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Major issues in health education in 1987–1988, as identified by leaders in the Association for the Advancement of Health Education: A Delphi study

Bixler, Melissa Wells, Ph.D.
The Ohio State University, 1988
MAJOR ISSUES IN HEALTH EDUCATION IN 1987 - 1988, AS IDENTIFIED BY LEADERS IN THE ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION: A DELPHI STUDY

DISSERTATION

Presented in Partial Fulfillment of the Requirements for the Degree Doctor of Philosophy in the Graduate School of the Ohio State University

By

Melissa Wells Bixler, M.A.

* * * * *

The Ohio State University

1988

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1988
DEDICATION

I dedicate this document to my mother, Jean Wells, who serves as my personal definition of tenacity and to my family, Tom, Staci-rae and Tyler, who gave me boundless love and support throughout this endeavor.
VITA

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FIELDS OF STUDY

Major Field: Health Education
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Chapter I: Introduction

Each profession is faced with contentious opinions or views. So, too, it is with health education. Health education, as defined by the professionals collaborating on the Role Delineation Project, is "the process of assisting individuals, acting separately and collectively, to make informed decisions about matters affecting individual, family and community health. Based upon scientific foundations, health education is a field of interest, a discipline and a profession" (Bureau of Health Education, 1980).

Fitch and Gobble wrote, "There is perhaps more controversy both internally and externally regarding the health education profession today than ever before" (1982). While they used the word "controversy", they believe it has negative connotations. They further suggested, "Perhaps 'diverse opinions' rather than 'controversies' would be a better way to express the ongoing introspection and dialogue among health professionals and between them and the lay public concerning theoretical and substantive issues inherent in the health education profession" (Fitch and Gobble, 1982).
The word issue has been utilized frequently and may denote a different concept to some than to others. Fraser perhaps best identified the concept of an issue when she wrote,

A controversial issue involves a problem about which different individuals and groups urge conflicting courses of action. It is an issue for which society has not found a solution that can be universally or almost universally accepted. It is an issue of sufficient significance that each of the proposed ways of dealing with it is objectionable to some section of the citizenry and arouses protest. The protest may result from a feeling that a cherished belief, an economic interest, or a basic principle is threatened. It may come because the welfare or organizations or groups seems at stake. When a course of action is formulated that virtually all sectors of society accept, the issue is no longer controversial (1982).

Therefore, each of the many sides of an issue may be supported in part by tradition, new information, institutions, or social or ethical beliefs. Specific issues facing a profession are not static but are constantly changing; some are perhaps cyclic in nature. Professions need to identify the major issues which face them and be knowledgeable about the many variables which influence them.

The identification and compilation of major themes surrounding issues has value for a number of reasons. Issues may be resolved hastily without benefit of debate or
application of current information. Then, too, issues faced by one profession may have been resolved already by another similar profession. The identification of major arguments surrounding this similar issue would have been identified, facts collected, and alternatives explored. Why, then, should time and energy be expended to replicate these efforts? Rather, one should use past research as a springboard for future analysis and utilize, where applicable, past research.

Some issues might be resolved, not by research or accumulation of facts, but on limited information or with jaundiced or provincial rationale. The time and inclination required to gather facts and refine positions may deter the decision makers from exploring issues fully and result in inferior solutions for that situation.

The exploration of issues confronting a profession also demonstrates that learned and respected leaders within a profession can disagree and, thereby, sets the tenor for critical thinking among members. So long as professionals realize that the status quo is just that, the present state, not necessarily the ultimate, they can search freely a multitude of paths which will lead a profession to the cutting edge.

Specific and conflicting points of view concerning issues in health education have been expressed in the
professional literature concerning, among others, goals, ethics, philosophy, professional preparation, methods, role models, and accountability. But no one has attempted to focus on the identification of the major issues facing health education today.

Need for the Study

Various sides of health education issues have been explored. Attempts to classify and categorize issues have been the focus of several health education professionals and organizations.

Creswell suggested classification of issues into the broad areas of goals, theories, content or method, training, and status (1984). A 1979 conference sponsored by the Association for the Advancement of Health Education (AAHE) identified fifty-five ethical issues, but no attempt was made to identify major issues or to prioritize them (Barnes, Fors, & Decker, 1980). Richardson and Jose gathered opinions of selected health educators on specific ethical issues, but these pertained only to school health (1983).

Some professional journals, such as Health Education, have devoted entire issues to the exploration of selected issues. While this format did stimulate thought and
discussion, some articles were of limited scope and left several unanswered questions (Health Education, 1982).

Hochbaum wrote

"...the lack of consensus regarding the goals of health education, and other issues stemming from that is a serious problem. It splits the profession along conceptual lines, militates against the emergence of even reasonably uniform standards for professional training, makes it difficult to evaluate its programs in ways that allow either comparisons among them or comparisons with similar programs conducted by other professions, raises perplexing ethical problems for practitioners, and prevents any consistent definition and interpretation of health education to outsiders" (1982).

This demonstrates evidence of a developing concern within the profession to identify, study, and discuss positions with regard to important issues in health education.

Therefore, at this point in time, no one has attempted to identify and rank major issues facing health education. Nor has anyone sought to identify acceptable alternative positions for these same issues.

Statement of the Problem

The problem of this study concerns the extent to which there is agreement among expert health educators relative to the identification of alternative positions for possible resolution of selected issues, and the rank order of major issues in health education for 1987 - 1988.
Research Questions

The questions to be investigated included

1. What are the accepted alternative positions of selected issues as perceived by expert professional health educators?

2. What is the level of support for each accepted alternative position on the selected issues?

3. What is the rank order of the major issues in health education in 1987 - 1988?

Limitations of the Study

1. The basis for the issues and alternative positions identified on the instrument reflect a literative review of written perceptions which have appeared primarily in Health Education, Health Values, Eta Sigma Gamman, Journal of School Health, and Health Education Quarterly.

2. The results of the study reflect only the views of individuals who have been identified as expert professional health educators. The criterion utilized for this definition was previous selection by the Association for the Advancement of Health Education as an elected officer, recipient of the Professional Service Award and/or as an Association Scholar.
Definition of Terms

The following terms have been defined to clarify specific word choices for this study.

**Issue**: a point of debate which has at least two sides or alternatives from which to choose.

**Problem**: a question involving uncertainty or difficulty but not possessing two or more conflicting positions.

**Expert professional health educator**: any individual who has been recognized by the Association for the Advancement of Health Education as an elected officer, recipient of the Professional Service Award and or selected as an AAHE Scholar.

**Consensus**: 100% agreement or disagreement among subjects in each round of the Delphi process.

**Majority**: 51% agreement or disagreement among subjects in each round of the Delphi process.

**Alternative positions**: various options or choices, any of which could resolve the issue in question.

**Accepted alternative positions**: those views which garnered support from at least 51 percent of the respondents.

**Delphi process**: a multi-round method of determining consensus among experts by utilizing an informational feedback system.
Chapter II: Review of Literature and the Delphi Process

The focus of this study is to identify the major issues in health education in 1987 - 1988, to identify the alternative positions that might lead to resolution of the issues, to determine the level of support for the identified alternatives, and to rank the issues according to importance.

This chapter includes (1) a discussion of issues in general as well as those with specific implications for health education, (2) a review of methodology for identifying and describing alternative positions, and (3) a review of the Delphi technique, and its suitability and application for studies concerning issues.

Definition of Issues

Issues are by definition controversial. Webster's Third New International Dictionary defines an issue as "a point of debate or controversy....something entailing alternatives between which to choose or decide" (1966).
A problem, on the other hand is, "any question or matter involving doubt, uncertainty, or difficulty" (Gove, 1966). Therefore, while problems and issues are similar, they are not always identical. A problem does not assume two or more conflicting views or sides. "Lack of research" is a problem, not an issue. An issue would exist if research monies were limited and two or more proposals requiring a greater amount than that which was available were submitted. The issue would be "Shall we fund Project A or Project B"? The fact that insufficient funds exist is the problem. Solving the problem would mean resolving one or more issues. "An issue is a problem. Issues can arise from problems and problems can arise from an issue, but a problem is not necessarily an issue" (Sanborn and Hartman, 1964).

A trend is another term occasionally utilized in place of the word "issue". A trend is "the general course, drift, or tendency" (Gove, 1966). By definition, a trend is the accepted manner or concurrence or that which is not in contention. Therefore, if a trend is the accepted position rather than a contentious position, a trend is not the same as an issue.
Methods of Identifying Issues and Alternative Positions

The literature reveals that there are primarily four major methods for the identification of issues and alternative positions in health education. These methods include (1) individual written perceptions, (2) a review of related literature, (3) conference reports, and (4) research studies. These four methods have been utilized frequently in combination.

Individual written perceptions have been described in the format of manuscripts and journal articles. Specifically, articles have appeared primarily in Health Education, Health Values, Eta Sigma Gamman, Journal of School Health, and Health Education Quarterly. The importance of the issues and the discussion of alternative positions varied according to forces both within and outside of the profession as well as the perceptions of the authors.

A review of related literature identified issues within the profession which have undetermined degrees of support. Issues in health education have been viewed with a different focus by a number of professionals. In 1984, Creswell organized issues into five groups, "(1) the goals or purposes of health education, (2) the theories or guiding principles for health education, (3) the
content and method of health or health education, (4) the nature of professional preparation or training needed by the health educator, and finally, (5) an assessment of the status of health education" (1984).

Penland and Beyrer further clarified ethical issues but organized them into four different categories; "those that relate to (1) specific content and methodologies, (2) the health education curriculum, (3) the selection of future health educators and (4) the mission of health education" (1981).

Hochbaum also contrasted various positions relative to ethical issues in health education. He believed that "As long as health educators consider ethical issues on the most general, abstract level, few will have doubts. But as we descend from that level toward a more concrete, experiential level, problems increase" (Hochbaum, 1980).

St. Pierre and Shute discussed four issues which they felt would have implications for the professional preparation of health educators. The issues encompassed ethics, political activism, concepts of accountability, and behavioral change (St. Pierre, 1984). The changing focus of professional preparation programming and employment practices in health education were studied, also. Issues concerning the alternatives for assuring quality in such programming were raised (Pigg, 1984).
Conferences have focused also on issues. The Association for the Advancement of Health Education identified 55 ethical issues in 1979. Their subdivisions included philosophy, professional preparation, methods, health educators as role models, content selection, research, accountability and political activities. The issues were not placed in a specific order or ranked (Barnes, Fors, & Decker, 1980).

In 1983 the National Conference on School Health Education Research in the Heart, Lung and Blood Areas. It was sponsored by The National Heart, Lung and Blood Institute, National Institute of Health, The Office of Disease Prevention and Health Promotion, The Office of the Assistant Secretary for Health of the United States Public Health Service, and The United State Department of Health and Human Services, was held. Issues concerned with the design and implementation of school health education research were included. Possible future issues relative to school health education research were explored, also (Basch).

Research studies have had implications for this study. In 1983, opinions of selected health educators were sought on ten specific ethical issues pertaining to school health. In that study some of the issues identified by the AAHE conference on ethical issues were
utilized as the focus for the questions asked of the subjects (Richardson and Jose). Toohey and Shirreffs completed a Delphi study concerning future trends in health education as seen by national leaders in health education. A number of the trends that were forecasted were at issue in 1987 (1980, p. 16 - 17). The top ten research questions in health education were identified in 1983 (Frazer). The selected research questions reflected the need to develop answers and alternatives for various issues.

Thus, specific and conflicting points of view have been expressed by individuals in the professional literature, at conferences and in research concerning issues in the broad areas of goals, ethics, philosophy, professional preparation, methods, and content. But which health education issues are most significant, whether specific alternatives or contending positions of these issues can be identified, and to what extent acceptance exists for various positions has not been the focus of a study.

**The Delphi Technique**

The Delphi technique was developed in the early 1950's by the RAND Corporation, a "think tank" in California. The Delphi evolved from a study sponsored by
the United States Air Force concerning a consensus of expert's opinions relative to "the probable effects of a massive atomic bombing attack on the United States" (Linstone & Turoff, 1975).

The technique was named for the Oracle of Delphi in ancient Greece. So famous was this wise man that a steady stream of information seekers journeyed from all over Greece and foreign kingdoms asking for advice and predictions. He in turn would offer cryptic responses. Frequently, an oracle was visited more than once before an understandable response was received (Botsford and Robinson, 1956; Bengtson, 1965).

Therefore, inasmuch as information is sought from learned individuals, and clarification may be required, the modern Delphi technique is not dissimilar from the process in Greece.

Uses for the Delphi

Initially the Delphi technique was used for forecasting purposes, but clearly this use has expanded considerably in the last thirty years. Helmer, one of the two original authors, was responsible for moving the Delphi away from a solely military exercise, and identified other possible uses such as, "normative forecasts: the ascertainment of values and preference
estimates concerning the quality of life, simulated and real decision making, and what may be called inventive planning" (Linstone & Turoff, 1975).

More specific applications include:
- Gathering current and historical data not accurately known or available
- Examining the significance of historical events
- Evaluating possible budget allocations
- Exploring urban and regional planning options
- Planning university campus and curriculum development
- Putting together the structure of a model
- Delineating the pros and cons associated with potential policy options
- Developing causal relationships in complex economic or social phenomena
- Distinguishing and clarifying real and perceived human motivations
- Exposing priorities of personal values, social goals (Linstone & Turoff)

Hostrop (1975) indicated that researchers could employ the Delphi technique as an objective means to assess the range of ideas, to establish priority ranking and to identify the degree of consensus about goals and objectives.

The Delphi Process

While Delphi studies have been employed in a variety of settings and for a multiplicity of purposes, the process is fairly consistent. Hostrop described a specific sequence in the administration of a Delphi:

1. Participants (who usually remain anonymous to one another) are asked to list their opinion on a specific topic in the form of
brief written statements to prepared questionnaires, such as recommended activities or predictions for the future.

2. Participants are then asked to evaluate their total listing against some criterion, such as importance, chance of success, etc.

3. Next the statements made by the participants are received and are clarified by the investigator.

4. Each participant then receives the refined list and a summary of responses to the items and, if in the minority, is asked to revise his opinion or to indicate his reason(s) for remaining in the minority.

5. The statements made by the participants are again received by the investigator who further clarifies, refines, and summarizes the responses.

6. Each participant then receives the further refined topical list which includes both an updated summary of responses and a summary of minority opinions. Each participant is also given a final chance to revise his opinions.

7. Finally, the investigator receives the last round of the questionnaires which he then summarizes in a final report. The successive, individual and independent process of requesting of each of the experts, combined with feedback supplied separately from each of the other experts, via the investigator, is designed to eliminate misinterpretation of questions and the feedback and bring to light knowledge available to one or a few members of the group but not to all of them (1975).

**Modified Delphi**

Many adjustments have been made to the Delphi as originally developed by RAND. One modification is a reduction in the number of rounds that initially totaled seven but more recently have been reduced to three or less. Weaver concluded that one never conducts a Delphi, but
rather, "modified" Delphi's are always conducted. He also identified several typical modifications. One that is important to this research is a focus on explanation. Participants are asked to consider and explain or justify their personal views relative to each alternative to each issue (1972).

Delphi Rounds

Dalkey believed that a Delphi study would infrequently require less than two or more than four rounds (1975). Sutphin concluded that the amount of convergence on the previous round is the prime determinate of the number of rounds necessary, inasmuch as no specific criteria appears to exist (1981). Cyphert and Gant found that little change in position occurred after only three rounds and questioned the need to go beyond that point (1971). Therefore, the seven rounds utilized in the original RAND study appear seldom justified.

Panel of Experts

Another consideration concerns the use of experts. The Delphi panel was originally comprised of experts and there is substantial, although varied, documentation on how to define and identify them. Weaver wrote, "experts are experts because they are objective, take into account new
or discrepant information, construct logically sound deductions" (1972).

Helmer differentiated between experts who are specialists and those who are generalists. But in either case, while he believed judgments frequently came from "explicit application of existing theories, more often it may be highly intuitive in character and based on insights" (1965). Nash postulated that experts frequently occupy the most influential positions and are, therefore, more likely to see their opinions accepted since they possess a position of power (1978).

Martino supported the need for experts particularly "in fields where progress may be more dependent on external social and economic factors than on technological factors intrinsic to the field; and in fields where ethical or moral considerations may weight heavily" (Martino, 1972). Helmer thought that many of the experts selected for consultation were usually chosen because of their reputations "such as years of professional experience, number of publications, status among his peers, etc." (1965).

Traditionally, one of the strongest tools a researcher utilized was randomization. This, however, does not apply to the majority of Delphi studies. Cyphert cautioned that in no way should experts resemble a random selection, but
rather, that each expert should be selected because he/she "represent(s) a significant segment of the power structure." Cyphert also supported Nash's view above that "what those persons in positions of influence believe will happen or should happen is the best indication of what actually will occur in the near future" (1970).

Panel Size


Sutphin concluded "Indications were that the sample should be large enough to obtain the amount of expertise
necessary to effectively conduct the study. Beyond this number, the sample size should be held to a minimum to reduce cost and reduce an over abundance of data which become cumbersome and yield no additional information for the study (1981).

Validity of the Delphi Technique

The nature of a Delphi study precludes many traditional forms of establishing validity. However, the Delphi technique has been the focus of studies addressing similar concerns. Dalkey explored the relationship between informational feedback, the usual Delphi format, and anonymous interaction and found accuracy was enhanced significantly with the former (1969).

Campbell compared forecasting accuracy between two groups of graduate students in business relative to economic measures such as Gross National Product, and the Dow Jones 30 Industrials. One group employed the Delphi method which included a justification of their responses if those subjects were outside of the interquartile ranges, while the second group was limited to fact finding and additional outside sources of information. The Delphi group "forecasted more accurately, as a group and as
individuals than did group participants functioning under the controlled-interaction method" (1966).

One should remember, too, that the Delphi technique is most appropriately utilized when precise information is not known and for futuristic forecasting (Linstone & Turoff, 1975). Therefore, the passage of time is both essential and, yet, a detriment to the traditional establishment of validity. This does not negate the Delphi for research applications, but rather acknowledges a limitation as viewed by some researchers.

**Delphi in Education**

Three uses for the Delphi in the field of education were identified by Weaver (1972). They were:

1. a method for studying the process of thinking about the future
2. a pedagogical tool or teaching tool which forces people to think about the future in a more complex way than they ordinarily would, and
3. a planning tool which may aid in probing priorities held by members and constituencies of an organization.

Weaver continued by comparing two common types of Delphi studies, the normative and the exploratory. The normative identifies which goals and alternatives were most desirable, regardless of the time frame, and measured the degree of consensus of the participants. The exploratory
Delphi, in contrast, was focused not on what was desirable but on what was probable. The exploratory, also, concerned a specific future time frame whereas the normative does not. Both, however, relied on informational feedback (Weaver, 1972).

**Delphi in Health Education**

While the Delphi technique has been utilized in virtually hundreds of educational studies, it has had somewhat limited use in the field of health education. Both normative and exploratory Delphi studies have been completed in health education. Six of the following seven studies are examples of normative Delphi applications, while one, Toohey, is exploratory.

Travis utilized the Delphi to study the role of the physician's assistant and to determine consensus concerning community health problems, needs, and goals. Interestingly, consensus was reached but the process did not change individual opinion (1976).

Frazer completed a Delphi study which identified the most important research questions in health education. Those areas so identified included understanding the parameters of health education, concerns for the quality of professional preparation, the ramifications of behavioral change, ethical considerations, and evaluation and
discovery of unique characteristics of health education methodology. This study concluded that the "Delphi technique is a most viable tool for research endeavors....it is economical; it is productive; it stimulates rather than seeks closure; it is future than past oriented" (Frazer, 1983).

Hentges and Hosokawa applied the Delphi as a needs assessment for curriculum development. The curriculum reflected the consensus of judgment of the subjects relative to subject area, time span, and the development of classroom materials. Hentges and Hosokawa also included an evaluation of the process by the participants as part of the same study. The participants were overwhelmingly positive in their view of the Delphi process (1980).

Banks utilized the Delphi technique in her study of health education and a spiritual dimension. The purpose of the study was two fold. First, she identified the perceptions of health educators relative to the spiritual dimension of health. And, secondly, she explored the extent to which professional preparation programs should include materials on the spiritual dimension in the training of future professionals (1979).

Detert and Russell employed a four round Delphi technique to identify and describe content elements of stress management for use in high school health education
curriculum development. The study utilized a five point Likert-type scale to rank the identified stress components according to importance and feasibility (Detert, 1987).

A most ambitious study was completed by Crowley and Johnson which attempted to involve close to 500 located in all states and the District of Columbia. The study explored the definition of school health, national and local issues in school health, who and what methods should be included in the implementation of school health, and what constitutes the ideal school health program. The information from this study, which included definitions, issues, and questions, was incorporated in the conference framework and format for the National School Health Conference in 1977 (Crowley, 1977).

In 1980, Toohey completed an exploratory Delphi to determine whether leaders in health education could reach a consensus in forecasting future trends in health education. Some of the forecasted trends on which consensus was reached addressed such issues as credentialing, cost effectiveness, and the unification of various health education societies are still at issue in 1987.

**Summary**

In conclusion, the Delphi technique is employed when specific hard data concerning a subject are unavailable
and/or for identifying priorities or personal attitudes or beliefs. The identification and ranking of major issues and alternative positions in health education and their resolution, are a function of personal attitudes and beliefs and, therefore, can be effectively studied by utilizing the Delphi technique.
Chapter III: Procedures

This chapter includes the procedures utilized for determining (1) the criteria for the selection of the panel of experts, (2) the identification of issues and the alternative positions, (3) the development of the instrument format, (4) validation of the instrument through a field test, (5) Round 1, (6) Round 2, (7) Round 3, (8) the study summary, and (9) the analysis of the data.

Introduction

The recent literature indicates that most Delphi studies require only three rounds. Therefore, a three round Delphi study was utilized to explore selected issues in health education. The expert panel consisted of individuals who had been acknowledged as AAHE Scholars, officers, and/or recipients of the Service Award by the Association for the Advancement of Health Education, a national professional health education organization.

Initially, most Delphi studies employed open ended questions but those proved difficult to quantify. For this reason examples of structures instruments have become
more common. A structured, but modifiable, instrument was utilized in this study. Such a format established parameters but provided the participants the opportunity to modify, justify, or add to the instrument during all phases of the study.

**Selection of Expert Panel Members**

The panel of experts participating in this study were all individuals who had been recognized by the Association for the Advancement of Health Education (AAHE).

AAHE is, not only the largest organization of health educators in the United States but, generally viewed as the single professional health education organization that provides leadership in all areas of health education (Nolte, 1985). AAHE can trace its' beginning back to 1886 and the formation of the American Association for the Advancement of Physical Education, later changed to American Physical Education Association (APEA). School health education was formally recognized by the NEA in 1937 and when the NEA merged with the APEA, the American Association for Health and Physical Education was established. Through the years a number of name changes took place for both the parent organization as well as the division association with health education. In 1974 the School Health Division became the Association for the

The expert panel consisted of individuals who were either elected officers, recipients of the Professional Service Award or selected as Scholars by AAHE. The list of living experts was comprised of 40 individuals, 29 men and 11 women. The target population included the total population of all professionals so identified between and including the years of 1974 and 1987 save Mary K. Beyrer, adviser to this investigation. The year of 1974 established the inception of AAHE in the present structure.

Development of the Instrument

The development of the first round instrument incorporated two research procedures, a literature review to determine broad categories of issues, a literative review to identify alternative positions for each identified issue, and a field test. First, a review of articles and conference materials concerning issues. Eight broad categories of issues were identified at the 1979 AAHE conference of ethical issues. The categories included philosophy of ethics, professional preparation, methods, health educators as role models, content selection, research, accountability, and political
activities. In 1984, Creswell suggested five broad areas of issues to study: goals or purpose, theories, content and method, the nature of preparation for the health educator and an assessment of the status of health education (Creswell, 1984). Penland and Beyrer organized ethical issues into four areas, those that related to mission, content and methodology, curriculum, and the selection of the health educators of the future (Penland, 1981). These broad areas were collapsed into, but not limited to, a framework of nine. This framework included the areas of goal or mission, methodology, accountability, content, professional preparation or credentialing, research, role models, and political activities.

Secondly, a review of literature of professional journals in health education was completed for the years 1980 - 87. These journals included Health Education, Health Values, Eta Sigma Gamman, Journal of School Health, and Health Education Quarterly. Specific articles, as well as research and conference reports, were sought concerning, but not limited to, issues within the broad areas identified above. It became clear that the titles of many journal articles were not as descriptive as first expected. It was, therefore, necessary to review all the journals page by page to obtain a comprehensive view.
Remembering that issues are points of contention or alternatives for a solution, the literature was reviewed for articles or research that explored several alternatives to an issue or for research or articles that supported only one point of view if other contending positions also could be found. For example, one of the broad areas of concern identified at the 1979 conference was "Should health educators involve themselves in political activities?" (Barnes, 1980). Professional publications have explored how to effectively access the political system, case studies of the political system in operation, the advantages of political activities, and the political knowledge and participation of students (Butler, 1983; Carra, 1984; Cooper, 1986; Henderson, 1981; Kane, 1982; Noak, 1982; Solleder, 1981; Torney, 1981). However, the authors did not separately nor comparatively address contrasting views to support or dispute the advisability of political activism in health education, or to offer alternatives for access. Further, contentious positions concerning political activism could not be found in the literature. Therefore, by definition, political activism could not be considered an issue for this study.

The 1979 conference also considered whether health educators should be positive role models. Limited information, only two sources, was available for this
issue and that which existed was found either before or early in 1980 (Hochbaum, 1980; Russell, 1975). The consideration of this as a possible major issue seemed remote and, therefore, was not included. Face validity for the development of the other suggested issues identified in the instrument reflected these same criteria.

Issues questioning the goal or mission of the health educator were identified in all articles which explored issues in general and behavior change specifically and were also part of the national conference concerning ethical issues (Hochbaum, 1980; Penland, 1981; Richardson, 1983; Creswell, 1984; Frazer, 1983; Russell, 1983; Cooper, 1985; O'Connell, 1983; Balog, 1981; Kolbe, 1981; St. Pierre, 1984; Terhune, 1986; Heit, 1981; Black, 1981; Stainbrook, 1982; Hamrick, 1980; Barnes, 1980).

Issues concerning appropriate methodology to be utilized by the health educator were identified in all articles which examined issues in general, at the national conference on ethical issues, and in articles and books concerning methodology (Barnes, 1980; Richardson, 1983; Penland, 1981; Kolbe, 1980; Frazer, 1983; O'Connell, 1983; Hochbaum, 1980; Creswell, 1984; St. Pierre, 1984).

Issues concerning accountability for the health educator were considered at the national conference and
included in articles which addressed issues in general (Barnes, 1980; Rubinson, 1984). Numerous articles which explored the ramification of accountability also were found (Ogden, 1980; Kolbe, 1981; Green, 1985 and 1980; Russell, 1983; Hamrick, 1980; McKenzie, 1986).

Issues related to content addressed both general concerns namely, "Who should be responsible for content selection?" and specific topics, "Is it ethical to discuss spirituality?" Numerous citations were found to justify the inclusion of the broad area of content in a study involving issues (Barnes, 1980; Penland, 1981; Creswell, 1984; Richardson, 1983; Russell, 1983; St. Pierre, 1984).

AIDS education has received a great deal of attention in both the news and in professional journals and is one of the most controversial content issues of recent years (Balog, 1981; Black, 1986; Conte, 1983; DiClemente, 1986; Glover, 1984; Kantrowitz, 1986; Marwick, 1985; O'Connor, 1987; Price, 1986; Price, 1985; U.S. Department of Education, 1987; Fiumara, 1983; Fulton, 1987; Pfeffer, 1986; Skeen, 1987; Verniero, 1986).

The issues surrounding the professional preparation and credentialing of health educators have been discussed for years in books, articles, and at national conferences and have been the topic of some research. The focus has been whether commonalities and differences should exist in
the education and/or recognition of the health educator (Barnes, 1980; Henderson, 1982; Bureau of Health Education, 1980; Smith, 1985; Creswell, 1984; St. Pierre, 1984; Toohey, 1980; Grossshans, 1980).

Issues addressing the need for research on specific topics in health education have been the subject of professional contributions to conferences, articles and research (Barnes, 1980; Frazer, 1983; Kolbe, 1980; Kreuter, 1983; Basch, 1983; Cristenson, 1981; Toohey, 1980; McKenzie, 1986; Warner, 1987; Richardson, 1986; Wylie, 1983; Roos, 1984).

During recent years AAHE has been moving toward, and gaining, greater autonomy within AAHPERD. During the 1987 national convention in Las Vegas, a session was devoted to organization changes within AAHE. The need to explore organizational configurations has been the subject of many articles and the focus of discussion in professional organization other than AAHE that also serve health educators (Shirreffs, 1980; Taub, 1985; Cortese, 1986; Hochbaum, 1983; Toohey, 1980; Howell, 1980).

All alternative positions that might lead to resolution of the selected issues were included in the instrument. No attempt was made to select or limit the number of alternatives. Each issue and all alternative positions are explained in depth in Chapter Four, Issues.
The third technique utilized in the development of the instrument was a field test. The experts participating in the field test were chairpersons of health education departments in the state universities of Ohio. The chairpersons were identified as experts and leaders of their departments at their institutions. There is no single adopted health education state curriculum in Ohio; therefore, independent views about issues facing health education were likely. The field test is described in detail later in this chapter.

**The Instrument Format**

The instrument format, although developed specifically for this study, was modeled after Sutphin and follows, for the most part, the guidelines suggested by Dillman (Sutphin, 1981; Dillman, 1978). The questions probed the attitudes and beliefs of the participants concerning important issues in health education in 1987 - 1988. The instrument was an example of both an ordered and unordered, partially close-ended questionnaire. As such, each ordered question as "a graduation of a single dimension of some thought or behavior. The respondent's task was to find the most appropriate place on an implied continuum for his or her response" (Dillman, 1978).
Participants were asked to review each of the issues and the alternative positions before marking the instrument. If they thought an alternative position was clearly stated and identified a valid alternative position for that issue, though not necessarily their own, they were to mark the space under "AGREE". If an alternative position needed to be modified, or clarified, or if they believed that the position did not reflect attitudes or beliefs held by health educators, they were to mark the space under "DISAGREE". They should not have any one alternative position marked both "AGREE" and "DISAGREE". The alternative positions that they personally supported were to be indicated by checking the space under "SUPPORT". Accordingly with each issue, the participants were provided the opportunity to (1) modify proposed alternatives, (2) to justify or expand their own responses, if those offered did not adequately represent their views, and/or (3) to suggest other alternatives which they considered valid.
An example of the Round I is shown below.

**Issue A:** To what extent should behavioral change be the primary goal of the health educator?

**Alternative Positions:**

<table>
<thead>
<tr>
<th>The primary goal of the health educator should be</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. to facilitate the acquisition of facts concerning health behaviors and wellness.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. to facilitate decision making skills applied to healthy behaviors.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. to change unhealthy behaviors.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

During all three rounds, the subjects were also asked to rank the proposed issues in order of importance. As issues were added by the panel, they too, were included in the ranking process.

The instrument was in an attractive, easy to score format as identified by Dillman. He found that the professional appearance of the instrument assured the respondent that a great deal of work had gone into the
development of the questionnaire and, thereby, enhanced the importance of the study (Dillman). The instrument was printed on 8 1/2" x 11" paper.

Each instrument was marked by both an identification number and an abbreviation of a month printed in the upper left hand corner. The number provided the researcher with identification of each expert and at the same time assured confidentiality. The month identified each round.

Minimal personal information was sought such as phone numbers for both home and work, verification of address, and general classification of professional position. Subjects who failed to respond to the first round or other subsequent rounds, even after follow-up communication, were not included in further rounds. Linstone suggested that input for a Delphi should come from sincere respondents and that nonrespondents, after several reminders, should be excluded from participation (1975).

Validation of the Instrument

A field test was utilized to validate the instrument. On November 10, 1987, a packet was sent to the chairperson of the Health Education Departments, or equivalents, of all nine state universities in Ohio that
had such departments. The packet included (1) a letter briefly explaining the study and asking for content validation of the instrument, (2) an abstract of the study, (3) the instrument, (4) a McDonald's coupon as a token of appreciation, and (5) a stamped return addressed envelope. (See Appendix, p. 165 for a copy of the letter and Appendix, p. 180 for a copy of the instrument.) A return date of one week was requested. All correspondence was written on official department letterhead, included the real signature of the researcher, and an endorsement by the major adviser (Dillman). All envelopes and cards were hand addressed. All cards, letters, and envelopes were signed in green ink, and all announcement and reminder cards were green.

A postcard was sent on November 17, 1987, thanking those who had responded and as a reminder to the nonrespondents that their comments had not as yet been received. (See Appendix, p. 166 for a copy of the card.) On November 24, 1988, a replacement instrument and cover letter was sent to the chairpersons who had not responded. A plea was made for their participation in the study. (See Appendix, p. 169 for a copy of the letter.) Of the nine chairpersons contacted, all but one chairperson responded by the designated date for a
response rate of 88.9 percent. Phone calls to the nonrespondent were unable to be completed.

The chairpersons suggested several additions and refinements. If more than one chairperson suggested an addition and/or a refinement, it was incorporated into the Round One instrument. The word "small" was changed to "limited" in alternative two of Issue C. An additional alternative position for Issue C was suggested by the chairpersons and was included as alternative four. And finally, a definition of health educator was suggested for and included in Issue F.

A potential bias also was identified for Issue E. Of the nine chairpersons responding, all but one not only agreed with alternative two, but supported it. It was felt that the order of the issues and the reference to grade level in the previous issue may have been a factor. The position of the issues was subsequently reversed. Issue E replaced Issue D and was reworded to ask for ages rather than grade levels.

**Issues and Alternative Positions**

Eight issues and thirty-one alternative positions were identified through a literature review and a field test. Those issues and the alternative positions listed below, comprised the Round I instrument.
Issue A: To what extent should behavioral change be the primary goal of the health educator?

Alternative Positions:

1. to facilitate the acquisition of facts concerning health behaviors and wellness.
2. to facilitate decision making skills applied to healthy behaviors.
3. to change unhealthy behaviors.

Issue B: Which methods should the health educator utilize when attempting to change the behavior of student or client?

Alternative Positions:

1. attempts to persuade them to alter their behavior as long as they are willing listeners.
2. "fear arousing" methods if necessary.
3. subtle behavior modification techniques which could be effectively utilized on students or clients that are unaware of them.
4. coercion if risk factors are life threatening to the individual.
Issue C: To what extent should the health educator be held accountable for behavioral change in students or clients?

Alternative Positions:

1. Health educators can present information coupled with methods that lead to behavioral change; beyond that manipulation is present.

2. Education accounts for only a small portion of an individual's life; therefore, the health educator should not be held accountable for continued poor health behaviors of students or clients.

3. Behavioral change is the ultimate goal and reflects the competency of the health educator.

Issue D: What should be the focus of AIDS education for grades four through six?

Alternative Positions:

1. Based primarily on the importance of chastity and abstinence with some information on barrier protection.

2. Limited to the importance of chastity and abstinence.
3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence.
4. limited to the importance of barrier protection.
5. based on the biomedical aspects of the syndrome and related diseases.

Issue E: At which age should education concerning the transmission and prevention of AIDS be introduced?

Alternative Positions:
1. Ages 6 - 7
2. Ages 8 - 9
3. Ages 10 - 11
4. Ages 12 - 13

Issue F: Which commonalities should exist in the professional preparation of health educators?

Alternative Positions:
1. a minimum of a baccalaureate degree with a major in health education.
2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project.
3. successful completion of a state competency examination leading to licensure, e.g. nursing.
4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by Holmes group.

Issue G: In which of the areas of health education should research be primarily focused?

Alternative Positions:
1. identification of critical factors in the implementation and maintenance of health education programs.
2. understanding the causes of behavioral change.
3. the formulation of cost effective ratios so that various health education programs could be evaluated and compared.

Issue H: To what extent does the health education profession need a single organization to represent health educators?

Alternative Positions:
1. The continuation of the present multi-organizational system which offers many options.
2. further separation of AAHE from AAHPERD and support for a consolidation of AAHE and SOPHE.
3. a reorganization of the Coalition of National Health Education Organization to allow for individual memberships.

4. creation of a new capstone organization, similar to the American Medical Association, which would have subdivisions to serve specialists.

Round One

Round One was initiated on January 5, 1988. A green postcard was sent to each expert announcing the study and encouraging their participation. (See Appendix, p. 168 for a copy of the card.) Some researchers believe that pre-contact with prospective respondents increases response rate (Smith, 1972; Stafford, 1966). One expert in this study wrote, "Your colorful card did succeed in peaking my curiosity."

One week later, on January 12, 1988, experts were sent a packet. The packet included a cover letter which stressed the value of the study to the profession, the criteria which had identified their "expert" status and the importance of their participation in the study (Cyphert, 1971). The tenor of the letter implied that the researcher was subordinate to the experts and was requesting a favor from them concerning important issues facing their profession (Dillman, 1978). The letter
further explained that participation in a Delphi study can be a highly motivating experience (Dalkey). All correspondence was hand addressed and signed with green ink. (See Appendix, p. 167 for a copy of the letter).

Each packet also contained (1) an abstract of the study, (2) the instrument, (3) a McDonald's coupon, and (4) a stamped return addressed envelope. Experts were asked to either (1) agree or disagree with each alternative position, (2) to modify proposed alternatives, (3) to justify their selections, and/or to suggest other alternatives if they chose, and (4) to rank the issues according to importance. (See Appendix, p. 194 for a copy of the Round One instrument.)

Dillman stressed the importance of mailing information early in the week with Tuesday being designated as the best day; more importantly, the mailing date should appear on all materials rather than the date of preparation (1978). All materials, save one, were mailed on Tuesdays.

One week after the initial mailing, January 12, 1988, a green postcard was sent as a thank you to those who had responded and as a polite reminder to those who had not. (See Appendix, p. 170 for a copy of the card.) During that week, four phone calls were received from experts indicating, that due to chronically late mail
delivery and/or their schedules, they would need additional time. On January 26, 1988, a replacement instrument was mailed along with a letter informing all nonrespondents that their materials had not yet been received and an additional plea for a prompt return. The letter also indicated that some of the experts had requested additional time and the deadline had subsequently been extended. (See Appendix, p. 169 for a copy of the letter.)

By the extended deadline of February 9, 1988, 30, or 75 percent, of all instruments had been returned. All but two of the instruments was deemed usable. Of the unusable instruments, one was completed by an individual other than the identified expert. The second was completed by an expert who wrote this researcher stating, "I have retired and do not really know the issues in Health Education." That expert's completed instrument arrived later that same week. Two packets were returned marked "No Forwarding Address." One expert wrote that he did not like the format of the instrument. Correspondence was received in behalf of one expert indicating that poor health precluded the expert from participation. Two packets arrived after the extended deadline. No information was received from four experts. Therefore, of the 40 instruments sent, 28, or 70 percent, were
accepted for Round One. Of the 12 who were not included in the first round, demographic information was available for four persons. These four did not appear to differ significantly from those included in Round One.

Results from Round One were analyzed and summarized in the Round Two instrument. Percentages were calculated for level of agreement, disagreement, and support for each alternative position. If two or more respondents in Round One made similar comments or suggested a similar new alternative, these suggestions were included in the revised second round instrument in Note from Researcher. Also, when the need for clarification or refinement of issues or alternative positions became apparent, additional information was included in this same section. If a single respondent asked for clarification or suggested a new alternative, this information was included in the section Other Comments from Round 1. The section Responses from Round 1 indicated summarized data for each alternative position. Individual experts' responses were underlined in red in the succeeding round instruments.

During Round One, eight experts supported multiple alternatives for issues that asked for a single selection. For example, in Issue A, some individuals supported all positions as the "primary goal" of the
health educators. The statement, "The major focus in this issue is 'primary goal' as opposed to multiple goals" was included in the Note from the Researcher section of the Round Two instrument for clarification. A similar modification was made for Issue D which asked, "At which age should education concerning the transmission and prevention of AIDS be introduced?" The word "first" was inserted before the word "introduced."

Experts were asked to rank issues according to importance with the most important ranked 1 and the least important ranked 8. If an expert did not consider a specific issue as a major issue, they were to mark it with a 0. All 0 scores were calculated as a number 9. The mean and median reflected marked issues. Five of the respondents failed to rank the issues according to importance, but included suggested revisions. Additional refinements were made in the Round Two instrument reflecting their input and a hand written plea to complete the total instrument was included in all five of their Round Two packets. Experts in Round One suggested four new issues to be considered in Round Two. Experts were encouraged also to include viable alternative positions for these newly proposed issues. (See Appendix, p. 207 for a copy of the Round Two instrument.)
The Round Two instrument was then presented winter quarter to a panel of health education doctoral students in the winter quarter course Health Education 822, Curriculum in Health Education, to read for both clarity and refinement of format. (See Appendix, p. 177 for the Round One panel.)

**Round Two**

Round Two was mailed on February 29, 1988. The mailing contained (1) a cover letter praising the efforts of the experts, (2) the instrument, (3) a stamped return addressed envelope, and (4) a pack of instant coffee as a token of appreciation. (See Appendix, p. 172 for a copy of the cover letter.) The experts were requested (1) to review their previous positions relative to the summarized data from Round One, (2) to consider the additional information and justifications provided by other study participants, (3) to suggest new alternatives, alter previous alternatives, or justify their position on any alternative, and (4) to respond to the second round in the same manner as the first round.

A follow-up postcard was sent on March 8, 1988, one week later, to each nonrespondent. Card recipients were thanked for their continuation in the study and reminded
if they had not already returned the instrument, to do so. (See Appendix, p. 173 for a copy of the card.) Phone calls were placed to 11 experts who had not responded by March 8, 1988.

One expert wrote that personal time constraints prevented further participation. During Round One an expert expressed concern about the Delphi method in general, but returned a completed instrument which was included in the sample. During the second round, this expert asked to be removed from the subsequent rounds of the study. One instrument was not returned by the deadline. Therefore, 25, or 89 percent, of the Round One panel of experts were retained for Round Three.

The instruments were analyzed and summarized as in the prior round. The Round Three instrument was then prepared. Reflecting the additional alternative positions and comments by the experts, the third round instrument was printed on larger, 11" x 11", paper. This adjustment in size allowed the instrument format to be consistent with previous rounds and still continued to provide all information concerning individual issues suggested by the experts to appear on a single page. (See Appendix, p. 206 for a copy of the Round Three instrument.)
During Round Two, the number of experts supporting multiple alternatives for issues that asked for a single selection was 16. A clarification was included for Issue A that read, "You may 'Agree' with several of the alternative position but select only one as the one you 'Support'." Issue G presented a similar problem. The following statements were included for clarification, "The purpose of this issue is to identify the most critical research needed in Health Education. You should select only one alternative to 'Support'." These statements were underlined on the instruments of the individuals who had marked multiple selections on the previous instrument.

All five experts who chose not to rank the issues in Round One, also, did not rank them in Round Two. However, two wrote thorough explanations of their positions. Further refinements were made and a plea to rank the issues was included on those five instruments. No expert included alternative positions for the new issues proposed in Round One.

The Round Three instrument was presented again to a panel of health education doctoral students to read for clarity. These graduate students were members of the spring quarter course Health Education 822, Moral and
Ethical Issues in Health Education. (See Appendix, p. 165 for the second round panel.)

Round Three

One April 29, 1988, the third and final round was mailed. The mailing included (1) a cover letter thanking the experts for their continued participation, (2) the instrument, (3) a return addressed stamped envelope, and (4) a large, brightly colored paper clip. (See Appendix, p. 161 for a copy of the cover letter.) This mailing, unlike all previous mailings, was sent at the end of the week. This mailing deviation reflected a concern that attrition would be increased due to summer vacation schedules and, accordingly, the final round should be mailed at the earliest possible time. Experts were requested to (1) review their Round Two positions relative to the summarized data from Round Two, (2) consider the additional information and justifications provided by other study participants, (3) suggest new alternatives, alter previous alternatives, and/or (4) respond to the third round in the same manner as the first two rounds. Two additional questions were included in Round Three. Information was sought concerning the length of time it took to complete the instrument and to what extent ranking the issues proved difficult.
Green reminder cards were mailed on May 10, 1988, thanking those who had responded and as a reminder to the nonrespondents that their comments had not as yet been received. (See Appendix, p. 175 for a copy of the card.) Phone calls were placed to six experts who had not responded by May 13, 1988. By the deadline date 22, or 79 percent, had returned the instrument. None were received late.

Final Results Document

A study summary which included the analyzed, summarized results of Round Three were included in a final report to the study participants. (See Appendix, p. 220 for a copy of the final report.) On June 28, 1988, a packet was sent to the experts who had completed all three rounds. The packet included (1) a thank you letter, (2) the final report, and (3) demographic information of the expert panel. (See p. 84 for a copy of the demographic report.) (See Appendix p. 176 for a copy of the letter.)

Of the five respondents who previously did not rank the issues according to importance, only two continued to do so. On the Final Round, two did rank the issues and one was lost to attrition.
Analysis of Data

Descriptive statistics, traditionally utilized for Delphi studies, were employed to analyze the data of this study. Acceptance, rejection, and support of alternative positions for each issue was indicated by percentiles. Comments from experts were reviewed and verified to eliminate researcher bias.

During all three rounds, the experts also were asked to rank in order of importance, with the most important as number one, the issues under consideration. As additional issues were suggested for consideration, they too were included in the ranking procedure. Reflecting the small sample size, both the median and the mean were calculated as well as a Spearman rank correlation.

Summary

Eight issues and thirty-one alternative positions were identified through a literature search and a field test. These issues and alternatives were the Round I instrument. A three round Delphi was completed for this study by a panel of experts from the Association for the Advancement of Health Education. Each round of the Delphi was subsequently analyzed and summarized. Experts received not only statistical data, but also comments by other panel members for each round.
Chapter IV: Discussion of the Identified Issues

This chapter includes (1) the eight issues in health education selected for inclusion in this study and (2) alternative positions for each of the issues as identified by a review of literature and substantiated by a field test. Each issue and its alternatives are discussed. The following issues and the alternatives are the basis for the Round One instrument of this study.

Introduction

In 1979, a conference sponsored by the Association for the Advancement of Health Education (AAHE) identified eight broad categories of issues. Health Education devoted an entire issue to the exploration of selected issues in 1982 and numerous articles in Health Education and other professional journals have focused on various sides, or alternative positions, of a variety of issues facing health education. Individual written perceptions of both issues and alternative positions have appeared in Health Education, Health Values, Eta Sigma Gamman,
Journal of School Health, and Health Education Quarterly and related literature.

An issue as defined for this study is a point of debate which has at least two sides or alternatives from which to choose.

Major Selected Issues in Health Education and Possible Alternative Positions for Resolution

Following are the issues (underlined) and the alternative positions explored in this study.

Issue A: To what extent should behavioral change be the primary goal of the health educator? The alternatives are: The primary goal of the health educator should be (1) to facilitate the acquisition of facts, (2) to facilitate decision making skills applied to health behaviors, or (3) to change unhealthy behaviors.

Over time, the goals of health education have changed. Initially health educators were interested in imparting knowledge, believing that would ultimately result in healthier lifestyles for their students/clients. And while the attainment of knowledge could be evaluated, there was evidence that increased knowledge did not necessarily translate into changed
behavior which ultimately resulted in healthier lifestyles.

During the 1960's, behavioral objectives became an integral part of education in general and curriculum development specifically. Educators were asked to identify precise student behaviors as goals, and to then evaluate the effectiveness of the curriculum and instruction by the attainment of these same goals. This brought to the forefront the question of behavioral change as a primary goal of health education. One study found that "Of the behavior-change related articles published, the majority (58%) had a behavioral change focus rather than a behavioral science or behavioral self-control focus" (Werch, 1984).

Whether behavior is to be controlled or changed is neither a new question nor one that is relevant only to the health educator and his/her clients or students; rather it is one that is at the very foundation of society as we know it in the United States. The basis of these beliefs formulated in England in mid 1800. Even at that early time, there were unresolved issues concerning behavior. John Stuart Mill in On Liberty wrote eloquently, "Over himself, over his own body and mind, the individual is sovereign" (1978). Mill continued "All errors which he is likely to commit against advice and
warning are far outweighed by the evil of allowing others to constrain him to what they deem his good" (1978). Mill believed liberty to be essential to life and was one of the first to explore issues surrounding minority rights and majority rule. He was not without his opponents and one of the most worthy was Lord Patrick Devlin.

Devlin believed that mankind was not only responsible for himself but as a member of society also for society as a whole. To ignore individuals who, in their personal lives lack certain standards of behavior, was to disregard principles of the sanctity of human life that society must preserve for continued existence (Devlin, 1979).

The application of these two positions to health education embodies the conflict identified in the issues surrounding behavioral change as a goal of health education.

Many who oppose behavioral change as a primary goal of health education do so because it may reflect manipulation of the student or client by the health educator. In fact, in one study concerning health care marketing, manipulation was found to be the most important ethical issue viewed by the health educators (Cooper, 1985). If a behavior is changed in any part due
to manipulation, then the student/client loses freedom of choice and ultimately freedom of behavior. Hochbaum believed that if methods are used to even "weaken an individual's ability to resist, ethical considerations become acutely disturbing" (1980, p.5). Most would agree, however, that a health educator could give reinforcement for positive behaviors already being practiced (Russell, 1983).

The inadvisability of behavior change as the major goal of health education had been supported by the lack of solidity of medical knowledge (O'Connell, 1983; Hochbaum, 1980). Many health care practices have changed because of the rapidly expanding fields of medicine and wellness. Hence, the knowledge base of health education has constantly changed. Therefore, previously held views concerning sound health practices have later been considered high risk behavior. Examples of changed views include the diminished utilization of radiation for the treatment of acne, dental care, and the recommendation of regular x-rays. Should the health educator be held responsible for a risky behavior, which was in part changed by the health educator, but according to current information would now be considered unhealthy?

Others have seen the major goal of health education to be one of acquisition of knowledge and decision making
skills rather than actual behavioral change. This would allow the student or client the opportunity to apply knowledge to change self selected behaviors. Additionally, this would prepare the student/client for future changes in medical science and the resultant impact of such information on his/her life. Teaching specific behaviors rather than decision making skills would prepare the student for today only and not the future (Balog, 1981; Kolbe, 1981). Hamrick wrote, "the capacity to make decisions is an innate aspect of man's total functioning and as such separates him from other forms of life" (1980). In 1979 a government publication, Healthy People, further supported this idea by stating "The goal of health education is....to guarantee the individual's freedom of choice regarding his own health by giving him the reliable information he needs to make decisions about how he wants to lie" (1979).

Those who believe behavioral change should be a primary goal, point out, that health education has recently been supported at levels heretofore never imagined, because it has been associated with specific outcomes (Terhune, 1986). Black and Newton have written "The modification of health behavior is an objective of school health personnel that is consistent with the modern role of the school health program" (1981).
Heit and Meeks wrote that the expectation of the public is that "we effect specific behavior changes among our students" and that "if our discipline is to achieve the status and respectability of that given to other disciplines, we must demonstrate our effectiveness as it relates to changing health behavior" (1981).

Stainbrook and Green believed as long as the subjects knowingly agreed to behavior modification methods, that behavior modification would be consistent with other methods of health education and as such was not a threat. They further concluded "Thus, behavior modification involves altering the nature of the controlling conditions, rather than imposing control where none existed before" (1982).

Issue B: Which methods should the health educator utilize when attempting to reduce risk factors of students or clients? The alternatives are: The health educator's role relative to behavioral change in his/her students or clients could include (1) attempts to persuade them to alter their behavior as long as they are willing listeners, (2) "fear arousing" methods if necessary, (3) subtle behavior modification techniques which could be effectively utilized on students or clients that are unaware of them, or (4) coercion if risk
factors are life threatening to the individual.

Health educators have a variety of methods that they can employ to enhance learning. But if they have a student or client that has a health threatening behavior, to what extent should the health educator utilize methodology to actually change behavior? Health educators have viewed this situation from different reference points.

Persuasion is one method. Persuasion occurs when attitudes or behaviors are influenced by reasoning and arguments but direct control is not exerted. But, because persuasion limits choices and controls the flow of information, it too is seen by some as manipulation of the individual (O'Connell, 1983).

Some have employed fear-arousing methods effectively. In a 1983 study of 206 health educators, almost 60 percent considered it ethical to use sensationalism or fear-arousing methods in teaching health education (Richardson, 1983).

Coercion is another method. Coercion is the process by which an individual is forced to act or stopped from acting due to a threat or by withholding valued goods. This is the most direct method of controlling behavior and the most effective. One need only look at
fluoridation of drinking water or the lowering of speed limits for validation of the positive effect of coercion. But, concurrently, it diminishes individual freedom of choice.

If the teaching of health is limited only to providing information without employing the most effective methodology known, even if ethical issues existed, students would not have the advantage of being exposed to a variety of learning experiences. Also, other educators utilize multiple methods; therefore, why should health educators be limited in their selection of methodology?

**Issue C: To what extent should the health educator be accountable for behavioral change in students or clients?**

The alternatives are: The health educators should be held accountable for behavioral change in students or clients to the extent that: (1) health educators can present information coupled with methods that lead to behavioral change, beyond that manipulation is present; (2) education accounts for only a limited portion of an individual's life; therefore, the health educator should not be held accountable for continued poor health behaviors of students or clients; (3) behavioral change is the ultimate goal and reflects the competency of the
health educator; or (4) is dependent upon organizational setting and the role requirements for the professional.

Ogden wrote, "We are being asked, in effect, to demonstrate that a given health education program or set of interventions leads to a reduction in unwanted teenage pregnancies, or a reduction in cardiovascular disease and cancer related to smoking, or a reduction in accident tolls related to alcohol abuse, and so on" (1980). A number of health educators have expressed concern that they have been placed in a position of accountability for the continued risk factors of students they have contact with for only a limited time each day. They further point out that behavior is formed by many competing forces such as the individual's age, personal intelligence, beliefs, attitudes and feelings, the individual's friends and family, their decision making skills, their focus of control, sociocultural pressures and expectations and is, therefore, not limited to classroom experiences alone (Kolbe, 1981; Green, 1985). Green further cautions the health educator "To establish immediate behavior change as the criterion for success in school health education would be technically and politically naive" (1980).

When Russell explored both sides of this issue, he wrote, "in health related matters, the learning is
irrelevant and inconsequential unless it results in changes in behaviors toward those more conducive to health. Knowledge and attitudes must lead to desirable behavior or the education must be judged inferior" (1983). Hochbaum echoed this concern when he questioned the health educators' concern for only the quality of the decision making process without consideration of the behavioral outcome, which could result in death (1981).

As health education programs continued to move into the corporate setting, there were even greater demands for the programs to produce improved levels of health, not just changes in knowledge or attitudes (Hamrick, 1980; McKenzie, 1986). Companies expected to see reductions in the cost of employee health care benefits and lost work days, and an increase in productivity and morale.

**Issue D:** At which level should education concerning the transmission and prevention of AIDS be introduced? The alternatives are: The transmission and prevention of AIDS should be introduced in health education classes for (1) ages 6 - 7, (2) ages 8 - 9, (3) ages 10 - 11, or (4) ages 12 - 13.

Perhaps not since the epidemic of poliomyelitis in the 1940's and 1950's has a nation been as concerned
about a disease as serious as Acquired Immunodeficiency Syndrome (AIDS). First identified in May of 1981, AIDS has dominated the health concerns of the public ever since (Toolief, 1981). The Center of Disease Control estimated that 1.5 million Americans have been infected with this disease, although not stricken. AIDS is thought to be fatal 100 percent of the time (Monmaney, 1987).

At issue is at which age do children become sexually active and how much information concerning AIDS should they know before that time? Age and AIDS education has received attention at the national level. Surgeon General Koop has not only suggested that sex education should begin in kindergarten, but that AIDS education should be offered at the lowest grade possible. He further recommends that even if children as young as eight years of age have not asked the usual questions, they should be given information about sex and AIDS (Barol, 1987; Kantrowitz, 1987). Verniero, an educator, has suggested, "in the absence of objective, age appropriate discussion, early childhood fears related to AIDS present a much greater threat to children's present emotional health than the likelihood of contracting the disease threatens their long-term physical health" (Verniero, 1986). Verniero has also identified
appropriate ways that AIDS education can be adapted to ages 5 - 14 (1986). Others, however, find this to be too early and better handled at home. Skeen and Hodson believe that "Most children eight years old and younger do not yet have an adequate knowledge base about sex, blood, death, and what they can count on from their parents to be able to interpret lethal AIDS information constructively" (1987). They continue by saying that when those younger than eight years of age ask about AIDS they are seeking reassurance, that they personally are safe and do not seek a discussion of sexual behavior or drug usage and that "To soothe is sufficient" (1987). Brick suggests "For children eight years old and younger, this means age-appropriate sex education--naming body parts, answering questions about bodies, birth, and babies--that prepares them for more explicit information they will need as they reach puberty" (cited in Strouse, 1987).

The age that sexuality activity begins has relevance to the introduction of AIDS education. One study concerning the age of first coitus, found that 44 percent of adolescents studied had their first coitus at age 16 or younger (Faulkenberry, 1987). Another study found that 12% of those 12, 14% of those 13 and 39% of those 14 years of age had already had their first coital
experience (Smith, 1986). A study conducted by Louis Harris for Planned Parenthood found 4% of those age 12, 10% of those age 13, and 20% of those age 14 had their first sexual experience. While the risk of pregnancy, the cyclic nature of unwed teen-age mothers and low income families has been the impetus for much of this research.

Clearly the early onset of coital activity cannot be overlooked in terms of exposure to AIDS and sexuality education (Wattleton, 1987).

**Issue E:** What should be the focus of AIDS education for grades four through six? The alternatives are: The focus of AIDS education should be (1) based primarily on the importance of chastity and abstinence with some information on barrier protection, (2) limited to the importance of chastity and abstinence, (3) based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence, (4) limited to the importance of barrier protection, or (5) based on the biomedical aspects of the syndrome and related disease.

Initially the journals discussed the biomedical aspects of the syndrome and the related diseases (Glover, 1984). But issues rapidly developed surrounding AIDS and
education.

The first concern was whether children who had AIDS should be allowed to attend school. Throughout the nation, communities united in a common fear which reflected the concern for the communicability of the AIDS virus and the subsequent risk to school age children (Newsweek, 1985; Price, 1986; Marwick, 1985; National Education Association, 1986; Reed, 1986). And while many parents continue to have fears concerning this matter, experts generally agreed that other children were not at risk if a school mate had AIDS (Price, 1986; Black, 1986; Conte, 1983).

When the disease spread more rapidly than expected, health experts discussed the focus that AIDS education should adopt to reduce the incidence of AIDS. Some experts believed, that since a cure for AIDS does not exist, the best approach is prevention through education (Price, 1986; Nader, 1986; DiClemente, 1986). McCormick believed that "The question of whether schools should teach kids about AIDS--including how it's transmitted in blood and semen and how to prevent infection--is virtually moot, considering how the disease is spreading" (1987). Brick supports the need for complete information and has written "Armed with facts, students can evaluate
the behaviors that put a person at risk for contacting AIDS and those that eliminate or reduce the danger. A continuum, from abstinence and masturbation on one end to shooting drugs with shared needles and anal sex without a condom on the other, will dramatize the progression from "safe" to extremely dangerous behaviors" (cited in Strouse, 1987). In October of 1986, Surgeon General C. Everett Koop, advocated not only abstinence, but also supported early and explicit sex education in schools and advocated the use of condoms, a barrier form of birth control, as protection against AIDS (Newsweek, November 3, 1986; Barol, 1987).

Because this position included alternatives other than abstinence for teenagers, the questions of sex education and moral education again were raised. The position of Koop, in fact, was in conflict with two other Reagan appointees, domestic policy chief Gary Bauer and Education Secretary William Bennett (O'Connor, 1987). Bennett believed that contraception, abortion and condom-protection should not automatically be made part of a curriculum as it "encourages those children who do not have sexual intimacy on their minds to have it on their minds" (Barol, 1987). In February of 1987, principles were developed to guide education about AIDS from the Federal level. The book, AIDS and the Education
of Our Children, presents the U.S. Department of Education's view. Two principles in the text which addressed content were (1) "Any health information developed by the Federal Government that will be used for education should encourage responsible sexual behavior--based on fidelity, commitment, and maturity, placing sexuality within the context of marriage" and (2) "Any health information provided by the Federal Government that might be used in schools should teach that children should not engage in sex, and should be used with the consent and involvement of parents" (U.S. Department of Education, 1987).

The Surgeon General, therefore, was in direct conflict with the Secretary of Education concerning specific content for a single subject area to be included in health education classes in public schools.

The question of content in sex education classes, has always been controversial and complex. Because sex is considered to be a moral issue, some parents and churches were concerned about the school usurping their authority (Scales, 1980). One health educator, Gordon, wrote, "The schools, religious institutions, and community agencies all have a secondary role in providing information...the primary responsibility for educating children about sexuality from birth to adulthood always
has been, and must remain, in the home. Parents provide the love, warmth and caring that are the foundation of many future values and attitudes concerning sexuality" (1981). Anspaugh and Dignan believed parents, peer groups, mass media, and church, in that order have the greatest influence on sexual value systems of an individual (1980, p.71). Most agree that sex education courses should include values, but whose values?

Not all opponents of sex education are religious zealots. "Some people raise reasonable questions about how well teachers are trained, the best age at which certain subjects should be covered, how parents should be involved in designing programs and how sensitive questions might be handled" (Scales, 1981). Clearly, there should be communication between all individuals involved, educators, parents and administrators.

Issue F: Which commonalities should exist in the professional preparation of health educators? The alternatives are: Certain commonalities should exist in the preparation of the professional health educators. They include (1) a minimum of a baccalaureate degree with a major in health education, (2) completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role
Delineation Project, (3) successful completion of a state competency examination leading to licensure, e.g., nursing, or (5) a five year program leading to M.A. degree with a liberal arts base, e.g., as suggested by the Holmes Group.

The issue was essentially one of credentialing. A survey was completed in 1982 relative to the status of credentialing of health educators (Henderson). Credentialing has been defined as "the process designed to grant formal recognition of professional competence" (Henderson, 1982). In 1972 Seldon, the former Director of the Study of Accreditation of Selected Health Education Programs in Washington, D.C., defined accreditation and licensure and their application to health education.

"Accreditation is the process by which an agency or organization evaluates and recognizes a program of study or institution as meeting certain predetermined qualifications or standards. It shall apply only to institutions and their programs of study, or their services" (1972). Most accreditation in the United States is voluntary. It is a nongovernmental system that evaluates quality and acknowledges adherence to predetermined criteria. The approval of the National Commission for Accreditation of Teacher Education (NCATE)
is one such criterion for teacher education colleges. The NCATE procedures are comprehensive but do not review specific programs, such as health education, within teacher education. Another voluntary accreditation organization which has some impact on health education, is the Council on Education for Public Health (CEPH). CEPH is concerned with schools of public health, community health education graduate programs and community health programs found in medical schools. Although CEPH accredits some specific graduate programs, for the most part, it accredits schools in the same manner as NCATE (Henderson).

The Role Delineation Project, a national effort to determine desired competencies of entry level health educators, was initiated in the late 1970's. The final report on the first phase, role specification, was submitted in 1980. Initially the project task was to establish standards of acceptable performance but ultimately it could include other forms of credentialing such as examinations leading to licensure or certification (Bureau of Health Education, 1980).

Licensure, another form of credentialing, is "the process by which an agency of government grants permission to persons meeting predetermined qualification to engage in a given occupation and/or use a particular
title, or grants permission to institutions to perform specialized functions" (Seldon, 1972). In education, state teacher boards fulfill the responsibilities associated with licensure, namely the review of credentials, administration of examinations, and the discipline of those who abuse the standards. Licensure is the strictest form of credentialing as it carries with it the binding forces of the law (Henderson, 1982).

Interestingly, a study concerned with future trends in health education found "that it is unlikely that credentialing in the form of requiring new professionals to pass National Board exams will ever take place" (Toohey, 1980).

In 1986, The Holmes Group held a consortium for 123 of the national research universities to explore reforms in teacher education that would change teaching into a true profession. In the view of some professionals, it meant development of "publicly credible, professionally sound, and intellectually defensible entry standards for teaching" (Cole, 1987). The specific agenda included a strong liberal arts base, removal of the undergraduate education programs and the institution of professional programs at the graduate level, establishment of three levels of teaching careers based on educational preparation, experience, and performance, and the
formation of Professional Development Schools and licensure (Holmes Group, 1986).

The Holmes Group, as well as their suggestions, has many critics. The formation of the group has been called divisive and exclusionary. In the view of some, the shifting of courses from undergraduate to the graduate level will not assure reform. Others are concerned about the hundreds of four year institutions that educate the vast majority of teachers and are not included within the Holmes Group. And, some question the wisdom of having only one model for teacher education (Olson, 1987; Tuckman, 1987; Pietig, 1987; Jacobson, 1986).

**Issue G:** In which of the areas of health education should research be primarily focused? The alternatives are: Research in health education should be focused primarily on (1) identification of critical factors in the implementation and maintenance of health education programs, (2) understanding the causes of behavioral change, or (3) the formulation of cost effective ratios so that various health education programs could be evaluated and compared.

In recent years the importance of research in health education has grown. Complete issues of professional journals as well as a number of professionals have
addressed the needs of research in health education. In research completed by Frazer and Kush, questions concerned with the implementation and maintenance of health education programs in schools were found to be the most pressing research needs in health education (1983). Additional support for this concern has also been identified in the literature (Kolbe, 1980; Kreuter, 1983; Basch, 1983).

The question of behavioral change and the need to identify and understand which variables most influence it, has appeared frequently as a research concern (Kolbe and Iverson, 1980; Kreuter and Christenson, 1981; Frazer, 1983; Toohey and Shirreffs, 1980). The importance of research concerning behavior change cannot be underestimated, "for without an understanding of the complex variables which interact to produce health-destructive or health-generating behaviors, the health educator lacks a stable foundation from which to design programs and risk-specific intervention strategies" (Toohey and Shirreffs, 1980).

The need for research concerning economic evaluation has gained support in recent years. The two analysis most frequently utilized for economic evaluation are cost-benefit (CBA) and cost-effectiveness analysis (CEA). Cost-benefit analysis is essentially the cost of the
intervention compared to the results. This is expressed in ratio form indicating the dollars saved or spent when compared to cost of the intervention. A problem which previously existed with this form of analysis was the difficulty in quantifying human life. More recently the value of livelihood rather than life has been factored into the analysis which more closely aligns the CEA. Cost-effectiveness analysis evaluates the cost of intervention contrasted to the impact. This is usually expressed in dollars per successful until such as pounds lost and years saved. The most prevalent form of analysis is the CEA (McKenzie, 1986). Warner concluded, "If many health promotion efforts have great potential to be cost-effective means of improving employees' health....then sound economic analyses of workplace HP programs will convey this message."

While corporate wellness programs have certainly been a major impetus in the development of both CEA and CBA, school programs have been moving in this direction as well (Richardson, 1986; Wylie, 1983; Roos, 1984). Yet, sophisticated CEA and CBA are not usually available for the vast number of health education programs. A study which focused on future trends in health education, found that the respondents believed the profession would develop techniques for the documentation of the cost
effectiveness of programs and activities (Toohey, 1980).

**Issue H: Which professional organizational configuration would best serve health educators?** The alternatives are: The health education profession would best be served by (1) the continuation of the present multi-organizational system which offers many options, (2) further separation of AAHE from AAHPERD and support for a consolidation of AAHE and SOPHE, (3) a reorganization of the Coalition of National Health Education Organization to allow for individual memberships, or (4) creation of a new capstone organization, similar to the American Medical Association, which would have subdivisions to serve specialists.

Professional organizations serve a variety of purposes. Professional organizations in general provide members with current information, opportunities to interact with colleagues, and job placement service. These same organizations provide public recognition for its membership and their views and acceptance of the roles they assume. Organizations have also marshaled resources and developed and utilized power to influence society. Some professional organizations control and sanction their members, thereby limiting membership to the well prepared and competent (Shirreffs, 1980). While
health educators have a number of professional organization from which to choose, the question has arisen as to what would be the best organization configuration for the professional as a whole.

AAHE has been moving steadily toward greater autonomy within AAHPERD. Although it still retains many of the organizational services, the impetus was clearly seen as an attempt to broaden AAHE's appeal to the nonteacher and those not affiliated with the parent organization, AAHPERD.

In 1971 the Coalition of National Health Education Organization was formed. The Coalition is comprised of: American College Health Association (Health Education Section), American Public Health Association (Public Health Education Section), American Public Health Association (School Health Education and Services Section), American School Health Association, Association for the Advancement of Health Education (American Alliance for Health, Physical Education, Recreation and Dance), Conference of State and Territorial Directors of Public Health Education, Society for Public Health Education, and Society of State Directors for Health, Physical Education and Recreation. Only two of these organizations focus entirely on health education, The Society for Public Health Educations and Association for
the Advancement of Health Education. The Coalition does not have individual memberships but rather organizational members. A delegate represents their specific organization and each organization contributes a small amount for operating costs. But, in order for the Coalition to represent health educators in general, a federation would need to be formed which would have representation based on the size of each member organization and monetary support should flow from each organization (Taub, 1985).

The Association for the Advancement of Health Education and the Society for Public Health Education have met to determine ways to bring health educators together in one organization. Several joint committees have been formed to continue discussion on this topic (Cortese, 1986).

Another answer to the multi-organization problem has been forwarded by Hochbaum. He suggested "a single umbrella organization which represents a united front on all issues of common concern without infringing on the concerns and functions of organizations representing more specialized groups within the general profession....analogous to the American Medical Association" (1983). Cooper supports that idea and has suggested, "The autonomy of present health education
organizations must give way to focus on a single coordinated entity which can provide for variations in role responsibilities of the growing numbers of professionally trained health educators (Howell, 1980).

Therefore, while a number of presently professional organization configurations have been suggested, a clear choice has not emerged.

**Summary**

Eight issues in health education were identified. They include: (1) To what extent should behavioral change be the primary goal of the health educator?, (2) Which methods should the health educator utilize when attempting to change the behavior of student or client?, (3) To what extent should the health educator be held accountable for behavioral change in students or clients?, (4) What should be the focus of AIDS education for grades four through six?, (5) At which age should education concerning the transmission and prevention of AIDS be introduced?, (6) Which commonalities should exist in the professional preparation of health educators?, (7) In which of the areas of health education should research be primarily focused?, and (8) To what extent does the health education profession need a single organization to represent health educators?
The preceding specific and conflicting points of view have been expressed by individuals, in the professional literature, at conferences and in research concerning issues in the broad areas of goals, ethics, philosophy, professional preparation, methods, and content. But which health education issues are most significant, whether specific alternative or contending positions of these issues can be identified, and to what extent acceptance exists for various positions has not as yet been determined.
Chapter V: Analysis of Data

This chapter includes (1) the demographics of the expert panel for each round, (2) the level of acceptance or rejection of each alternative position for each selected issue, (3) examples of comments made by the expert panel throughout the study, (4) the level of support for each of the alternative positions, (5) the rank order of the issues as well as, (6) findings concerning questions raised by the panelists during the study relative to the time needed to complete the instrument and the perceived difficulty in ranking the issues.

Expert Selection and Demographics

The criterion for the selection of individuals to serve as experts was their previous identification as either an officer, Association Scholar, and/or recipient of the Professional Service Award by the Association for the Advancement of Health Education. The total population meeting the criterion of expert was 40. A number of the experts had been selected for more than one of the three categories of honor. Of the 28 participants, 21 had received the Professional Service
Award, 6 had been named as AAHE Scholars and 11 were selected as officers. In total, nine had received multiple honors.

The participants in Round One represented seven occupational groups within the profession of health education. They included: educator, both elementary/secondary and college, administrator/professor, administrator, community based, retired, and other. While attrition of the expert panel did occur between rounds, the representation of each of the occupational groups never varied more than 5% throughout. All occupational groups and the percent of participation, round-by-round, are included in Table 1.

**Data Analysis for Alternatives**

For each alternative in every round, the percentage of agreement, disagreement, and support was calculated. All percentages were rounded off to the nearest hundredth. New alternatives suggested by two or more experts in the first or second rounds were included in Rounds Two and Three respectively. Suggestions made by a single expert were included in the **Other Comments** section.
Table 1

GROUP AFFILIATION OF PANEL FOR THREE ROUNDS

<table>
<thead>
<tr>
<th></th>
<th>Educator</th>
<th>Professor/ Administrator</th>
<th>Administrator</th>
<th>Community</th>
<th>Retired</th>
<th>Other</th>
<th>Total</th>
</tr>
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<td>n</td>
</tr>
<tr>
<td>Round 1</td>
<td>1 (4%)</td>
<td>9 (32%)</td>
<td>4 (14%)</td>
<td>4 (14%)</td>
<td>2 (7%)</td>
<td>6 (21%)</td>
<td>2 (7%)</td>
</tr>
<tr>
<td>Round 2</td>
<td>1 (4%)</td>
<td>8 (32%)</td>
<td>4 (16%)</td>
<td>3 (12%)</td>
<td>2 (8%)</td>
<td>5 (20%)</td>
<td>2 (8%)</td>
</tr>
<tr>
<td>Round 3</td>
<td>1 (5%)</td>
<td>6 (27%)</td>
<td>4 (18%)</td>
<td>2 (9%)</td>
<td>2 (9%)</td>
<td>5 (23%)</td>
<td>2 (9%)</td>
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<tr>
<td></td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
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</tbody>
</table>
Findings of the Study

The first research question concerning the identification of accepted alternative positions of selected issues in health education was answered by majority acceptance or rejection of 40 of the 48 alternatives considered. Of the 27 alternatives accepted by the majority of the experts, 15 of those were researcher generated and 12 were suggested by the expert panel. There were 13 alternatives rejected by a consensus of the experts, 11 were suggested by the researcher and 2 were suggested by the panel of experts.

There were 8 alternative positions that lacked a majority for either acceptance or rejection. Of these 8 alternatives, 6 were suggested by the researcher and 2 by the panel of experts.

The second research question concerning the level of support for each alternative position was answered by the majority of the experts supporting 6 of the alternative positions. Of these, five were suggested by the researcher and one by the experts.

The level of acceptance or rejection and the level of support for the issues and the alternative positions in Round Three, as well as the expert generated comments for each of the issues and the alternative positions, are included below. Results from Round One and Round Two may
be found in the Appendix in the instruments for Round Two and Three, respectively.

**Issue A:** To what extent should behavioral change be the primary goal of the health educator?

During the study, this issue was rephrased to more clearly reflect alternatives suggested by the experts. This issue had more alternatives generated by the panel than any other. Nine alternative positions were considered for Issue A. Of these, three were suggested by the researcher and six by the panel of experts. Of the nine alternative positions, eight were refined and accepted by a majority as viable alternatives while one was rejected. The accepted positions included alternatives 1, 2, 3, 4, 6, 7, 8, and 9. Support of 51% or more was expressed for one of the positions, alternative three. Refer to Table 2 for complete information concerning results of Issue A.

**Alternative Position 1:** to facilitate the acquisition of facts concerning health behaviors and wellness.

Acceptance of this position was expressed by 100% agreement. One individual wrote, "Facts are among the elements that facilitate decision making." Another
<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. to facilitate the acquisition of facts concerning health behaviors and wellness.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>2. to facilitate the acquisition of values concerning health behaviors and wellness.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>32%</td>
</tr>
<tr>
<td>3. to facilitate problem solving and decision making skills as applied to health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>82%</td>
</tr>
<tr>
<td>4. to facilitate the changing of health compromising behaviors to health-promoting behaviors.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>36%</td>
</tr>
<tr>
<td>5. to change health compromising behaviors to health-promoting behaviors.</td>
<td>41%</td>
<td>55%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>6. to reinforce health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>36%</td>
</tr>
<tr>
<td>7. to promote health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>8. to facilitate the acquisition of concepts, facts, perceptions and value positions concerning healthy behaviors and wellness.</td>
<td>91%</td>
<td>0%</td>
<td>9%</td>
<td>36%</td>
</tr>
<tr>
<td>9. to facilitate voluntary, informed changes in health related behaviors including: actions, practices and skills, as well as cognitive and affective behaviors.</td>
<td>86%</td>
<td>5%</td>
<td>9%</td>
<td>41%</td>
</tr>
</tbody>
</table>
expert argues, "I disagree because acquisition of knowledge is merely gaining a tool for decision making and that is not always effective." The level of support for alternative 1 was 27%.

Alternative Position 2: to facilitate the acquisition of values concerning health behaviors and wellness. Acceptance of this position as a viable alternative for Issue A was expressed by 95% agreement. This alternative was suggested by the experts for inclusion in Round Two. A suggestion that "positive" should precede "values" in the Round Three instrument was not commented on by other experts in the subsequent round and therefore was not included. The level of support for alternative 2 was 32%.

Alternative Position 3: to facilitate problem solving and decision making skills as applied to health-promoting behaviors. Acceptance of this position was expressed by 100% agreement. This alternative was modified twice. First, "problem solving and" was included in Round Two and secondly, "health-promoting" replaced "healthy" in Round Three. One expert commented that alternative three was the most comprehensive and spoke to all elements needed to affect behavior. The level of support for
alternative 3 was 82%. This was the only alternative for Issue A that had support by the majority of the experts.

**Alternative Position 4: to facilitate the changing of health compromising behaviors to health-promoting behaviors.** Acceptance of this position was expressed by 91% agreement. This alternative was suggested by experts for inclusion in Round Two. In Round Two, experts also requested that the term "health-promoting" replace "healthy" in Round Three. One expert wrote, in Round Two, that alternatives 4, 5, and 7 were too much the same. The level of support for alternative 4 was 36%.

**Alternative Position 5: to change health compromising behaviors to health-promoting behaviors.** Rejection of this position was expressed by 55% disagreement that this was a viable alternative position for Issue A. This alternative was modified at the suggestion of the panel in Round One to read "to change health compromising to healthy behaviors" instead of the original "to change unhealthy behaviors." One expert wrote in Round Two that "health educators don't change; people---students, patients, clients---change whenever they choose or decide to do so." In Round Two the experts suggested that
"health-promoting" replace "healthy" for Round Three. The level of support for alternative 5 was 9%.

Alternative Position 6: to reinforce health-promoting behaviors. Acceptance of this position was expressed by 100% agreement. This alternative was suggested by experts for inclusion in the Round Two instrument. It was originally stated as "to reinforce health behaviors" but was further clarified for Round Three as "to reinforce health-promoting behaviors." The level of support for alternative 6 was 36%.

Alternative Position 7: to promote health-promoting behaviors. Acceptance of this position was expressed by 100% agreement. This alternative also was suggested by the panel for inclusion in the Round Two instrument. The experts were consistent in wanting the original wording of "healthy behaviors" changed to "health-promoting behaviors" for Round Three in this alternative, too. In Round Two, one individual commented that alternatives #4, #5, and #7 were "too much the same." Another expert responded in Round Three that "I disagree with 'other comments' relative to #4, #5, #6 and #7. #4 speaks to facilitating; #5 is more prescriptive. #6 and #7 speak
to two sides of the same coin." The level of support for alternative 7 was 24%.

Alternative Position 8: to facilitate the acquisition of concepts, facts, perceptions and value positions concerning health behaviors and wellness. Acceptance of this position was expressed by 91% agreement. This alternative was suggested by one individual for Round Two, but, since only one expert made this suggested, it was included in the Other Comments from Round 1 section for consideration by other panel members in the following round. This position was then requested by other panel members as an alternative in the Third and Final Round. The level of support for alternative 8 was 36%.

Alternative Position 9: to facilitate voluntary, informed changes in health related behaviors including: actions, practices and skill, as well as cognitive, and affective behaviors. Acceptance of this position was expressed by 86% agreement. This position was first suggested for Round Two by one individual and then requested by other panel members for the succeeding round. One expert felt that it "was too complex." Another individual felt that position 8 and 9 were "somewhat more of the same." And finally, one expert
suggested that 

"#8 is a synthesis of #1, #2, #6, #7—just another way to say what has been said earlier. Same is true for #9." The level of support for alternative 9 was 41%.

Concerning the issue in general and the limitation placed on the experts by this researcher to make only one selection, one expert wrote, "Primary goal implies only one. I would 'weigh' these quite differently, one from another."

**Issue B: Which methods should the health educator utilize when attempting to affect the behavior of student or client?**

This issue was rephrased during the study, at the request of the expert panel. Initially it was "to change the behavior." It was changed to read "to affect the behavior." There were six alternative positions identified for Issue B. Four were suggested by the researcher and two by the panel. Of the six positions, four were accepted as viable alternatives and two were rejected. Those positions accepted were alternatives 1, 2, 5, and 6. Majority support of 51% was declared for two positions, alternatives 1 and 5. See Table 3 for specific results.
Table 3

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. attempts to persuade them to alter their behavior if they express a willingness to do so.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>68%</td>
</tr>
<tr>
<td>2. &quot;fear arousing methods if appropriate.&quot;</td>
<td>59%</td>
<td>41%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>3. behavior modification techniques which could be effectively utilized on students or clients who are unaware of them.</td>
<td>14%</td>
<td>86%</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>4. coercion if risk factors are immediately life threatening to the individual.</td>
<td>18%</td>
<td>77%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>5. providing alternatives and behavior modification techniques when students/clients request assistance.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>6. attempts to persuade them to alter their behavior by providing alternatives and behavior modification techniques.</td>
<td>73%</td>
<td>18%</td>
<td>9%</td>
<td>32%</td>
</tr>
</tbody>
</table>
Alternative Position 1: attempts to persuade them to alter their behavior if they express a willingness to do so. Acceptance of this position was expressed by 100% agreement. During Round One, several experts suggested that "if they express willingness to do so" be placed at the end of the original statement. Interestingly, that same phrase was asked to be deleted in Round Two, but, by only one individual. This was one of two positions receiving support of the majority of the panel. The level of support for this alternative was 68%.

Alternative Position 2: fear "arousing" methods if appropriate. Acceptance of this position was expressed by 59% agreement. In response to experts' feedback, the last word was changed from "necessary" to "appropriate" for Round Two. One expert commented, "Fear arousing methods should be used very sparingly, in certain cases only, and only if threat-avoidance behavior is perceived by clients as effective, possible, and available to them." The level of support for this alternative was 18%.

Alternative Position 3: behavior modification techniques which could be effectively utilized on students or clients who are unaware of them. Rejection of this
position was expressed by a 86% disagreement that it was a viable alternative for Issue B. During Round One, the adjective "subtle" preceded "behavior modification." The experts asked that it be removed for Round Two. The **Note from Researcher** section in Round Three provided some additional information which indicated that the actual techniques would be unknown to student or client. A comment from Round Three concerning this issue was that it was antithetical to the health educator's goal of **voluntary, informed** changes in health related behavior."

**Alternative Position 4: coercion if risk factors are immediately life threatening to the individual.**

Rejection of this position was expressed by a 77% disagreement with it as a viable alternative for Issue B. During Round One, experts recommended that the word "immediately" precede "life threatening." One expert commented, "I don't know of any cases where a health educator could apply coercion. He/she might advocate it--but use it?" Another wrote, "Assuming I were in a position to save someone from a 'life threatening' consequence, I definitely would use coercion if I believed it necessary. However, such an approach is tantamount to 'control'--an anathema to health educators." Finally, one expert commented, "coercion is
in no way a form of education." The level of support for this alternative was 9%.

**Alternative Position 5:** providing alternatives and behavior modification techniques when students/clients request assistance. Acceptance for this position was expressed by 95% agreement. Experts included this alternative for consideration in Round Two. One expert wanted the qualifying phrase "when students/clients request assistance" deleted. This suggestion remained uncommented on by other panel members in future rounds. A number of experts wanted a consolidation of alternatives 1 and 5 as a new position. This combination was alternative 6. This was one of the two positions receiving support of the majority of the experts. The level of support for this alternative was 59%.

**Alternative Position 6:** attempts to persuade them to alter their behavior by providing alternatives and behavior modification techniques. Acceptance for this position was expressed by 73% agreement. During Round Two, experts asked for a combination of alternative 1 and 5; this became position 6. There were only two suggestions made concerning this issue. One expert wrote, "I'd let #6 substitute for #5; you don't need
both." Another commented, "I like the new #6. We do this all the time, learner willing or not." The level of support for this alternative was 32%.

Other comments made by experts for Issue B included, "Different methods are appropriate for different health education settings and different issues. If I were a community health educator with the task of reducing the spread of AIDS, my methods would be different than teaching about death and dying to senior and graduate university students." Another said, "Expand the range of alternatives open to students." Still another commented, Behavior modification consists of 'rewards' and 'punishments'. I disagree with the punishment component of behavior modification."

**Issue C: To what extent should the health educator be held accountable for behavioral change in students and clients?**

The wording of this issue remained the same throughout the study. The researcher suggested four alternatives for this issue and the expert panel added one alternative. Of the five identified alternatives, three were accepted and two were rejected, but one was rejected by only 1 percentage point. The accepted alternative positions were 1, 2, 4, and 5. Only one
Table 4  

### Issue C  
**Extent of Agreement, Disagreement and Support for the Accountability for Behavioral Change by the Health Educator.**

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. health educators can present information coupled with methodology that may lead to behavioral change; beyond that they are not accountable.</td>
<td>89%</td>
<td>18%</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>2. health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued health compromising behaviors of students or clients.</td>
<td>91%</td>
<td>9%</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>3. behavioral change is the ultimate goal and to a degree reflects the competency of the health educator.</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>4. the behavioral change is dependent upon organizational setting and the role requirements for the professional.</td>
<td>64%</td>
<td>36%</td>
<td>0%</td>
<td>23%</td>
</tr>
<tr>
<td>5. the objectives for conducting and evaluating the health education programs had been previously articulated and adopted.</td>
<td>77%</td>
<td>23%</td>
<td>0%</td>
<td>36%</td>
</tr>
</tbody>
</table>
position received support from 51% of the panel, alternative 2. This issue was unique in that there were no nonresponses in the final round for any of the alternatives. Complete results are displayed in Table 4.

**Alternative Position 1:** health educators can present information coupled with methodology that may lead to behavioral change, beyond that they are not accountable. Acceptance for this position was expressed by 82%. Previously, alternative 1 was "health educators can present information coupled with methods that lead to behavioral change, beyond that manipulation is present." It was reworded to the above for Round Two and remained unchanged through the completion of the study. In Round Three, an expert suggested, "I believe they are accountable for how they present information, for their behavior in response to students, clients, etc. after presenting the information." Support for alternative 1 was 45%.

**Alternative Position 2:** health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued compromising behaviors of students or clients. Acceptance for this position was expressed by 91%. This
alternative was reworded for both Round Two and Three. The first phrase originally read "education accounts for a limited portion of an individual's life." It was replaced in Round Two with the above phrase. In Round Three, the former "poor behaviors" was replaced by health compromising behaviors". One expert wrote that "the word 'poor' should be changed to risky." No one, however, responded to this suggestion. The level of support for alternative 2 was 59%, the only alternative having majority support.

Alternative Position 3: behavioral change is the ultimate goal and to a degree reflects the competency of the health educator. This was the only alternative for any of the issues which reflected an equal split of 50% for the acceptance of the issue and 50% for rejection of the issue with no nonresponses. In Round One, one expert suggested "to a degree" be inserted before "reflects." This modification was requested for consideration by other experts for Round Three. The level of support for alternative 3 was 18%.

Alternative Position 4: the behavioral change is dependent upon organizational setting and the role requirements for the professional. Acceptance for this
position was expressed by 64% agreement. In Round Two, one individual suggested that it be changed to "dependent upon the person, the organized setting and the role requirements." This was not commented on by any other expert. The level of support for alternative 4 was 23%.

Alternative Position 5: the objectives for conducting and evaluating the health education programs had been previously articulated and adopted. Acceptance for this position was expressed by 77% agreement. This alternative was added for the second round. During Round Two, one individual wrote, "True enough, but not related to #1-#4." Another expert would have preferred "health education programs are determined by program objectives" to be added to the end of the statement. In Round Three one expert wrote, "If one of the objectives is behavioral change, then the health educator will be held accountable. One would have to be dumb to articulate such an objective, due to many other factors. He/she would soon be out of business if a job was based on successful achievement. Behavior change comes much later, at the conclusion of a program in most cases." The level of support for alternative 5 was 36%.

There were three additional comments concerning the issue. First, one expert wrote, "You are asking for
absolutes where absolutes are not possible." Another panel member commented, "You can never account for the amount the health educator is accountable for." And finally, one expert said, "The health educator can be held accountable for the effort but not the outcome."

**Issue D: At which age should education concerning the transmission and prevention of AIDS be first introduced as a planned part of the curriculum?**

During the study, this issue was rephrased. The word "first" was inserted before "introduced" for Round Two. The phrase "as a planned part of the curriculum" was added for Round Three in response to concerns expressed by several experts that AIDS might be included as a categorical "crisis" topic rather than an integral part of the curriculum. Four of the alternative positions were suggested by the researcher and one position by the panel. Of the five positions, ultimately only one alternative, position 3, was accepted and four were rejected. Interestingly, during the first round all four alternatives were accepted; during the second round, three of the five were accepted, and in the final round, only one was accepted by a majority. It is unclear if further refinement of the issue was a factor. Also, the
Table 5

Issue D

Extent of Agreement, Disagreement and Support for the Age that AIDS Education Should be First Introduced as a Planned Part of the Curriculum.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ages 6 - 7</td>
<td>41%</td>
<td>50%</td>
<td>9%</td>
<td>36%</td>
</tr>
<tr>
<td>2. ages 8 - 9</td>
<td>45%</td>
<td>36%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>3. ages 10 - 11</td>
<td>77%</td>
<td>9%</td>
<td>14%</td>
<td>50%</td>
</tr>
<tr>
<td>4. ages 12 - 13</td>
<td>36%</td>
<td>45%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>5. ages 14 - 15</td>
<td>18%</td>
<td>64%</td>
<td>18%</td>
<td>14%</td>
</tr>
</tbody>
</table>
nonresponse rates for these alternatives were among the highest for the entire study and yet considerable feedback was generated by the experts. No position received support by 51% of the panel although one, alternative 3, received support of 50%. For specific results, see Table 5.

**Alternative Position 1: ages 6 - 7.** A 51% majority neither accepted nor rejected this alternative. This position was rejected by 50% and accepted by 41%, with a nonresponse rate of 9%. During Round One, one expert wrote, "I have a hunch 6 - 7 is too early unless a six year old asks a question, then it should be introduced at that age." In Round Two, one panel member suggested, "I'd have reservations about introducing the topic of AIDS at levels of #1 and #2. However, realistically, we must recognize that AIDS will increasingly be a topic of conversation that we cannot ignore." In Round Three, an expert said, "So much depends upon how and in what context and by whom the subject is introduced.... If handled appropriately, the subject can be introduced as early as 6 - 7." The level of support for alternative 1 was 36%.
Alternative Position 2: ages 8 - 9. This position was neither accepted nor rejected by a majority of 51%. However, 45% did agree while only 36% disagreed with a nonresponse rate 18%, one of the highest of all for the entire study. No discussion centered on this alternative specifically in any of the rounds. The level of support for alternative 2 was 18%.

Alternative Position 3: ages 10 - 11. Acceptance of this position was expressed by 77% agreement. There was a nonresponse rate of 14%. This alternative generated considerable discussion by the experts. One noted, "Ages 10 - 11 coincides with adolescent growth spurt." Another expert suggested, "Depending on the community and ages of sexual activity, AIDS should be included in context of prevention of drug abuse at 10 - 16 years, and in context of STD's at ages 11 - 15." One expert commented, "It is never too late to introduce the material, however, 5th and 6th grade students are capable of understanding the information." Another expert shared, "Illinois just passed a state law requiring AIDS education to be taught in grades 6 - 12." In Round Two, one expert said, "A new Washington state law (enacted since Round One) requires AIDS education beginning in grade 5." In the final round, an expert commented, "I've checked both #3 and #4,
thus covering the possibility of 'first' introduced in health education classes somewhere between 10 and 13 years of age. Age 12 is probably idea." The level of support for this alternative was 50%, one percentage point from acceptance by the majority.

Alternative Position 4: ages 12 - 13. This position was rejected by 45% of the panel and accepted by 35%. The nonresponse rate was 18%, one of the highest of the entire study. The only comment concerning this alternative specifically came in the first round, "Ages 12 - 13 because one strikes youth while the 'iron is hot'." The level of support for this alternative was 18%.

Alternative Position 5: ages 14 - 15. Rejection of this alternative was expressed by 64% disagreement. This position was suggested by an expert in the first round. In Round Two, one expert commented, "probably too late." The level of support was 14%.

There were a number of general comments concerning this issue. During Round One, an expert wrote, "Issues D and E deal with AIDS. Although very important at this time, they represent one small aspect of a 'comprehensive health education' program. Thus, they are out of place
in a study such as this." Another suggested, "this isn't an important issue related to 'moving the profession forward'." One expert even suggested, "This issue should be removed." One panel member believed that, "It depends on how it is presented. Some aspects are suitable at any age." Another suggested, "Transmission and prevention of AIDS could be introduced and discussed in a community health unit early, but sex and AIDS should be later." Another thought, "Environmental factors are related to this question--age could vary." And finally, one commented, "It seems to me that, unlike some other diseases, AIDS and other STD's are issues deeply embedded in and inseparable from sexuality. Hence, the question is really at what age should sexuality education be introduced, in what form, depth, and scope?" Refer to Table 6 for complete results.

Issue E: What should be the major emphasis of AIDS education for grades four through six?

This issue was rephrased for Round Two, the word "focus" was replaced by "major emphasis." Further clarification of terms included annotation that "chastity and abstinence referred to sexuality" and "barrier protection referred to condoms." The researcher suggested five alternatives and the expert panel
<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. based primarily on the importance of chastity and abstinence with some information on barrier protection.</td>
<td>36%</td>
<td>59%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2. limited to the importance of chastity and abstinence.</td>
<td>14%</td>
<td>82%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence.</td>
<td>32%</td>
<td>64%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>4. limited to the importance of barrier protection.</td>
<td>0%</td>
<td>95%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>5. based on the biomedical aspects of the syndrome and related diseases.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>55%</td>
</tr>
<tr>
<td>6. addressed toward a community health infectious disease point of view.</td>
<td>77%</td>
<td>18%</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>7. directed toward the transmission of the disease by contaminated needles.</td>
<td>50%</td>
<td>45%</td>
<td>5%</td>
<td>14%</td>
</tr>
</tbody>
</table>
suggested two additional ones. Of the seven identified alternatives, two were accepted and five were rejected, as viable alternatives. One position received support from the majority of the experts, alternative 5. Refer to Table 6 for complete results.

Alternative Position 1: based primarily on the importance of chastity and abstinence with some information on barrier protection. Rejection for this position was expressed by 59% disagreement. One expert wrote, "#1 and #3--I would emphasize abstinence as desirable but, if unrealistic in the view of some children, treat barrier protection as an acceptable and safe alternative." Another argued that, "#1 and #3 could be considered pretty much alike, for all practical classroom purposes." Support for alternative 1 was 5%.

Alternative Position 2: limited to the importance of chastity and abstinence. Rejection of this alternative was expressed by 82% disagreement, the second highest for an alternative for this issue. No expert commented on this alternative in any of the rounds. Support for this alternative was 9%. 
Alternative Position 3: based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence. Rejection of this alternative was expressed by 64% disagreement. The experts made only two comments concerning this alternative, those were previously included in the discussion of alternative 1 as they concerned both alternatives. See above Alternative Position 1. Support for this position was 18%.

Alternative Position 4: limited to the importance of barrier protection. Rejection of this alternative was expressed by 95% disagreement with 5% nonresponse. This alternative had the highest percentage of disagreement. The experts did not comment on this alternative in any of the round. Support for this position was 5%.

Alternative Position 5: based on the biomedical aspects of the syndrome and related diseases. Acceptance of this position was expressed by 91% agreement. One expert said, "I think #5 is important but not broad enough." Support for this position was 55%, the only position with majority support.
Alternative Position 6: addressed toward a community health infectious disease point of view. Acceptance of this position was expressed by 77% agreement. This position, suggested by experts, first appeared in Round Two. But one expert commented, "#6 is, I believe, totally inappropriate for grades 4 - 6." Another expressed an opposing view, "#6 probably incorporated the biomedical and behavioral emphasis needed." Support for this position was 50%.

Alternative Position 7: directed toward the transmission of the disease by contaminated needles. This position was accepted by 50% and rejected by 45% with a nonresponse rate of 5%. This alternative was introduced in the third and final round in response to the panel's suggestion. One expert said, "#7, as #1 - #4, is very limited in scope." Another commented, "I support #7 but there is more to the AIDS topic, than this...so it should be apart of the whole AIDS presentation." Support for this position was 14%.

Members of the panel expressed concern that AIDS should be part of a comprehensive curriculum rather than part of a "crisis" curriculum. Clarification was made for Round Three relative to this concern.
Issue F: What form of credentialing would best serve the profession of health education?

For Round Two, the issue was clarified and reworded to more accurately reflect the alternatives. Previously it was "Which commonalities should exist in the professional preparation of health educators?" A definition of a health educator was also requested and appeared in Round Two. Of the final five alternatives, four were provided by the researcher and one by the panel. The only two alternatives accepted as viable positions were provided by the researcher. One alternative had the support of the majority of the panel of experts, position 2. Specific results are displayed in Table 7.

Alternative Position 1: a minimum of a baccalaureate degree with a major in health education. Acceptance of this position was expressed by 95% agreement. One expert wrote, "#1 as one criterion." Support for this position was 27%.

Alternative Position 2: completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project. Acceptance of this position was expressed by 86%.
Table 7

**Issue F**

Extent of Agreement, Disagreement and Support for the Basis of Credentialing for Health Education.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a minimum of a baccalaureate degree with a major in health education.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project.</td>
<td>86%</td>
<td>9%</td>
<td>5%</td>
<td>64%</td>
</tr>
<tr>
<td>3. successful completion of a state competency examination leading to licensure, e.g., nursing.</td>
<td>45%</td>
<td>50%</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes Group.</td>
<td>32%</td>
<td>64%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>5. no one standard form.</td>
<td>23%</td>
<td>73%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
agreement. One expert wrote, "I would deleted reference to Role Delineation Project." Another said, "A combination of #2 and #3." One expert explained, "I checked both #2 and #4 because I believe that any credentialing should take into consideration the person's level of competence, i.e., a health educator may be fully qualified to do a good job but may not be able to do a job that requires a master-level preparation. Hence, I would advocate differential levels of credentialing. Also, one may be fully qualified as a school health educator but not as a community or a patient health educator, and vice versa. Hence, credentialing needs to also take into account the variety of preparation for a variety of sub-specialties in health education." The level of support was 64%, the only position with the support of the majority.

Alternative Position 3: successful completion of a state competency examination leading to licensure, e.g., nursing. This position was accepted by 45% and rejected by 50%, with a 5% nonresponse. As mentioned above for alternative 2, a combination of positions 2 and 3 was suggested by one panel member. No other expert concurred with that point of view, however. One expert wrote, "I support this examination idea, but chiefly for
credentialing—not obtaining a license to practice. A person would have the valuable credential of the association concerned with health education. The potential employer, knowing this, would give them top consideration." Another panel member said, "Alabama is an example of #3." The level of support was 14%.

**Alternative Position 4: five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes Group.** This position was rejected by 64%. One expert selected both alternatives 2 and 4; for that comment see above alternative 2. One expert suggested, 

"#4 should be a goal, not the starting place." The level of support was 5%.

**Alternative Position 5: no one standard form.** Rejection of this alternative was expressed by 73% disagreement. This position was added in Round Two at the suggestion of the experts. Only one comment was made relative to this alternative, "I believe we can agree on some general competencies necessary to practice health education. This will also allow programs and individuals to develop unique strengths."

Some thoughts concerning this issue, not specific to one alternative, also were expressed. One panel member wrote, "At least one degree with a major in health
science from an established program." Another argues that, "Each state can best assess its needs." And finally, one expert suggested, "School health educators are already credentialed in a way."

**Issue G:** In which of the areas of health education should research be primarily focused?

The purpose of this issue was to identify the most critical research need in health education. Three additional alternative positions were requested by the expert panel for Round Two. This brought the total of alternative positions to six. However, some panel members found that to be too limiting and selected multiple areas to support. During Round Two and Round Three reminders of the scoring procedures appeared in the Note from the Researcher section. This did not deter the experts, however, from making multiple selections. It is unclear whether this was a function of the issue, the presentation of the issue, or other factors. Of the four alternative positions accepted, two were generated by the researcher and two by the expert panel. No one single position had the support of the majority. Complete results are available in Table 8.
### Table 8

**Issue G**

**Extent of Agreement, Disagreement and Support for the Primary Research Need in Health Education.**

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identification of critical factors in the implementation and maintenance of health education programs.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>41%</td>
</tr>
<tr>
<td>2. Understanding the factors that contribute to behavioral change.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>41%</td>
</tr>
<tr>
<td>3. The formulation of cost effective ratios so that various health education programs could be evaluated and compared.</td>
<td>41%</td>
<td>41%</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>4. Determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups.</td>
<td>91%</td>
<td>9%</td>
<td>0%</td>
<td>36%</td>
</tr>
<tr>
<td>5. Evaluation.</td>
<td>64%</td>
<td>32%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>6. Theories of health education.</td>
<td>41%</td>
<td>45%</td>
<td>14%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Alternative Position 1: identification of critical factors in the implementation and maintenance of health education programs. Acceptance of this position was expressed by 91% agreement. Only two comments were made by panel members concerning this issue. One wrote, "Both #1 and #2, but from the individual or groups perspective." Another wanted "evaluation" added to the position so that it would read "identification of critical factors in the implementation, maintenance and evaluation of health education programs." However, no one agreed with this suggestion. Support for this position was 41%.

Alternative Position 2: understanding the factors that contribute to behavioral change. Acceptance of this position was expressed by 91% agreement. For Round Two, at the suggestion of experts, the position was reworded from "understanding the causes of behavioral change" to the above form. Other than the shared comment with position 1 addressed above, only two other suggestions were made. One was, "The great majority of health educators below the doctoral level lack training, knowledge and skills to carry out any meaningful research on factors that contribute to behavioral change. When they do such research, it is usually unacceptable and
misleading." Another wrote, "I define research as re-search. Looking for answers. If people's unhealthy behaviors are the focus, then #2 is all important." The level of support for this position was 41%.

Alternative Position 3: the formulation of cost effective ratios so that various health education programs could be evaluated and compared. The panel was evenly split on this position with 41% agreeing and 41% disagreeing and a nonresponse rate of 18%, the highest nonresponse rate for any position for this issue. The position remained unchanged throughout and received only one comment from a panel member, "#3 is the last kind of research in which health educators should ever engage." The level of support for this issue was 9%.

Alternative Position 4: determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups. Acceptance of this position was expressed by 91% agreement. This alternative was suggested by the panel for Round Two. No comments were made by the panel concerning this issue during the succeeding rounds. The level of support for this position was 36%.
Alternative Position 5: evaluation. Acceptance of this position was expressed by 64% agreement. This alternative was suggested by the panel and first appeared in Round Two. This alternative generated a significant amount of feedback from the experts. One individual wrote, "#5 - too broad to respond." Another suggested, "Often our greatest weakness. If we were truly held accountable for dollars expended, we would often be hard pressed to justify." Another expert argued, "Evaluation is really the basis of research within definitive format." One expert said, "#5 and #6--Evaluation and theories are obviously important to us in health education research, but to say they should receive primary emphasis is really incomplete and too narrow a focus. If we say that evaluation is the point of emphasis, we are then in danger of measuring and evaluating without a sense of purpose or direction. On the other hand, if we place the emphasis on theories we are giving all our attention to direction without implementation and action." The level of support for this position was 5%.

Alternative Position 6: theories of health education. This position was accepted by 41% and rejected by 45% with a nonresponse of 14%. This alternative was
suggested by experts for inclusion in Round Two. One expert wrote, "#6—Guess this would include Health Belief model and PRECEDE." Another thought that it "Relates also to research-testing analysis." Support for this position was 9%.

A number of experts resisted the attempts to have them identify the most critical research need. To this point one wrote, "I can't support any of the alternatives, because I believe there is no one most critical research need in health education. I believe there are several equally critical research needs." On this same point, another said, "I really know no one who would suggest H.E. research should focus 'primarily' on any of these." One expert commented that "primarily focused" called for "value judgments, but only 3 alternatives for such a 'broad issue'." In Round Two, one expert wrote, "The above are not topics for pure research." In Round Three, an expert replied, "What is pure research anyway? Is everything else impure?"

**Issue H:** Which professional organizational configuration would be most beneficial for health education?

All the alternative positions for this issue were generated by the researcher, although the original
### Table 9

**Extent of Agreement, Disagreement and Support for the Most Beneficial Organizational Configuration for Health Education.**

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. the continuation of the present multi-organizational system which offers many options.</td>
<td>41%</td>
<td>55%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>2. greater autonomy of AAHE within AAHPERD.</td>
<td>68%</td>
<td>27%</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>3. a consolidation of AAHE and SOPHE.</td>
<td>68%</td>
<td>27%</td>
<td>5%</td>
<td>23%</td>
</tr>
<tr>
<td>4. a reorganization of the Coalition of national health Education Organization to allow for individual membership.</td>
<td>14%</td>
<td>77%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>5. creation of a new capstone organization.</td>
<td>27%</td>
<td>64%</td>
<td>9%</td>
<td>18%</td>
</tr>
</tbody>
</table>
alternative 2 was separated into two alternative positions by the panel. The issue was clarified for Round Two. Previously it was, "To what extent does the health education profession need a single organization to represent health educators?" Two of the five alternatives were accepted as viable alternative positions but no one alternative position had the support of the majority of the panel. During Round Two, the scoring lines for alternative 3 were inadvertently omitted from the questionnaire, thus invalidating that alternative and the following two alternatives for that round. Results of these alternatives did not appear in the Responses from Round Two in the Round Three instrument. For complete findings, refer to Table 9.

Alternative Position 1: the continuation of the present multi-organizational system which offers many options. Rejection of this position was expressed by 55% disagreement. One expert wrote, "The concept of multi-organization can be incorporated into a large organization-a single alliance concept analogous to APHA an its many public hence related sections. Over specialization poses several problems, isolation [is one example]. To a base of interest--there is need for interdiscipline relationships--thinking, etc." Another
wrote, "[The] Alliance has served well--we should build on what we have." One expert commented, "The fact that the profession has been doing pretty well tells us that a single organization is not needed." The level of support for this position was 18%.

Alternative Position 2: greater autonomy of AAHE within AAHPERD. Acceptance of this position was expressed by 91% agreement. This was clarified and divided into position 2 and position 3. The original position was, "further separation of AAHE and AAHPERD and support for a consolidation of AAHE and SOPHE." One expert commented, "The negative effect would be loss of support services." A panel member pointed out that "Although AAHE has been given considerable autonomy now, there are still problems." Another said, "There is now developing a significant interest in health and fitness which could lead to important development in health education by physical educators." Arguing the opposite view, one wrote, "AAHPERD is dominated by physical educators and is preoccupied with physical fitness." Another said that this position "breeds elitists but does not strengthen the grass roots--workers only isolated by self-imposed leaders." One expert justified his choice by writing, "I support #2 for now because I believe it is the best (most
beneficial), specific next step in the continuing evolution of our professional organizations. Further, I wouldn't want to have to leave AAHPERD in order to consolidate with SOPHE—if, in fact, such a consolidation should prove to be mutually desirable and beneficial. So, if that consolidation ever is to take place without the exit of AAHE from AAHPERD, then AAHE would have to have greater autonomy (permanently) than we now have within AAHPERD." The level of support for this position was 45%, the highest of any position.

Alternative Position 3: a consolidation of AAHE and SOPHE. Acceptance of this position was expressed by 68% agreement. This alternative was previously part of alternative two and was separated for the second round. The scoring lines were omitted from this position for Round Two, however. Therefore, the experts did not receive acceptance/rejection percentages as feedback from this round. One expert commented that "#3 is a little too specific" Another said, "#'s 3, 4, 5 are well documented in your statements above. We need few new groups but more implementation by the present organizations off stage and with students!" The level of support for this position was 23%. 
Alternative Position 4: a reorganization of the Coalition of National Health Education Organization to allow for individual memberships. Rejection of this position was expressed by 77% disagreement. The percentages from Round Two were not reported due to the omission of the scoring lines, but this position was also rejected in the first round. One comment was, "Total waste of money--social groups." The opposite view was expressed by one expert who wrote, "#4 is my support choice because we need a strong single headquarter organization for the administration of the certification process already referred to in your study." The level of support for this position was 9%.

Alternative Position 5: creation of a new capstone organization. Rejection for this position was expressed by 64% disagreement. During Round One, this position was accepted by 64% of the panel. The scoring lines were omitted from Round Two as discussed above. The level of rejection was 64% in Round Three, a complete reversal from the first round. It remains to speculation, as to why this change occurred. During Round One, experts suggested that reference to the AMA should be deleted from alternative 5. This was done for Round Two. One expert wrote, "Ridiculous, waste of time, personal
energies, money, and efforts which should be spent in classrooms." Another commented, "#5 is not needed unless SOPHE and AAHE all fold into that organization." One expert felt that APHA and ASHA attempt to meet needs of members with sections, courses, forums--opportunity for membership in AAHE without joining AAHPERD. Support for consolidation of AAHE and SOPHE, and a merger of the SHES and PHE sections of APHA." One expert illustrates his opinion, "My view of a capstone would be National Alliance of Health Education Organizations--most elements of Coalition with addition of Eta Sigma Gamma. This would allow us to speak with a single voice upon occasions and yet maintain identity." See below for his organizational structure.

```
N A H E O

AAHE / / \ \ ESG

/ \ \\

SOPHE ASHA
```

The level of support for this position was 18%.

One expert indicated that time might be a factor, "The issue should include a specific time frame, right now versus further down the road."
The Rank Order of Major Issues

The third research question investigated the rank of major issues in health education according to importance. Experts were asked to consider both the issues presented by the researcher and to suggest important issues they felt had been omitted. Secondly, the panel was asked to rank the issues with the most important ranked number one (1) and the least important ranked number fifteen (15). The mean and median were calculated for each issue. The prioritized ranking shown in Table 10 reflects the median rank, selected because it best describes a small sample size. A significant positive relationship among the mean and median was found with a Spearman rank correlation of +.97.

Panel Suggested Issues

During the study the panelists suggested seven additional issues. For consideration in Round Two, the following issues were suggested:

Issue I: What criteria should be used to measure the relative success of health education programs?

Issue J: How should the profession of health education change to meet the needs of the future?
Issue K: Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to M.D.'s, nurses, dietitians, etc.

Issue L: What standards should be used to evaluate professional preparation programs?

Experts were also asked to consider whether any of the newly proposed issues were in fact extensions of those previously identified.

For consideration in Round Three, the following issues were suggested:

Issue M: What standards should be used to evaluate the competencies of health educators?

Issue N: What form of credentialing would best serve the consumer/public?

Issue O: How much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can't be?

Panel members were requested also to identify viable alternatives for resolution of new issues suggested by
<table>
<thead>
<tr>
<th>Priority Ranking</th>
<th>Issue</th>
<th>n</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Issue A: What should be the primary goal of the health educator?</td>
<td>10</td>
<td>2.9</td>
<td>1.9</td>
</tr>
<tr>
<td>2</td>
<td>Issue B: What form of credentialing would best serve the profession of health education?</td>
<td>10</td>
<td>3.3</td>
<td>3.0</td>
</tr>
<tr>
<td>3</td>
<td>Issue C: Which methods should the health educator utilize when attempting to affect the behavior of student or client?</td>
<td>20</td>
<td>4.9</td>
<td>4.0</td>
</tr>
<tr>
<td>4</td>
<td>Issue D: In which of the areas of health education should research be primarily focused?</td>
<td>19</td>
<td>6.8</td>
<td>6.0</td>
</tr>
<tr>
<td>5</td>
<td>Issue E: What standards should be used to evaluate professional preparation programs?</td>
<td>19</td>
<td>6.7</td>
<td>7.0</td>
</tr>
<tr>
<td>6</td>
<td>Issue F: What criteria should be used to assess the relative success of health education programs?</td>
<td>19</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>7</td>
<td>Issue G: What standards should be used to evaluate the competencies of health educators?</td>
<td>19</td>
<td>6.0</td>
<td>7.0</td>
</tr>
<tr>
<td>8</td>
<td>Issue H: To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>20</td>
<td>7.2</td>
<td>7.5</td>
</tr>
<tr>
<td>9.8</td>
<td>Issue I: Which professional organizational configuration would be most beneficial for health education?</td>
<td>19</td>
<td>8.4</td>
<td>9.0</td>
</tr>
<tr>
<td>9.5</td>
<td>Issue J: How should the profession of health education change to meet the needs of the future?</td>
<td>19</td>
<td>8.1</td>
<td>9.0</td>
</tr>
<tr>
<td>11</td>
<td>Issue K: What form of credentialing would best serve the consumer/public?</td>
<td>19</td>
<td>9.6</td>
<td>10.0</td>
</tr>
<tr>
<td>12</td>
<td>Issue L: Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to N.D.'s, nurses, dietitians, etc.?</td>
<td>19</td>
<td>11.3</td>
<td>12.0</td>
</tr>
<tr>
<td>13</td>
<td>Issue M: How much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can’t be.</td>
<td>19</td>
<td>10.9</td>
<td>13.0</td>
</tr>
<tr>
<td>14.8</td>
<td>Issue N: What should be the major emphasis of AIDS education for grades four through six?</td>
<td>19</td>
<td>12.3</td>
<td>14.0</td>
</tr>
<tr>
<td>14.9</td>
<td>Issue O: At which age should education concerning the transmission and prevention of AIDS first be introduced?</td>
<td>19</td>
<td>12.9</td>
<td>14.0</td>
</tr>
</tbody>
</table>
their colleagues, if they agreed that those issues should be considered. No alternative positions were developed by any member of the expert panel in any round. A number of experts commented that most of the panel suggested issues were duplicates, expansions or at least related to those first presented. Those specifically cited were Issues K, L, M, and N.

Panelist Concerns

During the course of the study, some experts expressed some concern about the length of time it took to complete the instrument and suggested that data from all experts should be collected. A question was included in the Round Three instrument, asking for the completion time of Round Three and to estimate the time that was needed to complete Rounds One and Two. For results see Table 11. The range of time was from fifteen to ninety minutes. One expert commented that it took 44 minutes for her to commute and 44 minutes to complete the instrument.
Table 11

Minutes Needed to Complete Instrument

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Round 1</td>
<td>13</td>
<td>48.4</td>
<td>44</td>
</tr>
<tr>
<td>Round 2</td>
<td>13</td>
<td>40.7</td>
<td>44</td>
</tr>
<tr>
<td>Round 3</td>
<td>18</td>
<td>45.7</td>
<td>40</td>
</tr>
</tbody>
</table>

During the study a few experts expressed concern about ranking the issues according to importance. A question was added to the third round asking if indeed this was a difficult task, and if so, what changes should be made. Of the eighteen who responded to this question, six found the task difficult. Few commented on possible changes. One who did said, "Yes, primarily since I believe that most of the 'add ons' were related to the originals." Another would have preferred the word "critical" rather than "importance" be utilized to describe the basis for ranking. One expert argued that ranking, in general, is over done.
Summary

In conclusion, experts were able to (1) identify 27 accepted alternative positions for 8 researcher selected issues in health education, (2) to indicate their support for 6 of the alternative positions, and (3) to rank the issues according to importance. Experts also suggested 7 additional issues for consideration by their colleagues.
Chapter VI: Summary, Conclusions, and Recommendations

The purpose of this study was to investigate issues in health education by: (1) compiling accepted alternative positions that could lead to resolution of the issues, (2) ascertaining the degree of support for each of the alternative positions and (3) ranking the issues in order of importance. A modified three round Delphi was employed to investigate the following research question:

1. What are the accepted alternative positions of selected issues as perceived by expert professional health educators?

2. What is the level of support for each of the accepted alternative positions of the selected issues?

3. What is the order of importance of the major issues in health education in 1987-1988?

Summary of the Procedures

The Delphi panel was comprised of individuals who has been recognized by the Association for the
Advancement of Health Education (AAHE) as an elected officer, recipient of the Professional Service Award and/or selected as an AAHE Scholar. Of the total population of 40 so identified individuals, 28 participated in Round One, 25 in Round Two and 22 in Round Three. The retention rate for Round Two was 89% and for Round Three 79%.

The issues and alternative positions were identified through a literature review of leading health education periodicals and textbooks from 1980-1987, field tested by chairpersons of health education Departments in state universities in Ohio and further refined by an expert panel utilizing the Delphi Technique.

The study and instrument format followed, for the most part, the total design methods developed by Dillman (1978). The instruments were examples of both ordered and unordered, partially close-ended questionnaires. Announcement cards were sent to each expert one week prior to the start of the study to raise their interest. During Round One, experts were asked to consider the selected issues and alternative positions provided by the researcher. Experts were encouraged to either (1) agree or disagree with each
alternative position; (2) modify or refine the alternative; (3) justify their selections, and/or suggest other alternatives if they choose; (4) indicate their support for the alternative that best describes their perceptions or beliefs; and (5) to rank the issues according to importance. Experts also were asked to provide limited demographic information and to verify addresses and phone numbers. One week after the mailing of each round, reminder postcards were sent. Follow up phone calls were placed to nonrespondents one week before the due date. Data analysis for Round One included (1) the percentage of agreement and disagreement for each alternative position, (2) summary of the panel's comments and (3) the mean and median rank order of the issues.

During Round Two and Three, experts were provided with feedback information from the previous round. It included (1) the percent of agreement, disagreement and support of each of the alternative positions with their own responses (underlined in red), (2) new alternatives suggested by the panelists, (3) comments from other panelists, (4) clarification and/or additional information from the researcher, (5) the mean and median rank of issues by importance and (6) additional panel suggested issues for consideration.
During the Third Round experts were asked to estimate the time necessary to complete the instrument and to comment on the difficulty of ranking issues. At the conclusion of the study, experts received a summary of the Third Round findings and demographic data of the expert panel.

**Summary of the Findings**

The first research question concerning the identification of accepted alternative positions for selected issues was answered by a majority of 51% agreement on 27 or 56% of the 48 alternatives. There were 13 or 27% of the alternatives which a majority of experts rejected and 8 or 17% of the alternatives that lacked a majority for either acceptance or rejection by the expert panel. There were 5 or 10% of the alternatives that had 100% acceptance. No alternative was rejected by all experts.

It was less clear what the findings suggested for the second research question which concerned the level of support for specific alternative for resolution of an issue. During every round of the study, a number of individuals failed to comply with the scoring
instructions by selecting multiple positions to support. It is unclear whether the scoring noncompliance was a function of the material under consideration, the explanation of the scoring directions or other factors. There were six alternative positions for five separate issues supported by 51% or more of the experts.

Notwithstanding personal pleas and clarification by the researcher, the third research question regarding the rank order of issues, remained underscored in each round by several individuals. However, the number of experts choosing not to rank the issues dropped from a high of five in Round One to a low of two in Round Three, with only one lost to attrition. If in the opinion of the experts, a listed issue was not a major issue they could score it accordingly. Many issues were so scored by individual experts; however, no single issue was eliminated.

Literature indicated that little convergence occurs after the Second or Third Round, therefore a Three Round Delphi is generally appropriate (Dalkey, 1975; Cyphert, 1971). It remains to speculation whether those alternatives in which a majority opinion was not reached could have been either accepted or rejected, whether the scoring noncompliance of the instrument
relative to indication of support could have been
resolved, and whether eventually all panelists would have
participated in the ranking process, if additional rounds
were utilized.

Conclusions

The following conclusions address the development of
the instrument, the findings of the research and the Delphi process.

Instrument Development

There are three methods for establishing content for
the Round one instrument of Delphi studies, (1) a review
of literature, (2) interviews, (3) open ended
questionnaires, e.g. Identify the major issues in health
education in 1987-1988. The most common type is the
first. Of the 27 positions accepted as viable
alternatives by a majority of the expert panel, 15 or 56%
were generated by the researcher and 12 or 45% by the
panelist. This compares unfavorably with results from
some other studies. This may be due in part to the time
differential between authorship and publication of
materials in health education; a literature review that
spanned seven years; the publication of a broad spectrum
of views concerning health education though not necessarily reflecting majority opinion; a literature review that included journals and materials other than *Health Education*, the AAHE publication; an instrument that required only one choice; researcher error or unknown factors. The literature review appeared more accurate for identifying alternatives than those that were ultimately supported by a majority of the experts for resolution of the issue. Of the 6 alternative positions having majority support for resolution of the issue, four or 67% were confirmed by the literature and two or 33% were suggested by the panelists. A literature review was even more accurate in determining the ranking of the most important issues, with the top four being so determined.

**Research Findings**

There is limited information concerning acceptance levels for Delphi studies. Most rely simply upon concensus, 100% agreement. Stuphin suggested data could also be interpreted as "strongly" agreed to or supported for those with 100% acceptance, data "generally" agreed to or supported with panelist acceptance of 95% but less
than 100%, and data having "little" support if acceptance level was less than 50% (1981).

The following conclusions for each issue reflect both this standard and the results of this study. Summaries are included for both the agreement of the identification of an alternative as a valid alternative and for the support of an alternative as the best selection for resolution of the issue.

**Issue A: What should be the primary goal of the health educator?** Four positions were strongly agreed with: "to facilitate the acquisition of facts concerning health behaviors and wellness", "to facilitate problem solving and decision making skills as applied to health-promoting behaviors", "to reinforce health-promoting behaviors", and to promote health-promoting behaviors."

One position was generally agreed to: "to facilitate the acquisition of values concerning health behaviors and wellness." One position had limited agreement; it concerned changing behavior. All other positions except one, reflected little support for acceptance. That single position, which concerned problem solving and decision making skills, lacked general agreement.
**Issue B:** Which methods should health educators utilize when attempting to affect the behavior of students of client? One position, "attempts to persuade them to alter their behavior if they express a willingness to do so", had strong agreement. One position, which was generally agreed with was, "providing alternatives and behavior modification techniques when students/clients request assistance." Little agreement was expressed for positions reflecting behavior modification for the unsuspecting and the use of coercion. No position received either strong or general support. Little support was found for four positions including "fear arousing" techniques, behavior modification techniques for the unsuspecting, coercion and attempts at persuasion for behavioral changes through the provision of alternatives. Although the level of support was greater for two positions concerned with utilizing persuasion to alter behavior and behavior modification alternatives and techniques, neither had general support.

**Issue C:** To what extent should the health educator be held accountable for behavioral change in students of clients? No alternative position for this issue was either strongly or generally agreed with by the panelists. Four positions concerned with the
"accountability for presentation of material coupled with methodology", "health education as one of many influences", "the specific role requirements and setting", and "articulated and adopted objectives"; were agreed to by some panelists. Another position that concerned behavioral change reflecting the competency of the educator showed little agreement. The only position that demonstrated more than a little support concerned the total lack of accountability for the health educator but that position failed to receive even general support. Those positions that had little support include "accountability for only the presentation of material", for "behavioral change as the ultimate goal", for "behavioral change as defined by the setting and role requirements", and "for adopted objectives."

**Issue D: At which age should education concerning the transmission and prevention of AIDS be first introduced as a planned part of the curriculum?** Only one position was found to have more than little agreement to suggest it as a viable alternative. That position, which suggested ages 10-11 were the best ages, still lacked general agreement. Those positions for which there was little agreement included ages; 6-7, 8-9, 12-13 and
14-15. Little support was found for any one of the five positions.

It should be noted that the panel of experts selected for this study may not be the best group to survey for Issue D and Issue E.

**Issue E:** What should be the major emphasis of AIDS education for grades four through six? No position received either strong or general support. Two positions, one suggesting a disease point of view and another emphasizing the biomedical aspects did show more than a little agreement. Another which addressed the importance of only barrier protection, was not agreed to by any expert. Four positions reflecting "chastity and abstinence with some additional information", "only chastity and abstinence", "primarily barrier protection" and "a concern for transmission via contaminated needles", showed little agreement. Little support was shown for any position except one concerned with the biomedical aspects and it failed to gain general support.

**Issue F:** What form of credentialing would best serve the profession of health education? There was general agreement for the position that suggested a minimum of a baccalaureate degree with a major in health education. Only one other position concerned with
specific standards, e.g. the Role Delineation Project, received more than little agreement. Little agreement was shown for positions that addressed "competency examinations leading to licensure", "five year programs as suggested by the Holmes Group" or "no standard form." Little support was given to all positions but one. That single position, though lacking general agreement, also addressed the need for specific standards as discussed above.

**Issue G:** In which of the areas of health education should research be primarily focused? Only two positions received little acceptance as viable alternatives, one that concerned "cost effective ratios" and one that addressed "theories of health education." The others which concerned "implementation and maintenance of programs", "factors contributing to behavioral change", "determining the effectiveness of behavioral change strategies" and "evaluation", though not strongly or generally agreed with did find some acceptance. Little support was shown for any position.

**Issue H:** Which professional organizational configuration would be most beneficial for health education? Little agreement was indicated for alternative positions concerned with the continuation of
the status quo, reorganization of the Coalition, and creation of a capstone organization. Some, but less than general, agreement was expressed for AAHE to have either greater autonomy with in AAHPERD or to consolidate with SOPHE. Little support was evident for any position.

Ranking According to Importance

The ranking of the most important issues in health education indicated that the three in the top 20%, with a median rank of 1 through 4 on a list of 15, were concerned with (1) the primary goal of health education, (2) the basis for credentialing and (3) the selection of methodology affecting behavioral change. All three of these issues were also the only issues with alternatives that were either strongly or generally accepted.

The highest ranking of the issues generated by the panelists was sixth position, but three issues shared that position. These three (L, I, and M) concerned (1) standards for evaluation of professional preparation programs, (2) criteria for measurement of health education programs and (3) standards for measurement of health educators. Interesting, all three addressed the issues of evaluation and/or measurement.
The two issues that were ranked the lowest shared that position, it was 14.5. The issues were D and E and were concerned with (1) the age at which AIDS education should be introduced and (2) the emphasis of AIDS education in grades four through six. During the study some experts indicated that while these two issues were important, they were too specific and not really critical as far as moving the profession forward.

The ranking process, while not difficult for the majority, did concern some participants. A Likert-type scale might be an alternative for future research.

**Conclusions Regarding Panel**

Some conclusions may be drawn concerning the panel of experts from the Association for the Advancement of Health Education and this Delphi study: (1) they were willing to spend a substantial amount of time exploring issues in their field; (2) they were willing to express their beliefs and justify their positions relative to issues and alternative positions; (3) they were able to move towards consensus concerning the identification of issues and alternative positions; (4) they were willing to express support for alternative positions; (5) they were able to move towards consensus in support of
alternative positions; (6) they continued to hold many contentious opinions concerning the identification of alternative positions for major issues; (7) they were unable to either strongly or generally support any one alternative for the resolution of any issue; and (8) they were able to rank issues according to importance.

Recommendations

As a result of this study, the following recommendations are made for further consideration.

1. Students preparing to enter the profession of health education should continue to identify, study, and discuss issues and alternative positions relative to the field.

2. Issues in health education should continue to be explored at the professional level during national, state and local conferences and conventions.

3. A study such as this should be replicated every five years so that the identification of major issues and their alternative positions can be noted and variations can be chronicled.
4. A Likert-type scale might be an alternative for future use instead of the ranking process.

5. Due to possible limitations of a literature review, a study of this dimension should be done using an open-ended Delphi instrument.
Bibliography


Appendix A
November 10, 1987

Dear:

As the health education Chairperson of the (NAME OF INSTITUTION), I know you are concerned about the identification of the most important issues facing health education in 1987. You are one of eight health education department chairpersons of a state university in Ohio selected to participate in the initial phase of this study. The purpose of this study is to determine which issues facing health educators today are most important, to identify "alternative positions" for each of these issues, and to determine which alternative positions have greatest support. In your position at the (NAME OF INSTITUTION), your assistance with this study is essential.

I am asking for your guidance in the content validation of the enclosed instrument. Would you review, modify and/or suggest alternative positions to the selected issues? If you believe an important issue has been omitted, please include it for consideration. Your response will be strictly confidential and utilized only in the further refinement of the instrument. I urge your participation in this study which may help to clarify acceptance of various positions of critical issues in health education.

Enclosed please find an abstract of the study, the questionnaire, a self-addressed stamped envelope for returning the questionnaire, and a coupon as a token of my appreciation for your participation in this study.

I would be happy to answer any questions you might have. Call me collect prior to 8:00 a.m. or after 3:00 p.m. at (614) 453-2931.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University

College of Education
Last week you received a questionnaire seeking your counsel about a research instrument to be utilized in an important study concerning issues in health education. If you have already completed and returned it to me, please accept my sincere thanks. If not, could you please do so today? It has been sent to only eight professionals with similar expertise as your own. It is extremely important that the thoughts of individuals with your background and leadership experiences be included in the verification of this instrument.

If by some chance the packet of information did not reach you, or if it got misplaced, please call me collect at (614) 453-2931 and I will mail another to you.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
Dear:

Today there are many important issues facing the health educator. In order to move the profession forward, leaders need to explore the many alternative positions encompassed within these issues and hopefully reach a consensus concerning these positions.

As a recognized leader in health education, your insights into the major issues confronting our field are vital if we are to chart a clear and forceful course. Only experts who have the distinction of being recognized by the Association for the Advancement of Health Education as either an elected officer, recipient of the Professional Service Award and/or selected as AAHE Scholar, are being invited to participate in this study.

You are assured of complete confidentiality. The instrument has been imprinted with an identification number for follow-up purposes. This allows me to check your name off the mailing list when I receive your completed questionnaire. Your name will never be placed on, or appear on, the instrument at any time.

This study will employ a modified Delphi technique which will include two rounds in addition to this one. Therefore, you will receive two more packets of information which will require your attention. Each packet will include (1) a summary of responses of the previous round, (2) an indication of your previous responses, (3) a summary of modifications and/or justifications for each position in the previous round, and (4) a request that you review your responses relative to the packet under consideration.

I am asking you to complete and return the enclosed questionnaire by January 19, 1988. A stamped, addressed envelope is provided for your convenience. The enclosed coupon is a token of my appreciation for your participation in this study. Thank you for your assistance.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University

This study and letter have met my approval.

Mary K. Beyrer, Ph.D., Adviser

College of Education
Dear,
In one week you will receive an exciting opportunity to participate in an important study concerning major issues facing health education in 1987. Only 40 experts are being invited to take part in this research project. All have been recognized by the Association for the Advancement of Health Education for leadership, scholarship, or service. Your opinions and expertise are essential for the continued growth of the health education profession. Don't miss this opportunity to have a significant impact on the future of the profession.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
January 26, 1988

Dear:

About two weeks ago I wrote to you concerning an important study relative to major issues in health education. As of today, I have not yet received your completed instrument.

As an expert in the field of health education, I realize your schedule is quite busy but only a few minutes of your time is needed to complete the questionnaire. In order for the study to proceed, it is important for each expert to return the completed questionnaire.

Some participants in the study have indicated that additional time was needed. For your convenience, in the event the questionnaire was lost or misplaced, a replacement is enclosed. Please return the materials by February 9, 1988. A stamped preaddressed envelope has been included for your convenience. If you have already responded to this request, please disregard this letter and accept my sincere appreciation for your efforts.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
Last week I sent an invitation to you concerning participation in an important study of present issues in health education. While the response rate has been excellent, I have not as yet received your questionnaire as soon as possible.

If by some chance you did not receive the correspondence, if it got misplaced, or if you have questions concerning the instrument, please call me collect (614 453-2931).

If you have already sent the materials, please disregard this request, and thank you for your participation.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
January 26, 1988

Dear : 

About two weeks ago I wrote to you concerning an important study relative to major issues in health education. As of today, I have not yet received your completed instrument.

As an expert in the field of health education, I realize your schedule is quite busy but only a few minutes of your time is needed to complete the questionnaire. In order for the study to proceed, it is important for each expert to return the completed questionnaire.

Some participants in the study have indicated that additional time was needed. For your convenience, in the event the questionnaire was lost or misplaced, a replacement is enclosed. Please return the materials by February 9, 1988. A stamped preaddressed envelope has been included for your convenience. If you have already responded to this request, please disregard this letter and accept my sincere appreciation of your efforts.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
February 29, 1988

Dear:

I want to thank you for your participation in this study concerning important issues in health education. The response has been excellent and the comments thought provoking. The enclosed second round instrument reflects your comments as well as those of your colleagues. Your advice, concerning the study in general, was both welcome and appreciated. The overview of this study has been included in this round too for your reference.

Some participants in this study requested additional time in which to complete the first round. With this in mind, your response to the second round is requested by March 31, 1988. If you have any questions concerning this round, contact me collect at (614) 453-2931 after 3:00 p.m.

Enclosed is a token of my appreciation for your continued efforts in the second round. Have a cup of coffee on me while you complete this round.

Sincerely yours,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
A week ago you should have received the second round of the Delphi study concerning issues in health education. It is vital for those who participated in the first round to continue. Although the response has been excellent, I have not as yet received yours.

I know you must be very busy, but I need to have your round two instrument by March 31, 1988. If you have lost or misplaced the packet, please call me collect at (614) 453-2931 after 3:00 p.m. I anxiously await your correspondence. If you have already sent the materials, thank you for your assistance.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
April 29, 1988

Dear [Name],

Enclosed you will find the third and final round of the Delphi study concerning important issues in health education. Again, the response has been excellent; obviously your continued participation in this last round is vital to the study.

Your responses and suggestions, as well as those of the other expert panel members, are included for your consideration. The format for reporting the results is the same as for the previous rounds. It is hoped that your familiarity with both the instrument and the summary data will minimize the time you will need to complete this round.

Your completed Round 3 instrument is requested by May 23, 1988. If you have any questions concerning Round 3, or problems with the May 23 deadline, please call me collect at (614) 453-29031 after 3:00 p.m. Shortly after the conclusion of this study, you will receive Round 3 results as well as a demographic summary of this research.

It has been a real pleasure to work with you and I hope you have found this experience as interesting as I have. Please accept the brightly colored paper clip at the top of this letter as a token of my appreciation for your continued participation in this study.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
A little over a week ago you received the final round of the Delphi study concerning issues in health education. Your contribution to this research has been invaluable to date. One task remains, the completion of the third and final round. I need to have your completed Round 3 instrument by May 23, 1988.

If you need a replacement instrument or have any questions, please call me collect at (614) 453-2931 after 3:00 p.m. If your materials have already been sent, accept my sincere appreciation for your continued assistance.

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
June 28, 1988

Dear: 

Enclosed please find the results of the third and final round of the Delphi study concerning issues in health education, as well as demographic data. I want to extend to you my sincere appreciation for your continued participation during the past months.

I know involvement with this study has required more of your time than other studies. Your professional judgments have been invaluable and the study would have been incomplete without them.

Thank you again for your perseverance and professionalism. I am hopeful that the results of this study will be of value to our field.

Have a great summer!

Sincerely,

Melissa W. Bixler
Ph.D. Candidate
The Ohio State University
Round One Review Panel

R. Meibi Akah
John Hjelm
Nancy Keinow
Margaret Kruckemeyer
Joanne Sherwood
Dave Willcox
Round Two Review Panel

Judith Asmus
Kristen Body
Kathy Riddle
Kathleen Rowland
Bob Swift
David Willcox
Round Three Review Panel

Judith Asmus
Kristen Body
Kathy Riddle
Kathleen Rowland
Bob Swift
FIELD TEST
For the purpose of this study, an issue is a point of debate which has at least two sides or alternative positions from which to choose. Alternative positions are various options or choices, any of which could resolve the issue in question. Health education literature has often explored issues concerning goals, methodology, content, professional preparation, and research which pertain to the profession. The purpose of this study is to investigate issues in health education by:

1. identifying the major issues in rank order according to importance,
2. compiling accepted alternative positions for possible resolution of the issues,
3. determining the degree of support for each alternative position.

A modified Delphi with a minimum of three rounds will be employed. The instrument, designed specifically for this study, is an example of both an ordered and unordered partially close ended questionnaire. The instrument, developed from a literature search and field test, identifies both the issues and the alternative positions which could lead to resolution of each issue. Subjects are encouraged to modify the instrument during each phase of the study.

The subjects for this study are individuals who have been recognized by the Association for the Advancement of Health Education as either an elected officer, recipient of the Professional Service Award and/or selected as a Scholar. The entire population includes 40 individuals.

Both the mean and median will be calculated to determine the rank order of the issues. Percentages will be utilized to determine both the extent of acceptance of alternative positions and the degree of support for each.
An issue is a point of controversy which has alternatives from which to choose.

Review each of the following issues and the alternative positions. If an alternative position is clearly stated and identifies a valid alternative position for that issue, though not necessarily your own, mark the space to the right under "AGREE."

If an alternative position needs to be modified, or clarified, or if you believe the position does not reflect attitudes or beliefs held by health educators, mark the space to the right under "DISAGREE."

You may have several alternative positions marked "AGREE" and several marked "DISAGREE." You should not have any one alternative position marked both "AGREE" and "DISAGREE."

The alternative positions that you personally support should be indicated by checking the provided space under "SUPPORT."

If you wish to comment, make modifications, or additions to the list of alternative positions, you are encouraged to do so in the space provided.
**ISSUE A:** To what extent should behavioral change be the primary goal of the health educator?

Alternative Positions:  

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
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The primary goal of the health educator should be

1. to facilitate the acquisition of facts concerning health behaviors and wellness  
   -  

2. to facilitate decision making skills applied to health behaviors.  
   -  

3. to change unhealthy behaviors.  
   -  

Comments or suggested alternatives:
**ISSUE B:** Which methods should the health educator utilize when attempting to change the behavior of student or client?

**Alternative Positions:**

The health educator's role relative to behavioral change in his/her students or clients could include:

1. attempts to persuade them to alter their behavior as long as they are willing listeners.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

2. "fear arousing" methods if necessary.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

3. Subtle behavior modification techniques which could be effectively utilized on students or clients that are unaware of them.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

4. coercion if risk factors are life threatening to the individual.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

**Comments or suggested alternatives:**
**ISSUE C:** To what extent should the health educator be held accountable for behavioral change in students or clients?

<table>
<thead>
<tr>
<th>Alternative Positions:</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The extent to which health educators should be held accountable for behavioral change in students or clients</td>
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<tr>
<td>1. health educators can present information coupled with methods that lead to behavioral change; beyond that manipulation is present.</td>
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<td>2. education accounts for only a small portion of an individual's life; therefore, the health educator should not be held accountable for continued poor health behaviors of students or clients.</td>
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<tr>
<td>3. behavioral change is the ultimate goal and reflects the competency of the health educator.</td>
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</table>

Comments or suggested alternatives:
ISSUE D: What should be the focus of AIDS education for grades four through six?

Alternative Positions:

<table>
<thead>
<tr>
<th>The focus of AIDS education should be</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. based primarily on the importance of chastity and abstinence with some information on barrier protection.</td>
</tr>
<tr>
<td>2. limited to the importance of chastity and abstinence.</td>
</tr>
<tr>
<td>3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence.</td>
</tr>
<tr>
<td>4. limited to the importance of barrier protection.</td>
</tr>
<tr>
<td>5. based on the biomedical aspects of the syndrome and related diseases.</td>
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<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
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Comments or suggested alternatives:
**ISSUE E:** At which age should education concerning the transmission and prevention of AIDS be introduced?

**Alternative Positions:**

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
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</table>

The transmission and prevention of AIDS should be introduced in health education classes for:

1. grades one through three.
   -   
   -   
   -   

2. grades four through six.
   -   
   -   
   -   

3. grades seven through nine.
   -   
   -   
   -   

4. grades ten through twelve.
   -   
   -   
   -   

Comments or suggested alternatives:
ISSUES F: Which commonalities should exist in the professional preparation of health educators?

A health educator is an individual prepared to assist individuals acting separately or collectively to make informed decisions regarding matters affecting their personal health and that of others.

Alternative Positions:

<table>
<thead>
<tr>
<th>Commonalities</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
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<tbody>
<tr>
<td>1. a minimum of a baccalaureate degree with a major in health education.</td>
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<tr>
<td>2. completion of a baccalaureate collegiate program that incorporates specific</td>
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<td>preparation standards, e.g., the Role Delineation Project.</td>
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<tr>
<td>3. successful completion of a state competency examination leading to</td>
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<tr>
<td>licensure, e.g. nursing.</td>
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<tr>
<td>4. five year program leading to M.A. degree with liberal arts base, e.g.,</td>
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<td>as suggested by Holmes group.</td>
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</table>

Comments or suggested alternatives:
ISSUE G: In which of the areas of health education should research be focused?

Alternative Positions:

Research in health education should be focused primarily on

1. identification of critical factors in the implementation and maintenance of health education programs.

2. understanding the causes of behavioral change.

3. the formulation of cost effective ratios so that various health education programs could be evaluated and compared.

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
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Comments or suggested alternatives:
ISSUE H: To what extent does the health education profession need a single organization to represent health educators?

Alternative Positions:  

The health education profession would best be served by

1. the continuation of the present multi-organizational system which offers many options.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

2. further separation of AAHE from AAHPERD and support for a consolidation of AAHE and SOPHE.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

3. a reorganization of the Coalition of National Health Education Organization to allow for individual memberships.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

4. creation of a new capstone organization, similar to the American Medical Association, which would have subdivisions to serve specialists.  
   - AGREE  
   - DISAGREE  
   - SUPPORT

Comments or suggested alternatives:
RANKING OF ISSUES ACCORDING TO IMPORTANCE

Below are issues concerning health education which have been identified by a literature search. Rank the issues by importance with the most important ranked number one (1) and the least important number ten (10).

In your opinion if one of the listed issues is NOT a major issue place a zero (0) in the space provided.

If you believe an important issue has been omitted, please include it in the space below so that it can be considered for Round Two. DO NOT RANK this proposed issue at this time.

<table>
<thead>
<tr>
<th>PROPOSED ISSUES</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue A: To what extent should behavioral change be the primary goal of the health educator?</td>
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<tr>
<td>Issue B: Which methods should the health educator utilize when attempting to change the behavior of student or client?</td>
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<tr>
<td>Issue C: To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
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</tr>
<tr>
<td>Issue D: At which age should education concerning the transmission and prevention of AIDS be introduced?</td>
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</tr>
<tr>
<td>Issue E: What should be the focus of AIDS education for grades four through six?</td>
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<tr>
<td>Issue F: Which commonalities should exist in the professional preparation of health educators?</td>
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<tr>
<td>Issue G: In which of the areas of health education should research be primarily focused?</td>
<td></td>
</tr>
<tr>
<td>Issue H: To what extent does the health education profession need a single organization to represent health educators?</td>
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</table>
DEMOGRAPHIC INFORMATION

The purpose of this portion of the instrument is to provide the researcher with basic information which will allow for an accurate description of the results of the study. The researcher will immediately, upon receipt of the questionnaire, separate the demographic data from the packet. This information will be held in total confidence and never reported with any specific individual, position, or location at any time.

Code Number: ______________

Address: Please edit any errors that exist in the mailing label below.

Phone Number: (area code and telephone number)

(____)______-_______ Home

(____)______-_______ Office

Gender: Male (____)

Female (____)

Greatest Percent of Responsibility:

- Educator
  - Elementary/Secondary Level (____)
  - College (____)
  - Worksit/Business (____)
  - Retired (____)
- Administrator (____)
- Community/Professional Assoc. (____)

Other: ____________________________
ROUND 1
Major Issues in Health Education in 1987-88, as Identified by Leaders in the Association for the Advancement of Health Education: A Delphi Study.

An Overview of the Proposed Study
(For Your Information)

For the purpose of this study, an issue is a point of debate which has at least two sides or alternative positions from which to choose. Alternative positions are various options or choices, any of which could resolve the issue in question. Health education literature has often explored issues concerning goals, methodology, content, professional preparation, and research which pertain to the profession. The purpose of this study is to investigate issues in health education by:

1. identifying the major issues in rank order according to importance,
2. compiling accepted alternative positions for possible resolution of the issues,
3. determining the degree of support for each alternative position.

A modified Delphi with a minimum of three rounds will be employed. The instrument, designed specifically for this study, is an example of both an ordered and unordered partially close ended questionnaire. The instrument, developed from a literature search and field test, identifies both the issues and the alternative positions which could lead to resolution of each issue. Subjects are encouraged to modify the instrument during each phase of the study.

The subjects for this study are individuals who have been recognized by the Association for the Advancement of Health Education as either an elected officer, recipient of the Professional Service Award and/or selected as a Scholar. The entire population includes 40 individuals.

Both the mean and median will be calculated to determine the rank order of the issues. Percentages will be utilized to determine both the extent of acceptance of alternative positions and the degree of support for each.
QUESTIONNAIRE

An issue is a point of controversy which has alternatives from which to choose.

Review each of the following issues and the alternative positions. If an alternative position is clearly stated and identifies a valid alternative position for that issue, though not necessarily your own, mark the space to the right under "AGREE."

If an alternative position needs to be modified, or clarified, or if you believe the position does not reflect attitudes or beliefs held by health educators, mark the space to the right under "DISAGREE."

You may have several alternative positions marked "AGREE" and several marked "DISAGREE." You should not have any one alternative position marked both "AGREE" and "DISAGREE."

The alternative positions that you personally support should be indicated by checking the provided space under "SUPPORT."

If you wish to comment, make modifications, or additions to the list of alternative positions, you are encouraged to do so in the space provided.
ISSUE A: To what extent should behavioral change be the primary goal of the health educator?

Alternative Positions:

1. To facilitate the acquisition of facts concerning health behaviors and wellness
2. To facilitate decision making skills applied to health behaviors.
3. To change unhealthy behaviors.

Comments or suggested alternatives:
ISSUE B: Which methods should the health educator utilize when attempting to change the behavior of student or client?

Alternative Positions:

The health educator's role relative to behavioral change in his/her students or clients could include

<table>
<thead>
<tr>
<th>Alternative</th>
<th>Positions:</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>attempts to persuade them to alter their behavior as long as they are willing listeners.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>&quot;fear arousing&quot; methods if necessary.</td>
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<tr>
<td>3.</td>
<td>Subtle behavior modification techniques which could be effectively utilized on students or clients that are unaware of them.</td>
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</tr>
<tr>
<td>4.</td>
<td>coercion if risk factors are life threatening to the individual.</td>
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</tbody>
</table>

Comments or suggested alternatives:
ISSUE C: To what extent should the health educator be held accountable for behavioral change in students or clients?

Alternative Positions:

The extent to which health educators should be held accountable for behavioral change in students or clients

1. Health educators can present information coupled with methods that lead to behavioral change; beyond that manipulation is present.

2. Education accounts for only a small portion of an individual's life; therefore, the health educator should not be held accountable for continued poor health behaviors of students or clients.

3. Behavioral change is the ultimate goal and reflects the competency of the health educator.

4. Is dependent upon organizational setting and the role requirements for the professional.

Comments or suggested alternatives:
### ISSUE D: At which age should education concerning the transmission and prevention of AIDS be introduced?

<table>
<thead>
<tr>
<th>Alternative Positions</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>The transmission and prevention of AIDS should be introduced in health education classes for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Ages 6 - 7</td>
<td></td>
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<tr>
<td>2. Ages 8 - 9</td>
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<tr>
<td>3. Ages 10 - 11</td>
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<td></td>
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<tr>
<td>4. Ages 12 - 13</td>
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</tr>
</tbody>
</table>

Comments or suggested alternatives:
**ISSUE E: What should be the focus of AIDS education for grades four through six?**

Alternative Positions:

<table>
<thead>
<tr>
<th>The focus of AIDS education should be</th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. based primarily on the importance of chastity and abstinence with some information on barrier protection.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. limited to the importance of chastity and abstinence.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. limited to the importance of barrier protection.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. based on the biomedical aspects of the syndrome and related diseases.</td>
<td></td>
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</tbody>
</table>

Comments or suggested alternatives:
ISSUES F: Which commonalities should exist in the professional preparation of health educators?

A health educator is an individual prepared to assist individuals acting separately or collectively to make informed decisions regarding matters affecting their personal health and that of others.

Alternative Positions:

Certain commonalities should exist in the preparation of the professional health educators; they include

1. a minimum of a baccalaureate degree with a major in health education.
2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project.
3. successful completion of a state competency examination leading to licensure, e.g., nursing.
4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by Holmes group.

Comments or suggested alternatives:
ISSUE G: In which of the areas of health education should research be primarily focused?

Alternative Positions:

Research in health education should be focused primarily on

1. identification of critical factors in the implementation and maintenance of health education programs.

2. understanding the causes of behavioral change.

3. the formulation of cost effective ratios so that various health education programs could be evaluated and compared.

Comments or suggested alternatives:
ISSUE H: To what extent does the health education profession need a single organization to represent health educators?

Alternative Positions:

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
</table>

The health education profession would best be served by

1. the continuation of the present multi-organizational system which offers many options.
2. further separation of AAHE from AAHPERD and support for a consolidation of AAHE and SOPHE.
3. a reorganization of the Coalition of National Health Education Organization to allow for individual memberships.
4. creation of a new capstone organization, similar to the American Medical Association, which would have subdivisions to serve specialists.

Comments or suggested alternatives:
RANKING OF ISSUES ACCORDING TO IMPORTANCE

Below are issues concerning health education which have been identified by a literature search. Rank the issues by importance with the most important ranked number one (1) and the least important number ten (10).

In your opinion if one of the listed issues is NOT a major issue place a zero (0) in the space provided.

If you believe an important issue has been omitted, please include it in the space below so that it can be considered for Round Two. DO NOT RANK this proposed issue at this time.

<table>
<thead>
<tr>
<th>PROPOSED ISSUES</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue A: To what extent should behavioral change be the primary goal of the health educator?</td>
<td>______</td>
</tr>
<tr>
<td>Issue B: Which methods should the health educator utilize when attempting to change the behavior of student or client?</td>
<td>______</td>
</tr>
<tr>
<td>Issue C: To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>______</td>
</tr>
<tr>
<td>Issue D: At which age should education concerning the transmission and prevention of AIDS be introduced?</td>
<td>______</td>
</tr>
<tr>
<td>Issue E: What should be the focus of AIDS education for grades four through six?</td>
<td>______</td>
</tr>
<tr>
<td>Issue F: Which commonalities should exist in the professional preparation of health educators?</td>
<td>______</td>
</tr>
<tr>
<td>Issue G: In which of the areas of health education should research be primarily focused?</td>
<td>______</td>
</tr>
<tr>
<td>Issue H: To what extent does the health education profession need a single organization to represent health educators?</td>
<td>______</td>
</tr>
</tbody>
</table>
DEMOGRAPHIC INFORMATION

The purpose of this portion of the instrument is to provide the researcher with basic information which will allow for an accurate description of the results of the study. The researcher will immediately, upon receipt of the questionnaire, separate the demographic data from the packet. This information will be held in total confidence and never reported with any specific individual, position, or location at any time.

Code Number: ______________

Address: Please edit any errors that exist in the mailing label below.

Phone Number: (area code and telephone number)

(____)____-_________Home

(____)____-_________Office

Gender: Male (___)

Female (___)

Greatest Percent of Responsibility:

Educator
Elementary/Secondary Level
College

College
Worksite/Business
Retired

Administrator
Community/Professional Assoc.

Other: __________________________
ROUND 2
An Overview of the Proposed Study
(For Your Information)

For the purpose of this study, an issue is a point of debate which has at least two sides or alternative positions from which to choose. Alternative positions are various options or choices, any of which could resolve the issue in question. Health education literature has often explored issues concerning goals, methodology, content, professional preparation, and research which pertain to the profession. The purpose of this study is to investigate issues in health education by: (1) identifying the major issue in rank order according to importance, (2) compiling accepted alternative positions for possible resolution of the issues, and (3) determining the degree of support for each alternative position.

A modified Delphi with a minimum of three rounds will be employed. The instrument, designed specifically for this study, is an example of both an ordered and unordered partially close-ended questionnaire. The instrument, developed from a literature search, identifies both the issues and the alternative positions which could lead to resolution of each issue. Subjects are encouraged to modify the instrument during each phase of the study.

The subjects for this study are individuals who have been recognized by The Association for the Advancement of Health Education as either an elected officer, recipient of the Professional Service Award and/or selected as a Scholar. The entire population includes 41 individuals.

Both the mean and the median will be calculated to determine the rank order of the issues. Percentages will be utilized to determine both the extent of acceptance of alternative positions and the degree of support for each.
The purpose of a Delphi study is to reach a consensus by means of shared feedback while remaining anonymous. An issue is a point of debate which has at least two sides or alternative positions. The purpose of this study is to investigate issues in health education by: (1) identifying the major issues in rank order according to importance, (2) compiling accepted alternative positions for possible resolution of the issues, and (3) determining the degree of support for each alternative position. For your reference, a more complete overview of this study is on the last page of this document.

DIRECTIONS FOR ROUND 2

If two or more respondents in Round 1 made similar comments or suggested a similar new alternative, or agreed with statements in Other Comments from Round 1, these suggestions are included in this revised version and are reflected in the section Note from Researcher. If a single respondent asked for clarification or suggested a new alternative, this was included in the section Other Comments from Round 1. This instrument for Round 3 provides the following sections for your assistance as follows:

Note from Researcher: This section has been included in response to comments from you concerning clarification of confusing items and to alert you to the addition of new alternatives.

Other Comments from Round 1: In order to include all the revisions suggested by a single participant, some of the responses have also been paraphrased.

Responses from Round 1: This section show the summarized data for each alternative position. Your specific response is underlined in red. Percentages of nonresponses has also been identified.

Final Comments: If you wish to support or further clarify your position, do so in this section. If you wish very select comments to be quoted exactly in the Summary of the Study, please use quotation marks. If additional space is needed, utilize the back of the page.

REVIEW OF QUESTIONNAIRE PROCEDURES

Review each of the following issues and the alternative positions before marking this instrument. If an alternative position is clearly stated and identifies a valid alternative position for that issue, though not necessarily your own, mark the space to the right under "AGREE".

If an alternative position needs to be modified, or clarified, or if you believe the position does not reflect attitudes or beliefs held by health educators, mark the space to the right under "DISAGREE".
ISSUE A: What should be the primary goal of the health educator?

Note from Researcher: This issue has been rephrased for clarification. The alternatives have been altered as follows: 03 "problem solving and" was added; 05 "unhealthy" was changed to read "health compromising to healthy behaviors". Alternatives 02, 04, 06, and 07 are new. The major focus in this issue is "primary goal" as opposed to multiple goals.

Other Comments from Round 1:
To assist the client in problem solving and decision making skills in matters that impact on health.
Facts are among the elements that facilitate decision making.
To facilitate the acquisition of concepts, facts, perceptions and value positions concerning health behaviors and wellness.
To facilitate voluntary, informed changes in health related behaviors including actions, practices and skills, as well as cognitive and affective behaviors.

Alternative Positions:

The primary goal of the health educator should be

1. to facilitate the acquisition of facts concerning health behaviors and wellness
   Responses from Round 1: Agree 79% Disagree 21% Nonresponse 0% Support 18%
2. to facilitate the acquisition of values concerning health behaviors and wellness
3. to facilitate problem solving and decision making skills as applied to healthy behaviors
   Responses from Round 1: Agree 69% Disagree 7% Nonresponse 4% Support 64%
4. to facilitate the changing of health compromising behaviors to healthy behaviors
5. to change health compromising behaviors to healthy behaviors
   Responses from Round 1: Agree 68% Disagree 29% Nonresponse 4% Support 11%
6. to reinforce healthy behaviors
7. to promote healthy behaviors

Comments for Round 2:
ISSUE 8: Which methods should the health educator utilize when attempting to affect the behavior of student or client?

Note from Researchers: The words "change the behavior" have been replaced by "affect the behavior" in the statement of the issue. In #1, "necessary" has been changed to "appropriate". In #3, the first word, "subtle", has been removed. In #4, "immediately" has been inserted. Alternative #3 is new.

Other Comments from Round 1:
Different methods are appropriate for different health education settings and different issues. If I were a community health educator with the task of reducing the spread of AIDS, my methods would be different than teaching about death and dying to senior and graduate university student.

"Fear arousing" methods should be used very sparingly, in certain cases only, and only if threat-avoidance behavior is perceived by clients as effective, possible, and available to them.
I don't know of any cases where a health educator could apply coercion. He/she might advocate it—but use it?
Assuming I were in a position to save someone from a "life threatening" consequence, I definitely would use coercion if I believed it necessary. However, such an approach is tantamount to "control"—an anathema to health educators.

Expand the range of alternatives open to students.
You might add a slightly reworded alternative #1 in Issue C as an alternative for this issue.

Alternative Positions:
The health educator's role relative to affecting behavior in his/her student or clients should include

1. attempts to persuade them to alter their behavior if they express a willingness to do so

   Responses from Round 1: Agree 62% Disagree 18% Nonresponse 0% Support 6%

2. "fear arousing" methods if appropriate

   Responses from Round 1: Agree 43% Disagree 54% Nonresponse 4% Support 7%

3. behavior modification techniques which could be effectively utilized on students or clients

   Responses from Round 1: Agree 56% Disagree 61% Nonresponse 4% Support 7%

4. coercion if risk factors are immediately life threatening to the individual

   Responses from Round 1: Agree 33% Disagree 64% Nonresponse 4% Support 14%

5. providing alternatives and behavior modification techniques when students/clients request assistance

   Responses from Round 1: Agree 33% Disagree 66% Nonresponse 4% Support 14%
ISSUE C: To what extent should the health educator be held accountable for behavioral change in students or clients?

Note from Researcher: Alternative #1 has been reworded. In Round 1, it was "health educators can present information coupled with methods that lead to behavioral change, beyond that manipulation is present." Alternative #2 has been reworded. In Round 1 the first phrase was "education accounts for a limited portion of an individual's life." #5 has been added.

Other Comments from Round 1:
#2—the word "poor" should be changed to risky
#3—should read "...behavioral change is the ultimate goal and to a degree reflects the competency of the health educator"

Alternative Positions:

1. health educators can present information coupled with methodology that may lead to behavioral change, beyond that they are not accountable

Responses from Round 1: Agree 54% Disagree 29% Nonresponse 18% Support 3%

2. health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued poor health behaviors of students or clients

Responses from Round 1: Agree 43% Disagree 50% Nonresponse 7% Support 2%

3. behavioral change is the ultimate goal and reflects the competency of the health educator

Responses from Round 1: Agree 43% Disagree 50% Nonresponse 7% Support 11%

4. the behavioral change is dependent upon organizational setting and the role requirements for the professional

Responses from Round 1: Agree 68% Disagree 21% Nonresponse 11% Support 25%

5. the objectives for conducting and evaluating the health education programs had been previously articulated and adopted

Comments for Round 2:
ISSUE 0: At which age should education concerning the transmission and prevention of AIDS be first introduced as a planned part of the curriculum?

Note from Researcher: The issue has been clarified to include the word "first". 05 has been added.

Other Comments from Round 1:
Ages 10-11 coincides with adolescent growth spurt
Depending on the community and ages of sexual activity, AIDS should be included in context of prevention of drug abuse at 10-16 years, and in context of STD's at ages 11-15
Ages 12-13 because one strikes youth while "the iron is hot"—not before
Issues D and E deal with AIDS. Although very important at this time, they represent one small aspect of a "comprehensive health education" program.

It is never too late to introduce the material; however, 5th and 6th grade student are capable of understanding the information
I have a hunch 6-7 is too early unless a 6 year old asks a question, then it should be introduced at that age
It depends on how it is presented. Some aspects are suitable at any age.
Illinois just passed a state law requiring AIDS education to be taught in grades 6-12.
Environmental factors are related to this question—age could vary.

Alternative Positions:
The transmission and prevention of AIDS should be first introduced in health education classes for

1. Ages 6-7
   Responses from Round 1: Agree 57% Disagree 39% Nonresponse 4% Support 32%

2. Ages 8-9
   Responses from Round 1: Agree 64% Disagree 27% Nonresponse 9% Support 29%

3. Ages 10-11
   Responses from Round 1: Agree 82% Disagree 7% Nonresponse 11% Support 36%

4. Ages 12-13
   Responses from Round 1: Agree 71% Disagree 21% Nonresponse 7% Support 18%

5. Ages 14-15

Comments for Round 2:
ISSUE E: What should be the major emphasis of AIDS education for grades four through six?

Note from Researcher: This issue has been rewritten to change "focus of AIDS education" to "major emphasis of AIDS education". Chastity and abstinence refer to sexuality, and barrier protection refers to condoms. #6 is a new alternative.

Other Comments from Round 1:
Depends on the population represented, the culture and the attitude of the community.
Depends on appropriate language.
Psychosocial aspects need to be addressed, most kids that age will not have AIDS, but may have to deal with classmates and/or relatives who have AIDS.

Alternative Positions:

The major emphasis of AIDS education should be

1. based primarily on the importance of chastity and abstinence with some information on barrier protection

   Responses from Round 1: Agree 46% Disagree 50% Nonresponse 4% Support 18%

2. limited to the importance of chastity and abstinence

   Responses from Round 1: Agree 15% Disagree 79% Nonresponse 4% Support 7%

3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence

   Responses from Round 1: Agree 46% Disagree 46% Nonresponse 7% Support 21%

4. limited to the importance of barrier protection

   Responses from Round 1: Agree 11% Disagree 86% Nonresponse 4% Support 4%

5. based on the biomedical aspects of the syndrome and related diseases

   Responses from Round 1: Agree 75% Disagree 21% Nonresponse 4% Support 50%

6. addressed toward a community health infectious disease point of view

Comments for Round 2:
ISSUE 1: What form of credentialing would best serve the profession of health education?

A health educator is an individual prepared to assist individuals acting separately or collectively, to make informed decisions regarding matters affecting their personal health and that of others.

Note from Researchers: The original intent on this issue was to identify professional preparation in terms of credentialing, that is the granting of formal recognition of professional competencies. Wording of this issue has been altered to more accurately reflect the alternatives. Alternative #3 has been added.

Other Comments from Round 1:
A combination of #2 and #3.
#3 should be a goal, not the starting place.
At least one degree with a major in health science from an established program.
Alabama is an example of #3.

Alternative Positions:

The health education profession would be best served if credentialing was based on:

1. a minimum of a baccalaureate degree with a major in health education

   Responses from Round 1: Agree 77% Disagree 10% Nonresponse 3% Support 10%

2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project

   Responses from Round 1: Agree 86% Disagree 7% Nonresponse 7% Support 6%

3. successful completion of a state competency examination leading to licensure, e.g., nursing

   Responses from Round 1: Agree 46% Disagree 50% Nonresponse 4% Support 0%

4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes Group

   Responses from Round 1: Agree 31% Disagree 57% Nonresponse 4% Support 19%

5. no one standard form

Comments for Round 2:

YOUR ROUND 2 RESPONSES

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
ISSUE 6: In which of the areas of health education should research be primarily focused?

Note from Researchers: The purpose of this issue is to identify the area in which research is most needed. Alternative 82 has been altered. In Round 1 it was "understanding the causes of behavioral change". Alternatives 84, 85, and 86 have been added.

Other Comments from Round 1:
83 is the last kind of research in which health educators should ever engage.
With the breadth of health education research needed, you make null and void all responses when you use "primarily".
The above are not topics for pure research.
"primarily focused" calls for value judgments, but only 3 alternatives for such a "broad issue".
Both 81 and 82, but from the individual or groups perspective.

Alternative Positions:
Research in health education should be focused primarily on

1. Identification of critical factors in the implementation and maintenance of health education programs
   Responses from Round 1: Agree 82% Disagree 7% Nonresponse 11% Support 46%

2. Understanding the factors that contribute to behavioral change
   Responses from Round 1: Agree 61% Disagree 14% Nonresponse 18% Support 43%

3. The formulation of cost effective ratios so that various health education programs could be evaluated and compared
   Responses from Round 1: Agree 94% Disagree 3% Nonresponse 14% Support 14%

4. Determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups

5. Evaluation

6. Theories of health education

Comments for Round 2:

YOUR ROUND 2 RESPONSES
AGREE DISAGREE SUPPORT
ISSUE H: Which professional organizational configuration would be most beneficial for health education?

Note from Researcher: Issue H has been reworded for clarification. In Round 1 it was "To what extent does the health education profession need a single organization to represent health educators?". The previous #2 has been separated into #2 and #3. Reference to AHA, as an example, has been deleted from #5.

Other Comments from Round 1:
#2—The negative effect would be loss of support services.
#2—There is now developing a significant interest in health and fitness which could lead to important development in health education by physical educators.
#2—AAHPERD is dominated by physical educators and is preoccupied with physical fitness.
#2—Breeds elitists but does not strengthen the grass roots—workers only isolated by self-imposed leaders.
#5—APHA and ASHA attempt to meet needs of members with sections, courses, forums—opportunity for membership in AHE without joining AAHERD. Support for consolidation of AAHE and SOPHE, and a merger of the SHES and PHE sections of APHA.

The fact that the profession has been doing pretty well tells us that a single organization is not "needed".

Alternative Positions:

1. the continuation of the present multi-organizational system which offers many options

   Responses from Round 1: Agree 46% Disagree 50% Nonresponse 4% Support 25%

2. greater autonomy of AAHE within AAHPERD

   Responses from Round 1: Agree 64% Disagree 29% Nonresponse 7% Support 39%

3. a consolidation of AAHE and SOPHE

4. a reorganization of the Coalition of National Health Education Organization to allow for individual memberships

   Responses from Round 1: Agree 21% Disagree 66% Nonresponse 11% Support 4%

5. creation of a new capstone organization

   Responses from Round 1: Agree 64% Disagree 25% Nonresponse 11% Support 25%

Comments for Round 2:
Below are the issues with summary statistics from Round 1. Consider these rankings relative to your ranking from Round 1 before ranking in the round 2 column.

Rank the issues by importance with the most important ranked number one (1) and least important ranked number twelve (12). Be sure to include newly proposed issues I through L in your deliberations.

In your opinion if one of the listed issues in not a major issue, place a zero (0) in the space provided. Each issue should have either a number or a zero beside it.

If you believe an important issue has been omitted, please include it in the space below Issue L so that it can be considered for Round 3. DO NOT RANK your proposed issue at this time.

**PROPOSED ISSUES**

![Table with issues and rankings]

<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
<th>Mean</th>
<th>Median</th>
<th>Your Round 1</th>
<th>Your Round 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>What should be the primary goal of the health educator?</td>
<td>3.16</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Which methods should the health educator utilize when attempting to affect the behavior of student or client?</td>
<td>4.04</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>4.87</td>
<td>3.5</td>
<td></td>
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</tr>
<tr>
<td>D</td>
<td>At which age should education concerning the transmission and prevention of AIDS first be introduced?</td>
<td>6.87</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>What should be the major emphasis of AIDS education for grades four through six?</td>
<td>7.20</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>What form of credentialing would best serve the profession of health education?</td>
<td>2.27</td>
<td>2</td>
<td></td>
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</tr>
<tr>
<td>G</td>
<td>In which of the areas of health education should research be primarily focused?</td>
<td>4.04</td>
<td>4</td>
<td></td>
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</tr>
<tr>
<td>H</td>
<td>Which professional organizational configuration would be most beneficial for health education?</td>
<td>4.38</td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO NOT OVERLOOK ISSUES I - L ON THE NEXT PAGE.
Proposed Issues generated from Round 1:

Note from Researchers: As you know, one purpose of this study is to compile alternative positions for each issue. If you rank any of the four new issues, please include suggestions for viable alternatives.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>&quot;What criteria should be used to measure the relative success of health education programs, where and how much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can't be.&quot;</td>
</tr>
<tr>
<td>II</td>
<td>&quot;Should the profession of health education change to meet the needs of the future, and if so, in what way?&quot;</td>
</tr>
<tr>
<td>III</td>
<td>&quot;Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to M.D.'s, nurses, dietitians, etc.?&quot;</td>
</tr>
<tr>
<td>IV</td>
<td>&quot;What standards should be used to evaluate (1) professional preparation in programs, and (2) the competencies of professional health educators?&quot;</td>
</tr>
</tbody>
</table>

Other Comments from Round 1:

The quality and status of health education in schools.
ROUND 3
(final)
A REVIEW

The purpose of a Delphi study is to reach a consensus by means of shared feedback while remaining anonymous. An issue is a point of debate which has at least two sides or alternative positions. The purpose of this study is to investigate issues in health education by: (1) identifying the major issues in rank order according to importance, (2) compiling accepted alternative positions for possible resolution of the issues, and (3) determining the degree of support for each alternative position. For your reference, a more complete overview of this study is on the last page of this document.

DIRECTIONS FOR ROUND 3

If two or more respondents in Round 2 made similar comments or suggested a similar new alternative, or agreed with statements in Other Comments From Round 2, these suggestions are included in this revised version and are reflected in the section Note from Researcher. If a single respondent asked for clarification or suggested a new alternative, this was included in the section Other Comments from Round 2. This instrument for Round 3 provides the following sections for your assistance as follows:

Note from Researcher: This section has been included in response to comments from you concerning clarification of confusing items and to alert you to the addition of new alternatives.

Other Comments from Round 2: In order to include all the revisions suggested by a single participant, some of the responses have also been paraphrased.

Responses from Round 2: This section show the summarized data for each alternative position. Your specific response is underlined in red. Percentages have been rounded off and may not total 100 percent. The percentage of nonresponses has also been identified.

Comments for Round 3 (Final Comments): If you wish to support or further clarify your position, do so in this section. If you wish very select comments to be quoted exactly in the Summary of the Study, please use quotation marks. If additional space is needed, utilize the back of the page.

REVIEW OF QUESTIONNAIRE PROCEDURES (as per Round 1 and 2)
ISSUE B: What should be the primary goal of the health educator?

Note from Researchers: You may "AGREE" with several of the alternative positions but only one selection can be accepted as the one you "SUPPORT".

Ten of the goals suggested in Other Comments from Round 2 have been requested as alternatives by several experts. They appear as #3 and #4.

The term "health-promoting" replaces "healthy" in #1, #4, #5, #6, and #7.

Other Comments from Round 2:
#1 = I disagree because acquisition of knowledge is merely gaining a tool for decision making and one that is not always effective.
#2 = "Positive" should provide "values".
#6, #5, #7 = are too much the same.
#5 = is usually not possible.
#6 = health educators don't change people-students, patients, clients-changes whenever they choose or decide to do so.

Alternative Positions

The primary goal of the health educator should be

1. to facilitate the acquisition of facts concerning health behaviors and wellness
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

2. to facilitate the acquisition of values concerning health behaviors and wellness
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

3. to facilitate problem solving and decision making skills as applied to health-promoting behaviors
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

4. to facilitate the changing of health compromising behaviors to health-promoting behaviors
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

5. to change health compromising behaviors to health-promoting behaviors
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

6. to reinforce health-promoting behaviors
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

7. to promote health-promoting behaviors
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

8. to facilitate the acquisition of concepts, facts, perceptions and values positions concerning health behaviors and wellness
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%

9. to facilitate voluntary, informed changes in health related behaviors including actions, practices and skills, as well as possessive and effective behaviors.
   - Responses from Round 2: Agree 30% Disagree 40% Neutral 30%
ISSUE 8: Which methods should the health educator utilize when attempting to affect the behavior of student or client?

Note from Researchers: A number of experts have suggested a combination of 01 and 03. This combination is new 06. 03 should be interpreted as unknown to students or clients.

Alternative Positions:

The health educator's role relative to affecting behavior in his/her student or clients should include

1. attempts to persuade them to alter their behavior if they express a willingness to do so

   Responses from Round 2: Agree 42% Disagree 58% Nonresponse 0% Support 60%

2. "Fear arousing" methods if appropriate

   Responses from Round 2: Agree 52% Disagree 40% Nonresponse 8% Support 28%

3. behavior modification techniques which could be effectively utilized on students or clients who are unaware of the

   Responses from Round 2: Agree 62% Disagree 38% Nonresponse 0% Support 16%

4. coercion if risk factors are immediately life threatening to the individual

   Responses from Round 2: Agree 26% Disagree 64% Nonresponse 0% Support 12%

5. providing alternatives and behavior modification techniques when students/clients request assistance

   Responses from Round 2: Agree 88% Disagree 12% Nonresponse 0% Support 56%

6. attempts to persuade them to alter their behavior by providing alternatives and behavior modification techniques

   Responses from Round 2: Agree 88% Disagree 12% Nonresponse 0% Support 56%

Comments for Round 2:

Other Comments from Round 2:

Behavior modification consists of "rewards" and "punishments". I disagree with the punishment component of behavior modification.

*trouble with 03 in that 05 can provide alternatives even without a request.

O1-"you wouldn't have to persuade if they were willing."

O3-"if they......so".

O4-To do so, by providing alternatives and behavior modification techniques.

O5-There is nothing to answer. The word "appropriate" implies there is such a time.

O5-Delete "whenever students....assistance".

YOUR ROUND 2 RESPONSES

<table>
<thead>
<tr>
<th>AGREE</th>
<th>DISAGREE</th>
<th>SUPPORT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
ISSUE C: To what extent should the health educator be held accountable for behavioral change in students or clients?

Note from Researchers: #2 "health compromising behaviors" replaces "poor behaviors". #3 "to a degree" has been added.

Other Comments from Round 2:
The health educator can be held accountable for the effort but not the outcome.
You can never account for the amount the health educator is accountable.
# add "...dependent upon the person, the organized setting and the role requirements..."
#5 true enough, but not related to #1-4.
#5—the ending should be changed to "...health education programs are determined by program objectives".
You are asking for absolutes where absolutes are not possible.

Alternative Positions:
The health educators should be held accountable for behavioral change in students or clients to the extent that

1. health educators can present information coupled with methodology that may lead to behavioral change, beyond that they are not accountable

Responses from Round 2: Agree 64% Disagree 28% Nonresponse 8% Support 4%

2. health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued health compromising behaviors of students or clients

Responses from Round 2: Agree 95% Disagree 4% Nonresponse 0% Support 4%

3. behavioral change is the ultimate goal and reflects the competency of the health educator

Responses from Round 2: Agree 72% Disagree 22% Nonresponse 0% Support 6%

4. the behavioral change is dependent upon organizational setting and the role requirements for the professional

Responses from Round 2: Agree 68% Disagree 24% Nonresponse 0% Support 8%

5. the objectives for conducting and evaluating the health education programs had been previously articulated and adopted

Responses from Round 2: Agree 60% Disagree 32% Nonresponse 8% Support 3%

Comments for Round 3 (final comments):
ISSUE 5: At which age should education concerning the transmission and prevention of AIDS be first introduced as a planned part of the curriculum?

Note from Researcher: The presentation of this issue does not advance AIDS education as a categorical "crisis" topic, but rather asks when in a health education curriculum it should first be included. The issue has been reworded to reflect this. The last seven words in the issue have been included for this purpose.

Other Comments from Round 1:
A new Washington State law (enacted since Round 1) requires AIDS education beginning in grade 5.
I have reservations about introducing the topic of AIDS at levels of 1 and 2. However, realistically, we must recognize that AIDS will increasingly be a topic of conversation which we cannot ignore.
It seems to me that, unlike some other diseases, AIDS and other STDs are issues deeply embedded in and inseparable from sexuality. Hence, the question is really at what age should sexuality education be introduced in what form, depth and scope?
I agree with comments from Round 1, that this isn't an important issue related to "moving the profession forward". Transmission and prevention of AIDS could be introduced and discussed in a community health unit early, but sex and AIDS should be later. Ages—probably too late.
Environmental factors are related to this question—age could vary.

Alternative Positions:
The transmission and prevention of AIDS should first be introduced in health education classes as a planned part of the curriculum

1. Ages 6-7

Responses from Round 2: Agree 44% Disagree 44% Nonresponse 12% Support 2%

2. Ages 8-9

Responses from Round 2: Agree 44% Disagree 24% Nonresponse 12% Support 2%

3. Ages 10-11

Responses from Round 2: Agree 44% Disagree 12% Nonresponse 12% Support 36%

4. Ages 12-13

Responses from Round 2: Agree 12% Disagree 4% Nonresponse 4% Support 84%

5. Ages 14-15

Responses from Round 2: Agree 9% Disagree 91% Nonresponse 2% Support 1%

Comments for Round 3 (final comments):
ISSUE 1: What should be the major emphasis of AIDS education for grades four through six?

**Note from Reprinter:** This issue does not advance AIDS education as a categorical "crisis" curriculum, but addresses the major focus of content which should be emphasized. 07 is a new alternative.

**Other Comments from Round 2:**
I agree that it isn’t an important issue related to "moving the profession forward".
None of the alternatives can answer the question for all populations.
All known means of reducing one’s risk of transmitting, or contracting, the infection.
AIDS within the curriculum is appropriate at all levels. 47t, the content and outcomes are very different.
Depends on the population represented, the culture and the attitude of community.
01 and 03-I would emphasize abstinence as desirable but, if unrealistic in the view of some children, treat barrier protection as an acceptable and safe alternative.
We 16, I believe, totally inappropriate for grades 4-6.
This issue should be removed.

**Alternative Positions:**

<table>
<thead>
<tr>
<th>Alternative Position</th>
<th>Round 2 Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Agree</td>
</tr>
<tr>
<td>The major emphasis of AIDS education should be</td>
<td></td>
</tr>
<tr>
<td>1. Based primarily on the importance of chastity and abstinence with some information on barrier protection</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 44% Disagree 56% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>2. Limited to the importance of chastity and abstinence</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 17% Disagree 83% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>3. Based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 44% Disagree 56% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>4. Limited to the importance of barrier protection</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 42% Disagree 58% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>5. Based on the biomedical aspects of the syndrome and related diseases</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 42% Disagree 58% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>6. Addressed toward a community health infectious disease point of view</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 34% Disagree 66% Neutral 0% Support 0%</td>
<td></td>
</tr>
<tr>
<td>7. Directed toward the transmission of the disease by contaminated needles</td>
<td></td>
</tr>
</tbody>
</table>

**Comments for Round 2:**
**ISSUE F:** What form of credentialing would best serve the profession of health education?  
A health educator is an individual prepared to assist individuals acting separately or collectively, to make informed decisions regarding matters affecting their personal health and that of others.

---

**Note from Researcher:** The intent of this issue is to identify the best basis for credentialing individuals.

---

**Other Comments from Round 2:**  
I checked both #2 and #4 because I believe that any credentialing should take into consideration the person's level of competence, i.e., a health educator may be fully qualified to do a good job but may not be able to do a job that requires a master-level preparation. Hence, I would advocate differential levels of credentialing. Also, one may be fully qualified as a school health educator but not as a community or a patient health educator, and vice versa. Hence, credentialing needs to also take into account the variety of preparation for a variety of sub-specialties in health education.

Each state can best assess its needs.  
You are using the word "credentialing" incorrectly.

### Alternative Positions:

<table>
<thead>
<tr>
<th>The health education profession would be best served if credentialing were based on:</th>
<th><strong>YOUR ROUND 2 RESPONSES</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a minimum of a baccalaureate degree with a major in health education</td>
<td></td>
<td><strong>AGREE</strong> <strong>DISAGREE</strong> <strong>SUPPORT</strong></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 44% Disagree 52% Nonresponse 4% Support 1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Definition Project</td>
<td></td>
<td><strong>AGREE</strong> <strong>DISAGREE</strong> <strong>SUPPORT</strong></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 88% Disagree 12% Nonresponse 0% Support 5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. successful completion of a state competency examination leading to licensure, e.g., nursing</td>
<td></td>
<td><strong>AGREE</strong> <strong>DISAGREE</strong> <strong>SUPPORT</strong></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 44% Disagree 56% Nonresponse 0% Support 17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes Group</td>
<td></td>
<td><strong>AGREE</strong> <strong>DISAGREE</strong> <strong>SUPPORT</strong></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 52% Disagree 42% Nonresponse 6% Support 16%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. no one standard form</td>
<td></td>
<td><strong>AGREE</strong> <strong>DISAGREE</strong> <strong>SUPPORT</strong></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 20% Disagree 72% Nonresponse 8% Support 12%</td>
<td></td>
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</tr>
</tbody>
</table>

**Comments for Round 2 (final comments):**
ISSUE 8: In which of the areas of health education should research be primarily focused?

Note from Researchers: The purpose of this issue is to identify the most critical research need in health education. You should select only one alternative to "Support."

Other Comments from Round 1:
02: The great majority of health educators believe the doctoral level lacks training, knowledge, and skills to carry out any meaningful research on factors that contribute to behavioral change. When they do such research, it is usually unacceptable and often excluding. I disagree with 06 in these cases specifically for the same reason.
03: Too broad to respond.
04: Evaluation is really the basis of research and not definitive format.
07 and 11: Evaluation and theory are obviously important but in health education research, but if we say they should receive primary emphasis it is really incomplete and too narrow a focus. If we say that evaluation to the point of emphasis, we are then in danger of measuring and evaluating without a sense of purpose or direction. On the other hand, if we place the emphasis on theories we are giving all our attention to direction without the implementation and action.
08: Related also to research-testing analysis.

In response to other comments from Round 1 relative to whether the alternatives were topics for pure research and wrote, "What is pure research anyway? It is everything else secure?"

Alternative Positions:

<table>
<thead>
<tr>
<th>Research in health education should be focused primarily on</th>
<th>YOUR ROUND 2 RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Identification of critical factors in the implementation and maintenance of health education programs</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 89% Disagree 11% Nonresponse 0% Support 68%</td>
<td></td>
</tr>
<tr>
<td>2. Understanding the factors that contribute to behavioral change</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 97% Disagree 3% Nonresponse 0% Support 96%</td>
<td></td>
</tr>
<tr>
<td>3. The formulation of effective rationales as to what various health education programs could be evaluated and compared</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 97% Disagree 3% Nonresponse 0% Support 99%</td>
<td></td>
</tr>
<tr>
<td>4. Determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 86% Disagree 14% Nonresponse 0% Support 86%</td>
<td></td>
</tr>
<tr>
<td>5. Evaluation</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 86% Disagree 14% Nonresponse 0% Support 86%</td>
<td></td>
</tr>
<tr>
<td>6. Theories of health education</td>
<td>AGREE DISAGREE SUPPORT</td>
</tr>
<tr>
<td>Responses from Round 7: Agree 80% Disagree 20% Nonresponse 0% Support 83%</td>
<td></td>
</tr>
</tbody>
</table>

Comments for Round 2:

228
ISSUE 4: Which professional organizational configuration would be most beneficial of health education?

Note from Researchers: The lines for alternative 03 were inadvertently omitted from Round 2, thus invalidating that alternative and the two subsequent alternatives. Percentages from Round 2 are therefore not reported for 03, 04, and 05.

Other Comments from Round 2:
01—The concept of multi-organization can be incorporated into a large organization—a single alliance concept analogous to ANHE, except for public health-related sections. Over-specialization poses several problems, isolation. To a base of and interorganizational relationships-thinking, etc.
02—Although ANHE has been given considerable autonomy now, there are still problems.
02 and 03 are still two separable items.
03—Too specific.
04—Total waste of money—social groups.
05—Ridiculous; waste of time, personal energies, money, and efforts which should be spent in classrooms.
The issue should include a specific time frame; right now versus further down the road.
Should the issue be worded: what professional organization configuration...?

<table>
<thead>
<tr>
<th>Alternative Positions</th>
<th>YOUR ROUND 3 RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>The health education profession would best be served by</td>
<td></td>
</tr>
<tr>
<td>1. the continuation of the present multi-organizational system which offers many options</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 40% Disagree 5% Nonresponse 4% Support 2%</td>
<td></td>
</tr>
<tr>
<td>2. greater autonomy of ANHE within ANHE</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 7% Disagree 12% Nonresponse 12% Support 32%</td>
<td></td>
</tr>
<tr>
<td>3. a consolidation of ANHE and SFHE</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 1% Disagree 1% Nonresponse 1% Support 1%</td>
<td></td>
</tr>
<tr>
<td>4. a reorganization of the Coalition of National Health Education Organizatons to allow for individual memberships</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 1% Disagree 1% Nonresponse 1% Support 1%</td>
<td></td>
</tr>
<tr>
<td>5. creation of a new coalition organization</td>
<td></td>
</tr>
<tr>
<td>Responses from Round 2: Agree 1% Disagree 1% Nonresponse 1% Support 1%</td>
<td></td>
</tr>
</tbody>
</table>

Comments for Round 3 (final comments):
**RANKING OF ISSUES ACCORDING TO IMPORTANCE**

Below are the issues with summary statistics from Round 2. Consider these rankings relative to your ranking from Round 1 before marking in the Round 3 column.

Rank the issues by importance with the most important ranked number one (1) and least important ranked number fifteen (15). Be sure to include newly proposed issues 1 through 0 in your deliberations.

In your opinion if one of the listed issues is NOT a major issue, place a zero (0) in the space provided. Each issue should have either a number or a zero beside it. All lines should be marked.

**PROPOSED ISSUES**

1. Note from Researchers: The "importance" of an issue is defined as the need for further study and resolution.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Question</th>
<th>Mean</th>
<th>Median</th>
<th>Round 2</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>What should be the primary goal of the health educator?</td>
<td>2.5</td>
<td>2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Which methods should the health educator utilize when attempting to affect the behavior of student or client?</td>
<td>4.4</td>
<td>4.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>6.4</td>
<td>6.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>At which age should education concerning the transmission and prevention of AIDS first be introduced?</td>
<td>10.0</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>What should be the major emphasis of AIDS education for grades four through six?</td>
<td>9.4</td>
<td>10.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>What form of credentialing would best serve the profession of health education?</td>
<td>4.4</td>
<td>3.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>In which of the areas of health education should research be primarily focused?</td>
<td>5.2</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Which professional organizational configuration would be most beneficial for health education?</td>
<td>6.0</td>
<td>5.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO NOT OVERLOOK ISSUES 1 - 0 ON THE NEXT PAGE.
Proposed Issues generated from Round 1 AND 2:

Note from Researchers: As you know, one purpose of this study is to compile alternative positions for each issue. If you rank any of the seven panel generated issues, please include suggestions for viable alternatives. Issues 1 and 0 were previously one issue. The ranking from Round 1 is listed for 1. Issue J has been reworded to ask the question "how should?" Issues L and M were previously one issue. The ranking from Round 2 is listed for L. M is a new issue.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Question</th>
<th>Mean</th>
<th>Median</th>
<th>Your Round 2</th>
<th>Your Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>What criteria should be used to measure the relative success of health education programs.</td>
<td>6.6</td>
<td>6.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J</td>
<td>How should the profession of health education change to meet the needs of the future.</td>
<td>8.5</td>
<td>9.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K</td>
<td>Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to M.D.'s, nurses, dietitians etc.?</td>
<td>8.4</td>
<td>11.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>L</td>
<td>What standards should be used to evaluate professional preparation programs?</td>
<td>6.7</td>
<td>7.0</td>
<td></td>
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</tr>
<tr>
<td>M</td>
<td>What standards should be used to evaluate the competencies of professional health educators?</td>
<td></td>
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</tr>
<tr>
<td>N</td>
<td>What form of credentialing would best serve the consumer/public?</td>
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</tr>
<tr>
<td>O</td>
<td>How much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can't be.</td>
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</tr>
</tbody>
</table>

Comments from Round 3 (final comments):

I want to thank you again for your participation in this study. The results of Round 3 will be sent to you in the near future. Please turn the page for a few questions concerning the study in general.
I would appreciate your comments on the following questions:

1. How long did it take to complete Round 3? ______________
   Can you estimate the time it took to complete Round 1? ___________  Round 2? ___________

2. Did you find it difficult to rank the issues according to importance as previously defined? If so, what changes would you suggest?
An Overview of the Proposed Study

For the purpose of this study, an issue is a point of debate which has at least two sides or alternative positions from which to choose. Alternative positions are various options or choices, any of which could resolve the issue in question. Health education literature has often explored issues concerning goals, methodology, content, professional preparation, and research which pertain to the profession. The purpose of this study is to investigate issues in health education by: (1) identifying the major issue in rank order according to importance, (2) compiling accepted alternative positions for possible resolution of the issues, and (3) determining the degree of support for each alternative position.

A modified Delphi with a minimum of three rounds will be employed. The instrument, designed specifically for this study, is an example of both an ordered and unordered partially close-ended questionnaire. The instrument, developed from a literature search, identifies both the issues and the alternative positions which could lead to resolution of each issue. Subjects are encouraged to modify the instrument during each phase of the study.

The subjects for this study are individuals who have been recognized by the Association for the Advancement of Health Education as either an elected officer, recipient of the Professional Service Award and/or selected as a Scholar. The entire population includes 41 individuals.

Both the mean and the median will be calculated to determine the rank order of the issues. Percentages will be utilized to determine both the extent of acceptance of alternative positions and the degree of support for each.
FINAL RESULTS
What should be the primary goal of the health educator?

Other Comments from Round 1:

Primary goal implies only one. I would "weight" these quite differently, one from another.

I disagree with "other comments" relative to A, B, C, D, E agree to facilitating. A is more prescriptive. B and C speak to the same coin. A is the most comprehensive and speaks to all elements needed which could affect behavior. It would be easy to support B also but as restricted to only one choice.

B is too complex.

A and C are somewhat more of the same.

A is a synthesis of 1, 7, 6, 7--just another way to say what has been said earlier. Same is true for B.

Alternative Formulations:
The primary goal of the health educator should be:

1. To facilitate the acquisition of facts concerning health behaviors and wellness.
   - Final Responses: Agree 100% Disagree 0% Nonresponse 0% Support 27%

2. To facilitate the acquisition of values concerning health behaviors and wellness.
   - Final Responses: Agree 95% Disagree 5% Nonresponse 0% Support 32%

3. To facilitate problem solving and decision making skills as applied to health-promoting behaviors.
   - Final Responses: Agree 100% Disagree 0% Nonresponse 0% Support 82%

4. To facilitate the changing of health compromising behaviors to health-promoting behaviors.
   - Final Responses: Agree 71% Disagree 5% Nonresponse 3% Support 36%

5. To change health compromising behaviors to health-promoting behaviors.
   - Final Responses: Agree 41% Disagree 59% Nonresponse 5% Support 9%

6. To reinforce health-promoting behaviors.
   - Final Responses: Agree 100% Disagree 0% Nonresponse 0% Support 36%

7. To promote health-promoting behaviors.
   - Final Responses: Agree 100% Disagree 0% Nonresponse 0% Support 77%

8. To facilitate the acquisition of concepts, facts, perceptions, and value positions concerning health behaviors and wellness.
   - Final Responses: Agree 91% Disagree 0% Nonresponse 9% Support 36%

9. To facilitate voluntary, informed changes in health related behaviors including actions, practice and skills, as well as cognitive and affective behaviors.
   - Final Responses: Agree 0% Disagree 52% Nonresponse 48% Support 41%
ISSUE B: Which methods should the health educator utilize when attempting to affect the behavior of student or client?

Other Comments from Round 3:
I like the new #6. We do this all the time, learner willing or not.
I'd let #6 substitute for #5; you don't need both.
#3 is antithetical to the health educator's goal of voluntary, informed changes in health related behavior.
#4 also is antithetical to that goal. Moreover, coercion is in no way a form of education.

Alternative Positions:
The health educator's role relative to affecting behavior in his/her student or clients should include

1. attempts to persuade them to alter their behavior if they express a willingness to do so.
   Final Responses: Agree 100% Disagree 0% Nonresponse 0% Support 68%

2. " fear arousing" methods if appropriate.
   Final Responses: Agree 59% Disagree 41% Nonresponse 0% Support 18%

3. behavior modification techniques which could be effectively utilized on students or clients who are unaware of them.
   Final Responses: Agree 14% Disagree 86% Nonresponses 0% Support 14%

4. coercion if risk factors are immediately life threatening to the individual.
   Final Responses: Agree 18% Disagree 77% Nonresponse 5% Support 7%

5. providing alternatives and behavior modification techniques when students/clients request assistance.
   Final Responses: Agree 95% Disagree 5% Nonresponse 0% Support 59%

6. attempts to persuade them to alter their behavior by providing alternatives and behavior modification techniques.
   Final Responses: Agree 73% Disagree 18% Nonresponses 9% Support 52%

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ISSUE C: To what extent should the health educator be held accountable for behavioral change in students or clients?

Other Comments from Round 3:

1. Two additional underline words: health educators can present accurate information coupled with appropriate methodology that may lead to behavioral change, beyond that they are not accountable.

5. If one of the objectives is behavioral change, then the health educator will be held accountable. One would have to be dumb to articulate such an objective, due to many other factors. He/she would soon be out of business if a job was based on successful achievement. Behavior change comes much later, at the conclusion of a program in most cases.

11 I believe they [are accountable] for how they present information; for their behavior in response to students, clients, etc., after presenting the information.

You are asking for absolutes where absolutes are not possible.

Alternative Positions:

The health educators should be held accountable for behavioral change in students or clients to the extent that

1. health educators can present information coupled with methodology that may lead to behavioral change, beyond that they are not accountable.
   Final Responses: Agree 82% Disagree 18% Nonresponse 0% Support 45%

2. health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued health compromising behaviors of students or clients.
   Final Responses: Agree 91% Disagree 9% Nonresponse 0% Support 59%

3. behavioral change is the ultimate goal and to a degree reflects the competency of the health educator.
   Final Responses: Agree 50% Disagree 50% Nonresponse 0% Support 18%

4. the behavioral change is dependent upon organizational setting and the role requirements for the professional.
   Final Responses: Agree 64% Disagree 36% Nonresponse 0% Support 23%

5. the objectives for conducting and evaluating the health education programs had been previously articulated and adopted.
   Final Responses: Agree 77% Disagree 23% Nonresponse 0% Support 36%
ISSUE D: At which age should education concerning the transmission and prevention of AIDS be first introduced as a planned part of the curriculum?

Other Comments from Round 7:
Too late. Should be part of a comprehensive program K-12.
I agree that this isn't an important issue related to "moving the profession forward."
I've checked both #3 and #4; thus covering the possibility of "first" introduced in health education classes somewhere between 10 and 13 years of age. Age 12 is probably ideal.
So much depends upon how and in what context and by whom the subject is introduced... If handled appropriately, the subject can be introduced as early as 6-7. Depends on local community.
#3 since "planned part of the curriculum" has been added. I think most children that age are able to comprehend the basics of the transmission of communicable diseases. However, I'd introduce it as an unplanned part of the curriculum at 6-7 if any child in the school has AIDS, ARC, or a positive reaction to the HIV antibody test and that information is "out and about."

Alternative Positions:

The transmission and prevention of AIDS should be first introduced in health education classes as a planned part of the curriculum.

1. ages 6 - 7.
   Final Responses: Agree 41% Disagree 50% Nonresponse 9% Support 36%

2. ages 8 - 9.
   Final Responses: Agree 45% Disagree 36% Nonresponse 18% Support 18%

3. ages 10 - 11.
   Final Responses: Agree 77% Disagree 9% Nonresponse 12% Support 50%

   Final Responses: Agree 36% Disagree 45% Nonresponse 18% Support 18%

5. ages 14 - 15.
   Final Responses: Agree 18% Disagree 64% Nonresponse 18% Support 14%
ISSUE E: What should be the major emphasis of AIDS education for grades four through six?

Other Comments from Round 3:

#7. As #1-#4, it is very limited in scope. I think #5 is important but not broad enough. #6 probably incorporates the biomedical and behavioral emphasis needed.
I don't think this is an important issue and should be removed.
#1 and #3 could be considered pretty much alike, for all practical classroom purposes.
I support #7 but there is more to the AIDS topic than this... so it should be a part of
the whole AIDS presentation.
I believe the major emphasis of AIDS education for students grades 4-6 should be all known
means of reducing one's risk of transmitting, or contracting the infection.

Alternative Positions:

The major emphasis of AIDS education should be

1. based primarily on the importance of chastity and abstinence with some information on
   barrier protection.
   Final Responses: Agree 36% Disagree 59% Nonresponse 5% Support 5%

2. limited to the importance of chastity and abstinence.
   Final Responses: Agree 14% Disagree 82% Nonresponse 5% Support 9%

3. based primarily on the importance of barrier protection with some discussion
   concerning chastity and abstinence.
   Final Responses: Agree 52% Disagree 44% Nonresponse 5% Support 18%

4. limited to the importance of barrier protection.
   Final Responses: Agree 0% Disagree 95% Nonresponse 5% Support 5%

5. based on the biomedical aspects of the syndrome and related diseases.
   Final Responses: Agree 91% Disagree 5% Nonresponse 5% Support 55%

6. addressed toward a community health infectious disease point of view.
   Final Responses: Agree 77% Disagree 18% Nonresponse 5% Support 50%

7. directed toward the transmission of the disease by contaminated needles.
   Final Responses: Agree 50% Disagree 45% Nonresponse 5% Support 14%
ISSUE F: What form of credentialing would best serve the profession of health education?

A health educator is an individual prepared to assist individuals acting separately or collectively, to make informed decisions regarding matters affecting their personal health and that of others.

Other Comments from Round 3:

#1 as one criterion.
School health educators are already credentialed in a way.

#2 I would delete reference to Role Delineation Project. #3 I support this examination idea, but chiefly for credentialing—not obtaining a license to practice. A person would have the valuable credential of the association concerned with health education. The potential employer, knowing this, would give them top consideration.

#5 I believe we can agree on some general competencies necessary to practice health education. This will also allow programs and individuals to develop unique strengths.

Alternative Positions:

The health education profession would be best served if credentialing was based on:

1. a minimum of a baccalaureate degree with a major in health education.
   Final Responses: Agree 95% Disagree 5% Nonresponse 0% Support 27%

2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project.
   Final Responses: Agree 86% Disagree 9% Nonresponse 5% Support 64%

3. successful completion of a state competency examination leading to licensure, e.g., nursing.
   Final Responses: Agree 45% Disagree 50% Nonresponse 5% Support 14%

4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes group.
   Final Responses: Agree 32% Disagree 64% Nonresponse 5% Support 5%

5. no one standard form.
   Final Responses: Agree 23% Disagree 73% Nonresponse 5% Support 5%
ISSUE B: In which of the areas of health education should research be primarily focused?

Other Comments from Round 1:
#1 add "and evaluation"...identification of critical factors in the implementation, maintenance and evaluation of health education programs.
#2 Guess this would include Health Belief model and PRECEDE.
#3 Often our greatest weakness, if we were truly held accountable for dollars expended, we would often be hard pressed to justify.
#4 I define research as re-search. Looking for answers. If people's unhealthy behaviors are the focus, then #2 is all important.
#5 I really know no one who would suggest H.E. research should focus "primarily" on any of these. Emphasis is really incomplete and too narrow a focus. If we say that evaluation is the point of emphasis, we are then in danger of measuring and evaluating without a sense of purpose or direction. On the other hand, if we place the emphasis on theories we are giving all our attention to direction without implementation and action.
#6 I disagree only because your lead in sentence refers to "focused primarily."
I can't support any of the alternatives, because I believe there is no one most critical research needed in health education. I believe there are several equally critical research needs.

Alternative Positions:
Research in health education should be focused primarily on

1. identification of critical factors in the implementation and maintenance of health education programs.
   Final Responses: Agree 91% Disagree 5% Nonresponse 5% Support 41%

2. understanding the factors that contribute to behavioral change.
   Final Responses: Agree 91% Disagree 5% Nonresponse 5% Support 41%

3. the formulation of cost-effective ratios so that various health education programs could be evaluated and compared.
   Final Responses: Agree 41% Disagree 41% Nonresponse 18% Support 9%

4. determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups.
   Final Responses: Agree 91% Disagree 9% Nonresponse 0% Support 36%

5. evaluation.
   Final Responses: Agree 64% Disagree 32% Nonresponse 5% Support 5%

6. theories of health education.
   Final Responses: Agree 41% Disagree 45% Nonresponse 14% Support 9%
ISSUE II: Which professional organizational configuration would be most beneficial for health education?

Other Comments from Round 7:
Alliance has served well—we should build on what we have.
My view is a capstone would be National Alliance of Health Education Organizations--most elements of Coalition with addition of Eta Sigma Gamma. This would allow us to speak with a single voice upon occasions and yet maintain identity.

AAHE

/ / / /

/ / / /

SOPHE

ASHA

I support #2 for now because I believe it is the best (most beneficial), specific next step in the continuing evolution of our professional organizations. Further, I would want to have to leave AAHPERD in order to consolidate with SOPHE if, in fact, such a consolidation should turn out to be mutually desirable and beneficial. So, if that consolidation ever is to take place without the exit of AAHE from AAHPERD, then AAHE would have to have greater autonomy (permanently) than we now have within AAHPERD.

#3 is a little too specific.
#5 is not needed unless SOPHE/AAHE all fold into that organization.
#3, 4, 5 are well documented in your statements above. We need few new groups but more implementation by the present organizations off stage and with students.

#4 is my support choice because we need a strong single headquarter organization for the Administration of the certification process already referred to in your study.

Alternative Positions:
The health education profession would best be served by

1. the continuation of the present multi-organizational system which offers many options.

   Final Responses: Agree 41% Disagree 55% Nonresponse 3% Support 18%

2. greater autonomy of AAHE within AAHPERD.

   Final Responses: Agree 91% Disagree 9% Nonresponse 0% Support 95%

3. a consolidation of AAHE and SOPHE.

   Final Responses: Agree 60% Disagree 27% Nonresponse 5% Support 22%

4. a reorganization of the Coalition of National Health Education Organizations to allow for individual memberships.

   Final Responses: Agree 14% Disagree 77% Nonresponse 9% Support 9%

5. creation of a new capstone organization.

   Final Responses: Agree 27% Disagree 44% Nonresponse 9% Support 18%
RANKING OF ISSUES ACCORDING TO IMPORTANCE

Below are issues concerning health education which have been identified by a literature search. Rank the issues by importance with the most important ranked number one (1) and the least important number ten (10).

In your opinion if one of the listed issues is NOT a major issue place a zero (0) in the space provided.

If you believe an important issue has been omitted, please include it in the space below so that it can be considered for Round Two. DO NOT RANK this proposed issue at this time.

PROPOSED ISSUES

<table>
<thead>
<tr>
<th>Issue</th>
<th>Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue A: To what extent should behavioral change be the primary goal of the health educator?</td>
<td></td>
</tr>
<tr>
<td>Issue B: Which methods should the health educator utilize when attempting to change the behavior of student or client?</td>
<td></td>
</tr>
<tr>
<td>Issue C: To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td></td>
</tr>
<tr>
<td>Issue D: At which age should education concerning the transmission and prevention of AIDS be introduced?</td>
<td></td>
</tr>
<tr>
<td>Issue E: What should be the focus of AIDS education for grades four through six?</td>
<td></td>
</tr>
<tr>
<td>Issue F: Which commonalities should exist in the professional preparation of health educators?</td>
<td></td>
</tr>
<tr>
<td>Issue G: In which of the areas of health education should research be primarily focused?</td>
<td></td>
</tr>
<tr>
<td>Issue H: To what extent does the health education profession need a single organization to represent health educators?</td>
<td></td>
</tr>
</tbody>
</table>
DEMOGRAPHIC INFORMATION

The purpose of this portion of the instrument is to provide the researcher with basic information which will allow for an accurate description of the results of the study. The researcher will immediately, upon receipt of the questionnaire, separate the demographic data from the packet. This information will be held in total confidence and never reported with any specific individual, position, or location at any time.

Code Number: __________________

Address: Please edit any errors that exist in the mailing label below.

Phone Number: (area code and telephone number)

(____)______-______Home

(____)______-______Office

Gender: Male ()
Female ()

Greatest Percent of Responsibility:

Educator
Elementary/Secondary Level
College
Worksite/Business
Retired

Administrator
Community/Professional Assoc.

Other: ______________________
RANKING OF ISSUES ACCORDING TO IMPORTANCE

Note from Researchers: The "importance" of an issue is defined as the need for further study and resolution. Issues were ranked from the most important (1) to the least important (15).

<table>
<thead>
<tr>
<th>Issue</th>
<th>Importance Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue A: What should be the primary goal of the health educator?</td>
<td>2.9</td>
</tr>
<tr>
<td>Issue B: Which methods should the health educator utilize when attempting to affect the behavior of student or client?</td>
<td>4.9</td>
</tr>
<tr>
<td>Issue C: In what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>7.2</td>
</tr>
<tr>
<td>Issue D: At which age should education concerning the transmission and prevention of AIDS first be introduced?</td>
<td>12.9</td>
</tr>
<tr>
<td>Issue E: What should be the major emphasis of AIDS education for grades four through six?</td>
<td>12.3</td>
</tr>
<tr>
<td>Issue F: What form of credentialing would best serve the profession of health education?</td>
<td>5.3</td>
</tr>
<tr>
<td>Issue G: In which of the areas of health education should research be primarily focused?</td>
<td>6.0</td>
</tr>
<tr>
<td>Issue H: Which professional organizational configuration would be most beneficial for health education?</td>
<td>8.1</td>
</tr>
</tbody>
</table>

Proposed Issues generated by Panel of Experts:

<table>
<thead>
<tr>
<th>Issue</th>
<th>Importance Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue I: &quot;What criteria should be used to measure the relative success of health education programs?&quot;</td>
<td>7.0</td>
</tr>
<tr>
<td>Issue J: &quot;How should the profession of health education change to meet the needs of the future?&quot;</td>
<td>6.3</td>
</tr>
<tr>
<td>Issue K: &quot;Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to M.D.'s, nurses, dietitians, etc.?&quot;</td>
<td>11.7</td>
</tr>
<tr>
<td>Issue L: &quot;What standards should be used to evaluate professional preparation programs?&quot;</td>
<td>6.7</td>
</tr>
<tr>
<td>Issue M: &quot;What standards should be used to evaluate the competency of professional health educators?&quot;</td>
<td>8.0</td>
</tr>
<tr>
<td>Issue N: &quot;What form of credentialing would best serve the consumer/public?&quot;</td>
<td>9.6</td>
</tr>
<tr>
<td>Issue O: &quot;How much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can't be.</td>
<td>10.0</td>
</tr>
</tbody>
</table>
### Table 10
Priority Rankings of Important Issues in Health Education

<table>
<thead>
<tr>
<th>Priority Ranking</th>
<th>Issue</th>
<th>n</th>
<th>Mean</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Issue A: What should be the primary goal of the health educator?</td>
<td>19</td>
<td>3.9</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>Issue B: What form of credentialing would best serve the profession of health education?</td>
<td>19</td>
<td>5.3</td>
<td>3.0</td>
</tr>
<tr>
<td>3</td>
<td>Issue C: Which methods should the health educator utilize when attempting to affect the behavior of student or client?</td>
<td>20</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>4</td>
<td>Issue D: In which of the areas of health education should research be primarily focused?</td>
<td>19</td>
<td>4.0</td>
<td>4.0</td>
</tr>
<tr>
<td>5</td>
<td>Issue E: What standards should be used to evaluate professional preparation programs?</td>
<td>19</td>
<td>6.7</td>
<td>7.0</td>
</tr>
<tr>
<td>6</td>
<td>Issue F: What criteria should be used to assess the relative success of health education programs?</td>
<td>19</td>
<td>7.0</td>
<td>7.0</td>
</tr>
<tr>
<td>7</td>
<td>Issue G: What standards should be used to evaluate the competencies of health educators?</td>
<td>19</td>
<td>9.0</td>
<td>7.0</td>
</tr>
<tr>
<td>8</td>
<td>Issue H: To what extent should the health educator be held accountable for behavioral change in students or clients?</td>
<td>20</td>
<td>7.2</td>
<td>7.5</td>
</tr>
<tr>
<td>9.5</td>
<td>Issue I: Which professional organisational configuration would be most beneficial for health education?</td>
<td>19</td>
<td>9.4</td>
<td>9.0</td>
</tr>
<tr>
<td>9.3</td>
<td>Issue J: How should the profession of health education change to meet the needs of the future?</td>
<td>19</td>
<td>9.3</td>
<td>9.0</td>
</tr>
<tr>
<td>11</td>
<td>Issue K: What form of credentialing would best serve the consumer/public?</td>
<td>19</td>
<td>9.0</td>
<td>10.0</td>
</tr>
<tr>
<td>12</td>
<td>Issue L: Can the health education profession develop and enforce minimal standards that would be required to practice health education similar to M.D.'s, nurses, dietitians, etc.?</td>
<td>19</td>
<td>10.0</td>
<td>12.0</td>
</tr>
<tr>
<td>13</td>
<td>Issue M: How much health education should be offered in the public schools assuming that health education should be available every year, but sometimes can't be.</td>
<td>19</td>
<td>10.9</td>
<td>13.0</td>
</tr>
<tr>
<td>14.5</td>
<td>Issue N: What should be the major emphasis of AIDS education for grades four through six?</td>
<td>19</td>
<td>10.3</td>
<td>14.0</td>
</tr>
<tr>
<td>14.5</td>
<td>Issue O: At which age should education concerning the transmission and prevention of AIDS first be introduced?</td>
<td>19</td>
<td>12.9</td>
<td>14.0</td>
</tr>
</tbody>
</table>
Table 4

Issue C

Extent of Agreement, Disagreement and Support for the Accountability for Behavioral Change by the Health Educator.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. health educators can present information coupled with methodology that may lead to behavioral change; beyond that they are not accountable.</td>
<td>89%</td>
<td>18%</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>2. health education is only one of many influences in an individual's life; therefore, the health educator should not be held accountable for continued health compromising behaviors of students or clients.</td>
<td>91%</td>
<td>9%</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>3. behavioral change is the ultimate goal and to a degree reflects the competency of the health educator.</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>4. the behavioral change is dependent upon organizational setting and the role requirements for the professional.</td>
<td>64%</td>
<td>36%</td>
<td>0%</td>
<td>23%</td>
</tr>
<tr>
<td>5. the objectives for conducting and evaluating the health education programs had been previously articulated and adopted.</td>
<td>77%</td>
<td>23%</td>
<td>0%</td>
<td>36%</td>
</tr>
</tbody>
</table>
Table 3

Extent of Agreement, Disagreement and Support for Methods to Affect Behavioral Change.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. attempts to persuade them to alter their behavior if they express a willingness to do so.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>68%</td>
</tr>
<tr>
<td>2. &quot;fear arousing methods if appropriate.</td>
<td>59%</td>
<td>41%</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>3. behavior modification techniques which could be effectively utilized on students or clients who are unaware of them.</td>
<td>14%</td>
<td>86%</td>
<td>0%</td>
<td>14%</td>
</tr>
<tr>
<td>4. coercion if risk factors are immediately life threatening to the individual.</td>
<td>18%</td>
<td>77%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>5. providing alternatives and behavior modification techniques when students/clients request assistance.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>59%</td>
</tr>
<tr>
<td>6. attempts to persuade them to alter their behavior by providing alternatives and behavior modification techniques.</td>
<td>73%</td>
<td>18%</td>
<td>9%</td>
<td>32%</td>
</tr>
<tr>
<td>Alternatives</td>
<td>Agree</td>
<td>Disagree</td>
<td>Non - Response</td>
<td>Support</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
<td>----------------</td>
<td>---------</td>
</tr>
<tr>
<td>1. to facilitate the acquisition of facts concerning health behaviors and wellness.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>2. to facilitate the acquisition of values concerning health behaviors and wellness.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>32%</td>
</tr>
<tr>
<td>3. to facilitate problem solving and decision making skills as applied to health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>82%</td>
</tr>
<tr>
<td>4. to facilitate the changing of health compromising behaviors to health-promoting behaviors.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>36%</td>
</tr>
<tr>
<td>5. to change health compromising behaviors to health-promoting behaviors.</td>
<td>41%</td>
<td>55%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>6. to reinforce health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>36%</td>
</tr>
<tr>
<td>7. to promote health-promoting behaviors.</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>8. to facilitate the acquisition of concepts, facts, perceptions and value positions concerning healthy behaviors and wellness.</td>
<td>91%</td>
<td>0%</td>
<td>9%</td>
<td>36%</td>
</tr>
<tr>
<td>9. to facilitate voluntary, informed changes in health related behaviors including: actions, practices and skills, as well as cognitive and affective behaviors.</td>
<td>86%</td>
<td>5%</td>
<td>9%</td>
<td>41%</td>
</tr>
</tbody>
</table>
Table 1

GROUP AFFILIATION OF PANEL FOR THREE ROUNDS

<table>
<thead>
<tr>
<th>Educator</th>
<th>Professor/Administrator</th>
<th>Administrator</th>
<th>Community</th>
<th>Retired</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Elem/Secondary College</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>Round 1</td>
<td>1 (4%)</td>
<td>9 (32%)</td>
<td>4 (14%)</td>
<td>4 (14%)</td>
<td>2 (7%)</td>
<td>6 (21%)</td>
</tr>
<tr>
<td>Round 2</td>
<td>1 (4%)</td>
<td>8 (32%)</td>
<td>4 (16%)</td>
<td>3 (12%)</td>
<td>2 (8%)</td>
<td>5 (20%)</td>
</tr>
<tr>
<td>Round 3</td>
<td>1 (5%)</td>
<td>6 (27%)</td>
<td>4 (18%)</td>
<td>2 (9%)</td>
<td>2 (9%)</td>
<td>5 (23%)</td>
</tr>
</tbody>
</table>
### Table 5

**Issue D**

Extent of Agreement, Disagreement and Support for the Age that AIDS Education Should be First Introduced as a Planned Part of the Curriculum.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ages 6 - 7</td>
<td>41%</td>
<td>50%</td>
<td>9%</td>
<td>36%</td>
</tr>
<tr>
<td>2. ages 8 - 9</td>
<td>45%</td>
<td>36%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>3. ages 10 - 11</td>
<td>77%</td>
<td>9%</td>
<td>14%</td>
<td>50%</td>
</tr>
<tr>
<td>4. ages 12 - 13</td>
<td>36%</td>
<td>45%</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>5. ages 14 - 15</td>
<td>18%</td>
<td>64%</td>
<td>18%</td>
<td>14%</td>
</tr>
</tbody>
</table>
### Issue E

**Extent of Agreement, Disagreement and Support for the Major Emphasis of AIDS Education for Ages Four through Six.**

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. based primarily on the importance of chastity and abstinence with some information on barrier protection.</td>
<td>36%</td>
<td>59%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>2. limited to the importance of chastity and abstinence.</td>
<td>14%</td>
<td>82%</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>3. based primarily on the importance of barrier protection with some discussion concerning chastity and abstinence.</td>
<td>32%</td>
<td>64%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>4. limited to the importance of barrier protection.</td>
<td>0%</td>
<td>95%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>5. based on the biomedical aspects of the syndrome and related diseases.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>55%</td>
</tr>
<tr>
<td>6. addressed toward a community health infectious disease point of view.</td>
<td>77%</td>
<td>18%</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>7. directed toward the transmission of the disease by contaminated needles.</td>
<td>50%</td>
<td>45%</td>
<td>5%</td>
<td>14%</td>
</tr>
</tbody>
</table>
### Table 7

**Issue F**

Extent of Agreement, Disagreement and Support for the Basis of Credentialing for Health Education.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. a minimum of a baccalaureate degree with a major in health education.</td>
<td>95%</td>
<td>5%</td>
<td>0%</td>
<td>27%</td>
</tr>
<tr>
<td>2. completion of a baccalaureate collegiate program that incorporates specific preparation standards, e.g., the Role Delineation Project.</td>
<td>86%</td>
<td>9%</td>
<td>5%</td>
<td>64%</td>
</tr>
<tr>
<td>3. successful completion of a state competency examination leading to licensure, e.g., nursing.</td>
<td>45%</td>
<td>50%</td>
<td>5%</td>
<td>14%</td>
</tr>
<tr>
<td>4. five year program leading to M.A. degree with liberal arts base, e.g., as suggested by the Holmes Group.</td>
<td>32%</td>
<td>64%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>5. no one standard form.</td>
<td>23%</td>
<td>73%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>
### Table 8

**Issue G**

**Extent of Agreement, Disagreement and Support for the Primary Research Need in Health Education.**

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. identification of critical factors in the implementation and maintenance of health education programs.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>41%</td>
</tr>
<tr>
<td>2. understanding the factors that contribute to behavioral change.</td>
<td>91%</td>
<td>5%</td>
<td>5%</td>
<td>41%</td>
</tr>
<tr>
<td>3. the formulation of cost effective ratios so that various health education programs could be evaluated and compared.</td>
<td>41%</td>
<td>41%</td>
<td>18%</td>
<td>9%</td>
</tr>
<tr>
<td>4. determining the relative effectiveness of strategies designed to facilitate informed voluntary changes in behavior with various types of target groups.</td>
<td>91%</td>
<td>9%</td>
<td>0%</td>
<td>36%</td>
</tr>
<tr>
<td>5. evaluation.</td>
<td>64%</td>
<td>32%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>6. theories of health education.</td>
<td>41%</td>
<td>45%</td>
<td>14%</td>
<td>9%</td>
</tr>
</tbody>
</table>
Table 9

Issue H

Extent of Agreement, Disagreement and Support for the Most Beneficial Organizational Configuration for Health Education.

<table>
<thead>
<tr>
<th>Alternatives</th>
<th>Agree</th>
<th>Disagree</th>
<th>Non-Response</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. the continuation of the present multi-organizational system which offers many options.</td>
<td>41%</td>
<td>55%</td>
<td>5%</td>
<td>18%</td>
</tr>
<tr>
<td>2. greater autonomy of AAHE within AAHPERD.</td>
<td>68%</td>
<td>27%</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>3. a consolidation of AAHE and SOPHE.</td>
<td>68%</td>
<td>27%</td>
<td>5%</td>
<td>23%</td>
</tr>
<tr>
<td>4. a reorganization of the Coalition of national health Education Organization to allow for individual membership.</td>
<td>14%</td>
<td>77%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>5. creation of a new capstone organization.</td>
<td>27%</td>
<td>64%</td>
<td>9%</td>
<td>18%</td>
</tr>
</tbody>
</table>