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SOCIAL WORK IN ILLNESS PREVENTION AND HEALTH PROMOTION

In the future, the health care system's current treatment orientation, which determines the point of intervention too late in the course of many diseases, will be replaced by an orientation toward disease prevention and health promotion. It will move toward the realization of health as "physical, mental, and social well-being," an idea proposed by the World Health Organization (WHO) more than 50 years ago. That movement will involve not only a vital shift in the philosophy and priorities of the health care system but also a significant change in the nature of the roles and relationships of health care providers and recipients. The system has been philosophically treatment and procedure centered and driven by incentives for costly and often excessive treatment of mostly preventable morbidity (Gellert, 1993). As the system's focus gradually shifts from illness to wellness, the patient will become a true partner of health care providers in the joint effort to stay healthy. In the past, the patient put all the faith and confidence in health care providers to keep him or her healthy. This dependence resulted in failure of the patient to take responsibility for healthy living. As Taylor, Denham, and Ureda (1982) put it,

The past generation of men and women have consumed nutritionally deficient foods, accepted increasing weight as a natural consequence of aging, used tobacco despite well-documented hazards, ingested unnecessary and sometimes dangerous drugs, failed to get necessary rest and sleep, exercised infrequently, and accepted prolonged stress as though immune to its damaging sequelae. (p. 1)

On the other hand, health care providers, particularly physicians, restricted their role to only diagnosis and treatment of disease. Illness prevention and health promotion have not been parts of their role as healers. For most of them, advising the patient in proper nutrition and exercise has lacked the professional self-fulfillment of managing a serious illness episode such as an asthmatic attack or excising an inflamed appendix (Taylor et al., 1982). All this has been a part of the larger cultural context.

Industrial societies have placed their management of health and human welfare issues into the hands of "experts," who in turn are typically associated with large, centralized bureaucracies. Thus, a relatively impersonal service takes over some of the most intimate and important human concerns—birth,

death, sickness, health, education, care of the elderly and disabled, to mention just a few. (Green & Raeburn, 1990, p. 37)

This will gradually change. Besides the illogic of the way things are, the cost (in every sense of the term) to the individual and to society of waiting until problems become full-blown will become increasingly unbearable.

Conceptually, illness prevention and health promotion are distinct. Health promotion is a much wider concept than illness prevention. In *health promotion*, intervention is directed at improving the general well-being of people, and no specific disease agent or process is targeted. “Health promotion transcends narrow medical concerns and embraces less well-defined concepts of wellness, self-growth, and social betterment. Concepts related to illness prevention are more specific” (Bracht, 1987, p. 318). Health promotion is a prepathogenic level of intervention, whereas in *disease prevention*, the known agents or environmental factors are the focus of intervention, with the aim of reducing the occurrence of a specific disease (Leavell & Clark, 1965). *Illness prevention* involves actions to eliminate or minimize conditions known to cause or contribute to different diseases.

In the public health literature, all health-related activities are conceptualized as preventive and categorized as primary prevention, secondary prevention, and tertiary prevention. *Primary prevention* involves actions to keep conditions known to result in disease from occurring, thus preventing the disease process from starting; *secondary prevention* involves actions to limit the extent and severity of an illness, after it has begun, by early detection and treatment; and *tertiary prevention* involves efforts, during and after the full impact of illness, that would minimize its effects and preclude its recurrence (Barker, 2003; Watkins, 1985). In this scheme, health promotion and illness prevention are two phases of primary prevention. Together, they refer to actions and practices aimed at *preventing* physical, psychological, and sociocultural problems; *protecting*

current strengths, competencies, or levels of health; and *promoting* desired goals and the fulfillment or enhancement of human potentials (Public Health Service, 1979). These actions and practices are concerned with the total population generally and the groups at high risk particularly. To be effective, they must be comprehensive and multifocused—aimed at changing individual health behaviors, creating a positive climate for health in the community, and bringing about policy change in favor of a social and physical environment free of health hazards.

HISTORY OF SOCIAL WORK IN ILLNESS PREVENTION AND HEALTH PROMOTION

As we have seen in Chapter 2, public health has been the main actor on the illness prevention and health promotion stage. Because of the congruence between the broad goals of social work and public health, social work has been a part of public health activities and programs for more than 100 years. As Bracht (1987) put it,

Interest in health promotion and illness prevention is certainly not new, especially to social workers whose professional role has historically been targeted on the broader aspects of health and social betterment. Jane Addams engaged the first woman physician graduate of Johns Hopkins Medical School to come to Chicago in 1893 to open the country’s initial well-baby and pediatric clinic. In Ohio, the Cincinnati Social Experiment, a neighborhood health center, was established by a group of social workers stressing neighborhood and environmental health. (p. 316)

In the second half of the 19th century, social workers collaborated with others in organized efforts to control communicable diseases. Their help was considered essential for the success of public health programs that required the cooperation of citizen groups. They not only collaborated with health professionals but also demonstrated the utility of social work approaches and methods

for health-related work. The major social work approaches of those days were illustrated by the work of charity organizations and settlement houses. The Children's Bureau, created in 1912, had its origins in the settlement house movement. Four of the first five chiefs of the bureau were social workers. The fourth, Martha May Eliot, a physician, had worked as a social worker in the Social Service Department at Massachusetts General Hospital before entering medical school (Hutchins, 1985). During the influenza epidemic of 1918 to 1919, social workers tracked and reached out to children in the community who were at high risk because their parents had died of the flu (Harris, 1919). After World War I, the passage of the National Venereal Disease Control Act led to the development of clinics for surveillance, early diagnosis, and treatment of venereal disease. As part of those clinics, social workers educated the victims of venereal disease and their families about the cause and dissemination of syphilis (Kerson, 1979).

Social workers also participated in political advocacy, at times at great cost. They had to work against societal biases and prejudices. In the early 20th century, for their efforts to increase government's role in maternal and child health, social workers of the day were maligned by their opposition as communists, subversives, endocrine perverts, and derailed menopausalists (Siefert, 1983). Nevertheless, they led a campaign culminating in the passage of the Sheppard-Towner Act of 1921. The work made possible by this law contributed

substantially to the reduction of infant mortality, demonstrated the effectiveness of preventive health services, and established the principle of shared federal-state responsibility in health and social welfare (Doss-Martin & Stokes, 1989). Passage of the Social Security Act of 1935, which created the Maternal and Child Health and Crippled Children's Services, brought social workers into public health programs much more prominently. They have worked in public health and other health care organizations not only as case workers with the ill and the disabled but also as case finders, planners of outreach services, prevention workers (in maternal and child health, family planning, alcohol and drug abuse, and mental health programs), health educators, advocates for and planners of comprehensive health projects, consultants, researchers, and trainers of paraprofessional personnel (Bracht, 1978).

Social workers have believed in the widest definition of *public health*. In 1981, the National Association of Social Workers adopted, with minor modifications, Winslow's definition of public health (given in Chapter 2) as part of its official policy statement on social work in health settings and laid down the standards for social work practice in public health. Others (e.g., Morton, 1985) have built on those ideas. Table 6-A below provides a list of general objectives of public health social work.

These objectives have demanded that social workers assume different and varied roles, such as provider of direct services, case manager,

Table 6-A General Objectives of Social Work in Public Health

- Ensuring the provision of psychosocial services for individuals and families
- Providing information and knowledge about community service networks to consumers and health care providers
- Collaborating with professionals from other disciplines in delivering comprehensive care
- Promoting social work values, such as self-determination, within the health care system
- Encouraging consumer participation in the planning and evaluation of services
- Discovering systemic factors that prevent access or discourage use of services
- Documenting social conditions that interfere with the attainment of health and working for program/policy changes to address those conditions

administrator of a program, coordinator of services, program planner, consultant, and program evaluator. Social workers work in all kinds of illness prevention settings/programs, such as prenatal and postnatal clinics, health centers, health maintenance organizations, clinics for children with developmental or physical disabilities, and special programs for genetic counseling, bereavement work, prevention of child abuse, teenage pregnancy, teenage suicide, AIDS, and substance abuse.

Social work also has contributed to the theory and technology of illness prevention and health promotion. While incorporating the principles of epidemiology into social work practice, social workers have applied the philosophy, principles, and methods of their profession to public health work. The work of social work theoreticians such as Bloom (1981), Bracht (1990), Germain (1984), and Germain and Gitterman (1980) is noteworthy. Basic social work philosophy, theory, and techniques have significant relevance for the illness prevention and health promotion field, and social workers can enter this field with a high degree of confidence in their abilities. The major elements of their professional repertoire are highlighted below.

The philosophy of social work is based on democratic values, as well as the values of science. In the words of Weick (1986),

The profession has developed an intellectual heritage based on two separate but related intellectual approaches: a commitment to scientific inquiry spawned by the rise of an empirical, technical world view and a commitment to philosophical principles motivated by humanistic, democratic beliefs. (p. 551)

This philosophy, on the one hand, generates the belief that people can change if given the reason and the wherewithal, and creates such practice principles as self-determination, individualization, and participation of people (as individuals, groups, and communities) in the change efforts. On the other hand, it emphasizes the need for rationality, objectivity, and a nonjudgmental

attitude, and the study and assessment of people and their situations for professional intervention. This philosophy is essentially optimistic and strength oriented, as is reflected in the social work axioms "Let people determine the course of their own lives," "Work with people's strengths," and "Consider people within their social environment." In illness prevention and health promotion work, whether the emphasis is on increasing personal strengths, decreasing personal weaknesses, increasing social environmental resources, or decreasing social environmental stresses, the overall social work philosophy will keep the worker on the right professional path. Moreover, this theme blends well into the philosophical basis of health education practice, which is founded on democracy as a political philosophy and citizen participation as a professional principle (Steckler, Dawson, Goodman, & Epstein, 1987).

Because the focus of social work is on person in environment, systems theory provides a useful model for conceptualizing social work practice. This theory offers a holistic view of people and their problems and situations; it (a) helps social workers perceive and better understand the social environment, (b) helps in identifying practice principles that apply across different contexts, and (c) can help in integrating social work theories and unifying the profession (Martin & O'Connor, 1988). Therefore, social workers engaged in illness prevention and health promotion work can apply the systems perspective to their assessment, planning, and intervention, yielding significant results at all levels of their activity. This perspective fits into the ideal health promotion approach, the ecological perspective that seeks to influence intrapersonal, interpersonal, institutional, community, and public policy factors. This approach adds to educational activities "advocacy, organizational change efforts, policy development, economic supports, environmental change, and multimethod programs" (Glanz & Rimer, 1995, p. 15). Other social work concepts effective in this work include "enabling," "empowerment," and "community organization."

FUTURE SOCIAL WORK ROLES IN ILLNESS PREVENTION AND HEALTH PROMOTION

In Chapter 3, we discussed the *lack of resources* jeopardizing the ability of state and local public health departments to perform effectively even their basic functions. The Institute of Medicine (1988a) study on the future of public health found that

public health functions are handicapped by reductions in federal support; economic problems in particular states and localities; the appearance of new, expensive problems such as AIDS and toxic waste; and the diversion of resources from communitywide maintenance functions to individual patient care. (p. 156)

The study recommended the following: (a) Federal support of state-level health programs should help balance disparities in revenue-generating capacities through “core” funding, as well as funds targeted for specific uses, and (b) state support of local-level health services should balance local revenue-generating disparity through “core” funding. In the future, the wellness movement will gradually improve the legitimacy of the claim of public health departments for a greater share of resources, but the claim will not automatically translate into the availability of more resources.

Without major health reform in the interim, projections of the Health Care Financing Administration, based on continued inflation of costs, indicate a national expenditure by 2030 of 15,969 trillion dollars, with 206 billion dollars remaining for preventive programs. This will represent a further reduction in the public health share of expenditures to 1.29%, or about half of the current proportion. (Koplin, 1993, p. 400)

Even if a greater share of the national dollar for health activity is allowed for illness prevention and health promotion, public health departments will be competing with many other public

and private entities providing illness prevention and wellness services.

In the future, more and more hospitals will expand their activities to include illness prevention and health promotion work, and most of them will expect that work to generate profit or at least be self-sustaining financially. Similarly, other agencies involved in such work are likely to need greater financial resources to improve the extent and quality of their efforts.

Besides the paucity of funds, one major hurdle to the effectiveness of the local health department is organizational. Most of such departments are too small to have adequate resources for effectiveness and efficiency; they lack the necessary infrastructure. The large number of local departments can be traced to a necessity valid in the horse-and-buggy days of transportation. More than 60 years ago, Emerson (1945) saw the small size of local health units as a problem and proposed their restructuring, but the then-prevailing local home-rule philosophy would not allow for any sacrifice of the local unit’s autonomy (Koplin, 1993). The consensus about the core functions of public health departments is sufficient, and the Institute of Medicine (1988a) study suggested a number of significant attainable courses of action for public health units at all levels. The focus of planning must be on the removal of barriers to the effective and efficient functioning of these units. Creating greater resources and convincing politicians of the need for reorganization would break most of those barriers.

Beyond that, *planning* community-based health promotion and illness prevention programs would involve a bifocal approach that considers and provides for activities that help modify health-risk behaviors *and* the conditions and environments that support those behaviors. These activities include communitywide health education, risk-factor interventions, and efforts to change laws and regulations in areas that affect health (Wickizer et al., 1993). Planning for a hospital’s illness prevention and health promotion program would involve deciding on the “what,”

“where,” and “how” of its activities. Planning in agencies devoted to the prevention of a specific illness or problem would involve the same process but would be much more focused. At the national level of these organizations, planning also would be guided by the particular focus/foci of the agency’s activity. Ganikos et al. (1994) identified the following four roles that a national health education and promotion organization can take: (a) a broker of knowledge, information, and communication strategies and skills; (b) a producer of educational strategies, messages, and materials; (c) an energizer, through sponsorship of market research, educational model development, and demonstration programs; and (d) a catalyst, serving as the consensus builder and coordinator of a national strategy.

Even *service provision* activities in the area of illness prevention and health promotion must be bifocal—focused on individuals and groups as well as the community at large. Individuals must be educated and encouraged to change their health-related behaviors directly, as well as through the community’s reinforcing atmosphere, pressure, and sanction. This would be true whether the agency was the public health department, a hospital, or a voluntary nonprofit organization. While recognizing that the two important components of a public health program are enforcement and education, even the public health department would rather convince than coerce people.

Even though police power exists and can be used as necessary, public health workers recognize their inability to be in all places at all times to enforce good health practice in public and private sectors. It is necessary, therefore, to concurrently emphasize health education to enhance voluntary compliance with recommended health practices. (Brecken, Harvey, & Lancaster, 1985, p. 37)

In the future, in every illness prevention and health promotion organization—public health departments, hospitals, and disease-specific agencies such as the American Cancer Society—social workers will be able to assume roles that

have relevance to the organization’s major needs. In different combinations, these needs are (a) generation of financial resources, (b) planning for appropriate service programs, and (c) provision of effective services.

Social Work Role in Creating and Mobilizing Financial Resources

Social workers can make significant contributions to all agencies engaged in illness prevention and health promotion in exploring and generating financial resources. Despite the commitment to the idea of general welfare, as a nation, the United States generally has been reluctant to provide for those with special needs—the disabled, disadvantaged, distressed, defeated, dependent, and deviant—which are people of special concern for social workers. Social workers, therefore, have been forced to be creative and skillful in generating and mobilizing resources. Generating future funds for the three types of agencies will require different approaches. For augmenting the resources of state and local public health departments, applying for grants from the federal government will be the major strategy. For hospitals, marketing their wellness activities both as part of their health maintenance package and as an independent program will be the preferred approach. For other organizations, streamlining their fundraising efforts will be the focus of the social worker’s contributions. Social workers will play the role of the *creator and mobilizer of financial resources*.

Social Work Role in Program Planning

Planning involves specifying objectives, evaluating the means for achieving them, and making deliberate choices about the appropriate courses of action (Barker, 2003). This process is applicable at all levels and is relatively easy for social workers to practice and perfect because of their understanding of and expertise in problem solving. The different needs of the three types of

agencies will dictate differential emphasis on the various steps of the planning process.

The possibilities of “what” activities to include in a health promotion program are countless. For example, Longe and Wolf (1983) listed six categories of health promotion activities offered by hospitals: (a) *community patient education* in such areas as living with arthritis, management of asthma, and parenting a child with diabetes; (b) *behavior change* for smoking cessation, stress reduction, and weight control; (c) *wellness and lifestyle* involving aerobic exercises and walking, communication and conflict resolution, and low-calorie, low-sodium, and low-fat cooking; (d) *medical self-care*, providing knowledge and skills about choosing a physician and understanding medications; (e) *lifesavers*, including baby-sitting certification, cardiac crisis program, cardiopulmonary resuscitation (CPR), and first aid; and (f) *workplace-related activities* such as employee assistance programs, organizational safety or hazard assessments, safety education, and worksite chronic disease control programs.

The question of “where” a hospital’s health promotion activities should be offered can also have numerous possible answers. These activities can be offered at the hospital, its clinics in the community, community centers, churches, libraries, recreational sites, schools, workplaces, and conferences and fairs. Similarly, the “how” of these activities is limited only by the imagination and resources that can be devoted to them. Basic social work skills, with some focus and refinement, are relevant for these functions. Social workers can easily play the role of *program planner* in all agencies engaged in illness prevention and health promotion work.

Social Work Role in Program Implementation and Service Provision

Illness prevention and health promotion agencies also will offer social workers opportunities in areas other than resource generation and program

planning. Social workers can significantly contribute to the implementation of an agency’s program and provision of its services. Their major roles will be as *educator* and *community activator*. Community activation is a means to public education. These roles involve planning, conducting, and evaluating the necessary activities.

Other Social Work Roles in Illness Prevention and Health Promotion

Social workers have special sensitivity for, understanding of, and expertise in the problems of child abuse, intimate partner violence, AIDS, and old age. They should, therefore, take on leadership roles appropriate for illness prevention and health promotion in these areas. They also have something special (in terms of professional attitude and skills) to give in the area of health promotion in multicultural populations. Moreover, in the future, illness prevention and health promotion organizations will be required by policymakers and third-party payers to show that their efforts lead to the desired health status outcomes and are cost-effective. Social workers will be able to contribute to the needed research activities pertaining to this requirement.

SOCIAL WORK KNOWLEDGE AND SKILLS FOR ROLE-RELATED INTERVENTIONS

As in earlier chapters, our discussion of social work knowledge and skills necessary for illness prevention and health promotion work is organized in relation to the roles identified above.

Social Worker as Generator of Financial Resources

The social worker should know that the possible sources of funds for illness prevention and health promotion programs are likely to be different

for different agencies. On the one hand, for most local public health departments, the local government is not likely to be a resource beyond the minimal funds it already allocates for public health activities. Social workers must seek more resources from the federal and state governments. Similarly, state public health departments must look to the federal government and the state legislature for extra resources. On the other hand, voluntary organizations engaged in illness prevention and health promotion work must raise funds from the general public and supplement those with grants from government and charitable foundations. Social workers can bring their skills for grant writing, fundraising, and political advocacy to bear on the agency's efforts to increase its financial resources. They will find the following information and suggestions helpful in enriching and refining those skills.

Grant Writing

The federal government makes money available to local governments and nongovernmental agencies by contract and by grant. By contract, the government buys the effort of someone to do specifically what the government wants done. A grant provides the money for the recipient to do something he or she wants to do that also is in the government's area of interest. Thus, a grantee has much more freedom of action than a contractor. The various kinds of grants can be broadly grouped as formula grants and project grants.

A formula grant is money distributed to a class of entitled agencies (e.g., state or local governments, universities). All members of the class are entitled to receive a portion of the total sum appropriated as long as they meet the conditions governing entitlement to the money. The money is distributed on approval of the application on the basis of some mathematical formula, which, with state government, typically is weighted according to population and per capita income. . . . *Project grants* are not entitlement. These are grants awarded on a competitive basis. The applicant develops a plan or proposal stating what is to be done if money is awarded. The applications are

reviewed competitively, though, in fact, the government is sensitive to the need to spread the awards around. (Raffel & Raffel, 1989, p. 308)

Block grants and capitation grants are kinds of formula grants. Some grants, both formula and project, require that the applicant match the government grant. Local and state public health departments should seek formula grants and insist that these grants be based on need. "Project grants and those requiring matching local funds are not recommended because they favor the better-established entities and are therefore disadvantageous for the poorer, rural, and otherwise underserved areas" (Koplin, 1993, p. 396). Project grants can supplement the resources of local and state public health departments. Similarly, hospitals and other voluntary organizations should seek project grants to add to their funds from other sources.

Other sources of grants include foundations of various kinds—community trusts (e.g., Cleveland Foundation), special-purpose foundations, corporations (e.g., General Electric Foundation), family foundations, and general-purpose foundations (e.g., Rockefeller Foundation). A foundation may fall into more than one category. The appropriate foundation can be located in the latest edition of the *Foundation Directory*, which has a double listing—alphabetical by state and by field of interest. Foundations are likely to fund demonstration projects more easily than ongoing programs. All federal invitations/requests for grant applications are published in the *Federal Register*. Another source of information about federal funds is the *Catalog of Federal Domestic Assistance*. The following suggestions about grant writing are based on workshops on fiscal resource development that the author attended over the years and on his experience as a grant reviewer for the U.S. Department of Health and Human Services.

Elements of grant proposals submitted to the government or private foundations are essentially the same, although foundation requests are generally shorter. A summary of the proposal is followed by these detailed sections: (a) introduction,

(b) problem statement or assessment of need, (c) project/program objectives, (d) methodology, (e) evaluation, (f) budget, and (g) future support for the project/program. While writing a grant proposal, the social worker should give special attention to the following suggestions:

- Learn as much as possible about the funding source and its expectations of the grant seeker; study the material about the grant, call and talk with the appropriate officer in the funding department of the government or contact the grantmaker at the foundation—"discover what that source is interested in supporting, and figure out how your organization can help the source meet its funding priority" (Nickelsberg, 1988, p. 126). In the proposal, address what the funding organization wants to fund.
- In the introduction, build the agency's credibility as one that deserves to be supported.
- Be specific about the problem and the target population; document the need for the project/program. Be truthful about the population being served by the agency or the number of potential beneficiaries of the project.
- Do not mix project objectives and methodology; list specific objectives that are realistic and measurable.
- Be innovative in the approach to the problem, but justify the proposed methodology; do not make assumptions that cannot be backed; describe the "how" of the methods; and show how the agency has the capacity to carry out the project/program, particularly in terms of the experience and skills of its personnel. Most funding sources are also interested in the replicability of the projects they fund. Show how yours can be easily replicated.
- Build in an evaluation design for ongoing and final evaluation, both in terms of the project implementation process and its impact on those served.
- Make sure the proposed budget is appropriate, reasonable, and adequately justified; describe the fiscal control and accounting procedures to be used.
- Present a plan for the continuation of the program beyond the grant period.
- Overall, be clear, concise, and logical; avoid unsupported assumptions and the use of jargon;

and package the proposal so as to make it attractive in terms of proper typing, spacing, margins, tabs, and correctness of spelling.

- Read, review, and rewrite the proposal as many times as necessary to make it as good and strong as possible. Have someone who knows nothing about the project read the proposal and point out which parts are confusing or unclear. Also, in this process of refining the document, consult the appropriate officer in the government or the grantmaker at the foundation, if needed.
- Mail the proposal in plenty of time; let your proposal be among the first to arrive, and after a week or so, call your contact and ask whether any other information is needed.
- Do try to know the people who make decisions about funding proposals or those who influence the decision makers. Some authors are of the opinion that, in the case of an application for a federal grant, copies of the proposal should be sent to one's congressperson and senators. "Get to know either the members themselves or, more important, one of their key staff people who might be interested. That staff person could go with you to your interview with the grantmaker or could help his or her boss follow up with letters and phone calls" (Nickelsberg, 1988, p. 129).

Fundraising

Social workers in voluntary organizations are likely to be involved in all major functions of the agency, including fundraising. With their professional expertise, particularly communication and problem-solving skills, they can easily assume leadership in this activity as well. The literature on different aspects of the "how" of fundraising is vast and rich. For example, Bakal (1979) described at length the various techniques of fundraising [1]. Most of these require elaborate planning in terms of "what," "where," "when," and "how." The "how" part invariably involves skills appropriate for communication, persuasion, and motivation.

Social workers should realize that their basic communication skills are as applicable in approaching people for charity as they are in

problem-oriented assessment and intervention with individuals, groups, and larger entities. Persuasion strategies involve giving information that influences the recipient to feel, think, and act in a new way. The attributes of successful persuaders are expertise, trustworthiness, and likability. An effective persuader is perceived as possessing one or more of these (Simon & Aigner, 1985). The social worker should make conscious efforts to conduct himself or herself well and to come across as an expert and trustworthy. This task can be accomplished by (a) a thorough grasp of the agency's mission, programs, and activities, and the material being shared with people, and (b) an unwavering commitment to social work values. Likability depends on many factors, and the individual may have no control over some of these. However, "individuals are more likely to like, or be attracted to, workers whom they view as genuine, understanding, and accepting" (p. 120). People have differing reasons for giving; they are guided by their philosophies, upbringing, religious attitudes, and social desirability of the people giving, as well as their experience with the particular cause. In general, giving is considered more blessed than receiving, and giving may also enhance an individual's social and self-esteem.

For motivating people to give, the approach must be both generalized and special. The generalized approach is based on answers to the question, "What does everyone need to know about us and our cause?" The special approach builds on assumptions about "what the particular person needs to know about us and our cause." Nickelsberg (1988) is of the opinion that making people feel good about giving will stimulate them to give. Appreciate their giving by giving them something tangible—a little gift (with your logo on it) that people cannot get any other way, something they can show off. This possibility will make them feel good about it. Nickelsberg's other advice: "Set up categories of support to make people feel they are joining an elite club. Finally, always publish lists of joiners because it's nice to have personal recognition—and testimonials encourage joiners" (quoted in N. M. Davis, 1988, p. 125).

To motivate organizations to give, the approach should be directed at appealing to their self-interest, pride, and social values. With his focus on large corporations, Nickelsberg (1988) proposed several tenets of fundraising: (a) People give only to people, (b) people give only to people they know, (c) people who give want visibility, (d) people love to support a winner, and (e) people want to invest in the future.

These tenets can be turned into techniques for fundraising. "People give only to people, the people they know" suggests that fundraisers should be people-people and should try to know the prospective givers before approaching them. Social workers are people-people by training and can thus provide one basic ingredient of a successful fundraising program. Knowing the potential corporate giver may require talking with the agency's board members (who are generally businesspersons with contacts and connections) and requesting one of them to accompany the worker while approaching for funds. The worker should approach corporate givers with the aim of establishing common interest between them and his or her agency, showing them how the agency's programs are likely to bring about improvement in the community, and explaining how contributing to the cause is an investment in the community's future. Therefore, the worker should be armed with facts when approaching a corporate executive.

Most social workers are creative and resourceful. They should let those qualities inform their fundraising work as well and just be themselves. A social worker with the Salvation Army in a large Midwestern town conceived the idea of approaching the corporate office of the area's largest chain of food stores and suggesting that the chain give its shoppers the option of donating to the Salvation Army any change less than a dollar that was due to them. The corporation agreed and thereby became a proud partner in the raising of thousands of dollars on a regular basis for a local charity.

Social workers should always remember and remind others in their organizations that accountability is an absolute necessity for fundraising.

They all can learn an important lesson from Canada. A poll of Ontario hospital foundations showed that 96% of them published audited financial statements and made these available to their donors and community. Members of the Association for Healthcare Philanthropy made presentations to an Ontario government committee in support of legislation requiring disclosure (Locke, 1993).

Political Advocacy

In Chapter 5, we discussed the concept of “advocacy” and its application at the case and class levels—that is, advocacy in micro as well as macro social work practice. Here are a few suggestions that social workers will find helpful in sharpening their political advocacy skills. More are presented later in the section on community organizing.

1. *Be proactive.* Proactivity involves being on top of the issues pertaining to the cause one is advocating. It requires gathering facts and formulating a clear position on the issues.

It means generating a social view of oneself as someone who is prepared and has to be dealt with, rather than as someone who is reactionary and who comes to confront well after the fact of a decision having been made or action having been taken. (Flynn, 1995, p. 2177)

Proactivity creates credibility with those who have authority, influence, and power.

2. *Know the local, state, and federal legislative systems and understand the legislative processes.* To influence legislation appropriately, besides expert knowledge of the issues, one must know how the system works and keep abreast of changes in policymaking bodies—for example, the membership of various legislative committees.

3. *Remember that influence can result from several approaches, such as provision of information on the issues, personal persuasion, negotiation, and constituency support* (Checkoway, 1995). Lawmakers and their staffs welcome valid

information on issues, but persuasion has limits. It is often wiser to concentrate on reinforcing the opinions of those who are in basic agreement with one’s stance. Negotiation and compromise go hand in hand. Politicians are sensitive to the support of their constituents. Combining these and other approaches in a systematic and pragmatic strategy will yield greater results.

4. *Build on basic social work communication skills for approaching and educating policymakers and program administrators, mobilizing clients and community groups, and forming alliances with other groups and organizations.* Many human service organizations and groups have tried and tested different approaches to influencing sources of power. Their examples (e.g., see Douglass & Winterfeld, 1995; McFarland, 1995; Myers, 1995; O’Toole, 2007) can also guide advocacy work.

Social Worker as Program Planner

The term *planning* refers to both a process and an outcome. The planning *process* deals with the movement from problem definition to problem solution along the various stages between the two points. The planning *outcome* is a plan, a design for action that specifies the essential elements of the program. It spells out *what the objectives* of the program (short-term as well as long-term) will be; *what targets* will be influenced or changed; *how the change* will be brought about in terms of the tasks, tactics, and procedures to be used; *who will perform* the required tasks and procedures; *where and when* the services will be provided in terms of the facilities and timing for the use of personnel and their procedures; *what fiscal and other resources* will be needed to implement the program; and *how the program will be monitored and evaluated*.

There are several planning models. The PRECEDE-PROCEED model (Green & Kreuter, 1991) is a noteworthy one because it has been widely applied in illness prevention and health promotion programs and tested in research and evaluation projects with more than

1,000 published applications (Frankish, Lovato, & Poureslami, 2007). It has nine phases, the first five of which are diagnostic: (a) *social diagnosis* of the self-determined needs, wants, resources, and barriers in a community; (b) *epidemiological diagnosis* of health problems; (c) *behavioral and environmental diagnosis* of specific behaviors and environmental factors for the program to address; (d) *educational and organizational diagnosis* of the behavior-related predisposing, enabling, and reinforcing conditions; and (e) *administrative and policy diagnosis* of the resources and barriers within the organization and community. The remaining four phases pertain to implementation and evaluation: (f) *implementation*, (g) *process evaluation*, (h) *impact evaluation*, and (i) *outcome evaluation*. Process evaluation begins as soon as the program implementation starts, and impact evaluation begins as the implementation proceeds. The impact evaluation is done when enough time has passed, as specified in the program objectives. Rainey and Lindsay (1994) divided the community health promotion program planning process into eight stages: (a) epidemiologic assessment, (b) needs assessment, (c) analysis of behavior, (d) working through social institutions, (e) goals and objectives, (f) political groundwork, (g) implementation, and (h) evaluation. They listed 101 questions that a planner should ask to ensure that nothing of importance has been left out. The planning-related suggestions, listed below, elaborate on some of these stages. Social workers can enrich their knowledge and skills by taking these suggestions to heart:

1. *Take the task of developing program objectives seriously.* This may be the single most important part of the job as a planner. Many plans fail because the objectives are too loose, too subjective, too narrow, or too difficult to measure. Build the objectives on a thorough analysis of all relevant factors, such as the problem, policy, program, and environment. An understanding of the nature, origin, and scope of the problem or need is an absolute necessity for this task.

2. *Know the various approaches to problem analysis and needs assessment.* The major strategies include (a) review of the literature; (b) interviews with key informants—the people with special knowledge or expertise about the problem or the people with the problem; (c) use of focus groups made up of agency staff members and potential program beneficiaries, with the aim of learning people's preferences regarding community health promotion and the reasons for their choices (Longe & Wolf, 1983); (d) study of statistical documents on the problem and the people affected by it, as well as reports of the local and regional health planning agencies; (e) surveys of prospective program participants; and (f) community forums where interested community members can express their opinions about the proposed program. Similarly, an analysis of the policy relevant to the problem and the proposed program is important for specifying program objectives.

3. *Know the various models of policy analysis.* Policies determine major approaches, priorities, and funding for programs. Various models of *policy analysis* learned in basic social work courses are appropriate for this purpose. A *program analysis* of either the agency's past efforts regarding the problem or similar other programs would help in developing the appropriate objectives. Particular attention should be paid to the organizational, budgetary, and cost-benefit aspects of the programs being analyzed. For example, the design and implementation of a hospital's community health promotion program would depend on the hospital's mission, scope of the program, and decision about where the program would fit into its organization and what kind of personnel and resources would be allowed for it. Longe and Wolf (1983) discussed three organizational structures for hospital-based health promotion programs. Such a program can be operated as a function of an existing department or division, as a department in itself, or as a separate corporate entity. All of these can be either for-profit or not-for-profit. In cases of multi-institutional hospital systems, again, there

are several possibilities. Each hospital may have its own health promotion program, one hospital may have the program that provides health promotion services for the entire system, or the program may be part of the corporate management entity separate from individual hospitals (Longe & Wolf, 1983).

4. *Include in an environmental analysis the study of factors likely to help and hinder the program being planned, as well as the major trends that may affect it positively or negatively.* A hospital that wants its illness prevention and health promotion program to make a profit or at least pay for itself may also need a market analysis along with a needs assessment. A *market analysis* shows who the actual and potential consumers of community health promotion activities will be, which offerings they will participate in, and how they will determine their satisfaction with an offering (Longe & Wolf, 1983).

5. *Let the carefully selected realistic objectives lead to the specification of other elements of the program, such as the appropriate technologies, staff functions, personnel policies, and procedures.* Make sure the program will have the necessary tools for its implementation; these are economic, informational, management, legal, and political. For health promotion, make sure the program allows for multilevel integrated interventions. Elder, Schmid, Dower, and Hedlund (1993) categorized a community heart health program's interventions as (a) social marketing; (b) direct behavior change efforts that include health education, skills training, and contingency management; (c) screening; and (d) environmental change efforts that include changes in policy, as well as in physical environment.

6. *Build into the program a strong evaluation element with the appropriate needed information system.* Evaluation of the program—ongoing, periodic, and final—is as important as its implementation. In this age of accountability and scarce resources, an agency's ability to document

the effectiveness and efficiency of its program determines the program's continued existence. All kinds of designs—pre-experimental, quasi-experimental, and experimental (Campbell & Stanley, 1966)—can be used for evaluating programs. Similarly, an evaluation can have many foci, such as the program's acceptability, accessibility, adequacy, comprehensiveness, continuity, cost-effectiveness, efficiency, effort, impact, integration of services, performance, and process (Attkisson & Brokowski, 1978; Suchman, 1967). Choose a design and the focus according to the purpose of the program and the need and resources of the agency. Select evaluation measures that quantify the extent to which the program objectives would be met and even capture the qualitative aspects of the program consequences.

Social Worker as Educator and Community Activator

The social work educator role involves giving new information and helping in the acquisition and practice of new behaviors and skills. It is one of the oldest professional roles, sometimes standing out as the major thrust of social work activity and often embedded in a worker's total practice. Social workers have played this role not only in their work with individual clients but also in community programs, in family life and consumer education, and in the training of volunteers for community service (Siporin, 1975). In the words of Connaway and Gentry (1988),

Social workers helped Asian and European wives of returning servicemen learn how to shop, cook, and negotiate social institutions in their adopted country. We taught budgeting and food commodity preparation to financially struggling families. We taught members of youth clubs how to make decisions. We assisted immigrants to learn how a democratic society works. We helped unemployed persons practice filling out job applications. We designed learning opportunities for persons with specific developmental lags and disabilities to acquire skills to master environmental tasks. (p. 114)

Social workers traditionally have engaged in the educator role in two contexts: with one person at a time and with groups of persons. Most social workers today come out of their training programs adept at playing this role. Social workers in illness prevention and health promotion will be expected to play this role not only with individuals and groups but also at the larger community level. The importance of the community cannot be minimized. We agree with the view of Green and Raeburn (1990):

The most effective vehicle for health promotion activity, whether it be directed at policy, environmental change, institutional change, or personal skills development, is the human group, a coalition with all its aspects of social support and organizational power. Community groups can exist to set priorities in health promotion, to run programs, to advise public officials, and to help each other in a wide variety of ways. These groups are perfect vehicles for an enabling approach. (p. 41)

Community organization has been an area of social work practice throughout its history, and social work has made significant contributions to the development of the theory and technology of community organization. Earlier, we alluded to the role of social workers in public health who functioned both as caseworkers and community organizers. The significance of their contributions is reflected in the judgment of Rosen (1974) that “the roots of social medicine are to be found in organized social work” (p. 112).

Before suggesting effective approaches to individual-, group-, and community-level illness prevention and health promotion work, we discuss the concepts of “enabling,” “empowerment,” and “community organization” relevant for this work.

Enabling is to make able, to provide the means or opportunity, and to help in the improvement of capacity. Enabling traditionally has been viewed as a social work role. As an enabler, a social worker helps individuals, groups, and communities articulate their needs; identify and clarify their problems; explore, select, and apply strategies to resolve those problems; and develop

their capacities to deal with their problems more effectively (Zastrow, 1985). Skills for this role include conveying hope, reducing ambivalence and resistance, recognizing and managing feelings, identifying and supporting strengths, breaking down problems into solvable parts, and maintaining a focus on goals (Barker, 2003). WHO’s (1986) Ottawa Charter defined *health promotion* as “the process of enabling people to increase control over and improve their health.” To be effective, illness prevention and health promotion work has to be bifocal. Green and Raeburn (1990) called these foci theoretical and ideological perspectives:

The first emphasizes political and sociological or “system” factors in health. The second emphasizes personal and small group decision making, psychological factors, and health education methods. An integration of these viewpoints appears to prevail in actual policies and practice, though some advocates and practitioners continue to defend or push for one of the more polar views on the health promotion spectrum. (p. 30)

The principle of “enabling” is not only applicable at both these levels but also can be used to merge the two perspectives into an integrated, total, person-environment approach in which the responsibility for health is shared between individuals and systems. This enabling approach involves “returning power, knowledge, skills, and other resources in a range of health areas to the community—to individuals, families, and whole populations” (Green & Raeburn, 1990, p. 38).

Empowerment refers to the process of gaining, developing, facilitating, or giving power. Because the history of social work is essentially the history of its work with the poor and the powerless, empowerment has been a part of the social work approach to serving its clients. Simon (1994) identified the following five components of the empowerment approach that have existed across every period of social work history since 1893: (a) the construction of collaborative partnerships with clients; (b) the emphasis on their strengths rather than their weaknesses; (c) the focus on both individuals and their social

and physical environments; (d) the recognition of the clients' rights, responsibilities, and needs; and (e) the direction of professional energies toward helping historically disempowered individuals and groups. Despite this history, some questioned the ability of social workers to empower their clients because of their own powerlessness. Others considered power to be a central theme in social work practice and wanted client empowerment to be made the cornerstone of social work theory and practice (e.g., see Calista, 1989; Hasenfeld, 1987; Heger & Hunzeker, 1988). Over the past 40 years, social workers have been making significant contributions to the development of a theory of empowerment and formulating empowerment-related practice principles and techniques (e.g., Gutierrez, 1992; Hasenfeld, 1987; Kieffer, 1984; Parsons, 1988; Pinderhughes, 1983; Soloman, 1976; Staples, 1990). Others (for our purpose, those in the fields of health, education, and community psychology) also have recognized the importance of empowerment and explored this concept and ways of operationalizing it (e.g., Bernstein et al., 1994; Flynn, Ray, & Rider, 1994; Israel, Checkoway, Schulz, & Zimmerman, 1994; Schillinger, Villela, & Saba, 2007). Now there is a consensus regarding empowerment processes and outcomes in social work practice. "Building on empowerment theories of the 1980s and 1990s, social work has moved the concept of empowerment from value and philosophical levels to practice principles, frameworks, and methods" (Parsons, 2008). Empowerment-based practice is used in work with vulnerable populations such as women, minorities, people with mental illness, those with disabilities, and the aged (Parsons, 2008). Neighbors, Braithwaite, and Thompson (1995) hold that empowerment operates on multiple levels and suggest that personal empowerment and community action must go together. Social workers should keep themselves abreast of new and emerging empowerment-related knowledge and skills.

Community organizing means helping people understand and join together to deal with their shared problems and build social networks for

collective action (Rubin & Rubin, 2001). Community can be defined in many ways: It can refer to geopolitical, geocultural, or interest communities. Various entities and ideas such as race, ethnicity, faith, gender, age, physical or mental disability, and sexual orientation can be the focus of organizing. Examples of community organizing abound in arenas such as

labor, agrarian reform, racial justice, neighborhood improvement, welfare rights, the women's movement, senior power, immigrant rights, the LGBT movement, housing, youth-led organizing, environmental justice, education, tax reform, health care, transportation, public safety, city services, and disability rights. (Mondros & Staples, 2008)

There are several models of community organization practice. For example, Rothman (1970) proposed the following three models, which he has further revised and elaborated on (Rothman, 2001): locality development, social planning, and social action. *Locality development* seeks to bring about community change through broad participation of citizens in identifying goals and selecting actions. The emphasis here is on the process of generating self-help and improving community capacity and integration. *Social planning* emphasizes the use of technical processes to solve substantive community problems by rational, deliberate, and controlled efforts. *Social action* seeks basic changes in the institutions and/or community practices by shifting power relationships and resources. "Innovation and creativity are the norm in this dynamic field of practice, which goes to the heart of social work values such as justice, empowerment, participatory democracy, self-determination, and overcoming all forms of oppression" (Mondros & Staples, 2008). Community organizing draws from many different disciplines and includes both "conflict" and "consensus-building" approaches to social action. The "conflict" approaches assume that people can organize to force power holders to acquiesce to community demands, whereas "consensus-building" approaches encourage partnering with power holders in an effort to produce community improvements (Mondros & Staples, 2008).

New models and strategies of community organization incorporating advances in information and communication technology are being developed. For example, campaign organizers can now use cell phones, conference calls, video teleconferencing, faxes, transmittance of images, video streaming, text messaging, organization of webpages, webcasting, e-mail discussion lists, chat rooms, Internet information or resources, and computer programs to produce flyers, letters, PowerPoint presentations, and videos (Hick & McNutt, 2002; Roberts-DeGennaro, 2004). The strategies and techniques of the various models can be mixed and matched for different purposes. We discuss more of the “what” and “how” of community organizing in Chapter 8.

Bracht and Kingsbury (1990) proposed an extensive five-stage model of community organizing for health promotion. They discussed the key elements of each of the stages: (a) community analysis, (b) design initiation, (c) implementation, (d) maintenance-consolidation, and (e) dissemination-reassessment. On the basis of experience from the community heart health programs, Elder et al. (1993) offered the following helpful ideas that can serve as practice principles: (a) Community participation in planning, designing, and evaluating the program promotes its adoption by the community; (b) feedback to the community is essential; (c) primary prevention should be given priority over secondary prevention; (d) interventions using multiple strategies and promoted through multiple channels are more effective; and (e) policy and environmental interventions should be preferred over direct behavioral change efforts.

Different approaches to education may be taken when the target is an individual or small group rather than the community. For their role as educators of individuals and groups, social workers will find the following suggestions helpful:

1. *Strive for a match between the educational strategy and the characteristics of the system (individual, group, or community) to be worked with in terms of its composition, demographics, and culture.* Answers to the question, “Given

what is to be learned and the characteristics of the system, how best can it learn the needed information and skills?” will guide in ensuring the needed communication fit.

2. *Remember that different people learn in different ways.* Some learn primarily by doing (enactive learners); others by summarizing, visualizing, and organizing perceptions into patterns and images (iconic learners); and still others by abstracting and conceptualizing (symbolic learners; Jerome Bruner, mentioned in Gitterman, 1988). Social workers should try to respond to different learning styles by using the appropriate teaching methods, which may include (a) the *didactic* method, which involves sharing information and ideas; (b) the *discussion* method, which allows for much more interaction between the worker and the client system; (c) the *visual* method, which uses graphs, diagrams, pictures, films, and other aids for learning and understanding; and (d) the *action* method, which emphasizes learning through experiencing and allows for role-modeling and coaching.

Beyond the above general educational methods, Gitterman (1988) listed the following specific educational skills and strategies for social workers in health care: (a) providing relevant information, (b) clarifying misinformation, (c) offering advice, (d) offering interpretations, (e) providing feedback, (f) inviting feedback, (g) specifying action tasks, and (h) preparing and planning for task completion.

3. *Be sensitive to such system characteristics as intelligence, verbal ability, and self-respect in choosing an educational strategy.*

In general, the most effective strategies are those that partialize information and tasks into manageable units applied to real problems or tasks. Some system members who do not tolerate stress well can benefit from learning opportunities arranged in a clear, step-by-step manner to fit their needs. (Connaway & Gentry, 1988, p. 123)

For health promotion aimed at behavioral change, the educational strategy must include

skills training and contingency management. The components of skills training are “instruction, modeling, practice during training sessions, feedback, reinforcement, and practice between sessions,” and “contingency management involves altering consequences for behavior to change the probability of the behavior in the future” (Elder et al., 1993, p. 470).

4. *Carefully select the context of educational activity.* Again, an understanding of the system’s characteristics will help in selecting the context that promises a high degree of success. Any context has room for mixing and matching the various educational approaches and techniques mentioned above. Similarly, the social worker should determine the degree of structure for the educational activity, with an eye toward maximizing the impact of that education.

Degree of structure is the extent to which a technique determines what information is presented and how persons interact about this information. We determine degree of structure imposed by examining precisely what the technique requires people to do. A paper-and-pencil test has different behavioral requirements than watching a film or participating in a discussion or role-playing (Connaway & Gentry, 1988, p. 126).

Social workers are able to engage in the educational role at the larger community level without much difficulty. Nolte and Wilcox (1984) considered two sets of abilities essential for success in reaching the public: personal characteristics and skills. Their list of personal characteristics includes awareness, courage, creativity, curiosity, diplomacy, empathy, judgment, speed, and thoroughness; these are not at all uncommon in social workers. The required skills are essentially the same as the problem-solving skills that all social workers have learned and practiced. In organizing community-level educational activities, social workers will be able to benefit from the following suggestions:

- *Supplement knowledge and skills with ideas and strategies from the literature on health education and social marketing.* Social marketing is a methodology that applies profit-sector marketing techniques to the task of increasing the acceptance of social ideas and practices and thereby changing people’s attitudes and behaviors (see e.g., Hastings, Devlin, & MacFadyen, 2005; Kotler, 1982).
- *Use existing resources in the community.* Various disease-specific organizations, such as the American Heart Association, American Lung Association, and National Kidney Foundation, are doing impressive illness prevention and health promotion work. “They have produced publications, public service announcements, and programs which have frequently been both sustained and effective” (McGinnis, 1982, p. 413). Other groups are engaged in more generic wellness activities. Social workers should reach out to these organizations, collaborate with them, and coordinate their own educational activities with theirs.
- *Target specific groups and populations for intensive education and use audience-appropriate educational strategies.* A multipronged approach involving several strategies is likely to produce the maximum impact. Social workers should remember that the goal of their activities is not merely imparting information but being instrumental in bringing about behavioral changes.
- *Let knowledge of the target population and its need, agency’s resources, other resources in the community that can be mobilized, and imagination create a package of appropriate strategies.* (This suggestion is given because there is no standard list of educational strategies for illness prevention and health promotion work.)
- *Treat the local mass media—both print and electronic—as a special resource.* Attract their attention, gain their support, and cultivate an ongoing positive relationship with them. The media are moving toward what Joslyn-Scherer (1980) called “therapeutic journalism”; that is, besides being sources of information, they want to become active shapers of helping trends. Helping the media with their need would serve the social worker’s public education purpose well. Flora and Cassady (1990) defined three roles that media organizations can play in community-based health promotion: (a) media organization as a news producer, (b) media organization as an equal partner, and (c) media organization as a health promotion leader.

These authors discussed ways of integrating those media functions into the health promotion process. Several books on how to make the media work for you (e.g., Brawley, 1983; Klein & Danzig, 1985) can help in improving workers' know-how.

- *Master the media advocacy approach.* In the literature on health education, *media advocacy* refers to the use of mass media (including paid advertising) for influencing individual behavior, stimulating community action, and changing public policies. Wallack (1994) considered it a strategy for empowering people and communities. According to him, whereas the traditional media approaches seek to fill the "knowledge gap," media advocacy addresses the "power gap." "Social, economic, and political determinants of health have been largely ignored by the most pervasive media. Media advocacy tries to change this by emphasizing the social and economic, rather than individual and behavioral, roots of the problem" (p. 421). The primary strategy is to work with individuals and groups to claim power of the media for changing the environment in which health problems occur.
- *Remember that much planning goes into media advocacy.* The major steps are (a) establishing the policy goal, (b) deciding the target, (c) framing the issue and constructing the message, (d) delivering the message and creating pressure for change, and (e) evaluating the process and its outcome. Social workers, well versed in the problem-solving process, should not have much difficulty in mastering the media advocacy approach. Wallack, Dorfman, Jernigan, and Themba (1993) provide several examples of media advocacy works.
- *Stay abreast of technological advancements and enrich activities and programs from the same.* Emerging technologies, such as CD-ROM, interactive videodiscs, and virtual reality programs, are providing newer media with tremendous possibilities for illness prevention and health promotion programs. "Enter-education" or "edutainment" is a concept that combines entertainment and education for changing attitudes and behaviors. Its operationalization as an approach to health promotion has great potential for success because "the entertainment media are pervasive, popular, personal, and persuasive" (Steckler et al., 1995, p. 320).

The social work educational role may need to be directed toward educating politicians and policymakers. Social workers should sharpen their class advocacy skills, which are appropriate for educating and influencing policymakers. There are many time-honored methods,

including one-to-one lobbying; collecting and presenting signed petitions; initiating and managing letter-writing, telephone call, and telegram campaigns; mobilizing groups to appear at public hearings; preparing and presenting statements at public hearings; and suggesting the wording of the proposed law. (Dhooper, 1994a, p. 159)

They should make sure that their cause and point of view are presented in a forceful, dignified, and polite manner.

Facts, arguments, and demonstrations of power are the tools for influencing policymakers. Therefore, social workers should use a strategy that includes presentation to the policymakers and their staffs of accurate and unbiased information on their cause, rational and nonemotional argument in favor of that cause, and subtle hints about the backing of an organized voting block whenever possible.

Social workers should keep in mind that all politicians want to stay popular, desire to be viewed as sensitive and responsive to the needs and situations of their constituents, and need to give the impression of being tough-minded and responsible public servants. Social workers should try to meet these needs by keeping in touch with them, providing them information and opinions on important issues, sending them reports of their agency's work, inviting them to its events, and being involved with their offices.

This section ends with two sets of principles of health education, one focusing on the "what" and the other on the "how." Freudenberg and his associates (1995) drew the first list from relevant theories, practice, and research. Although presented as hypotheses, these can guide social work activities. We present these principles in Table 6-B below.

In Chapter 5, we presented theories of behavior change. Frankish et al. (2007) reviewed the various theories of behavior change and health

Table 6-B Principles of Health Education

- Effective health education interventions should be tailored to a specific population within a particular setting.
- Effective interventions involve the participants in planning, implementation, and evaluation.
- Effective interventions integrate efforts aimed at changing individuals, social and physical environments, communities, and policies.
- Effective interventions link participants' concerns about health to broader life concerns and to a vision of a better society.
- Effective interventions use existing resources within the environment.
- Effective interventions build on the strengths found among participants and their communities.
- Effective interventions advocate for the resource and policy changes needed to achieve the desired health objectives.
- Effective interventions prepare participants to become leaders.
- Effective interventions support the diffusion of innovation to a wider population.
- Effective interventions seek to institutionalize successful components and to replicate them in other settings.

and identified a number of common elements. They presented the following principles of behavior change and health education based on that work. These principles are relevant for multicultural health promotion activities as well.

- *Principle of educational diagnosis:* This involves identification of the causes of health behavior in specific groups. An intervention linked to a diagnosed problem in its social and cultural context has the greatest chance of success.
- *Principle of hierarchy:* This states that there is a natural order in the sequence of factors influencing health behavior. Predisposing factors must be dealt with before influencing enabling factors, which in turn must be dealt with before focusing on reinforcing factors.
- *Principle of cumulative learning:* Experiences must be planned in a sequence that takes into account the person's prior learning experiences and the concurrent incidental learning experiences or opportunities.
- *Principle of participation:* Persons must be involved so that they can identify their own need for change and select a method or approach that they believe will enable them to change.
- *Principle of situational specificity:* There is no "magic bullet" approach to health education. The effectiveness and efficiency of a method depend on circumstances and characteristics of people—both the target audience and the change agent. Success lies in the application of an approach to the right audience, at the right time, in the right way.
- *Principle of multiple methods:* A comprehensive program should employ different methods in consideration of the interaction of person-specific and situation-specific factors.
- *Principle of individualization:* The program method should be tailored to persons, their need, and their situation so that they can be actively involved in their learning experiences.
- *Principle of relevance:* The contents and methods of the program should be relevant to the learner's interest and circumstances.
- *Principle of feedback:* The program should provide feedback on participants' progress and effects of their health behaviors. It allows them to adapt to both the learning process and behavioral responses within their own situation and at their own pace. This principle is relevant to both program participants and health professionals.
- *Principle of reinforcement:* Build into the program an activity or feedback that is designed to reward a person for the desired health behavior, because a behavior that is rewarded tends to be repeated. Reinforcement may be intrinsic or extrinsic in nature.
- *Principle of facilitation:* Make the intervention provide the means for people to take the desired action or reduce barriers to health behavior.

Social Work Role in Work With Special Populations/Problems

In this section, we discuss the knowledge and skills appropriate for social work with problems and populations for which social workers are likely to be looked to for leadership. These problems include (a) health promotion for AIDS prevention, (b) prevention of child abuse, and (c) illness prevention and health promotion among the elderly. Involvement in these will require social workers to assume several professional roles simultaneously.

Health Promotion for AIDS Prevention

AIDS will continue as a major health and public health concern for the foreseeable future. More than a million Americans are living with HIV or AIDS (Centers for Disease Control and Prevention [CDC], 2007), and there are 40,000 new HIV infections each year (Kaiser Family Foundation, 2007). Despite the high rates of prevalence and incidence of the disease, society has been reluctant to respond to it in the past. Because the majority of those affected by AIDS belonged to groups viewed as socially marginal (e.g., gay men, intravenous drug users, Hispanics, and blacks), society let bigotry, racism, homophobia, and elitism dictate its responses. On the one hand, these attitudes promoted ignorance and antipathy, delayed recognition of the disease, and obstructed development of effective prevention efforts (Altman, 1987); on the other hand, they allowed most U.S. citizens to believe that they were not at risk of contracting HIV (House & Walker, 1993). Even after 20 years, these opinions have not lost their validity.

As mentioned earlier, social workers have been among the pioneers in creating programs and activities to serve AIDS patients. They have much to offer to the prevention efforts as well. Some impressive medically oriented preventive work has been done—for example, antiretroviral treatment, which reduces the risk of transmission of HIV from a woman to her baby to less than 2%,

has reduced the rates of mother-to-infant transmission of HIV (Kaiser Family Foundation, 2007). All efforts to prevent the infection of children are welcome, but prevention of infection of women is the ideal strategy. That will require combining and integrating birth control, family planning, HIV testing, and counseling services. Social workers engaged in AIDS prevention programs will find the following facts and suggestions helpful.

1. *Most people at risk of AIDS are not a cohesive community.* Despite the decline in the incidence of the disease among gay men, they—particularly rural gays and younger gays who do not see themselves at risk—must be given special attention. Men who have sex with other men and do not openly identify themselves as gay are another hidden population. Similarly, most intravenous drug users are at high risk for AIDS, but they are an invisible minority. Adolescents are also at great risk for the spread of HIV. Other populations of concern are runaways, prostitutes, the homeless, older persons, and those with disabilities. Racially, Hispanics and blacks continue to be at greater risk.

2. *Identifying and reaching out to most of these high-risk groups is difficult.* Even after they are identified, each of these groups poses special problems for reaching out to, educating, and influencing them. It is difficult to educate those under the influence of drugs. Adolescence is characterized by a sense of immortality and invulnerability, experimentation, confusion, and challenging of authority (Gray & House, 1989). Merely giving adolescents information is not sufficient to change their behaviors. Cultural and religious factors discourage Hispanics from being open about sex and drugs. The belief that it is wrong to touch their own bodies and that spermicides may hurt them is widespread (Lewis, Das, Hopper, & Jencks, 1991). The taboo against homosexuality is strong in the black population. Dalton (1989) listed reasons why blacks resist AIDS education, including their reaction to larger society's blaming of race as a reason for the origin and spread of the disease, their general

mistrust and suspicion of whites, and their resentment about being dictated to once again.

3. *Overall, AIDS education has been underfunded, erratic, uncoordinated, confusing, and timid* (Levine, 1991). Numerous AIDS education programs, many of them quite innovative and targeted to specific at-risk populations, have been tried with varying degrees of success, but they often have been implemented without community input or formal planning (House & Walker, 1993). This observation is true not of the past alone.

Social workers should use their community organizational skills for designing top-down community AIDS-prevention programs. They should refine and strengthen those skills with ideas and suggestions from the literature on community assessment, coalition building, community involvement, and service coordination, and tailor these to the specific task at hand. The following is an impressive design for a blueprint to organize an HIV education program:

- Obtain political commitment from community members.
- Establish a community education task force.
- Review existing education information and materials.
- Identify the high-risk groups targeted for education in your community.
- Develop, implement, and evaluate a short-term plan of action.
- Develop and implement a long-term plan of action.
- Evaluate the program results. (House & Walker, 1993, p. 286)

4. *AIDS prevention work involves challenging and changing social norms, and, therefore, community institutions must be made a part of the effort.* As Wolfred (1991) put it, "AIDS educators must be prepared to push social norms and community leaders to new limits in order to stop the spread of HIV infection" (p. 135). Most institutions can be involved somehow, directly or indirectly, in some aspect of the effort. Social workers should try to make the task force (Item 2 in the above suggestions) as broad-based as possible. They should educate the task force about

what has been learned from past efforts in this area. The major lessons are as follows:

- A long-term commitment to inform and motivate people to change behavior is needed.
- Programs must be designed to reach all at-risk populations with their specific needs.
- It is necessary to slant messages toward members of specific high-risk groups.
- All AIDS education programs must be culturally and community sensitive.
- Educational programs that merely provide information are not likely to be effective.
- Programs that provide specific tools and techniques for behavioral change are most effective.
- Peers teaching peers will have positive results in both attainment of knowledge and behavioral change (Ostrow, 1989).

5. *Planning of an AIDS prevention and control program should involve the following elements:*

- Establishing goals. These may be (a) to prevent HIV infection, (b) to reduce the personal and social impact of HIV infection, or (c) to reduce the AIDS-related fear and stigma.
- Doing an initial assessment of people's AIDS-related knowledge, behavior, culture, and sources of information.
- Defining the target audiences by demographic indicators, reference groups, organizations, or risk-prone behaviors.
- Setting objectives and performance targets on the basis of information from the assessment.
- Developing (a) messages and materials appropriate for target audiences and (b) channels of communication, institutional networks, and activities that can best attract the attention of target audiences.
- Promoting and ensuring support services such as counseling, HIV testing, promotion of condoms and spermicide, development and distribution of educational materials, and training of health educators.
- Deciding monitoring and evaluation procedures and process.
- Establishing a schedule and budget for the different components of the plan.
- Reassessing on the basis of any new data on changes in the program, audiences, program impact, and so on (WHO, 1989).

6. *Both primary and secondary prevention efforts should appropriately target different groups.* Primary prevention focuses on (1) increasing education regarding transmission of HIV/AIDS facts, (2) improving risk reduction skills, (3) reducing high-risk behaviors such as drug use, (4) building social and peer normative support for risk-reduction behavior change, (5) increasing self-efficacy, and (6) encouraging positive intentions and attitudes regarding the individual's ability to change behavior (Kelly & Kalichman, 2002). High-risk populations that should be differentially targeted are youth under age 25, drug users, men who have sex with men, and heterosexual women. They are the most vulnerable to HIV exposure groups. The CDC (2001) has released a Compendium of HIV Prevention Interventions with Evidence of Effectiveness, which consists of descriptions of programs targeting high-risk populations. Secondary prevention attempts to reduce the damage for those who are already infected and living with HIV/AIDS by focusing on early detection, medication adherence, risk reduction, and quality of life. Through the Replicating Effective Programs initiative, the CDC is identifying and replicating evidence-based successful programs. Partnership for Health project (Richardson et al., 2004), the Healthy Relationships project (Kalichman et al., 2001), the CLEAR (Choosing Life: Empowerment, Action, Results) program (Lightfoot, Rotheram-Borus, & Tevendale, 2007), and CHAMP+ (Collaborative HIV/AIDS and Adolescent Mental Health Project-Plus) (McKay, Block, Mellins, & Traube, 2005) are some of the population-specific programs.

7. *The importance of assessing, mobilizing, and creating the needed resources cannot be minimized.* The local mass media are a vital resource for any educational endeavor. Social workers should keep in mind that awareness and education also create expectation for services. A health promotion program for AIDS prevention, for example, cannot simply educate people about the risks of unsafe sex. It must ensure that people have access to the wherewithal for safe sex, that testing services are available, and that

those who are HIV-seropositive but asymptomatic, those who have AIDS-related complex symptoms, and those who have full-blown AIDS have the necessary counseling, health, and social services. In providing services, targeting the setting should also be considered important. Latkin and associates (1994) examined the relationships between HIV-related injection practices of drug users and injection settings. They found that injecting at a friend's residence, in shooting galleries, and in semipublic areas, and the frequency of injecting with others were significantly associated with the frequency of sharing unclean needles. Social workers' grant-writing skills would be helpful in exploring financial resources. Myers, Pfeiffle, and Hinsdale (1994) described the building of a community-based consortium for obtaining federal funds for the treatment of AIDS patients.

8. *Understanding the psychosocial barriers to behavioral change is extremely important.* The relevant barriers include (a) a person's perceived vulnerability to HIV infection, (b) perceived benefits of changing behavior, and (c) self-efficacy (Hayes, 1991). Social workers should address these barriers by convincing the targets of their efforts that they are vulnerable, highlighting for them the benefits of change, and helping them become competent and comfortable in trying new behaviors. Similarly, given the significance of cultural and religious values pertaining to sex-related behaviors, workers should try to understand and work with those values.

9. *Social work values should guide the selection of intervention strategy.* Workers should eschew scare tactics and even hints of moral condemnation. Their strategy should incorporate techniques of education, motivation, and enabling for responsible behavior. While working with adolescents for education and behavioral change, social workers should treat them as grown-ups and at the same time use their propensity for influence by their peers to reinforce their learning and efforts to change. Treating them as responsible grown-ups demands

that, beyond giving them information and facts, they are engaged and encouraged to discuss those facts and to learn about the “what” and “how” of the desired behavioral change.

10. *Social workers as health promoters for AIDS prevention should observe the following “dos” that WHO (1989) called the health promoter’s responsibility:*

- *Be informed:* Remain abreast of fresh knowledge.
- *Be bold:* Challenge their assumptions about sexuality, find new resources, and work with people previously considered unimportant.
- *Be clear:* Speak plainly, honestly, and directly, and avoid ambiguous language, half-truths, and technical jargon.
- *Avoid stereotyping and blaming:* HIV is a virus with no racial, ethnic, or sexual preference.
- *Concentrate efforts on changing the behavior of target groups.*
- *Act on a broad front:* Under people’s reasons for maintaining their behavior, find acceptable alternatives and provide the resources and support required to introduce the alternatives.

Child Abuse Prevention

The problem of child abuse will persist in the future, both as part of the overall violence in society and because of changes in the family. Families will become more complex and unstable in their structure and weaker in their social supports and other resources. Both these sets of factors will likely increase the risk of abuse and neglect for children, and the need for efforts to deal with the problem will continue. Two decades ago, the U.S. Advisory Board on Child Abuse and Neglect concluded that child abuse and neglect in the United States represented a national emergency and that the country’s lack of an effective response was a moral disaster. It presented 31 recommendations organized into the following eight areas: (a) recognizing the national emergency, (b) providing leadership, (c) coordinating efforts, (d) generating knowledge, (e) diffusing knowledge, (f) increasing human resources, (g) providing and improving

programs, and (h) planning for the future (U.S. Department of Health and Human Services, 1990). The validity of these recommendations has not diminished and is not likely to diminish in the future. Social workers always have been a significant part of the efforts to deal with the problem of child abuse and will continue to contribute to all the above areas of activity.

Earlier, we introduced the concepts of “primary prevention,” “secondary prevention,” and “tertiary prevention.”

In the area of child maltreatment, primary intervention efforts aim to completely avoid the onset of parenting dysfunction; secondary intervention efforts attempt early detection of parenting problems so remediation procedures can be applied; and tertiary interventions are treatment-oriented services designed to rehabilitate maltreating parents. (Kaufman & Zigler, 1992, p. 271)

The primary prevention of child abuse has been the most overlooked dimension of the work done in the field of child abuse and neglect. From the beginning, the focus has been on “child rescue,” preventing child abuse from recurring. “Although the definitive intellectual history of child abuse has yet to be written, it appears to have taken nearly 50 years before primary prevention was actually embedded in child abuse and neglect program designs” (Rodwell & Chambers, 1992, p. 160). Given the enormity and complexity of the problem, interventions at all levels will continue to be needed, and prevention of recurrence through secondary and tertiary interventions is also of vital importance.

Gordon (1993) proposed a different system of classifying preventive interventions in behavioral/mental health problems, with the focus on who receives the intervention. According to his system, interventions are “universal,” “selected,” and “indicated,” with universal interventions targeted to all segments of the population, selected interventions targeted at high-risk populations, and indicated interventions directed at those already affected by the disorder. The following discussion of social work contributions to the prevention of

child abuse includes primary and secondary or universal and selected interventions.

How can social workers intervene at the primary prevention level? The first requirement is knowledge of the predictors of child abuse. The utility of the available knowledge is questionable. Winton and Mara (2001) listed 12 theories of child abuse and neglect and classified those into the following three groups.

1. *Psychiatric/medical/psychopathology models*: (1) medical (biological) model, (2) sociobiological/evolutionary theory, and (3) psychodynamic/psychoanalytic theory.
2. *Social/psychological models*: (1) social learning theory, (2) intergenerational transmission theory, (3) exchange theory, (4) symbolic interaction theory, and (5) structural family systems theory.
3. *Sociocultural models*: (1) ecological theory, (2) feminist/conflict theory, (3) structural-functional/anomie/strain theory, and (4) cultural spillover theory.

However, no theory is adequate to explain the complex problem of child abuse, and as Rodwell and Chambers (1992) concluded, "No set of variables, or combination, does a good enough job of early identification to allow those committed to child protection to speak thoroughly about the efficacy of primary prevention because accurate targeting is practically impossible" (p. 173). They recommended that priority be given to secondary prevention or treatment programs that are effective in limiting the damage of the first abuse incident and/or preventing recurrence.

Although it is true that social work does not have and is not likely to have an empirically validated grand theory of child abuse, considerable work has been done in studying its etiology, and various conceptual frameworks have been presented. Belsky's (1980) ecological framework is the most comprehensive and akin to the social work perspective. It conceptualizes child maltreatment as a psychosocial phenomenon determined by multiple forces across four levels: the individual (ontogenetic development), the

family (the microsystem), the community (the exosystem), and the culture (the macrosystem).

On the ontogenetic level, Belsky gave characteristics of parents who mistreat their children, such as a history of abuse or experience of stress. On the microsystem level, he discussed aspects of the family environment that increase the likelihood of abuse, such as having a poor marital relationship or a premature or unhealthy child. On the exosystem level, he included work and social factors, such as unemployment and isolation; and on the macrosystem level, he depicted cultural determinants of abuse, such as society's acceptance of corporal punishment as a legitimate form of discipline. (Kaufman & Zigler, 1992, p. 269)

Kaufman and Zigler extensively reviewed the literature on intervention programs and delineated strategies appropriate for each of the four levels in the Belsky model.

1. The *ontogenetic level* strategies include (a) psychotherapeutic intervention for abusive parents, (b) treatment for abused children, (c) alcohol and drug rehabilitation, (d) stress management skills training, and (e) job search assistance programs.
2. The *microsystem level* strategies include (a) marital counseling, (b) home safety training, (c) health visiting, (d) parent-infant interaction enhancement, (e) parents' aids, (f) education for parenthood, and (g) parenting skills training programs.
3. The *exosystem level* strategies involve the development/establishment or facilitation of (a) community social and health services, (b) crisis hot lines, (c) training for professionals to identify abuse, (d) foster and adoptive homes, (e) informal community supports, (f) family planning centers, (g) Parents Anonymous groups, (h) respite child-care facilities, and (i) a coordinating agency for child abuse services.
4. The *macrosystem level* strategies include (a) public awareness campaigns; (b) formation of National Commission on Child Abuse and Neglect grants for research; (c) establishment of a National Commission on Child Abuse and Neglect; (d) the requirement that states adopt

procedures for the prevention, treatment, and identification of maltreatment; (e) a legislative effort to combat poverty; (f) establishment of laws against corporal punishment in schools; and (g) research on incidence of maltreatment and effectiveness of prevention and treatment.

Guterman and Taylor (2005) mentioned the following among prominent efforts to prevent child abuse and neglect that are being tried across the country.

1. *Home visitation services* for at-risk families identified via the health care system at the point of birth of a child. Home visitors provide parenting guidance and link those families with the necessary resources and supports.
2. *Nurse home visitation program* aimed at improving the outcomes of pregnancy, quality of maternal caregiving, child health and development, and maternal life course development.
3. *Social support interventions* focused on helping at-risk parents overcome social isolation; tap informal support networks for emotional, informational, and material help; and link with mutual aid groups such as Parents Anonymous.

There is also a movement toward universal prevention strategies addressing the problem of child abuse, analogous to other universal preventive health strategies such as child immunization. On the other hand, Daro and Donnelly (2002) highlighted the difficulty of the preventive work by identifying mistakes made by the field, such as oversimplifying the problem of child abuse, overstating the potential of prevention, ignoring significance of partnership with child protective services, sacrificing the depth and quality of programs for the breadth and quantity of coverage, and failing to fully engage the public through multiple ways.

Despite the complexity and multidimensionality of the problem, comprehensive child abuse prevention programs can succeed with an extensive coordination among health and human service agencies such as hospitals, clinics, child protective services, schools, and public health departments. The social work profession historically

has been involved in the design and delivery of child protective services as well as in addressing the social conditions that perpetuate the problem (Wells, 2008). Social workers' training makes them superbly qualified to take the lead in this work. Depending on their work setting, they can contribute to primary and secondary prevention. Those working in hospitals can exploit the special advantage that hospitals provide in this respect. As Kaufman, Johnson, Cohn, and McCleery (1992) put it,

The hospital's influence can be viewed at a number of levels. Educational efforts, such as prenatal classes, postnatal instruction, and parental skills workshops, are directed toward the community as a whole. In-service trainings provide medical and psychological updates necessary for community physicians and community mental health providers to offer high-quality educational, diagnostic, and treatment-oriented services. Finally, prenatal visits, well-child visits, annual physicals, and specialty clinics for chronically ill children represent opportunities for hospital personnel to intervene at the individual level. (p. 193)

Despite their emphasis on tertiary care, hospitals have been involved in primary and secondary prevention activities, and these can be further strengthened. Altepeter and Walker (1992) mentioned several relatively short-term parent-training programs that can be made available to parents of all socioeconomic levels. Social workers can be instrumental in institutionalizing such programs. They can easily help other health care professionals sharpen their basic interviewing skills to screen parents of infants and children seen in the hospital outpatient departments using criteria across the four areas included in the Belsky model. Belsky (1980) conceptualized child abuse as a psychosocial phenomenon determined by many forces at work across the four levels mentioned above. He drew from diverse theories, including psychological disturbance in parents, abuse-eliciting characteristics of children, dysfunctional patterns of family interaction, stress-inducing social forces, and abuse-promoting cultural values. A follow-up system for families at high risk can be built into

outpatient services. These programs should be directed at meeting parent-child needs.

Social workers, whether based in hospitals or working as a part of other agencies, should take a lead or significantly collaborate with others in building a systematic evaluation of program outcomes in child abuse prevention efforts.

In addition to ongoing quality improvement, addressing public perceptions regarding funding of social services and preventive efforts could be tackled through the conducting and use of cost-effectiveness studies to show how much financial and societal cost can be saved by early intervention. (Wells, 2008)

There are strong reasons for targeting school-age children and their families for child abuse prevention work. The developmental period spanning the ages of 6 to 12 years represents the highest risk period for at least one type of abuse: sexual abuse (Finkelhor & Baron, 1986). Moreover, most abused or potentially abused children come to the attention of authorities when they start school. Planning preventive interventions at this time also takes advantage of the child's (and, thereby, the family's) expanding connection with the community. "Even the most isolated families will need to contend with the myriad changes brought on by their child's increased involvement with school and other community settings" (Rosenberg & Sonkin, 1992, p. 79). Social workers in public health and those in hospitals with strong community-oriented health promotion programs can organize school-based child abuse prevention programs. Although school-based programs are only part of the answer, and parents, other adults, and potential abusers must also be the focus of preventive efforts, these programs have been found to be helpful. They clearly prompt many victimized children to disclose their abuse. On the basis of a review of evaluation studies of sexual abuse prevention education programs, Finkelhor and Strapko (1992) said that

they certainly rescue many children, who would not have otherwise been rescued, from extremely troublesome situations, and they short-circuit situations

which might otherwise have continued for an extended period of time at much greater ultimate cost to the child's mental health. (pp. 164–165)

The prevention and treatment of abuse of adolescents has been a particularly neglected area. "Adolescent maltreatment tends to be associated with problematic acting-out behavior of the teenager or dysfunction with the family, and tends to be dealt with as such by agencies other than protective services" (Garbarino, 1992, p. 105). Garbarino proposed several hypotheses about adolescent maltreatment and found support for them in the available research literature:

- Prevention programs should target adolescents, because the incidence of adolescent abuse equals or exceeds the incidence of child maltreatment.
- These programs should give special attention to female adolescents and the issues they face.
- Some adolescent abuse is the continuation of abuse and neglect begun in childhood; other abuse represents the deterioration of unwise childhood patterns or the family's inability to meet new challenges of adolescence. Programs should take account of these different etiologies.
- Programs in general should reach families across the board, regardless of their socioeconomic resources.
- Families with stepparents should be special targets.
- Less socially competent adolescents are at high risk and should be given special attention.
- Programs should adopt a broadly based approach to supporting and redirecting families that tend to be at high risk on the dimensions of adaptability, cohesion, support, discipline, and interpersonal conflict.

These recommendations can be woven into family preservation approaches that are being tried all over the country and are likely to become more popular in the future. Social workers can also help in incorporating these recommendations into school health programs.

The area of child sexual abuse is particularly difficult for preventive work. Determining targets for intervention is all the more difficult

because sexual abuse is not strongly linked to demographic factors and because knowledge about the characteristics of offenders is insufficient (Melton, 1992). Finkelhor (1979) conceptualized four preconditions—at the individual and societal levels—for sexual abuse: (1) factors related to motivation to abuse sexually; (2) factors predisposing to overcoming internal inhibitors; (3) factors predisposing to overcoming external inhibitors; and (4) factors predisposing to overcoming a child’s resistance. Most prevention efforts so far have focused on the last precondition. Social workers should keep themselves abreast of the latest research and programmatic work in the field and enrich their interventions with lessons from that work.

Whatever setting they are working in, social workers should engage in larger systemic change efforts aimed at effective coordinated involvement of the various societal systems in child abuse prevention. That will require the use of their lobbying skills.

Illness Prevention and Health Promotion Among the Elderly

In the future, the elderly will constitute a substantial proportion of the population, and their health care needs will demand special attention. Social workers will realize more and more the importance of preventive work with the elderly as well. Illness prevention and health promotion work focused on the elderly is quite new. For example, public health has turned its attention to older persons only lately. “The Gerontological Health section of Aging and Public Health Association was founded in 1978” (Kane, 1994, p. 1214). Several reasons have been proposed for the past neglect of this work [2], including the following: (a) The focus of health promotion programs is on extending life, and the elderly are not perceived as having a future; (b) the goal is usually prevention of premature death, and the elderly are considered to be beyond that point; (c) the programs often promote looking youthful and preventing signs of aging; and (d) their focus is on avoidance of

chronic disease, which is irrelevant for older adults because almost 85% of them have one chronic disease (Minkler & Pasick, 1986).

This picture is slowly changing. Realization is increasing that people of all ages can benefit from health promotion activities, although the progress of illness prevention and health promotion activities for the elderly is impaired by a lack of scientific data. The need for health promotion in the elderly is, however, obvious. The circular pattern of unhappy and unhealthy aging that results *in* and *from* poor nutritional intake, lack of physical and social activity, depression, and chronic disease (Fallcreek, Warner-Reitz, & Mettler, 1986) needs to be broken. Social workers have the skills to create and implement illness prevention and health promotion programs, as well as to contribute to the generation of much-needed knowledge.

Arnold, Kane, and Kane (1986) divided the preventive strategies into two groups: those focused on conditions or disease states, and those focused on specific behaviors that are likely to have beneficial or adverse effects on the disease states. They showed that the elderly have generally been excluded from studies of both these types of preventive strategies.

In planning illness prevention and health promotion programs for the elderly, social workers should do the following:

- Realize that needs of the elderly are manifold and that no agency’s own resources are likely to be adequate to meet all needs. Take stock of what and how much their own agency can do.
- Design the program to meet the unique needs of the target population. For identifying and specifying the target population and its needs, do a systematic assessment. We have discussed elsewhere the various approaches to needs assessment. These efforts should be aimed at a twofold purpose: (a) an assessment of the needs and (b) a survey of the relevant community resources. In looking for resources, include both the current and potential resources and define the concept of “resources” broadly. These should include (a) funder service providers and volunteers; (b) use of space and facilities

and other in-kind contributions; (c) special-interest groups such as the Heart Association and Cancer Society, and service clubs such as the Lions Club; (d) local newspapers and other mass media; and (e) experience, skills, and knowledge of the target population itself (Fallcreek et al., 1986).

- Take advantage of existing programs for the elderly. For example, nutrition programs have become a central and permanent part of services under the Older Americans Act. These provide hot, nutritious meals to millions of elderly on a daily basis. These can be used for surveying the needs of the elderly, imparting information about illness prevention and health promotion programs, and motivating them for participation.
- Strive for the best possible match between the identified needs and available resources. Within the overall goals of the program, involve the participants in setting its specific objectives that reflect their existing health status and motivation for change.
- Mix and match the preventive strategies and, in general, aim at the prevention or minimization of functional impairment, rather than the cure for particular ailments. Select general health promotion activities on the basis of an assessment of the realistically achievable improvements. A multifaceted health promotion program may address physical fitness, safety, nutrition, appropriate use of medication, stress management, and communication skills. Choose a mix of educational approaches and strategies. We discussed several earlier in this chapter. Again, try to match the educational strategies to the audiences.
- Use imagination and creativity in planning illness prevention and health maintenance and promotion activities. In Japan, “health notebooks” have been used to aid the aged in managing their health (Gotou et al., 1994). The elderly are given notebooks in which they record their concerns, questions, and health data, as well as health professionals’ advice, recommendations, and suggestions.
- Make sure that appropriate measures have been taken to legally protect the agency’s assets and employees, as well as program participants. These measures include screening participants (through such tools as preprogram

health-screening examination), having appropriate liability insurance, and using appropriate release forms. “All participants are required to sign a program release-from-liability form; physician release forms are obtained when possible. Although such measures are not always legally binding, they demonstrate that care and precaution have been taken to provide for participants’ safety” (Fallcreek et al., 1986, p. 232).

- Build into the program a strong evaluation component that captures its process, as well as its impact, so that the experience gained adds to the knowledge and skills of the service community.

Social Worker as Researcher

Evaluation of illness prevention and health promotion programs for their effectiveness and efficiency on a continuing basis will become an absolute necessity in the future. In Chapter 7, we discuss at some length social work’s contribution to the various approaches to quality assurance. Here, we briefly discuss areas of health promotion work that should be subjected to systematic research not only for quality assurance purposes but also for building theories and testing intervention models.

Health promotion approaches and strategies can be categorized by the level of intervention—individual, community, and policy. These are based on different theoretical assumptions and models. At the individual level, strategies that deal with both intrapersonal and interpersonal dimensions are based on theories of *social learning and self-efficacy* (Bandura, 1986), *learned helplessness* (Seligman, 1975), *coping* (Lazarus & Folkman, 1984), *social support* (Cassel, 1976), and *consumer information processing* (Bettman, 1979), as well as models such as the *stages of change model* (Prochaska, DiClemente, & Norcross, 1992) and the *health belief model* (Rosenstock, Strecher, & Becker, 1988). Some impressive work has been done on individual-level strategies, but much more needs to be learned.

Steckler and his colleagues (1995) suggested that future research should further explore the role

of social support and the mechanism of its action, the most effective combinations of strategies in comprehensive interventions, approaches to long-term adherence to changed health behaviors, ways of adapting what we already know works to the needs of new and diverse groups, and the impact of emerging learning technologies on individuals.

At the community level, strategies have been built on ideas from theories of *community organization*, *organizational change*, and *diffusion of innovation*, and interventions have included mediating social structures (e.g., through community coalition building), linking agents (e.g., through network interventions), empowerment, and ecological approaches (Steckler et al., 1995). More research is needed to discover the effectiveness of these strategies in various combinations for health promotion.

At the policy level, there is an obvious neglect of research into effects of the sociopolitical environment on health behavior and health status. As Wallack (1994) put it,

Even though 30% of all cancer deaths and 87% of lung cancer deaths are attributed to tobacco use, the main focus of cancer research is not on the behavior of the tobacco industry, but on the biochemical and genetic interactions of cells. (p. 429)

Even researchers in health education, while acknowledging the importance of sociopolitical environmental factors for health-related behaviors, have focused most of their work on factors at the individual level. Future research should be aimed at enhancing the understanding of the nature of social, economic, and political power, and ways of influencing the policy processes.

Social workers could use their research-related knowledge and skills to contribute to this dimension of their agency's work. They should strive to design research studies that not only evaluate the efficacy and effectiveness of particular strategies but also test the validity of the underlying theoretical assumptions.

We end this section with Table 6-C, which recaps future social work roles in illness prevention

Table 6-C Future Social Work Roles in Illness Prevention and Health Promotion

- Social work role in creating and mobilizing financial resources
- Social work role in program planning
- Social work role in program implementation and service provision
- Social work role as educator and community activator
- Social work role in work with special populations/problems
- Social work role as researcher
- Other social work roles in illness prevention and health promotion

and health promotion and appropriate role-related skills.

RELEVANT ETHICAL CONSIDERATIONS

Individuals and groups that are culturally different from mainstream Americans have many more barriers to health care in all sectors of the health care system. These are demographic, cultural, and health care system barriers. This reality raises several ethical questions. In this section, we discuss the ethical problems, issues, and dilemmas in illness prevention and health promotion programs.

Although significant cultural differences exist among as well as within the various minority groups, there are clear differences between Anglo-American and other ethnocultural groups in their worldviews as well as their theories of illness and approaches to health care and wellness [3].

The terms *ethical problem*, *ethical issue*, and *ethical dilemma* denote three different ethically challenging situations. Kachingwe and Huff (2007) provided the following examples of these situations:

Ethical Problems. A client comes to his or her appointments 10 minutes late on four consecutive occasions, perhaps because in that client's culture, the perception of time is different. If so, this is a cultural problem. Such problems are easy to resolve. The practitioner can make the appointment time more flexible or discuss with the client the significance of his or her coming on time because the clinic schedules depend on everyone coming on time.

Ethical Issues. A health promoter wants to organize an AIDS awareness workshop for students at a local high school, but parents of those students have a number of issues with the holding of such a workshop based on their religious and cultural values and traditions. Such situations are harder to deal with and require much imagination and work. It may be necessary to conduct a focus group or a survey of parents to identify the issues in clear and concrete terms. That may be followed by an open discussion with a sample of parents in order to get their input and support. At this step, their agreement on the topics to be covered in the workshop can be sought. Finally, it may be appropriate to conduct a workshop for parents first in order to gain their support for the workshop for their teens.

Ethical Dilemmas. A health promoter is faced with an ethical dilemma when the situation allows for two equally favorable or unfavorable options. An ethical dilemma also occurs when two moral reasons come into contact and the course of action is not obvious (Gabard & Martin, 2003). Searight and Gafford (2005) gave the following example of an ethical dilemma: A practitioner is asked by the family of a newly diagnosed cancer patient not to disclose the diagnosis to the patient. In their judgment, disclosure will cause unnecessary stress to the patient, which may lead to the patient giving up hope of recovery. That judgment might be culturally conditioned. Ethical dilemmas occur when a client's views on health and health care delivery conflict with those

of the health practitioner. These are also likely to occur when a client's cultural behaviors and practices appear to violate the ethical and moral definitions of human rights and obligations. Kachingwe and Huff (2007) offered female circumcision and wife beating as examples of such violations. Ethical dilemmas can be resolved through culturally proficient practice.

The term *cultural proficiency* denotes a higher level of ability than denoted by terms such as *cultural awareness*, *cultural sensitivity*, and *cultural competence*.

Cultural competence is a process of possessing the knowledge to appreciate and respect the cultural differences and similarities within and between cultural groups, acknowledging and incorporating the importance of culture, and working within the cultural context of an individual in an unbiased manner to meet the client's needs. (Kachingwe & Huff, 2007, p. 46)

The aim is the provision of *culturally congruent* care. *Culturally proficient* practice involves not only culturally competent care at the individual level but also reaching out to the community to meet its needs through advocacy and other community-level activities.

We present here the Kachingwe-Huff model of culturally proficient and ethical practice. The model involves the following five steps:

Step 1: Cultural Awareness. This begins with practitioners reflecting on their personal and professional cultures. This reflection makes them cognizant of their own personal identity and helps them assess how their personal beliefs, attitudes, and behaviors affect their views of others. This also makes them realize that they were socialized into the culture of their profession, with its set of beliefs, practices, and rituals. This realization shows how their views, attitudes, and actions are affected by their professional values and commitments. This model also acknowledges the fact that individuals are innately ethnocentric, and ethnocentrism tends to lead to distorted

perceptions of others' behaviors and unfounded judgments and stereotyping of others. Therefore, authors have suggested a series of questions that can help in getting in touch with one's own ethnocentric attitudes.

Step 2: Cultural Knowledge. Practitioners should increase their understanding of various cultures. This will enable them to acknowledge and respect similarities and differences among cultural groups. They can increase their knowledge by learning about the cultural beliefs and practices of their clients, including differences in communication, variations in personal space, and differences in the perception of time. They can learn from their clients as well as through reading the relevant literature and visiting their communities. Going to these communities to shop and eat or attend cultural events makes it possible to interact with cultural groups outside the confines of practice settings. They should grasp the differences within cultural groups, because people sharing a common culture are likely to be at different levels of acculturation and differ in their adherence to cultural beliefs and practices. Nevertheless, generalization about cultural groups is necessary in order to build further enquiry or initiate program activities, but generalization should be done carefully. Kachingwe and Huff (2007) point to one pitfall in generalization: "When cultural generalizations relate more to the motive behind a behavior than to the actual observed behavior, the generalization may be oversimplified—leading to stereotyping" (p. 48). Stereotyping can lead to a lack of respect for and stigmatization of a culture.

Step 3: Interpersonal Communication Skills. Practitioners should improve their communication skills, as these are an absolute must for effective interviewing at the individual client level and for designing and implementing health promotion programs. Conducting a cultural assessment should be the aim of first interviews with culturally diverse clients. Effective

communication with those who cannot speak English adequately will involve working with an interpreter. Practitioners should make sure that the interpreter is well trained and is not a member of the client's family, particularly his or her child. "It is also important to realize any potential discrepancies between the interpreter's ethical code of conduct mandating objectivity and neutrality and the realities of the client-interpreter cultural interaction" (Kachingwe & Huff, 2007, p. 49). In addition to effective verbal communication, practitioners should be cognizant of nonverbal communication, particularly touching the client. A touch considered inappropriate by the client can lead to misinterpretation of intentions, whereas an appropriate and respectful touch can help build trust with the client.

Step 4: Cultural Collaboration. This involves working as a practitioner-client team that formulates goals and a mutually agreed-on plan of care. It is often possible to come up with a plan that combines the Western medical and folklore healing practices, leading to better client compliance and outcomes (Lattanzi & Purnell, 2006). This may involve practitioners of conventional medicine working with the practitioners of traditional healing techniques. Cultural collaboration is also critical for planning programs at the community level. It involves connecting with organizations and individuals who represent the targeted population and seeking their insights, suggestions, and support at all stages of program planning and implementation.

Step 5: Cultural Experiences. This step emphasizes practitioners enriching their professional repertoire with cultural experiences. These experiences can be gained through immersion projects or other approaches. However, these should have an important self-reflection component so that, along with the experience of another culture, practitioners become aware of their ethnocentrism. These experiences will heighten their ability to provide culturally proficient care. No model

can help practitioners provide culturally proficient and ethical care unless they have a personal conviction in the fundamentalism of culture. Conviction is a belief, held as a truth, that becomes an ideology compelling one to action (Kachingwe, 2000). Practitioners' ability to act on their convictions is enhanced if those convictions are backed by their professional codes of ethics. The National Association of Social Workers (2000) Code of Ethics clearly mandates culturally competent practice. Section 1.05 ("Cultural Competence and Social Diversity") under "Social Workers' Ethical Responsibilities to Clients" requires the following:

- a. Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- b. Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
- c. Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability (National Association of Social Workers, 2006).

We end this section with a list of "shoulds" for ethical health promotion by social workers. These are taken from Kline and Huff (2007).

- Be aware that there is a high likelihood of encountering health promotion issues that contain an ethical component because of the vast differences among multicultural groups.
- Recognize that within and outside multicultural settings, the most important ethical principles for health promotion practitioners are (1) autonomy that allows an individual to make his or her own decisions, (2) beneficence—the duty to do good in the best interest of the client or the community, (3) confidentiality in respecting the privacy of information, (4) nonmaleficence—causing no

harm to the client or the target group, (5) respect for people and their rights, and (6) justice—equity or fair treatment for all.

- Be attentive to the influences of a client's or target group's culture when working within ethnically diverse communities.
- Recognize that in order to resolve an ethical dispute, cultural collaboration may necessitate working in partnership with traditional forms of medicine and healing.
- Remember that ethical practice requires cultural competence, which involves having appropriate knowledge and relevant skills.

Appropriate knowledge includes

- concepts of culture, ethnicity, acculturation, and ethnocentrism and how these may affect their ability to assess, plan, implement, and evaluate an illness prevention and health promotion program;
- many ways of perceiving, understanding, and approaching health and disease processes across cultural and ethnic groups that can present barriers to effective health care intervention;
- perceptions of target groups about their agency, as these may not be positive and may impede the health promotion process;
- possible barriers that may be encountered when a program is targeted to a community primarily composed of first-, second-, or even third-generation Americans;
- communication style of the target group and the rules governing the communication process;
- the typical Western medical model of communication (which seeks to quickly establish the facts of the case and often relies on the use of negative and double-negative questions) and how it may be seen as cold, too direct, and otherwise in conflict with the target group's traditional beliefs, values, and ways of communicating;
- health concepts about the locus of control for disease causality (being outside the individual) held by many cultural groups that may result in those groups choosing not to seek Western medical intervention;
- differences between the biomedical model and lay model of illness—the more disparate the differences, the greater the likelihood the

patient will resist the Western illness prevention and health promotion program; and

- various health promotion and health behavior theories that can guide their thinking about devising effective approaches to planning interventions.

Relevant skills include

- appreciation and respect for cultural differences within and between cultural groups and work in an unbiased manner to meet the client's or target group's needs;
- care in assessment, intervention, and evaluation processes that do not overlook, misinterpret, stereotype, or otherwise mishandle encounters with those who are different from them;
- assessment of the degree of acculturation in the target group, as there is a tendency in many to resist acculturation;
- reframing of the term *race* to *multicultural ethnic* or *culturally diverse* in order to promote greater sensitivity to the challenges, potentialities, and awards of working with culturally diverse groups;
- stepping out of their current frames of reference and risking the discovery of their biases, stereotypes, and ethnocentrism;
- using strategies that have been demonstrated to be effective in overcoming barriers to illness prevention and health promotion work with culturally diverse groups;
- using appropriate assessment instruments, including acculturation scales; and
- flexibility in the design of programs, policies, and services to meet the needs and concerns of target groups.

Critical Thinking Questions

1. Interview a member of your immediate or extended family who is at least two generations removed from you, and explore his or her concepts of health, illness, and disease. Compare and contrast those with the present-day Western biomedical explanations.
2. Based on your exposure to culturally different clients/people, make a list of a group's cultural

values and religious beliefs that are totally different from yours. Identify from that list beliefs and values that can be used as positive elements in working on a disease prevention and health promotion program for that group.

NOTES

1. These techniques include (a) advertising appeals, (b) street and door-to-door collections, (c) silent salespeople (coin-collecting devices in stores and restaurants), (d) “something” for the money—special events, (e) selling services and things (e.g., Girl Scout cookies), (f) secondhand chic (charity-run thrift shops), (g) auctions—live and televised, (h) art shows, (i) fashion shows, (j) other people's homes (showing outstanding homes with such treasures as rare paintings), (k) movie and theater benefits, (l) fun and games, (m) gambling—leaving charity to chance, and (n) walk-a-thons and other “thons” (Bakal, 1979).

2. Reasons given by Arnold, Kane, and Kane (1986) include (a) difficulty in applying the traditional taxonomy of prevention—primary, secondary, and tertiary prevention—to the chronic diseases that the elderly suffer (a condition may be at once a preventable disease and a risk factor for another disease); (b) lack of adequate understanding of the propensity of the elderly to change their behavior for reducing the risk factor; (c) uncertainty of effectiveness of an altered risk factor for preventing the disease; (d) issues of cost and efficacy, which are often hard to demonstrate; (e) the long past-time horizon of the elderly posing questions such as when to intervene, especially when time of exposure to risk is a significant factor; and (f) difficulty in distinguishing between the possibilities of doing good and doing harm.

3. Commonalities among groups culturally different from mainstream Americans include the following:

- *Meaning of the family*—family has a special meaning and place in their lives. Family members are socialized to consider family's needs, prestige, stability, and welfare as more important than the individual's aspirations, comfort, and well-being.

- *Extended family ties*—great importance is placed on maintaining a wide network of kinship.
- *Place of religion*—religion affects their attitudes and practices regarding food, medical care, mental health, recreation, and interpersonal relationships both within and outside the family. Religious faith and institutions influence their ability to deal with their problems.
- *Experience as Americans*—these groups have a history of being the victims of racism. Their experiences include hostility from the mainstream community in the form of prejudice, economic discrimination, political disenfranchisement, immigration exclusion, physical violence, and social segregation.
- *Poverty and lower economic status*—large proportions of these groups live below the poverty line.
- *Level of acculturation*—all these groups have concerns, needs, and priorities related to their level of acculturation.
- *Culture-related disorders*—many of these groups experience culture-related disorders and syndromes. Many discourage owning mental and physical problems, and in some, psychological problems are expressed as somatic complaints (Dhooper & Moore, 2001).