Chapter 8

Health Promotion and the Community

objectives

After completing this chapter, the reader will be able to:

• Describe the 11 functional health patterns and explain how they are used for data collection to assess communities.
• Evaluate community characteristics that indicate risk.
• Identify developmental aggregates of potential or actual dysfunctional health patterns.
• Explain methods of community data collection and sources of information.
• Describe a method of planned change for the community.
• Discuss planning, implementing, and evaluating nursing interventions in health promotion with communities.
• Develop a health-promotion plan based on community assessment (includes resources), nursing diagnosis, and other contributing factors.

key terms

Ambient
Community
Community diagnosis
Community evaluation
Community health promotion
Community nursing intervention
Community outcomes
Community pattern
Community risk factors
Demography
Developmental theory
Function of a community
Interview data
Measurement data
Observation data
Risk factor theory
Structure of a community
Systems theory
Windshield survey

website materials

These materials are located on the book’s website at http://evolve.elsevier.com/Edelman/.
• WebLinks
• Study Questions
• Glossary
• Website Resources

8A: Functional Health Patterns: Data Collection Guide to Community Assessment
8B: Guidelines for Nursing Interventions for Ethnic Elders
Teenagers: Drinking and Driving

In a small rural community, 7 teenagers have died in alcohol-related car accidents within the past 3 months. Alcohol and drug education is taught during the first year at the local high school, but driver’s education classes are not offered because the school cannot afford the program. Parents within this community are extremely concerned.

1. What other information must be acquired before making a diagnosis?
2. What health-promotion ideas could be recommended based on the information provided?

Over the last few decades, several social trends in the United States have increased public interest in health promotion and disease prevention. The landmark project, Healthy People 2010 documents the U.S. Department of Health and Human Services (2000; 2007) published (see Chapter 1) have been helpful in changing the focus of health care from a reactive stance to a proactive stance that emphasizes prevention of disease and promotion of health. By stating national health objectives as population-specific risks to good health, these documents aim to guide community strategies and to promote health, thereby reducing the risk factors to disease.

Another social trend creating interest in these issues is the changing population of the United States (see Chapter 2). The U.S. Census Bureau estimates that between 2000 and 2030, for example, the population 65 and older will grow faster than the total population doubling this population in 26 of the states (U.S. Census Bureau, 2005). Older people tend to have more chronic diseases and consume larger portions of health care resources than people in other age groups. The aging population, for example, requires more home health care and nursing home services than previous generations, due to increased lifespan and the concurrences of health problems (including altered levels of functioning).

The term community is used in various contexts with various meanings, depending on the frame of reference. In this text, the definition of community is the same definition used by Healthy People 2010 and the Health Promotion Glossary of the World Health Organization (WHO), “A specific group of people, often living in a defined geographical area, who share a common culture, values, and norms and who are arranged in a social structure according to relationships that the community has developed over a period of time” (U.S. Department of Health and Human Services, 2007; World Health Organization, 1998). Using this definition, community encompasses a wide variety of settings. For example, community includes workplaces and schools (U.S. Department of Health and Human Services, 2007).

Nurses in the nation’s schools serve youth and provide access to community resources. Linking school nurses with communities can increase access to resources to improve health-promoting behaviors (Frankowski et al., 2006). Results from the School Health Policies Programs Study indicate support for the Healthy People 2010 Objective 7-4: “Increase the proportion of the Nation’s elementary, middle, junior high, and senior high schools that have a nurse-to-student ratio of at least 1:750” (U.S. Department of Health and Human Services, 2007). Since 1998, the percentage of schools who meet this objective has risen from 28% to 53%, with a target of 60% by 2010 (U.S. Department of Health and Human Services, 2007).

People are integral to any concept of community; human beings give each community shape, character, and form. Individual health is reflected in each community through each person’s contribution to its statistical rates and cultural and psychological makeup. Conversely, the community is reflected in the individual through similar modes of expression (Aday, 2001).

This chapter focuses on the application of the nursing process to the community with independent, interdependent, and dependent nursing activities. Methods of data collection and sources of information about communities may differ from individual sources. Systems theory, developmental theory, and risk factor theory guide nursing process. Developmental theory refers to a variety of explanations of phases of human development—physical, psychosocial, cognitive, and spiritual dimensions—based on descriptive research studies. Similarly, risk factor theory identifies human characteristics and behaviors that increase the likelihood of the manifestation of health problems. Gordon’s (2007) functional health patterns provide the assessment framework. An example of a data collection guide is presented to facilitate the comprehension, synthesis, and application of observation data, interview data, and measurement data. An example of data analysis, nursing diagnosis, planning, implementation, and evaluation follows along with a description (also see website materials).

THE NURSING PROCESS AND THE COMMUNITY

Gordon’s (2007) health-related patterns provide a useful guide to collect observation, interview and measurement data. Health-related patterns chosen by the nurse for assessment depend on community settings, assessment focus, and preference. Assessing all pattern areas provides a basic data set to analyze and use for comparison during evaluation (see Chapter 6).

Risk factors and development also influence health patterns. For example, a health concern might be identified in one pattern area, such as the increased age-related factor of teenage pregnancy (sexuality-reproductive pattern). Data from other areas may reveal that parental opposition (values-beliefs pattern) tends to restrict sex education to
the home (coping–stress tolerance pattern) and thus limit
sex education in school. Attempting to restrict sex educa-
tion to the home and “ignoring” it in school and primary
care may place young people of childbearing age in the
community at risk for unwanted pregnancies. Factors from
several pattern areas may form clusters of risk for certain
groups (see Chapter 6).

THE NURSE’S ROLE
Community health nursing combines nursing practice and
public health concepts to promote the health of popula-
tions. It is not limited to any particular individual or group
of individuals (Clark, 2007). Nursing concerns become commu-
nities’ responses to existing and potential health-related
problems, including such health-supporting responses as
monitoring and teaching population groups. Nurses supply
educational information to at-risk communities to develop
health-oriented skills, attitudes, and related behavioral
changes.

Community nurses also develop essential relationships
aimed to accomplish communities’ health-related missions.
Complex and dynamic communities, with their increasing
public involvement in health and health policy, highlight
the importance of human interactions inherent in nurses’
responses to potential health problems, needs, and expecta-
tions. Community nursing practice, therefore, requires
a broad knowledge base derived from the natural, behav-
ioral, and humanistic sciences with application of intellec-
tual, interpersonal, and technical skills using the nursing
process.

Community nurses’ roles include the interaction of
independent, interdependent, and dependent functions.
Independent functions include assessing, analyzing, diag-
nosing, planning, implementing, and evaluating nursing
activities such as health promotion and health education.
Interdependent functions include collaboration with com-
munity members and interdisciplinary teamwork functions
that are crucial to effective community health. Dependent
functions include implementing the therapeutic plans of
team members.

Community health promotion includes all of the follow-
ing:
• Community participation, with representatives from
multiple community sectors including government,
education, business, faith organizations, health care,
media, voluntary agencies, and the public;
• Assessment guided by a community-planning model
to determine health problems, resources, perceptions,
and priorities for action;
• Targeted and measurable objectives to address health
outcomes, risk factors, public awareness, services, and
protection;
• Comprehensive, multifaceted, culturally relevant
interventions that have multiple targets for change;
• Monitoring and evaluation of objectives and strategies
used (U.S. Department of Health and Human
Services, 2007).

METHODS OF DATA COLLECTION
Nurses obtain community assessment data through obser-
vation, interviews, and measurement. These three meth-
ods are used most frequently in various combinations to
test the validity of the information. Obtaining data
through observation—often referred to as the windshield
survey approach to assessment—includes the use of the
senses (sight, touch, hearing, smell, and taste) to determine
community appearances. These appearances include types
and condition of residential dwellings, people, and physi-
cal and biological characteristics, such as animal and plant
life, temperature, transportation, sounds, and odors. Some
communities have a characteristic “flavor.” Communities’
physical characteristics influence health. What type of
space is available? Children need space to run and play;
young and middle-aged adults require space for recreation
and exercise. What spatial barriers exist? Community nurses
obtain abundant subjective data by simply walking or rid-
ing around a community. Data obtained by observation
provides important clues about the community, its actual
or potential health problems, and its strengths. Analysis of
observation data generates hypotheses to explore further
using interview and measurement data.

Interview data, the most common source of information
from people, includes verbal statements from community
residents, key community officials, health care personnel,
and various community agency staff. Interviewing provides
a useful way to learn how members perceive their commu-
nity. Key community leaders often provide important infor-
mation about community health concerns, necessary health
resources, and community strengths along with particular
health beliefs and community health goals. Community
residents provide useful information about their percep-
tions of health, health concerns, and needs as well as of the
availability, accessibility, and acceptability of health ser-
dices. Health agency personnel provide data about health
resources, population served, availability, and perceptions
of concerns and needs. Developing a basic set of questions in
advance enhances the relevance of interview data.

Measurement data uses instruments to quantify data dur-
ing information collection. Measurement data include pop-
ulation statistics, pollution indices, morbidity and mortal-
ity rates, census statistics, and epidemiological data. These
data can be accessed by Internet or locally in community librar-
ies; health departments; environmental protection agencies;
schools; police and fire departments; local health system
agencies; and town, city, or state planning offices. Publicly
supported agencies share their information, and community
nurses readily use such data.

SOURCES OF COMMUNITY INFORMATION
Census information located at www.census.gov and also
found in libraries and public agencies is the most com-
plete source for population information. Because the U.S.
Census is completed once every 10 years at the beginning of
a decade, data for most communities become less accurate.
as the decade progresses. Community agencies and local planning commissions project statistics and developmental trends, which nurses use to understand population patterns and dynamics.

Environmental measurement data can be obtained from the local branch of the U.S. Environmental Protection Agency. Generally local health departments monitor water, food, and sanitation systems. Health departments along with school nurses and administrators provide school health information. Town, city, or county administrations provide information about land use, boundaries, housing conditions, utilities, and community services. Community newspapers supply information about community dynamics, health-related concerns, cultural activities, and community decision-making. Documentation techniques for community observation, interview, and measurement data are similar to those used for individuals and families. A triple-column format that separates the data of each method facilitates coding.

**COMMUNITY FROM A SYSTEMS PERSPECTIVE**

Systems theory provides an overall framework to connect and integrate community data. Systems consist of interrelated, interacting parts or components within boundaries that filter both the type and rate of input and output (Clark, 2007; McLeroy, 2006; Sterman, 2006). Similar to how families form systems (see Chapter 7), communities viewed as systems have both structure and function. Assessment of communities includes exploration of aspects of populations within specific geographical areas.

**Structure**

The structure of a community system or subsystem consists of a formal or informal arrangement of parts, including both animate and inanimate properties. Nursing, which operates within the context of the health system, can be considered within the context of community systems. Figure 8-1 shows a hierarchical arrangement of a community system. The suprasystem, often a county or state, shapes the larger part of the system that encompasses numerous subsystems. Community structural parts form the subsystems, each of which is in itself a system. Health agencies, schools, fire departments, and governmental bodies are examples of structural parts. Arrangement and organization of a community, such as age distribution and types of health-promotion/protection programs, change over time. Parts fluctuate depending upon environmental processes occurring locally and within the larger environment.

Community leadership provides direction for both health-promotion and health-protection activities; therefore, community assessment includes exploration of various community systems as they relate to health. The practice of viewing the community structure as a population (collection of people) and considering the arrangement of the community’s health care parts (existing health services) plays an important role in the assessment process.

The study of a population is referred to as demography. Demography provides information about population characteristics—such as size and racial composition, along with the distribution of age, gender, marital status, nationality, language, religious affiliations, education, and occupation. Demographic data provide the basis for analysis and a means to identify groups who may have high risk for health concerns. Such information also provides clues for the direction of health strategies. For example, examining age distribution over several years reveals important population shifts with associated needs for additional health-promotion activities. The increase in the number of individuals over age 65 requires changes in community health priorities that reflect this group’s needs.

Comparison statistics about population characteristics, which also need to be considered in community structure, enable nurses to make inferences about the community. Comparisons are made among three systems: (1) the town, which is a part of the county; (2) the county, which is a part of the larger system; and (3) the state. Comparisons between communities of similar population size typically occur.

**Function**

The function of a community refers to the process of dynamic change with adaptation in the system’s parts and how community systems and subsystems interact. Decision-making and allocation of health-promotion and health-protection resources are important considerations for community assessment. As health educators, nurses interact with the community to promote health. Community health promotion involves a complex array of responsibilities. Nurses act as advocates using proactive planning and collaboration with other disciplines and agencies. As a community liaison, the nurse establishes priorities for programming; matches resources with needs determined by a community needs assessment; empowers community members; and facilitates social, environmental, and...
political change. These multifaceted functions require expertise in communication and interpersonal relations that involve a deliberate approach. Using such an intentional process, while maintaining the community’s vision, can produce effective change.

**Interaction**

Through dynamic interaction with the environment, systems exchange matter, energy, and information (in such communication forms as verbal and behavioral) to make decisions. Interaction also contributes to the community system’s ability to survive, as well as to protect and promote the health of its members. Through environmental interactions, community systems use adaptation mechanisms. Nurses determine how communities apply these mechanisms toward health services.

Various health-related patterns emerge from these interactions. For example, certain human activity patterns negatively alter natural environmental patterns, which in turn influence human health patterns. Gordon’s (2007) assessment framework focuses on 11 health-related functional patterns that each assume community and environment interaction from a systems perspective.

**COMMUNITY FROM A DEVELOPMENTAL PERSPECTIVE**

A framework based on developmental theory can be used to identify existing or potential health problems for particular age groups in communities. A population is a group defined as an aggregate of people who share similar personal or environmental characteristics. Community nurses, focusing on the total community population, use a developmental, age-correlated approach to identify health-promotion and health-protection activities.

Nurses identify age-related risks at each life stage taking steps to maximize wellness and health promotion as a lifelong concern (U.S. Department of Health and Human Services, 2007). For example, adolescent single mothers of infants, at risk both emotionally and physically, require parenting skills. Accidents are the greatest threat to children’s health; therefore, accident-prevention activities become a priority for adolescent mothers. Age-related risk factors (see Chapters 6 and 7) associated with individuals and families can be extended to include community groups.

**COMMUNITY FROM A RISK FACTOR PERSPECTIVE**

Risk factors associated with community disease, illness, and death rates, although not causally associated, play a role in predicting the likelihood of a particular adverse health condition (U.S. Department of Health and Human Services, 2007). Risk factors include a combination of demographic, psychological, physiological, or environmental characteristics (or they may include a single characteristic). For example, age, gender, race, geographical location, consumption pattern, or lack of health services may be considered risk factors, because one or more may contribute to disease or death and place the population sharing them at risk (Research Highlights box). The degree of influence of various risk factors differs from person to person and group to group because of genetic makeup, geographical location, lifestyle patterns, resources, socioeconomic status, level of education, or environmental variation. Some groups may be at high risk from a single risk factor such as insufficient immunizations or exposure to asbestos. A combined potential for adverse health effects exists when many risk factors are present, because they interact in multiple ways and synergistically influence each other (U.S. Department of Health and Human Services, 2007).

Communities, therefore, experience substantial variability in health conditions in regard to both incidence and susceptibility. Risk factor theory views health and disease as multifactorial with etiology attributed to no single risk factor. For example, risk factors such as air pollution, smoking, and forms of radiation in various combinations may be related to high rates of lung cancer, emphysema, and bronchitis in a community. The potential to control risk factors and to make relevant health-related resources available forms the basis for health-promotion and health-protection activities.

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**Research Highlights**

**Passenger Safety for Latino Children**

The purpose of this research was to demonstrate that the use of a community health worker education program would improve proper use of child automobile safety seats for Latino (primarily of Mexican descent) children in an urban area. Motor vehicle crash injuries are a leading cause of death for Latino children in the United States. In this study, an education intervention was provided by Latino community health workers trained to teach families about proper child safety seat usage. Families who received the intervention were compared to those who did not in regard to proper seat usage. A community participatory approach was used with members of the community participating in both design and implementation of the study. Families that participated in the study were primarily Mexican with low income, education, and acculturation levels. Child safety seats (n = 90) were checked for proper use. The authors concluded that the intervention contributed to proper safety seat usage in this urban low-income Latino community. This study provides some support for nurses to use community-based interventions as appropriate techniques to prevent injuries. The role of the nurse as community advocate and community facilitator is instrumental in promoting positive community change. Effective injury prevention programs need to be analyzed to better describe the patterns of injury, the needs of children in their community, and the interventions that would be most effective to promote more positive outcomes.

Website Resource 8A contains a general description of Gordon’s 11 functional health patterns with guidelines for posing questions in interviews and pertinent observations. A variety of functional health pattern assessments are used with communities. Nurses use Gordon’s (2007) functional health reference assessment as exemplified in this chapter or other assessments described in the literature (Clark, 2007).

**FUNCTIONAL HEALTH PATTERNS: ASSESSMENT OF THE COMMUNITY**

**Health Perception–Health Management Pattern**

The Health Perception–Health Management Pattern identifies data about community health status, health-promotion and disease-prevention practices, and community members’ perceptions of health (Gordon, 2007). Residents may perceive a substance abuse problem in adolescents or a high rate of unwanted pregnancies, breast cancer, or sexually transmitted disease as concerns. Valuable information can be elicited from interviewing key community members about their health concerns and issues. Mortality and morbidity statistics and other public health information sources provide measurement data (see Chapter 2).

**Nutritional-Metabolic Pattern**

The Nutritional-Metabolic Pattern identifies data relevant to community consumption habits as reflected in accessibility and availability of food stores and subsidized food programs for infants, children, and older adults. Community well-being, which depends on adequate dietary habits, food intake, and supply of nutrients, is influenced by culture, the presence or absence of kitchen facilities, and adequate plumbing.

Collecting data by driving or walking through the community while employing all five senses provides information about grocery stores, fast-food establishments, ethnic shopping facilities, and street corner vendors. Government programs, private soup kitchens, and food donations by houses of worship also provide information about nutritional patterns of communities.

**Elimination Pattern**

The Elimination Pattern identifies environmental factors including exposure to pollutants in the community through contaminated soil, water, air, and the food chain. This pattern further classifies environmental factors into the two broad categories of physical and biological. Alterations in environmental processes threaten health and integrity of communities, necessitating health-promotion and health-protection activities.

Physical agents include geological, geographical, climatic, and meteorological aspects of the community. Certain population groups are particularly susceptible to acute respiratory disease and aggravated asthma episodes when the air quality is poor. Geographical locations of communities and major waterways, highways, or mountains located within communities act as barriers to health facilities.

Inaccessibility of health care services also hinders health in at-risk groups. Knowledge of climatic conditions provides clues to susceptibility to illness resulting from temperature or humidity in certain populations.

Biological agents include living things—such as plants, animals and their waste products, disease agents, microbial pathogens, and toxic substances—that can be hazardous to health. For example, Lyme disease, viral hepatitis, pneumonia, influenza, and the large number of diseases associated with childhood continue to be threats to community health. Observation and interviews with key community members reveal information concerning elimination patterns. The Environmental Protection Agency and Centers for Disease Control and Prevention provide excellent resources for community health nurses.

**Activity-Exercise Pattern**

The Activity-Exercise Pattern identifies physical activities and recreational options within communities. Science and technology have increasingly influenced productivity while simultaneously reducing or eliminating physical work. Consequently, physical activity no longer occurs during the work day for most community members, leaving leisure time as the only time for physical activity. Physical activity reduces the risk of many diseases, including obesity, heart disease, hypertension, cancer, osteoporosis, and diabetes mellitus.

Physiological evidence demonstrates that physical activity improves many biological measures associated with health and psychological functioning. Regular physical activity and musculoskeletal fitness are important to healthy, independent living as people grow older. Observation and interviews provide clues to a community’s ability to provide cultural and recreational activities (Figure 8-2).

**Sleep-Rest Pattern**

The Sleep-Rest Pattern identifies a community’s rhythm of sleeping, resting, and relaxing. Some towns never close with stores, traffic flow, and recreational facilities operating during both day and night hours. This ongoing activity produces...
unpleasant disturbances, such as unwanted noise that may be harmful to community well-being. Excessive noise from highways or airplanes produces physiological or psychological problems eliciting responses ranging from mild irritation to pain or permanent hearing loss. Although noise cannot be eliminated, efforts to minimize and control it are possible. Observation and interviews provide clues to this pattern.

**Cognitive-Perceptual Pattern**

The Cognitive-Perceptual Pattern identifies information about problem solving and decision-making within communities. Systems depend on decision-making and resource allocation processes for survival. Communities require functional decision-making bodies to ensure adherence to rules and goals attainment. Individual patterns and environmental patterns connect with important implications for community health. Community assessment includes appraisal of interaction with the environment along with effectiveness of strategies used to meet health concerns and needs (Clark, 2007; McLeroy, 2006).

One strategy, bargaining, offers the community an exchange for health service. For example, a community that owns a mammography machine but has no primary care facility might negotiate with another community to provide mammography for primary care services in return. Strategies using outside authority (legal bureaucratic methods) ensure compliance through rules and structures. In this case, states may mandate that communities maintain certain health standards. For example, a law may require all school children to be immunized against specific diseases before entering public school. Cooperative strategies promote health when members share common goals. For example, community residents may join together to oppose a chemical landfill that is a health hazard.

Convincing people to comply because they hold some loyalty in the situation or relationship is another method that mobilizes communities. For example, community residents might expend a great deal of effort and money to retain a particular health clinic because of loyalty to the agency. Identifying decision-making patterns used by communities provides clues about health priorities and values, as well as matches and mismatches between existing circumstances, health goals, and planning strategies. Data can best be obtained by observation and interviews.

**Self-Perception–Self-Concept Pattern**

The Self-Perception–Self-Concept Pattern identifies self-worth and personal identity of communities. Characteristics such as image, status, and perceived competency with problem solving indicate community self-concept. Housing conditions, buildings, and cleanliness reflect community image. School systems, crime rates, accidents, and opinions about whether the community is considered a good place to live suggest community perception of self-worth. Competency with social and political issues as well as community spirit creates positive self-evaluation. Community pride facilitates development of innovative health programs. Emotional tone (fear, depression, or positive emotional outlook) relates to findings in other pattern areas. For example, tensions in the cognitive-perceptual pattern (conflict between groups concerning health issues) may explain a general feeling of fear among the residents. Data are obtained through observation and interviews.

**Roles-Relationships Pattern**

The Roles-Relationships Pattern identifies communication styles along with formal and informal relationships. Of particular concern are roles and relationships affecting community ability to realize health potential. Patterns of crime, racial incidents, and social networks form indices of human relationships in communities. Publicizing health promotion becomes more effective using patterns of official communication. Health program success depends upon support from prominent community members. Community members involved in health programs help identify other key community leaders. Use of media and other mass information programs improves communication, the flow of health information, and the number of community members reached. Interviews, television, the Internet and newspapers are examples of ways to obtain and convey information.

**Sexuality-Reproductive Pattern**

The Sexuality-Reproductive Pattern identifies reproductive data of communities, which is reflected in live birth statistics, mothers’ ages, ethnicity, and marital status. This information provides clues to the health-promotion needs of a particular community group. Premature infant rates, low–birth-weight infants, abortion rates, as well as neonatal, infant, and maternal death rates reflect reproductive patterns of communities. Such information identifies at-risk groups based on particular characteristics associated with these rates. Mismatches between existing health services, health education, and community health statistics also indicate health concerns. Availability of sex education in schools; spouse and child abuse; and sex-related crimes also indicate health-promotion issues. Minutes of meetings, health records, statistical data, and public documents provide sources for these data.

**Coping–Stress Tolerance Pattern**

The Coping–Stress Tolerance Pattern identifies community ability to cope or adapt. Communities respond to stress in different ways, some of which might threaten their integrity. Community responses reveal the group coping patterns. Communities develop abilities to exchange goods, services, goals, values, and ideals to survive and to promote community health. Community efforts to obtain goods from the environment, contain goods within the environment, retain goods within the community, and dispose of goods play significant roles to influence health. Examples of goods that communities obtain from the environment to promote health include local, state, or federal funding; health services; health-related workforce personnel; new knowledge; and technological advances. Some communities obtain abundant health care services; however, primary
services often remain inadequate or nonexistent. Lack of available health services, or lack of ability to obtain them, characterizes community health need. Examples of goods communities may attempt to control include sex-related crimes, diseases, substance abuse, industry, hazardous waste in the water supply, and noxious chemicals in the air.

Community coping patterns aim to retain certain health-protection services, such as immunization services for children and adequate health facilities. Coping efforts may also include strict zoning laws and housing codes or certain values such as sex education within the home. Expendable goods communities include industrial and human wastes. Data can be obtained through minutes of meetings, public documents, health surveys, statistical data, and health records.

**Values-Beliefs Pattern**
The Values-Beliefs Pattern identifies the community values and beliefs. Such information provides clues for health promotion and protection efforts valued by the community. Values underlie decisions about community health education and tax support for schools, hypertension screening for the public, prevention programs, or well-child clinics. Traditions, norms, and cultural and ethnic groups share values and beliefs in communities. Data can be obtained through interviews with key community members and health-related personnel.

**ANALYSIS AND DIAGNOSIS WITH THE COMMUNITY**
Analysis refers to data categorization and pattern determination. Data synthesis and organization occur to ascertain patterns of health activities and trends. An example of a clinical scenario about a particular community is presented in the Case Study and Care Plan at the end of this chapter. Decision-making and judgment inherent in the nursing process become most important during the analysis and diagnostic phases. Table 8-1 presents an example of one way to organize community data using Prochaska's stages of change (Clark, 2007; Prochaska & Norcross, 2006).

<table>
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<th>Table 8-1 Stages of Change</th>
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<td><strong>Stages</strong></td>
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**Organization of Data**
Charts, figures, and tables graphically display population distributions, morbidity and mortality data, or vital statistics to pinpoint significant community concerns with actual or potential health problems along with health-related responses to these concerns. Another valuable organizational technique, mapping, facilitates data analysis. For example, a series of maps can be used to display data that change over time. Analysis of several variables simultaneously occurs. Overlap of locations of environmental hazards, densely populated areas, health-promotion services, and major highways becomes apparent. Poor environmental conditions; distribution of illness, disease, and death rates; and the accessibility of health-protection and health-promotion activities for the population appear at a glance with dotted scatter maps. Use of maps requires knowledge about the community's population base. Less-populated geographical areas with fewer health facilities or fewer neonatal deaths in a community with fewer women of childbearing age are examples of how population statistics influence interpretation of mapping techniques. Using theoretical frameworks and Gordon's 11 pattern areas facilitates analysis of community data. Several guidelines, presented below, help community nurses analyze population data. Analysis often supports the need for further data collection.

**Guidelines for Data Analysis**

**Check for Missing Data**
Complexity, size, and number of community characteristics prohibit gathering all possible facts about the health-related pattern areas; however, missing or insufficient data that indicate areas for further assessment should be identified. Additional assessment may determine specific approaches or a particular community diagnosis. Examples of missing data in community assessment include pollution indicators, links between health resources and population groups, accessibility to resources, and morbidity statistics. Dates for census data used should be noted.

The nurse examines community data for incongruities and conflicting information. For example, a key community official might deny the existence of pollutants in the water supply, whereas newspaper reports of health department water analysis findings indicate otherwise. The nurse evaluates such inconsistencies before identifying existing or potential health concerns.

**Identify Patterns**
Clues about a community pattern emerge from subjective and objective data gathered. During this stage, community nurses make decisions, begin to formulate diagnostic hypotheses (ideas and tentative judgments about possible health concerns), identify community groups that might be at risk, and establish probable causes or relationships. Ideas generated from this activity direct the search for additional clues in the data to confirm, reject, or revise hypotheses. Judgments about hypotheses continue to support patterns in the data.
To narrow the huge list of possible community health-promotion and health-protection concerns, community nurses formulate broad problem statements based on the health-related pattern areas (Gordon, 2007). For example, the community nurse differentiates among elimination problems (noxious chemicals), coping and stress-tolerance problems, and health perception–health management problems (high teenage mortality rate from motor vehicle accidents). Developing these general categories facilitates analysis.

Apply Theories, Models, Norms, and Standards

Analyzing community data requires extensive knowledge about developmental, age-related risks, theories, concepts of nursing, public health, and epidemiology. Such a broad foundation enables nurses to identify additional clues in health-related patterns that contribute to community nursing diagnoses and intervention. Developmental approaches form a basis to identify groups with potential health concerns. Age groups vary in susceptibility; therefore, nurses examine community resources directed toward highly susceptible groups. For example, community data that indicates increases in live births among older women indicates a need for health-promotion services for this group. If community data show increasing numbers of aging citizens, nurses explore availability and accessibility of existing health services for this older group.

Analysis of data for common personal or environmental characteristics also occurs. For example, select groups may be at risk based on a shared health concern, such as substance abuse, lack of immunizations, unsafe housing conditions, high exposure to asbestos or noxious chemicals, or inadequate health services. Shared characteristics, such as race or ethnicity, provide clues to susceptibility and need for screening activities. For example, Black populations warrant screening for hypertension. Also if fluoridated water supply is unavailable, additional intervention to prevent dental caries in children is justified. In addition, community literacy contributes to health-promotion activity development methods used by nurses to establish educational programs. Literacy level limits the ability to use all available resources.

Environmental information is readily available on the Internet. Databases and search engines provide useful information about environmental hazards and other environmental problems in communities. Prevention of disease worldwide depends on the dissemination of global environmental health information (U.S. Department of Health and Human Services, 2007). Analysis of data relies on standards developed nationally or globally. For example, community data regarding air quality can be compared with state or national ambient air quality standards to determine health (Health Canada, 2006). In this context the term ambient refers to outside air in a town, city, or other defined region. Air-monitoring stations are generally located in urban and rural areas within each state (United States Environmental Protection Agency, 2006). One source for air quality information is the CHARTing Health Information website (www.sph.uth.tmc.edu/charting/) maintained by the University of Texas Health Science Center at Houston School of Public Health. The goal of this center is to serve as a resource in Texas for publicly available data to use for analysis and research. Data and links to other sites are continually monitored and updated (The University of Texas Health Science Center at Houston, 2007). Current information about community resources enables more effective strategies to prevent risk factors and avoid health problems. Internet access facilitates identification of gaps in health-promotion and health-protection services.

Identify Strengths and Health Concerns

Interpretation of community data occurs with regard to community concerns, community strengths, and feasibility studies. Community nurses make judgments and inferences about community health, community responses to health situations, and population needs. One approach assumes health concerns exist unless assessment data indicate otherwise (Gordon, 2007). Nurses make diagnoses based on summarized data using the nursing process, which results in one or more of the following determinations:

1. No problem exists, but providing health-promotion or health-protection services may address a potential health concern. For example, providing health education in the high school could offset a potential for increased sexually transmitted disease in the high school population.
2. A problem exists but is recognized by community members or health-related professionals with effective strategies for problem solving; for example, flu immunizations.
3. A problem exists that the community recognizes, but resources are inadequate or the community has not responded. Assistance is needed; for example, highway traffic noise.
4. A problem exists that the community recognizes but cannot cope with at this time, such as a lack of fluoridated water systems. Dentists, nurses, and nutritionists could be assigned to assist the community in resolving actual problems of dental caries.
5. A problem or potential health concern exists that needs further study; for example, lack of sidewalks.

Identifying community strengths integrates plans for health-promotion and health-protection activities. For example, a community may have nutritional feeding programs for older adults, women, and children that are underutilized. Community members may not use them because communication is inadequate. Examples of community strengths and concerns are shown in Table 8-2.

Identify Causes and Risk Factors

Data are examined for factors or characteristics that contribute to identified potential and existing health-related concerns. Nurses make inferences about population groups and identify risk factors. Identifying risk factors guides community
nursing actions. Some risk factors signify immediate health concerns, such as polluted water supply, whereas other risk factors indicate potential problems, such as lack of knowledge about childhood disease prevention. Nurses consider whether community risk factors can be altered, eliminated, or regulated through nursing actions. Nurses modify factors when possible by using strategies such as health education (Multicultural Awareness box).

**Community Diagnosis**

Community assessment, as previously described, culminates in nursing diagnoses. The community diagnosis process includes (1) community situations or states within a population or population group; (2) data collection using some combination of observation, interview, and measurement; (3) a framework; (4) existing or potential health concerns; (5) risk factors related to health concerns; and (6) potential solutions through nursing actions. Diagnoses form the basis for planning, implementing, and evaluating solutions to health concerns (Carpenito-Moyet, 2008; Clark, 2007; Gordon, 2007). The Hot Topics and Health Teaching boxes discuss a diagnosis of violence and some recommendations for problem reduction.

Community diagnoses facilitate communication among community health professionals, team members, and laypeople through the use of clear and concise nomenclature with development of diagnostic categories specific to community nursing (Carpenito-Moyet, 2008; Clark, 2007). Diagnoses may be written or stated according to the structural and functional aspects of a community.

Structural aspects include those related to the population, such as the demographic characteristics of groups with similar characteristics (preschool children, adolescents, or a high school population). Functional aspects include those related to the psychosocial, physiological, or spiritual health patterns, such as decision-making (cognitive-perceptual pattern) or communication links among health care resources (roles-relationships pattern). Functional health patterns guide data collection about health concerns and risk factors. Structural and functional aspects of the community provide a framework for diagnostic statements (see Chapter 6).

### PLANNING WITH THE COMMUNITY

Community health planning begins with nursing diagnoses. Nurses design goals to resolve existing or potential health concerns. For example, high rates of childhood diseases in the community require goals aimed to decrease rates. Identifying specific or potential health concerns with planned actions to achieve desired community outcomes provides the framework and data for community evaluation.

### Purposes

Major purposes of the planning phase include:

1. Prioritization of problems and diagnoses identified through assessment;
2. Differentiation of problems resolved through nursing actions from those best resolved by others;
3. Identification of immediate, intermediate, and long-term goals, as well as behavioral objectives oriented to the community derived from the goals and specific actions to achieve objectives; and
4. Formalization of a community nursing care plan (see the Care Plan at the end of this chapter) that includes written problems, actions, and expected behavioral outcomes.

### Comparing Poverty Rates by Racial and Ethnic Categories

Comparisons must take into account that racial and ethnic census categories were redefined in 2002. Blacks constitute 12.9% of the population (reported as Black or African American). This number and those that follow include the 0.6% of the population who reported as Black as well as one or more other races. Although Blacks are represented in every socioeconomic group, 24.1% live in poverty. This is a rate 3 times higher than the non-Hispanic White American rate (8.0%). Among people who reported themselves as being Asian American, 10.3% lived in poverty. Poverty rates have remained the same for non-Hispanic Whites and Asians when compared to the closest available data groupings from 2001. However, the poverty figures among people who reported being Black in 2002 show that there was an increase (U.S. Census Bureau, 2003).

Based on these figures, it seems that poverty is rising in the Black population. Most of the Black population (54%) lived in the South according to Census 2000. The remaining 46% was spread out over the rest of the United States. In areas other than the South, concentrations of the Black population were located in urban areas (McKinnon, 2000).
## Workplace Violence

The terrorist attacks on September 11, 2001, or 9/11, were a tragic reminder that targets often chosen by the terrorists are not military in nature. Targets may be places where people work to support their families. Workplace violence was put in a new context that day. Before then, workplace violence was considered as isolated, unplanned incidents that fell under the jurisdiction of the federal Occupational Safety and Health Administration (OSHA). Since 9/11, workplace violence prevention and preparation has included external threats of terrorism. With these new issues in mind, a document called *Workplace Violence: Issues in Response* was prepared to assist in prevention and management of potential workplace violence. The recommendations from this report included the following general categories:

1. Public awareness campaigns
2. Workplace policies and plans
3. Preventive law enforcement
4. Government agencies making workplace violence a priority
5. Training
6. Protection of the abused person when domestic violence or stalking occurs in the workplace
7. Development and distribution of clear and comprehensive legal and legislative guidelines
8. Evaluation of programs and strategies

Suggestions for approaches included the following strategies:

- Educational efforts should reflect cooperative efforts by government agencies, major corporations, unions, and advocacy groups, with OSHA acting as a facilitator and coordinator.
- Put multidisciplinary no-threats-no-violence policies and prevention plans in place.
- Violence prevention training should occur regularly and include practicing the plan.
- Work space and policies should provide a physically secure work environment.
- Preventive measures should be in place including documenting incidents, antiviolence planning, and conducting threat assessments.
- Systems should be developed for monitoring incidents of workplace violence.
- Resource lists should be maintained and include social service, mental health, legal, and other agencies that provide assistance.
- Training programs should extend community policing concepts to workplace violence.
- Government or private organizations should develop training materials for small employers.
- Employers should keep the abuser out of the workplace (e.g., screening telephone calls, making the victim’s work space physically more secure, instructing security guards or receptionists).
- Employers should provide resources for emotional, financial, and legal counseling.
- Clear, comprehensive, and uniform legal guidelines should be distributed widely.
- Incentives for employers should be identified and instituted.

## Health Teaching

### Intervention Techniques to Prevent and Diffuse Workplace Violence

**Recognize warning signs, which include changes in mood, personal hardships, mental health issues (e.g., depression, anxiety), negative behavior (e.g., untrustworthy, lying, bad attitude), verbal threats, and history of violence. Do not limit at-risk behavior to a standard profile. Environments should be designed to detect signs of impending violence and to prevent violence with security cameras, key card access, administrative controls, and behavioral strategies. Reporting systems should be confidential and seamless.**

- Use nonthreatening body language; build trust and direct; be open and honest.
- Keep your verbal communication simple, clear, and direct; be open and honest.
- Reflect on the person’s message to allow time for clarification, allow the person to verbalize, listen attentively, and stop what you are doing and give full attention.
- Ask for examples to help illustrate the points that are being made. Carefully define the problem, exploring with open-ended questions.
- Silence allows the individual time to clarify thoughts.
- Monitor the tone, volume, rate, and rhythm of your speech.
- Seek opportunities for agreement.
- Be creative and open to new ideas.

The planning phase culminates in a nursing plan that provides the framework for evaluation. Once developed, the plan is implemented. Costs associated with delivery of health services and personnel, as well as financial resources available, influence priorities for implementation. Community values and the nurse’s philosophy about people, health, the community, and nursing also influence implementation. High-priority issues often include infectious agents, sexually transmitted disease, alcohol and drug use, smoking, inadequate nutrition, inadequate infant and child care, high death rate from motor vehicle accidents, and unwanted teenage pregnancies.
Community participation in health planning facilitates effective assignment of priorities. As health service recipients, community members strive for reasonably priced, high-quality services. Residents aim to acquire appropriate benefits for the needs and concerns of the population. Communication and rationale for designating priorities help to resolve differences in opinion.

During the planning phase, nurses determine those problems most amenable to community nursing intervention, behavior implemented by the nurse to fulfill a health goal of the community. Community nurses differentiate problems nursing can resolve from those health concerns that could best be handled by community members, referred to health-related professionals, or handled with community support. Nurses refer problems related to rodents, poor sanitation conditions, or absence of community recreational facilities to appropriate community leaders or agencies.

Community nurses focus on determining goals, developing measurable behavioral objectives and designating actions to achieve expected outcomes. Nurses describe specific behaviors intended to reach projected outcomes. Evaluation includes appraisal of the effectiveness of nursing actions. Health planning emphasizes promoting and protecting population health; therefore, problems, solutions, and actions are defined at the group level. Community nurses plan and implement health plans for groups, such as school-aged children, and facilitate development of health-promotion services for all residents. Nurses frequently act as change agents by taking responsibility for influencing health patterns and behavior. Decisions about health interventions stem from community nurses’ appreciation of human behavior and principles of planned change. Website Resource 8B offers guidelines for interventions with one population group: ethnic elders.

Planned Change

Planned change results from efforts by individuals or groups and involves fundamental shifts in behavior (Prochaska & Norcross, 2006). Individuals act as agents of their own health conditions. Community health objectives often depend upon active decisions by individuals to change their lifestyles (reducing alcohol consumption or giving up smoking). Efforts to influence and reinforce changes in community health behavior become the central focus of effective risk reduction programs.

Studies attempt to explain why some groups of people effectively participate in certain health programs or make lifestyle changes, whereas others do not. The early health belief model proposed by Rosenstock (Rosenstock, 1974) and more recent models developed by Pender (Pender et al., 2006) and Prochaska (Prochaska & Norcross, 2006), among others, identify critical concepts for understanding how individuals change their health behavior. Rosenstock’s model includes the following four steps:

1. Perceiving behavior as a health threat in terms of susceptibility and seriousness;
2. Believing the behavior is a threat to their personal health;
3. Taking action to adopt preventive health behaviors; and
4. Reinforcing the behavior.

In Rosenstock’s model, community members take a passive role at first, then transition from passive to active between steps two and three (belief to action). Ultimately, to improve community health through risk reduction programs, community members assume more responsibility for their own health, become more active in adopting healthy lifestyles, and monitor resources in the community to gain healthy behaviors. In planning health-promotion activities, nurses consider effective strategies to motivate and support community transition from a passive to an active state.

Plans guide nursing actions. Nurses make additions and changes based on community problems, resources, and problem resolution to maintain a viable plan. Table 8-3 provides one example of a community-oriented, health-promotion plan based on the goals recommended by the Surgeon General’s report about health promotion and disease prevention. The report’s general goal generates several specific objectives. Nursing diagnoses guide the direction of the objectives including risk factors to address. Examples of various rationales in Table 8-3 show how nurses incorporate important concepts of planned change into community-based health-promotion plans.

Communicating plans to other health professionals, community members, and key officials remains an essential aspect of planning. Local newspapers, local bulletins, and school correspondence to parents provide avenues to communicate with the community about health-promotion plans. Other community-based actions for nursing involvement in prevention of alcohol abuse in the community are listed in Box 8-1. The various plans have been categorized according to the health patterns to show that a community problem can be approached from many directions. Feasible plans that are well formulated facilitate implementation (U.S. Department of Health and Human Services, 2005).

Box 8-1 Plan Options for Community-Based Action: Alcohol Abuse

**Coping-Stress Tolerance Pattern**
- Identify community alcohol treatment resources.
- Develop local alcohol control laws oriented toward prevention of abuse; develop consistent state regulation and control laws.

**Roles-Relationships Pattern**
- Increase communication among community control agencies, the school, residents, and health-related agencies.
- Restrict community advertisements for alcohol in local newsletters and newspapers.
CHAPTER 8

IMPLEMENTATION WITH THE COMMUNITY

Implementation of the nursing process begins based on the health-promotion and health-protection plans. In collaboration with community members or other health team members, the nurse tests feasibility and implements the plan. Success depends on intellectual, interpersonal, and technical skills as well as on how well the community members accept the plan. Success also depends on overcoming expected resistance to change. Resistance to new health-promotion and health-protection activities, however, provides useful feedback to use to improve planning. People generally resist change to defend values that appear to be threatened by the change. Table 8-4 lists factors that deter community participation. Informed nurses take steps with community members to ensure the successful implementation of plans.

Community nurses implement health-promotion and health-protection plans in multiple community settings (schools, industry, public and private health agencies, and ambulatory care settings) where population groups experience relatively good health. Nursing centers provide nursing faculty, staff, and students unique opportunities to assess health and plan, implement, and evaluate care (including holistic health promotion and primary health care) to individuals, families, and communities with unmet health care needs (Rothman et al., 2005; Wilde et al., 2004). Complexity of health actions varies from one community to another. As plans evolve, nurses learn more about the community and their own responses, strengths, limitations, and abilities to cope or adapt (Baker et al., 2002).

Table 8-3

<table>
<thead>
<tr>
<th>Objective</th>
<th>Plans</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1. Community will have access to information about the incidence of fatal motor vehicle accidents and substance abuse in the community. Interview local police about the incidence of fatal auto accidents and substance abuse in the community. Interview parents of deceased high school students, students, teachers, physicians, clergy, and emergency room personnel about the incidence of the problem and suggested measures for decreasing the incidence; suggest that interviews be broadcast over the high school station. Have several people write to the community newspaper commenting on the broadcast and the problem.</td>
<td>Unfreezing: For change to occur, the community has to become dissatisfied with status quo and sense a need for change. Empiric-rational strategy: People are rational; discussion of facts can bring about support for change. Important elements for preventing the problem include educating the public and having key community leaders discuss their views; concern lends credibility and is necessary for action. People tend to listen to those with informal power. Keeping the issue before the community can raise consciousness.</td>
<td></td>
</tr>
<tr>
<td>2. Community will take action to inform the population at risk about responsible drinking and driving by June. Suggest to school principal and school board the creation of a task force of community residents to plan a health program on individual responsibility and alcohol use in high school. Task force should include teachers, students, parents, clergy, police, nurse, and physician. Task force will examine ways to determine and teach content, integrate it into the curriculum, and recommend that community members, such as a nurse, be involved in teaching content.</td>
<td>Changing: Moving to a new level; community involvement will influence acceptability of changes. Community residents like to be involved in decision-making. It is important to establish trust and collaboration between community groups; this opens communication channels between adolescents and the health community. Community involvement facilitates acceptance of change.</td>
<td></td>
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<tr>
<td>3. Community will implement and educational program for its high school population related to the use of alcohol and individual responsibility. Implement educational plans.</td>
<td>Refreezing: Moving to the level of change brought about by community forces. Educational strategies built around the concept of individual responsibility are essential elements in promoting the health of young adults.</td>
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Although implementation takes an action focus, it also includes assessment, planning, and evaluation activities to monitor actions taken to resolve, reduce, eliminate, or control the health concern.

**EVALUATION WITH THE COMMUNITY**

During the evaluation phase of the process, community nurses learn whether planned actions achieved desired outcomes. Communities and nurses determine progression toward goal achievement (Clark, 2007). Nurses take responsibility for evaluation, although community members or health team members may participate in the process. For example, if implemented plans intended to reduce the incidence of fatal motor vehicle accidents, nurses take the responsibility to obtain community outcomes data, which should reveal reduced fatalities and the nursing actions that contributed to these outcomes.

Nursing plans, which include nursing diagnoses, expected outcomes, and interventions, provide the evaluation framework. With a community focus, goals and objectives define the evaluation, considering how the community responded to planned actions. For example, if childhood disease rate reduction is expected to result from certain nursing actions, community responses before the actions are compared to those after the actions. This comparison determines the level of effectiveness (complete, partially effective, or ineffective) of the nursing actions to achieve the goal.

The community nurse approaches the dynamic process of evaluation in a purposeful, goal-directed manner (Clark, 2007; U.S. Department of Health and Human Services, 2007). Determining effectiveness of nursing actions evaluates the degree to which goals are achieved. Frequency of evaluation depends on situations, changes expected, and objectives. For example, an individual who is bleeding may need evaluation at frequent intervals, whereas behavioral changes in community groups occur slowly and require less frequent evaluation intervals. Evaluation intervals vary depending upon immediate, intermediate, and long-range goals. The evaluation process is continued until the community realizes the established goals.

Community nursing plan evaluation results indicate needs for reassessment, revision, or modification of plans. Community nurses reassess situations, plan new approaches, then implement and evaluate revised plans creating the continual cycle of the nursing process. Self-evaluation determines strengths and weaknesses as well as ways the nursing plan could have been more effective or efficient. The quality of community health-promotion and health-protection depends on the professional qualities of those providing services along with effective use of the nursing process.

Workable, cost-effective programs of community health promotion are needed. Nurses play an important role in providing evidence to support effective community health plans. Historically documentation of effective health promotion activities has been limited (Tagliareni & King, 2006). Effectiveness is determined through research studies that include analyses and outcome evaluation of home-based and community-centered nursing interventions designed to meet needs of high-risk families, geographical communities, and vulnerable populations. For example, in a study of the implementation of a new protocol for management of leg ulcers by community health nurses, the researchers were able to demonstrate improvement in healing with fewer nursing visits and a statistically significant decrease in cost per case (Harrison et al., 2005). Such evidence-based practice and research help to garner support for community health-promotion programs. The Healthy People 2010 Toolkit: A Field Guide to Health Planning (2002) (www.healthypeople.gov/state/toolkit/toolkitAll2002.pdf) includes examples of national and state partnerships setting health objectives and sustaining the initiatives (U.S. Department of Health and Human Services, 2007).

**SUMMARY**

Risk factors, injury, and disease are not inevitable events experienced equally among a community’s members. Effective community nurses understand the dynamic and complex nature of communities. Nurses use various theoretical frameworks to assess health-related patterns, health concerns, and health action potential and to implement the nursing process within communities. Collection and analysis of community data identify at-risk subpopulations. Planning contributes to the development of effective and efficient health-promotion and health-protection services. Nursing process enhances the efficacy of planning activities.

### Table 8-4: Potential Sources of Resistance to Health-Promotion Programs, with Agent Responses

<table>
<thead>
<tr>
<th>Source of Resistance</th>
<th>Response</th>
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<tbody>
<tr>
<td>Lack of communication about the implementation of the program</td>
<td>Communicate through community newsletter, newspapers, high school radio station, and posters</td>
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<tr>
<td>Misinformation regarding time and place of healthy activity</td>
<td>Disseminate valid information</td>
</tr>
<tr>
<td>Fear of the unknown</td>
<td>Inform and encourage Clarify intentions and methods</td>
</tr>
<tr>
<td>Need for security</td>
<td>Demonstrate opportunity for change</td>
</tr>
<tr>
<td>No desired need to change behaviors</td>
<td>Enlist key community leaders in planning change</td>
</tr>
<tr>
<td>Cultural or religious beliefs or vested interests threatened</td>
<td>Focus activities near the largest target population and in an area accessible by public transportation</td>
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</tbody>
</table>
Many communities experience obvious deficiencies in health services that warrant health planning action. Community nurses play a significant role in health planning directed toward reducing risks associated with disease, premature death, and injury as well as health promotion among community members. Nurses use principles of planned change to increase community awareness of health, healthy behavior, and participation in preventive health services. Complexity varies from one community or geographical area to another. Community nurses connect health-promotion actions to specific community phenomena providing scientific evidence that supports the benefits of nursing actions.

**CASE STUDY**

Community Efforts to Decrease Adolescent Pregnancy Rates

The community health nurse is facilitating a grassroots community group that is determined to decrease the adolescent pregnancy rate in the city. The community population hovers around 100,000. It is a community that lies on the Mexican border of the United States. The population is predominantly Mexican American, and there is a high poverty rate.

The schools offer health courses twice between seventh and twelfth grades. The only formal sex education provided occurs within the context of these two health courses. There is community opposition to increasing the amount of sex education in the curriculum. A community group that has researched the problem has decided to use a social marketing approach because of this community resistance.

Most of the materials reviewed do not address the cultural needs of the region. Many of the Spanish language materials use Spanish from countries other than Mexico. The situations posed in the audiovisual materials show people who the adolescents will perceive as different from themselves.

Reflective Questions:
1. How could the community group approach their goal to decrease the adolescent pregnancy rate in a manner that will be culturally competent?
2. How might the community group approach this issue without the support of the school district?

**CARE PLAN**

Community Efforts to Decrease Adolescent Pregnancy Rates

**Nursing Diagnosis:** Risk for Ineffective Community Coping Related to Increased Levels of Teen Pregnancy

**DEFINING CHARACTERISTICS**

- Absence of education or support for sexually active teenagers
- Absence of programs for pregnancy testing, counseling, or teaching young women to care for infants
- Absence of sex education in the home, school, and community
- Community conflicts over what to teach adolescent and preadolescent children about sex
- Failure of teenagers to perceive long-term effects of having babies
- High incidence of infants who are born prematurely or with health problems
- High rate of teen pregnancy
- Lack of access to birth control pills or devices for teenagers
- Lack of community support for preventing teen pregnancy

**RELATED FACTORS**

- Community members’ lack of knowledge about causes and contributing factors in teen pregnancy
- Inadequate community resources for preventing teen pregnancy

**EXPECTED OUTCOMES**

- Community members express awareness of the seriousness of the high adolescent pregnancy rate in their community.
- Community members express the need for a plan to reduce the prevalence of teen pregnancies.
- Community members develop and implement plans to prevent teen pregnancy.
- Community members evaluate the success of the plan in meeting goals and objectives.
- Community members continue to revise the plan to prevent teen pregnancy.

**INTERVENTIONS**

- Lack of adequate communication patterns and community cohesiveness regarding strategies to prevent teen pregnancy
- Assess teenagers’ knowledge about sex and sexuality to determine their educational needs.
- Work with schools to develop pregnancy prevention programs that provide adolescents with information about the risks, problems, and complications of early pregnancy.
- Work closely with individual adolescents who are pregnant to assess their needs and provide care.
• Implement an outreach and health-promotion program to raise community members’ awareness of the need to approach teen pregnancy as a community problem. Consider taking the following five steps:
  • Work with teachers, school psychologists, counselors, school nurses, students, and the parent-teacher association to determine the extent of the teen pregnancy problem.
  • Encourage local youth groups, churches, and social service organizations to feature presentations on pregnancy prevention at their meetings.
  • Contact representatives of local corporations to ask for funding for educational programs.
  • Help community members (school nurses, counselors, and teachers) recognize adolescent girls who need counseling regarding such issues as peer pressure to be sexually active and the long-term consequences of pregnancy. Remind community members of the importance of listening attentively and remaining nonjudgmental.
  • Provide education on birth control measures (including abstinence from sex) and make this information available at school.

• Establish clubs for adolescent girls in the community. The goal of these clubs is to foster self-esteem. During club meetings, members should have the opportunity to openly discuss difficult questions, such as why girls consider a baby a status symbol and how to respond to peer pressure to be sexually active. Improved self-esteem has been found the most effective way to reduce teen pregnancy rates.

• Encourage adolescents to participate in peer support networks where they can openly discuss social and dating pressure and other issues related to teen pregnancy, to allow them an opportunity to express their feelings openly and obtain support from peers.

• Encourage community members to establish school-based clinics in which teens can have access to reproductive system models, pregnancy tests, and nonprescription birth control measures to support the teenagers who make the decision to protect themselves from unwanted pregnancies.

• Develop a list of referrals for teenagers, such as hospitals with human sexuality courses, charities that provide prenatal care and childbirth services, women’s clinics, and Planned Parenthood, to compensate for restricted access to information in the adolescent’s home or school.

• Encourage community members to implement an information campaign to educate adolescents, parents, and community members about the problems associated with teen pregnancy.

• Work with community members to evaluate the effectiveness of the teen pregnancy prevention program and assist in modifying it as needed to ensure its effectiveness and promote the program as a model for preventive health.

• Collect statistical data from the schools to analyze the teen pregnancy rates, to help evaluate the effectiveness of the prevention program.


REFERENCES

The University of Texas Health Science Center at Houston. (2007). CHARTing health...