CHAPTER 1

Introduction to Health Education, Health Promotion, and Program Planning

CHAPTER OBJECTIVES

After reading this chapter and answering the questions at the end, you should be able to:

1. Describe health and its value.
2. Describe the evolution of health education and health promotion.
3. Explain the technical difference between health education and health promotion and how they work in unison.
4. Explain the lengths to which the health education profession checks and validates its core responsibilities and competencies.
5. Identify the assumptions of health promotion.
6. Describe the significance of program planning and the basic elements of the Generalized Model.

KEY TERMS

advanced 1-level practice
advanced 2-level practice
Certified Health Education Specialist (CHES®)
community
entry-level practice
Framework
health
health education
health education specialist
health promotion
Healthy People
Master Certified Health Education Specialist (MCHES®)
pre-planning
primary prevention
priority population
Role Delineation Project
secondary prevention
social determinants of health
stakeholders
tertiary prevention
wellness

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Health is a means to an end. It enables us to pursue things that matter most in our lives and helps us thrive and achieve our potential. It allows us to work and enjoy life and recover from setbacks and tragedies. Although health is not synonymous with longevity, being healthy for as long as possible provides more opportunities for fulfillment. The Greek physician, Hippocrates, known as the Father of Medicine (see **Figure 1.1**), discerningly observed that "health is the greatest of human blessings." But health is also complicated. It is a multidimensional state influenced by genetics, behavior, the environment, our communities, and adequate health care, among other things.

The World Health Organization (WHO) further defines **health** as a "state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (WHO, 2021a). The National Wellness Institute has long asserted that **wellness** (i.e., "an active process through which people become aware of, and make choices toward, a more successful existence") consists of the six dimensions displayed in **Figure 1.2** (National Wellness Institute, 2021). Over the decades, several other models have portrayed relationships between these or similar dimensions in various other forms. While labels and terminology change over time, health's multidimensionality has held constant in scientific and popular literature.

In more recent decades, the **social determinants of health** (see **Figure 1.3**) have become an increasingly useful paradigm to portray the multidimensionality of health. The social determinants of health are the "conditions in the environments where

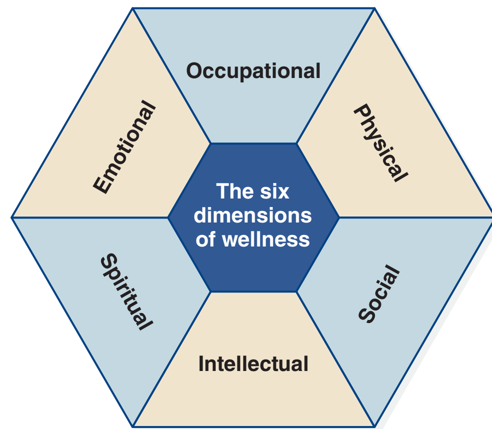

Figure 1.2 The Six Dimensions of Wellness.

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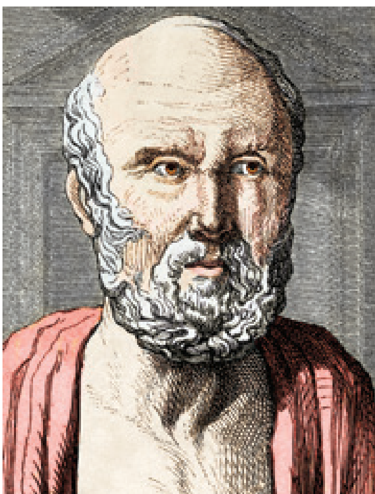

Figure 1.1 Hippocrates, the Father of Medicine.

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Figure 1.3 Social Determinants of Health.

Reproduced from U.S. Department of Health and Human Services (USDHHS). (2020b). *Healthy People 2030: Social determinants of health.* Retrieved October 21, 2020, from https://health.gov/healthypeople/objectives-and-data/social-determinants-health

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people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (USDHHS, 2020a). "Factors such as safe housing and quality of neighborhoods, transportation, access to health care and other services, discrimination, violence, education, employment, and income, have a significant impact on people's health and well-being" (USDHHS, 2020b).

Understanding the multidimensionality and related complexity of changing and improving health assists those working in health promotion to approach their work with humility, especially when considering the number of health problems affecting our global population. For example, a lack of the most basic human needs (e.g., clean water, food, safe shelter) represents the most significant health priority in some locations. Infectious or communicable diseases are a primary concern in other populations. In contrast, other parts of the world are impacted more by chronic diseases (i.e., diseases of long duration requiring constant and specialized care). Concurrently, unintentional injuries (e.g., automobile crashes, drownings, falls) and intentional injuries (i.e., suicide and homicide) affect all populations.

Double or triple burdens of disease occur in populations, meaning that two or three (or even more) of these categorical problems exist concurrently. For example, in the United States, heart disease is the leading cause of death for men, women, and people of most racial and ethnic groups (CDC, 2021l), while cancer accounts for almost as many deaths (National Cancer Institute (NCI), 2020). At the same time, the United States has experienced an increase in homicides and aggravated assaults (National Commission of COVID-19 and Criminal Justice, 2020) and a significant number of deaths due to suicide (CDC, 2021n) and unintentional injuries (CDC, 2021a). Moreover, the National Institute of Mental Health (2021) reported that nearly 20% of adults live with a mental illness, defined as a mental, behavioral, or emotional disorder. Simultaneously, the CDC (2021c) reported that anxiety and depression affect many children and have increased over time, and that poor mental health is increasing among adolescents (CDC, 2021d and 2021e). In addition, in the early 2020s, the COVID-19 pandemic was on track to become one of the leading causes of death in the United States (CDC, 2021g).

These data provide only a snippet of the enormity of work facing those involved in health promotion-related professions. When we factor in the multidimensionality of health and the disparities of disease, we can better understand and appreciate that health promotion requires us to think holistically and scientifically in clinical, behavioral, and social terms. It also demands that we conduct all planning and evaluation efforts strategically using best practices proven over time. Finally, it requires that programs or interventions are tailored to the needs of the people who receive them.

As we move forward in the 2020s, the good news is that the world's population lives longer and healthier lives and that we are making "enormously encouraging progress" (WHO, 2020). While inequality persists (WHO, 2020), behaviors can change, social conditions can improve, and health disparities can decrease. Another cause for optimism is that health promotion's collective work across various sectors over time has contributed to these health improvements (CDC, 1999b; CDC, 2011c).

Most health promotion scholars would identify 1974 as a seminal year that positioned health promotion as a significant element of national health programming and policy. That year, Canada published its landmark policy statement, *A New Perspective on the Health of Canadians*, (see **Figure 1.4**) often referred to as the Lalonde Report (Lalonde, 1974).

The Lalonde Report introduced the "Health Field Concept," which included four determinants of health, human biology, healthcare systems, the environment, and lifestyle, and called attention to a fragmentation of efforts to respond effectively to health problems

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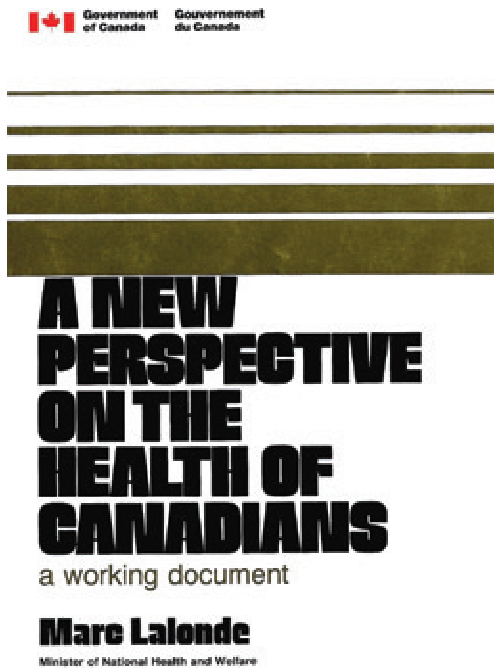

Figure 1.4 The Lalonde Report.

Courtesy of Ministry of National Health and Welfare, Canada.

(Glouberman & Millar, 2003). Moreover, the report identified the need for intersectoral collaboration and use of multiple interventions, such as health education, social marketing, community development, and legislative and healthy public policy approaches, to successfully address the determinants of health (Glouberman & Millar, 2003). In the United States, Congress passed the groundbreaking Health Information and Health Promotion Act, which created the Office of Health Information and Health Promotion, later renamed the Office of Disease Prevention and Health Promotion (Green 1999, p. 69). This office still operates today as part of the U.S. Department of Health and Human Services.

These historic actions paved the way for ***Healthy People***: *The Surgeon General's Report on Health Promotion and Disease Prevention* (USDHEW, 1979), which helped establish the relationship between personal behavior and health status. The document also provided recommendations to reduce health risks and enhance health. Perhaps more significantly, *Healthy People* summarized research in an understandable way to the general public. *Healthy People* also cleared the way for the first set of health goals and objectives for the nation, titled *Promoting Health/Preventing Disease: Objectives for the Nation* (USDHHS, 1980).

These 10-year goals and objectives, previously known as *Healthy People 1990, 2000, 2010, 2020*, and now *Healthy People 2030*, helped define and guide the U.S. health agenda since their inception (USDHHS, 2020c). And, in part, they have kept the importance of good health visible to all Americans. The *Healthy People 2030* framework builds upon an underlying value of thriving and equitable societies that address social determinants of health to eliminate or reduce health disparities. It aims to improve health for all across the physical, mental, and social dimensions of health (USDHHS, 2020a).

The Healthy People framework has demonstrated that a widely accessible plan can become the basis for local, state, and national health programming to bring populations together to improve health and reduce the burden of death and disease. It has also helped monitor health problems and has facilitated the sharing of high-quality data (USDHHS, 2020c). Perhaps most significantly for this book's purposes, *Healthy People* has given rise to the work of health promotion and health education and the significance of effective program planning.

Health Education and Health Promotion

Health education is defined as "any combination of planned learning experiences in which theory and evidence-based/evidence-informed practices are used to provide equitable opportunities for the acquisition of knowledge, attitudes, and skills that are needed to adapt, adopt, and maintain healthy behaviors"

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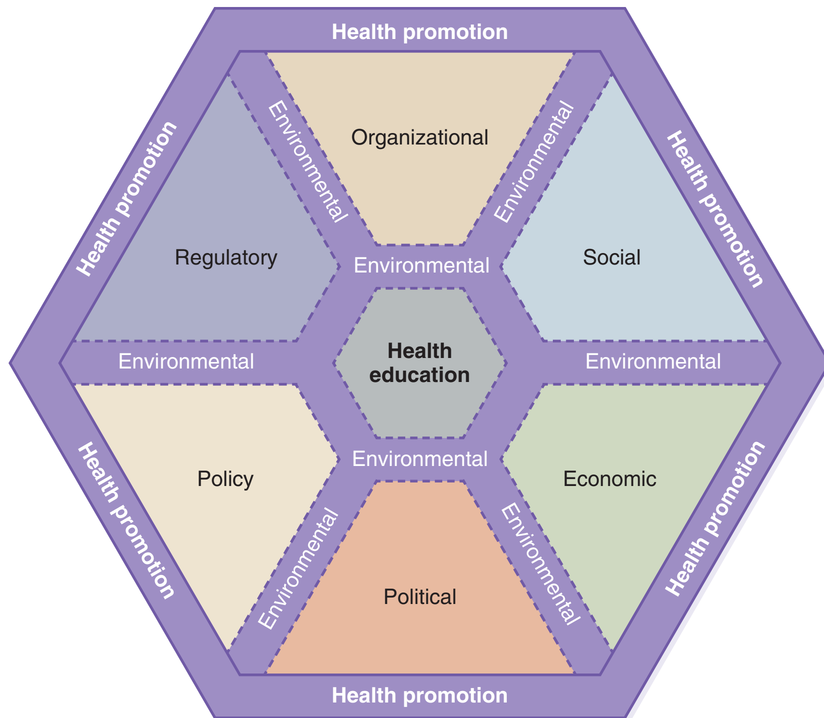

Figure 1.5 Relationship Between Health Education and Health Promotion.

(Green & Kreuter, 2005, as cited in Videto & Dennis, 2021, p. 13).

In contrast (see **Figure 1.5**), **health promotion** is defined more broadly as "any planned combination of educational, political, environmental, regulatory, or organizational approaches that support actions and conditions of living and are conducive to the health of individuals, groups, and communities (Green & Kreuter, 2005, as cited in Videto & Dennis, 2021, p. 14).

Based on these definitions, health education involves communication efforts to influence the antecedents to behavior change, such as knowledge, attitudes, skills, beliefs, and values (Sharma, 2022). It is delivered in various settings (e.g., homes, healthcare sites, communities, schools (K–12), colleges and universities, and worksites) and uses several communication methods or channels as displayed in **Box 1.1**.

Both health education and health promotion involve primary, secondary, and tertiary prevention (see **Table 1.1**). According to Videto and Dennis (2021), **primary prevention** is "actions and interventions designed for individuals or populations to

Box 1.1 Examples of Channels Used in Health Education

- Face-to-face or remote classes or webinars
- Video conferencing
- Hard copy or electronic documents
- Social media
- Texting and blogging
- Seminars or other forums
- Counseling or small group discussions
- Chat groups
- Podcasts
- Websites and apps

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Table 1.1 Primary, Secondary, and Tertiary Prevention

Level of Prevention	Explained	Health Status	Examples
Primary Prevention	Actions & interventions to identify risks & reduce susceptibility to health threats	Healthy with no current signs of disease or condition	■ Rules, ordinances, & laws to protect health (e.g., no smoking policies, use of safety belts) ■ Exercise or smoking cessation classes ■ COVID-19 immunizations
Secondary Prevention	Early diagnosis & treatment to prevent progress or recurrence	Early stage of disease or condition	■ Self-breast or self-testicular exams ■ Use of medications to control disease or condition (e.g., for high blood pressure or high cholesterol)
Tertiary Prevention	Treatment of disease, condition, or injury to reduce complications or disability	Disease treatment or rehabilitation	■ Support groups (e.g., Alcoholics Anonymous) ■ Rehabilitation programs (e.g., cardiac or stroke programs) ■ Occupational therapy programs

Information taken from Cottrell, R. R., Seabert, D., Spear, C., & McKenzie, J. F. (2023). *Principles of health promotion and education* (8th ed.). Jones and Bartlett Learning; and Videto, D. M., & Dennis, D. L. (2021, Spring). Report of the 2020 joint committee on health education and promotion terminology. *The Health Educator, 53*(1), 4–21.

identify risks and reduce susceptibility or exposure to health threats prior to disease onset" (p. 15), while **secondary prevention** "detects and treats disease in early stages to prevent progress or recurrence" (p. 15), and **tertiary prevention** "alleviates the effects of the disease and injury" (p. 15).

For this book's purposes, we view health education as a subset of health promotion, which includes strategies such as policy and advocacy, multisectoral support, and community mobilization, etc. The WHO's Health Promotion Conferences, which began in Ottawa in 1986, have added to our working definition of health promotion. These conferences have emphasized concepts such as creating supportive environments, capacity building for health promotion, evidence-based applications, "health in all policies approaches," and sustainable development (WHO, 2017). The 2016 Shanghai Conference was founded on what was characterized as three thematic pillars: good governance, healthy cities, and health literacy, all important elements of health promotion.

Assumptions of Health Promotion

Bates and Winder (1984) originally outlined what they viewed as critical assumptions of health education. Their assumptions have been modified here, and we refer to them as the assumptions of health promotion (see **Box 1.2**). If these assumptions hold and become central to health promotion practice, we can move forward with confidence that our work will lead to better health outcomes for all.

The importance of these assumptions is made clearer if we refer to the definitions of health education and health promotion presented earlier in the chapter. Implicit in those definitions is the goal of having program participants voluntarily adopt actions conducive to health. Conversely, we cannot expect people to adopt lifelong health-enhancing behavior if we are scientifically uniformed or overbearing in our approach. Nor can we expect people to change behaviors

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Box 1.2 Assumptions of Health Promotion

1. Health status can be changed (WHO, 2020).
2. Behavior can be changed, and those changes can influence health (IOM, 2001, p. 333).
3. Initiating and maintaining behavior change is complex and difficult (Pellmar, Brandt, & Baird, 2002).
4. Before behaviors can change, the determinant(s) of behavior, the nature of the behavior, and the motivation for the behavior must be understood (DiClemente et al., 2019). Individuals must be ready to change.
5. Health is multidimensional and is determined by fluid interactions between individual behavior, social factors, biology and genetics, health services, and policymaking (USDHHS, n.d.a.; Pellmar et al., 2002). Successful health promotion efforts tailor interventions to the unique characteristics of a **priority population**, defined as "a group or subset of a group of people who are the focus of an assessment or an intervention due to their identified, common characteristics" (Agency for Healthcare Research and Quality, 2019, as cited in Videto & Dennis., p. 15).

just because they have been exposed to a health promotion program. Health education specialists should not expect to motivate change in every person in a priority population. However, the likelihood of change and healthier behaviors improve when health promotion programs are facilitated by professionals with the relevant skills and training.

While we distinguish between health education and health promotion in theory, it may be more useful to view them as complementary and synergistic. In practice, the terms are interchangeable. For example, how can we engage in the broader work of health promotion without engaging in health education? Conversely, health education is more effective with the social scaffolding provided by health promotion efforts. From a practice perspective, "the terms health education and health promotion have different definitions both within the United States and between the United States and other countries," but ultimately, despite variation in terminology and distinctions in definition, health education and health promotion are conceptually more alike than distinct (Taub et al., 2009, p. 441).

One difference among the terms worth considering has less to do with the definition of processes and scope and more to do with professional structure. For example, there is an entire professional discipline and network referred to as health education. A consortium of nine professional societies is known collectively as the Coalition of National Health Education Organizations (CNHEO) (2021). The organization that has provided credentialing certification to tens of thousands of professionals is named the National Commission for Health Education Credentialing (NCHEC). Besides preparing health education specialists for their careers, we have designed this book to prepare individuals for the examination associated with receiving either the **Certified Health Education Specialist (CHES®)** or **Master Certified Health Education Specialist (MCHES®)** designations. These designations are meaningful and represent professional competency and commitment to ongoing professional development (NCHEC, 2021).

The title, **health education specialist**, is defined as "an individual who has met, at a minimum, baccalaureate-level health education academic preparation" (NCHEC, 2017, as cited in Videto & Dennis, 2021, p. 17). The use of the title, health education specialist is becoming more standard in practice. However, other designations such as health educator, community health worker or specialist, and health promotion or prevention specialist are also commonly used. While "health educator" has significant

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historical professional meaning and is used by the Bureau of Labor Statistics as an official job classification, we use the designation in this book only as a reference to a formal title in the chronological development of the profession.

Health Education as a Profession

As we know it today, health education has evolved partly through the scientific method, partly through trial and error, more generally through collaboration with allied professions, and in response to societal and professional norms and expectations. In the late nineteenth century, academic programs preparing school health educators, followed by the preparation of public health educators, began laying the foundation for the profession (NCHEC & SOPHE, 2020).

Health education took firmer root in the 1930s and 1940s with more precise terminology and job duties, mainly applied to school and public health education efforts (Armstrong et al., 1934). In the 1940s, quality assurance associated with specific standards began to appear (NCHEC & SOPHE, 2020). Professional associations in the Coalition of National Health Education Organizations emerged and performed substantial work to establish strategic direction for health education. As one current example, the coalition recently produced its *Code of Ethics for the Health Education Profession* (Coalition of National Health Education Organizations (CNHEO), 2020). This document outlines core ethical expectations for health education specialists, expectations for practice, and responsibility in professional preparation and continuing education. It provides an excellent foundation to guide the work of all health education specialists.

Perhaps the most significant advancements to develop health education occurred in the late 1970s with role delineation efforts that would lead to modern-day credentialing. This work helped clarify the health education specialist's evolutionary functions and established primary responsibilities and competencies for the profession.

In January of 1978, the landmark **Role Delineation Project** began (NCHEC & SOPHE, 2000). The result was a generic role for an entry-level health educator composed of seven areas of responsibility or the expectations of a new professional entering the job market regardless of the work setting. Once the role of the entry-level health educator was delineated, the next task was to translate the role into a structure that professional preparation programs (i.e., colleges and universities) in health education could use to design competency-based curricula. The resulting document, *A Framework for the Development of Competency-Based Curricula for Entry Level Health Educators* (NCHEC, 1985), and its revised version, *A Competency-Based Framework for the Professional Development of Certified Health Education Specialists* (NCHEC, 1996), provided such a structure. These documents were collectively called the ***Framework*** and became the foundation for the creation of NCHEC in 1988 and the subsequent delivery of credentialing in the late 1980s with the first certification examination in 1990 (NCHEC & SOPHE, 2020).

Even though the seven areas of responsibility defined the role of the entry-level health educator, they did not fully reflect the work of a health educator with an advanced degree. Thus, over a 4-year period beginning in 1992, the profession worked to define the role of an advanced-level practitioner. By July 1997, the governing boards of NCHEC, the American Association of Health Education (AAHE), and the Society for Public Health Education (SOPHE) endorsed three additional responsibilities for the advanced-level health educator. Those responsibilities focused on research, administration, and the advancement of the profession (AAHE, NCHEC, & SOPHE, 1999).

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The seven entry-level and three advanced-level responsibilities served the profession well. However, through the years, additional revalidation studies modified the language and intent of the responsibilities and related competencies and subcompetencies. For example, a 6-year multiphase study known as the *National Health Educator Competencies Update Project* (CUP) included the development of a three-tiered hierarchical model of practice. The three levels of practice included **Entry-level** (fewer than 5 years of experience with a baccalaureate or master's degree), **Advanced 1-Level** (5 or more years of experience with a baccalaureate or master's degree), and **Advanced 2-Level** (5 or more years of experience with a doctoral degree) (NCHEC & SOPHE, 2020).

The results of the CUP, which were published approximately 20 years after the initial role delineation project, lead to the creation of a revised framework titled, *A Competency-Based Framework for Health Educators* (NCHEC, SOPHE, & AAHE, 2006). Subsequent validation studies, including the Health Educator Job Analysis in 2010 and the Health Education Specialist Practice Analysis in 2015 brought several other modifications including tiered subcompetencies and a transition from the title of health educator to health education specialist (NCHEC & SOPHE, 2020).

The NCHEC and the SOPHE co-sponsored the most recent health education specialist practice analysis, named the Health Education Specialist Practice Analysis II 2020 (NCHEC & SOPHE, 2020). As in previous analyses, its purpose was to "revalidate the contemporary practice of entry- and advanced-level health education specialists and use findings to update the CHES® and MCHES® exams, as well as to report validated changes since the HEPSA I" (NCHEC & SOPHE, 2020, p. 13)." An eighth area of responsibility, ethics and professionalism, was added to the original seven responsibilities. At present, the health education profession is based on eight areas of responsibility (see **Box 1.3**), 35 competencies and 193 subcompetencies (NCHEC & SOPHE, 2020).

In reviewing the eight areas of responsibility, it is clear that five of the eight are directly related to program planning, implementation, and evaluation and that the other three could be associated with these processes, depending on the type of program being planned. In effect, these responsibilities distinguish the brand and expectations of health education specialists from other professionals who provide similar services. Those with CHES® and MCHES® certification have preparation in all of the responsibilities listed in Box 1.3, including program planning, implementation, and evaluation, which might

Box 1.3 Areas of Responsibility for Health Education Specialists

Area of Responsibility I:	Assessment of Needs and Capacity
Area of Responsibility II:	Planning
Area of Responsibility III:	Implementation
Area of Responsibility IV:	Evaluation and Research
Area of Responsibility V:	Advocacy
Area of Responsibility VI:	Communication
Area of Responsibility VII:	Leadership and Management
Area of Responsibility VIII:	Ethics and Professionalism

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be considered cornerstones of the health education profession.

The importance of the defined role of the health education specialist is becoming greater as the profession continues to mature. This is exhibited by its use in several major professional activities. First, the *Framework* has provided a guide for colleges and universities to use when designing and revising their curricula in health education. Second, as stated, the *Framework is* used by the NCHEC to develop the core criteria for certifying individuals as health education specialists.

Third, the *Framework* is used by program-accrediting bodies to review college and university academic programs in health education.

The use of the *Framework* to guide academic curricula, provide the core criteria for the health-education specialist examinations, and form the basis of program accreditation processes has done much to advance the health education profession. In 1998, the U.S. Department of Commerce and Labor formally acknowledged "health educator" as a distinct occupation. Such recognition was justified, based to a large extent, on the ability of the profession to specify its unique skills (AAHE, NCHEC, & SOPHE, 1999, p. 9).

Program Planning

Because several of the responsibilities involve program planning, implementation, and evaluation, health education specialists need to become proficient in these processes. All three processes require time, effort, practice, and on-the-job training to do them well. Even the most experienced health education specialists find program planning challenging because of constant changes to settings, resources, and priority populations.

Hunnicutt (2007) offered four reasons why systematic planning is important. The first is that planning forces planners to think through details in advance. Detailed plans can help to avoid future problems. Second, planning helps to make a program transparent. Good planning keeps the program **stakeholders** (any person, community, or organization with a vested interest in a program; e.g., decision makers, partners, clients) informed. The planning process should not be mysterious or secretive. Third, planning is empowering. It helps everyone involved feel more confident that actions being taken are justified and reasonable. And fourth, planning creates alignment. This helps all members of an organization feel they are working toward the same goals and objectives. As noted by Bryson (2018, p. 33), strategic planning "can help organizations clarify and resolve the most important issues they face. It can help them build on strengths and take advantage of major opportunities while they overcome and minimize weaknesses and serious challenges. It can help them be much more effective in what seems to be a more hostile world."

A general understanding of everything involved in planning a health promotion program can be facilitated by focusing on the Generalized Model (see **Figure 1.6**). (A more in-depth explanation of this model can be found in Chapter 3.)

This model includes the major steps involved in planning a program. However, prior to undertaking the first step in the Generalized Model, it is important to consider engaging in **pre-planning**, which allows a core group of people (or steering committee) to gather answers to key questions (see **Box 1.4**) that are critical to the planning process before the actual planning process begins. It also helps to clarify and give direction to planning, and helps stakeholders avoid confusion as the planning process progresses.

Also, before starting the actual planning process, planners need to have an adequate understanding of the community where the program will be implemented. **Community**

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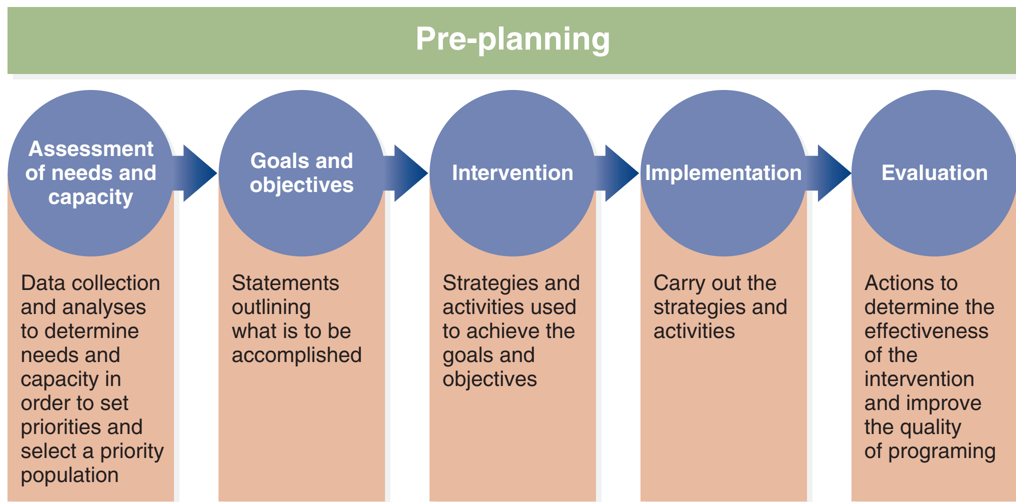

Figure 1.6 The Generalized Model.

is defined as "a collective body of individuals who share commonalities that are identified by characteristics and demographics, such as geography, interests, experiences, concerns, values, race, ethnicity [and/] or culture" (McCormack et al., 2012 as cited

Box 1.4 Key Questions to Be Answered in the Pre-Planning Process

Purpose of the Program

- Who is the priority population?
- How are we defining the community?
- What are the desired health outcomes?
- Does the community have the capacity and infrastructure to address the problem?
- Is a policy change needed?
- Are environmental changes needed?

Scope of the Planning Process

- Is it intra- or inter-organizational?
- Who are our partners or potential partners?
- What is the time frame for completing the project?

Planning Process Outcomes (Deliverables)

- Written plan?
- Program proposal?
- Program documentation or justification?

Leadership and Structure

- What authority, if any, will the planners have?
- How will the planners be organized?
- What is expected of those who participate in the planning process?

Identifying and Engaging Partners

- How will the partners be selected?
- How will programs be tailored to the priority population?
- How will we engage the priority population?
- Will the planning process use a top-down or bottom-up approach?

Identifying and Securing Resources

- How will the budget be determined (i.e., how much will the program cost and who will pay for it?)
- Will a written agreement (i.e., MOA—memorandum of agreement) outlining responsibilities be needed?
- If a MOA is needed, what will it include?
- Will external funding (i.e., grants or contracts) be needed?
- Are there community resources (e.g., volunteers, building space, donations) to support the planned program?
- How will the resources be obtained?

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in Videto & Dennis, 2021, pp. 11–12). For example, a community could be a religious community, a cancer-survivor community, a workplace community, or a digital community, etc., and should not be limited to a geographic area with specific boundaries such as a neighborhood, city, county, or state. Understanding the community, or priority population, means finding out as much as possible about them to create better partnerships and programs. However, it is not enough to understand the community; planners also need to engage with members of the priority population and include them in the planning process in meaningful and productive ways.

The remaining chapters of this book present a process that health education specialists can use to plan, implement, and evaluate successful health promotion programs and will introduce you to the necessary knowledge and skills to carry out these tasks.

Summary

The increased interest in personal health and behavior change, and the flood of new health information have expanded the need for high-quality health promotion programs. Individuals are seeking guidance to enable them to make sound decisions about behavior that is conducive to their health. Properly trained health education specialists are aware of the limitations of the discipline and understand the assumptions on which health promotion is based. They also know that good planning does not happen quickly or by accident. Much time, effort, practice, and on-the-job training are needed to plan an effective program that begins with pre-planning.

Review Questions

1. Explain the role *Healthy People* played in developing health promotion.
2. What is the relationship between health education and health promotion?
3. What are the eight Areas of Responsibilities of health education specialists?
4. What assumptions are critical to health promotion?
5. What are the steps in the Generalized Model?
6. What is meant by the term *pre-planning*? Why is it important? What are some questions to answer during the pre-planning process?
7. How have stakeholders, decision makers, and communities been defined in this chapter?

Activities

1. Based on what you have read in this chapter and your knowledge of the profession of health education, write your own definitions for *health, health education, and health promotion*.
2. With your knowledge of health promotion, what other assumptions would you add to the list presented in this chapter in Box 1.2? Provide a one-paragraph rationale with at least two ideas.
3. Go to https://profiles.nlm.nih.gov/spotlight/nn/catalog/nlm:nlmuid-101584932X94-doc (Reports of the Surgeon General) and read *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*.

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4. Assume you are in your senior year and will graduate next May with a bachelor's degree in health education. What steps do you need to take to register and prepare for the CHES® examination in April prior to your graduation. (Hint: Check the website of the National Commission for Health Education Credentialing. Inc.)
5. In a one-page paper, describe the differences and similarities in the two credentials—CHES® and MCHES®—available to health education specialists. (Hint: Check the website of the National Commission for Health Education Credentialing, Inc.)
6. In a one-page paper, describe the projected job outlook for health education specialists for the next 10 years. (Hint: Check the website of the Bureau of Labor Statistics *Occupational Outlook Handbook*.)

Weblinks

https://health.gov/healthypeople
Healthy People
This is the webpage for the U.S. government's Healthy People initiative including a complete presentation of *Healthy People 2030*.

http://www.nchec.org/
National Commission for Health Education Credentialing, Inc. (NCHEC).
The NCHEC, Inc. website provides the most current information about the CHES® and MCHES® credentials. It is also the place where you will find a complete list of the Areas of Responsibility, Competencies, and Sub Competencies.

http://www.bls.gov/ooh/community-and-social-service/health-educators.htm
Occupational Outlook Handbook
This is a webpage provided by the Bureau of Labor Statistics that describes the occupation outlook for health educators and community health workers.

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