Adapting Evidence-Based Programs to Meet Local Needs

Sponsored by:
The Illinois Department of Public Health
and
Illinois Public Health Institute
Center for Community Capacity Development
Webinar Objectives

• Define “evidence-based” and differentiate like terminology
• Identify where to find population-based public health evidence-based models and how to adapt those programs
• Define “fidelity” and how to measure program fidelity
• Identify cultural needs for a particular community
• Describe types of process data that may be used to measure likelihood of producing program outcomes
Presenters

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Assistant Professor of Public Health Policy, University of Illinois at Springfield

Laurie Call
Director, Center for Community Capacity Development
Illinois Public Health Institute
What is Evidence-based?

• The National Cancer Institute (NCI) says:

An evidence-based program has been:

• Implemented with a group
• Evaluated
• Found to be effective.
What Is Evidence?

- Surveillance Data
- Systematic Reviews of Multiple Intervention Studies
- An Intervention Research Study
- Program Evaluation
- Word of Mouth
- Personal Experience

OBJECTIVE

SUBJECTIVE

Adapting Evidence-Based Programs to Meet Local Needs
May 14, 2010
Why Evidence Based Practice?

- Meta-analyses/systematic reviews
- Research-tested intervention programs (RTIPs)
- Evidence informed
Rationale

• What are advantages to evidence-based programs?
  – Effective in the study populations
  – Cost effective
  – Shorten the time it takes to develop a program
  – Reduce the time it takes to research a community
  – Help narrow the evaluation.
Disadvantages

• Using evidence-based programs limits my creativity.
• Evidence-based programs take too much time and/or money.
Definitions

Adapting:

• the process or state of changing to fit new circumstances or conditions, or the resulting change

• Something adapted to fit need: something that has been modified for a purpose (e.g., a film adaptation of a novel).
Definitions

• Fidelity
  – Implementation fidelity is the degree to which an intervention is delivered as intended and is critical to successful translation of evidence based interventions into practice (Breitenstein, et al, 2010).
  – *Program Fidelity*: the degree of fit between the developer-defined components of a substance abuse prevention program, and its actual implementation in a given organizational or community setting.

• Theory
  – A theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables (Rimer and Glanz, 2005).
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May 14, 2010
Theory

- **Concepts** are the building blocks—the primary elements—of a theory.
- **Constructs** are concepts developed or adopted for use in a particular theory. The key concepts of a given theory are its constructs.
- **Variables** are the operational forms of constructs. They define the way a construct is to be measured in a specific situation. Match variables to constructs when identifying what needs to be assessed during evaluation of a theory-driven program.
- **Models** may draw on a number of theories to help understand a particular problem in a certain setting or context. They are not always as specified as theory.

(Rimer and Glanz, 2005)
Figure 1. Using Explanatory Theory and Change Theory to Plan and Evaluate Programs

Explanatory Theory
Why?
What can be changed?

Problem Behavior or Situation

Evaluation

Change Theory
Which strategies?
Which messages?
Assumptions about how a program should work

Planning

(Rimer and Glanz, 2005)
Figure 2. A Multilevel Approach to Epidemiology


(Rimer and Glanz, 2005)
Ecological Approach-

An ecological approach that addresses public health issues at all levels is essential as we study population health and craft policies and interventions.
<table>
<thead>
<tr>
<th>Concept</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrapersonal Level</td>
<td>Individual characteristics that influence behavior, such as knowledge, attitudes, beliefs, and personality traits</td>
</tr>
<tr>
<td>Interpersonal Level</td>
<td>Interpersonal processes and primary groups, including family, friends, and peers that provide social identity, support, and role definition</td>
</tr>
<tr>
<td>Community Level</td>
<td></td>
</tr>
<tr>
<td>Institutional Factors</td>
<td>Rules, regulations, policies, and informal structures, which may constrain or promote recommended behaviors</td>
</tr>
<tr>
<td>Community Factors</td>
<td>Social networks and norms, or standards, which exist as formal or informal among individuals, groups, and organizations</td>
</tr>
<tr>
<td>Public Policy</td>
<td>Local, state, and federal policies and laws that regulate or support healthy actions and practices for disease prevention, early detection, control, and management</td>
</tr>
</tbody>
</table>

*Rimer and Glanz, 2005*
Theories

• **The Health Belief Model (HBM)**
  – addresses the individual’s perceptions of the threat posed by a health problem (susceptibility, severity), the benefits of avoiding the threat, and factors influencing the decision to act (barriers, cues to action, and self-efficacy).

• **The Stages of Change (Transtheoretical) Model**
  – describes individuals’ motivation and readiness to change a behavior.

• **The Theory of Planned Behavior (TPB)**
  – examines the relations between an individual’s beliefs, attitudes, intentions, behavior, and perceived control over that behavior.

(Rimer and Glanz, 2005)
Evidence-Based Resources

- Community Guide
- Cochrane Reviews
- US Clinical Preventive Services Task Force
- Community Toolbox
- National Cancer Institute
- Evidence Based Public Health - Brownson
Community Preventive Services

- *Community Guide to Preventive Services*
- Systematic reviews (meta-analyses) of the effectiveness of community interventions commendations
- Similar to the Clinical Guide
  - Scale:
    - Recommended
    - Insufficient evidence
    - Recommend against
Tobacco Use

Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States (CDC).

It is recognized as a cause of:

- Multiple cancers
- Heart disease
- Stroke
- Complications of pregnancy
- Chronic obstructive pulmonary disease

Community Guide Systematic Reviews

The Community Guide includes systematic reviews of interventions in the following areas:

Reducing tobacco use initiation

http://www.thecommunityguide.org/
Reducing Tobacco Use Initiation

These interventions seek to reduce the number of people who begin using tobacco products.

**Task Force Recommendations & Findings**

This table lists interventions reviewed by the Community Guide, with Task Force findings for each ([definitions of findings](#)). Click on an intervention title below for a summary of the review.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing the unit price for tobacco products</td>
<td>Recommended</td>
</tr>
<tr>
<td>Mass media education campaigns combined with other interventions</td>
<td>Recommended</td>
</tr>
</tbody>
</table>

**Supporting Materials**

- Logic Model
- Publications

**For More On This Topic**

- CDC, Office on Smoking and Health
- Partnership for Prevention Action Guide

Reducing Tobacco Use Initiation: Increasing the Unit Price for Tobacco Products

These interventions increase the unit price for tobacco products through municipal, state, or federal legislation that raises the excise tax on these products. Such increases make the use of tobacco products less attractive to young people with limited incomes and a variety of ways to spend their money.

Task Force Recommendations & Findings

The Task Force on Community Preventive Services recommends interventions that increase the price of tobacco products based on strong evidence of their effectiveness in:

- Reducing tobacco use among adolescents and adults
- Reducing population consumption of tobacco products
- Increasing tobacco use cessation (described in Strategies to Increase Tobacco Use Cessation)

Task Force findings

Results From The Systematic Reviews

Eight studies qualified for the review of this intervention.

- Tobacco use prevalence among adolescents (13-18 years old): a median decrease of 3.7% for every 10% increase in product price (8 studies)
- Tobacco consumption among adolescents: a median decrease of 2.3% for every 10% increase in product price (6 studies)
- All of the included studies were conducted in the United States.
- Five studies evaluated the effect of price on tobacco use for study periods that included the 1990s, and three studies reported the effect of price on tobacco use for periods before 1990.
Clinical Preventive Services

• Examples
  – Immunizations
  – Screening
  – Counseling

• USPSTF- Guide to Clinical Preventive Services
  – Researches effectiveness and makes recommendations
  – Grades ‘strength of evidence” on scale of A, B, C, D or I
Guide to Clinical Preventive Services

The U.S. Preventive Services Task Force (USPSTF) was convened by the Public Health Service to rigorously evaluate clinical research in order to assess the merits of preventive measures, including screening tests, counseling, immunizations, and preventive medications.

Clinical Categories

- Cancer
- Heart and Vascular Diseases
- Injury and Violence
- Infectious Diseases
- Mental Health Conditions and Substance Abuse
- Metabolic, Nutritional, and Endocrine Conditions
- Musculoskeletal Disorders
- Obstetric and Gynecologic Conditions
- Pediatric Conditions
- Vision and Hearing Disorders
- Miscellaneous

http://www.ahrq.gov/clinic/cps3dix.htm#misc
Table of Contents 

Part F. Analyzing Community Problems and Designing and Ad... >
Chapter 19. Choosing and Adapting Community Interventions >
Section 1. Criteria for Choosing Promising Practices and Com... >

Section 1. Criteria for Choosing Promising Practices and Community Interventions

- Main Section - Introduction, what, why, when, who, and how.
- Examples - Real world situational examples.
- Related Topics - Hyperlinks to related chapters and sections.
- Tools & Checklists - A checklist that summarizes the major points contained in the section.
- Power Point - A Power Point presentation summarizing the major points in the section.
Adapting Community Interventions for Different Cultures and Communities

Tools & Checklists
Contributed by Eric Wadud and Bill Berkowitz Edited by Bill Berkowitz and Jerry Schultz

Tools Checklist

Tool #1: Questions to Consider in your Search for Information about the Community

Historical Issues

- What is the history of the community?
- What name or names do the cultural groups use to refer to themselves?
- What is the significance of the different names?
- What are the major differences between cultural groups in your target community, particularly across generational, educational, socio-economic and geographic lines?
- What have been the major historical events which describe the target group’s experiences in the United States?
- What were and are the major conflicts between or among the cultural groups in the target community? What were the outcomes?
- What were and are the major conflicts within each group? What were the outcomes?
Adapting Evidence-Based Programs to Meet Local Needs

May 14, 2010

http://www.cochrane.org
Cochrane Reviews search

Interventions for promoting physical activity
... Interventions for promoting physical activity. ... Summary.
Interventions for promoting physical activity. ...
www2.cochrane.org/reviews/en/ab003180.html - 23k

Physical activity and enhanced fitness to improve cognitive function
... Physical activity and enhanced fitness to improve cognitive function in older people without known cognitive impairment. ...
www2.cochrane.org/reviews/en/ab005381.html - 23k

www2.cochrane.org/reviews/en/ab006489.html
... Cochrane Methodology abstracts ... Physical activity programs for persons with dementia. Forbes D, Forbes ...
www2.cochrane.org/reviews/en/ab006489.html - 23k

Cochrane Reviews - Physical activity for improving cognition
The Cochrane Collaboration Cochrane Reviews, ... Title: Physical activity for improving cognition in older people with mild cognitive impairment. ...
www2.cochrane.org/reviews/en/protocol_6CB1323F82E26AA2009DC1BB64EE513F.html - 13k

Physical activity programs for promoting bone mineralization
The Cochrane Collaboration Cochrane Reviews, ... Physical activity programs for promoting bone mineralization and growth in preterm infants. ...
www2.cochrane.org/reviews/en/ab005387.html - 23k

http://www.cochrane.org
School-based physical activity programs for promoting physical activity and fitness in children and adolescents aged 6-18

Some Cochrane Reviews investigate interventions to prevent ill health rather than simply treatments for it. Maureen Dobbins from McMaster University in Canada describes her Cochrane Review of physical activity programs in schools.

Download [mp3] | Read Review

http://www.cochrane.org
Adapting Evidence-Based Programs to Meet Local Needs

May 14, 2010

http://www.cochrane.org

Abstract

**Background**
Child and adolescent obesity is increasingly prevalent, and can be associated with significant short- and long-term health consequences.

**Objectives**
To assess the efficacy of lifestyle, drug and surgical interventions for treating obesity in childhood.

**Search strategy**
We searched CENTRAL on The Cochrane Library Issue 2 2008, MEDLINE, EMBASE, CINAHL, PsycINFO, ISI Web of Science, DARE and NHS EED. Searches were undertaken from 1985 to May 2008. References were checked. No language restrictions were applied.

**Selection criteria**
We selected randomised controlled trials (RCTs) of lifestyle (i.e. dietary, physical activity and/or behavioural therapy), drug and surgical interventions for treating obesity in children (mean age under 18 years) with or without the support of family members, with a six months follow-up (three months for actual drug therapy). Interventions that specifically dealt with the treatment of eating disorders or type 2 diabetes, or included participants with a secondary or syndromic cause of obesity were excluded.

**Data collection and analysis**
Two reviewers independently assessed trial quality and extracted data following the Cochrane Handbook. Where necessary authors were contacted for additional information.

**Main results**
We included 64 RCTs (5231 participants). Lifestyle interventions focused on physical activity and sedentary behaviour in 12 studies, diet in 6 studies, and 36 concentrated on behaviourally orientated treatment programs. Three types of drug interventions (metformin, sibutramine) were found in 10 studies. No surgical intervention was eligible for inclusion. The studies included varied greatly in intervention design, outcome measurements and methodological quality.

**Authors' conclusions**
While there is limited quality data to recommend one treatment program to be favoured over another, this review shows that combined behavioural lifestyle interventions compared to standard care or self-help can produce a significant and clinically meaningful reduction in overweight in children and adolescents. In obese adolescents, consideration should be given to the use of either orlistat or sibutramine, as an adjunct to lifestyle interventions, although this approach needs to be carefully weighed up against the potential for adverse effects. Furthermore, high quality research that considers psychosocial determinants for behaviour change, strategies to improve clinician-family interaction, and cost-effective programs for primary and community care is required.
Main Menu

Tips For Trainers

Module 1- Introduction: What Do We Mean by Evidence-Based?

Module 2- Needs Assessment: Getting To Know Your Audiences Better

Module 3- Finding an Evidence-Based Program

Module 4- Making the Evidence-Based Program Fit Your Needs: Adaptation and Your Program Summary

Module 5- Does It Work? Evaluating Your Program

Appendix A: Bibliography (.pdf)

Appendix B: Glossary (.pdf)

Appendix C: Cambodian Women's Health Project Materials
   Outreach Worker Manual (.pdf)
   Video: "The Preservation of Traditions"
   (in Cambodian w/ subtitles) (.mpg)

http://cancercontrol.cancer.gov/use_what_works/start.htm
NCI Steps for Adapting Evidence-based Programs

1. Identify What Can and Cannot Be Modified
2. What Do I Need To Modify and What Can Stay the Same?
3. Making the Modifications
What Can Be Modified

- Names of health care centers or systems
- Pictures of people and places and quotes
- Hard-to-read words that affect reading level
- Ways to reach your audience
- Incentives for participation
- Timeline
- Cultural elements based on population
What Cannot Be Modified

- The health topic
- Deleting whole sections of the program
- Putting in more strategies
- The health communication model or theory.
Making Modifications

• Brand materials with your contact information. (This includes contact names, mail and e-mail addresses, and phone numbers).
• Replace general pictures and drawings with ones that reflect your audience’s culture.
• Think about the best media and channels that should be used to publicize your program.
Making Modifications

- Choose incentives that appeal to your audience.
- Make a timeline that makes sense based on your resources.
- Try not to remove existing or add extra materials.
- Use the original health or communication model from the evidence-based program.
Making Modifications

In addition to reading level, you should ask yourself:

• Is the language appropriate for the culture?

• Are there different meanings for words? Could the words be misinterpreted?

• Do the materials fit with my audience’s culture?
Adaptation Guidelines

If you plan to adapt this program for use with your population, consider these nine recommended guidelines:

1. Determine the needs of your audience and whether this program addresses those needs.
2. Review the program and its materials with your intended audience for feedback on its appropriateness (see Program Adaptation Checklist).
3. Define the extent of adaptation needed and potential ways to implement the new program.
4. Develop “mock-up” versions of the adapted products.
5. Work with expert advisors to ensure that the adapted products maintain the accuracy of the originals.
6. Pilot test the adaptation with representatives from your audience (see Pilot Testing).
7. Modify or revise the adapted program and products based on pilot test feedback.
8. Implement the program.
9. Evaluate the effectiveness of your adapted program and products.

Fidelity

• Implementation fidelity is the degree to which an intervention is delivered as intended and is critical to successful translation of evidence based interventions into practice (Breitenstein, et al, 2010).

• A lack of implementation fidelity may be the reason why programs found to be effective in trials don’t work in the field

Breitenstein, et al 2010
Fidelity

• Adherence
  – The extent to which practitioner behaviors conform to the intervention protocol

• Competence
  – Relates to the skillfulness in the delivery of the intervention

• Assessing Fidelity
  – Self Report
  – Observation

Breitenstein, et al 2010
Fidelity

- Methods for assessing fidelity
  - Self report
  - Can be collected from participant or interventionist
  - Primarily focus on adherence
  - Checklist, short surveys

- Advantages
  - Inexpensive and less time consuming

- Disadvantages
  - Practitioners may not accurately report
  - Participants may not have necessary information or report may reflect feeling toward the practitioner
Fidelity

• Methods for assessing fidelity
  – Observations
  – More objective but expensive and may alter the practitioner’s and participant’s behavior
  – Video recording
    – Advantages- Perfect data collection
    – Disadvantages- Loss of anonymity, cost
  – Audio recording
    – Advantages- Less expensive, less intrusive
    – Disadvantages- Doesn’t capture non-verbal communication
Process Evaluation
Measures and Fidelity

- Dose delivered
- Dose received
- Reach
- Recruitment
- Context

Saunders, Evans and Joshi, 2005
### Process and Fidelity

**Table 1: Elements of a Process-Evaluation Plan, With Formative and Summative Applications**

<table>
<thead>
<tr>
<th>Component</th>
<th>Purpose</th>
<th>Formative Uses</th>
<th>Summative Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fidelity (quality)</strong></td>
<td>Extent to which intervention was implemented as planned.</td>
<td>Monitor and adjust program implementation as needed to ensure theoretical integrity and program quality.</td>
<td>Describe and/or quantify fidelity of intervention implementation.</td>
</tr>
<tr>
<td><strong>Dose delivered</strong></td>
<td>Amount or number of intended units of each intervention or component delivered or provided by interventionists.</td>
<td>Monitor and adjust program implementation to ensure all components of intervention are delivered.</td>
<td>Describe and/or quantify the dose of the intervention delivered.</td>
</tr>
<tr>
<td><strong>Dose received</strong></td>
<td>Extent to which participants actively engage with, interact with, are receptive to, and/or use materials or recommended resources; can include “initial use” and “continued use.”</td>
<td>Monitor and take corrective action to ensure participants are receiving and/or using materials/resources.</td>
<td>Describe and/or quantify how much of the intervention was received.</td>
</tr>
<tr>
<td><strong>Dose received</strong></td>
<td>Participant (primary and secondary audiences) satisfaction with program, interactions with staff and/or investigators.</td>
<td>Obtain regular feedback from primary and secondary targets and use feedback as needed for corrective action.</td>
<td>Describe and/or rate participant satisfaction and how feedback was used.</td>
</tr>
<tr>
<td><strong>Reach</strong></td>
<td>Proportion of the intended priority audience that participates in the intervention; often measured by attendance; includes documentation of barriers to participation.</td>
<td>Monitor numbers and characteristics of participants; ensure sufficient numbers of target population are being reached.</td>
<td>Quantify how much of the intended target audience participated in the intervention; describe those who participated and those who did not. Describe recruitment procedures.</td>
</tr>
<tr>
<td><strong>Recruitment</strong></td>
<td>Procedures used to approach and attract participants at individual or organizational levels; includes maintenance of participant involvement in intervention and measurement components of study.</td>
<td>Monitor and document recruitment procedures to ensure protocol is followed; adjust as needed to ensure reach.</td>
<td></td>
</tr>
<tr>
<td><strong>Context</strong></td>
<td>Aspects of the environment that may influence intervention implementation or study outcomes; includes contamination or the extent to which the control group was exposed to the program.</td>
<td>Monitor aspects of the physical, social, and political environment and how they impact implementation and needed corrective action.</td>
<td>Describe and/or quantify aspects of the environment that affected program implementation and/or program impacts or outcomes.</td>
</tr>
</tbody>
</table>

**Note:** Adapted from Stockler and Linnan (2002a) and Baranowski and Stablers (2000)

Process-Evaluation Methods

Because the process evaluation of the Media Matters program will be for both formative and summative purposes, one of the first issues to consider will be the timing for data collection and reporting. This required the planners to develop a data-collection, analysis, and reporting scheme that would assure that the program planners would receive formative feedback in a timely manner so that they could make adjustments to the program if necessary. Media Matters would also require a highly trained and coordinated data-collection and management staff. However, to maximize internal validity, evaluation staff will not perform both formative and summative assessments; an independent evaluation team that had no part in the intervention design or planning would be utilized for summative measures.

Potential process-evaluation methods (data sources, data-collection tools, and timing) for the Media Matters curriculum are summarized below:

*Implementation fidelity for Media Matters curriculum.* Possible data sources and methods include reports from teachers implementing the curriculum and Media Matters staff observation; both require developing a checklist of the expected characteristics of implementation.

*Dose delivered for Media Matters curriculum.* Possible data sources and methods include reports from teachers implementing the curriculum and Media Matters staff observation; both require developing a checklist of content to be covered and methods to be used in the curriculum.

*Dose received.* Possible data sources include teachers, staff, administrators, and students in the school; methods and tools include administering brief satisfaction scales and conducting interviews or focus groups with open-ended questions.

*Reach.* Data sources are the classes in which the Media Matters curriculum is taught; for each Media Matters session, the teacher could write down and report the head count, have students sign in on a sign-in sheet, or check students’ names off on a class roll.

*Recruitment.* Media Matters staff document all activities involved in identifying and recruiting teachers for the Media Matters curriculum training.

*Context.* Possible data sources include school teachers, staff, and administrators. The primary method and tool are interviews with open-ended questions to assess barriers to implementation.

Framework for Adapting EB Programs

Select evidence-based strategies to solve the health problem of interest.

Segment the target population into discrete groups with the same or similar characteristics.

Determine which local leaders and organizations have influence on the target population.

Conduct research with each segment to learn its perception of the benefits of and barriers to each selected evidence-based strategy.

Conduct research with these leaders and organizations to learn their assessment of the selected evidence-based strategies.

On the basis of the research findings, determine how best to disseminate the selected strategies in ways that appeal to the target population.

Design distribution channels through which to disseminate the adapted evidence-based strategies.

Conduct academic research to test the effects of the disseminated evidence-based strategies (including any disparity in the effects among various populations).

(Van Duyn, et al, 2007)
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(Van Duyn, et al, 2007)
Adapting for Cultural Differences

- Show respect for another culture's values and identity
- Improve your ability to connect with your target community
- Increase the relevance of your actions
- Decrease the possibility of unwanted surprises
- Increase the involvement and participation of members of other cultural groups

- Increase support for your program by those cultural group members, even if they don't participate or get directly involved
- Increase the chances for success of your intervention (and its community impact)
- Build future trust and cooperation across cultural lines -- which should raise the prospects for more successful interventions in the future.

The Community Tool Box - [http://ctb.ku.edu/en/](http://ctb.ku.edu/en/)
Adapting Community Interventions for Different Cultures and Communities

Questions to Consider in your Search for Information about the Community

**Historical Issues**

- What is the history of the community?
- What name or names do the cultural groups use to refer to themselves?
- What is the significance of the different names?
- What are the major differences between cultural groups in your target community, particularly across generational, educational, socio-economic and geographic lines?
- What have been the major historical events which describe the target group's experiences in the United States?
- What were and are the major conflicts between or among the cultural groups in the target community? What were the outcomes?
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*Contributed by Eric Wadud and Bill Berkowitz Edited by Bill Berkowitz and Jerry Schultz*
Adapting Community Interventions for Different Cultures and Communities

Questions to Consider in your Search for Information about the Community

**Culture and Tradition-Specific Issues**

- What are the values of the different groups in the community?
- How do various members of each cultural group define health and illness?
- What are some of the more common health beliefs and practices of community groups, both in general and with respect to specific problems?
- What are the predominant family structures within the community's cultural groups? Patriarchal, matriarchal, single parent household, extended families, etc.?
- What are some of the traditional roles of different family members in these cultural groups, particularly where health care is concerned?
- Who are the formal and informal leaders in the community, and what role do they have in the area of health promotion?
- How many languages and dialects are spoken?
- What are the formal and informal channels of communication within and between different groups

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Questions to Consider in your Search for Information about the Community

**Medical Orientation**
- What are the group's general beliefs about the cause, prevention, diagnosis and treatment of disease?
- What are the group's attitudes towards "Western" medicine?
- In general, what has been the experience of different groups when trying to access the health care system?
- To what extent is there use of traditional medicine or healers?
- Where do people go for health information?

**Diet**
- What are traditional foods, and what role do they play in health, religion, and social activities?
- How has diet here in the U.S. changed over time as compared to in their country of origin?
- Is there access to foods that constitute traditional diet? Are there acceptable substitutes

*Contributed by Eric Wadud and Bill Berkowitz Edited by Bill Berkowitz and Jerry Schultz*
Adapting Community Interventions for Different Cultures and Communities

Questions to Consider in your Search for Info about the Community

Religion
• What are the different religions practiced within the cultural groups in the community?
• How is practice of their religion influenced by their culture?
• What is the size of membership, and who are the members?
• Who are the religious leaders, and what is their role in the larger community?
• Are there conflicts among or within the various religious groups?
• What involvement do various religious groups have in the area of health education and promotion?
• Do religious beliefs conflict with the philosophy of health promotion? Can the beliefs be incorporated into your program?

Contributed by Eric Wadud and Bill Berkowitz Edited by Bill Berkowitz and Jerry Schultz
 References

• Community Tool Box: http://ctb.ku.edu.
Administrative Capacity and Governance

A1.3 B: *Maintain socially, culturally, and linguistically relevant approaches in agency processes, programs and interventions*

Documentation: Policy or procedures for culturally and linguistically appropriate interventions and materials, 2 examples, documentation of training content and staff participants.

Domain 9: Evaluate and continuously improve processes, programs and interventions

**Standard 9.1 B**: Evaluate public health processes, programs and interventions provided by the agency and its contractors

**Standard 9.2 B**: Implement quality improvement of public health processes, programs and interventions

http://www.phaboard.org/index.php/beta_test/standards/
Domain 10: Contribute to and apply the evidence-base of PH

Standard 10.1 B: Identify and use evidence-base and promising practices.

10.1.1 B: Review and use applicable evidence-based and/or promising practices when implementing new or improved processes, programs or interventions.

Documentation and Scoring Guidance: 2 examples from within the past 3 years of review and use of evidence-based or promising practices including source of EBP or practice and description of how EBP or promising practice was implemented in the agency processes, programs and interventions.

http://www.phaboard.org/index.php/beta_test/standards/
Domain 10: Contribute to and apply the evidence-base of PH

**Standard 10.2 B:** Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

**10.2.1 B:** Communicate research findings, including public health implications.

Documentation and Scoring Guidance: 2 examples of communication of research findings (evaluated pursuant to 10.2.3 S) and their implications to stakeholders, public health system partners, and/or the public.

http://www.phaboard.org/index.php/beta_test/standards/
Domain 10: Contribute to and apply the evidence-base of PH

Standard 10.2 B: Promote understanding and use of the current body of research results, evaluations, and evidence-based practices with appropriate audiences.

10.2.2 B: Develop and implement policies that ensure human subjects are protected when the agency is involved in research activities.

Documentation and Scoring Guidance: Policies regarding research, such as Institutional Review Board (IRB) policy and one example within the last 3 years, where applicable, of use of policies.

http://www.phaboard.org/index.php/beta_test/standards/
Feedback

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