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Implications of Mandatory National Technology Competencies for Professional Preparation in Health Education

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As technological literacy increasingly becomes necessary to access and communicate health-related information, instructional technology competency standards for educators, including health educators, are needed to ensure compliance with professional development goals and guidelines. This article examines proposed recommendations by the National Council for the Accreditation of Teacher Education, the International Society for Technology in Education, the Association for Educational Communications and Technology, the International Technology Education Association, the National School Board Association, and other recognized educational organizations. The concept of technological competence as related to the National Health Standards Project and current status of health education is explored, with areas in need of further research or development identified.

Physical Activity Among Certified Health Education Specialists

Mary K. Dinger, John Massie, and Lynda Ransdell

This study examined the self-reported physical activity behavior of a randomly selected sample of certified health education specialists (CHESs) in the United States. A cross-sectional descriptive study was conducted. The independent variables were gender, race, exercise physiology course experience, exercise prescription course experience, and education. The dependent variables were total physical activity (TPA) and total physical activity excluding household activities, stair climbing, and lawn work (PA excluding HSL). Stratified random sampling was used to select 1,000 CHESs who received the Aerobics Center Longitudinal Study Physical Activity Questionnaire through the U.S. mail. A total of 540 (54%) surveys were returned. Household activities (91.8%), stair climbing (84.8%), and walking (73.0%) were the most frequently reported physical activities. There were no statistically significant differences in TPA among or between the various groups. Significant differences in PA excluding HSL were found by gender (men > women), exercise physiology course work (course work > no course work), exercise prescription course work (course work > no course work), and education (doctoral > master and/or bachelor). In addition, the majority of CHESs (89%, n = 475) met the surgeon general's recommendation by expending at least 1000 kcal per week in TPA. CHES subjects were very active compared with the average American adult.

On-Line Medical Information and Service Delivery: Implications for Health Education

Jo Ann Oravec

This article provides an overview of on-line medical information and service delivery. It outlines the immediate implications of these advances for health education professionals as well as projects some of their potentials and regulatory repercussions for the future. The article also analyzes the varieties of medical misinformation and rumor that are common on networks, and discusses attempts by health organizations to control them. Many individuals are using the Internet to become more autonomous in their health care activities, but are encountering various hazards. Health educators can be instrumental in empowering individuals to be critical and cautious yet effective in their use of medical applications on the Internet.

Ranking of Doctoral Programs of Health Education

Stephen J. Notaro, Thomas W. O'Rourke, and James M. Eddy

This study ranked doctoral programs of health education based on the productivity of the faculty and the scholarly activity of doctoral students. The methodology, unique to ranking studies, uses a multiple set of variables weighted by scholars and leaders in the field of health education. Variables were articles published, citations received, journal editorships, external funding for research, student activity, student/faculty ratio, mentoring and placement, and student support. An overall ranking is provided as well as the ranking for each of the eight individual variables. Twenty-eight of the 44 doctoral programs of health education participated in this study (a response rate of 64%). Twenty-six programs had at least one variable ranked in the top 10 programs, and all programs had at least two variables ranked in the top 20. Correlation analysis of the eight variables provided additional insights. Interestingly, the four variables related to the faculty were not related to the four student variables. Implications of the ranking for administrators, faculty, students, and the health education profession are provided.

Predictors of Fighting Among Rural Elementary School Students

Eduardo Monge, John Massie, Karl Larson, and Paul Sarvela

Violence in the school setting is receiving increased attention by educators, parents, and the media. It is important for health educators to understand predictors and risk factors of fighting, so appropriate intervention programs can be developed and implemented. Little research has been conducted concerning fighting among rural children. This study identified predictors of fighting among rural elementary school children. In 1997, data were collected concerning several Healthy People 2000 priority health behaviors from 1,187 kindergarten to 6th grade children in southern Illinois. Reliability of the behavior subscale was .63 as estimated by Cronbach's alpha. Data were analyzed using bivariate odds ratios and logistic regression. Survey findings suggested that having been involved in a fight "where someone was punched, hit, kicked, or hurt in some way" was related to a number of risk factors. Unadjusted odds ratios (ORs) showed that using smokeless tobacco (OR = 5.5), smoking (OR = 3.6), drinking alcohol (OR = 3.3), gender (OR =

3.3), and having carried or shot a gun (OR= 3.1) were significantly related to having been involved in a fight. A logistic regression model based on significant bivariate risk factors explained approximately 44% of the variance of having been involved in a fight (Somers' D = 0.443). The logistic regression model suggested that use of smokeless tobacco, gender, and drinking alcohol were the strongest predictors of having been involved in a fight, with adjusted ORs of 3.4, 2.5, and 2.0, respectively. These data help identify children at high risk for being involved in a fight. Health educators and others charged with the development of intervention programs can use these data to develop relevant programs for this target population.