

# Continuing Education Contact Hour Opportunity

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## Assessing the Efficacy of a School Health Education Advocacy Lesson with College Students

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### Abstract

**Purpose:** The researchers evaluated the efficacy of an advocacy lesson to assess change in intentions to advocate for school health education. This study also measured changes in participants' understanding the importance of school health education and perceived effectiveness in applying advocacy skills. **Methods:** A convenience sample of college students participated in an advocacy lesson. Pre and posttests to assess changes in intentions to advocate for school health education and student perceptions of effectiveness of the lesson were completed by 161 students. Summed factor mean scores were compared using paired samples *t*-tests. Multiple linear regression analysis was used to determine the extent to which changes in participants' attitudes, subjective norms, and perceived behavioral control predicted their intentions to advocate for school health education. **Results:** Changes in attitude and subjective norms served as significant predictors of intention to advocate for school health education. Participants perceived the lesson to be effective in building advocacy skills, creating awareness of the impact of school health education, and understanding of quality school health education. **Discussion:** Study implications suggest this advocacy lesson can help students understand the importance of quality health education, increase perceived abilities to effectively advocate, and increase intentions to advocate for school health education.

### Background

Health education advocacy is a critical factor in supporting the practice of health education and promotion of health (Auld & Dixon-Terry, 1999; Birch, 1991; Galer-Unti, 2010; Galer-Unti, Tappe, & Lachenmayer, 2004; Radius,

Galer-Unti & Tappe, 2009). Advocacy has been recognized as a professional responsibility for health educators; therefore, faculty at institutions of higher education should include the teaching of health education advocacy as part of professional preparation (National Commission for Health Education Credentialing, Society for Public Health, & American Association for Health Education, 2010).

Communities have traditionally relied upon health educators and health professionals' advocacy efforts to influence policies and practices, which protect and enhance the environment and human health (Goodhart, 2002). For maximum impact, advocacy efforts must become the responsibility of wide range of community members. To become effective advocates, individuals outside of health education must become aware of advocacy messages and become skilled in advocacy strategies. One example of this is advocacy education for college students. Birch, Wallen, & Chaney (2011) have proposed specific strategies for educating the many students enrolled in college personal health courses about health education advocacy messages and strategies. Personal health courses are typically offered as part of a college or university's general education curriculum and designed to expose students to a broad range of information and issues related to personal health and wellness. During these courses, students are creating conceptual understandings of the value of informed health-related decision-making associated with risk-reduction and avoidance, and strategies to manage health-enhancing behaviors. This can be an opportune time for students to recognize the power of health education in changing and improving lives and help them develop skills needed to advocate for quality school health education, so that students in grades K-12 can receive similar benefits.

Radius, Galer-Unti, and Tappe (2009) found many health education faculty members expressed a lack of professional preparation and a lack of competence to teach undergraduate students health education advocacy strategies. Birch et al. (2011) created an advocacy lesson in an effort to: promote the sharing of advocacy strategies with college students in personal health courses; increase a large number of college students' intentions to advocate for school health education; and increase instructor confidence by providing a step-by-step interactive approach to an advocacy lesson that can be conducted in one 50-minute class.

According to the Theory of Planned Behavior, human behavior is guided by three factors: (a) beliefs about the likely outcome of the behavior and evaluations of these outcomes

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(attitudes), (b) beliefs about the expectations of others and motivation to comply with those perceived expectations (subjective norms), and (c) beliefs about the power to control factors that will affect the behavior (perceptions of behavior control) (Fishbein & Ajzen, 1975). Fishbein and Ajzen (1975) posit that interventions designed to change behavior directed at one or more of the aforementioned factors should produce changes in behavioral intentions and when adequate control over the behavior is provided, the new intentions should be carried out under appropriate circumstances.

The lesson used in this study was designed to change students' attitudes and perceived behavioral control beliefs related to school health education advocacy. The objectives for the lesson stated that as a result of this lesson, students will be able to: identify characteristics of a quality school health education program, summarize the potential impact of quality school health education, identify a variety of strategies for advocating on behalf of school health education, access and utilize available advocacy strategies, and demonstrate the ability to effectively advocate for school health education. A variety of advocacy strategies were presented during the lesson and participants had the opportunity to apply at least one of these strategies when creating and advocacy plan to address scenarios depicting real-life challenges related to school health education. This study measured changes in school health education advocacy intentions as a result of participation in an advocacy lesson and students' perceptions of effectiveness of the lesson.

### **Purpose**

The primary purpose of this study was to: (a) assess changes in intentions to advocate for school health education after exposure to a school health advocacy lesson; (b) assess students' perceptions of the effectiveness of the school health advocacy lesson to increase: advocacy skills, understanding of quality school health education programs, awareness of potential impact of quality school health education, and interest in advocating for school health education.

### **Methods**

#### **Procedures**

In the spring of 2010, a convenience sample of 195 college students enrolled in two sections of a personal health course at a southeastern university participated in a 50-minute advocacy lesson. These students were provided the option to participate in a 53-item pre- and posttest. One hundred sixty-one students completed pre- and posttests evaluating the effectiveness of the lesson and measuring intentions to advocate for school health education. Those students who did not complete the pre- or posttest were excluded from the data analysis. The University's Institutional Review Board granted approval for this study.

### **Participants**

Eighty-two percent of the sample ( $n = 161$ ) completed the pre- and posttests, 37% identified themselves as freshman, 38% sophomores, 17% juniors and 8% seniors. There were substantially more female participants (75%) than male (25%). Fifty-one percent of the participants were intending to major in a health-related profession and 49% of participants were majoring in non-health related disciplines. More than one-half of the sample was white (59%); 17% of the sample identified their race as Black/African American, 14% Asian, and 10% as Other. Twenty-six percent indicated their ethnicity as Hispanic/Latino/Mexican American.

### **Instrument**

The investigators developed an instrument guided by Ajzen and Fishbein's Theory of Planned Behavior and the health advocacy intentions research of McCrary-Quarles, Pettit, Rahman, and Brown (2006) in an effort to assess intention to participate in local advocacy for school health education after exposure to advocacy lesson targeting college students in a personal health course. This instrument utilized attitude toward the behavior, subjective norms associated with the behavior, and perceived behavioral control as the determinants for behavioral intention. The instrument was piloted, revised, and tested for construct validity and reliability. Fit indexes based on Factor 1—attitude toward school health education advocacy, Factor 2—subjective norms associated with school health education advocacy, and Factor 3—perceived behavioral control as part of a confirmatory factor analysis indicated an acceptable fit for parameter estimates and standard error for parameter estimates for a structural model constructed to test students' intentions to engage in advocacy activities. Reliability tests on each factor reported Cronbach's alpha as 0.80 for items measuring attitude toward advocacy, 0.86 for items measuring subjective norms, and 0.86 for perceived behavioral control items. Items measuring intention to conduct specific advocacy activities as a result of the lesson yielded a Cronbach's alpha of 0.83 and items measuring students' perceived effectiveness of the lesson reported a Cronbach's alpha of 0.88. One general item measuring students' intentions to advocate for school health education was also included in the instrument (Chaney, Wallen, & Birch, 2011).

### **Data Analysis**

Data were analyzed using Predictive Analytics SoftWare Statistics version 18.0. Mean scores and standard deviations were calculated for each pretest and posttest item (see Tables 1 and 2). Sum mean scores for each factor were determined for pre- and posttests and used in subsequent analyses. The data were normally distributed; therefore, paired samples *t*-tests were used to compare pretest and posttest sum mean scores for each factor (see Table 3). A multiple linear

Table 1

*Pre- Posttest and Paired Samples t-Test Results for Intention Items (Part 1)*

	Survey Items	Pretest Mean (sd)	Posttest Mean (sd)	t-test (df)	p- value
<i>Attitudes toward advocacy</i>					
Q1	School health education advocacy plays an important role in my life.	3.4 (.897)	4.00 (.923)	-6.850 (155)	*<.001
Q2	School health education advocacy makes a positive difference in the lives of people living in the local community.	3.98 (.657)	4.38 (.667)	-6.055 (155)	*<.001
Q3	Making a positive difference in the lives of the people living in the local community is important to me.	4.32 (.683)	4.39 (.638)	-1.197 (154)	.233
Q4	School health education advocacy makes a positive difference in the lives of students.	4.08 (.662)	4.49 (.647)	-6.171 (155)	*<.001
Q5	Making a difference in the lives of students is important to me.	4.24 (.722)	4.43 (.683)	-3.088 (155)	*.002
Q6	School health education advocacy makes a difference in the lives of the people I serve (or plan to serve in my professional life).	4.01 (.880)	4.23 (.777)	-2.708 (155)	*.008
Q7	Making a difference in the lives of the people I serve (or plan to serve) in my professional life is important to me.	4.51 (.617)	4.53 (.637)	-.232 (155)	.817
Q8	School health education advocacy makes a difference in the lives of the school staff.	3.64 (.736)	4.06 (.756)	-5.477 (155)	*<.001
Q9	Making a difference in the lives of school staff is important to me.	3.71 (.858)	4.06 (.751)	-4.708 (155)	*<.001
<i>Subjective norms</i>					
Q10	Community members' likelihood of encouraging or discouraging your involvement in school health education advocacy.	3.63 (.719)	3.81 (.796)	-2.661 (155)	*.009
Q11	Friends' likelihood of encouraging or discouraging your involvement in school health education advocacy.	4.01 (.736)	4.21 (.736)	-3.572 (155)	*<.001
Q12	School teachers' likelihood of encouraging or discouraging your involvement in school health education advocacy.	3.96 (.829)	4.12 (.693)	-2.112 (154)	*.036
Q13	My school health experience's likelihood of encouraging or discouraging your involvement in school health education advocacy.	4.19 (.746)	4.30 (.799)	-1.437 (155)	.153
Q14	Top-level administrators' likelihood of encouraging or discouraging your involvement in school health education advocacy.	3.55 (.948)	3.70 (.913)	*1.615 (154)	.108
Q15	Family's likelihood of encouraging or discouraging your involvement in school health education advocacy.	4.46 (.695)	4.56 (.614)	-1.636 (155)	.104
Q16	Parents of school kids likelihood of encouraging or discouraging your involvement in school health education advocacy.	3.62 (.918)	3.96 (.837)	-4.195 (155)	*<.001
Q17	Current or future students' likelihood of encouraging or discouraging your involvement in school health education advocacy.	3.63 (.833)	3.92 (.873)	-3.775 (152)	*<.001
Q18	How likely are you to comply with the desires of community members?	3.42 (.882)	3.75 (.909)	-4.887 154	*<.001
Q19	How likely are you to comply with the desires of friends?	4.17 (.763)	4.31 (.687)	-2.282 155	*.024
Q20	How likely are you to comply with the desires of school teachers?	3.92 (.741)	4.10 (.738)	-2.834 (155)	*.005
Q21	How likely are you to comply with desires based on your school health education experiences?	4.01 (.698)	4.18 (.856)	-2.167 (154)	*.032
Q22	How likely are you to comply with the desires of top-level administrators in schools?	3.65 (.871)	3.78 (.992)	-1.644 (155)	.102
Q23	How likely are you to comply with the desires of family?	4.49 (.677)	4.62 (.573)	-2.359 (155)	*.020
Q24	How likely are you to comply with the desires of parents of school kids?	3.48 (.960)	3.78 (.852)	-4.160 (155)	*<.001
Q25	How likely are you to comply with the desires of current or future students?	3.54 (.870)	3.81 (.954)	-3.877 (154)	*<.001

\**p* < .05

Table 2

*Pre- Posttest and Paired Samples t-Test Results for Intention Items (Part 2)*

Survey Items	Pretest Mean (sd)	Posttest Mean (sd)	t-test (df)	p-value
<b>Perceived behavior control</b>				
Q26 How much do available resources support or hinder your involvement in school health education advocacy?	3.86 (.974)	4.01 (1.029)	-1.666 (155)	.098
Q27 How much does the influence of stakeholders support or hinder your involvement in school health education advocacy?	3.16 (.807)	3.53 (1.012)	-4.355 (155)	*<.001
Q28 How much does the knowledge of the advocacy process support or hinder your involvement in school health education advocacy?	3.59 (1.017)	4.05 (.881)	-5.389 (154)	*<.001
Q29 How much does the knowledge of school health education advocacy issues support or hinder your involvement in school health education advocacy?	3.79 (.938)	4.22 (.885)	-5.139 (154)	*<.001
Q30 How much does the level of advocacy training support or hinder your involvement in school health education advocacy?	3.66 (.990)	3.92 (1.003)	-3.012 (154)	*.003
Q31 How much does available time support or hinder your involvement in school health education advocacy?	3.38 (1.312)	3.71 (1.218)	-3.505 (155)	*.001
<b>Intentions to participate in specific school health education advocacy activities</b>				
Q32 How likely are you to attend a local school board meeting to advocate for school health education?	2.16 (1.022)	2.76 (1.280)	-6.601 (154)	*<.001
Q33 How likely are you to use social networking (Facebook, etc) to voice a school health education advocacy issue?	3.29 (1.156)	3.81 (1.140)	-6.411 (154)	*<.001
Q34 How likely are you to write a letter/send an email to the editor regarding a local school health education advocacy issue?	2.46 (1.158)	3.01 (1.279)	-5.926 (154)	*<.001
Q35 How likely are you to meet with a local school board member or administrator regarding school health education?	2.17 (1.080)	2.75 (1.240)	-6.453 (154)	*<.001
Q36 How likely are you to email or text a local school board member or administrator regarding school health education?	2.43 (1.151)	3.01 (1.312)	-6.136 (154)	*<.001
Q37 How would you rate your advocacy skills prior to enrolling in /after completing this course?	2.26 (.730)	3.23 (.681)	-15.583 (153)	*<.001

\* $p < .05$ .

regression analysis was used to determine the extent to which changes in participants' attitudes, subjective norms, and perceived behavioral control predicted their intentions to advocate for school health education. In addition to predicting participants' advocacy intentions, the survey also instructed participants to indicate their perceptions of effectiveness of the advocacy lesson. Participants responded by selecting from the following options: *very ineffective*, *somewhat ineffective*, *undecided*, *effective*, and *very effective*. Data were recoded into new variables by collapsing very ineffective and somewhat ineffective responses into one value, and effective and very effective responses into one value. Undecided responses were excluded from the analysis. A paired samples *t*-test was calculated to compare pre- and posttest intention difference scores with responses to items measuring perceived effectiveness of the advocacy lesson.

### Results

A statistically significant increase was found from pretest to posttest for each factor: Factor 1—attitude toward advocacy for school health ( $t(155) - 5.426, p < .001$ ), Factor

2—subjective norms ( $t(155) - 5.426, p < .001$ ), and Factor 3—perceived behavioral control ( $t(155) - 5.205, p < .001$ ) (see Table 3). The mean scores for items measuring intentions to advocate for school health education were also summed and *t*-tests were used for comparison and a statistically significant increase was found ( $t(154) - 8.146, p < .001$ ) (see Table 3).

Multiple linear regression analysis was calculated to predict participants' intentions to advocate based on pretest and posttest change scores for each factor (attitude toward school health advocacy, subjective norms, and perceived behavioral control). A statistically significant regression equation was found ( $F(3,151) = 18.454, p < .001$ ), with an  $R^2$  of .268. Increases in participants' posttest scores related to subjective norms  $B(-.151), p < .05$  and perceived behavioral control  $B(-.277), p < .05$  served as significant predictors for increases in items measuring intentions to participate in specific school health advocacy strategies. An increase in posttest attitude scores was not found to be a significant predictor of participants' intentions to participate in specific school health advocacy strategies  $B(-.104), p > .05$  (see Table 4).

Table 3

*Pre-Post Differences for Summed Intention Constructs and t-Test Results*

Constructs	Pretest Mean (sd)	Posttest Mean (sd)	t-test (df)	p-value
Attitudes toward advocacy (Summed Q1-Q9)	35.929 (4.11)	38.557 (4.59)	-6.972 (155)	*<.001
Subjective norms (Summed Q10-Q25)	61.660 (7.66)	64.794 (7.85)	-5.426 (155)	*<.001
Perceived behavioral control (Summed Q26-Q31)	21.410 (4.677)	23.423 (4.55)	-5.205 (155)	*<.001
Intentions to participate in specific school health education advocacy activities (Summed Q32-37)	12.509 (4.523)	15.341 (5.407)	-8.146 (154)	*<.001

\* $p < .05$ .

Participants were asked to rate their advocacy skills prior to participation in the advocacy lesson and again following the delivery of the lesson. A paired samples  $t$ -test revealed a significant increase in participants' ratings of their advocacy skills ( $t(153) = 15.583, p < .001$ ). The investigators allowed participants an opportunity to provide feedback on perceived effectiveness of the advocacy lesson. Most participants reported that the advocacy instructional activities were effective or very effective in increasing their understanding of quality school health education programs (96%) and awareness of the impact of school health education on their lives (97%). Ninety-two percent of participants indicated the advocacy lesson was effective in increasing their school health education advocacy skills. This increase in advocacy skills was also found when comparing participant self-assessment of advocacy skills before and after participation in the advocacy lesson. Fifty-nine percent of participants rated their advocacy skill level as poor or fair on the pretest and after completing the advocacy lesson, only 12% of participants continued to report their advocacy skills as poor or fair and 88% of students reported their advocacy skills as good or excellent. In addition to improvements in advocacy skills, posttests also revealed that participants found the advocacy lesson effective in improving their personal understanding

of the importance of quality school health education (85%) and their interest in current school health advocacy issues (92%). Paired samples  $t$ -tests found statistical significance when comparing participants' responses to questions related to the effectiveness of the advocacy lesson with pre- posttest intention difference scores (see Table 5).

## Discussion

This study assessed the effectiveness of a previously developed advocacy lesson in an effort to reach a less utilized audience for school health education advocacy training. It was important to the researchers to evaluate the effectiveness of this lesson by creating a valid instrument, piloting, and testing the lesson. Based on pre- and posttest responses, it was found that intentions to advocate for school health education were significantly increased after participation in the lesson. In addition, perceptions of the relevance of quality school health and rating of personal advocacy skills also increased as a result of participation. Pre/post changes in perceived behavioral control and subjective norms served as significant predictors for intentions to advocate for school health education; however, attitude was not a significant predictor of intentions to participate in advocacy. Two

Table 4

*Regression Analysis to Predict Participants' Intentions to Advocate*

Pretest and posttest change score	B	Std. Error	Significance
Subjective norms	-0.151	.050	*.003
Perceived behavioral control	-0.277	.068	*.000
Attitude	-.0104	.080	.192

Note.  $R^2 = .268$ .\* $p < .05$ .

Table 5

*Intention Change Scores and Perceived Effectiveness Items Paired Samples t-Test Results*

Items	Mean (sd)	t-test (df)	p-value
To what extent were the health education activities effective in increasing your understanding of quality of school health education programs?	.821 (4.24)	2.375 (150)	*.019
To what extent were the health education advocacy activities effective in increasing your school health advocacy skills?	.893 (4.36)	2.504 (149)	*.013
To what extent were the health education advocacy activities effective in increasing your understanding of the importance of quality school health education?	.883 (.4.32)	2.536 (153)	*.012
To what extent were the health education advocacy activities effective in increasing your interest in current school health advocacy issues?	.876 (4.31)	2.519 (153)	*.013
To what extent were the health education advocacy activities effective in increasing your intentions to engage in school health education advocacy?	.909 (4.30)	2.62 (153)	*.010

$p < .05$ .

attitude items that addressed participants' perceptions related to making a difference in the lives of community members lacked significant positive change in pre/post measurements. One attitude item related to students' attitudes about the importance of making a difference in the lives of those in the community while the second attitude item addressed making a difference in the lives of the people they serve or plan to serve. However, students showed significant changes in attitudes toward making a difference in the lives of students and school staff in pre/post measurements. This community/school difference in the changes or lack of changes in attitude pre/post measurements may be a result of the content of the lesson being focused specifically on advocacy for school-age population rather than all community members. It was also noted that students were much more likely to utilize social media than print advocacy strategies or strategies that required a physical presence. Based on student response after piloting and evaluating the advocacy lesson, researchers included additional strategies and scenarios utilizing social media and networking to advocate for school health education. A positive influence on intentions to advocate and perceived effectiveness of the lesson was found when piloting the revised lesson with a smaller sample ( $n = 36$ ). The use of technology and other social media tools for school health education advocacy should be explored and promoted. Galer-Unti (2010) offers multiple examples of how the utilization of social media can serve as efficient, cost-effective, and relevant platforms for advocacy messages. Hey, Temple, and Hey (2004) also provide informative examples of utilization of Internet sites and networks to advocate for health education and suggest the concept of using technology to provide instruction and technical assistance as mechanisms for interactive learning, which can focus on health education advocacy. Future research may continue to investigate advocacy lessons and

professional development sessions through the use of various technologies and Internet delivery platforms.

### Limitations

A strength of the study was the 82% participation rate; however, the researchers can only make generalizations about the population sampled. All data collected were self-reported measures creating an opportunity for participants to be biased in their response by social desirability. A random sampling for data collection was not used which resulted in a disproportionate number of female participants and the racial and ethnic makeup of the sample is more diverse than that of the university population. A cross-sectional design was used and without a comparison group, researchers have no control comparison group resulting in a limitation of the broader implications of this study. The posttest was administered immediately following the advocacy lesson due to factors related to the course schedule. Future research should measure effect when using a delayed post assessment, as intentions are likely to be higher directly following an intervention. Future research should also include multiple treatment and control groups using an experimental design.

### Translation to Health Education Practice

With increasing pressure on public schools to meet common core standards in reading, writing, and mathematics while making decisions related to budget constraints and other competing priorities, there will be an increasing need for advocacy in all non-tested disciplines, including health education in grades K-12 (Willis & Sandholtz, 2009). Students enrolled in personal health classes may be directly and indirectly affected by quality school health education in public schools or lack thereof (Birch et al., 2011). These

students may find themselves in a position to serve as an advocate for school health with individuals who make decisions directly impacting health education in schools as they will be members of local communities and many will become parents. Study implications suggest that this advocacy lesson can help students in personal health courses understand the importance of quality school health education, increase their perceived abilities to interact effectively when presented with advocacy opportunities, and increase their intentions to advocate for school health education. While the necessity for advocacy and the teaching of advocacy strategies is increasingly recognized among faculty at institutions of higher education (Birch, 1991; Goodhardt, 2002; McCrary-Quarles et al., 2006; Radius et al., 2009) it will be important moving forward to also consider including effective advocacy strategies in courses that reach students outside of the health education major, particularly students enrolled in personal health courses. Radius et al. (2009) suggest that adequate instructional materials for teaching advocacy for health education are essential to the planning, implementation, and assessment of advocacy-related instruction. The lesson evaluated as part of this study was found to be effective in increasing students' intentions to advocate for school health education and improve their perceived level of advocacy skills and can be considered as a tool for future instructors planning and preparing advocacy lessons as part of their personal health courses. However, as previously noted, a limitation of this study was the timing of the posttest survey and future research is needed to determine the impact on intentions over longer periods of time. Instructors should consider personal health courses as conduits for teaching and promoting the utilization of advocacy strategies to enhance school health education, when planning curriculum and instruction in these courses. Publishers of texts, intended for use in personal health courses, should also consider including effective school health education advocacy strategies as a resource for instructors and students in future editions. Health educators must continue to look beyond the parameters of those within the discipline to serve as voices for maintaining and enhancing school health education by creating awareness and advocacy capacity through effective advocacy instruction.

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**This article may provide one  
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**Instructions and self-study questions may be found on page 44.**