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Health Promotion Practice, Standards and Activities of Local Health Departments in the United States

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Ⅰ. Introduction

As the nation is moving into the 21st century, the fundamental challenge facing local health departments in the United States is to improve the quality of peoples lives by preventing disease, injury, and disability through collaboration with public and private partners. During this century, life expectancy in the United States has increased remarkably from less than 50 years at the turn of the century to 79 years for woman and 72 years for men (CDC 1999; Bunker et al. 1994). Major portions of this gain can be attributed to advances in public health. Ten great public

health achievements in the United States are; nearly universal childhood vaccination, motor-vehicle safety, safer workplaces, control of infectious diseases, decline in deaths from coronary heart disease and stroke, safer and healthier foods, healthier mothers and babies, family planning, fluoridation of drinking water, and recognition of tobacco use as a health hazard (CDC 1999).

This decade is the decade of healthcare reform and the rebirth of the governmental public health system. Regardless of the health care financing reform, the nations health status may not substantially improve without simultaneous reform of the public health system. Thus, health system reform should not be restricted primarily to medical care; it should also encompass strengthening the practice of public health and stimulating new systems of integration among all organizations within a community (Baker et al. 1994). The redefinition of public health practice extends well beyond traditional concepts and seeks skills and resources of many new nontraditional players. There is already an increasing role for managed care systems. Community hospitals (5,300 hospitals in the U.S. with 3.5 million employees) have become another important partner. Both entities have begun to emerge as important forces in public health practice and in some instances, as territorially competitive to the 2,888 existing local health departments throughout the U.S.(Baker et al. 1994; Iglehart 1993; Ford et al. 1995; Turnock 1997). However, local governmental public health agencies are distinctive from private health care sectors. Their focus is on population based health or community health. They are established by law to protect the health of the entire community. In short, the vision of public health is *Healthy People in Healthy Communities* (Office of Disease Prevention and Health Promotion 1998). In 1998, the WHOs 50th Anniversary Report presents encouraging evidence about the impact of health promotion approaches. It is clear that when there is dynamic leadership and public participation and support, health status can be substantially improved. The themes that a health promotion perspective brings include; activities that are *person focused*, are *based in a holistic health perspective*, are *values dominant* and *determents based*, *embrace social capital and outreach*, and as on the *cutting edge of creativity* (*i.e., have a gimmick*) and *are capacity building* (Catford 1999).

The Institute of Medicine described that the Future of Public Health depends on

redefining and reintegrating the public health agencies role with two integral elements, namely prevention and community (Remington et al. 1988). The prevention of disease or injury is accomplished primarily through health protection and health promotion. In this regard, community partnerships toward a new public health practice will be achieved through providing health information to the community, leading in health planning and mobilizing the community for health, and assuring the availability of quality community health services (Baker et al. 1994). The Future of Public Health, the landmark report, also outlined three *core* functions of public health; *assessment*, *policy development*, and *assurance* (Remington et al. 1988). Core public health functions must be examined and modified in light of an analysis and rendering of the Essential Elements to create and maintain a *Healthy Community.*

II. Definitions

The frequently used terminology for health promotion and/or health education is defined as follows (ASTDHPPHE 1994):

Health Education is any combination of learning experiences designed to facilitate voluntary actions conducive to health.

Health Education Process is that continuum of learning which enables people, as individuals and members of social structures, to voluntarily make decisions, modify behaviors and change social conditions in ways which are health enhancing.

Health Education Program is a planned combination of activities developed with the involvement of specific populations and based on a need assessment, social principles of education and periodic evaluation using a clear set of goals and objectives.

Health Educator is defined as an individual whose primary responsibilities are to provide any planned combination of learning experiences designed to predispose, enable, and reinforce voluntary behavior conducive to health in individuals, groups, or communities.

Health Promotion is the combination of educational and environmental supports for actions and conditions of living conducive to health. The purpose of health promotion is to enable people to gain greater control over the determinants of their own health. The actions or behaviors in question may be those of individuals, groups or communities, of policy makers, employers, teachers, or others whose actions control or influence

the determinants of health.

Community is defined as a collective of people identified by common values and mutual concern for the development and well-being of their group often but not always in a specific geographical area.

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

Ⅲ. Essential Public Health Services

The concept of Healthy Community require that the following ten essential elements be performed by the local health department in close partnership with active community organizations (PHPPO 1999):

1. Monitor health status to identify and solve community health problems (e.g., community health profile, vital statistics, and health status).

2. Diagnose and investigate health problems and health hazards in the community (e.g., epidemiological surveillance systems and laboratory support).

3. Inform, educate, and empower people about health issues (e.g., health promotion and social marketing).

4. Mobilize community partnerships and action to identify and solve health problems (e.g., convening and facilitating community groups to promote health).

5. Develop policies and plans that support individual and community health efforts (e.g., leadership development and health systems planning).

6. Enforce laws and regulations that protect health and ensure safety (e.g., enforcement of sanitary codes to ensure safety of environment).

7. Link people to needed personal health services (e.g., services that increase access to health care).

8. Assure a competent public and personal health care workforce (e.g. education and training for all public health care providers).

9. Evaluate effectiveness, accessibility, and quality of personnel and population - based health services (e.g., continuous evaluation of public health programs).

10. Research for new insights and innovative solutions to health problems (e.g., links with academic institutions and capacity for epidemiological and economic

analyses).

Healthy communities require much more than the components of a health care system but also requires a system approach to health, which addresses factors such as housing, nutrition, education, crime and employment. Each level of government is responsible for assuring that the ten (10) essential elements are carried out in a fashion appropriate to the level of government. *Local health departments are required to have certain capacities* in order to carry out their roles of government entities, these *capacities* are: *health assessment, policy development, administration, health promotion, health protections, quality assurance, training & education and community empowerment* (Blue Print for a Healthy Community 1994).

Health Education encompasses a wide variety of tasks, talents and concepts. This paper provides a birds eye view of the practice of Health Promotion. There are several trends which deserve special mention as illustrations of how Health Education/ Promotion is integrated into the entire body of the Practice of Public Health. In addition, it is important to study the basics of the discipline of Health Promotion. The Healthy People 2010 Objectives codifies the current way of thinking about the coordinated role of Health Promotion. The specific Health Education objectives lay out a blueprint for community practice which leads naturally to a look at the Healthy People in a Healthy Community Movement. An example of how one geographic community (Colorado) is using this model to plan and implement programs is briefly discussed. Finally, there is newness to the most basic tool of health education and that is in the importance and methodology of Communication. This is a central thread to keep in mind as Standards of Practice are explored.

Ⅳ. Healthy People 2010 Objectives

In September 1998, The US Department of Health & Human Services released the Draft Version of Healthy People 2010 Objectives (USDHHS 1998) for public review and input. The final set of the nations health blueprint for the first decade of the 21st century is expected to be in place by January 2000. One of the toughest challenges of Healthy People 2010 Objectives is how to promote target policy attention and resources to Americans with poor

health in order to achieve the improvement of health for all.

There are a number of noteworthy aspects to HP2010 Objectives, which distinguishes it from its predecessor HP2000 Objectives. It sets two primary goals; *1) increasing quality and years of life and 2) eliminating all disparities in health status that are based on role, ethnicity, and in some cases socioeconomic status, gender or age.*

HP2010 is articulated into twenty-six (26) major groups of objectives to achieve the two (2) primary goals, and these twenty-six groups are further organized into four (4) main areas:

1) promoting healthy behaviors, 2) promoting healthy and safe communities, 3) Improving systems for personal and public health, and 4) preventing and reducing diseases and disorders.

V. HP2010 Objectives for Education and Community-Based Programs (Health Promotion/ Health Education

Attainment of the Healthy People 2010 objectives and improvement in the health outcomes in the United States by the year 2010 will depend substantially on educational and community-based efforts. These objectives should stimulate and encourage collaborative action and efficient use of resources from multiple sectors and community systems to improve individual health and create healthier communities. Although more research is needed in community health improvement, much has been learned in the past few decades. We know that the health of our communities does not depend just on the health of individuals, but also on whether the physical and social aspects of the communities make it possible for people to live healthy lives.

Today, a growing number of communities strive to achieve a healthier community by using community health planning processes such as APEX/PH (Assessment Protocol for Excellence in Public Health), Healthy Cities, Healthy Communities, and PATCH (Planned Approach to Community Health). These communities take ownership of their health and quality of life improvement process and work to sustain initiatives that result in *healthy people in healthy communities.*

Because many health problems relate to more than one behavioral risk factor and to social and environmental factors, effective communities also work to improve health

by addressing the multiple determinants of a health problem. The most effective community health promotion programs are those that implement a comprehensive intervention plan that uses multiple intervention strategies, such as educational, policy, and environmental strategies, within various settings, such as the community, schools, health care facilities, and work sites (Steckler et al. 1995).

Ⅵ. Healthy People in Healthy Communities Movement

Healthy People in Healthy Communities movement is defined broadly to include the full range of quality of life issues (ODPHP 1998). According to the World Health Organization (WHO) a Healthy City or Community is working to become clean and safe, with a physical environment and ecosystem that is sustainable. The Healthy City/Community strives to provide a thriving economy, opportunities for individual and industrial growth, and adequate provision for public health, medical care, and other essential needs of its population. It demonstrates an element of interconnectivity. When a community or a group of communities undertakes a healthy community project, a reorientation occurs, linking public and private sectors addressing the underlying causes of poor health.

In 1985, participants in the Beyond Health Care Conference in Toronto, Canada developed an innovative idea of community Healthy Promotion that was promptly taken up by WHO. In a little over 10 years, this simple innovation has become an international movement. Today, there are 35 WHO sponsored projects in Europe, North America, and Australia. Seven (7) International Healthy Cities Networks are in operation that touches more than 100 million peoples lives. In the U.S. the first statewide health networks launched in California and Indiana in 1988. Statewide networks are also currently working in Colorado, South Carolina, and New Mexico. At present, these networks include some 80 communities. The philosophy of this movement is based on the power of localities to make significant positive changes in the health of their own communities.

In general, the Healthy City and Community projects; *1) take a broad view of health, focusing on well-being and quality of life, 2) include all sectors of the community in identifying priorities and developing and*

implementing plans, and 3) recognize that structural change at the local level is necessary for real improvement in the communitys well-being. Effective approaches of the movement are holistic and link citizen, environmental, physical and design factors, to build *healthy people in healthy communities* (CDC 1999).

Ⅵ. Colorado Healthy Community Initiative

The Colorado Healthy Community Initiative (CHCI) was initiated by the Colorado Trust in 1992 to empower citizens to define their own vision of healthier communities and then take action to achieve that vision in reality (Conner et al. 1998, 1999). CHCI has involved 28 different Communities in Colorado in a general process within each community over 15 to 18 months of guided strategic planning followed by 2 to 3 years of action project implementation. The program model is based on a set of 4 principles; *1) the inclusion of a representative set of community members who undertake the process, 2) the use of consensus decision-making during the process, 3) the creation and use of a broad definition of health, and 4) the development of capacities within individuals and in community groups.*

The planning phase had a set of seven well-articulated steps: 1) provide a catalyst for the project via an initiating committee that then helped to form the stakeholder group, 2) hold a project kickoff and define or redefine community health, 3) conduct an environment scan, 4) evaluate current realities and trends, *5) establish a healthy community vision, 6) select and evaluate key performance areas, and 7) create an action plan.*

The 28 participating communities ranged from small to large, both geographically and demographically. As a result, key findings of the planning processes are:

- It brought many new community members into community - based decision-making.
- It succeeded in involving many but not all individuals and sectors that made up the larger communities.
- Stakeholders generally maintained involvement throughout the planning process.
- Consensus decision-making was generally achieved at a cost.
- The planning process succeeded in

causing participants to think differently about health and to select different types of projects to undertake.

- The majority of proposed action projects have the potential to result in significant changes in communities and in their health.

- The planning process built individual and group capacities.

In conclusion, this project brought a vision of what their community would look like 20 years into the future, which assumed an achievement of a healthy community.

Ⅷ. Health Communication

As we enter the Information Age, assurance of quality health information and communication will be vital to the achievement of Healthy People 2010 Objectives. Heath Communication is relatively a new field (USDHHS 1998). CDC defines health communication as the crafting and delivery of messages on strategies, based on consumer research, to promote the health of individuals and communities (USDHHS 1998). However, it is often interpreted more broadly as the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. Its scope includes disease prevention, health promotion, health care policy, and business, as well as enhancement of the quality of life and health of individuals within the community (Ratzan 1994).

Health communication encompasses a range of activities that often overlap or build upon each other. Some are population based, addressing entire communities or specific population groups. Others focus on individuals. In addition, health communication can be used to promote structural changes among institutions that impact social norms and health. There are many new information technologies that impact directly on the practice of Health Promotion. Distance learning is an example of new technology that it is vital to incorporate into Health Promotion practice, i.e. satellite broadcasting, e-mail, chat room, web pages, etc.

Information and education plays a vital role in promoting health. For individuals, effective health communication can help raise awareness of health risks and provide the motivation and skills to reduce them. For the wider community, health communication

can set the public and social agenda, advocate and promote positive changes in the socioeconomic environment and health infrastructure, and encourage social norms that benefit health and the quality of life.

As we learned from Stanford Three Cities Project (NIH supported), *effective communication* includes; *availability, repetition, accuracy, reliability, reach, consistency, timeliness, balance, cultural sensitivity, understandability, and evidence-based.* Four(4) strategic areas offering for improving and extending health communication are; *1) effective infrastructure, 2) quality standards, 3) capacity of health consumer to understand, and 4) ability of health communicator to be effective.*

Local health departments will certainly take a bridge role in organizing health communication to help affect informed health decisions that ultimately contribute to positive changes in health behaviors at the individual and population levels.

IX. Health Promotion/Health Standards/Guidelines

A. Leading Organizations

There are a number of organizations are involved in establishing professional credentialing, practice standards and activity guideline for health education/health promotion programs. They are; Council on Education for Public Health(CEPH), National Commission for Health Education Credentialing, Inc.(NCHEC), American Association for Health Education (AAHE), Association of State and Territorial Directors of Health Promotion and Public Health Education(ASTDHPPHE), Society for Public Health Education, Inc.(SoPHE), Coalition of National Health Organizations, U.S.A.(CNHEO), National Task Force on the Preparation and Practice on Health Education(NTFPPHE), etc.

B. Samples of Health Education/ Health Promotion Standards

Since there are 50 states, District of Columbia, 8 U.S. Territorial health departments and nearly 3,000 local health departments in the United States, a huge number of individual standards and guidelines exist.

In preparing this article, the following standards were reviewed; Roles and Functions of Health Education in the State Health

Department by ASTDHPPHE, Standards for Preparation of Graduate Level Health Educators Responsibilities and Competencies by NCEHC, Criteria for Accreditation of Graduate Programs in Community Health Education by CEPH, Criteria and Guidelines for Baccalaureate Programs in Community Health Education by SoHPE, Health Education Standards of Practice by the North Carolina Department of Environment, Health, and Natural Resources (May 1993), Standards of Practice for Public Health Education in California Local Health Departments by the California Conference of Local Directors of Health Education (2nd Printing in 1993), Quality in Health Promotion by the Texas Department of Health (February 1996), Colorado Health Education Standards by the Colorado Health Education Task Force (Reprint in March 1996), Health Education and Planning by the Harford County Health Department, Md., etc.

C. Standards for the Preparation of Graduate Level Health Educators

Responsibilities and Competencies (NCHEC 1997)

1. Assessing Individual and Community Needs for Health Education

a. Obtain health-related data about social and cultural environments, growth and develop-ment factors, needs and interests.
b. Distinguish between behaviors that foster and those that hinder well being.
c. Infer needs for health education on the basis of obtained data.
d. Determine factors that influence learning and development.

2. Planning Effective Health Education Programs

a. Recruit community organizations, resource people, and potential participants for support and assistance in program planning.
b. Develop a logical scope and sequence plan for health education program.
c. Formulate appropriate and measurable program objectives.
d. Design educational programs consistent with specified program objectives.
e. Develop health education programs using marketing principles.

3. Implementing Health Education Programs

a. Follow through to carry out planned education programs.
b. Infer enabling objectives as needed to

implement instructional program in specified settings.

c. Select methods and media best suited to implement program plans for specific learners.

d. Monitor educational programs, adjusting objectives and activities as necessary.

4. Evaluating Effectiveness of Health Education Program

a. Develop plans to assess achievement of program objectives.

b. Carry out evaluation plans.

c. Interpret results of program evaluation.

d. Infer implications from findings for future program planning.

5. Coordinating Provision of Health Education Services

a. Develop a plan for coordinating health education services.

b. Facilitate cooperation between and among levels of program personnel.

c. Formulate practical modes of collaboration among health agencies and organizations.

d. Organize in-service training programs for teachers, volunteers and other interested personnel.

6. Acting As A Resource Person in Health Education

a. Utilize computerized health information retrieval systems effectively.

b. Establish effective consultative relationships with those requesting assistance in solving health-related problems.

c. Interpret and respond to requests for health information.

d. Select effective resource materials for dissemination.

7. Communicating Health and Health Education Needs, Concerns and Resources

a. Interpret concepts, purposes and theories of health education.

b. Predict the impact of social value systems on health education programs.

c. Select a variety of communication methods and techniques in providing health information.

d. Foster communication between health care providers and consumers.

8. Apply Appropriate Research Principles and Methods In Health Education

a. Conduct thorough reviews of literature.

b. Use appropriate qualitative and quantitative research methods.

c. Apply research to health education practice.

9. Administering Health Education Program

a. Develop and manage fiscal resources.
b. Develop and manage human resources.
c. Exercise organizational leadership.
d. Obtain acceptance and support for programs.

10. Advancing the Profession of Health Education

a. Provide a critical analysis of current and future needs in health education.
b. Assume responsibility for advancing the profession.
c. Apply ethical principles as they relate to the practice of health education.

D. Core Functions of A State Health Promotion/Health Education Unit

Establishing a health promotion/health education unit in a state health department is essential in assuring a systematic application of health promotion, health education, disease prevention and medical care activities statewide. Core functions include but not limited to the following (ASTDHPPHE 1994).

1. Program Management

a. Control the application process and administers program related funding.
b. Develops and administers program related resources.
c. Conducts needs assessments, research and evaluations in health promotion and health education areas.
d. Translate health promotion, health education and behavior change research and theory into practice.
e. Integrates and coordinates health promotion/health education programming into other existing department programming.
f. Develops, conducts and evaluates health promotion/health education initiatives, projects, etc.
g. Designs and evaluates existing efforts for planned, systematic and audience-segmented outreach and marketing activities.
h. Collaborates with departmental staff on legislative issues and initiatives.

2. Consultation/Technical Assistance

a. Locates, selects and/or develops educational materials and resources.
b. Assists state and local public health personnel with selecting appropriate health education/health promotion materials and methodologies.
c. Assists local and state personnel with

developing strategies to address health promotion/risk reduction toward the Nations Healthy People Objectives.

d. Reviews other health education programming occurring in the state and local health departments and make recommendations, when appropriate, for improvements.
e. Provides assistance to non-public health personnel on selecting resources and initiating community and grassroots health promotion programming.
f. Assists local community with community 3assessment and planning through programs, such as PATCH (Planned Approach to Community Health), APEX (Assessment Protocol for Excellence), etc.
g. Serves on statewide health promotion coalition.

3. Health Education/Resources Information Services

a. Serves as a clearinghouse and distributes health information and resources, e.g., films, videotapes, interactive computer programs, educational kits, newsletters, posters, brochures, booklets, and successful community programs
b. Maintains a public health library
c. Provides or assists in mass media campaigns and determines media advocacy strategies

4. Training

a. Provides continuing education and in-service education for health educators and those involved in health education/health promotion programming, e.g., behavior change theory, marketing, community mobilization
b. Conducts assessment of health promotion/health education training needs
c. Facilitates continuing education for Certified Health Education Specialist (CHES) credit

E. Health Education Standards of Practice and Activities

Scope

Throughout the process of developing, implementing and evaluating health education programs, quality must be maintained. In assuring quality, health education standards of practice constitute indicators of acceptability. While specific program guidelines and policies may change, these standards are constant and apply to all health education programs.

Application and Outcome

Improve the level of health education practice; Assure the quality of health education services; and Guide the training of professionals and others involved in health education work.

Categories of Standards

1.0 Diagnosis and Planning

1.1 Diagnosis

Practice Concept

Diagnosing the health problem defines the specific individual and societal changes that are the focus of health education interventions.

Standards

1.1 Maintain a community profile that includes (in addition to health data) data describing economic, social, and political variables that affect health, for example:

literacy levels; unemployment; ethnic structure; high crime areas; cultural diversity; political structure; substandard housing; population demographics; people on public assistance; incidence/prevalence of abuse and violence; community resources, agencies and institutions, etc.

1.12 Identify community health issues and problems with:

a. groups/agencies that can provide needed skills, services, or resources; and
b. members of the population to be reached by the program.

1.13 When determining how to address health problems and issues, diagnose the following factors:

a. associated risk factors - behavioral and nonbehavioral;
b. contributing factors- attitudes, beliefs, values, cultural norms, knowledge, skills, resources, rewards;
c. population(s) at risk; and
d. delivery system strengths and barriers-e.g., responsiveness to clients, accessibility of services.

1.14 For each health problem, maintain a community resource inventory that describes and list agencies, groups, formal and informal leaders, and the potential contributions of each, e.g., skill-building; direct healthcare services; facilities; information capabilities; social support; and financial, administrative, or resource support.

1.15 Planned patient education is based on a diagnosis of the following points:

a. what the client knows about the subject;
b. the highest grade level completed by the client;
c. the clients attitudes and beliefs towards the condition or behavior being addressed;
d. skills the client needs to learn;
e. the clients readiness level; and
f. the clients social support system and other reinforcing factors.

1.16 Planned presentations to community groups are based on a diagnosis of the following information:

a. what the group members want to know;
b. what the group members already know about the subject;
c. the general education level of group members;
d. the level of action desired, such as to be more informed, provide support, furnish resources, use services, change behavior, and
e. the general attitudes and beliefs of group members.

1.2 Planning

Practice Concept Planning based on the diagnosis helps endure that effective interventions are used to bring about desired change.

Standards

1.21 When planning health education programs, the planning group consists of:

a. members from the potential target group;
b. health educators and other staff in the sponsoring organization; and
c. representatives of outside organizations that can provide needed skill, services, or resources.

1.22 Develop a written plan for influencing changes that describes:

a. objectives;
b. strategies for achieving each objective;
c. resources to carry out educational strategies;
d. roles and time frames; and
e. evaluation methods to be used.

This plan should describe multiple interventions (knowledge, attitudes, skills, resources, rewards, legislative/ regulatory, environmental) directed at various audiences (e.g., individuals, families, worksites, schools, social networks, community groups, health care organizations, etc).

1.23 Within the agency set up a system to ensure multidisciplinary involvement in the total process of patient care, including:

a. establishing written policies and procedures for patient education (these should be consistent with mandates, guidelines, and policies of the policies of the public health program);
b. creating lesson plans that include learner objectives, content, and methods;
c. evaluating and selecting appropriate education materials;
d. defining roles and coordinating delivery of education;
e. developing/refining adequate documentation procedures; and
f. establishing procedures for evaluating patients status, including progress in acquiring needed skills for self-care.

2.0 Administration and Management Practice Concept

Organizing the efforts of the agency and other participants assures the procurement and use of needed resources to carry out planned health education interventions.

Standards

2.1 Within the agency establish a system to ensure:

a. The competency of person involved in the planning or delivery of health education activities;
b. The training needed to develop or enhance these abilities; and
c. The employment of, contracting with, or otherwise having access to the expertise of a health education specialist.

2.2 Within the agency should be a record-keeping system to document information in the following areas:

a. changes in the community profile; and
b. program implementation

1. the number of clients participation in the program;
2. needs of and services for individual clients;
3. the degree to which program clients are members of the target population;
4. the degree to which program activities are completed and program objectives are achieved;
5. an analysis of the enablers and barriers to program implementation;
6. client feedback on services being used; and
7. feedback from potential users who did not use the services.

2.3 Within the agency, set up a system to ensure the timely and effective communication with the users of program services among all other participating organizations,

agencies, and groups. This system includes:

a. a mechanism and procedures for reviewing educational materials for readability level, comprehension, and appropriateness. (If the agency develops materials, messages are based on diagnostic findings, sound educational concepts, and are refined through pretesting.);
b. procedures for the procurement, dissemination, and use of educational materials;
c. a mechanism for working with and using mass media;
d. a mechanism for communicating with medical and other health-related professionals regarding the problem and the efforts to address it; and
e. a procedure for determining what needs to be reported, to whom, and how often.

2.4 The administrative portion of the health education program addressing the problem includes written policies and procedures for:

a. carrying out the program and for the programs administrative functions;
b. assuring health education expertise in planning, implementing, and evaluating the program;
c. evaluating the program and using the findings; and
d. carrying out patient education.

3.0 Implementation

Practice Concept

The delivery of health education services as planned requires:

a. the continued partnership of community groups and agencies;
b. the maximum use and development of resources;
c. the monitoring of activities and making needed adjustments;
d. the delivery of appropriate services for the target population; and
e. the empowerment of the community to effect change.

Standards

3.1 Health education activities are carried out as planned when:

a. educational interventions and strategies are applied;
b. participating agencies carry out their roles;
c. The target population is reached;
d. targeted behaviors and environmental risks for individual and collective action

are addressed;

e. Evaluation data are collected and records are maintained; and

f. The achievement of objectives is monitored.

3.2 When necessary, the program plan is updated based on suggestions from the evaluation:

a. users and participating agencies are involved in making adjustments or modifications;

b. planned modifications are communicated to appropriate persons; and

c. the modifications are integrated into the implementation process.

3.3 Promotion of community awareness ad involvement in health issues includes:

a. identification and use of formal and informal channels of communication for specific target groups;

b. policies and procedures for working with media outlets;

c. strategies for media relations;

d. expertise in writing for print and electronic media and in giving interviews;

e. a process for producing appropriate messages, public service announcements, media events and campaigns; and

f. a plan for communicating during a crisis.

3.4 The design, delivery, and evaluation of communication messages for the target population using social marketing principles that include:

a. segmenting the audience;

b. framing messages in terms of consumers wants and needs;

c. delivering segmented educational messages using appropriate communication channels or approaches;

d. assessing whether messages reach their intended audience; and

e. assessing the reasons why messages are used/not used by the target audience.

4.0 Evaluation

Practice Concept

Evaluation helps assure the quality of health education service delivery as well as program effectiveness.

Standards

4.1 Evaluation procedures are developed before program implementation and included in a written program plan (see Standard 1.22).

4.2 Within the agency set up a system to ensure program quality. The system generates accurate information on the following topics (see Standards 2.1, 2.2, 2.4, 3.1, and 3.2):

a. the skill and performance of program providers;
b. the adequacy of program resources including evaluation;
c. the appropriateness of the programs selected interventions;
d. the degree to which the programs educational strategies are being accomplished;
e. the nature of the barriers to program implementation; and
f. adherence to health education standards of practice.

4.3 Within the agency establish a system to determine the extent to which health objectives are achieved. This system generates information on the following:

a. changes in predisposing factors;
b. changes in enabling factors;
c. changes in reinforcing factors; and
d. changes in environmental risks.

4.4 Program evaluation data and conclusions are:

a. documented and used as a resource and data base for future program planning and evaluation activities; and
b. dissemination as appropriate.

4.5 Within the agency develop a system to ensure that program deficiencies are addressed and appropriate action(s) are defined.

Note: This standards were prepared by the Office of Health Education and Communication of the North Carolina Department of Environment, Health, and Natural Resources.

X. The Future: Evaluation and Discussion

The field of health promotion throughout the public and private sectors, those who plan and deliver services and policies, faces increasing pressure to demonstrate that the health promotion program is process-effective, cost-efficient and outcome-focused. A question is raised to whether the health promotion program is a good investment in terms of short or long-term returns (CDC/USDHHS 1999). To what degree can social and economic initiatives be measured? This is no simple task. Health promotion policies and programs are complex and procedurally tedious. Health Promotion action often requires multiple approaches, relies on interdisciplinary inputs and operates at several levels over long period of time. Visible immediate results are rarely seen (Brown et al. 1996).

In June 1995, the WHO European Regional

Office established a Working Group on Health Promotion in cooperation with US CDC, the Health Canada, and the United Kingdoms Health Education Authority. The Working Group selected four (4) core evaluation features, which are *1) participation, 2) multiple methods, 3)capacity and 4) appropriateness.* (WHO 1998). Coincidentally, during the same period, the National Commission for Health Education Credentialing, Inc. and Coalition of National Health Education Organizations, U. S.A. jointly established an ambitious goals for health promotion profession for the next millenium (Brown et al. 1999). They are; 1) Assure its services are state-of-the-art and based on theory, research, best practice standards, and ethical practices, 2) Assure its research is founded in theory and based in practice, 3) Plays a role in the development, diffusion, implementation, and evaluation of policies that influence the status of health, 4) Incorporates current technology and is contemporary and dynamic, 5) Utilizes appropriate pedagogy, 6) Considers social, cultural, economic, and political influence in promoting health, and 7) promotes social justice.

In conclusion, as the Working Group recommended, health promotion initiatives by local health departments in the United States should be empowered by citizens, widely participatory, holistically planned, broadly intersectoral, equitable to all recipients, sustainable as intended, culturally sensitive and multi-strategic.

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