

# Employers' Perceived Importance And Use of Skills That Are Specific to Health Educators: A Replication Study in a Rural Setting

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## Abstract

*This study examined the perceptions of rural community health employers in regard to the importance of specific skills defined as the roles of entry-level health educators. A survey developed by Sondag, Taylor, and Goldsmith (1993) was modified and used to gather information from 16 public, private, and nonprofit health agencies. Additional data concerning who performed these roles within the organization and future plans to hire health educators were also obtained. Results showed that almost all listed skills were perceived to be important to the organization. The most important skill was communicating health and health education needs, followed by assessing needs, planning programs, implementing planned programs, coordinating, acting as a resource person, and evaluating programs, in that order. The majority (50% to 75%) of the health officials reported that the listed skills were performed by someone other than professional health educators. Only 25% of the respondents reported that health educators evaluated programs in their organizations. About 69% of the respondents indicated that they may hire health educators with described skills in the future.*

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## Introduction

Entry-level competencies are the skills and knowledge a student acquires from the bachelor's degree program at an accredited university or college with a major emphasis in health education (National Task Force on the Preparation and Practice of Health Educators 1985). Members of the health education profession have worked toward delineation of entry-level competencies for health educators for some time. A credentialing system was developed to verify that health educators possess minimum entry-level competencies that are specific to health education and to establish a mechanism for professional quality control (Cleary, 1986).

Unfortunately, awareness about health educators and their competencies seems to be limited among health employers. A study conducted by Sondag et al. (1993) demonstrated that most employers perceived defined skills of health educators being important to their organizations. However, none of the respondents in the study identified themselves as health educators. Employees other than health educators were performing functions the health education profession identifies as specific roles of "health educators." Furthermore, community agencies were more likely to employ other individuals such as nurses and social workers who, because of their health backgrounds, are

perceived as capable of carrying out these functions. These trends are evident more often in the rural setting.

This particular area for the study (The Aroostook County, Maine) had a population of 86,936 in 6,453 square miles resulting in a population density of 13.5 persons/square mile compared to the southern county of the state which has the population density of 285 persons/square mile (Maine Register, 1994). Geographical isolation and distance, extreme cold climate, sparse population, lack of industry, poor economy, and lack of academic institutions with community health education programs are some of the characteristics of the County.

A significant number of US population resides in rural areas. There are numbers of health education programs offered by federal, state, local, and private agencies to meet their needs. However, there are few individuals with a community health education background to perform such functions in these settings. Although the success of these programs rests on the proper programming and evaluation by professionally trained community health educators health care agencies are using personnel such as nurses, social workers, educators, counselors, nutritionists, and even high school graduates to perform these jobs. There may be two important reasons for this dilemma: 1) many employers are not aware that the health education discipline is preparing professional health

educators; and 2) the health educators have been, until recently, nonexistent in some areas.

The purpose of this study was to replicate the study by Sondag et al. (1993) in the rural setting by investigating the employers' awareness about the health education profession and to assess the present and future use of health educators in their organizations.

## **Methods**

### **Sample**

The study sample involved personnel from all 25 agencies from Aroostook County, Maine. These included local health departments, voluntary health organizations, nursing homes, and hospitals located at different sites. The respondents were identified as the individuals who were responsible for hiring and/or supervising health education personnel for each agency. A total of 16 employers returned the survey with a return rate of 64 percent. All employers reported having degrees in areas other than health education.

### **Data instrument**

A three-page survey developed by Sondag et al. (1993) was modified and used for the data collection. The survey defined job skills which are indicative of mastery in all areas of responsibility described by the Role Delineation Project. Skills are grouped into the seven areas of competence: communicating health and health education needs; assessing needs; planning programs; implementing programs; evaluating programs; coordinating health programs; and serving as a resource for health and health education (Table 1). Thirty specific job skills were described in a well organized narrative form. Three new questions were added to Sondag's survey list. These included skills related to: 1. analyzing evaluation data; 2. promoting in-house wellness activities; and 3. writing grants. Participants were asked to indicate, using a five point Likert scale, how important it was to their organization to have an employee perform each skill and to check one of the options provided (health educator, none, unknown, and other) showing who performed the stated tasks within their organizations. Employers were also asked to indicate whether they will hire health educators in the future. Cronbach's alpha reliability estimate for the instrument was 0.96.

### **Data collection**

The research proposal was approved by the University Institutional Review Board before data collection. The relevant person from each organization was contacted to receive a short

introduction of the project either by phone or by postcard followed by the actual survey instrument. The instrument included a self-addressed/stamped envelope for return of the survey. A reminder letter was sent to each participant two to three weeks after the surveys were mailed to them and follow-up calls were made.

### **Data analysis**

The data were analyzed using descriptive statistics. The score on the Likert scale reflected the importance of each of the listed skills, 1 being "not important" to 5 being "extremely important." A mean score for skills within each competence was estimated in order to rank the perceived importance of the seven areas of responsibility. The frequency distributions revealed the skills of importance for the agencies and the kind of personnel hired to perform the job in different agencies.

## **Results**

The employers' perceptions regarding the importance of the skills are presented by the mean score for each skill in Table 2. Higher mean scores 4.7, 4.6, 4.6 were obtained for items 1, 2, and 3 (the skill under communicating health education needs) and for item 23, the skills under coordinating programs with a mean score of 4.6. Out of three new items the lowest score was secured by item #30 "writing grants" with a mean score of 3.9.

The cumulative mean score for skills within each of the seven competencies revealed that the most important perceived responsibility for the majority health agencies was communicating health education needs (4.5) followed by assessing needs (4.4) and planning programs (4.4), implementing and coordinating (4.3), acting as resource person (4.1), and evaluating the programs (4.0), in that order (see Table 3).

The frequencies of the kinds of health personnel employed in participating agencies are presented in Table 4. Results revealed that skills that are defined as entry-level skills for health educators are, for the most part, performed by personnel other than professional health educators. About 53% to 75% of the respondents indicated that most jobs are performed by other professionals compared to 25% who indicated that the jobs were done by health educators. About 27% reported that grant writing was not done by anyone, 20% said it was done by health educators, and 53% reported that it was done by others.

Out of the total (N=16) participants, 69% believed that they will/may hire health educators in the future.

Fifty percent of the respondents were directors of the health education service programs with nursing degrees. Others held degrees in social work, and behavior sciences. Some of the employers were interested to find out whether there is a possibility of training for already employed personnel such as RN's and the like in health education and whether the department will accept credits from past degrees. Some participants stated that there is no need for personnel trained in health education since others are doing an adequate job.

**Discussion**

The sample population came from community health settings only since worksite health education was nonexistent in this area at the time of study. The sample size is small due to extreme rural conditions with the small number of health agencies. Since the purpose of the study was to explore the situation specifically in this area the results can be applied only for this county. However, it is important to note that there were many similarities between the findings of the Sondag et al. (1993) study which took place in an urban setting with a larger sample size than this rural study. It was found that most of the skills listed were perceived to be important to community health organizations. The highest ranking was given to the competency, “communicating health education needs,” which was similar to the previous study. It was followed by “assessing needs and planning programs” and “implementing and coordinating health education activities.” It is important to note that the lowest ranking was received by the competence, “evaluating health education programs,” which was also identical to the previous study by Sondag et al. (1993).

**Table 1. Skills Statements**

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- Communicating Needs:**
1. Provide information about health
  2. Interpret health information
  3. Facilitate communication regarding health issues
  4. Disseminate information about health education programs
  5. Advocate health education in policy formulation
- Assessing Needs:**
6. Collect health related information about clients
  7. Analyze health information to determine areas of need
- Planning Programs:**
8. Participate in the educational planning process for health programs

9. Participate in developing health promotion program objectives based on information acquired from the needs assessment
10. Design educational programs consistent with specified educational objectives.

**Implementing Programs:**

11. Assist in mobilizing personnel needed to carry out health program plans
12. Secure operational resources necessary to carry out the plan
13. Implement health education programs

**Evaluating programs:**

14. Assist in developing an evaluation plan for health programs
15. Assemble resources required to carry out program evaluation
16. Help implement the evaluation plan
17. analyzing evaluation data
18. Communicate results of evaluation

**Coordinating Programs:**

19. Assist others in carrying out health education activities
20. Promote awareness of health education's contributions to achieving individual and organizational goals
21. Carry out designated health related administrative activities.

**Acting as a Resource:**

22. Gather information from various sources regarding needs, concerns, and interests of clients
23. Respond to requests for health information
24. Refer clients for consultation regarding health issues
25. Seek consultation from others regarding health program needs
26. Provide consultation to others regarding health program planning
27. Help others perform health education related activities
28. Provide educational resource materials to clients
29. Promote wellness activities for agency staff through in-house programming
30. Write or assist in writing grants to support health education activities

This consistent result seems to point out that most employers in community health settings perceive the listed skills as important competencies. However, in both studies employers ranked evaluation as the lowest competency. A careful examination of Table 4 on “who performs this (evaluation) skill within your

**Table 2. Rating of the Importance of Skills**

Skills	Mean	Standard Deviation
1. provide information	4.7	0.6
2. interpret information	4.6	0.8
3. facilitate communication	4.6	0.7
4. disseminate information	4.4	0.9
5. advocate policy	4.0	1.2
6. collect client data	4.4	1.1
7. analyze client data	4.5	0.7
8. plan programs	4.4	1.0
9. develop objectives	4.4	0.8
10. design programs	4.4	0.9
11. mobilize personnel	4.3	1.0
12. secure resources	4.3	0.9
13. implement programs	4.4	0.8
14. develop evaluation plan	3.9	1.3
15. assemble evaluation resources	3.9	1.3
16. implement evaluation	4.1	1.3
17. analyzing evaluation data	4.1	1.4
18. communicate results	4.1	1.3
19. assist other practitioners	4.3	1.0
20. promote awareness	4.4	1.0
21. administer programs	4.2	1.0
22. gather resource information	4.1	1.1
23. respond to requests	4.6	0.6
24. refer for consultation	4.3	1.2
25. seek consultation	4.0	1.3
26. provide consultation	3.8	1.4
27. provide education	4.0	1.2
28. provide materials	4.5	0.9
29. promote wellness activities	4.1	1.2
30. write grants	3.9	1.4

organization?" revealed that almost 19-20% of the respondents said evaluation skills are performed by "no one" or "unknown." Because the organizations do not perform evaluative functions, the use of such an important skill is probably minimized. Or, given the

responses, it could be because the respondents from non-profit organizations who do not consider evaluation as critical factor in program planning.

**Table 3. Ratings of Importance of Areas of Competence**

Competency Ratings	Mean	STD
1. communicating needs (skills 1-5)	4.5	0.7
2. planning programs (skills 8-10)	4.4	0.9
2. assessing needs (skills 6-7)	4.4	0.9
3. implementing (skills 11-13)	4.3	0.8
3. coordinating (skills 19-22)	4.3	1.0
4. acting as resource (skills 23-30)	4.1	1.1
5. evaluating (skills 14-18)	4.0	1.4

Although the evaluation technique is one of the most crucial competencies of the health education profession, it seems not all health employers perceive it in the same way. Further, a recent study on the performance on the CHES exams reported that the majority of people scored low on the evaluation section (Cleary, Hubbard, & DuShaw, 1997). Evaluation of health education programs should be addressed critically in order to combat the grave health care economy of the present time. We need to make sure that employers know that certified health educators can or are supposed to perform specialized functions beyond mere teaching health education. In order to gain public confidence in our profession we must demonstrate the positive impact of our programs using proper evaluation. Such a skill can produce strong evidence that an organization's programs are working and provide justification for continued, increased, or new funding. It is critical to let the health employers know the value of evaluation and the ability of health educators to perform this function systematically and scientifically. Such analytical competency helps our profession build a strong and distinct identity. Health education certification involves more than just labeling ourselves as health educators whose job is basically to educate people about health. If that were true, health education could be done by anybody who has some health or education background. Although "grant writing" does not seem to be a critical skill for the entry-level health educator, it should be considered important for the upper level health educator.

**Table 4. Summary of Responses to the Question  
“Who performs this skill within your organization?”  
(Percentage of Responses in Each Category)**

Skills	Health Educator	No One	Un-known	Other
1. provide information	25.0	06.3	00.0	68.8
2. interpret information	25.0	06.3	06.3	62.5
3. facilitate communication	25.0	00.0	06.3	68.8
4. disseminate information	25.0	00.0	12.5	62.5
5. advocate policy	18.8	18.8	00.0	62.5
6. collect client data	25.0	06.3	00.0	68.8
7. analyze client data	18.8	00.0	06.3	75.0
8. plan programs	25.0	06.3	06.3	62.5
9. develop objectives	25.0	06.3	06.3	62.5
10. design programs	25.0	06.3	06.3	62.5
11. mobilize personnel	25.0	00.0	06.3	68.8
12. secure resources	25.0	00.0	00.0	75.0
13. implement programs	25.0	06.3	00.0	68.8
14. develop evaluation plan	25.0	12.5	06.3	56.3
15. assemble evaluation resources	25.0	12.5	06.3	56.3
16. implement evaluation	25.0	12.5	06.3	56.3
17. analyzing evaluation data	26.7	13.3	06.7	53.3
18. communicate results	25.0	12.5	06.3	56.3
19. assist other practitioners	25.0	06.3	00.0	68.8
20. promote awareness	25.0	00.0	00.0	75.0
21. administer programs	18.8	00.0	06.3	75.0
22. gather resource information	25.0	06.3	06.3	62.5
23. respond to requests	26.7	00.0	00.0	73.3
24. refer for consultation	25.0	06.3	06.3	62.5
25. seek consultation	25.0	06.3	06.3	62.5
26. provide consultation	25.0	12.5	12.5	50.0
27. provide education	25.0	00.0	12.5	62.5
28. provide materials	25.0	00.0	00.0	75.0
29. promote wellness activities	26.7	06.7	00.0	66.7
30. write grants	20.0	26.7	00.0	53.3

Another noteworthy finding is the employment of health educators in rural community health settings. Most participants (50% to 75%) in this rural setting responded that the listed skills were performed by

“other” personnel. The percentage was much higher in this study than in the previous one from the urban area. Majority of these “other” personnel were nurses, social workers, physicians, PAs, and administrators in

that order. Alperin and Miner (1993) explained that agencies often fill health education positions with people who have diverse preparation because of not having uniform credentialing mechanisms that can be used as a measure of their competencies to practice in most community settings. Majority of respondents participating in this study were professionals other than health educators. Despite the perceived importance of health education skills only one fourth of the responding employers hired health educators. It could be because of both the lack of awareness about the health education professionals and their functions and the paucity of them in this area. Girvan and Kearns (1993) explained that the benefits of credentialing a school health educator are more significant because of the lack of trained professionals in these areas. This is even more critical in the rural community health setting where there is a constant need for program justification and a continuous struggle for funding. Data on the number of health educators applying for health education positions or the ratio of community health educators to community members being served in any given area would help us to distinguish whether the less use of CHES skills is because of the lack of awareness or the unavailability of health educators.

About 69% of the respondents felt that they will/may hire health educators who possess those listed skills in the future. This indicates that there is a market for community health educators. It seems we need to focus on producing more community health educators by expanding academic degree programs in the rural areas. Furthermore, the market can be increased by convincing county agencies of the value of community health specialists, possibly through consultative services especially in the area of program evaluation or maybe by using the Entry-Level Skills Portfolio (ELSP) for the agency employers to review (Cleary, 1992). In addition, a student intern/practicum would help them realize the benefits of hiring health educators and not rely on inadequately trained employees to fill a variety of roles.

One of the respondent's comments pointed out that depending on the organization, any particular skill may or may not be important or may or may not be used as frequently as perceived. Therefore, instead of finding out only "how important" the job is, we also need to find out "how often" a certain job is performed. Based on the frequency of the skills used, one can

determine the importance of skills for various health organizations. It seems that due to financial constraints and importance of the job in terms of frequency of use, many employers hire individuals who can perform diverse functions. Therefore, data on the use of skills in a majority of health organizations may help health education professionals to focus on the important competencies that are relevant to the job market of the present time. Furthermore, we have to educate employers who are not familiar with the identified competencies of health educators, about the discipline, and its responsibilities.

It appears that we not only need to work harder to clarify our professional identity, strengthen curriculum, and expand our programs to produce more health educators, but also to communicate with the public and private health agencies (prospective employers) on a regular basis. This may help employers understand and consider professional competencies as the basic requirements for a health education career. Alperin and Miner (1993) have concluded that these skills which guarantee a primary prevention model of health services can be instrumental for the public health profession in the 21<sup>st</sup> Century. These skills are the keys to prevent diseases and promote community health. Hiring professional health educators may be the stepping stones to assure these functions in the rural settings. Eventually that will help meet the health objectives for the year 2000, at the local, state, and at the national level.

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