STUDY SESSION 1 OF 2
CROSS-CUTTING TOPICS

SESSION LEADER:
CDR AIMEE WILLIAMS, LCSW-C, BCD, USPHS

(Study session 1 of 8)
for the Certified in Public Health Exam
Date: Thursday, September 3rd, 2015
Time: 1200 – 1315 (EST)
Conference Call Line: (800) 988-0476
Passcode: 6293734
Adobe Connect URL: https://hrsa.connectsolutions.com/cph_study_group/
BACKGROUND:
CERTIFIED IN PUBLIC HEALTH (CPH) EXAM

• The intent of this 75 minute review session is to assist PHS Officers from a wide range of agencies and disciplines with an opportunity to take the Certified Public Health (CPH) exam through the National Board of Public Health Examiners (NBPHE). As a “pilot” program, this test can be taken by PHS Officers at a reduced cost during the month of October 2015.

• In an effort to assist those PHS Officers interested in obtaining this certification, a total of 8 weekly, 75-minute review sessions will be led. In addition, these sessions will have additional review materials, resources, and “homework” in which the goal is to assist the officer in being prepared to test for this for the CPH exam.

• Please visit the following website if you are interested in the Certified in Public Health (CPH) Exam through the National Board of Public Health Examiners (NBPHE) under this pilot program for the month of October 2015. At this website you will also have access to information on the pilot project (ie: target population) and resources to begin to prepare you for examination:
  
www.nbphe.org

For questions please email LCDR Evelyn Seel at Evelyn.Seel@hhs.gov or CDR Harvey Ball at Harvey.Ball@hhs.gov
Over the next series of slides for both sessions 1 and 2, we will discuss a variety of factors that within the testing “arena” are considered “Cross Cutting Topics”.

- There are a total of 200 questions on the exam
- Within the “Cross-Cutting Topics”, of the 200 exam questions, approximately 12.5% or 25 questions will be presented.
- It is estimated that the entire exam can take up to 4 hours
- All questions on the exam are either (a) multiple choice or (b) single best answer

Reference:
https://www.nbphe.org/CPHexaminfo.cfm
CROSS-CUTTING TOPICS & THE CPH EXAM

CROSS-CUTTING TOPICS & THE CPH EXAM

CPH Webinars

The National Board of Public Health Examiners (NBPHE) both hosts and sponsors webinars geared to explaining the Certified in Public Health (CPH) credential, the exam, and the future of the field.

January 2015 Review Session Webinars Are Now Available For Viewing

Each session is two and a half to three hours long and includes lectures and interactive segments. Please click on the below links to view for each study session.

Archived Webinars

Behavioral & Social Sciences

Jan 2015: [View Webinar] [Powerpoint Slides]
Jan 2014: [View Webinar] [Presentation PDF]
Jan 2013: [View Webinar for Windows] [View Webinar for Mac]
CROSS-CUTTING TOPICS & THE CPH EXAM

**Biostatistics**
- **Jan 2015:** [View Webinar] [Powerpoint Slides]
- **Jan 2014:** [View Webinar] [Powerpoint Slides]
- **Jan 2013:** [View Webinar for Windows] [View Webinar for Mac]

**Environmental Health**
- **Jan 2015:** [View Webinar] [Powerpoint Slides]
- **Jan 2014:** [View Webinar] [Powerpoint Slides]
- **Jan 2013:** [View Webinar for Windows] [View Webinar for Mac]

**Epidemiology**
- **Jan 2015:** [View Webinar] [Powerpoint Slides]
- **Jan 2014:** [View Webinar] [Powerpoint Slides]

https://www.nbphe.org/CPHstudyResources.cfm
Each of the 5 topic areas are provided at the below website for further review and study in preparation for the exam.

Reference:
https://www.nbphe.org/CPHstudyResources.cfm
SESSION 1 AND 2
CROSS-CUTTING TOPICS (12.5%)

Session 1
• Communications and Informatics
• Diversity and Culture
• Leadership

Session 2
• Ethics and Professionalism
• Program Planning and Evaluation
• Public Health Biology
• Systems Thinking
Public Health Communication:

Communication on a multitude of levels within the healthcare field is essential. The public health “information” infrastructure is considered a process that focuses on both health communication and health information technology (IT). These processes are central to (a) health care, (b) public health, and (c) societal views of health.

These processes make up the context and the ways professionals and the public search for, understand, and use health information, significantly impacting their health decisions and actions (Office of Disease Prevention & Promotion, 2015b).

Public Health Informatics:

Public health informatics has been defined as the systematic application of information and computer science and technology to public health practice, research, and learning. The field of informatics also serves other facets of public health including (a) emergency response, (b) environmental health, (c) nursing, and (d) administration. It is an interdisciplinary profession that applies mathematics, engineering, information science, and related social sciences (e.g., decision analysis) to important public health problems and processes. Public health informatics is a subdomain of the larger field known as biomedical or health informatics (Thomas & Foldy, 2012).
DESIGNING THE MESSAGE

• In regards to communication and communicating to targeted populations regarding issues surrounding “public health”, the design and delivery of the message is extremely important.

• Current research identifies that through the field of communication science, there is valuable insight indicating that the way population health advocates and researchers should develop messages to shape public opinion, which in turn shape the debate about the social conditions that outline the health and well-being of populations (Niederdeppe et al., 2008).
## COMMUNICATION THEORIES AND STRATEGIES

### Individual:
- A. Health belief model
- B. Theory of reasoned action
- C. Theory of planned behavior
- D. Social Support

### Interpersonal:
- A. Social learning/ social cognitive theory
- B. Theory of reasoned action
- C. Theory of planned behavior
- D. Social Support

### Community:
- A. Community organization model
- B. Ecological approaches
- C. Organizational change theory
- D. Diffusion of innovations theory
MODEL & THEORY DEFINITIONS

• **A. Health belief model** - Health behavior is determined by perception of the threat of a health problem, appraisal of the recommended behavior to prevent problem, and cues to action. Individual beliefs as determinants of behavior.

• **B. Theory of reasoned action** – This concept focuses on behavioral intentions. In this, the focus is on behavior as the best predictors of behavior, and behavioral intentions are directly influenced by the attitude about performing the behavior and the belief whether important others approve or disapprove.

• **C. Theory of planned behavior** – In the theory of planned behavior (abbreviated TPB) the theory indicates that beliefs and behaviors are linked.

• **D. Social Support** – The relationships between individuals (families, peers, friends, etc.) and how these relationships influence beliefs and behaviors.

• **E. Social learning/social cognitive theory** – This theory is based on a learning process as the determinant of health and change. Learning through either or both personal experience or watching others. Key feature is reciprocal determinism, in which behavior, interpersonal factors, and environmental events interact as determinants of each other.

• **F. Community organization model** – The goal of this model is for community-based organizations and building to serve as determinants of health. This is done through community groups identify problems, mobilize resources, and design and implement strategies to reach common goals.

• **G. Ecological approaches** - Ecological systems theory, also called development in context or human ecology theory, identifies five environmental systems with which an individual interacts. This theory provides the framework from which community psychologists study the relationships with individuals' contexts within communities and the wider society.

• **H. Organizational change theory** – The intent behind this theory is to promote change in health disparities through policy and practices as determinants of health.
With the onset of new and rapidly developing health care technology, medications, treatments, and procedures, providers and clinicians are expected more than ever, expected to incorporate the use of these “informatics” and activities into their daily practices.

These same providers and clinicians are also the “gatekeepers’ and ‘translators” as it relates to the expectation to (a) assimilate both old and new knowledge, (b) apply that knowledge to their patients, (c) remember each patient’s individual health status and background, and (d) communicate quickly with patients, hospitals, and other providers. This is where the healthcare informatics and communication infrastructure becomes the foundation for daily and future healthcare communication and operations (AHCQ, 2015).
KEY THEORIES & STRATEGIES

Systems Theory
• Characteristics of Systems
• Systems and the Change Process

Information Theories
• Shannon and Weavers Information – Communication Model
• Blum’s Model

Learning Theories
• Behavioral Theories
• Information Processing/Adult Learning Theories
• Learning Styles

Change Theories
• Planned Change
• Diffusion of Innovation
• Using Change Theory
• Trans-Theoretical Models
DEFINITIONS

- **Systems, Change Theory and the Change Process** - Theory of Change (ToC) is a specific type of methodology for planning, participation, and evaluation that is used in the philanthropy, not-for-profit and government sectors to promote social change. The idea and concept of the theory of Change, defines long-term goals and then maps backward to identify necessary preconditions.

- **Shannon and Weavers Information – Communication Model** - This model is specially designed to develop the effective communication between sender and receiver. Also they find factors which affecting the communication process called “Noise”. At first the model was developed to improve the Technical communication. Later it’s widely applied in the field of Communication. The model deals with various concepts like Information source, transmitter, Noise, channel, message, receiver, channel, information destination, encode and decode.

- **Blum’s Model** - Blum (1974, 1981) has usefully grouped the determinants of health within a model (Blum’s model) which comprises the four fields of Environment, Lifestyle, Heredity (Genetics), and Health Care Services.

- **Behavioral Theories** – these are theories that stem from initial research in the field of Operant Conditioning. The theory of B.F. Skinner is based upon the idea that learning is a function of change in overt behavior. Changes in behavior are the result of an individual's response to events (stimuli) that occur in the environment. These behavioral theories have since expanded.

- **Information Processing/Adult Learning Theories** – Although there is no one identified “best” theory for adult learning, three major theories—andragogy, self-directed learning, and transformational learning, have begun to emerge and prove to be successful.

- **Diffusion of Innovation** – This theory basis its premise on dissemination of successful intervention or innovations to address disparities. The process of dissemination includes the development of the innovation, the process to communicate about the innovation, the “uptake” of the innovation by the target population, the regular use of the innovation, and a focus on sustainability and institutionalization of the behavior.

- **Trans-Theoretical Model** – This model focuses on individual readiness to change as a determinant of behavior. In turn, the change is a process, individuals differ in their readiness to change, and intervention strategies must be tailored for each stage of readiness to change.
LEGAL AND ETHICAL ISSUES IN INFORMATION TECHNOLOGY

- Protecting private information
- HIT system vendor-provider relationships
- Patient safety
- Ethics of good design and data displays
- User involvement
- System implementation
- Liability
- Risk assessments
- Training adequacy
- Biobanking
- Computer decision support
- Curriculum development

- Ethical dilemmas created by the use of health information technologies
- Secondary data use
- Public health
- Security
- Surveillance
- Research ethics
- Autonomy and empowerment (especially in light of new health and telehealth technologies)
- Social networking
- Policy and Regulation
LEGAL & LEGISLATIVE IMPACTS

Electronic Health Records:

- EHR and HIE systems collate information about individual patients from different information systems (e.g., registration, clinical record, laboratory, and imaging) and through information exchange or aggregation from across different provider entities. Adoption of the systems is being incentivized and facilitated by the Health Information Technology for Economic and Clinical Health (HITECH) Act in the United States. Enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, the HITECH act authorized Medicaid and Medicare financial incentives for providers to adopt and use EHRs and authorized funding for the Office of the National Coordinator for Health Information Technology (ONC) to encourage health IT adoption, aid in standard-setting, build work force, and support state- and regional-level development of HIE (Thomas & Foldy, 2012).

The potential contributions of EHRs to US population and public health are substantial.

HIPAA and the HITECH Act’s meaningful use provisions provide a solid grounding and structure for expanding the contributions of EHRs to public health.

However, the statutory grounding for expanding the contributions of EHRs to population health remains unclear.

Challenges to the use of EHRs for population health information extend beyond legal and funding issues to include the need to improve EHR data quality, expand EHR data content and develop and implement EHR data standards for a broad range of population health measures (Friedman, Parrish, & Ross, 2011).
Technology:

Technology that seems the most innovative often relies on adopting and leveraging technology standards. Systems must have the ability not only to talk and listen, but also to understand each other. Unfortunately, adopting only certain standards is insufficient. Both semantic (vocabulary) and syntactic (sentence structure) standards must be implemented and tested to ensure a system's validity. Certain types of errors are associated with data manipulation. Even highly structured data-collection techniques do not completely eliminate data errors. For example, providing data elements that can be selected from a drop-down list cannot prevent the entry of a male who is documented as receiving a Papanicolaou test. However, structured data collection techniques can simplify minimizing or identifying many such data-quality problems.

The standardization process that facilitates computer-readable forms of data, by its very nature, risks losing the richness of information found within unstructured documents (i.e., clinicians' notes or field observations).

Accessing and integrating both structured and unstructured data is a major focus in health informatics. As public health surveillance systems collect more and more structured data directly from clinical information systems, this capacity for structured and unstructured data access is increasingly important.

Economic pressures on health care and public health are diminishing the practicality of conducting active surveillance techniques (e.g., using detailed patient interviews, manual chart reviews, or manual data entry). In addition, the need for speed in the face of rapid global pandemics and bioterrorism makes the often incomplete ascertainment from passive reporting processes a substantial challenge. The application of informatics science can help ensure that 21st century systems are as valid as current methods while providing improved efficiency.
Virtually every day, crisis and emergency risk communication is needed somewhere in public health. Whenever a crisis occurs, communicators must be ready to provide information to help people make the best possible decisions for their health and well-being. This must be done in rapid timeframes and without knowing everything about the crisis. Yet often the types of disasters that public health must address can be anticipated. CDC has developed a process for planning and conducting crisis and emergency risk communication. On this page you will find this process and a wealth of information to help you prepare if an emergency occurs and you are part of the response team (CDC, 2011).

One of the most valuable resources to be tapped is the diverse population of public health professionals (formally trained or not) who have already made informatics a priority in their work. These include staff at CDC and other federal agencies; state and local health departments, members of the Public Health Data Standards Consortium and informatics leaders in several public health associations, workers from all walks of public health life who attend Public Health Information Network meetings, university scholars of public health informatics, and staffs of nonprofit organizations like the Public Health Informatics Institute. Representatives of these groups come together to harmonize an ongoing agenda for public health informatics at the Joint Public Health Informatics Taskforce, a coordinating body of several associations. By educating leaders and peers, testing innovations, and disseminating lessons learned, these persons and agencies are improving public health surveillance (and ultimately health outcomes) by reducing costs, bridging silos, and improving access to timely, quality information (Thomas & Foldy, 2012).
COMMUNICATION TOOLS

Social Media:
One of the key steps in the health communication and social marketing process is identifying the population segments that can benefit from a specific health behavior. The more you know about your primary segment, the better you can reach them with messages, activities and policies. Your upfront research includes understanding the needs and wants of the target audience on a more personal level, and their motivations and lifestyles so you can truly engage with them. This effort will pay dividends later when you begin preparing your campaign activities, health messages, channels and campaign materials (CDC, 2012).

Technology:
Addressing public health challenges in the 21st century requires a workforce familiar with current technology. Areas include blogs, wikis, and video casting, but numerous other electronic media are available for delivering educational content (Lobb & McDonnell, 2009).

Electronic Health Records:
Electronic health records (EHRs) could contribute to improving population health in the United States. Realizing this potential will require understanding what EHRs can realistically offer to efforts to improve population health, the requirements for obtaining useful information from EHRs, and a plan for addressing these requirements. Potential contributions of EHRs to improving population health include better understanding of the level and distribution of disease, function, and well-being within populations (Lobb & McDonnell, 2009).
REFERENCES:


SESSION 1
DIVERSITY AND CULTURE

1. History of Definitions, Perceptions of Race and Ethnicity, Data Collection
2. Cultural Competence, Principles, and Practices
3. Health Disparities
4. Availability, Accessibility, Acceptability of Services
5. Culturally Appropriate Community Engagement and Empowerment
6. Community Based Participatory Research
7. Health Literacy
   A. Assuring Accurate Cross-Cultural Communication
   B. Cultural Influences on Communication
8. Cultural Influences on Behavior, including Health-Seeking Behavior
9. Environmental Justice and Equity
Over time, academic and popular understandings of racial and ethnic identities have changed dramatically. Prior to the 20th century, racial and ethnic groups were perceived as permanent, biological types. Scholars of race and ethnicity turned to Biblical passages and, later, theories of natural history to explain the origins of differences among ethnic and racial groups (Anderson, Bulatao, & Cohen, 2004).

Because of this, perceptions of race and ethnicity have had a significant and long term negative impact on the health of human beings within the United States. Specifically, those of different races, ethnicities, and religions.
CULTURAL COMPETENCE, PRINCIPLES, AND PRACTICES

What is cultural competency?

When working with any population, including vulnerable populations, it is essential that you have a basic understanding of the populations culture. Culture is often described as several aspects that include an individual or community (a) body of knowledge, (b) body of belief, and a (c) body of behavior.

Elements of culture that allow for cultural competency include, but are not limited to (a) personal identification, (b) language, (c) thoughts, (d) communications, (e) actions, (f) customs, (g) beliefs, (h) values, and (i) institutions that are often specific to ethnic, racial, religious, geographic, or social groups.

For a provider or individual who works within the health care system, these elements influence beliefs and belief systems surrounding (a) health, (b) healing, (c) wellness, (d) illness, (e) disease, and (f) delivery of health services.

The concept of cultural competency has a positive effect on patient care delivery as it allows providers and other healthcare personnel to deliver services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients (NIH, 2015).
**HEALTH DISPARITIES**

What are “Health Disparities?"

The CDC best describes health disparities as preventable differences in the burden of (a) disease, (b) injury, (c) violence, or (d) opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC, 2015).

**Types of Health disparities:**

There is an extremely vast wide range of (a) diseases, (b) behavioral risk factors, (c) environmental exposures, (d) social determinants, and (e) health-care that is further impacted by access due to (a) sex, (b) race and (c) ethnicity, (d) income, (e) education, (f) disability status, and other (g) social characteristics (CDC, 2013).

**Key Strategies in Addressing “Health Disparities”**

- Increased access to services for all through financing mechanisms, organizational changes, and removal of legal and transportation barriers
- Culturally and linguistically competent programs
- Improved patient-provider communication
- Programs to eliminate provider discrimination
- Increased minority representation among the health care workforce
AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY OF SERVICES

“The right to health”

Underlying determinants
water, sanitation, food, nutrition, housing, healthy occupational and environmental conditions, education, information, etc.

Health-care

AAAQ
Availability, Accessibility, Acceptability, Quality

(General Comment No. 14 of the Committee on Economic, Social and Cultural Rights)

http://www.who.int/mediacentre/factsheets/fs323/en/
AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY OF SERVICES

THE RIGHT TO HEALTH FOR ALL - contains four elements:

1. Availability: A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes.

2. Accessibility: Health facilities, goods and services accessible to everyone. Accessibility has four overlapping dimensions:
   • non-discrimination
   • physical accessibility
   • economical accessibility (affordability)
   • information accessibility.

3. Acceptability: All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and life-cycle requirements.

4. Quality: Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

http://www.who.int/mediacentre/factsheets/fs323/en/
CULTURALLY APPROPRIATE COMMUNITY ENGAGEMENT AND EMPOWERMENT

To engage and empower vulnerable, poor – to middle-income individuals, let alone countries one must keep in mind:

Track 1: Community empowerment
Track 2: Health literacy and health behaviour
Track 3: Strengthening health systems
Track 4: Partnerships and intersectoral action
Track 5: Building capacity for health promotion
Community-based participatory research (CBPR) is an applied collaborative approach that enables community residents to more actively participate in the full spectrum of research (from conception – design – conduct – analysis – interpretation – conclusions – communication of results) with a goal of influencing change in community health, systems, programs or policies. Community members and researchers partner to combine knowledge and action for social change to improve community health and often reduce health disparities.
HEALTH LITERACY:

HEALTH LITERACY HAS BEEN DEFINED AS THE COGNITIVE AND SOCIAL SKILLS WHICH DETERMINE THE MOTIVATION AND ABILITY OF INDIVIDUALS TO GAIN ACCESS TO, UNDERSTAND AND USE INFORMATION IN WAYS WHICH PROMOTE AND MAINTAIN GOOD HEALTH. HEALTH LITERACY MEANS MORE THAN BEING ABLE TO READ PAMPHLETS AND SUCCESSFULLY MAKE APPOINTMENTS. BY IMPROVING PEOPLE’S ACCESS TO HEALTH INFORMATION AND THEIR CAPACITY TO USE IT EFFECTIVELY, HEALTH LITERACY IS CRITICAL TO EMPOWERMENT.

Assuring Accurate Cross-Cultural Communication

**Health literacy in action**

Communities in project sites in eight countries in Mesoamerica were encouraged to keep their environment mosquito-free in order to prevent and control the spread of malaria without the use of DDT. Individuals and families kept their homes, patios and surroundings free of collected water, covered water storage containers, and managed their drainage systems.

They also jointly organized community cleanings of their neighbourhood, including streets, forested areas, swamps and riverside areas. These efforts helped reduce the vector density and therefore malaria cases. In a three year period, the demonstration sites saw a reduction of 63% in malaria cases and 86.2% in cases caused by plasmodium falciparum, the parasite that causes the greatest morbidity and mortality on account of malaria in the world.

(Source: WHO/PAHO 2009, Proyecto DDT/FNUMA/GEF/OPS, Programa Regional de Acción y Demostración de Alternativas de Control de Vectores de la Malaria sin el uso del DDT en México y Centroamérica)

Cultural Influences on Communication

- **Language** - Speaking the language is a great benefit for cultural influence in regards to communication.
- **Cultural Competency** – Being culturally competent builds the relationship with the community and patient population.
- **Health Literacy** – If you work with a population with low literacy levels, handing them a brochure on a health education defeats the purpose. Determine where your populations health literacy needs are and meet them there.
ENVIRONMENTAL JUSTICE AND EQUITY

Justice, Inequity & The Belmont Report

- 1932 Tuskegee Syphilis Study
- 1939 Nazi experiments
- 1946 Nuremberg Trial, resulting in the Nuremberg Code
- 1948 United Nations adopts Universal Declaration of Human Rights
- 1963 Willowbrook Study (hepatitis research on mentally retarded children)
- 1964 Declaration of Helsinki
- 1972 Public exposure of Tuskegee syphilis study
- 1974 First federal protections for human research participants
- 1979 Belmont Report promoting three principles for research
ENVIRONMENTAL JUSTICE AND EQUITY

Belmont Report

To address the man atrocities cited previously, The U.S. Congress passed the National Research Act in 1974. From this report, the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research was put in place. The intent or goal of this commission was to identify the basic ethical principles guiding the conduct of research with human subjects.

The Belmont Report summarizes the work of the Commission, including strongly influencing the boundaries between practice and research, basic ethical principles of respect for persons, beneficence, justice, informed consent, and the thorough assessment of risks and benefits, in regards to selection of subjects.
Q&A

Websites:
https://www.nbphe.org/

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** Take the pre-test ** located at https://www.nbphe.org/
DO NOT MOVE FORWARD

• END OF SESSION I
SESSION I: SECTION 3
CDR AIMEE WILLIAMS, BCD, LCSW-C, USPHS

Leadership
SESSION 1
LEADERSHIP

1. Attributes
   A. Visionary
   B. Inspiring
   C. Mentoring
   D. Risk-Taking
   E. Motivating Others for Problem-Solving and Decision-Making

2. Leadership Theories and Principles

3. Vision, Mission, Values, Goals, and Objectives

4. Communicating, Listening, and Responding
SESSION 1
LEADERSHIP (CONT...)

5. Problem Solving and Conflict Resolution
6. Teambuilding
7. Leadership vs Management
8. Engaging Stakeholders, Building Coalitions
   A. External Stakeholders and Partners
   B. Building Coalitions
9. Social Justice and Human Rights Principles
10. Advocacy
ATTRIBUTES OF LEADERS

Visionary

Inspiring
ATTRIBUTES OF LEADERS (CONT...)
ATTRIBUTES (CONT....)

Motivating Others for Problem-Solving and Decision-Making:
LEADERSHIP THEORIES AND PRINCIPLES
VISION, MISSION, VALUES, GOALS, AND OBJECTIVES

Motivating Others for Problem-Solving and Decision-Making:
COMMUNICATING, LISTENING, AND RESPONDING

Motivating Others for Problem-Solving and Decision-Making:
Motivating Others for Problem-Solving and Decision-Making:
LEADERSHIP VS MANAGEMENT
SOCIAL JUSTICE AND HUMAN RIGHTS
PRINCIPLES
ADVOCACY