Teaching Program Planning and Evaluation: Measuring Acquired Skills of Alumni in Health Education Settings

Authors:
Alicia Wodika, PhD, CHES®
Assistant Professor
Illinois State University
Department of Health Sciences
Felmley Hall
Normal, IL 61761
Telephone: 309-438-5957
Email: abwodik@ilstu.edu

Darson Rhodes, PhD, MCHES®
Associate Professor
The College at Brockport
Department of Public Health
Hartwell Hall
Brockport, NY 14420
Telephone: 585-395-5901
Email: drhodes@brockport.edu

ABSTRACT

Purpose: *The aim of this study was to better understand how program planning and evaluation courses prepare students for their future careers in various health settings. Participants (n=20) from three different institutions with Health Education programs in the U.S. participated in the study.* ***Methods:*** *A modified snow-ball sampling technique was used to contact alumni to participate in an online closed and open-ended survey using Qualtrics. Likert-scales assessed skills used in participants' respective fields and types of theories and planning models used for program development and implementation. Open-ended questions allowed participants to share ways in which they practiced cultural competency, suggestions to enhance program planning and evaluation courses and advice for early-career professionals in health education and public health. Closed questions were analyzed using IBM SPSS and open-ended questions were analyzed using a constant comparison method for themes.* ***Results:*** *Findings varied based on the type of health assessment activity with surveys being the most used method for needs assessments and pre/post comparisons used for program evaluation. Strengths, Weaknesses, Opportunities, Threats (SWOT) was the planning model most likely used by participants for program development, with the health belief model and social cognitive theory being the most utilized theories. Regarding cultural competency, three themes focused on sustained community engagement, material development, inclusive environments. Themes that were developed pertaining to advice for future professionals included immersion with experiences, sustained learning, self-advocacy, and creativity with opportunities. The last open-ended question included themes focusing on integration of real-world experiences, practical skill development, and course adaptation to contemporary issues.* ***Conclusions:*** *The study concluded that health educators in the sample conduct activities and skills related to Areas I, II, III, and IV which include skills expected for entry-level health educators. Advanced skills within the Areas V, VI, and VII were not frequently reported. The sample of this study was very diverse in terms of occupational placement and therefore, reflects the current work settings of health educators.* ***Recommendations:*** *Program planning and Evaluation courses should develop projects that focus on*

civic engagement and service learning to address the practical, realistic, and contemporary needs of students' learning.

Key Words: *Program Planning, Evaluation, Health Education, Professional Preparation*

INTRODUCTION

Health education specialists and public health practitioners have been working to address significant health issues facing the U.S. Looking at the ten greatest public health achievements of the 20th century including decreasing vaccine-preventable diseases and deaths, tobacco control, vehicle safety, and cardiovascular disease prevention (CDC, 2011), many, if not all these health issues, could not have been addressed without effective planning and evaluation (Godwin & Heymann, 2015). Addressing current health issues of the 21st century is incredibly challenging as many are very complex; as addressing one portion of the issue usually leads to other challenges and problems (Kreuter, De Rosa, Howze, & Baldwin, 2004; Demers & Mamary, 2008).

From the development of essential protective services to emergency planning, comprehensive program planning is essential and can involve maintaining partnerships with governmental agencies (Redd, 2018). It is therefore expected that workforce training should focus on preparedness-specific training and skill-building (Redd, 2018). In Health Promotion and Health Education programs at institutions of higher education, program planning courses usually include a focus on applying appropriate planning models, identifying evidence-based programs to address current events, developing goals and objectives to measure program progress, integrating and applying theories to planning and implementation, and developing appropriate tools for evaluating community-based programs. Program planning ultimately becomes a keystone course for students to develop essential skills as they progress in health education promotion programs.

Studies have been conducted to identify competencies important within the workforce (Allegrante, Moon, Auld, and Gebbie, 2001; McKenzie, et al., 2016), but more can be done to understand how activities in the classroom impact practices in the field. In response to Allegrante et al.'s (2001) article, Ellery (2002), identified that health education training evaluations should have a strong focus on those actually practicing within the workforce. After the Competencies Update Project (CUP) was conducted, a follow up study was developed assessing public health educators self-identified needs for workforce development (Demers & Mamary, 2008). Participants identified the importance of information technology, enhanced advocacy skills, and more opportunities and training for working with individuals across the lifespan (Demers & Mamary, 2008).

While program planning and evaluation courses often include the completion of a program plan artifact or project, determining the types of projects that offer the most meaningful application of the course objectives and if those projects are practical in the workplace setting is essential. Regarding acquired skills from courses, Godwin and Heymann (2015) recommend that future public health leaders should be able to work with policy makers and civil society leaders in addressing health issues, while also able to "address the social, economic, and environmental problems as part of a community" (p. S37).

Other opportunities to apply course material is to include focusing on problem-centered learning; which is an engaging tool allowing students pragmatic experiences with community members (Merriam and Bierma, 2014; Schmidt and Lawson, 2018). Identifying skills and activities that assist in student professional development can be helpful in tailoring course learning outcomes. Program planning courses also have an important role in cultivating students' appreciation for cultural competency and diversity in working with communities. According to Mincey and Gross (2017), multiple lessons were gained after developing a program planning and evaluation course at a Historically Black College and University (HBCU) with an emphasis of enhancing diversity among people and programs in the workplace. Lessons learned included, "planning group dynamics, making assignments feasible, covering course material early, having assignments in pieces, giving

opportunity to practice health education skills, remaining current, and working with health organizations" (Mincey & Gross, 2017, p. 5-6).

PURPOSE

In order to better understand how alumni are utilizing course material in their professions, a study was developed to 1) determine the applicability of program planning course content to public health and health education settings; and to 2) identify how alumni are applying previously learned skills into their respective occupations. Developing an understanding of how programs are currently preparing health education students for the workforce, and what content, skills, and topics remain essential for work within communities, is important to ensure faculty are developing pragmatic assignments and utilizing contemporary examples to prepare the next generation of health educators.

METHODOLOGY

Sample

Participants (*n*=20) included currently practicing health education/public health alums (<10 years of experience) from accredited institutions from the Midwest and Northeast United States with 65% being Certified Health Education Specialists (CHES). The work settings of participants included health care (25%), community-based organizations (CBO's) (25%), health departments (25%), higher education (15%), and worksite wellness (5%); approximately 40% of participants completed a post-graduate program. See Table 1. Participants represented various work settings of health educators, and therefore, provided various perspectives of skills used in different fields.

Data Collection

Before any data were collected, IRB approval was obtained at participating universities. Informed consent was included as an opening page before the online survey and proceeding forward to the survey indicated consent. Using a modified snow-ball sampling technique, participants from an alumni email list (*n*=91) from two universities were contacted from November 2018-February 2019 via email to participate in the study. The alumni list was not an exhaustive list of all alumni of each program, however, it contained alumni who were interested in still being involved with their respective programs after graduation. The response rate for the survey was 21%.

Using Qualtrics, a 12-item online survey was developed containing nine closed and three open-ended questions. Closed questions focused on skills used in participants' respective fields with a 4-point Likert scale (often, sometimes, rarely, never) response option (α=.703). Skills (11) included conducting needs assessments, grant writing, conducting literature reviews, planning and implementing programs, social marketing, pamphlet development, performing evaluation managing human resources, advocating for communities, and developing policies to promote health. Skills were chosen based on the Areas of Responsibility of Health Educators (National Commission for Health Education Credentialing [NCHEC], 2015). The reliability of Likert scale was measured using Cronbach's alpha (α) and was deemed reliable (>0.7) (Nunnally, 1978, Pallant, 2007).

For specific skills used for data collection and the usage of theories and program planning models in their fields, a check all that apply response option was utilized. Regarding the content validity of the survey, selected theories (Theory of Reasoned Action, Theory of Planned Behavior, Health Belief Model, Transtheoretical Model of Change, Precaution Adoption Process Model, Information Motivation Behavior Theory, Social Cognitive Theory, Social Network Theory, Social Capital Theory, Diffusion of Innovations, Community Readiness Model, Community Organization Theory), planning models (Mobilizing for Action through Planning and Partnerships [MAPP], Social Marketing Assessment and Response Tool [SMART], Strengths, Weaknesses, Opportunities, Threats [SWOT], PRECEDE-PROCEED, Mobilize, Assess, Plan, Implement, and Track [MAP-IT], Intervention Mapping, Healthy Communities, Evidence-based Planning Framework for Public Health, and Whole School, Whole Community, Whole Child [WSCC], needs assessment (surveys, observations, interviews, windshield/walk tours, focus groups, and secondary data analysis) and evaluation techniques (pre/post data comparison, observations, interviews, focus groups, knowledge/attitude/behavior surveys, and participation frequencies) were chosen based on the widely used program planning and evaluation textbook by McKenzie, Neiger, & Thackeray (2017). Open-ended questions focused on ways

in which participants practiced cultural competence, as well as suggestions to enhance program planning and evaluation courses and advice for future professionals. Demographic questions included current health education/ public health setting, CHES or MCHES certification, and years in the workforce.

Data Analysis

Closed questions were analyzed using descriptive statistics and frequencies with *IBM SPSS 25*. The 4-point Likert scale response options were coded with four being the highest score (always) and one being the lowest score (never). Check-all-that-apply questions were coded with a one for a checked response and a zero for unchecked. Frequencies were tabulated to compare the response options. Open-ended questions were analyzed using constant comparison and content analysis to develop codes, categories, and themes (Merriam, 2009). The open-ended questions were analyzed by hand in which both researchers examined the data and developed categories for each question. The categories were then shared and condensed between the researchers to collectively develop overarching themes that were mutually exclusive.

RESULTS

Public Health and Health Education Skills

Of the 11 specific tasks that were investigated, respondents reported planning, implementing, and evaluating programs most often with mean scores of 3.75 (*SD* = 0.44), 3.70 (*SD* = 0.80), and 3.50 (*SD* = 0.69), respectively. Tasks completed the least often were developing policies to promote health (*M* = 2.30, *SD* = 1.08), managing human resources (*M* = 2.35, *SD* = 1.04), and conduct literature reviews (*M* = 2.55, *SD* = 1.00). See Table 2.

Needs Assessment and Evaluation Techniques

When specifically considering the methods used for needs assessment, surveys were reported as being used by the greatest number of respondents (*n* = 17, 85%) while windshield or walk tours were used by the fewest number of respondents (*n* = 1, 5.0%). There were two "other" responses including the use of Geographic Information System (GIS) for an assessment and partnering with a non-health educator to conduct the needs assessment. Pre/post data comparison was used by the most respondents to perform evaluation (*n* = 18, 90.0%) while focus groups were used by the fewest number of respondents for evaluation (*n* = 3, 15.0%). One respondent marked "other" and wrote in "program evaluation."

Planning Model and Theoretical Application

Use of SWOT analysis was reported by the most respondents with regard to planning models (*n* = 11, 55.0%) as well as Evidence-Based Planning Framework (*n* = 10, 50.0%), and two respondents (10.0%) reported not using any of the planning models noted, nor reported using other models. The theories utilized by the most respondents included both the Health Belief Model and Social Cognitive Theory with 13 respondents having reported to use them (65.0%). Only one respondent reported to have used the Precaution Adoption Process Model and the Social Capital Theory (5.0%). See Table 3.

Qualitative Theme Development

For the open-ended question that solicited suggestions for instructors to enhance their courses to better serve students as they prepare for careers in the field, three broad themes emerged. The most common theme was the *integration* of real-world experience into course work. Of the 15 respondents who offered commentary for this question, six participants had comments that addressed this theme. Some of these comments were, "Utilize real world projects more with real clients/patients rather than just lectures with examples," "Provide students as many opportunities to work in the field as possible," and "Include very hands-on learning…" The second theme was *practical* skill development for students. Within this theme, there were specific skills identified that would enhance students' ability to be successful in their fields. Some skills included coding, data analysis, programming; grant writing; public speaking; lesson planning; pre/post-test surveying, data reporting; use of GIS; developing resource materials; interpret research; evaluation; and cultural competence/ humility. The third theme was the *adaptation* of courses to be more contemporary and flexible. Within this theme, participants identified examples where course content should include current issues (i.e. health insurance and navigating the health care field (i.e. Medicaid, Medicare, Affordable Care Act), as well as discussions about profit versus non-profit

organizations, and theoretical application outside of a textbook. See Table 4.

The second open ended question sought advice from participants for students preparing to enter the workforce in which 14 respondents provided commentary. The four themes that were built from the data included *immersion* with experiences, *sustained learning, self-advocacy*, and *creativity with opportunities*. Immersion included examples such as volunteering, participating in research and/or internships, and networking. The second theme, sustained learning, included the ideas of being a life-long learner by "Continue learning…" An important theme of self-advocacy emerged with a focus on assertiveness skills including, "play up your world experience" and "trust in what you know." The last theme, creativity with opportunities, incorporated examples such as not limiting yourself and being opening minded. See Table 5.

For the final open-ended question, which addressed strategies to ensure programs/ practices are culturally competent, three themes emerged. These themes included sustained community engagement, inclusive environments, and material development. Of the 14 respondents who commented on this question, eight participants made comments that addressed the theme of *sustained community engagement*. Examples of such comments include, "review with community stakeholders/ leaders who have been involved with the community…", and "Ensure that community members are involved…" The second theme of *inclusive environments* focused on trainings and staff of the workplace and included examples such as hiring a diverse workforce, holding diversity trainings and preparation of staff for implementation events. The third theme of *material development* included categories such as representation of community members and ensuring literacy of resources. One additional comment that did not address any of the aforementioned themes included, "take program evaluations seriously." See Table 6.

CONCLUSIONS

The health educators in this sample most often reported spending their time conducting activities that were related to Areas I, II, III, and IV of the Seven Areas of Responsibility, as defined by the National Commission for Health Education Credentialing, Inc. (NCHEC). These areas address needs assessment, planning, implementing, and evaluating health education/ promotion programs and interventions. These areas are comprised of many competencies and sub-competencies of entry-level health educators, with the exception being Area IV, evaluation and research, which is largely defined by advanced competencies (NCHEC, 2015). However, this study examined what may be considered some basic evaluation strategies (i.e. pre/post surveys, frequency counts) that entry-level health educators would be expected to use in their respective fields. Area V and VI, which focus on administration of health education/promotion and serving as a resource person are comprised predominately of advanced level skills. The sub-competency related to policy development under Area VII is also deemed an advanced level skill (NCHEC, 2015). Thus, less time spent on this skill is reflective of the early career health educator. Additionally, a substantial amount of time was reported to be dedicated to social marketing, which is reflective of the known growth in technology currently in use by all levels of health educators as described by Satterfield (2015).

The strategies to conduct the work of this sample were very diverse and reflect the current work settings of health educators. While NCHEC (2015) defines a set of skills needed by health educators that cut across multiple settings, the approaches by which health educators exercise these skills continues to be adaptive, allowing them to be flexible for their community's needs. Participants in healthcare and health department settings were most likely to use planning models and theories when working with communities. However, participants from other settings are still utilizing and applying theories (health belief model, social cognitive theory, and community readiness model) and planning models (Whole School, Whole Community, Whole Child [WSCC], PRECEDE-PROCEED) just at different levels and applications. With the health belief model and social cognitive theory being the most utilized theories among participants, these echo the work of Johns and Moyer (2018) in that the health belief model, theory of planned behavior, the integrated behavioral model, and the social cognitive theory are the most prominent theories utilized in health education due to their validity of addressing behavior change (Glanz et al., 2015; Johns & Moyer, 2018).

The importance of acquiring real-world experience was a reoccurring theme among participants. This theme was present not only in offering advice to students as defined as "immersion with experiences" but also in offering advice to instructors as defined as "integration of real-world experience into course work." This finding affirms the previous recommendation made for a field exposure and applied experience to be a critical component of undergraduate public health major curriculum (Wykoff, Petersen, & Weist, 2013). Mincey and Gross (2017) provide examples of enhancing health education skills including the collaboration of different courses, practicing public speaking with a like-minded group, and enhancing advocacy skills by incorporating projects focusing on advocating for a local ordinance or bill at their state capital.

For future practitioners to be competent working with communities, themes focusing on adaptation of course content (for instructors) and sustained learning (for students) specify the need to incorporate contemporary policies and practices into the lessons and skill set of health educators. The diversity of strategies used by health educators requires that college instructors ensure they are exposing students to the diversity of these strategies in their professional preparation. Incorporating and continuous updating of guidelines (i.e. nutritional, health policy, etc.) into course material remains important to ensure competency of students (Mincey & Gross, 2017).

RECOMMENDATIONS

Godwin and Heymann (2015) recommend that future public health leaders should work with policy makers and civil society leaders (p. S37) while they are students to gain more practical skills of community engagement. By developing projects that incorporate aspects of civic engagement and service learning, students can work with community partners to apply their developing skills while seeing the outcomes in 'real-time.' However, even minimal exposure to these strategies in a classroom setting to familiarize students to community engagement may be helpful. Utilization of existing resources in classrooms, such as Community Tool Box (The University of Kansas, 2018) would allow for enhancing and learning such exposure. While this may be challenging, it is essential to develop a well-rounded health educator. In part, this may be done by ensuring that students have real-world experiences, as the student may have the opportunity to engage with the variety of strategies professional health educators report using. Instructors should be aware of current public health organizations in their state, as well as current initiatives happening in professional organizations to allow students opportunities to become involved early in their careers.

However, incorporating these skills into the classroom need not be cumbersome with the addition of many extra lessons and/or strategies. Instead, instructors should think of these as opportunities to scaffold these teachable moments. For example, program planning courses could incorporate a program plan assignment that incorporates 'real' opportunities for students. Those opportunities could be partnering with a community organization or agency to plan and implement a program, writing a grant with a community partner, or performing research.

To discuss and address the intersectionality of public health and health education, as the developed qualitative themes (sustained community engagement, inclusive environments, and material development) represent, enhancing diversity and cultural competency should be intertwined to *all* activities and lessons so that it is a continuous process. According to one participant, they mentioned that aspiring professionals in the field should, "acknowledge that racism cannot be divorced from public health. Race matters in every part of public health. Act like it." Helpful articles and resources focused on diversity, intersectionality, and inclusion are plentiful (Bowleg, 2012; Caiola, Docherty, Relf, & Barroso, 2014; National Collaborating Centre for Determinants of Health and National Collaborating Centre for Healthy Public Policy, 2016; National Association of School Psychologists, 2017; Rao, Andrasik, & Lipira, 2018) and should reflect contemporary needs of communities. Students should have a chance to debrief and reflect about their experiences of working with the community. These experiences allow students, as a class, to identify what culture means and how to respect and work with community members to achieve their desired quality of life. Reflecting on their experiences also allows students a chance to identify their subjectivities about health issues.

Although this study sought a representative sample of alumni and practitioners across the United States, the study is limited by a small sample size and response rate. Recommendations to address the needs of students and course objectives as well as measure the impacts of acquired skills in communities is to measure via post-graduation surveys of alumni consistently and continuously. Finally, although the instrument used in this study was developed based on the Areas of Responsibility (NCHEC, 2015) and McKenzie et al. (2017), in order to develop a survey that measures what practitioners are doing in the field, it would be helpful to develop an instrument with the help of practitioners themselves with a Delphi technique and pilot the study to obtain a larger sample size.

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Table 1: ***Demographics of Study Participants (n = 20)***

Demographic Variable	Frequency (n)	Percentage (%)
Length of Time in Professional Practice		
0-3 Years	15	75.0
4-6 Years	4	20.0
7-10 Years	0	0.0
10+ Years	0	0.0
Highest Level of Education		
Bachelor's Degree	11	55.0
Master's Degree	8	40.0
Professional Degree	0	0.0
Doctoral Degree	0	0.0
Other	0	0.0
Current Work Setting		
Healthcare	5	25.0
Worksite Wellness	1	5.0
Community Based Organization	4	20.0
Health Department	5	25.0
University/Higher Education	3	15.0
Other	2	10.0
CHES/MCHES Certification		
Yes	13	65.0
No	7	35.0

Note: Percentages not totaling 100% indicate missing data

Table 2: ***Frequencies, Percentages, and Measures of Tendency and Dispersion for Frequency of Tasks (n = 20)***

In the public health setting in which you work(ed), how often did/do you perform each of the following:	Often n (%)	Sometimes n (%)	Rarely n (%)	Never n (%)	Mean	Std Dev
Conduct needs assessment	10 (50.0)	6 (30.0)	3 (15.0)	1 (5.0)	3.25	0.91
Grant writing	4 (20.0)	8 (40.0)	6 (30.0)	2 (10.0)	2.70	0.92
Conduct literature reviews	4 (20.0)	6 (30.0)	7 (35.0)	3 (15.0)	2.55	1.00
Plan programs	15 (75.0)	5 (25.0)	0 (0.0)	0 (0.0)	3.75	0.44
Implement programs	17 (85.0)	1 (5.0)	1 (5.0)	1 (5.0)	3.70	0.80
Social marketing	11 (55.0)	5 (25.0)	2 (10.0)	2 (10.0)	3.25	1.02
Pamphlet development	6 (30.0)	8 (40.0)	5 (25.0)	1 (5.0)	2.95	0.89
Manage human resources	2 (10.0)	9 (45.0)	3 (15.0)	6 (30.0)	2.35	1.04
Perform evaluation	12 (60.0)	6 (30.0)	2 (10.0)	0 (0.0)	3.50	0.69
Lead advocacy issues related to health	10 (50.0)	4 (20.0)	1 (5.0)	5 (25.0)	2.95	1.28
Develop policies to promote health	3 (15.0)	6 (30.0)	5 (25.0)	6 (30.0)	2.30	1.08

Note: 4 = Often; 3 = Sometimes; 2 = Rarely; 1 = Never

Table 3: ***Frequencies and Percentages for Use of Selected Strategies (n = 20)***

Strategies	Frequency (n)	Percentage (%)
Methods for needs assessment		
Surveys	17	85.0
Secondary Data Analysis	12	60.0
Focus Groups	11	55.0
Observations	10	50.0
Interviews	10	50.0
Windshield/walk tours	1	5.0
Other	2	10.0
None of the above	0	0.0
Methods for Performing Evaluations		
Pre/post data comparison	18	90.0
Knowledge, attitudes, behavior surveys	14	70.0
Participation frequencies	10	50.0
Observations	7	35.0
Interviews	6	30.0
Focus groups	3	15.0
Other	1	5.0
None of the above	0	0.0
Planning Models Utilized for Planning and Implementing Programs		
Strengths, Weakness, Opportunities, Threats (SWOT)		
Evidence-based planning framework for public health	11	55.0
PRECEDE-PROCEED	10	50.0
Social Marketing Assessment and Response Tool (SMART)	7	35.0
Whole School, Whole Community, Whole Child (WSCC)	6	30.0
Healthy Communities	6	30.0
Mobilizing for Action through Planning and Partnerships	5	25.0
(MAPP)	3	15.0
Mobilize, Assess, Plan, Implement, and Track (MAP-IT)	3	15.0
Whole School, Whole Community, Whole Child (WSCC)	3	15.0
Intervention Mapping	2	10.0
None of the above		
Theories Utilized for Planning and Implementing Programs		
Social Cognitive Theory	13	65.0
Health Belief Model	13	65.0
Theory of Planned Behavior	8	40.0
Community Readiness Model	7	35.0
Theory of Reasoned Action	6	30.0
Transtheoretical Model of Change	6	30.0
Diffusion of Innovations	6	30.0
Community Organization Theory	5	25.0
None of the above	3	15.0
Information Motivation Behavior Theory	2	10.0
Social Network Theory	2	10.0
Social Capital Theory	1	5.0
Precaution Adoption Process Model	1	5.0

Note: Each item was check all that apply; therefore, percentages will not sum to 100%.

Table 4: ***Themes and Quotes for Suggestions for Faculty to Enhance their Courses***

Theme	Quotes
Integration of real-world experiences	• "Real world" public health is not as neat as it seems on paper. Times you are thrown into a project half way through, or you have to bend and mold your work to fit into the funding streams demands. It isn't as simple as assess, plan, implement, evaluate. Many grants come with specific assessment tools that may or may not fit your community. Grant timelines can also be a huge challenge- as they move too fast or too slow for the community they are supposed to serve. • Perhaps broaden the scope of learning to mental health settings. • Engage in practicum learning where people are in agencies learning how the work goes in real life. They should be engaged in research tools so that they know how to interpret research in practice. Teach students how to evaluate evidence-based practices. • Utilize real world projects more with real clients/patients rather than just lectures with examples. • Emphasize enhancing cultural competency and how to stay up to date with best practices as the field (and society in general) are always evolving and changing. • I think I was surprised by the amount of people who don't want your help, because they have too many other responsibilities weighing on them to make their health a priority. It's important to stress the social determinants of health to give students an answer to "why?" and a place to focus efforts.
Practical Skill Development	• It would be useful to have more practice with theories and using these in implementation in real life. I feel like I only know the definitions but not how to actually use them. • [Develop] an intro [course] where we are exposed to press releases, memos, newsletters, etc. then take it a step up to analyze how health media/communications impacts health policy/advocacy. • Ensure students have a clear understanding of the differences between working in non-profit vs a government organization. • GIS and developing resource materials. • Put a lot more emphasis on Lesson planning, pre/post-test surveying, reporting, inclusion and most IMPORTANTLY public speaking. • Have them write at least 2 practice grants (I wish I had more grant writing experience).
Course Adaptation	• Build opportunities to work with other departments to add a factor of interdisciplinary partnerships. After being in the field and working in a few settings I am the only health educator. It would help to educate others about our field and learn about the people we would be working with before we enter the workplace (i.e. engineers/planners - built environment, political science, health policy / advocacy, communications). • Incorporate community engagement or service-learning activities in their courses that provide students with real world experiences of what it is like to work with community to address public health issues. Community based public health can be messy and students would benefit from learning how to navigate these situations in a campus-community setting where they are able to apply what they learn in the classroom to the context of a community, agency, etc.

Table 5: ***Themes and Quotes for Suggestions to Students Preparing to Enter the Workforce***

Theme	Quotes
Immersion with Experiences	• Go volunteer… • …doing an internship somewhere. • Participate in research as much as possible, seizing every opportunity presented. Participate in internships. • Get as much experience as you can. • Try to have something on the resume that is valuable and relevant • …some experience with organizations in the field to build professional skills. • Networking. • Stay connected to those in your cohort… • Reach back out to college mentors and professors.
Sustained Learning	• …open to learning more • Continue learning… • Be humble – you don't know all you need to know. People are the experts in their own lives. • Be prepared to learn new things, and engage in professional development. Keep learning. • Take time to learn the community context where you plan/aspire to work in…
Self-Advocacy	• Don't underestimate your abilities. • Many new professionals are also not very good at talking themselves up in interviews. Perhaps giving them examples of ways things they've learned in the classroom and internships cold apply to common interview themes/questions. • Trust in what you know – you have skills and abilities that will advance public health. • Play up your world experience. There are not a large number of young professionals entering the public health field. As young professionals, you have a different set of inherent skills that you have been building throughout your life. Brag about your ability to successfully run a social media platform…
Creativity with Opportunities	• Public health/health education comes in many shapes and sizes (get creative with your career). • When applying for jobs, do no limit yourself by only searching for specific job titles. Many jobs are indeed public health jobs once you read the job description. • Keep an open mind. • Be open to new ideas, opportunities and partnerships.

Table 6: ***Themes and Quotes for Ways Health Educators Practice Cultural Competency***

Theme	Quotes
Sustained Community Engagement	• Strengthening diversity and actively trying to be more 'visually diverse' and inviting more representation to the table. • Review with community stakeholders/leaders who have been involved with the community through personal circumstances or through their own dedicated profession, also acknowledging the community by surveying what their needs are. • Ensure community is engaged and involved throughout stages of the planning and evaluation process. Identify key stakeholders in the community who can inform program decisions, and/or create a Community Advisory Board.
Cultivating Inclusive Environments	• I use an intersectional approach in my program planning and read a lot about other people's perspectives. I try to actively question the assumptions that I am making in my education/planning by writing them down and then challenging them as I go. I also expose my biases to the group that I'm working with at the beginning (i.e. I'm a white, queer, cisgender, middle-class person, etc.). • Continue to hold cultural competency trainings, communicate with individuals from all different backgrounds and be enthusiastic to learn more about individuals' cultures. • Prior to and during implementation we train our staff on cultural competency. • Hire a diverse workforce and take program evaluations seriously.
Material Development	• When designing material, we try to ensure that multiple races and ethnicities are being represented. We have community partners that work close with those with [limited English proficiency] LEP. • Audience testing. • We select evidence-based and evidence-informed programs/practices when we can. If we are creating something new, we gather feedback from the priority population and from our partners before implementing. • Using demographic data from the needs assessment to determine cultural needs. Ensure documents and directions are at a lower reading level and additional languages are available in all forms of communication.