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Area of Responsibility I: Assess Needs, Assets and Capacity for Health Education (12% of CHES exam)

Introduction: Primary purpose of needs assessment = determine what health education activities are appropriate in a given setting.

Needs assessment: systematic, planned collection of information about the health knowledge, perceptions, attitudes, motivation and practices of individuals or groups and the quality of the socioeconomic environment in which they live.

Assessment of needs should precede program planning
To conduct a needs assessment, it is necessary to identify health related database and valid sources of data. Also to gather data with reliable instruments, apply survey techniques and identify behaviors that influence health (interviews, focus groups, etc.)

Primary Data: data gathered by the health education specialist directly
Secondary Data: data that have been already collected by others and may not be directly gathered from the individual or population being assessed (ex. Census records, Disease Registries)

Competency 1.1 Plan Assessment Process

1.1.1 Identify existing and needed resources to conduct assessments - 6 step process: a) determine the scope of work and purpose of the needs assessment b) gather the data c) analyze the data d) identify any factors linked to the health problem e) identify the focus of the problem f) validate the need before continuing with the planning process

1.1.2 Identify stakeholders to participate in the assessment process – MCHES LEVEL

1.1.3 Apply theories and models to develop assessment strategies – common models include
   a) Epidemiological model: focus on epidemiological data (birth rates, death rates, etc.)
   b) Public health model: quantify health data
   c) Social model: investigates social or political issues that influence health
   d) Asset model: focuses on strength of community and looks to find ways to use existing assets to improve health
   e) Rapid model: used when time and money are lacking for needs assessment, offered basic information

1.1.4 Develop plans for data collection, analysis, and interpretation

1.1.5 Engage stakeholders to participate in the assessment process – MCHES LEVEL

1.1.6 Integrate research designs, methods and instruments in to assessment plan

Competency 1.2 Access Existing Information and Data Related to Health

Information can be primary data (pieces of information the health education specialist collects to answer unique questions about the specific needs assessment) or secondary data (data collected previously for some other purpose and are available for use by others).

1.2.1 Identify sources of data related to health – often using current literature review

1.2.2 Critique sources of health information using theory and evidence from the literature

1.2.3 Select valid sources of information about health

1.2.4 Identify gaps in data using theories and assessment models

1.2.5 Establish collaborate relationships and agreements to facilitate access to data

1.2.6 Conduct searches of existing databases for specific health-related data
Competency 1.3 Collect Quantitative and/or Qualitative Data Related to Health

**Quantitative Data**: numerically describe what is happening

**Qualitative Data**: not numerical, usually descriptions of what is happening

1.3.1 Collect primary and/or secondary data

*Examples of Primary Data*: surveys, interviews, observations, community forums, focus groups, nominal group process, Delphi panel, self-assessment instruments, community capacity inventory or community asset map.

**Nominal Group Process**: a few representatives from the priority population are asked to respond to questions based on specific needs. Privately rank ideas and then share ranking in round robin style.

**Delphi Panel**: group process generates consensus by using a series of mailed or e-mailed questionnaires. Involves decision makers, staff and program participants.

**Community Capacity Inventory**: list of skills and assets of community

**Community Asset Maps**: physical map of available resources (libraries, parks, churches, etc.)

*Examples of Secondary Data*: epidemiological data (birth rates, death rates, incidence and prevalence)

1.3.2 Integrate primary data with secondary data

1.3.3 Identify data collection instruments and methods – ex: email, telephone, face to face

1.3.4 Develop data collection instruments and methods

1.3.5 Train personnel and stakeholders regarding data collection

1.3.6 Use data collection instruments and methods

1.3.7 Employ ethical standards when collecting data – informed consent: the agreement to voluntarily and willingly participate in a study based on a full disclosure of what constitutes participation in the study as well as risks and benefits. **Institutional Review Board (IRB)**: composed of researchers and community members or stakeholders who review proposed research for compliance with federal regulations governing research involving human subjects. **Health Insurance Portability and Accountability Act (HIPAA)**: protect personal health information. In order for health data to be used, individual permission must be granted, with some exceptions.

Competency 1.4 Examine Relationships Among Behavioral, Environmental and Genetic Factors that Enhance or Compromise Health

1.4.1 Identify factors that influence health behaviors

a) **Behavioral (lifestyle) Factors**: behaviors or actions of individuals, groups or communities. May include compliance, consumption and utilization patterns, coping, preventative actions and self-care.

b) **Environmental Factors**: determinants outside of the individual that can be modified to support behavior, health and quality of life. Example: economic factors, physical factors, public services and access to and affordability of health services.

c) **Individual Factors**: educational, social and cultural characteristics of the individual. Include knowledge, attitude, beliefs and perceptions related to health.

1.4.2 Analyze factors that influence health behaviors – behavior has multiple influences including factors at the intrapersonal, interpersonal, organizational, community and public policy levels.
1.4.3 Identify factors that enhance or compromise health—biological factors, environmental factors, lifestyle factors, psychosocial factors (poverty, stress, cultural factors) and the use of and access to health services.

1.4.4 Analyze factors that enhance or compromise health—identify factors that are most important and most changeable to determine program goals and objectives.

Competency 1.5: Examine Factors that Influence the Learning Process

1.5.1 Identify factors that foster or hinder the learning process—discover knowledge base of target audience. Factors that hinder learning process include lack of time, schedule conflicts, attitudes, or other stressors. Factors that foster learning may be positive attitudes, community connectedness and self-interest.

1.5.2 Analyze factors that foster or hinder the learning process—MCHES level

1.5.3 Identify factors that foster or hinder attitudes and beliefs

1.5.4 Analyze factors that foster or hinder attitudes and beliefs—plan program to address negative attitudes and beliefs or encourage positive attitudes and beliefs

1.5.5 Identify factors that foster or hinder skill building—MCHES level

1.5.6 Analyze factors that foster or hinder skill building—MCHES level

Competency 1.6: Examine Factors that Enhance or Compromise the Process of Health Education

Factors that should be identified are:

a) **Predisposing Factors**: individual knowledge and affective traits

b) **Enabling Factors**: factors that make possible a change in behavior

c) **Reinforcing Factors**: feedback and encouragement results from a changed behavior

1.6.1 Determine the extent of available health education programs, interventions, and policies

1.6.2 Assess the quality of available health education programs, interventions, and policies

1.6.3 Identify existing and potential partners for the provision of health education services—identify gaps or overlaps in existing services

1.6.4 Assess social, environmental, and political conditions that may impact health education—ex: social stigma associated with disease, conditions of the learning environment, physical environment and safety, political climate related to controversial topics like teen pregnancy.

1.6.5 Analyze the capacity for developing needed health education— a) identify community resources, skills, abilities, networks, talents, etc. b) create or strengthen the relationship between community members and community organizations c) mobilize the community around its strengths/resources d) rally the community to develop a health vision of the future and e) introduce any outside resources to fill gaps.

1.6.6 Assess the need for resources to foster health education—analyze data from needs assessment. Identify and prioritize health problems, prioritize strategies to address them and identify resources to support them. **Resource inventory**: identify gaps or needs in health education services and the delivery of those services. At this stage, health educators can begin to outline a preliminary budget as well as search for funding opportunities.
Competency 1.7: Infer Needs for Health Education Based on Assessment Findings
Validate the needs identified in the assessment

1.7.1 Analyze assessment findings – a) analyze data, primary and secondary b) compare data with local, state, national or historical situation c) consider social, cultural, and political environment d) set priorities by assessing size/scope of problem, determining the effectiveness of possible interventions and determining appropriateness, economics, acceptability, resources and legality of the possible intervention.

1.7.2 Synthesize assessment findings – MCHES level

1.7.3 Prioritize health education needs - Primary prevention: targeted towards health individuals to attempt to reduce risk for illness or injury. Secondary prevention: often involve screenings to help diagnose existing disease so a person can seek treatment. Tertiary prevention: focus on rehabilitation after a major health event or diagnosis. Health Education specialists can prioritize health needs using the following criteria: a) assess the size or scope of problem b) determine effectiveness of possible interventions c) determine appropriateness, economics, acceptability, resources and legality of intervention.

1.7.4 Identify emerging health education needs – consider whether an intervention can make a change in the health problem and whether the health problem is important enough to address.

1.7.5 Report assessment findings
Area of Responsibility II – Plan Health Education (15% of CHES exam)

Competency 2.1: Involve Priority Populations and Other Stakeholders in the Planning Process –
**Stakeholders**: groups of key people, often include those involved in the program operations, those served or affected by the program, and the primary users of the program

2.1.1 **Incorporate principles of community organization** - organize at the grassroots level to involve populations that will be affected; provide a sense of ownership and empowerment among those in the population of interest. In general includes a) recognition of the issues b) entrance of health education specialists in to the community to help organize citizens c) community assessment d) priority setting e) selection and implementation of an intervention f) evaluation and reassessment of the action plan.

2.1.2 **Identify priority populations and other stakeholders - target audience**: individuals who are part of the at-risk population. **Participants**: individuals who receive the intervention or participate in the program.

2.1.3 **Communicate need for health education to priority populations and other stakeholders** – communication channels include intrapersonal, interpersonal, organization and community, and mass media

2.1.4 **Develop collaborative efforts among priority populations and other stakeholders** – often referred to as coalitions. Bringing together of representatives from diverse organizations, segments or constituencies within the community to work toward a common goal. Additionally, they bring together a combination of resources and expertise. Steps for an effective coalition: a) analyze the issue on which the coalition will focus b) create awareness of the issue c) conduct initial coalition planning and recruitment d) develop resources and funding for the coalition e) create coalition infrastructure f) elect coalition leadership g) create an action plan.

**Partnership**: when your organization pairs with just one community organization, often less challenging and complex than a coalition. Drawback = limited resources.

2.1.5 **Elicit input from priority populations and other stakeholders** – include, individuals who represent various groups within the priority population, representatives of other stakeholders not represented in the priority population, and individuals who have key roles within the organization sponsoring the program. Remove obstacles to obtaining input from these individuals.

2.1.6 **Obtain commitments from priority populations and other stakeholders** – important to have support from community leaders such as elected officials, clergy, influential members of the community, health departments, print media, etc. Also, identify members of the community to be part of the planning committee.

Competency 2.2: Develop Goals and Objectives

Goals help measure a program’s processes and outcomes. **Processes** include program components, activities, delivery, and time frame. **Outcomes** include short term changes (knowledge, attitudes, skills, behavior) or long-term changes (behavior adherence, health status).

2.2.1 **Use assessment results to inform the planning process – MCHES level**

2.2.2 **Identify desired outcomes utilizing the needs assessment results**
2.2.3 Select planning model(s) for health education – entry level health education specialists should have working knowledge of planning models commonly used:

a) **PRECEDE-PROCEED**: most used formal planning model.
   - phase 1: Social Assessment - define quality of life
   - phase 2: Epidemiological Assessment: identify the health problems of the population and determine and prioritize behavior (individual) and environmental (external) risk factors
   - phase 3: Education and Ecological Assessment: determine predisposing (individual knowledge and affective traits), enabling (those that make possible a change such as skills) and reinforcing (feedback and encouragement) factors
   - phase 4: Administrative and Policy Assessment: determine the resources available
   - phase 5: Implementation: select strategies and activities, begin program.
   - phase 6: Process evaluation: document program feasibility
   - phase 7: Impact evaluation: assess the immediate effect of an intervention
   - phase 8: Outcome evaluation: determines whether long-term program goals met

b) **MATCH: Multilevel Approach to Community Health**. Recognizes that intervention planning should be aimed at multiple objectives and a variety of individuals
   - phase 1: goals selection
   - phase 2: intervention planning
   - phase 3: program development
   - phase 4: implementation preparations
   - phase 5: evaluation

c) **Social Marketing for Community Level Planning**; designed to influence the voluntary behavior of an audience to achieve a social, rather than financial, objective. Includes “marketing mix” - encompassing price, place, promotion and product.

d) **Health Communication for Community Level Planning**: process of informing a priority population about a health issue. Includes media advocacy, written materials and other interactive communication. Uses interpersonal, small group, organizational, community and mass media channels.

e) **CDCnergy**: help to understand the priority population and what communication strategies will best help priority population change health behavior
   - phase 1: define and describe the problem
   - phase 2: analyze the problem
   - phase 3: identify and profile the audience
   - phase 4: develop communication strategies
   - phase 5: develop evaluation plan
   - phase 6: launch the plan and obtain feedback

2.2.4 Develop goal statements – MCHES level
2.2.5 Formulate specific, measurable, attainable, realistic and time-sensitive objectives – MCHES level
2.2.6 Assess resources needed to achieve objectives – include human resources and tangible resources (computers, paper, office space, etc.)

Competency 2.3: Select or Design Strategies and Interventions

2.3.1 Assess efficacy of various strategies to ensure consistency with objectives – MCHES level
2.3.2 Design theory-based strategies and interventions to achieve stated objectives
2.3.3 Select a variety of strategies and interventions to achieve stated objectives – should be based on theory, available resources and reasonable fit.
Strategy examples:

a. Educational strategies: associated with classroom based courses, workshops, distance learning courses or seminars (health fairs, field trips, social networking).

b. Health Engineering Strategies: change the social or physical environment in which people live or work. Impact large number of people; may change behavior by influencing awareness, attitudes and knowledge. Ex (including only health options in vending machine).

c. Community mobilization: directly involve participants in change process. Ex (coalition building and lobbying, community advocacy).

d. Health communication strategies: use all types of communication channels (print media, radio, tv, billboards, email) to change behavior. Communication may also provide cues for action and provide reinforcement of behaviors.

e. Health Policy and Enforcement strategies: mandate action through laws, regulations, policies or rules implemented to protect the public’s health.

f. Health related community service strategies: services, tests or treatments to improve the health of the priority population. Ex (blood pressure screenings, breast self-exams).

2.3.4 Comply with level and ethical principles in designing strategies and interventions – abide by a Code of Ethics for the Health Education Profession as well as HIPPA.

2.3.5 Apply principles of cultural competence in selecting and designing strategies and interventions – cultural competence is the ability of an individual to understand and respect values, attitudes, beliefs and morals that differ across cultures, and to consider and respond appropriately to these differences in planning, implementing and evaluating a health education and promotion program and intervention.

2.3.6 Pilot test strategies and interventions - ensure that messages and images are clear and consistent, culturally relevant and motivational.

Competency 2.4: Develop a Scope and Sequence Plan for the Delivery of Health Education

2.4.1 Determine the range of health education needed to achieve goals and objectives – decide what and how much information will be discussed regarding a specific health topic during the health education program. Consider: needs assessment data, culture of priority population, literacy level of population, previous experience with health issue, budget constraints, time restrictions and available space.

Program should include learning objectives to help facilitate learning process and should use the 10 learning principles below:

1. use several senses
2. actively involve participants
3. provide an appropriate learning environment
4. assess learner readiness
5. establish the relevance of the information
6. use repetition
7. strive for a pleasant learning experience
8. start with the known and move towards the unknown
9. generalize the information
10. appropriately pace delivery of the information

2.4.2 Select resources required to implement health education – important that materials are culturally appropriate
2.4.3 *Use logic models to guide the planning process* - logic models depict programmatic milestones in a flowchart that leads to program results. Include inputs, activities, outputs, outcomes and impact.

2.4.4 *Organize health education into a logical sequence* – MCHES level

2.4.5 *Develop a timeline for the delivery of health education* – MCHES level

2.4.6 *Analyze the opportunity for integrating health education into other programs*

2.4.7 *Develop a process for integrating health education into other programs*

**Competency 2.5:** Address Factors that Affect Implementation
Assess what is needed for program creation and delivery prior to implantation.

2.5.1 *Identify factors that foster or hinder implementation* – barriers may include lack of community support, agency administration support or funding, overextended health education specialists, lack of coordination or territorial issues among local agencies. Positive attitude, sense of humor can help overcome these barriers.

2.5.2 *Analyze factors that foster or hinder implementation*

2.5.3 *Use findings of pilot to refine implementation plans as needed*

2.5.4 *Develop a conducive learning environment* – psychological and physical characteristics.

**Psychological:** students feel comfortable, mix of instruction and methods of examination, open community, learning aids and consistency. **Physical:** learning environment must be clean, safe, lighted, well equipped, heated or cooled as needed.
Area of Responsibility III: Implement Health Education (24% of CHES exam)

Competency 3.1: Implement a Plan of Action - describes how goals and objectives will be achieved, identifies resources needed and how responsibilities will be assigned; developed in conjunction with members of the intended audience and those who can hinder or help implementation of the program.

Five Generic Phases of the Implementation Process:
1) Engagement of individuals or organizations that make a decision to adopt an intervention or program.
2) Specify tasks and estimate resources
3) Establish a system for program management
4) Put the plans into action – accomplished through pilot testing, phasing-in or total implementation. Piloting (field testing) allows for trial run on small scale, best if done with members of priority population in same setting by same individuals as full implementation. Phasing in: program offered in increments. Total implementation: entire program begins at same time.
5) Ending or sustaining a program or intervention-determine how long a program should run. Consider program outcomes, types of resources needed and support from community partners.

3.1.1 Assess readiness for implementation – determine capacity among stakeholders. When and where necessary, facilitate capacity building among stakeholders to increase readiness to move program forward.
3.1.2 Collect baseline data - review qualitative and quantitative data to assess health knowledge, beliefs, attitudes and values of the intended audience related to the health topic. Often, primary data collection is required. Secondary data (data collected for another purpose) might also be used, such as a US census.
3.1.3 Use strategies to ensure cultural competence in implementing health education plans – a sign of cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used to increase the quality of services, and improve outcomes. This means providing an environment in which people from diverse backgrounds feel comfortable. Health literacy – differs from general literacy in that it takes into account the setting or situation in which the reading and writing occur. Literacy level, preferred language and preferred media sources should be considered when delivering health messages. A higher percentage of adults in the below basic level of literacy get health information from TV and radio. When working with those with Limited English Proficiency (LEP) health information should be communicated plainly in primary language, using words and examples to make information understandable.
3.1.4 Use a variety of strategies to deliver a plan of action – behavior is multifaceted; therefore, multiple strategies are often needed to change behavior. Strategies may include intervention for groups or individuals, organizational, community, environmental or policy change levels.
3.1.5 Promote plan of action – use tailored messages: individually focused messages that appeal to a specific sub-population, typically using information obtained from the individuals themselves.
3.1.6 Apply theories and models of implementation – theories and models used in designing interventions allow health education specialists to select strategies for implementation based on what is known about influences on human behavior. Common theories used include:
   a. Social Cognitive Theory - states that learning is an interaction between a person and his/her environment, cognitive processes and behavior: referred to as reciprocal determinism. Key Constructs = behavioral capacity, expectations, expectancies, self-control, emotional coping responses, reciprocal
determinism and self-efficacy. Self-efficacy: a person’s confidence in performing a behavior and overcoming possible barriers to that behavior.

b. Trans theoretical Model: also called, the Stages of Change Model, incorporates components of many different theories; useful in that planned intervention can target people where they are in their motivation for a particular behavior. Key constructs = stages of change, processes of change, decisional balance, and self-efficacy. Appropriate materials and strategies for individuals would depend on each person’s readiness of change his/her behavior. Change occurs as people move through a series of stages to adopt a new behavior. Pre-contemplation: person is not intending to take action in the next 6 months, person may be unaware of or in denial about problem. Contemplation: person is aware of problem and is intending to take action in the next 6 months. Preparation: person is intending to take action in the immediate future, usually in the next month. Action: person has taken action (changed behavior) in the past 6 months. Maintenance: person has changed behavior and has maintained the change for more than 6 months. Termination: person has no temptation to return to old behavior and has 100% self-efficacy.

c. Health Belief Model: individual level model first developed to understand why individuals did not act on information about prevention or disease detection. Key constructs = perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action and self-efficacy.

d. Theory of Reasoned Action and Theory of Planned Behavior: recognize behavioral intention is key to determining behavior and assume that behavior change is influence by person’s attitude towards the outcome and the social or subjective norms. TPB adds construct of behavioral control. Theory used to examine motivation to perform behavior, determine what peers think of behavior and assess the difficulty the individual will have in performing the behavior.

e. Diffusion of Innovations Theory: community level theory that describes the rate at which a new program or activity will spread throughout a group of people; communication channels are used to integrate a new idea to the community. Innovators: first to adopt behavior. Early adopters: wait until after innovators adopt. Early Majority: adopt once the opinion leaders have done so. Late Majority: adopt once the new idea or program becomes the norm. Laggards: the last to adopt or may never adopt.

f. Ecological Models: focus attention on the interaction of the individual and environment, which requires the health education specialist to be familiar with individual behavior change strategies as well as strategies for policy and environmental change. Five levels of health promotion strategies: individual, interpersonal, organizational, community and public policy.

3.1.7 Launch plan of action – health education specialist works to facilitate relationships between organizations and groups. This can fall into one of four levels: networking – exchanging information for mutual benefit, coordinating – exchanging information and altering activities for mutual benefit and to achieve a common purpose, cooperating - exchanging information, altering activities, and sharing resources for mutual benefit and to achieve a common purpose, and collaborating – exchanging information, altering activities, sharing resources, and enhancing the capacity of another for mutual benefit and to achieve a common purpose.

Competency 3.2: Monitor Implementation of Health Education

3.2.1 Monitor progress in accordance with timeline – use methods such as the Gantt method, Program Evaluation and Review Technique (PERT) and a Critical Path Method (CPM). Allows health education specialist to visually identify progress of project implementation.

3.2.2 Assess progress in achieving objectives – use logic models which include 5 core components:
a. Inputs – resources, contribution and investments that go into the program
b. Outputs – activities, services, events and products that reach people who participate or who are targeted by the program. Helpful in tracking the program’s progress towards the objectives.
c. Outcomes – results or changes in individuals, groups, communities, organizations, or systems.
d. Assumptions – beliefs we have about the program, the people involved, and the context of the program or the way we think the program will work.
e. External factors – variety of factors that interact with and influence the program action.

3.2.3 Modify plan of action as needed
3.2.4 Monitor use of resources
3.2.5 Monitor compliance with legal and ethical principles – use the ethics code set by the Coalition of National Health Education Organizations (CNHEO); negligence is the failure to act in a careful or reasonable manner. May result from omission (not doing what you should have done) or commission (doing what you should not have done). Belmont Report: code of ethics for working with human subjects – includes respect for persons, beneficence and justice. Importance of establishing informed consent. Informed Consent – includes nature and purpose of the program, risks or dangers, any possible discomfort, any benefits of participation, alternative programs or procedures that would accomplish the same results. Important to use plan language to ensure comprehension.

Competency 3.3: Train Individuals Involved in Implementation of Health Education

3.3.1 Select training participants needed for implementation – think about characteristics of the individual who will do the training (i.e. desire to teach, good communication skills, etc), think about special skills needed or previous experience that would be helpful in an intervention specialist, understand the organizational context where the intervention will be delivered.
3.3.2 Identify training needs – MCHES level
3.3.3 Develop training objectives – MCHES level
3.3.4 Create training using best practices – MCHES level
3.3.5 Demonstrate a wide range of training strategies – Health education specialists should be media literate, have basic understanding of publication layout and design, editing, video, website management.
3.3.6 Deliver training – consider the best way to instruct an intended audience and also consider available funds and expertise of individuals providing the training. This can be on-the-job training, one-on-one training, in person group work or even distance learning.
3.3.7 Evaluate training – MCHES level
3.3.8 Use evaluation findings to plan future training – MCHES level
Area of Responsibility IV: Conduct Evaluation and Research Related to Health Education (15% of CHES exam)

Health Education specialists at all levels are expected to be able to conduct a thorough review of the literature and to apply research findings from basic and evaluative research.

Competency 4.1: Develop Plans for Evaluation and Research

Types of evaluation:

a. **Formative evaluation**: looks at ongoing process of evaluation from planning through implementation

b. **Process evaluation**: any combo of measures that occur as a program is implemented to assure or improve the quality of delivery

c. **Summative evaluation**: associated with measures of judgments that enable the investigator to draw conclusions; also associated with impact and outcome evaluations

d. **Impact evaluation**: focuses on immediate and observable effects of a program leading to the desired outcomes

e. **Outcome Evaluation**: focused on ultimate goal, product or policy. Often measured in terms of morbidity and mortality.

4.1.1 *Create purpose statement – MCHES level*

4.1.2 *Develop evaluation/research questions – MCHES level*

4.1.3 *Assess feasibility of conducting evaluation/research* – evaluation plans that include research designs such as control trials, cohort studies/case studies provide higher confidence level about the validity of an investigation.

4.1.4 *Critique evaluation and research methods and findings found in the related literature* – search strategies typically require health education specialists to: identify key terms, identify a period of time to conduct the search, characteristics of the target population, and health conditions of interest. Methods used to evaluate, critique, and report evidence are:

a. **Systematic Reviews**: published qualitative review of a comprehensive synthesis of publications on particular topics

b. **Meta-analyses**: systematic method of evaluating statistical data based on results of several independent studies of the same problem

c. **Pooled analyses**: method for collecting all the individual data from a group of studies, combing them into one large data set, and then analyzing the data as if it came from one big study.

4.1.5 *Synthesize information found in the literature*

4.1.6 *Assess the merits and limitations of qualitative and quantitative data collection for evaluation –*

4.1.7 *Assess the merits and limitations of qualitative and quantitative data collection for research – MCHES level*

4.1.8 *Identify existing data collection instruments* – be familiar with existing instruments commonly used in the field for data collection (ex. YRBSS, BRFSS, YTS, NHANES).

4.1.9 *Critique existing data collection instruments for evaluation* – make sure instrument is appropriate for the given population, make sure instrument measures variables of interest, be certain there are no extraneous items that are not associated with the intent of the research. Make sure language is clear and appropriate for the population, make sure instrument is tested for validity and reliability and/or pilot tested in the past.
4.1.10 Critique existing data collection instruments for research – MCHES level
4.1.11 Create a logic model to guide the evaluation process – MCHES level
4.1.12 Develop data analysis plan for evaluation – MCHES level
4.1.13 Develop data analysis plan for research – MCHES level
4.1.14 Apply ethical standards in developing the evaluation/research plan – respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm is the responsibility of each health education specialist.

Competency 4.2: Design Instruments to Collect Evaluation/Research Data

Common data collection strategies include face to face, telephone, self-administered, traditional mail, and electronic platforms. Creator should use plain language, make instrument easy to understand, organize questions in logical order, avoid technical jargon, keep survey as short as possible, and avoid unnecessary graphics.

4.2.1 Identify useable questions from existing instruments – use previously tested and reliable existing instruments. Consider: if the item is appropriate for the intended purpose, is the language appropriate, whether a test has been performed using a sample from the intended population, to when you should give credit for using the item.

4.2.2 Write new items to be used in data collection for evaluation – may include survey questions, behavior assessment items, interview questions/guides for face to face interviews or focus groups. Must ensure reliability and validity of the data collection instrument. Evaluator must decide whether items developed for quantitative methods, qualitative methods or mixed methods will be appropriate. For quantitative questions avoid: assumptions about common knowledge, abbreviations, leading questions, double negatives, long lists of choices, recall questions over extended time frames. For qualitative questions avoid: yes/no questions, being too broad, being too specific, and asking too many questions.

4.2.3 Write new items to be used in data collection for research – MCHES level

4.2.4 Establish validity of data collection instruments – consider content (face) validity: the instruments measurement of the relevant areas of interest. Criterion validity: refers to one measures correlation to another measure of a variable. Construct validity: ensures that the concepts of the instrument relate to the concepts of a particular theory.

4.2.5 Establish reliability of data collection instruments – assess whether the instrument is measuring concepts consistently. Internal consistency: considers intercorrelations among items within an instrument. Test-retest reliability: considers evidence of stability over time. Rater reliability considers differences among scorers of terms and controls for variation due to error introduced by rater perceptions.

Competency 4.3: Collect and Analyze Evaluation/Research Data

4.3.1 Collect data based on the evaluation/research plan – Evaluation models include:

a. Attainment: focused on program objectives and the program goals, serve as standards for evaluation
b. Decision-making: based on 4 components designed to provide user with the context, input, processes and products with which to make decisions
c. Goal-free: not based on goals; evaluator searches for all outcomes including unintended positive and negative side effects
d. **Naturalistic**: focused on qualitative data and uses responsive information from participants in a program; most concerned with narrative explaining “why” behavior did or did not change

e. **System analysis**: based on efficiency that uses cost-benefits or cost-effectiveness analysis to quantify effects of a program

f. **Utilization-focused**: done for and with a specific population

g. **CDC 6 step framework for program evaluation**: Engage stakeholders, describe the program, focus the evaluation design, gather credible evidence, justify conclusions, ensure use and share lessons learned. **STANDARDS = Utility, Feasibility, Propriety and Accuracy.**

**Research Studies**: conducted to understand disease etiology, determine effectiveness of programs and explore links between etiologies and interventions or develop and test new research methods. All experimental designs consist of some form of controlled trial.

a. Randomized: all participants in trial have equal chance of being allocated to each group of study

b. Quasi-randomized: allocate participation based on some scheme, such as assigned number (odd or even)

c. Non-randomized: do not use random allocation, also termed “quasi-experimental studies”.

**Study Designs**: fall into two categories (Descriptive or Analytic)

a. Descriptive: describe the occurrence of disease and disability in terms of person, place and time using prevalence surveys, surveillance data or other routinely collected data. Example: cross-sectional study.

b. Analytic: explain etiology and causal associations. Aim to estimate the strength of a relationship between an exposure and an outcome. Example: cohort or case control studies.

4.3.2 **Monitor data collection and management** – prior to administration, investigators decide about incentives for participants, respondents as proxies for other people, acceptable response rates and what documentation or information should be provided to the respondent.

4.3.4 **Analyze data using inferential and/or other advanced statistical methods** – used when researcher wishes to draw conclusions about a population from a sample (for example, mean, median or mode). A **probability sample (or random sample)** is drawn when observations and measurements from the total population would be too costly or not feasible. The term **random sample** means that each person in a population has an equal likelihood of selection. In random sampling, there is no bias in the selection of the sample. The larger the sample, the more representative it is considered. **Stratified sample**: divides a population into segments based on characteristics of importance for the research (for example, gender, age, social class, education level, religion). **Non-probability sample**: Not as representative as and less desirable than probability samples. For example, a convenience sample such as volunteers.

4.3.5 **Analyze data using qualitative methods** – qualitative methods help evaluator become more experienced with variables of interest; used to achieve a deep understanding of the issues; has special value for investigating complex or sensitive issues. Common approaches include:

a. Observation/audit

b. Participant observation
c. Document study  

d. Interviews  

e. Focus Groups  

Same size in qualitative data is often small. Several steps involved in qualitative analysis:  

a. **Data reduction**: selecting, focusing, condensing, and transforming data. The process should be guided by thinking about which data best answers the evaluation questions.  

b. **Data display**: creating an organized, compressed way or arranging data (such as through a diagram, chart, matrix, or text). Display helps to facilitate identifying themes, patterns, and connections. Usually involves coding or marking passages in text that have the same message or are connected in some way.  

c. **Conclusion drawing and verification**: data is revisited multiple times to verify, test, or confirm the themes and patterns identified.  

4.3.6 **Apply ethical standards in collecting and analyzing data** – Coalition of National Health Education Organizations (CNHEO) provides a code of ethics in Article V; establish an IRB and secure IRB approval before conducting research and data collection; follow codes outlined in HIPPA.  

Competency 4.4: Interpret the Results of the Evaluation/Research  

Interpretation is the effort of figuring out what the findings mean and is part of the overall effort to understand the evidence gathered. **Evidence-based practice** uses epidemiological insight while studying and applying research, clinical, and public health experience, practice, programs, and policies.  

4.4.1 **Compare results to evaluation/research questions** – properly interpreting results will put valuable information into perspective, enabling the evaluator to compare results and findings to the expected outcomes of stakeholders.  

4.4.2 **Compare results to other findings** – health educators should describe, in writing, the results of the data analyses clearly so that they can be compared to other programs or studies. Data comparisons are often presented graphically in tables, figures, bar or line graphs, and pie charts.  

4.4.3 **Propose possible explanations of findings** – five elements are critical for ensuring use of an evaluation including design, preparation, feedback, follow-up, and dissemination:  

a. **Design**, which refers to how the questions, methods, and overall processes are constructed  

b. **Preparation**, the steps taken to rehearse eventual use of the findings  

c. **Feedback**, the communication that occurs among all parties  

d. **Follow-up**, refers to the technical and emotional support that users need during the evaluation and after they receive evaluation findings  

e. **Dissemination**, process of communicating either the procedures or the lessons learned from an evaluation to relevant audiences in a timely, unbiased, and consistent fashion.  

4.4.4 **Identify possible limitations of findings** – acknowledge systematic errors in sampling, design, implementation, or analysis that compromises the results (i.e., sampling bias).
4.4.5 Develop recommendations based on the results – propose actions for considerations results from evaluation or research.

Competency 4.5: Apply Findings from Evaluation/Research

4.5.1 Communicate findings to stakeholders – an evaluation or research report is the typical method of dissemination. Consider: timing, style, tone, message source, vehicle, and format of information products. The goal for dissemination is to achieve full disclosure and impartial reporting.

Part I: Introduction and the executive summary

Part II: Literature review, relate to the purpose of the study, research questions, hypothesis and the target population. It will provide theoretical orientation.

Part III: Methodology, describes how the evaluation or research plan was carried out. Includes overview of the procedures, subjects, and data-gathering instruments used in the study. The data analysis plan is often described in this section.

Part IV: Results, presents evidence tested against stated hypothesis or research questions, provides statistical findings and also a discussion of what the findings mean.

Part V: Final portion, may include conclusions, recommendations or a summary. This is the section most likely to be reach by the stakeholders.

4.5.2 Evaluate feasibility of implementing recommendations from evaluation – MCHES level

4.5.3 Apply evaluation findings in policy analysis and program development – the profession of health education is moving towards more involvement in policy and environmental change. Policy analysis: the use of any evaluative research to improve or legitimate the practical implications of a policy-orientation program. Health Impact Assessments (HIAs) are used to objectively evaluate the potential health effects of a project or policy before it is developed or implemented; used to bring potential public health impacts and considerations to the decision-making process for plans, projects, and policies that fall outside transitional public health arena, such as transportation and land use. Steps in conducting an HIA include:

a. Screening to identify projects of policies for which an HIA would be useful
b. Scoping to identify which health effects to consider
c. Assessing risks and benefits to identify which people may be affected and how they may be affected
d. Developing recommendations to suggest changes to proposals to promote positive or mitigate adverse health effects
e. Reporting to present the results to decision-makers
f. Evaluating to determine the effect of the HIA on the decision

4.5.4 Disseminate research findings through professional conference presentations – MCHES level
Area of Responsibility V: Administer and Manage Health Education (11% of CHES exam)

Competency 5.1: Manage Fiscal Resources - All MCHES level

Competency 5.2: Obtain acceptance and support for programs
5.2.1 Use communication strategies to obtain program support – MCHES level
5.2.2 Facilitate cooperation among stakeholders responsible for health education – MCHES level
5.2.3 Prepare reports to obtain and/or maintain program support – MCHES level
5.2.4 Synthesize data for purposes of reporting – MCHES level
5.2.5 Provide support for individuals who deliver professional development opportunities – assist with curriculum development or continuing education, assist in securing fiscal and other resources necessary to deliver professional development activities.
5.2.6 Explain how program goals align with organizational structure, mission, and goals – often using logical models

Competency 5.3: Demonstrate Leadership

Leadership is the art of anticipating, planning, and managing change. Also defined as the ability to exercise influence, both formally and informally, in ways that facilitate positive and effective outcomes.

5.3.1 Conduct strategic planning – strategic planning should assist the administrative process by analyzing availability of resources in an organization, as well as barriers to implementation of the organizational mission. A process that encompasses individual, group, community, environment, policy and other system-level factors that support or impinge upon the successful implementation of an organizational mission. A strategic plan document serves as a roadmap that can be referred to over time to remind, check assumptions and measure progress. Four common critical questions to ask when developing plan: 1. what is the current status of the organization? 2. What is the desired direction of the organization? 3. What steps are necessary to move the organization to the desired future? 4. What progress is being made?
Planning models are used to develop strategic plan (such as PRECEDE-PROCEED), logic models used as well as organizational assessments and situational analysis (look at internal and external strengths and weaknesses of an organization). SWOT (strengths, weaknesses, opportunities and threats) and VMOSA (visions, mission, objectives, strategies and action plans) are two situational analysis tools that may be used to identify the internal and external variables that contribute to or impede the organization’s ability to meet goals.
5.3.2 Analyze an organization’s culture in relationship to health education goals – Planning models can be used (such as PRECEDE-PROCEED and MATCH) along with multi-system ecological approaches can guide health educator as they assess and monitor individuals and groups to achieve successful program development, sustainability, and change.

Organizational development: a term that encompasses strategies and interventions that focus on building capacities and well-being within groups and organizations to achieve maximum effectiveness and efficiency. Includes team building, organizational design, fostering strong and ethical organizational structures, intergroup relations, group problems solving and managing organizational change. Seven characteristics that can facilitate the assessment of organizational culture and its capacity for change:

1. Innovation and risk taking
2. Attention to detail
3. Outcome orientation
4. People orientation
5. Team orientation
6. Aggressiveness
7. Stability

5.3.3 Promote collaboration among stakeholders – MCHES level
5.3.4 Develop strategies to reinforce or change organizational culture to achieve health education goals
– Five aspects that contribute to the culture of an organization are: assumptions, values, behavioral norms, behavioral patterns and symbols and rituals that portray its message. Diffusion of Innovations theory provides insights relative to systems and strategies towards organizational change.
5.3.5 Comply with existing laws and regulations – must be aware of and comply with federal, state or local laws.
5.3.6 Adhere to ethical standards of the profession- Follow the Code of Ethics for the Health Education Profession. Responsibility to the public, the profession, employers, the delivery of health education, research and evaluation and professional preparation.
5.3.7 Facilitate efforts to achieve organizational mission- provide technical assistance, advocacy, strategic planning and building and supporting teams that plan and implement interventions/strategies. Health education specialists can also help discover possibilities within organizations.
5.3.8 Analyze the need for a systems approach to change – organizational change means moving organizations towards more effective and efficient operations.
5.3.9 Facilitate needed changes to organizational cultures – in this role health educator may be an organization’s staff member (internal change agent) or work in a consulting capacity (external change agent).

Competency 5.4: Manage Human Resources
Health education must be aware of the division of work to be accomplished within the context of designated roles and functions within the organization. The entry level health education specialist may be responsible for building, leading and sustaining teams within and between organizations.

5.4.1 Develop volunteer opportunities- create opportunities for change by using the extensions of volunteers, both internal and external to the organization. Four key tasks in working effectively with volunteers: recruiting, training, supervising and recognizing. Tips for working with volunteers: Determine the need for volunteers and hours served, create job descriptions and outline responsibilities of volunteers, use media and personal contacts to promote the organization to attract volunteers, interview and train volunteers with same rigor as paid employees, provide performance feedback and evaluation, praise volunteers for their community service, recognize their achievements publicly.
5.4.2 Demonstrate leadership skills in managing human resources – leadership: process of intentionally influences others to work toward the goals and objectives of the organization, group or program. Transactional approaches can be used (such as rewards and benefits) or transformational approaches (such as leaders asking followers to place their own interest second to the good of the group).
5.4.3 Apply human resource policies consistent with relevant laws and regulations – include, discrimination of employment, employment rights, employee benefits and compensation, and other federal laws.
5.4.4 Evaluate qualification of staff and volunteers needed for programs – select appropriate individuals to fill positions within an organization/program.
5.4.5 Recruit volunteers and staff – the recruitment process consists of planning, implementation, and evaluation.
5.4.6 Employ conflict resolution strategies – MCHES level
5.4.7 Apply appropriate methods for team development – such as goal setting, interpersonal relationship development, role and responsibility clarification and process analysis.
5.4.8 Model professional practices and ethical behavior
5.4.9 Develop strategies to enhance staff and volunteers’ career advancement – MCHES level
5.4.10 Implement strategies to enhance staff and volunteers’ career development – MCHES level
5.4.11 Evaluate performance of staff and volunteers – various methods of conducting performance appraisals exist such as comparative methods, straight rankings, alternative rankings, paired comparisons and forced distribution.

Competency 5.5: Facilitate Partnerships in Support of Health Education

5.5.1 Identify potential partners – MCHES level
5.5.2 Access capacity of potential partner(s) to meet program goals – MCHES level
5.5.3 Facilitate partner relationship(s) – partnerships may be facilitated through: community based participatory research; interfacing with other organizations with common agendas; working with special interest groups; providing critical links between community members and organizations to assure coordination, congruence and sustainability.
5.5.4 Elicit feedback from partner(s) - MCHES level
5.5.5 Evaluate feasibility of continuing partnership – MCHES level
Area of Responsibility VI: Serve as a Health Education Resource Person (16% of CHES exam)

Competency 6.1: Obtain and Disseminate Health Related Information

6.1.1 Assess information needs – start by defining the information needs of a population, which may include statistics for community assessment, education materials, evidence-based programs, survey tools for data collection or evaluation, or topic specific health information. Select resource materials from credible, reliable sources that match audience needs. Steps for identifying information needed:
1. Identify the need
2. Match the need to likely source
3. Pursue lead
4. Judge the quality and quantity of the information found
5. Organize the available material into a format most useful to the user.

6.1.2 Identify valid information resources - Primary data sources include published studies or experiments written by individuals who conducted the study. Secondary data sources include articles or study summaries written by individuals who were not part of the study or data collection. Tertiary data sources include reference tools (such as pamphlets or fact sheets) compiled from primary and secondary sources. Examples: U.S. Census and the National Center for Health Statistics (NCHS), World health Organization, American Red Cross, American Lung Association, MEDLINE (online resource).

6.1.3 Critique resource materials for accuracy, relevance and timeliness – be mindful of the following: purpose of the source, scientific methodology, qualifications of the author, standing of the publication or organization in the profession, as well as the quality of references and sources. Health educator must also evaluate appropriateness of materials for the priority population. Assess materials in terms of health literacy: the extent to which individuals have the ability to obtain, process, and understand basic health information and health care services to make appropriate health decisions. Consequences of poor health literacy include: inappropriate or no usage of health care services, improper use of medications, poor health outcomes, or poor self-management of chronic conditions. For individuals with lower health literacy, select resources that use simple language, short sentences, define medical or technical terms, and supplement the education with other materials such as videos and pictures. Educators can be literacy methods like SMOG, Fry Readability formula or Flesch-Kincaid readability tests to evaluate the reading level of a material. Health numeracy: the ability to understand numbers which affect individual’s health care decisions and behaviors.

6.1.4 Convey health-related information to priority populations – match the methods to the content and audience needs. Examples are presentations, discussions, lecture, demonstrations, printed materials, or posters.

6.1.5 Convey health-related information to key stakeholders – communicate regularly to increase the use of health-related information. Methods include: oral presentation, executive summary, short report, graphs or tables of data, or a Power Point. Consider if the presentation will be formal, semiformal or informal.

Competency 6.2: Provide Training

Health education specialists should have the skills and abilities to analyze, prioritize, deliver and evaluate training provided to interested groups.
6.2.1 Analyze requests for training – MCHES level
6.2.2 Prioritize requests for training – MCHES level
6.2.3 Identify priority populations – some considerations include, who will benefit the most from training or who has unmet needs for knowledge or skills, who are the primary stakeholders, and which groups may have the greatest impact on the organization after receiving the training.
6.2.4 Assess needs for training – MCHES level
6.2.5 Identify existing resources that meet training needs – MCHES level
6.2.6 Use learning theory to develop or adapt training programs – entry level health education specialist should have knowledge of learning theories commonly used in health education.
a) Adult Learning Theory (Andragogy) – learning is defined as the process of gaining knowledge or expertise. Consider: adults are motivated to learn what needs and interests are particular to them, adults are orientation to learning that is life-centered, experience is the richest source of learning for adults, adults are self-directed learners, and adult education considers individual differences as people age such as differences in time, place and pace of learning. It is helpful to allow adult learners to be part of the planning of learning and ensure that training is relevant to the participant’s job. Helpful to explain why the participants are learning a topic, explain the immediate value of new knowledge and skills, and approach teaching through problem-solving techniques to engage the learner.
b) ARCS (Attention, Relevance, Confidence, Satisfaction) Motivational Model – motivation may be extrinsic or intrinsic. Intent of ARCS model is to provide learners with the necessary time and effort to acquire new knowledge and skills.
c) Gagne’s Theory of Instruction – categories of learning: verbal information, cognitive strategies, intellectual skills, motor skills, and attitudes. Nine events of instruction provide conditions for learning:
1. Gain attention – describe why training important, ask stimulating questions
2. Inform learners of the objectives – present learning objectives
3. Build on prior knowledge
4. Present the stimulus – present the training content
5. Provide guidance – give examples, analogies to help learners retain knowledge or skill
6. Elicit performance – provide opportunities to practice new skill
7. Provide feedback – give immediate feedback on performance
8. Assess performance – assess knowledge/skills gained
9. Enhance retention and transfer – provide supplemental materials to reinforce learning
d) Bloom’s Taxonomy - classification of learning objectives. Learning in the cognitive domain should apply the higher order processes. Classifications are: knowledge, comprehension, application, analysis, synthesis, and evaluation.
e) Maslow’s Hierarchy of Needs – hierarchy of basic human needs. Each level must be met before moving to the next level. Start at physiological needs and move up to self-actualization. Needs include: physiological needs (food, water, and warmth), safety needs, needs of love, esteem, and self-actualization.

6.2.7 Develop training plan – MCHES level
6.2.8 Implement training sessions and programs – MCHES level
6.2.9 Use a variety of resources and strategies – MCHES level
6.2.10 Evaluate impact of training programs – MCHES level
Competency 6.3: Serve as Health Education Consultant

6.3.1 Assess needs for assistance – consultation should be established by meeting with key stakeholders of the organization, discussions of the reasons for consultation and review of organizational documents supporting the need.

6.3.2 Prioritize requests for assistance – consider if the request matches skills of health educator, falls into the major category of services offered, the scope and nature of the request, level of commitment, and presence of other consultations who may also provide same services.

6.3.3 Define parameters of effective consultative relationships - may be internal consultant (informally advising colleagues within an agency) or an external consultant (outside of the agency, more formal). External consulting usually requires a contract between the consultant and the client.

6.3.4 Establish consultative relationships – the following skills are needed: facilitation, presentation, data collection, meeting management, resource material evaluation, networking and report writing.

6.3.5 Provide expert assistance – MCHES level

6.3.6 Facilitate collaborative efforts to achieve program goals – benefits of partnering are: increasing credibility beyond individual organizations, leveraging or maximizing resources, improving the reach to the community, increased broad support for an effort, and minimizing the duplication of efforts.

6.3.7 Evaluate the effectiveness of the expert assistance provided – MCHES level

6.3.8 Apply ethical principles in consultative relationships - particularly informed consent and privacy of information.
Competency 7.1: Assess and Prioritize Health Information and Advocacy Needs

7.1.1 Identify current and emerging issues that may influence health and health education – information needs are based on an understanding of factors that influence health status including medical care, public health, and socio-behavioral and environmental factors.

7.1.2 Access accurate resources related to identified issues – sources may include, peer reviewed publications, health education professional organizations, federal websites, non-governmental websites such as the American Heart Association, American Lunch association, nationally recognized health philanthropies, professional organizations of policymakers, or state health agency websites.

7.1.3 Analyze the impact of existing and proposed policies on health – important considerations in health policy development include community needs assessment and a scientific assessment of the results, impacts of current programming, and available resources to maintain the policy.

7.1.4 Analyze factors that influence decision-makers – legislative advocacy, media advocacy, and grassroots activities are ways to influence decision-makers. Legislative advocacy – contacting policy maker to discuss a public health problem. Media advocacy – attempts to change the normative behavior of the media to alter public policy/practice and create environmental change. Step 1: set the agenda to garner media attention Step 2: frame the issue by selecting content to present as important. Methods such as news, press, video or radio releases, interviews, letters to the editor and media alerts are strategies used. Grassroots activities – efforts that originate from individuals within a community, rather than originating with health agencies.

Competency 7.2: Identify and Develop a Variety of Communication Strategies, Methods and Techniques

7.2.1 Create messages using communication theories and models – public perceptions of health-related messages are influenced by: ease of solution and immediate results, perceived susceptibility, and personal beliefs. Using the social marketing process, the health educators can analyze the problem situation, environment and resources; segment the target audience; create strategies; and evaluate the results. Listen to the needs and wants of the consumer using the 4 P’s (product, price, place and promotion) – sometimes a fifth P is added (Partners), referring to the importance of mobilizing resources by working with other organizations.

7.2.2 Tailor messages to priority populations - Almost half of American adults read at or below basic levels. Messages need to be readable and attractive to the audience. To reach audience with low literacy, it is important to: keep material short, simple and organized; used examples and graphics; be clear and concise; generate a consistent message; pretest materials with the target audience; summarize or highlight the main points; include balance of white space with words and pictures; use few polysyllabic words; maintain readability at about a fourth grade level.

Culture – influences the perception of health messages, culture can impact health practices. Important to practice cultural competency. Remember: everyone is a member of a culture or cultures; acknowledge that culture affects health beliefs and practices; being both culturally sensitive and culturally competent are essential to effective communication.

7.2.3 Incorporate images to enhance messages - Photovoice is a powerful way to use images for communication and advocacy. Photovoice blends grassroots approach to photography and social action. It provides cameras to community members. Has three goals: enable community members to record both
their concerns about and strengths of their community; promote dialogue about the issues addressed in the videos; reach policy makers.

7.2.4 Select effective methods or channels for communicating to priority populations – consider interpersonal, organizational, community, mass media (newspaper), mass media (radio), mass media (TV), and mass media (internet).

7.2.5 Pilot test messages and delivery methods with priority populations - The CDCynergy Social Marketing Version outlines steps for piloting and revising materials.

1. Test creative concepts with intended audiences to see if the ideas resonate.
2. Pretest specific messages with intended audiences to ensure that they hear what you want them to hear.
3. Pretest products and materials with intended audiences to ensure that your products and materials elicit the intended response and produce the desired actions.
4. Choose pretest settings – the places where you hope to provide your services or expose your audience to messages.
5. Pretest product distribution plans.

7.2.6 Revise messages based on pilot feedback – after modifications, the communication message should be tested again. Pilot must take into consideration: the nature of the message; function of the message; goals and objectives of the message; activities and channels to reach; additional effort and implications by modifying the message; costs and accountability; budget and/or in kind resources from other sources. Regardless of channel, messages must be scientifically accurate, consistent, clear, credible and relevant to the intended audience.

Competency 7.3: Deliver Messages Using a Variety of Strategies, Methods and Techniques

7.3.1 Use techniques that empower individuals and communities to improve their health – individual level: effective health communication can help increase awareness, motivation, skill development, and positive attitudes. Community level: effective health communication can influence public policy, promote environmental change, improve health service delivery, empowerment, and assist in creating health social norms. On a social network level, effective health communication can change group communication patterns, usually though influencing the group’s opinion leader. On the organizational level, effective health communications can support organizational efforts and support policy change. On the societal level, effective health communications can influence norms, policies, laws, and environments. Persuasive communication: tailors health-related messages to audiences’ needs in an effort to persuade them to adopt health attitudes and behaviors. Challenge is identifying the most appropriate and effective channel, context and message content to motivate community members to seek and use health information. Health education specialists can use the Health Communication Campaign Model to analyze the community health problem, identify the priority audience’s needs and appropriate strategies to reach them, use communication theories and marketing techniques, select the setting, channels, and activities to be included in the message, and evaluate the outcomes.

7.3.2 Employ technology to communication to priority populations - Electronic communication: email, web surveys, internet, interactive TV, chat rooms, blogs, social networking, Web 2.0. Challenges- credibility and access. Advantages – customized information, on-demand access, wider distribution/faster content update, increased choices, access to experts on-demand, convenient, and viral spread.
Educational media: audiovisual aids such as charts/graphs, illustrations, maps, movies, fieldtrips, photographs, handouts, flipcharts, PowerPoint. To be effective, they need to be able to: stand alone, illustrate only one key point in each aid, use pictures/charts/graphs with short key words, represent facts in a clear, uncluttered manner.

7.3.3 Evaluate the delivery of communication strategies, methods, and techniques –

Competency 7.4: Engage in Health Education Advocacy

Advocacy: a way to systematically alter policy and infrastructure’ embraces the concept of influencing organizational decision makers as well as public officials or the legislative body.

7.4.1 Engage stakeholders in advocacy – ask, what community resources available? What are the allies and adversaries to this issue? Who else shares the problem? What would those groups who share the problem gain or lose by joining the campaign?

7.4.2 Develop an advocacy plan in compliance with local, state, and/or federal policies and procedures – Three areas of policy development: 1. Policy process investigates options to increase adoption 2. Policy content uses data to investigate effective elements 3. Policy outcomes evaluate the impact of policy. Be aware of advocacy policies and procedures. For example, non-profit agencies can perform lobbying as long as that lobbying meets the federal guidelines and does not exceed a certain percentage of the non-profit’s activities. Some health education specialists working for some state or federal agencies are not allowed to conduct lobbying activities.

7.4.3 Comply with organizational policies related to participating in advocacy – federal, state and organizational laws and policies affect the health education specialist’s ability to participate in certain types of advocacy while “on” organizational time. Health education specialist can strengthen advocacy efforts as a member of a professional organization that advocates and may lobby for issues of interest. An individual acting as a private citizen can participate in any level of advocacy or lobbying.

7.4.4 Communicate the impact of health and health education on organizational and socio-ecological factors – health education specialists are responsible for communicating about the role of the profession in implementing, evaluating, translating, and disseminating effective health education and promotion practices. In addition, health educators must communication the role of health education in generating policy changes that lead to creating optimal conditions that promote health.

7.4.5 Use data to support advocacy messages – role often includes preparing data for quick and practical dissemination. Data needs to be in a form that: shows public health burden, demonstrates priority over other issues, shows relevance at the local level, shows benefits of an intervention, personalizes the issue, and estimates the cost of intervention.

7.4.6 Implement advocacy plans – advocacy plan includes five elements: goals, organizational considerations, constituents, allies/opponents, targets, and tactics. Resource = Health Education Advocate Site www.healtheducationadvocate.org .

7.4.7 Incorporate media and technology in advocacy – Capwiz and other internet action networks are vital resources to use when working on advocacy issues. Also useful are tools to help mobilize members to send letters to congress electronically. Mobile technologies can also be used to send information or communication across distances.

7.4.8 Participate in advocacy initiatives – designed to influence policy and law, and often include activities such as education, lobbying, and mobilization. Can be categorized into six areas: voting behavior, electioneering (contributing to the campaign of an individual supportive of public health), direct lobbying,
grassroots lobbying, use of internet to access information on health issues, and media advocacy (responding to members of the media for health-related information).

7.4.9 Lead advocacy initiatives – MCHES level
7.4.10 Evaluate advocacy efforts – MCHES level

Competency 7.5: Influence Policy to Promote Health

7.5.1 Use evaluation and research findings in policy analysis – MCHES level
7.5.2 Identify the significance and implications of health policy for individuals, groups, and communities – the organizing, financing, and delivery of health-related policy are affected by the following forces: Congress, federal health agencies, states, health care providers, business, and local communities.
7.5.3 Advocate for health-related policies, regulations, laws or rules – before contacting an elected official, the health educator must have a good understanding of the issue being discussed. Email or faxed letters are preferred as they do not need to go through the bioterrorism screening process. Prior to first meeting, conduct research on the legislator. After meeting, follow up with thank you letter. When using media advocacy, tips to improve effectiveness: develop a strategy, understand the media, develop messages, and attract journalists’ attention and trust. Policy evaluation: 1. adopting a conceptual model for understanding the process of policy change 2. developing a theory about how and why planned activities lead to desired outcomes 3. selecting benchmarks to monitor progress 4. measuring progress toward benchmarks and collecting data.
7.5.4 Use evidence-based research to develop policies to promote health – MCHES level
7.5.5 Employ policy and media advocacy techniques to influence decision-makers - building relationships with the decision makers who control the means to the change sought is important.

Competency 7.6: Promote the Health Education Profession

7.6.1 Develop a personal plan for professional growth and service – professional development opportunities include: reading professional journals, attending professional meetings, taking courses, authoring journal articles, presenting at professional meetings, and participating in other professional development activities.
7.6.2 Describe the state-of-the-art health education practice – the Health Educator Job Analysis (HEJA). In this national survey, health education specialists rate tasks and knowledge performed within the most recent 12 months. To describe state-of-the-art health education, the health education specialist must know the theory behind health education practice, the unified code of ethics, and the basis of program, policy and practice evaluation.
7.6.3 Explain the major responsibilities of the health education specialist in the practice of health education - US Bureau of Labor Statistics defines health education specialists as those who promote, maintain, and improve individual and community health. Responsibilities include: assisting individuals and communities to adopt healthy behaviors; collecting and analyzing data to identify community needs prior; planning, implementing, monitoring, and evaluating programs.
7.6.4 Explain the role of health education associations in advancing the profession – The Coalition of National health Education Organizations (CNHEO) is a collaboration of health education membership organizations. Primary mission is the mobilization of the resources of the health education profession in order to expand and improve health education, regardless of setting.
7.6.5 *Explain the benefits of participating in professional organizations* – allows the health educator to update skills and knowledge, network with peers and mentors, and identify collaborators for research and publication opportunities. Also, may provide a job bank to assist members in finding new positions.

7.6.6 *Facilitate professional growth of self and others* – in any setting, health educator can function as a mentor or mentee open to the opportunity for acquisition of new knowledge and skills. Professional growth can also be the result of additional formal education.

7.6.7 *Explain the history of the health education profession and its current and future implications for professional practice* – history of health education dates back to the late 19th century with the establishment of the first academic programs preparing school health educators. In the 1970s health education began evolving as a true profession. In the mid-1970s, the profession began the process of developing the steps necessary to establish the credentialing of health education specialist. Through the **Role Delineating Project**, the responsibilities, functions, skills, and knowledge expected of the entry-level health education specialist were delineated, and the concept of the “generic role” of all health educators emerged and formed the basis for the credentialing process for health education specialists. The National Health Education Specialist Competencies Update Project (CUP) was created in 1998-2004 and outlined the roles of entry level and advanced level health education specialists. The CUP model introduced a hierarchical model in which advanced level builds on the entry level, paving the way for the MCHES commencing in 2010. 2000 – Code of Ethics adopted, 1990- first CHES exam given, 1978- National Task Force developed.

7.6.8 *Explain the role of credentialing in the promotion of the health education profession* – refers to several processes put in place to ensure that persons who deliver a given service have obtained a minimum level of competency. The CHES certification was developed by, and for, the health education profession to demonstrate the mastery of a set of fundamental skills across all practice settings. CHES has three components: academic preparation, passing written exam, and continued profession development of a minimum of 75 credit hours over a five year period.

7.6.9 *Engage in professional development activities* –

7.6.10 *Serve as a mentor to others* – reach out to new and emerging health education specialists to help them develop and build their professional growth.

7.6.11 *Develop materials that contribute to the professional literature* –

7.6.12 *Engage in service to advance the health education profession* – serving on boards of local, state or national health and human service non-profit organizations.