



Practice Notes: Strategies in Health Education

The Practice Notes section is intended to keep readers informed about health education practice around the country. It is an attempt to spread the word about exemplary strategies, initiatives, and programs and share successes in overcoming obstacles or challenges. Periodically, articles presenting perspectives on practice-related issues are also included in Practice Notes.

The Practice Notes in this special issue are focused on health disparities. These notes provide unique examples of efforts to reduce health disparities across diverse communities. The first presents the challenges and successes in developing an occupational health curriculum to improve the health and safety of young Latino workers in a border community. Another highlights an effort to involve barber and beauty shops in bringing health resources to an African American community. Finally, a technical assistance model is presented that is designed to enhance injury prevention programs in Native American tribal communities.

Program: Occupational Health and Safety Education for Hispanic Workers at the Border

**Sponsor: National Institute for Occupational Safety and Health (NIOSH)
Cooperative Agreements Under the Southwest Center for Agricultural Health
Injury Prevention and Education, University of Texas Health Center at Tyler,
and the Southwest Center for Occupational and Environmental Health,
University of Texas at Houston Health Sciences Center**

Objective

This project was designed as a needs and assets assessment to develop and evaluate a culturally appropriate, bilingual (Spanish/English), high school-level, occupational health and safety curriculum, specifically targeted for Latinos in a border community.

Assessment of Needs

Two vulnerable worker populations often underrepresented in occupational health research are young and Hispanic workers in the United States. Hispanics are substantially younger on average than non-Hispanics, resulting in a substantially higher proportion in the 18-to 24-year-old

range—a group likely to be working and particularly vulnerable to workplace hazards. Hispanic workers are overrepresented in the categories of manual work and service occupations (Richardson, Ruser, & Suarez, 2003). In fact, Hispanic construction workers have almost twice the risk of mortality because of occupational injuries when compared with their non-Hispanic counterparts. Hispanic men in the southern states have the nation's highest unintentional fatal occupational injury rate (Richardson, Loomis, Bena, & Bailer, 2004). Reported odds for injury for Hispanic adolescents working in South Texas are high for agriculture, restaurant, and construction (Weller, Copper, & Basen-Engquist, 2003). Work safety curricula have been developed in several states but not for Hispanic workers (Web sites: www.lohp.org, www.losh.ucla.edu, and main.edc.org). Applied research that promotes community partnerships to coordinate a broad-based school health promotion intervention represents a promising expansion for school-based programs and for expansions of approaches to occupational health and safety among Hispanic workers.

Program Strategy

The curriculum developed for Spanish-speaking workers included three phases: (a) needs and assets assessment via focus groups and interviews, (b) resource assessment and curriculum development, and (c) curriculum refinement.

Needs and assets assessment: Six focus groups consisting of 52 participants (high school administrators, teachers, parents, students, and farmworkers) were held to provide feedback about the high school-level occupational health and safety curriculum. The focus group protocol included assessment of building capacity such as classroom space and necessary audiovisual aids, curriculum development, and teachers' and administrators' motivation.

Curriculum development: The collaboration between the School of Public Health, University of Texas (Brownsville Regional Campus) and the Labor Occupational Health Program, University of California at Berkeley was established. After an extensive search, several English, but no bilingual, curricula were found. Several curricula were selected as primary resources for this project. Permission was obtained from all above organizations for use and/or adaptation of materials, and appropriate materials from these sources were selected.

Curriculum refinement: An "educator taskforce" consisting of general equivalency degree (GED) teachers, science teachers, GED program counselors, and high school administrators was formed to recommend modifications of course materials appropriate for high school-level workers. They made recommendations for specific activities to ensure literacy level, cultural, and language appropriateness. The course materials were translated into Spanish and back translated into English. The final product was a bilingual curriculum entitled *Work Safely—Trabaje con Cuidado*. It consisted of eight 60-minute lessons and included topics such as hazard recognition, injury prevention strategies, child labor laws, sexual harassment, workers' compensation rights, and communication skills needed to discuss work-related safety concerns.

The curriculum is interactive, requiring student participation in activities such as mapping safety hazards of common entry-level work sites, developing and prioritizing strategies to protect workers from these hazards, and practicing communication of work-related safety concerns through role-playing. The curriculum was pilot tested in two different South Texas cities, among laid-off workers in a GED program and among migrant farmworker students. In addition, the curriculum is being tested at a regular high school with 113 students attending a work study program.

Evaluation Approach

The educators' task force completed evaluations before and after the workshop. A follow-up evaluation was conducted via two focus groups with participants after the workshop. They considered barriers for implementation (at regular high school programs and high school equivalency programs), made suggestions for future trainings, and expressed willingness to participate in pilot testing. After pilot testing of the curriculum materials, data are being collected to assess the process of implementation in those two initial sites. The second "pilot study" at the regular education high school is also under way. A 6-week follow-up survey and several focus groups will be conducted.

Implications for Practitioners

The curriculum may be a useful educational bilingual intervention targeting young Hispanic workers. Reaching young Hispanic workers attending high school or GED programs is a promising approach providing occupational health education. Teachers and administrators were enthusiastic about participating in the development of the first bilingual curriculum for their students. However, those considering use of such curricula should be sensitive to the multiple demands educators are facing today. At GED programs, teachers may have more time to provide additional training that enhances the students' education. The potential avenue for occupational health and safety curricula at regular high schools may be in programs that are linked to job training. The partnership approach has been widely used among curriculum developers and may help sustain programs as well.

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Program: Take a Health Professional to the People: A Community Outreach Strategy for Mobilizing African American Barber Shops and Beauty Salons as Health Promotion Sites

Sponsor: EXPORT Health Center at the Center for Minority Health, Graduate School of Public Health, University of Pittsburgh

Objectives

In September 2002, the U.S. Department of Health and Human Services launched "Take a Loved One to the Doctor Day," a national effort to promote health and wellness in the African American (A-A) community. The Center for Minority Health (CMH) at the Graduate School of Public Health, University of Pittsburgh, adopted this model and tailored it to meet local needs by partnering with seven barbershops, two beauty salons, and more than 100 health professionals (HPs) to create what is now known as "Take a Health Professional to the People Day." The focus of this partnership was to provide screenings and health information to patrons and transform these shops and salons into health promotion sites.

Assessment of Needs

The national health initiative *Healthy People 2010* has two main goals—increasing quality and years of life and eliminating health disparities. Despite much progress in improving the health of American citizens, disparities between A-A health and the general population continue to exist. In a city with nationally ranked hospitals and health care training institutions, Pittsburgh's A-A community, like so many around the country, continues to be affected by preventable diseases, including cancer, cardiovascular disease, HIV, and diabetes. Socioeconomic, political, and cultural factors combine to influence health beliefs and behaviors. It is important that health messages be delivered with a strategy that considers those factors.

Prevention efforts that are culturally relevant and that incorporate the social norms and values of the A-A community may be effective, particularly if they are delivered by trusted and respected community members and institutions. In the A-A community, barber shops and beauty salons serve as gathering places and centers of information exchange. Research indicates that barber shops and salons are viable vehicles for health education and health promotion interventions and are important community outreach sites. The idea of using trusted community-based institutions to promote health and wellness has its roots in social network and social support theory.

Program Strategy

Barber shops and beauty salons were selected from a list of approximately 120, based on similarities of demographic profiles from the 2000 census. Recruitment of shops and salons began with phone calls to each owner to make appointments for formal introductions and pitch the idea. The strategy of "sampling the product" by getting a haircut proved instrumental in establishing relationships.

To recruit health professionals, a Web-based registration form was created and the link sent via e-mail with a letter of invitation to participate in Take a . . . Day to researchers, physicians, nurses, community-based health organizations, federally qualified health centers, the local health department, nursing sororities, and schools of health sciences at the University of Pittsburgh and other neighboring colleges and universities.

CMH deployed health professionals and students of all types into the A-A community via this network of shops and salons. Two CMH staffers were at each site to observe the interactions between shop/salon employees, customers, and HPs, recording what they saw and heard using an abbreviated “observational protocol” instrument. Standard services provided at each shop included blood pressures (BPs), “Ask the Pharmacist,” and referrals to and information on local health care providers.

Unique to this effort was the partnership with a competing university’s School of Nursing and our university School of Pharmacy. These schools used this initiative to give their students “field placement and cultural confidence” training by placing them in these sites under the supervision of a professor or proctor.

In addition, one of our shops partnered with a daycare center next door, and the Ronald McDonald Van of Children’s Hospital conducted full exams on the children.

The most significant highlight of the day was our attempt to engage A-A men in the barbershop to get a free prostate examination in the shop. We were successful in reaching nine customers who received either a PSA, DRE, or both.

CMH engaged the shops, salons, and their customers by making the atmosphere festive and inviting with the use of balloons, food, and water provided by our supermarket partner, and plenty of picture taking.

Evaluation Approach

Effectiveness of this project was evaluated through various process measures such as participant satisfaction, including shops/salons and health professionals, media coverage, increased health professional

participation, and diffusion of innovation measures, such as number of inquiries from other shops and programs to duplicate our efforts.

Implications for Practitioners

“Take a Health Professional to the People Day” represents an innovative method of community engagement for health promotion and health education and demonstrates a novel approach to using barber shops and beauty salons as both health promotion sites and venues for community-based training of health providers with a follow-up mechanism built in. In addition, the field placement opportunity will be developed in an “Adopt-a-Shop” model to allow CMH to act as a conduit for various schools of health sciences for ongoing community-based training.

Last, CMH believes that this type of infrastructure is necessary for future successful research activities with and in the A-A community.

This program is supported by NIH/NCMHD Grant P60 MD-000-207-02. For more information, please contact Mario C. Browne, MPH, CAC, Project Director, Center for Minority Health, Graduate School of Public Health, University of Pittsburgh, 125 Parran Hall, 130 DeSoto Street, Pittsburgh, PA 15261; phone: (412) 624-5665; fax: (412) 624-8679; e-mail: mbrowne@cmh.pitt.edu; Web address: www.cmh.pitt.edu. You may also contact Angela Ford, PhD, Associate Director, Center for Minority Health, GSPH, University of Pittsburgh; e-mail: afford@cmh.pitt.edu; or Stephen Thomas, PhD, Director, Center for Minority Health, GSPH, University of Pittsburgh; e-mail: sbthomas@cmh.pitt.edu.

**Program: Providing Technical Assistance to Tribal Entities
to Build Local Capacity for Injury Prevention**

**Sponsors: Indian Health Service, University of North Carolina School
of Public Health, Department of Health Behavior and Health
Education and the Injury Prevention Research Center**

Objectives

The Indian Health Service (IHS) Injury Prevention Program has established a Tribal Injury Prevention Cooperative Agreements Program (TIPCAP) to build the capacity of American Indian and Alaska Native communities to develop, implement, and evaluate injury prevention programs. Initiated in the fall of 2000, the IHS allocated \$50,000 per year for up to 5 years of support for TIPCAP sites.

Because of variation in the TIPCAP sites' program capacity, technical assistance was required to bridge the gap between needs and resources. IHS augmented the support provided by TIPCAP project officers and contracted with faculty and staff from the University of North Carolina (UNC) at Chapel Hill School of Public Health to provide tailored technical assistance that would move the programs toward self-sufficiency in implementing effective injury prevention activities (Neufeld, 1978).

Assessment of Needs

American Indians/Alaska Natives (AI/ANs) have the highest unintentional injury rates and suicide rates in the United States (National Center for Injury Prevention and Control, 1998). The AI/AN age-adjusted injury death rate is 2.6 times the overall U.S. rate, and AI/AN mortality because of motor vehicle crashes is 3.3 times that of the U.S. population (*Regional Differences in Indian Health*, 2003). The AI/AN injury mortality rate varies across the country, with some rates four to five times that of the general population (Smith & Robertson, 2000). Although the gap between mortality rates for the general

population and AI/ANs has decreased since the 1980s, the difference remains substantial (*Trends in Indian Health 2000-2001*, 2004).

Program Strategy

UNC staff provided ongoing assistance to 30 TIPCAP sites over a 5-year period. The technical assistance process began with an assessment of each site's plan to develop a program to reduce injuries. Assessment activities included document review, on-site visits, and structured-interview conference calls. Additional technical assistance activities included developing and implementing an annual 2-day training workshop, producing a project newsletter, and providing administrative support to IHS headquarters and field staff. After UNC identified specific needs for knowledge or skill development, technical assistance was tailored to deliver information and provide learning activities that could be conducted during site visits and/or discussed during conference calls. Training workshops and newsletter articles were specifically designed to increase knowledge and build skills related to the sites' program challenges. UNC also developed tools to assist program coordinators, including project-reporting templates, planning/evaluation worksheets, seat belt use observational protocol, monitoring tables, and budget-monitoring spreadsheets. UNC and IHS staff encouraged the implementation of comprehensive intervention approaches through a combination of education, enforcement, and environmental-change strategies to promote safe behaviors and situations. The most common interventions included

educational campaigns and equipment distribution to increase use of child passenger safety seats, seat belts, bicycle helmets, and smoke alarms. Some sites also sought to pass and/or enforce tribal ordinances to address the use of child safety seats, seat belts, helmets, and impaired-driving checkpoints.

Evaluation Approach

Evaluation of each TIPCAP program's change in capacity was obtained from progress reports, continuation applications, conference call/site visit summaries, and annual project coordinator/project officer surveys. To better document and track these measures, we developed a logic model, created a monitoring database, and coded the information abstracted from multiple sources into five program components: (1) support/setting, (2) staff capability, (3) management, (4) injury prevention interventions, and (5) impacts/outcomes.

Implications for Practitioners

The logic model and database proved useful for organizing programmatic information from 30 sites over 5 years. The logic model facilitated the provision of clear, consistent, and comprehensive technical assistance. It also enabled project team members to report site activities to IHS headquarters staff annually in an organized manner.

There are advantages to contracting with external organizations for technical assistance. They often have more current technical knowledge, are able to produce rapid results, and have a broader array of skills and expertise on staff. In addition, external organizations do not supervise the program, therefore staff may feel free to reveal program weaknesses and explore solutions (Neufeld, 1978).

To provide tailored technical assistance, we recommend understanding the funding agency goals; having relevant experience

with the content and the communities; emphasizing rapport building; continuously reflecting on how services are provided; and communicating the program progress, responsibilities, and recommendations in ways that are clear, consistent, and realistic.

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SUBMISSION INFORMATION

Abstracts for Practice Notes and all correspondence concerning abstract review should be sent to Lisa D. Lieberman, Healthy Concepts, 29 Ardsley Drive, New City, NY 10956. Submissions can be mailed (include one hard copy and disk in Word format or Word Perfect) or sent by e-mail attachment to llhealth@optonline.net in Word format. Published manuscript length is approximately 300 words (excluding headings and contact information). Submitted manuscripts may be up to 700 words and will be edited for length and clarity. Include the following: name of initiative or program, contact person, sponsoring agency or agencies, address, and phone number. The program description should include the following headings: Objectives, Assessment of Needs, Program Strategy (e.g., risk reduction, community organizing, media advocacy, disease management, policy advocacy, coalition building, social support, etc.), Evaluation Approach, and Implications for Practitioners (including descriptions of any special challenges or unique circumstances that the project has overcome). Authors should not include evaluation results because Practice Notes is intended to describe processes and programs, not to assess outcomes. Submissions will be judged on applicability and utility to the health education practitioner, clarity of objectives, innovativeness and creativity, existence of evaluation plan, and potential replicability. Additional artwork, graphs, or tables may be submitted in camera-ready form.

