infant deaths and encourage registration in the program. After a pregnant woman has registered, health workers visit her at least once a month, and once a week if necessary. Health workers are black or Hispanic, as are neighborhood residents, and the educational material they use is available in English and Spanish. Workers bring educational materials, including films and projectors, for the entire family and support system to watch. Postpartum followup continues for 6 months. The project coordinates its efforts with hospital clinics and other community agencies. Program staff review individual cases. Independent consultants evaluate the entire program in the context of the Hartford Action Plan on Infant Health, the partnership of city and State agencies, corporations and foundations, and the public schools under which the Maternity and Infant Outreach Project operates. (HE89P0013)

205

**Measuring Effectiveness of Service Aides in Infant Immunization Surveillance Program in North Central Texas.**

**Form:** Journal article.

**Author:** Moore, B.J.; Morris, D.W.;  
Burton, B.; Kilcrease, D.T.

**Source:** American Journal of Public Health.  
71(6):634-636, June 1981.

**Abstract:** The Immunization Division of Texas Public Health Region 5 applied

statistical models to secondary data to measure the effectiveness of service aides in influencing families to get immunizations. The data were routinely collected in the State reporting process during the 12-month period from November 1978 to October 1979. In the program, inquiry cards are mailed to parents of newborn children 3 months after birth. If parents fail to report immunization records or report that no diphtheria-tetanus-pertussis (DTP) immunizations and no trivalent oral polio vaccine (TOPV) have been initiated, another inquiry card is mailed at 6 months of age. Nonresponse to this card results in classifying a child as a newborn nonresponder. His or her name is then placed on a computerized referral list for followup by service aides. Followup is done primarily by telephone contact between an aide and a family. Field visits are sometimes necessary for hard to reach families. Upon followup, aides find that approximately 35 percent of the referrals contacted either have not yet started any immunizations or they are behind schedule. After analyzing the data, the researchers determined that 44 percent of the referral families who reported immunizations were influenced by the service aides to either start immunizations or obtain additional immunizations promptly. Further, the researchers analyzed response distributions from an urban sample of 1,611 and a nonurban sample of 1,150. The estimate of effectiveness for the urban area was 39 percent, and for the nonurban area 53 percent. 1 figure, 3 references. (HE9401359)



206

**Opening Doors for Healthier Families: A Guide for Resource Mothers. Resource Mothers Handbook.**

**Form:** Manual.

**Corporate Author:** International Medical Services for Health.

**Availability:** International Medical Services for Health (INMED), 45449 Severn Way, Suite 161, Sterling, VA 20166. (703) 444-4477.

**Abstract:** Opening Doors for Healthier Families: A Guide for Resource Mothers Handbook uses a question-and-answer format to address questions that clients might ask about pregnancy and prenatal care, delivery, and care of the newborn. Resource Mothers are lay community members who provide support to new parents within their own communities. They are selected because of their knowledge of the community, their leadership, their ability to teach women how to care for themselves and their families, and their compassion. Resource Mothers encourage early, continuous prenatal care, proper nutrition, and adequate social support to reduce the incidence of low birth weight babies and infant death. The personal contact, caring, and advice provided by a Resource Mother can change the life of a client and her baby. Visiting women in their homes helps them gain access to prenatal care, encourages healthier lifestyles, and helps reduce the number of infant deaths. The manual has 19 chapters: (1) Activities of a Resource Mother, (2) Building Rapport and Trust, (3) Coping with Stress, (4) Improving Self-Esteem, (5) How to Find Help in the Community, (6) Pregnancy and Prenatal Care, (7) Nutrition: Eating for Two, (8) Breastfeeding, (9) Labor and Delivery, (10) Concerns of the New Mother, (11) Family Planning, (12) Taking Care of a New Baby, (13) Infant Nutrition, (14) Child Growth and Development, (15)

Safety, (16) Families with Special Needs, (17) Using Support Materials, (18) Home Visits, and (19) Resource Mothers Speak Out. (HE9401266)

207

**Opening Doors for Healthier Families: A Guide for Training Resource Mothers. Curriculum Sourcebook.**

**Form:** Manual.

**Corporate Author:** International Medical Services for Health.

**Availability:** International Medical Services for Health (INMED), 45449 Severn Way, Suite 161, Sterling, VA 20166. (703) 444-4477.

**Abstract:** Opening Doors for Healthier Families: A Guide for Training Resource Mothers is for people who will be training new lay health Resource Mothers. The manual introduces the skills, experiences, knowledge, and emotional support needed to work effectively as a Resource Mother. The role of the Resource Mother includes (1) identifying pregnant women; (2) making home visits; (3) communicating with at-risk pregnant or parenting women and their families; (4) providing information on prenatal care, nutrition, breast-feeding, family planning, and newborn care; (5) documenting interactions with clients; (6) assisting with access to other community resources; and (7) helping clients feel positive about themselves so they are better able to cope with the problems and challenges they face. The manual provides basic information for Resource Mothers via training activities that require active involvement and participation of the trainees. The training emphasizes shared learning experiences and skill building. The curriculum includes 15 units to be completed over 14 full days of training: (1) Introduction to the Training, (2) Communication and



Relationship-Building Skills, (3) Coping With Stress: Problem-Solving and Decision-Making, (4) Helping Clients Build Self-Esteem and Deal with Feelings, (5) Using Support Materials, (6) Pregnancy and Prenatal Care, (7) Labor and Birth: Getting Ready for Baby, (8) Postpartum Care and Planning, (9) Family Planning Options, (10) Breastfeeding and Infant Nutrition, (11) Caring for Baby, (12) Child Growth and Development, (13) Interacting with Other Agencies Within the Community, (14) Managing Home Visits, and (15) Evaluation and Closing Ceremony. (HE9401267)

208

**Opening Doors for Healthier Families: How to Start a Resource Mothers Program. Implementation Guidelines.**

**Form:** Manual.

**Corporate Author:** International Medical Services for Health.

**Availability:** International Medical Services for Health (INMED), 45449 Severn Way, Suite 161, Sterling, VA 20166. (703) 444-4477.

**Abstract:** Opening Doors for Healthier Families: How to Start a Resource Mothers Program helps organizations start Resource Mothers Programs within their own communities. Resource Mothers are members of the community who receive training to reach out to pregnant women and parenting families. Resource Mothers go into the home and build a link between the family and the many health, social, and other community services that meet their needs. They are important in preventing and reducing infant mortality. The manual has seven sections. Section one, Resource Mothers Programs, describes the need, the solution, the program, and what organizations can do. Section two, Exploring Program Possibilities, discusses (1)

using a planning framework, (2) determining community needs, (3) assessing organizational resources, and (4) moving along. Section three, Starting a Program, explains how to (1) assemble an advisory board, (2) define the scope of the problem, and (3) establish helpful relationships. Section four, Program Monitoring and Evaluation, describes (1) program evaluation, (2) types and methods of evaluation, and (3) record keeping and documentation. Section five, Program Management and Administration, discusses (1) personnel management and policies, (2) recruiting and hiring staff, (3) the Resource Mother interview process, (4) supervision, (5) identifying and enrolling women in need, (6) case load, (7) other administrative considerations, and (8) changing the system. Section six, Training, describes (1) the trainer, (2) identifying training resources, (3) training considerations, and (4) inservice training. Section seven, Identifying and Sustaining Sponsorship, looks at (1) fundraising, (2) co-sponsorship, (3) foundation support, (4) government grants and other public funding, and (5) sustainability. There are 12 appendixes: (1) Recommended Readings, (2) Resources, (3) Sample Needs Assessment Questionnaire, (4) Home Visiting Goals and Learning Objectives, (5) Worksheets for Program Planning, (6) Sample Forms for Recording Home Visits, (7) Sample Job Descriptions, (8) Agencies that Provide Information on Maternal and Child Health, (9) Performance Appraisal Tool, (10) Sample Fact Sheets for Fundraising, (11) States Covering Home Visiting Under Medicaid: 1992, and (12) Community-Based State Prevention Grant Recipients. (HE9401265)

209

**Prenatal Care Assistance Programs: 1989 Annual Report.**

**Form:** Report.

**Corporate Author:** New York Department of Health.

**Availability:** New York Department of Health, Empire State Plaza, Corning Tower Building, Albany, NY 12237.

**Abstract:** Prenatal Care Assistance Programs: 1989 Annual Report describes three programs with the common objective of improving birth outcomes among New York State women. The Prenatal Care Assistance Program (PCAP) provides broad prenatal, nutrition, and related services to medically indigent women through contracts with approved providers. The seven Comprehensive Prenatal-Perinatal Services Networks (two rural and five urban) are community-based organizations that educate the community, coordinate services, and act as change agents in removing obstacles to prenatal care. This is accomplished through development of a local-level group of health and human services providers and consumers who work jointly to identify and resolve problems in the regional services system. The Community Health Worker Program began in 1988 to provide one-on-one advocacy and support for high risk childbearing families. Workers come from the target communities and act as a liaison for pregnant women and their families to needed social, health, and other services. The seven appendixes offer (1) PCAP cost and enrollment data, (2) impact analysis data, (3) Buffalo News article, (4) Community Health Worker Curriculum outline, (5) Community Health Worker Program regional coordinators, (6) anecdotes from Community Health Worker cases, and (7) Public Health Reports article. (HE9401271)

210

**Prenatal Care Assistance Programs: 1990 Annual Report.**

**Form:** Report.

**Corporate Author:** New York Department of Health.

**Availability:** New York Department of Health, Empire State Plaza, Corning Tower Building, Albany, NY 12237.

**Abstract:** Prenatal Care Assistance Programs: 1990 Annual Report describes a partnership of two State agencies and over 150 providers of prenatal and community outreach services designed to improve the health status of mothers and infants in New York State. Prenatal Care Assistance Programs (PCAP) encompasses three programs under a single title. The Prenatal Care Assistance Program offers service delivery and outreach. There are broad prenatal care services available to low-income women through a network of hospital clinics, freestanding diagnostic and treatment centers, county health departments, and private-practicing physicians. The Comprehensive Prenatal-Perinatal Services Networks provide the community mobilization intervention. They mobilize community resources to offer improvements at the local level in the service delivery system and to conduct targeted outreach to high risk segments of the population. Their primary purpose is to improve birth outcomes in their region. The Community Health Worker Program includes the one-on-one advocacy initiative, which targets women who are at greatest risk for not using prenatal and infant care, women who are not reached by traditional health care systems, and women who may not be reached by other outreach methods. The Community Health Worker Program visits women in their homes and gives needed help and support services. The report describes the three major components of the PCAP in detail, explaining (1) what the



model of care is, (2) who is eligible and how they learn about the program, (3) how many providers and participants there are, (4) how PCAP addresses Acquired Immunodeficiency Syndrome (AIDS) in pregnancy, (5) quality assurance, (6) the PCAP service delivery model, (7) program goals and objectives, (8) program successes, (9) program evaluation, and (10) staff training. (HE9401270)

211

**Preventing Low Birth Weight: Marketing and Volunteer Outreach.**

**Form:** Journal article.

**Author:** May, K.M.; McLaughlin, F.; Penner, M.

**Source:** Public Health Nursing. 8(2):97-104, June 1991.

**Abstract:** Health care professionals explore the role of the public health nurse in a community-based prenatal program and the effectiveness of social marketing and neighborhood outreach workers in the prevention of low birth weight. The Pregnancy Outreach Program (POP) of the Arizona Department of Health Services illustrates implementation of these strategies in targeted urban census tracts. The program attempted to prevent low birth weight through early and continuous prenatal care. The major responsibilities of the program's public health nurses were (1) development and social marketing of the program to potential clients, service agencies, and the community; (2) recruitment, instruction, supervision, and continuing in-service education for volunteer neighborhood outreach workers; and (3) case management. The program strategy included (1) planning and implementing volunteer neighborhood outreach workers, (2) service to clients, (3) community assessment and consumer feedback, (4) exchange of goods and services theory, (5) audience analysis and

segmentation, (6) formative research and channel analysis, (7) marketing mix, (8) process tracking, (9) marketing management, (10) neighborhood outreach workers, and (11) case management. The program evaluated community and consumer assessment of the program by obtaining data from windshield surveys, interviews, vital statistics, and other community sources. 35 references. (HE9200202)

212

**Primary Health Care Approach Using Hispanic Outreach Workers as Nurse Extenders.**

**Form:** Journal article.

**Author:** Bray, M.L.; Edwards, L.H.

**Source:** Public Health Nursing. 11(1):7-11, February 1994.

**Abstract:** In an effort to improve the health of Hispanic families, the Du Page Health Department in a suburban county located near Chicago instituted the Hispanic outreach worker program. In 1988, program services were expanded to include home visitation to pregnant Hispanic women. These women and their newborns are now the program's primary priorities and represent the majority of the workers' caseloads. The program uses bilingual, bicultural nurse extenders within a framework of primary health care. The outreach workers offer basic health information to improve families' skills and knowledge, and to assist with linkages to community resources. Workers receive 3 weeks of formal training at the health department from a variety of health professionals. After the formal classes, the workers observe well child and prenatal clinics, accompany public health nurses on observation home visits, and make many joint visits with the nurses. Public health nurses provide assessment, establish a plan of care,



evaluate progress, and supervise the workers. Program objectives include ensuring that (1) all women with low-risk pregnancies receive program services, (2) the number of Hispanic women registering for prenatal care during the first or second trimester will increase to 62 percent, (3) all program women in the third trimester of pregnancy will enroll in pregnancy and parenting education programs, (4) all infants born to program mothers will continue in the WIC program until age 12 months, and (5) all infants born to program mothers will be under regular medical supervision. The program has resulted in increased numbers of individuals receiving services, more women registering earlier for prenatal care and the WIC program, and increased numbers of infants receiving WIC services and regular medical supervision. Public health nurses report increased knowledge and positive changes in families' health behaviors. In addition, the program has strengthened relationships between the health department and Hispanic families. 15 references. (HE9401388)

213

**Resource Mothers: A Strategy to Reduce Infant Mortality Using Lay Home Visitors. The Norfolk State University Program's Experience.**

**Form:** Manual.

**Author:** Konefal, M.M.

**Availability:** Children's Hospital, Department of Nursing, 700 Children's Drive, Columbus, OH 43205. (614) 461-2712.

**Abstract:** Resource Mothers: A Strategy to Reduce Infant Mortality Using Lay Home Visitors is a manual that explains the Resource Mothers Program, a community-based initiative that uses lay home visitors to address the related problems of adolescent pregnancy, low birth weight infants, and infant mortality.

A resource mother is an experienced parent or paraprofessional who has training in helping pregnant adolescents and teen parents with nonmedical dimensions of pregnancy and child care. The resource mother is of the same race and socioeconomic status as the participating teens, whom she recruits for the program and encourages to get early, consistent prenatal care. The resource mother provides teen mothers and their families with practical help and increases community awareness of infant mortality and adolescent pregnancy issues.

Section one of the manual presents an introduction to the Resource Mothers Program. Section two explains how to select a lead agency, focusing on general considerations, the experience of Norfolk State University, and the program's relationship with the Department of Nursing. Section three examines organization and administration of the program, highlighting (1) program goals, (2) structure, (3) personnel, (4) services provided, (5) budget, and (6) evaluation. Section four describes the resource mother's role, explaining (1) the position description, (2) recruitment and selection, (3) training, and (4) administrative considerations. Section five discusses client services: (1) Referral criteria, (2) recruitment strategies, (3) assessment and planning, and (4) home visit guides. Section six explains about available materials and services. (HE9401268)

214

**Rural Alabama Pregnancy and Infant Health Program.**

**Form:** Journal article.

**Author:** Nagy, M.C.; Leeper, J.D.; Hullett, S.; Northrup, R.; Newell, W.H.  
**Source:** Family and Community Health. 11(2):49-56, August 1988.

**Abstract:** The Rural Alabama Pregnancy and Infant Health (RAPIH) Program targets high-

risk, Black, childbearing women in three of Alabama's poorest counties with services designed to improve perinatal outcomes, reduce infant mortality, and improve early child development. The RAPIH Program, like its parent program, Child Survival/Fair Start Initiative, is a home visit program that relies on lay community workers to provide outreach, education, and social support to low-income families. A model visitation program begins at the 20th week of gestation and continues to the child's second birthday. A full program consists of 10 prenatal and 28 postnatal visits. The information given to the client comes from an educational curriculum developed specifically to meet the needs of southern rural, Black families. During each home visit, the trained home visitor addresses a particular aspect of prenatal care or child health and development. The home visitor also introduces clients to other social services, arranges referrals for identified problems, and provides valuable social support. In addition, prospective mothers in the RAPIH Program are required to participate in the prenatal and postnatal educational programs of the West Alabama Health Services (WAHS). The WAHS education program consists of 10 prenatal education classes scheduled on prenatal clinic days (home visitors often attend along with their clients) and postnatal education classes held in conjunction with well-child visits. These programs reinforce the home-visit curriculum. 9 references. (HE8801010)

215

### **Rural Community Women as Leaders in Health Outreach.**

**Form:** Journal article.

**Author:** Clinton, B.; Lerner, M.

**Source:** Journal of Primary Prevention. 9(1-2):120-129, Fall-Winter 1988.

**Abstract:** Maternal Infant Health Outreach Workers (MIHOW) is an example of a growing grassroots movement that relies on rural women to support families coping with the damaging effects that poverty can have on family life. The goal of MIHOW is to demonstrate that children's quality of life can be improved. The effects of poverty on a child begin before birth, since low-income women are less likely to seek early parental care and their children are more likely to die at birth. In Lee County, Virginia, the infant mortality rate was 45 percent higher than for the United States as a whole for 1980-1984. Rural women in southern Appalachia formed MIHOW in a partnership with Vanderbilt University Center for Health Services (Tennessee) to prevent the harmful effects of poverty and to promote the healthy development of their families. With university support in planning, training and evaluation, local women in communities in Kentucky, Tennessee, West Virginia and Virginia are trained to educate other women in matters related to prenatal care and infant development. In one community alone, over a period of 5 years, 10 women were trained to provide MIHOW services that so far have benefitted 123 families. Each MIHOW outreach worker identifies women in their community who are pregnant, have a low income, and have inadequate personal support systems or are stressed by other effects of poverty. Community workers (1) are experienced as leaders; (2) are committed to women's and children's issues; (3) are mothers themselves; and (4) usually have a background in nursing, teaching, or social work. Each worker builds a caseload of about 20 pregnant women and makes sure that every client receives prenatal care. She visits high-risk pregnant women monthly in their home and continues to visit them during their pregnancy and for the first 2 years after the child is born; then she provides fewer home visits and increases her efforts to set up groups and

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classes that bring the toddlers and their isolated mothers together with their peers. By training and employing mothers who are already part of the natural helping network, the program expects to have a significant impact on rural child-rearing practices and to meet the immediate need for support felt by many low-income families. 18 references. (HE9401421)

216

### **Rural Perinatal Services: Three Models for Community and Migrant Health Centers.**

**Form:** Report.

**Author:** Zotti, M.

**Availability:** National Association of Community Health Centers, Inc., 1330 New Hampshire Avenue, NW., Suite 122, Washington, DC 20036. (202) 659-8008.

**Abstract:** Three models for community and migrant health center perinatal programs are presented to emphasize the message that relations between the health center and its community are the key to improving service delivery programs. La Clinica del Carino (Clinic of Caring) Family Health Center in Oregon has a unique perinatal program for migrant and seasonal farmworkers. Team case management, including the use of lay health promoters, ensures patient tracking and referral. In Florida, Tri-County Family Health Care provides nurse midwife case managed perinatal care. Private physicians working in the community and a for-profit community hospital in Tallahassee ensure coordinated care and provide back-up delivery services for the nurse midwives. In addition, Tri-County has developed strong public health linkages within the three counties. Shenandoah Community Health Center of West Virginia has diversified its patient mix to generate paying patients to offset the cost of services for low-income patients. Staff nurse

midwives provide perinatal services and rely on private obstetrics and gynecology practitioners for oversight and handling of high-risk patients. The center does all initial assessments and manages lower risk patients. Dramatic growth in the overall patient population required the development of multiple care sites. In each of these models, the centers have linked with other community resources to increase access to perinatal health care. For each center, the geographic location of the community and a description of the center is provided. The health center's patient population is also given, as well as a description of the perinatal program and patient outcomes. 1 table. (HE9401403)



217

**Social Support in Improving Perinatal Outcome: The Resource Mothers Program.**

**Form:** Journal article.

**Author:** Heins, H.C.; Nance, N.W.; Ferguson, J.E.

**Source:** Obstetrics and Gynecology. 70(2):263-266, August 1987.

**Abstract:** Researchers studied the Resource Mothers Program in South Carolina, which aims to improve perinatal outcome through social support. Resource Mothers are nonprofessional women who combine warmth, parenting experience, and knowledge of their local community services to reduce the hazards associated with rural adolescent pregnancy. Six women received 6 weeks of intensive training that included information on pregnancy, labor, delivery, family planning, nutrition, communication skills, infant stimulation, well-child development, home visiting skills and techniques, community resources, referral skills, and work with extended families. Each Resource Mother was assigned to a pregnant teenage primigravida and served as part of her support system throughout pregnancy and until the infant's first birthday. Home visits were highly structured with specific learning objectives. Researchers studied 565 matched pairs (case/control) of rural pregnant teenagers with and without the social support of a Resource Mother. Of the case population, 89 percent were black, 11 percent were white, 93 percent were single, and ages ranged from 13-18. Researchers compared matched case/controls on adequacy of prenatal care, low or very low birthweight, and size small for gestational age. A statistical test showed that there was inadequate prenatal care in 35.9 percent of the controls as compared with 18.3 percent of the cases, a significant difference. Controls had a significantly higher percentage of small-for-gestational-age infants than the cases (9.8 and

4.9 percent, respectively). Study participants had significantly fewer low birthweight infants than the controls (10.6 percent versus 16.3 percent). Results suggest the effectiveness of supportive intervention in improving prenatal care and birth weight, but do not prove if the improvement was due to better prenatal care alone or the services of the Resource Mothers. 1 table, 16 references. (HE9401214)

218

**South Carolina Department of Health and Environmental Control, Application for Maternal and Child Health Improvement Project. Resource Mothers for Pregnant Teens Narrative.**

**Form:** Report.

**Corporate Author:** South Carolina Department of Health and Environmental Control, Maternal and Child Health Improvement Project.

**Availability:** South Carolina Department of Health and Environmental Control, P.O. Box 101106, Columbia, SC 29211.

**Abstract:** For decades, South Carolina has consistently ranked among those States with the highest infant mortality rates in the United States. A significant component of this problem is due to teenage pregnancy. Health care systems in South Carolina generally have not fully addressed the special needs of the high risk population of low income, poorly educated, unmarried girls age 17 and under who are experiencing their first pregnancy. This proposal, Resource Mothers for Pregnant Teens, addresses this health service systems gap. Paraprofessionals are used to reinforce and supplement clinical services. The proposal has two goals. The first is to reduce the mortality and morbidity of infants born to primigravida adolescents age 17 and under. The second is to increase health and parenting activities of primigravida adolescents aged 17

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and under that positively affect pregnancy outcome and child development. The proposal describes implementation and evaluation of the program. It also shows how information developed from the project will be disseminated to agencies, graduate schools, and other organizations. The capabilities of South Carolina's Department of Health and Environmental Control are listed, and a budget is given. Appendixes include (1) an evaluation of the Council for Rural Improved Births (CRIB) Resource Mother Program, (2) data collection forms, (3) organization charts, (4) position descriptions, (5) letter of support, and (6) public health districts. (HE9401377)

219

**Southeast Asian Patient Representatives (Community Health Workers) Home-based Maternal and Child Health Education Training Manual: Increasing Numbers of Southeast Asians Receiving Comprehensive Health Care Services Project (INSEARCH).**

**Form:** Manual.

**Author:** Okello, R.A.

**Availability:** Rhode Island Department of Health, Division of Family Health, 3 Capitol Hill, Providence, RI 02908.

**Abstract:** Southeast Asian Patient Representatives (Community Health Workers) Home-based Maternal and Child Health Education Training Manual: Increasing Numbers of Southeast Asians Receiving Comprehensive Health Care Services Project (INSEARCH) is a training manual for community health programs and professionals who prepare patient representatives to deliver maternal and child health education and community services to Southeast Asian women and their families in Providence, Rhode Island. The manual is part of a project that provides a combination of outreach, education, and case management in order to increase the

availability and accessibility of health care services. The manual teaches Southeast Asian patient representatives to transfer learned information to clients through (1) verbal communication of maternal and child health community resource topics, (2) demonstration and/or illustration, (3) provision of maternal and child health educational materials, (4) encouragement to practice and apply new health skills or behaviors, and (5) presentation of information by other culturally appropriate means. The training modules cover 15 areas: (1) Orientation and Training of Trainers, (2) Orientation of Trainees, (3) Community Resources, (4) Genetics and Inherited Disorders, (5) Family Planning, (6) Prenatal Care, (7) Prenatal Diagnosis, (8) Child Development, (9) Nutrition, (10) Childhood Diseases, (11) Safety, (12) Problem Solving, (13) Sexually Transmitted Diseases, (14) Other Preventable Diseases and Environmental Hazards, and (15) Dental Care. (HE9401269)

220

**Teen Advisor Project.**

**Form:** Program.

**Corporate Author:** Salvation Army Booth Memorial Center.

**Author:** Lindsey, L.

**Availability:** P.O. Box 7023, Oakland, CA 94601. (415) 532-3345. July 1984-continuing.

**Abstract:** The Teen Advisor Project of the Salvation Army Booth Memorial Center, Oakland, California, provides comprehensive services to pregnant and parenting teens using adolescents recruited, hired, and educated to be health educators and advisors in community outreach activities. The teen advisors receive at least 15 hours of technical education before assuming duties as group leaders or in other aspects of the Center's services. Teen advisors assist in the development and



evaluation of educational materials such as brochures and flyers, television public service announcements, and educational posters. The advisors participate in hearings and public forums and in radio and television interviews. Most importantly, they conduct outreach presentations to social services agencies, community organizations, and teen groups. Services offered may involve education and prevention, case management, infant and toddler daycare, parenting education, and information and referral. Teen advisors present the realities of teen parenting, publicize agency services, recruit other teens into the agency for program services, offer support to other teens, and educate pregnant teens and teen parents on specific perinatal and parenting topics. Classes to train teen advisors are usually held on Saturday mornings and provide information on teenage pregnancy and parenting, communication with adults, and adolescent family life services and projects. As an outgrowth of its education programs, the Project has developed a training manual. Tests before and after completion of the teen advisor course measure learning.  
(HE88P1272)

221

#### **Use of Community Health Workers With Inner-City Children Who Have Asthma.**

**Form:** Journal article.

**Author:** Butz, A.M.; Malveaux, F.J.; Eggleston, P.; Thompson, L.; Schneider, S.; Weeks, K.; Huss, K.; Murigande, C.; Rand, C.S.

**Source:** *Clinical Pediatrics*. 33(3):135-141, March 1994.

**Abstract:** Researchers present data from a large intervention study designed to reduce morbidity in inner-city African-American children with asthma. The use of community health workers (CHW's) to obtain health,

social, and environmental information from African-American inner-city children with asthma was an important component of the intervention. This particular component was designed to facilitate access to medical care for families who had children with asthma. A subset of 140 school-aged children with asthma was recruited and enrolled in a program of home visits by CHW's for the purposes of obtaining medical information and teaching basic asthma education to the families. Data obtained by the CHW's revealed (1) low inhaled steroid use, (2) high beta sub 2 agonist use, (3) frequent emergency-room visits, and (4) high allergen and irritant exposure. Results showed that appropriately recruited and trained CHW's are effective in obtaining useful medical information from inner-city families with children with asthma and in providing basic asthma education in the home. Because of the difficulties inherent in visiting low-income, inner-city families, the use of CHW's most likely maximized access to these children. 3 tables, 21 references.  
(HE9401409)

222

#### **Use of Homemaker-Home Health Aides' Perinatal Care of High-risk Infants.**

**Form:** Journal article.

**Author:** Raff, B.S.

**Source:** *Journal of Obstetric, Gynecologic, and Neonatal Nursing*. 15(2):142-145, March-April 1986.

**Abstract:** The Homemaker-Home Health Aide program for high-risk neonates started in late 1982. Funded by a grant from the March of Dimes Birth Defects Foundation, several agencies in Pinellas County, Florida, set up a special training program for home health aides to teach families in the care of high-risk infants during the difficult transition period after release from the neonatal intensive care



unit. The program began with the development and implementation of a training course, which included 21 hours of lecture, 4 hours of demonstration, and three 2-hour sessions of practical experience in the nursery. Neonatal unit staff conducted the training. Criteria for selection of the aides included (1) completion of NHC's basic Homemaker-Home Health Aide course, (2) work experience, and (3) CPR certification. Topics covered in the training included (1) normal pregnancy and the development of parental attachment, (2) parental response to a sick newborn, (3) special formulas and medications, (4) infant-care safety, (5) the breathing problems of high-risk infants, (6) the high-risk infant's homecoming, and (7) the impending death of an infant. The program demonstrated that families who were recipients of services kept clinic appointments twice as often as families who did not have aides. Compliance has been attributed to the assistance of the aides in providing reliable transportation to the clinic, babysitting with other children, and acting as interpreters for foreign-speaking mothers. When the program began, researchers hoped that a controlled study could be set up. However, service could not be randomized, and common variables for all infants have not been ascertained. Program evaluation will be a primary objective when the project is replicated. 1 table, 3 references. (HE9401367)

223

### **Use of Paraprofessionals to Motivate Women to Return for Post Partum Checkup.**

**Form:** Journal article.

**Author:** Westheimer, R.K.; Cattell, S.H.; Connell, E.; Kaufman, S.A.; Swartz, D.P.

**Source:** Public Health Reports. 85(7):625-635, July 1970.

**Abstract:** A Planned Parenthood of New York City project was designed to determine whether paraprofessionals can be trained to motivate women who are discharged from obstetrical services to return for post partum or postabortal checkup and family planning services. Two municipal hospitals cooperated in the project. During the 27-month project, 1,841 patients who had not kept their initial appointments for post partum examinations were referred to project staff. An analysis showed that 65.9 percent of the women were born in the continental United States, 23.5 percent were born in Puerto Rico, and 7.8 percent were born in other countries. The women were divided into an experimental group of 1,112 women and 2 control groups with a total of 729 women. Each woman in the experimental group was telephoned or sent a letter 6 weeks after discharge. If she did not keep her appointment after this reminder, a home interview was attempted at week 10. Each woman in control group 1 was also telephoned or sent a letter at week 6, but no further contact was made. Control group 2 was not contacted until week 12, when a home interview was attempted. Of the experimental group, 269 women were reached by telephone; 165 made appointments, but only 28 kept them. Letters were sent to 679 women, but only 7 kept their appointments. Home interviews were carried out with 362 women; 275 made appointments, but only 79 kept them. The greatest difficulty encountered was locating the patients. Tables address the ethnicity, ages, marital status, pregnancy outcome, and number of living children of women in the experimental and control study groups; as well as home interviews attempted, and number of women who kept initial post partum appointments. 8 tables, 6 references. (HE9401370)

## Sexual Behavior

224

### **Findings From the Horizontes Acquired Immune Deficiency Syndrome Education Project: The Impact of Indigenous Outreach Workers as Change Agents for Injection Drug Users.**

**Form:** Journal article.

**Author:** Birkel, R.C.; Golaszewski, T.; Koman, J.J.; Singh, B.K.; Catan, V.; Souply, K.

**Source:** Health Education Quarterly. 20(4):523-538, Winter 1993.

**Abstract:** Researchers report on the Horizontes Project, conducted over a 3-year period from 1988 to 1991 in Laredo, Texas and San Diego, California, and from 1988 to 1989 in San Juan, Puerto Rico. The project tested the effectiveness of an intervention model using indigenous outreach workers (IOW's) in the prevention of HIV transmission in Hispanic communities. Indigenous outreach workers collected data on the prevalence of high-risk behavior among Hispanic injection drug users (IDU's) and their sexual partners and provided HIV/AIDS education to promote reduced-risk behavior. Three primary objectives of the Horizontes AIDS outreach program were defined as (1) collecting epidemiological data on the prevalence of HIV and HIV risk behaviors among the target population; (2) establishing contacts with the at-risk groups in natural community settings; and (3) comparing the effectiveness of standard (one session) versus enhanced (three session) educational interventions in modifying risk behavior among IDU's. Subjects in all three cities were almost exclusively Hispanic (96 percent in Laredo and San Juan, and 79 percent in San Diego). Data from the project

suggested that the presence of IOW's created significant reductions in both intravenous drug use and high risk sex behavior. IOW's were able to obtain essential data on the epidemiology and vectors of infection in their respective communities and provide education, referral, and reinforcement in the adoption of risk-reducing behaviors, thus inhibiting further transmission through the community. Educators indigenous to the at-risk community offer a mechanism for enhancing entry into the social networks of communities and providing HIV/AIDS education and intervention services that meet the cultural norms of a particular community. 4 tables, 15 references. (HE9401338)

225

### **Lay Volunteers' Knowledge and Beliefs About AIDS Prevention.**

**Form:** Journal article.

**Author:** Kaiser, M.A.; Manning, D.T.; Balson, P.M.

**Source:** Journal of Community Health. 14(4):215-226, Winter 1989.

**Abstract:** Researchers investigated whether volunteers have knowledge and beliefs that are consistent with the safer sex message they are expected to deliver to the general public, and if they do not, whether training is able to correct these deficiencies. They administered pre and post questionnaires to lay persons in training to become volunteers for the NO/AIDS Task Force in New Orleans, Louisiana. The NO/AIDS training program for lay volunteers consists of two 2-day workshops. The trainers include physicians, nurses, social workers, health educators, and



other health professionals who donate their services. Much of the training program is directed at preparing lay volunteers to inform the public about modified sexual behavior which prevents the exchange of body fluids, known as safer sex. The study used a questionnaire to measure knowledge and beliefs. Knowledge items consisted of 14 true or false statements regarding the facts about HIV/AIDS as determined by the Surgeon General. In constructing the items designed to measure beliefs about AIDS, the researchers used the Health Belief Model (HBM). Seminar leaders administered the questionnaire to prospective NO/AIDS volunteers at the beginning and the end of three two-day training sessions. A total of 203 lay volunteers completed both the pre and post training questionnaires. Questionnaires were computer scored using the Statistical Package for the Social Sciences (SPSS). Prior to training, lower knowledge volunteers differed from their higher knowledge peers on two of the five HBM dimensions; perceived vulnerability and barriers. After training, these differences disappeared, and all volunteers scored 100 percent on the knowledge section. 7 references. (HE9401391)

226

### **Peer Educator-Counselors in Sexuality for the Disabled.**

**Form:** Journal article.

**Author:** Bullard, D.G.; Wallace, D.H.

**Source:** Sexuality and Disability. 1(2):147-152, Summer 1978.

**Abstract:** Researchers describe the Sex and Disability Training Project at the Department of Psychiatry, University of California at San Francisco. The project was awarded a grant from the National Institutes of Mental Health (NIMH) to develop a program to train socio-

sexual educator-counselors for the disabled, their families, and health care providers. For the first training group, 9 of 38 applicants were selected. Of these, there were 4 men and 5 women ranging in age from 22 to 44; 7 were disabled, including 6 who used wheelchairs. Primary staff included a clinical psychologist; a marriage, family, and child counselor; a social worker; a consulting physician; and a consulting psychologist for evaluation. Staff also included disabled and nondisabled persons. Staff divided training into a didactic and a practicum phase. The practicum phase included field placements at four rehabilitation hospitals, three independent living centers, a disabled students' program, and a cooperative residential center for disabled persons. In their field placements, trainees were expected to provide consultation and inservice presentations to staff and to provide short term counseling to clients based on an educational rather than medical or psychotherapeutic model. Evaluations of each trainee's performance included (1) self-ratings and ratings by other trainees, clients, agency supervisor, and project staff; (2) critiques of workshop presentations; and (3) submission of a research paper and a final report of the field placement experience. Evaluation of the first group of trainees by their field placement supervisors supports the concept that disabled and nondisabled paraprofessionals can be effectively used to provide socio-sexual education and counseling services to staff and clients in a variety of habilitation and rehabilitation settings. 12 references. (HE9401356)



## Injury and Violence

227

### **Community Leader Educational Resource Package: Guidelines and Resources for Organizing Communities and Volunteers.**

**Form:** Information package.

**Corporate Author:** Texas State Dept. of Health, Austin. Safe Riders Program.

**Availability:** Available from Safe Riders Program, 1100 West 49th Street, Austin, TX 78756. Stock No. 4-50.

**Abstract:** The Safe Riders Program of the Texas State Department of Health has developed a resource package to assist community leaders in organizing community resources and volunteers to promote child passenger safety. The resource package includes (1) background information on child passenger safety and the Safe Rider Program; (2) a four-step outline for organizing a successful child passenger safety program; (3) guidelines for recruiting, selecting, and training volunteers; and (4) strategies for funding the program. The four-step outline for organizing a child passenger safety program includes (1) familiarizing oneself with child passenger safety, (2) finding out what is being done in one's area, (3) learning about resources available in one's locale, and (4) organizing a child passenger safety meeting. Materials provided in the appendix include a list of child passenger safety resources, a sample agenda for a child passenger safety organizational meeting, a volunteer training program outline, volunteer training materials and forms, a list of suggested fundraising projects, and suggestions for measures to protect against liability. (HE8600907)

228

### **Complex Issues for Sexual Assault Peer Education Programs.**

**Form:** Journal article.

**Author:** Simon, T.

**Source:** Journal of American College Health. 41(6):289-291, May 1993.

**Abstract:** Peer education programs are one aspect of an overall cluster of programs and services that colleges or universities must have in place to deal with the problem of campus sexual assault. An educator at Brown University in Providence, Rhode Island identifies these services and describes the development of their sexual assault peer education (SAPE) program. Services, policies, and programs necessary to support a peer education program include (1) a campus sexual assault task force; (2) a written policy condemning sexual assault; (3) investigative and reporting procedures; (4) comprehensive services for survivors; (5) security; (6) policies encouraging low-risk use of alcohol; and (7) comprehensive sexuality education and information. In establishing their peer education program, Brown's first important goal was to confront rape as a problem for both men and women. Another goal was to reach the people who most needed to discuss these issues. This included a variety of groups: (1) Males and females, (2) gays and lesbians, (3) fraternity members, (4) varsity athletes, (5) students of color, and (6) traditional and nontraditional students. The SAPE program began by training 90 female and male students at Brown to conduct a mandatory orientation meeting on sexual assault for all first-year students. Recognizing the need to address these issues to a younger

audience, SAPE expanded and developed an interactive theater workshop that, in its first year, was taken to more than 30 high schools, colleges, and professional organizations. The experience at Brown University revealed that to adequately address the complexities of date rape through peer education, training must (1) confront the controversial aspects of campus rape, (2) pay attention to language, and (3) challenge students' views on relationships between men and women. 5 references. (HE9401350)

229

### **Preventing Child Abuse: An Experimental Evaluation of the Child Parent Enrichment Project.**

**Form:** Journal article.

**Author:** Barth, R.P.; Hacking, S.; Ash, J.R.

**Source:** Journal of Primary Prevention. 8(4):201-217, Summer 1988.

**Abstract:** Researchers conducted an experimental evaluation of the Child-Parent Enrichment Project (CPEP), a program designed to prevent parenting problems and child abuse by enhancing parents' self-care and child-care skills. The study population consisted of 50 pregnant or postnatal women identified by community health or social service professionals as being at risk of engaging in child abuse. More than half of the participants were receiving public subsidies and 72 percent had family incomes of less than \$10,000. Twenty-four of the clients received CPEP services, and the remaining 26 clients received traditional community services. CPEP services involved 6 months of home visits by trained, paraprofessional parenting consultants and linkage to other formal and informal community resources. Multivariate analysis of covariance on posttest scores (controlling for pretest scores) show advantages for the CPEP group in prenatal

care, birth outcomes, reported child temperament, and indicators of child welfare. In addition, CPEP mothers tended to report better personal well-being than women in the traditional care group. However, reports of child abuse were similar for both groups. These preliminary findings argue for further use and evaluation of perinatal child abuse prevention services. 45 references. (HE8800624)

230

### **Volunteer Peer Support Therapy for Abusive and Neglectful Families.**

**Form:** Journal article.

**Author:** Upsal, M.

**Source:** Public Health Reports. 105(1):80-84, January-February 1990.

**Abstract:** Volunteer peer support therapy is designed to treat families in which a child has been physically abused or neglected. Project objectives include (1) reducing treatment cost, (2) increasing self esteem in clients, (3) developing appropriate expectations for their children, (4) reducing dysfunctional behavior, and (5) less attrition from therapy than clients receiving traditional counseling. The treatment plan randomly assigns half of the subjects to the peer support treatment group and half to the traditional treatment group. Volunteer support therapy involves three stages. In the first stage, dependency, a trusting relationship is formed as the volunteer plays the role of a parent. Stage two, interdependency, focuses on developing parenting skills. Stage three, independence, is characterized by stability in the client's family. Peer support therapy is reduced to every few months or stressful situations. The volunteer supervisor and social worker provide support and ongoing training to the peer support volunteer as needed as well as during monthly meetings. Clients are encouraged to attend meetings of Parents

Anonymous. Volunteer peer support therapy provides a means for cutting costs while effectively treating abusive and neglectful families. This project is the first to evaluate systematically and quantitatively volunteer support therapy. Effectiveness will be evaluated in terms of improvements in (1) parental self esteem using the Index of Self Esteem; (2) parental expectations of the child using the Adult-Adolescent Parenting Inventory; (3) parental perception of child behavior using the Eyberg Child Behavior Inventory; and (4) parental dysfunctional behavior. Six months after treatment begins, and six month after client termination, followup assessments will be made. 13 references. (HE9000661)





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