Health Education Standards and Key Elements

Standard I: Candidates assess individual and community needs for health education.

Key Element A: Candidates obtain health-related data about social and cultural environments, growth and development factors, needs, and interests of students.

Key Element B: Candidates distinguish between behaviors that foster and those that hinder well-being.

Key Element C: Candidates determine health education needs based on observed and obtained data.

Standard II: Candidates plan effective health education programs.

Key Element A: Candidates recruit school and community representatives to support and assist in program planning.

Key Element B: Candidates develop a logical scope and sequence plan for a health education program.

Key Element C: Candidates formulate appropriate and measurable learner objectives.

Key Element D: Candidates design educational strategies consistent with specified learner objectives.

Standard III: Candidates implement health education programs.

Key Element A: Candidates analyze factors affecting the successful implementation of health education and Coordinated School Health Programs (CSHPs).

Key Element B: Candidates select resources and media best suited to implement program plans for diverse learners.

Key Element C: Candidates exhibit competence in carrying out planned programs.

Key Element D: Candidates monitor educational programs, adjusting objectives and instructional strategies as necessary.
Standard IV: Candidates evaluate the effectiveness of coordinated school health programs.

**Key Element A:** Candidates develop plans to assess student achievement of program objectives.

**Key Element B:** Candidates carry out evaluation plans.

**Key Element C:** Candidates interpret results of program evaluation.

**Key Element D:** Candidates infer implications of evaluation findings for future program planning.

Standard V: Candidates coordinate provision of health education programs and services.

**Key Element A:** Candidates develop a plan for coordinating health education with other components of a school health program.

**Key Element B:** Candidates demonstrate the dispositions and skills to facilitate cooperation among health educators, other teachers, and appropriate school staff.

**Key Element C:** Candidates formulate practical modes of collaboration among health educators in all settings and other school and community health professionals.

**Key Element D:** Candidates organize professional development programs for teachers, other school personnel, community members, and other interested individuals.

Standard VI: Candidates act as a resource person in health education.

**Key Element A:** Candidates utilize computerized health information retrieval systems effectively.

**Key Element B:** Candidates establish effective consultative relationships with those requesting assistance in solving health-related problems.

**Key Element C:** Candidates interpret and respond to requests for health information.

**Key Element D:** Candidates select effective educational resource materials for dissemination.

Standard VII: Candidates communicate health and health education needs, concerns, and resources.

**Key Element A:** Candidates interpret concepts, purposes, and theories of health education.

**Key Element B:** Candidates predict the impact of societal value systems on health
education programs.

**Key Element C:** Candidates select a variety of communication methods and techniques in providing health information.

**Key Element D:** Candidates foster communication between health care providers and consumers.
STANDARD I

Candidates assess individual and community needs for health education.

In needs assessments, health educators gather and analyze information to determine which health education program goals and strategies are appropriate for a specified target population. Individual needs may be basic--those essential for learning, growth, and development (e.g., food, water, shelter, warmth). They may, however, be more complex (e.g., sense of safety, security, and emotional support, self-efficacy) and affected by multiple family, school, and community factors (e.g., family structure, available community resources, opportunities to contribute).

Basic individual needs and/or complex family, school, and community needs are indicators of gaps between "what currently exists" and "what is optimal." Needs assessment is the systematic, planned collection of information about individuals’ health-related knowledge, attitudes, beliefs, perceptions, motivations, skills, and behaviors as well as environmental factors that may impact health. If possible, health educators can conduct more comprehensive needs assessments examining existing health-related programs and resources in the surrounding community. Needs assessment is critical to designing relevant, developmentally-appropriate, and culturally-sensitive health education programs. Assessing needs logically precedes planning and implementing program goals and strategies.

Comprehensive School Health Education

In the school setting, needs assessments are used to determine developmentally-appropriate and culturally-sensitive health education instructional strategies to address diverse needs of all students. More comprehensive needs assessments conducted in school settings also examine the status of existing coordinated school health program (CSHP) components—health education; physical education; health services; healthy environment; counseling, psychological, and social services; nutrition services; family and community involvement; and staff health promotion.

School health educators can use findings of national youth surveillance systems and other databases to understand current student needs. For example, by examining results of the Youth Risk Behavior Survey (CDC, 2001; Kolbe, 1990) and other national representative surveys (e.g., Monitoring the Future Survey [NIDA, 2000]; National Longitudinal Study of Adolescent Health [Resnick, et al., 1997]), school personnel, parents, and community members can understand the prevalence of youth health-related behaviors (i.e., behaviors that result in intentional and unintentional injuries, tobacco use, alcohol and other drug use, sexual behaviors that result in unwanted pregnancy and sexually transmitted infections, dietary patterns, and physical inactivity).
Ultimately, some local school and community assessments will be essential for
development of effective health education curricula. School, community, and public
health data and records are important sources of information about local health-
related needs. For example, student health and referral records (i.e., school nurse's
office visits; absence from school), local hospital emergency room treatment (e.g.,
acute asthma; drug overdose), and sexually-transmitted disease and pregnancy rates
can provide a picture of local health concerns and support the need for expanded
school efforts. Finally, school health educators should use both qualitative and
quantitative methods to elicit information directly and indirectly from students,
parents, teachers, administrators, and other school personnel.

Findings of the School Health Programs and Policy Study (SHPPS) (CDC, 2000d)
describe the status of coordinated school health program components across the
country. Using SHPPS instruments or the School Health Index (CDC, 2000b;
2000c), school health educators can determine CSHP program gaps in their schools.
In addition, state and national guidelines for school-based health programs and
policies (e.g., CDC, 1988, 1994, 1996, & 1997) can be reviewed and used to provide
direction to program and policy development, as appropriate.

**Collaboration with Health Educators in Other Settings**

Health educators in other settings can offer support to school-based needs assessment
efforts. For example, community health educators can provide current local, state,
and national data about youth, assist in assessment of student and family needs, map
existing community health-related programs and services, and assess community
support for school health programming. Community health agencies also can partner
with schools to enhance health programs at alternative schools and/or determine
outreach program needs for youth who have dropped out of school, run away from
home, and/or become homeless.

Health educators in medical care settings can provide information about youth
problems/issues as presented to health care providers or within hospital emergency
rooms. Health educators at post-secondary institutions can work with local schools
and their partners to administer the Youth Risk Behavior Survey, conduct student and
family needs assessments, summarize and interpret results, and provide recommen-
dations for school health education and CSHPs. Finally, health educators in worksite
settings could include discussions about youth issues as part of worksite health
promotion programs for working youth, parents/guardians, and other adults.
**Key Element A:**
Candidates obtain health-related data about social and cultural environments, growth and development factors, needs, and interests of students.

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<tr>
<td>Candidates are unable to assess validity and reliability of sources of needs assessment data; fail to use technology-based sources of information; use inappropriate data-gathering instruments and procedures.</td>
<td>Candidates select valid, reliable, and credible sources of data and information about health needs, interests, and concerns; use technology-based sources of information; identify appropriate data-gathering instruments; apply various methods to collect health-related data and information.</td>
<td>Candidates use multiple formats to select valid, reliable, and credible sources of information about health needs, interests, and concerns; design valid and reliable instruments to assess baseline knowledge, attitudes, perceptions, and skills; develop culturally-sensitive plans for effective administration of needs assessment instruments; organize obtained data to facilitate analysis.</td>
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**Supporting Explanation:**

Conducting needs assessments requires that health educators are able to locate relevant existing information and statistics about student health needs; generate additional data, as appropriate; and verify validity, reliability, and credibility of information sources. To ensure a broad understanding of students’ developmental and health-related needs, related factors, interests, and concerns, health educators should access multiple sources of secondary data and information, including federal agencies, national organizations, and state/local agencies. These data include those that are routinely gathered as part of national, state, and local surveillance systems or funded research investigations. To gather primary data directly from students, families, teachers, and administrators, health educators first must understand school district protocols for conducting research and, upon approval, can administer surveys, conduct individual and focus group interviews, observe student behavior in classrooms and throughout the school, and/or conduct health risk assessments. A critical step is evaluation of all available data and information to determine if they are relevant and applicable to the local student population, school, and community.
Key Element B:
Candidates distinguish between behaviors that foster and those that hinder well-being.

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<td>Candidates are unable to identify individual, family, school, peer group, and community factors that influence health-related choices; describe how personal behaviors affect personal health and well-being; explain how personal experiences affect health-related decisions.</td>
<td>Candidates identify physical, social, emotional, intellectual, and other factors that influence one or more health-related behaviors of school-aged youth; distinguish between risk and protective factors within the family, school, peer group, and community; identify individual behaviors that promote and/or compromise personal health and well-being; articulate how cognitive, affective, and skill-based learning and other experiences impact patterns of health behavior.</td>
<td>Candidates compare and contrast the potential impact of diverse factors on health-related behaviors of school-aged youth; analyze the relationship between family, school, peer, and community risk and protective factors and specified health-related behaviors; predict immediate and long-range effects of health-related behaviors; examine interrelatedness of cognitive, affective, and skill-based learning experiences.</td>
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Supporting Explanation:

Personal behaviors affecting health are based upon a complex interaction of knowledge, attitudes, beliefs, perceptions, values, experiences, and skills. A young person's developmental needs, hopes and fears, short- and long-term goals, and desire for social acceptance also may impact health-related choices. Moreover, decisions about personal behavior can be influenced by risk and protective factors within the family, school, peer group, and community.

Principal determinants of students' behaviors differ dramatically depending on the situation and circumstances, and can change over time. Most personal behaviors are either beneficial or harmful for the short-term. Over the long-term, the aggregate of personal behaviors can foster or compromise personal health and overall well-being. Health educators must be able to identify individual, family, school, and community factors that can be addressed, modified, or eliminated to address factors that could
influence health-related behaviors of youth and implement effective health education curricula and CSHPs.

Key Element C: Candidates determine health education needs based on observed and obtained data.

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<tr>
<td>Candidates are unable to gather and summarize needs assessment data; classify needs of school-aged youth; recommend school-based strategies for prevention and early intervention.</td>
<td>Candidates review, display, and interpret needs assessment data for diverse student populations; establish criteria for prioritizing areas based on diverse student needs; apply established criteria to identify priority needs for school-based health education and CSHPs.</td>
<td>Candidates synthesize multiple sources of qualitative and quantitative needs assessment data; evaluate health-related data to determine priority needs for school-based health education, CSHPs, and supporting community programs and services for diverse student populations; communicate need for coordinated, collaborative school and community efforts.</td>
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Supporting Explanation:

Developmentally-appropriate health education needs of school-age youth and their families should not be assumed nor estimated, but must be based upon information obtained through multiple valid, reliable, and credible sources and data collection methods, as feasible. School health educators can obtain existing data about youth risk behaviors as well as predisposing, reinforcing, and enabling factors of health-related behavior in the family, school, and/or community from national, state, and local morbidity and mortality reports, local health department reports, youth risk behavior surveillance systems, and published/unpublished research, to name a few. Additional data can be collected through qualitative and quantitative methods, including individual and focus group interviews, classroom and school observations, written surveys of youth, families, teachers, and/or administrators, health risk appraisals, and other methods. To determine trends and patterns of needs relative to youth and their families, school health educators must be able to tabulate, organize,
and summarize needs assessment data. Established criteria used to determine health education and CSHP priorities should be applied to guide program planning.

**STANDARD II**

**Candidates plan effective health education programs.**

Health education program planning follows needs assessment and is based on identified health-related needs, problems, and concerns of the target population. Prior to initiation and throughout the planning process, health educators should involve key stakeholders, including but not limited to community leaders, representatives from community organizations, resource people, and representatives from the target population (e.g., youth/others from various cultural and ethnic backgrounds, and educational levels).

Health educators first must formulate program goals to provide overall direction and focus of the health education curriculum as well as other health promotion strategies. Then, measurable program and learner objectives are developed to address specific changes anticipated as a result of the health education program. Finally, based on characteristics of the target audience and available resources, health educators select and/or develop specific instructional strategies and program components to meet established program goals and objectives.

**Comprehensive School Health Education**

In the school setting, program planning relates both to the health education curriculum and CSHP. School health educators should facilitate a collaborative program planning process involving school administrators, teachers, nurses, counselors, food service managers, parents/guardians, students, and representatives from related community health agencies and organizations. Optimally, school health advisory councils should be established at both the school-site and district-level to ensure that the health education curriculum and other CSHP components are comprehensive, developmentally-appropriate, and culturally-sensitive. Composition of district-level and school-site health advisory committees will vary based on existing school and community resources.

Adopted health education curricula, whether locally-developed or commercially-published, should be based on district/state frameworks/guidelines and nationally-established criteria, and should reflect student, family, and community needs. In addition, preK-12 curricula should promote health literacy—the capacity to obtain, interpret, and understand basic health information and services and the competence to use information and services in ways that are health-enhancing (Joint Committee on Health Education Standards [JCHES], 1998). Decisions about curriculum content
and process (what health-related concepts and skills should be taught at which grade levels) as well as proposed student outcomes (what students will be able to do) should be based on state/national health education standards as well as current research findings (JCHES, 1998). Health education standards are supported by specific performance indicators that should guide learner objectives.

School health educators select instructional methods and strategies based on the cognitive, affective, and skills-based objectives to be met, developmental readiness and learning styles of students, and available resources. A variety of interactive teaching strategies is needed to address diverse student needs, to maintain interest and discipline, and to meet objectives in all domains of learning. A minimum of 50 hours of health education instruction at every grade level is necessary to provide and reinforce essential health skills for a lifetime (Connell, et al, 1985).

Because health-risk behaviors are complex and interrelated, school health educators should promote CSHPs; these complementary and synergistic components can address the needs of children and their families more comprehensively (Allensworth & Kolbe, 1987; Marx & Wooley, 1998). Within schools, efforts should be made to support and expand CSHPs so that the health education instructional program is well articulated with other CSHP components.

Collaboration with Health Educators in Other Settings

Health educators and other professionals in community, medical care, university, and worksite settings can support and enhance school health education and CSHP planning efforts in a variety of ways. As active members of school-level and/or district-level health advisory committees, their combined expertise related to program planning would more adequately address student, family, and community needs. Coordinating existing and potential resources in the surrounding community with school-based efforts will maximize funded efforts and minimize duplication of health-related programs and services. For example, in planning a comprehensive substance use prevention program, research-based classroom instruction could be supported by a variety of after-school youth activities sponsored by local youth serving organizations (e.g., Boys and Girls Clubs, YMCA, YWCA). Other community programs, such as Big Brothers/Big Sisters, could connect high-risk youth with adult mentors. Campaigns for drug-free school zones could be established by the local health department and law enforcement agencies. Professionals and youth from local treatment centers could address school-aged youth in classroom settings. Finally, university health educators could advocate with state representatives for increased school/community funding for substance use prevention programs.
Key Element A:
Candidates recruit school and community representatives to support and assist in program planning.

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<tr>
<td>Candidates are unable to identify and obtain commitments from individuals and/or groups who work in health-related programs; do not know how to elicit opinions of those who may affect or be affected by the school-based program.</td>
<td>Candidates identify individuals and/or groups whose cooperation and support will be essential to program success; integrate other school and community resources and recommendations within the health education program plan.</td>
<td>Candidates use persuasive communication skills to justify the need for health education and CSHPs to various audiences; involve key decision makers, resource people, representatives from community organizations, and potential participants as advisors in the planning process; obtain broad-based support for the health education program; demonstrate dispositions and skills to serve as a contributing member of a community advisory committee.</td>
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Supporting Explanation:
Planning effective health education and coordinated school health programs requires communication, cooperation, coordination, and collaboration with multiple individuals and groups within the school and the surrounding community. School health educators first must identify key stakeholders, including other school personnel (e.g., administrator, school nurse, social worker, guidance counselor, school psychologist, food service managers) as well as health professionals from other settings, parents, and students. Then, they must enlist support for stakeholder participation in the pre-planning and planning process by persuasively communicating the need for health education and CSHPs.

A formal school health advisory committee comprised of individuals who have desired expertise, are associated with related community programs, and/or are potential participants should be established before the planning process begins. Key functions of advisory groups include considering health-related problems of youth and their families (based on findings of needs assessments), mapping existing health-related programs and services,
identifying and prioritizing program and service needs, exploring potential solutions, and recommending feasible program goals and strategies.

Key Element B:
Candidates develop a logical scope and sequence plan for a health education program.

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<td>Candidates lack basic knowledge of health-related concepts and skills; cannot prioritize health-related content and skills based on needs assessment; display minimal knowledge of developmental and cultural characteristics of students; design a scope and sequence inappropriate for designated student populations.</td>
<td>Candidates apply decision-making, communication, goal-setting, self-management, and advocacy skills as they relate to health content; display functional knowledge of health concepts related to: alcohol and other drugs, injury prevention, nutrition, physical activity, sexual health, tobacco, mental health, personal and consumer health, and community and environmental health; determine the range of essential health concepts and skills that are developmentally-appropriate and culturally-sensitive to a diverse student population; organize and prioritize the scope of a health education program in a logical sequence.</td>
<td>Candidates demonstrate in-depth and substantive health knowledge and integrate key concepts; address physical, mental, intellectual, emotional, social, and spiritual dimensions of health; apply health-related skills across multiple health content areas; integrate developmentally-appropriate and culturally-sensitive functional knowledge and skill-building experiences for diverse groups of learners within the scope and sequence of proposed health education programs; link health concepts and skills with other subjects areas.</td>
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Supporting Explanation:

Decisions about health education scope and sequence (i.e., what health-related content and skills should be included at each grade level) are critical so that learning is logical, sequential, developmentally-appropriate, and culturally-sensitive. The scope of the health education curriculum sets boundaries as to what content and skills should be included in the instructional program. Sequence refers to the order in which
selected health content and skills are presented. School health educators must be able to sequence health content and skills consistent with the National Health Education Standards (JCHES, 1998). These concepts and skills build upon and reinforce previous learning from PreK through twelfth grades.

Based on results of the needs assessment, careful planning of the health education curriculum at each grade level should take into consideration students’ readiness and receptivity, their strengths and abilities, and their past experiences as well as the nature of the health content itself. For maximum effectiveness, the school health educator must be able to prioritize health promotion and risk reduction instructional strategies based on the amount of time allocated for health education.

**Key Element C:**
Candidates formulate appropriate and measurable learner objectives.

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<td>Candidates are unable to designate developmentally-appropriate performance indicators; cannot use national/state standards and guidelines to develop program goals, benchmarks, and performance indicators; cannot design learner objectives addressing multiple domains; fail to review and modify performance indicators and learner objectives, as needed.</td>
<td>Candidates use the scope and sequence plan and state/national standards and guidelines to designate performance indicators that describe functional health concepts and essential student skills; design measurable cognitive, affective, and skills-based learner objectives that are developmentally-appropriate; review and revise performance indicators based on current needs assessment findings.</td>
<td>Candidates formulate measurable learner objectives to address state/national standards; identify how health education performance indicators and learner objectives can be addressed and supported within other disciplines; delineate how other CSHP components can support the health education scope and sequence.</td>
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**Supporting Explanation:**

Health education curricula should be aligned with the National Health Education Standards (JCHES, 1998). The ability to design effective curricula based on national and state standards includes identifying benchmarks and formulating performance indicators that are behavioral and observable in an educational setting. If program objectives are not observable, the school health educator cannot assess lesson effectiveness or determine if the curriculum is increasing knowledge, enhancing skills, and facilitating adoption of healthful behaviors. Because knowledge by itself does not
change behavior, objectives should be written in the affective and skills-based domains of learning in addition to the cognitive domain.

**Key Element D:**
Candidates design educational strategies consistent with specified learner objectives.

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<td>Candidates fail to review existing curricula before developing learner objectives; propose instructional strategies unrelated to program objectives or performance indicators; design instructional strategies limited in scope.</td>
<td>Candidates <em>access and review existing or new health education curricula for consistency with performance indicators and research-based “best practice;” delineate a wide variety of instructional strategies aligned to meet diverse student needs; plan service learning opportunities that reinforce mastery of previously identified learner objectives.</em></td>
<td>Candidates design new and innovative instructional strategies consistent with “best practice” that support performance indicators and address diverse learning styles; propose multiple strategies within CSHP components to support health instruction.</td>
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**Supporting Explanation:**

After formulating a health education scope and sequence and writing performance indicators, the school health educator plans instructional strategies that support program objectives. Instructional strategies should be consistent with “best practices” in prevention education. Most important, a variety of instructional strategies are needed to address all domains of learning, diverse learning styles, and multiple intelligences, thus maintaining interest and enthusiasm on the part of students.

**STANDARD III**

**Candidates implement health education programs.**

The primary practice of a health educator, regardless of setting, includes motivating the adoption of a healthy lifestyle by providing functional information and skills related to health concepts and issues. This task is accomplished through implementation of a planned health education program reflecting student, family, and community needs.
Key to successful implementation is understanding and monitoring appropriate, effective instructional strategies and other health-related programs and services. Related to program implementation, health educators identify available internal and external resources, including personnel, funding, time allocation, and space and design or purchase instructional and other support materials. Health educators must be able to identify potential challenges to adoption of health education programs and develop strategies to overcome them.

**Comprehensive School Health Education**

In the school setting, implementation usually involves classroom instruction where the health educator strives to increase students’ knowledge, foster positive attitudes toward the value of health, improve health-related skills, and promote adoption of health-enhancing behaviors. The school health educator is responsible for implementing the planned, sequential, skills-based curriculum developed and approved by state- and/or district-level advisory committees. Based on established curriculum goals and cognitive, affective, and skill-based objectives appropriate for learners’ developmental levels, school health educators prepare and implement related lesson plans that progress toward achievement of those objectives.

School health educators use the widest range of instructional methods and techniques, most often interactive and experiential in approach. Implementation of theory-driven, research-based curricula should focus on providing functional health information and developing essential skills for adopting, practicing, and maintaining healthy behaviors (CDC, 2000d; Dusenbury & Falco, 1995; Kirby, 1997; National Institute on Drug Abuse, 1997). Careful selection and utilization of related community resources will enhance lesson implementation and strengthen the adopted health education curriculum. Incorporating service learning experiences will encourage application of health-related knowledge and skills in practice.

Additionally, school health educators work with other school-based professionals (e.g., physical educators, counselors, social workers, nurses, food service managers) to facilitate implementation of a CSHP (Allensworth & Kolbe, 1987; Marx & Wooley, 1997). School-based learning strategies and other CSHP components should be monitored on an ongoing basis to identify and address implementation barriers (e.g., administrative support; professionally-prepared personnel; time allotments; funding; available facilities; and perceptions of administrators, other staff, parents/guardians, and community members).

**Collaboration with Health Educators in Other Settings**

Health educators in other settings should work with school health educators to implement a more comprehensive approach to prevention and intervention. School health educators often collaborate with health educators in community and medical
care settings by scheduling outside speakers, programs, service learning opportunities, and/or community service projects. Before implementation, however, proposed community resources should be reviewed to ensure they are consistent with school district policy and state education codes, and reinforce curriculum goals and objectives. Public health educators can facilitate health-related community awareness campaigns. Health education faculty can assist by summarizing current research related to “best practices” and barriers to implementation of school-based programs. Health educators in worksite settings can provide awareness sessions to employees, including parents.

For example, health education curricula focusing on HIV prevention could be enhanced by incorporating HIV-positive speakers within classroom presentations and identifying available community resources, including HIV testing locations. As part of a service learning experience, school-aged youth could work with community members to provide HIV information/resources on World AIDS Day. Health educators in university settings (and students enrolled in professional preparation programs) could summarize current research and offer professional development sessions about key elements of effective HIV prevention programs and implementation strategies. In the worksite, health educators could provide sessions about universal precautions for blood borne pathogens and HIV-related community resources.

**Key Element A:**
Candidates analyze factors affecting the successful implementation of health education and CSHPs.

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<td>Candidates fail to pretest learners or use other data sources to determine students’ developmental level, readiness to learn, and level of health-related knowledge and skill relative to proposed learner objectives; are unable to design enabling objectives; fail to delineate facilitators and barriers to implementation of health education curriculum and CSHPs.</td>
<td>Candidates <em>gather</em> information about students’ previous knowledge, attitudes, perceptions, and skills; <em>determine readiness for proposed instructional strategies</em>; <em>identify supports and barriers to successful implementation of health education curricula and CSHPs and strategies to overcome barriers.</em></td>
<td>Candidates <em>interpret</em> information about students’ current knowledge, attitudes, perceptions, and skills; <em>revise</em> instructional strategies as necessary; <em>revise and pilot</em> preliminary instructional strategies that allow for differences in students’ readiness to learn; <em>identify</em> strategies to enhance and expand supports for health education and CSHP efforts.</td>
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Supporting Explanation:

Curricular goals or benchmarks are designed to provide structure and direction to educational programs and are intended to organize units of study rather than facilitate single classroom presentations. Within curricular units, learner objectives are representative of essential health content and skills; that is, what students should know and be able to do. Gathering and interpreting information about student readiness ensures that they can attain the requisite level of health-related knowledge, attitudes, perceptions, and skills within multiple contexts. This information helps school health educators prepare students to apply health knowledge and skills in real-world situations and make connections to prior and future learning experiences. In addition to practicing skills in the classroom, service-learning experiences can provide opportunities for students to apply and refine acquired skills.

Because health-related issues and concerns are complex, school health educators should be competent to work with other school-based professionals in the provision of CSHPs. CSHPs can provide a network of support programs and services to ensure acquisition and application of students’ health-related knowledge and skills. To ensure successful implementation of health education and CSHPs, school health educators should be able to identify existing and potential supports and barriers (e.g., policy/administrative support; adequate instructional materials, staff, facilities, time, and professional development) and propose ways to enhance supports and overcome barriers.

Key Element B:
Candidates select resources and media best suited to implement program plans for diverse learners.

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<td>Candidates are unable to identify factors that influence choices of curricula, strategies, and materials; are unaware of alternative methods to help students meet proposed learner objectives; are unable to assess availability of resources related to health education and CSHP implementation.</td>
<td>Candidates analyze diverse learner characteristics and other factors when choosing appropriate materials, technology, and media; access and use state-of-the-art resources, educational media, and instructional technology and equipment; develop criteria for choosing most promising instructional resources and CSHP strategies to match objectives for diverse learners.</td>
<td>Candidates create educational media that engage all students in meaningful learning experiences; as appropriate, vary learner objectives with different instructional groups; evaluate efficacy of alternative resources and materials to help diverse students meet proposed objectives and support health education and CSHP goals.</td>
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Supporting Explanation:

Student learning occurs through a variety of experiences and can be supported and enhanced through a CSHP. No one method is effective with all audiences and in all settings. School health educators must, therefore, competently use a wide repertoire of instructional strategies, technological applications, and related resources. Effective school health educators should employ textbooks, published curriculum units, and other print material as well as technology-based formats, such as health-related computer software programs, the Internet, computer-assisted instruction, and instructional television programming. School health educators must understand the strengths and weaknesses of these instructional materials and media and be able to appropriately apply these resources.

Key Element C: Candidates exhibit competence in carrying out planned programs.

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<td>Candidates use limited range of educational methods that are passive rather than experiential; fail to distinguish appropriateness and timeliness of individual and group strategies; lack classroom management skills; use limited instructional resources or media; make few, if any, connections with previous learning, other subject areas, or existing programs/services related to CSHP components.</td>
<td>Candidates employ “best practice” experiential methods that impact cognitive, affective, and skill domains; apply pedagogically sound learning strategies for diverse individuals and groups; use developmentally-appropriate and culturally-sensitive classroom strategies and service-learning experiences to support designated learner objectives; manage classroom logistics and maintain order; request, access, and use available facilities and space for instruction; effectively use a variety of resources and media.</td>
<td>Candidates apply diverse innovative instructional strategies that accurately match specific learner objectives and performance indicators; demonstrate dispositions and skills to facilitate large and small group discussions to increase students’ critical thinking skills; implement health-related skill-building strategies within other subject areas; appropriately apply classroom management skills; use state-of-the-art resources; coordinate the health education instructional program with other disciplines and CSHP components.</td>
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Supporting Explanation:

To carry out planned educational programs, school health educators must be able to present functional health information and facilitate application of health-related skills to relevant content areas of health education. In some cases, they also facilitate integration of health-related knowledge and skills in other disciplines and coordination of the health education program with other CSHP components. Implementation of a health education program involves carrying out a pedagogically-sound series of strategies to affect changes in knowledge, attitudes, perceptions, skills, behavioral intent, and personal behaviors, as appropriate, for individuals and groups of students. Because students have varied backgrounds, experiences, and learning styles, classroom strategies must be developmentally-appropriate and culturally-sensitive. Selection of instructional strategies—lecture, cooperative learning groups, role plays, case studies, audiovisual presentations—should be based upon intended learner outcomes, diverse learner characteristics, available time and equipment, and whether selected methods provide sufficient practice for health-skill development. To maintain order and enhance student learning during interactive student-centered strategies, school health educators need to develop effective classroom management skills. To maximize successful implementation of health education, CSHP strategies, such as parent/guardian workshops, health screenings, community service opportunities, community awareness campaigns, should be coordinated with instructional strategies.

Key Element D:
Candidates monitor educational programs, adjusting objectives and instructional strategies as necessary.

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<td>Candidates cannot assess relevance of existing learner objectives to meet student needs; adhere rigidly to established curricula, even when changes in instructional strategies will more adequately meet student needs; ignore or disregard student questions or concerns; produce mixed results when attempting to adjust lesson and objectives.</td>
<td>Candidates monitor educational strategies, resources, and materials as relevant to learner objectives; address emerging student questions, concerns, and interests on an ongoing basis; monitor student work as it relates to stated student outcomes; revise learner objectives and instructional strategies to meet emerging diverse student needs.</td>
<td>Candidates integrate revised learner objectives and instructional strategies with CSHP components with changing student needs; successfully make adjustments to lessons in progress; access effective alternative approaches for students who are unable to achieve mastery and need assistance.</td>
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</table>
Supporting Explanation:

Continuous and ongoing monitoring of health education programs ensures that learner objectives are relevant and appropriate to the needs, concerns, and interests of students. When planned activities are unable to meet current student needs or are too simple or too complex for student groups, instructional effectiveness is compromised. Likewise, as prevalence of health-related risk behaviors change, specific health content areas and/or skills may no longer be relevant and appropriate to specific age groups. Additionally, emerging needs, concerns, or issues may not be adequately addressed in the existing health education curriculum. On a regular basis, school health educators should review stated student outcomes of their health education programs to determine if they are consistent with current student needs. They must examine their current instructional and CSHP strategies to determine if they will lead to successful attainment of state student outcomes. They also must be able to adjust instructional strategies and CSHP components, as needed, to help all students become “health literate.”

STANDARD IV

Candidates evaluate the effectiveness of comprehensive school health education.

Evaluation is an integral part of planning, developing, and implementing health education programs. It is defined as the process of determining the degree to which program goals and objectives have been completed and/or met (Timmreck, 1995). A comprehensive evaluation incorporates an ongoing, cyclical process of collecting, interpreting, and applying information to improve health education programs. The evaluation process begins before program development, proceeds throughout implementation, and ends after health education program strategies are completed.

Health educators typically are involved with two types of evaluations: formative evaluations and summative evaluations. They conduct formative evaluations as “quality control” of programs and services in practice. Initial stages of formative evaluation include “pilot” or “preprogram studies” to detect any challenges or problems with instructional or other program strategies before full implementation (i.e., What instructional strategies seem to be working? Are there significant challenges to implementation?). Health educators also conduct “process evaluations” to determine efficacy of the implementation process (i.e., Are program strategies implemented as planned? Are students, teachers, administrators, parents satisfied with the program?), identify health education program strengths and weaknesses, and determine if program modifications are needed.
Health educators conduct **summative evaluations** to provide a summary of program effectiveness and draw conclusions about impact and outcome of a health education program (McDermott & Sarvela, 1999). “Impact evaluations” determine immediate changes in knowledge, attitudes, beliefs, perceptions, behavioral intent, and skills that occur as a result of a health education program (i.e., Is the health education program meeting its delineated objectives? How effective is the health education program?). “Outcome evaluations” assess changes or improvements in health status indicators (e.g., morbidity, mortality, and natality rates) over longer periods of time. Because health status can be affected by multiple outside factors, health educators should not use outcome evaluations to determine effectiveness of health education curricula.

**Comprehensive School Health Education**

In a school setting, health educators most often use their evaluation skills to “pilot” new instructional strategies, to ascertain if the teaching/learning “process” is working, and to determine the “impact” of the health education curriculum on students’ knowledge, attitudes, perceptions, behavioral intent, and skills.

Evaluation plans based on student needs and proposed learner objectives will provide critical input related to future health education curricular decisions. Evaluation data should monitor student performance on curriculum-embedded assessments to indicate progress toward predetermined health education standards and performance indicators. If students are or are not achieving a level of competence, information about fidelity to the health education curriculum, professional preparation/development of teachers, and time allotments may help indicate what changes are needed in curricular development and implementation.

Depending on the breadth and depth of evaluation methods, school health educators can use both formative and summative results. Formatively, generated data can inform school health educators about how well they have addressed learner objectives and apprise students about how well they have performed. In addition, program evaluation results can identify curriculum strengths and weaknesses and be used as the basis for revisions in learner objectives, instructional strategies, and other program components. Summatively, school health educators can evaluate changes in student knowledge, attitudes, perceptions, and skills as the basis of grading or self-evaluation, reevaluating program goals and learner objectives, and/or making recommendations for addition, deletion, or revision of health education instructional strategies.

If possible and appropriate, school health educators should work with other school/community professionals to facilitate evaluation of CSHPs. Formative evaluation efforts could include assembling portfolios to document CSHP-related activities; reporting numbers of participating students, parents, and staff and determining their satisfaction with existing and/or newly-implemented CSHP components; and monitoring one or more CSHP components to identify existing or potential challenges to
full implementation. Summative evaluations could include determining the impact of one or more CSHP components on student, parent, or staff knowledge, attitudes, perceptions and/or skills.

**Collaboration with Health Educators in Other Settings**

Health educators working in other settings can support evaluation of school health education curricula and coordinated school health programs in a variety of ways. Community health educators may work in concert with school health personnel to determine the efficacy and/or effectiveness of community-related programs such as speaker’s programs, service learning opportunities, parent awareness or health education programs, social service programs, and after-school/youth outreach interventions. University faculty can provide evaluation expertise and personnel related to data collection, analysis, and interpretation.

Because health educators and others working in medical care settings recently have expanded efforts into school settings, these professionals should work with school health educators to design evaluations to determine efficiency and effectiveness of school-based health clinics and other health service programs (e.g., immunizations, screenings, counseling, and medical treatment). Viewing schools as a workplace, health-related knowledge, attitudes, and skills of administrators, teachers, bus drivers, custodians, and other staff are integral to the healthy school environment. Evaluations of work-site health promotion programs, including process evaluation of staff wellness programs and ongoing assessment of morale, absenteeism, and job satisfaction, could provide critical information to use for expansion or revision of the worksite health promotion program.
Key Element A:
Candidates develop plans to assess student achievement of program objectives.

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<td>Candidates are unable to identify criteria to determine student progress; cannot create an evaluation plan that includes both formative and summative evaluation strategies; cannot identify and access technological or other resources to locate valid and reliable instruments measuring student performance and/or program impact; cannot articulate the relationship between formative evaluations and summative evaluations.</td>
<td>Candidates develop standards of performance as criteria for assessing impact on student learning; devise a realistic and feasible evaluation plan that spans health education and CSHP implementation; develop an electronic inventory of valid and reliable evaluation instruments; select appropriate formative and summative evaluation methods to determine student progress and levels of CSHP implementation and impact.</td>
<td>Candidates use current resources and technology to identify existing data to establish performance criteria; adapt existing or develop valid and reliable performance-based tools for measuring student outcomes; evaluate validity and reliability of existing evaluation instruments; select measures matched with designated evaluation purposes; apply appropriate qualitative and quantitative evaluation designs and methods for evaluation of health education and CSHPs.</td>
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**Supporting Explanation:**

The goal of school health instructional programs is to develop “health literate” students who use functional knowledge and skills to modify or maintain health-promoting behaviors. Health knowledge and skills are based on the national health education standards (JCHES, 1998) and/or state standards supported by performance indicators that guide selection and specification of learner objectives. Attainment of learner objectives should be the focal point for all decisions related to planning, implementing and assessing health instruction and student outcomes. Authentic assessment measures should be identified and used to measure the extent to which state and national standards have been achieved (e.g., CCSSO/SCASS, 1999).

The evaluation purpose(s) will determine components of the “plan,” including how the evaluation will be conducted and what data should be collected (Ames, Trucano, Wan, & Harris, 1995). The development of an evaluation plan allows the school health educator to “describe what is to be evaluated, what methods will be applied, and by what standards [or criteria] the results will be judged” (NCHEC, 1996, p. 38). For example, school health educators who want to determine how to improve the teaching/learning process or monitor CSHP implementation would conduct a formative evaluation. Of importance are curriculum content and process, policy development, and implementation procedures; instructional delivery systems,
methods, strategies, materials, resources, time allotments, and facilities; and staff qualifications, certifications, and professional development. To determine the impact of instructional programs, school health educators plan summative evaluations; proposed student outcomes are identified and appropriate qualitative and quantitative methods would be used systematically to measure resultant changes in students’ knowledge, attitudes, perceptions, behavioral intent, and skills.

School health educators also must recognize that no single source of information or method of evaluation can provide a sufficient amount of information about cognitive, affective, or skill-based improvements in learners and/or CSHP program impact. Evaluation methods should be varied, be performance-based, and relate directly to instructional and program objectives (NCHEC, 1996). To this end, the school health educator must be able to use technology and other resources to locate and evaluate instruments for validity, reliability, and appropriateness for the purpose(s) specified in the evaluation plan. If none are available, health educators must be able to develop authentic and/or psychometrically-sound measures to determine how the learning process should be modified to monitor student progress and achievement.

**Key Element B: Candidates carry out evaluation plans.**

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<td>Candidates are unable to administer assessment measures related to the evaluation plan; use limited range of potential assessment methods (e.g., paper-pencil tests); do not relate assessment techniques to student outcomes; unable to use computer technology and basic statistical procedures to input and analyze evaluation data.</td>
<td>Candidates <strong>delineate steps to implement evaluation plans; administer measurement instruments as specified in evaluation plan; use appropriate data collection methods to assess impact on student learning; use computer technology and basic statistical procedures to input and analyze evaluation data.</strong></td>
<td>Candidates <strong>utilize authentic assessment strategies to determine impact on student knowledge and skill; identify and address common barriers to implementation of evaluation plans; appropriately use both qualitative and quantitative measurement instruments and data collection methods to implement a comprehensive evaluation plan; use various software programs designed for statistical analysis of evaluation data; determine effectiveness of CSHP strategies.</strong></td>
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**Supporting Explanation:**

The careful and appropriate implementation of an evaluation plan is as critical as development of the plan itself. School health educators must be able to delineate steps involved in implementing evaluation plans as well as identify, use, and/or develop data collection instruments and methods to measure program fidelity and/or impact of health instruction and CSHPs.

Ideally, performance-based curriculum-embedded assessment techniques (e.g., *The Assessment Framework* [CCSSO/SCASS, 1999]) would be used to determine if students are achieving a level of “health literacy” based on developmentally-appropriate performance indicators. Other data collection methods, such as paper-pencil tests, questionnaires, surveys, observation checklists, and focus group/individual interviews also could be administered to gather information about program implementation and to determine the impact of the instructional program and/or CSHP.

**Key Element C:**

**Candidates interpret results of program evaluation.**

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<td>Candidates are unable to connect evaluation results with stated student outcomes; incorrectly summarize and interpret evaluation results for students, families, school personnel, and community members; are unable to propose program changes based on evaluation results.</td>
<td>Candidates use evaluation results to determine impact of instruction on student learning and group progress based on criteria stated in performance indicators; interpret evaluation results; demonstrate dispositions and skills to present findings to students, families, school personnel, and community members; identify limitations of evaluation design; use aggregate data to recommend changes in health instruction.</td>
<td>Candidates use multiple methods for analyzing qualitative (e.g., content analysis) and quantitative (e.g., univariate and bivariate statistical analyses) evaluation data; organize evaluation data in attractive and appropriate tables and graphs; compare evaluation results to findings of similar programs; use aggregate data to recommend changes in CSHP components.</td>
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Supporting Explanation:

Once data are collected, school health educators must organize, record, and analyze resulting evaluation data using various qualitative and quantitative methods (e.g., content analysis, observations, descriptive statistics). Then, results must be interpreted for students, families, school personnel, community members, and others. Most important, school health educators translate individual/group data and statistical terminology into meaningful concepts related to health education practice. Interpretation of results is dependent on criteria previously established during development of instructional objectives and program goals.

Key Element D:
Candidates infer implications of evaluation findings for future program planning.

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<td>Candidates are unable to determine or recommend program changes based on evaluation results; cannot relate evaluation results to student outcomes, teaching/learning strategies and/or other CSHP strategies; are unaware of potential bias and/or uncontrolled variables in evaluation results; make inappropriate recommendations for program changes.</td>
<td>Candidates interpret evaluation results to draw inferences about future program efforts; describe relationships among student outcomes, candidate dispositions and skills, and evaluation strategies; explore possible explanations for evaluation findings; provide explanations for bias in evaluation results; use results to determine and recommend modifications of instructional program and/or CSHPs.</td>
<td>Candidates make multiple recommendations for instructional programs and/or CSHP based on evaluation results; prepare an objective evaluation report; refine evaluation plan and/or process based on analysis and interpretation of results.</td>
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Supporting Explanation

Accurate interpretation of evaluation results leads to the exploration of explanations for evaluation findings. School health educators should ask questions that connect results of individual and group progress with learner objectives. Specifically, they must determine if performance criteria stated in instructional objectives were realistic, if instructional strategies allowed adequate practice for skill development among
students, and if adequate time was allotted for the development of functional knowledge and skills. School health educators also should analyze the evaluation process including the strategic plan, measurement instruments, and administration of measures to determine if and how current findings can be used to make program revisions. Their evaluation report should: (a) accurately interpret evaluation data; (b) explain strengths and limitations of the evaluation design; (c) delineate recommendations for program changes useful and appropriate to diverse members of the target population, program planners, and decision makers; and (d) explain the impact of uncontrolled variables on the evaluation results. Based on evaluation results, school health educators should refine evaluation plans and make recommendations for instructional programs and other CSHP components.
STANDARD V

Candidates coordinate provision of health education programs and services.

Coordination is an integral component of health education program development, implementation, and evaluation. To maximize success, health educators must move from sharing information through formal and informal relationships with professionals in a variety of settings (communication), to supporting other programs and services while functioning independently (cooperation), to establishing compatibility among health-related programs and services (coordination), to developing a common vision and priorities (collaboration).

Acting in a coordination role, health educators first must become aware of existing health-related resources and services in all settings and then work to ensure those resources and services support and enhance their health education efforts. Coordination of school and community efforts should include, but are not limited to assessing individual and community needs, planning effective programs, implementing program strategies, conducting evaluation strategies, and providing professional development to school and community personnel.

Comprehensive School Health Education

In the school setting, health educators should coordinate their instructional programs with those of other disciplines. Not only can key concepts and skills taught in health education be integrated within other subjects areas, but also thematic units developed across core curricula can be incorporated within health education lessons. Most often, elementary classroom teachers are responsible for delivering the preK-5 health education curriculum by infusing health concepts within other core curricula. Health education specialists at the middle and high school levels should work together to articulate and coordinate their health instructional programs to ensure that the K-12 curriculum is comprehensive, developmentally-appropriate, and sequential. School health education programs also should be coordinated with community-wide and statewide efforts (e.g., Great American Smokeout) and be consistent with state/national health education standards as well as education reform and other state/national initiatives (e.g., Healthy People 2010).

In some school districts, designated school health coordinators have responsibility for assessing student needs as well as planning, implementing, and evaluating health education and CSHP programs. A critical role of school health coordinators involves coordination of existing health-related programs and services in the school and surrounding community, most often by establishing a school and/or district health advisory council.
Communication, cooperation, coordination, and collaboration among health educators, physical educators, nurses, counselors, food services personnel, administrators, support staff, and others at the school site and district level are critical to implementation and sustainability of CSHPs. Not only will these processes ensure consistent messages to students, but also they will minimize program duplication, maximize funding, and most importantly, increase capacity to address diverse needs of students and their families.

**Collaboration with Health Educators in Other Settings**

Health educators in community, medical care, and post-secondary settings can directly and indirectly support school-based instructional programs and CSHPs. They can serve as members of school and/or district health advisory councils as well as community-based coalitions addressing specific health issues (e.g., violence prevention). They can work with school health educators and other school-site staff to establish speaker programs (e.g., health-related careers, HIV-positive speakers), strengthen community awareness and advocacy campaigns (e.g., World AIDS Day, National Breast Cancer Month, smoke-free restaurants and bars), and provide service learning opportunities, referrals to community-based programs and services, family outreach programs, adult mentor programs, and numerous other partnerships. Health educators employed in worksite settings can provide awareness sessions to parents and other adults about the school’s instructional program and CSHP, current health issues affecting youth (e.g., incidence and prevalence of health-risk behaviors), and parenting skills (e.g., communicating with your child about drug use; managing stress). University health education faculty can work with school health educators in the planning and delivery of professional development sessions related to health education “best practices” and implementation of CSHPs.
Key Element A:
Candidates develop a plan for coordinating health education with other components of a school health program.

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<td>Candidates are unaware of existing health-related programs and services in the school and community; do not coordinate health instruction with other CSHP components.</td>
<td>Candidates describe components of a CSHP; explain the value of coordinating CSHP components; determine the extent of existing health-related programs and services in the school and community; identify gaps and duplication in the provision of CSHP; develop a plan for coordination of CSHP.</td>
<td>Candidates analyze the benefits of coordinating existing health-related programs and services in the school and community; evaluate individual and organizational factors influencing successful coordination; facilitate integration of CSHP components.</td>
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Supporting Explanation:

A CSHP has multiple interrelated and synergistic components: health education, health services, healthy school environment, physical education, counseling/psychological/social services, family/community involvement, nutrition services, and staff health promotion (Allensworth & Kolbe, 1987). Although most schools have some elements of a CSHP, few have health programs incorporating all components at a fully-functioning level, and fewer still effectively coordinate these components.

Using this CSHP framework, school health educators can organize and coordinate existing categorical, fragmented health-related programs and services. Within the school, key individuals with responsibility for implementing various components should be contacted. Optimally, a school health council comprised of these individuals and others (i.e., parents, students, community representatives) would be established to assess student, family, and staff needs, assess existing resources, map existing health-related programs and services in the school community, identify gaps and duplications, explore funding sources, and develop plans for coordinating provision of programs and services. These plans should strengthen communication networks, provide for professional development, technical assistance and collegial support, and establish a system for managing, monitoring, and evaluating CSHPs.
Key Element B: Candidates demonstrate the dispositions and skills to facilitate cooperation among health educators, other teachers, and appropriate school staff.

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<td>Candidates cannot integrate health education concepts and skills within other subject areas; are unable to identify potential relationships with school-site staff; use limited range of established communication channels.</td>
<td>Candidates identify formal and informal channels of communication; demonstrate disposition and skill to facilitate cooperation among school-site staff and staff at other schools and/or the district-level; analyze the role of school health educators as liaisons among CSHP staff and representatives of community-based agencies and organizations.</td>
<td>Candidates establish effective communication networks; facilitate cooperation related to CSHPs among school-site staff and staff at other schools and/or the district-level; develop plans to address areas of potential disagreement and/or conflict among individuals; appropriately apply a variety of negotiation, mediation, and conflict resolution skills.</td>
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Supporting Explanation:

Within the school setting, cooperation among health educators, other teachers, other professional staff, support staff, and administrators is critical to implementation of effective health instruction and CSHPs. Not only must individuals responsible for implementing one or more CSHP components share information about their programs, but a mechanism must be established to get “buy in” from other staff. Health educators should use existing communication channels (e.g., faculty meetings, daily announcements, bulletin board flyers, informal discussions in the faculty lounge) to inform others about how each CSHP component supports and enhances others and how CSHPs can better address students’ needs, interests, and concerns. With effective communication, individuals and groups can work together in cooperative informal relationships.

Health educators, acting as liaisons, can facilitate communication and cooperation among school-site staff, among health educators across the district, and between school-site and district-level staff related to school health programs. These levels of communication and cooperation can increase potential for integration of learning
across disciplines, ensure continuity of health instruction, and prevent gaps and duplication within CSHPs. Establishing communication networks and enhancing cooperation among key individuals will facilitate understanding of varied perspectives, reconciliation of differences of opinion, reduction of interpersonal conflict, and respect for diverse ideas, opinions, and contributions of others.

**Key Element C:**
Candidates formulate practical modes of collaboration among health educators in all settings and other school and community health professionals.

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<td>Candidates are unable to identify ways to communication among health educators and professionals in the school and community; cannot make a case for collaborating with health educators and other professionals in the community</td>
<td>Candidates <em>describe strategies for enhancing communication among health educators and other personnel responsible for school and community health-related programs and services; suggest approaches for integrating comprehensive health education with community programs; identify commonalities and differences among selected health agencies and organizations; specify the benefits and challenges of collaboration.</em></td>
<td>Candidates <em>demonstrate</em> knowledge, dispositions, and skills to effectively communicate diverse viewpoints about specific health issues to personnel responsible for school and community health-related programs and services; <em>develop</em> plans for promoting collaboration among schools and community agencies with common goals, objectives, and perspectives.</td>
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**Supporting Explanation:**

While schools have great potential to help youth learn about factors affecting their health, build skills to make health-promoting decisions, and achieve academic success, the community also can play a vital and pivotal role in addressing students’ health needs and concerns. Most communities contain a plethora of public/private agencies and organizations that provide health-related programs and services for children and adolescents, often functioning independently.

School health educators can facilitate collaboration by bringing together individuals and/or groups in the school community who have a vested interest in the overall health of youth or in specific health issues (e.g., teenage smoking). These more formal relationships or collaboratives could include the following: voluntary health
organizations (e.g., American Cancer Society, American Lung Association), youth serving organizations (e.g., YMCA, Boys and Girls Clubs), community-based organizations, community health departments, health care providers, law enforcement, private businesses/industry, parents, school administrators and teachers, students, and other interested stakeholders.

Collaboratives are committed to common visions, program goals, and student-centered priorities; they have shared planning sessions and interrelated roles and responsibilities. The ultimate goal of collaboration is to improve the health status of youth, families, staff, and the community as a whole through comprehensive planning, implementation, and evaluation. The result would be effective health instruction supported by well-planned CSHPs.

**Key Element D:**
Candidates organize professional development programs for teachers, other school personnel, community members, and other interested individuals.

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<td>Candidates fail to recognize the need for professional development for teachers and other school personnel related to health instruction and CSHPs.</td>
<td>Candidates <em>plan competency-based professional development sessions; determine appropriate educational and technological resources and instructional methods to meet diverse needs of teachers and other school personnel.</em></td>
<td>Candidates <em>implement and evaluate professional development sessions related to “best practice” in health education and CSHPs; use current, valid, and reliable resources to identify a wide range of strategies for ongoing professional development and support (e.g., peer coaching, mentoring).</em></td>
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**Supporting Explanation:**

Health education is a dynamic discipline requiring that professionals stay current with emerging health problems/issues and innovative strategies for prevention education. Health educators must be lifelong learners and engage in ongoing professional development related to health education, pedagogy, educational reform, instructional technology, and skills in coaching and mentoring relationships.
Health educators often are called upon to conduct professional development sessions for teachers, community members, parents/guardians, volunteers, and other interested personnel. Health educators must be able to plan and deliver competency-based professional development programs addressing a wide range of health issues and concerns. In addition to accurate and current functional information, professional development sessions should include modeling of research-driven and skills-based instructional and CSHP strategies. A variety of instructional resources and methods should be used to meet diverse needs of adult learners.

**STANDARD VI**

Candidates act as a resource person in health education.

An important role of health educators is to access and evaluate a wealth of health information, resources, and services. The setting within which health educators function largely determines the nature of the resources that are provided and the functions that will be served. Health educators procure and disseminate educational materials and human resources; evaluate the validity, reliability, and credibility of information and resources; and make referrals to appropriate health-related programs and services. They also may be selected as experts on community need assessment projects as well as advisors for planning, implementing, and evaluating health education programs.

*Comprehensive School Health Education*

School health educators are the primary resource for classroom instruction designed to increase functional health knowledge; improve health-enhancing attitudes; develop health-related skills; and motivate students to prevent disease, reduce health risk behaviors, and increase health-promoting behaviors. To accomplish this, health educators must have a broad understanding of how to access up-to-date, reliable, and accurate health-related information. School health educators must be able to identify and recommend theory-driven and research-based instructional strategies to other teachers in the school who have been assigned to teach health education. They also must be able to apply educational strategies sensitive to community standards and parental concerns and reflect students’ abilities, developmental levels, learning styles, and cultural backgrounds.

School health educators often are responsible for reviewing or developing school or district health-related policies, professional development activities for staff, and school community initiatives for health education programs and services. Working beside other staff members, school health educators can help to support and enhance these efforts. A CSHP enables the limited resources of a school and community to better address health needs of all students. This team approach strengthens and expands the health educator's role as a resource person to improve student health and
the learning environment. When health educators are knowledgeable about informational, technological, material, and human resources both within the school and the broader community, they are more prepared to enable students and staff members to meet instructional, professional, and personal goals.

**Collaboration with Health Educators in Other Settings**

Health educators in community, medical care, and worksite settings are valuable resources for school-based health education efforts. It is not unusual for community health educators to have specific areas of expertise for which they can offer more in-depth knowledge, skills, and health-related services within the parameters of a comprehensive health instructional program as well as a CSHP. They may provide materials and other educational media, topic-related speakers, and greater insight into specific health issues of interest. For example, a community health educator who works with an HIV/AIDS agency would be able to provide in-depth information about the care and services needed by people infected with HIV and speakers who are persons with AIDS. The integration of community health resources within the school health program is an effective use of resources for accessing information; developing skills; assessing needs; and planning, implementing, and evaluating health education programs.
Key Element A:  
Candidates utilize computerized health information retrieval systems effectively.

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<td>Candidates do not demonstrate basic computer skills needed to process and manage information; cannot use information technology to obtain valid and reliable sources of information; are unable to communicate health messages or information to others using the language of computer technology (e.g., graphic images); are unfamiliar with other technology communication systems and resources utilized to enhance health; are unaware of technology resources available to support teachers and student instructional goals related to health education.</td>
<td>Candidates use basic communication technologies/applications (e.g., electronic mail, data processing, graphics programs, word processing); use the Internet to access health research database and surveillance systems and interact with web-based programs; identify on-line learning activities and resources aligned with health instructional goals and meaningful to students; use a variety of communication and technology systems that provide health information (e.g., compact discs, DVD players, videotape and audio tape, teleconferences/videoconferences); evaluate computerized health information for validity, reliability, credibility, and accuracy.</td>
<td>Candidates create a variety of on-line health-related resources and communication technologies; construct an electronic catalog, database, or graphic organizer to display and link retrieved health information; create computer-based multimedia presentations to disseminate health information; assess various resources and communication technologies for use in designing learning activities that engage diverse students in developmentally-appropriate, meaningful health-promoting experiences; convert analog resources to digital media.</td>
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**Supporting Explanation:**

Technological literacy, that is, the ability to use, manage, develop, and assess information and communication technologies is essential to successfully navigate life and optimize learning in the 21st century. School health educators must possess the technology skills that promote teaching and learning in an information rich society. Skills of using computers and information technologies are essential for teachers and students alike to make sense of and use the rapidly evolving body of health information, resources, and services. Electronic tools, such as graphic organizers, are powerful strategies for organizing thinking that can quickly help to arrange and connect data and provide a visual presentation of complex ideas or information. Sources of data provide the ability to sort, sift, compare, and find information rapidly. Computer-based multimedia allows for effective and persuasive visual presentation of select ideas, arguments, or perspectives.
Key Element B:
Candidates establish effective consultative relationships with those requesting assistance in solving health-related problems.

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<td>Candidates do not recognize or cannot describe ways to build communication skills for consultative activities; cannot relate concepts about consultation, disclosure, and confidentiality related to school policies and state mandates; are unaware of ethical and professional obligations in consultative situations; cannot match student needs with available services.</td>
<td>Candidates reflect on need for communication skills in effective consultative relationships; demonstrate dispositions and skills to interact and communicate with other school staff, students, parents, and community stakeholders; discuss ethical and professional dispositions related to student disclosure and confidentiality, sensitive issues, and adherence to school policy and state mandates; identify specialists and services available for students in crisis.</td>
<td>Candidates demonstrate dispositions and skills for effective communication (e.g., listening, empathizing, being approachable, problem solving, mediating, negotiating) with other school staff, students, parents, and community stakeholders; engage in professional and ethical practices when consulting and handling sensitive issues related to student disclosure and confidentiality; explain why district policy and state mandates must be followed when dealing with sensitive issues (e.g., child abuse, suicide); reflect on limits of professional training; use appropriate referral systems.</td>
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Supporting Explanation:

School health educators are a critical part of a professional academic staff that serves the community and functions to meet the needs of all students. To this aim, school health educators must develop effective communication skills and exhibit a professional disposition during all interactions with other school staff, parents, students, and community representatives. It is imperative that health educators conduct themselves according to highest ethical practices when handling sensitive issues (e.g., student disclosure and confidentiality) and follow state mandates and district policies to the letter. This knowledge includes recognizing the limits of their professional training and understanding the web of support services and professionals to which they can refer students who are in need of assistance.
**Key Element C:**
Candidates interpret and respond to requests for health information.

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<td>Candidates are unaware of national, state, or local research, recommendations, or laws relative to health of school aged youth; cannot identify trends in child and adolescent health risks or relate these to influences on learning, development of school policy, and design of health curricula and pedagogy; cannot identify resources for students in need.</td>
<td>Candidates use data from national, state, and local child and adolescent health research to respond to requests for information about health issues, school policy development, and adoption of health curricula; help all students locate current, reliable, and credible sources of information; identify health and safety youth-serving organizations, agencies, and associations.</td>
<td>Candidates synthesize research relative to health risks among diverse school-age youth and devise multiple modalities for communicating the requested information; use research data, laws, and professional recommendations as resources and evidence to advocate for youth; contact youth-serving organizations, agencies, and associations for information concerning health and safety.</td>
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**Supporting Explanation:**
Practitioners, consistently provided with new research about health issues, are challenged to stay current with the latest health-related information, programs, and services. To effectively respond to requests from multiple groups, health educators must develop skills that enable them to access, interpret, and evaluate the latest findings for validity, reliability, and accuracy. They also must translate the latest research into recommendations for the design and implementation of health education programs. Health educators must be able to locate and access professionals as well as community agencies and organizations that can serve as resources for specific health information.
Key Element D:  
Candidates select effective educational resource materials for dissemination.

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<td>Candidates cannot evaluate health information materials for accuracy or validity; cannot determine the credibility of community agency/organization resources and services; do not recognize and/or use health resources provided by professional agencies and associations.</td>
<td>Candidates <em>select, assemble, and distribute</em> valid and reliable health information related to diverse school-aged youth; <em>formulate</em> criteria for selection of instructional materials.</td>
<td>Candidates are <strong>aware</strong> of national, state, and local organizations/associations that support youth health initiatives and use publications disseminated by them; based on criteria for effectiveness, <em>select</em> appropriate health and safety materials from professional organizations, agencies, and associations for educational programming; <em>create</em> and <em>disseminate</em> accurate and valid health materials for diverse audiences.</td>
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*Supporting Explanation:*

Materials serve as educational tools for the dissemination of health information and the development of functional health knowledge and related skills. Health educators must be able to identify professional agencies and associations that develop and disseminate health information materials as well as access, evaluate, and assemble valid and reliable materials for appropriate use based on learners’ developmental levels and abilities. Criteria for effective instructional materials should include content accuracy, developmental-appropriateness, cultural sensitivity currency, provisions for multiple perspectives and individual differences, and parent/community involvement. Health educators also must be able to create their own materials for students, parents, other school staff, and community members as well as identify different strategies for distribution of these materials to selected audiences.
STANDARD VII

Candidates communicate health and health education needs, concerns, and resources.

Communication is a critical component of health promotion and disease prevention. Health educators must provide information about health and health education needs, concerns, and resources to a varied market of learners, consumers, employers, colleagues, and health providers. This broad goal is accomplished by tailoring health-promoting messages that can be delivered to and understood by diverse target audiences ranging from children to adults, from gifted to learning disabled to those with limited English proficiency, and from the general population to health professionals. Since a multitude of value systems are represented in our society, health educators must use a variety of educational strategies to communicate health information, including individual interactions, small group processes, and mass communication techniques.

By interpreting health information, needs, concerns, and issues, health educators put into practice their ability to clearly articulate the purposes, theories, concepts, and processes of health education to others in a manner appropriate for the setting in which they practice. Effective communication can function to change attitudes, beliefs, perceptions, skills, and behavioral intent related to specific health priority areas. When designing communication messages, health educators must consider the following: (a) source variables (i.e., who will deliver the message); (b) message variables (i.e., what is the content of the message and how does it appeal to the target audience); (c) channel variables (i.e., how will the message be delivered); (d) receiver variables (i.e., who will receive the message); and (e) destination variables (i.e., what is the scope and timing of the message) (McGuire, 1984). Social marketing and advocacy skills also can be used to increase acceptance of a health education program or alter public opinion and mobilize resources in favor of a health-related policy or issue.

Comprehensive School Health Education

In addition to communicating health concepts and skills during classroom instruction, health educators in school settings may be asked to present an overview of the health education curriculum, Youth Risk Behavior Survey results, and/or information about current health issues to other school staff; parents/guardians; health advisory boards; district-level administrators and staff; school board members; community groups; and state, regional, and national professional associations. Depending on the audience, these discussions might include slide or computer-generated presentations with graphics, tables, and figures, videotapes of classroom instruction, sample lesson plans, or other written documents. Health educators working at the district level often are responsible for developing position statements, drafting health-related school board policy, speaking to the media, and responding to
questions posed by various interest groups, individual community members, and parents. These situations require not only strong written and oral communication skills but also a solid foundation in health education communication theory and practice.

Collaboration with Health Educators in Other Settings

Health educators working in community and medical care settings can present local morbidity and mortality data collected by public health and other agencies (STD rates, pregnancy rates, AIDS cases, suicide rates); summaries of emergency room visits (e.g., acute asthma attacks, drug-related incidents, unintentional injuries, suicide attempts, gang-related injuries); and other local health-related data. These data can be used to provide a profile of youth health-related issues and concerns, support health education and CSHP policy development, and substantiate the need for a planned, sequential health education curriculum at all grade levels. Health educators in university settings can review and synthesize current prevention research to identify “best practices” in health education; provide expertise related to administration and analysis of Youth Risk Behavior Survey results; and assist in development and delivery of presentations to appropriate groups within schools and the broader community.

Key Element A:
Candidates interpret concepts, purposes, and theories of health education.

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<td>Candidates cannot articulate goals and objectives of health education; are unable to translate appropriate theory to practice; are unclear about major responsibilities of health educators.</td>
<td>Candidates define health education and identify current goals, objectives, and practice in diverse settings; examine educational, psychological, sociological, and anthropological theory in relation to health education practice; describe the historical basis of health education; reflect on knowledge, dispositions, and skills of health educators.</td>
<td>Candidates apply educational, psychological, sociological, and anthropological theories to health education, health promotion, disease prevention, and disease control; discuss historical trends in health education as they relate to current practice and the future of the profession.</td>
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Supporting Explanation:

Theoretical foundations of health education are derived from the fields of pedagogy, psychology, sociology, biology, and anthropology. In health education practice, health educators must apply related concepts, theories, and models, including but not limited to, the Health Belief Model, Social Cognitive Theory, Theory of Planned Behavior, Stages of Change Model, Diffusion of Innovations Theory, and various community organizing models.

Health education focuses on promotion of personal, family, and community health. Health education content addresses six health priority areas as identified by the Centers for Disease Control and Prevention (1999) (i.e., behaviors that result in intentional and unintentional injury, tobacco use, alcohol and other drug use, behaviors, sexual behaviors that result in sexually transmitted infections and unintended pregnancy, dietary patterns that contribute to disease, and inadequate physical activity) and three additional areas related to emotional and social contexts (such as, mental health, personal/consumer health, and community/environmental health (CCSSO/SCASS, 1999). Health education process uses strategies to build communication, goal-setting, decision-making, self-management, stress management, and advocacy skills (JCNHS, 1998).

School health educators must know how to integrate and apply learning and behavioral theories in relation to health concepts and skills, thus empowering individuals and communities to adopt positive health practices. They must learn to distinguish among different theories and select those most appropriate for children, young adults, and staff as well as those that could facilitate implementation and sustainability of CSHPs.
Key Element B:
Candidates predict the impact of societal value systems on health education programs.

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<td>Candidates are unable to describe the relationship between social forces/systems and various perspectives related to controversial health issues; cannot propose ways to deal with controversial health issues.</td>
<td>Candidates investigate potential impact of social forces, values, and systems on individual and community perspectives related to health issues; identify strategies for dealing with controversy related to health education needs and concerns.</td>
<td>Candidates describe how changes in societal values, norms, and priorities can impact health education practice; apply a wide range of strategies to deal with controversial health issues; delineate steps to effect social change.</td>
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Supporting Explanation:

Professional integrity is shaped by one’s personal values and includes respect for the values of others. An individual’s value system is a unique combination of knowledge, beliefs, perceptions, experiences, and practices, and is influenced by social forces in the family, school, peer group, and community. Health educators must be sensitive to differences related to religion, race/ethnicity, gender, age, cultural background, and sexual orientation as well as practices that may lead to discrimination.

Controversy often arises when there are opposing viewpoints related to health education practice (e.g., content of sexuality education program; condom availability program) and/or policy (e.g., zero tolerance policy for drugs in school, including over-the-counter medications). In some cases, personal viewpoints may be based on lack of information, misinformation, biased beliefs/perceptions, and popular practice rather than sound scientific evidence and accurate, reliable, and credible information. Within the classroom, school health educators must know how to establish a forum to allow for open, respectful communication about controversial issues. Established and enforced ground rules will provide opportunities for learners to explore alternatives that are reasonable, yet compatible with their value systems.

School health educators must be aware of opposing viewpoints of other school staff, administrators, parents/guardians, school board members, and community members...
regarding health education needs and concerns. They must anticipate opposition, establish professional relationships with individuals promoting opposing viewpoints, work to understand varied perspectives, and employ a wide range of strategies to manage controversy.

**Key Element C:**
Candidates select a variety of communication methods and techniques in providing health information.

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<td>Candidates have limited verbal and written communication skills; cannot identify ways to convey health information, develop ineffective communication campaigns related to current health issues; lack skills to facilitate group discussions.</td>
<td>Candidates deliver health-promoting messages clearly and concisely; identify a range of strategies for communicating health information to individuals, small groups, and large groups; facilitate small and large group discussions by modeling appropriate dispositions and skills.</td>
<td>Candidates use multiple strategies to communicate health information to diverse consumers; effectively use multiple channels (e.g., oral written, graphic, electronic) to deliver health-promoting messages; apply social marketing principles to develop effective public service announcements and other health communications.</td>
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**Supporting Explanation:**

Health education and health needs and concerns must be communicated to school personnel, parents/guardians, community members, legislators, and other designated groups. To effectively deliver health messages to a diverse population, school health educators need to understand strengths and limitations of various communication techniques and use multiple communication strategies that reflect written, verbal, audiovisual, graphic, and technological skills.

In addition, health educators must have a basic understanding of communication and marketing theory (see Andreasen, 1995; McGuire, 1984). Health communications must be designed, developed, and delivered based on an understanding of the target audience’s needs, perceptions, and values.
Key Element D: Candidates foster communication between health care providers and consumers.

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<td>Candidates cannot delineate factors affecting processing of health information; are unable to express scientific concepts in terms understandable by consumers.</td>
<td>Candidates identify factors influencing students’ and parents’ understanding of health information and acceptance of health services; translate scientific concepts for understanding by students, parents, and staff; act as a liaison between health care providers and diverse students, parents, and staff.</td>
<td>Candidates discuss the inter-relatedness of personal, family, community, and societal factors on access to health information; apply communication and marketing theory to advocate for health, health education, and/or CSHPs.</td>
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Supporting Explanation:

As medical technology and practice become more sophisticated, school health educators have an increased responsibility to promote understanding of health information, needs, and concerns among students, parents, and staff. Even though many consumers have become more knowledgeable about health issues and are taking an active role in maintaining and enhancing their personal health, youth, their families, and school staff are continually bombarded with health communications, products, and services.

School health educators act as liaisons between students and other health-related programs and services within the school/district. Inviting school nurses, counselors, psychologists, food service personnel, and other professionals to make classroom presentations and/or participate in panel discussions about their roles and available student programs and services can foster stronger communication among CSHP staff. Working in school health teams, these professionals can more effectively address individual students’ needs and facilitate referrals to appropriate community resources.

School health educators also can enhance communication among students, their families, and health care providers/organizations. Some ways to facilitate consumer understanding and satisfaction include: translating complicated medical and research studies into understandable health concepts; writing health-related articles in popular press; co-sponsoring panel discussions among health care providers about specific health concerns; developing and distributing newsletters/flyers addressing health
issues and incorporating contact information about available health care providers; developing public services announcements; and making appearances on television and radio programs.
Health Education Knowledge Base and Current Research

The revised Program Standards for Health Education Teacher Preparation support NCATE Professional Standards, primarily Standard 1, which addresses "Candidate Knowledge, Skills, and Dispositions" (NCATE, 2001). The contextual framework for candidate knowledge in health education is based on an integration of professional education standards, professional health education responsibilities, and health education standards for students.

**Professional education standards**

Consistent with other teacher preparation programs, the training of school health educators must include a foundation in pedagogical content, knowledge, skills, and dispositions. This preparation includes designing developmentally appropriate lessons that include content and skills specific to health education and are based on an understanding of child development and sound pedagogical practice. Candidates also must demonstrate how to establish an environment conducive to learning, communicate effectively, engage the students in the process of learning, and use appropriate assessment techniques for a diverse group of students. Other professional responsibilities at the heart of teaching are engaging in self-reflection and continued professional growth, advocating for students, communicating with families, and contributing to the profession (Danielson, 1996). Many professional skills required of all teachers are also specifically delineated in the professional responsibilities of health educators.

**Professional health education responsibilities**

While the original responsibilities of health educators were largely performance-based, the language and descriptors were generic to the field and not specific to teacher preparation. Much of the revision process, therefore, has focused on describing what health educators do as teachers and integrating the most recent health education research on program efficacy. The new standards are based not only on educational “best practice,” but also on research that supports comprehensive health instruction, which aims to increase knowledge, promote positive attitudes, and develop skills that ultimately could change health-compromising behaviors. Effective health education curricula should be designed according to the following criteria (AAHE, 1995; CDC, 1999; Kirby, 1997; Lohrman & Wooley, 1998):

- Are based on theory, using social learning theory and social skills development as a primary focus rather than information dissemination (Fetro, 1994);
- Are comprehensive (Pre/K-12), sequential, and planned based on students' needs and include clearly articulated benchmarks and performance indicators which describe the functional knowledge and skills required for healthy development;
- Provide lessons that include developmentally appropriate information and skills; teaching strategies that are interactive, engaging, and provide opportunities to practice and demonstrate skills; and instruction of sufficient duration of time;
• Include planned evaluation procedures that are formative and summative with regard to individual progress, determine the impact of instruction on student learning using performance-based assessment techniques, and utilize process evaluation to analyze constraints to learning (e.g., materials, time, instructor fidelity to curriculum)

• Address influences on health behavior, such as media, culture, technology, individual values, and group norms; and

• Allow for teacher training that enhances effectiveness. In other words, health education teacher training must integrate principles of educational psychology with behavior change strategies particular to health practices (e.g., tobacco use and sexual risks).

In addition to understanding and practicing principles of effective health instruction, health education teacher candidates also must understand the functioning of the coordinated school health program and how health instruction fits within this larger model (Allensworth & Kolbe, 1987). This model takes into account components of school health practice that already exist and coordinates them to more adequately meet all students' health and educational needs (McKenzie, & Richmond, 1998). This approach to school health is important for all teachers to understand, but especially those trained in health education, because the link between a child's health and his/her ability to learn has been firmly established (Tyson, 1999).

*Health education student standard*

The National Health Education Standards (NHES) are student-based outcomes that describe the functional knowledge and skills students need to develop into health-literate individuals (Joint Committee on National Health Education Standards, 1998). These standards also support four characteristics or educational outcomes that describe a health-literate person: (a) critical thinking and problem solving, (b) acting as a responsible citizen, (c) engaging in self-directed learning, and (d) communicating effectively. According to the NHES (1998, p. 6-7):

• Health literate individuals are **critical thinkers** and problem solvers who identify and creatively address health problems and issues at multiple levels, ranging from personal to international. They utilize a variety of sources to access the current, credible and applicable information required to make sound health-related decisions. Furthermore, they understand and apply principles of creative thinking along with models of decision making and goal setting in a health promotion context.

• Health-literate individuals are **responsible, productive citizens** who realize their obligation to ensure that their community is kept healthy, safe, and secure so that all citizens can experience a high quality of life. They also realize that this obligation begins with self. That is, they are responsible individuals who avoid
behaviors which pose a health or safety threat to themselves and/or others or an undue burden on society. Finally, they apply democratic and organizational principles in collaboration with others to maintain and improve individual, family, and community health.

- Health-literate individuals are **self-directed learners** who have a command of the dynamic health promotion and disease prevention knowledge base. They use literacy, numerical skills, and critical thinking skills to gather, analyze, and apply health information as their needs and priorities change throughout life. They also apply interpersonal and social skills in relationships to learn about and from others and, as a consequence, grow and mature toward high-level health status.

- Health literate individuals are **effective communicators** who organize and convey beliefs, ideas, and information about health through oral, written, artistic, graphic, and technologic mediums. They create a climate of understanding and concern for others by listening carefully, responding thoughtfully, and presenting a supportive demeanor which encourages others to express themselves. They conscientiously advocate for positions, policies, and programs that are in the best interest of society and intended to enhance personal, family, and community health.

These characteristics are interwoven throughout the NHES, which, at the time they were developed, were compatible with two national and parallel movements, *Goals 2000*; *Educate America Act* and *Healthy People 2000* (National Education Goals Panel, 1994; Public Health Service, 1991). The conceptual knowledge and skills identified in the following NHES are also critical to health education teacher preparation (Joint Committee on National Health Education Standards, 1998, p. 8):

- comprehend concepts related to health promotion and disease prevention;
- access valid health information, products, and services;
- practice health-enhancing behaviors that reduce health risks;
- analyze the influence of culture, media, technology, and other factors on health;
- use interpersonal communication skills to enhance health;
- use goal-setting and decision-making skills to enhance health; and
- advocate for personal, family, and community health.

With regard to NCATE Standard 1, entry-level health educators must also master the content of health education, which includes six health priority areas identified by the Centers for Disease Control and Prevention’s Division of Adolescent and School Health: (a) tobacco use; (b) dietary patterns that contribute to disease; (c) sedentary lifestyle; (d) sexual behaviors that result in HIV infection, other sexually transmitted infections, and unintended pregnancy; (e) alcohol and other drug use; and (f) behaviors that result in intentional and unintentional injury (Kolbe, 1990). Three additional areas also are presented in the CCSSO/SCASS (1999) assessment framework that include Personal/Consumer Health, Environmental/Community Health, and Mental and Emotional Health.