Eta Sigma Gamma Members' Participation in Advocacy Activities and Opinions on Advocacy Priorities for the Organization

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Abstract

Advocacy for health policies and programs can impact large segments of the population with the goal of promoting and protecting the nation's health. Historically, advocacy has not been viewed as seriously as other components of health education, and involvement in public policy work has been moderate by health education practitioners and health education faculty. The purpose of this study was to determine in which types of advocacy activities members of Eta Sigma Gamma currently participate, their rating of their personal advocacy skills and capacity, as well as their opinions on advocacy priorities for Eta Sigma Gamma. During fall 2013, a convenience sample of current members of Eta Sigma Gamma (N=2661) was invited to participate in a survey (based on the Health Belief Model) that contained five sections assessing their health advocacy activities, perceptions, and priorities. Although only 10.75% (n=286) of the sample returned the survey, voting was participated in by at least half (50%) of the respondents, and the majority (60%) reported barriers to advocacy engagement. Tobacco (30%) and nutrition polices (16%) were leading concerns for advocacy efforts. Members' input into advocacy activities and priorities allows for influence as well as accountability.

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Introduction

Advocacy for health-related policies and funding of programs has the potential to impact large segments of the population with the goal of promoting and protecting the nation's health. Historically, advocacy has not been viewed as seriously as other components of health education or public health; and involvement in public policy work has been moderate by health education practitioners, health commissioners, and health education faculty (Holtrop, Price, Boardley, 2000; Radius, Galer-Unti, & Tappe, 2008; Thompson, Boardley, Kerr, Green, & Jenkins, 2009). This may be reflective in the need to add additional advocacy-related competencies to the Framework for Health Education Specialists as suggested by the recent *Health Education Specialist Practice Assessment* (National Commission for Health Education Credentialing, Inc. & Society for Public Health Education, in-press). Health Educators can shape policy that affects the health of large populations (Galer-Unti, Tappe, & Lachenmayr, 2004). For example, tobacco polices that have been implemented in various settings have shown significant decreases in tobacco use (Callinan, Clarke, Doherty, & Kelleher, 2010). Another example is the passage of primary and secondary seat belt laws that can impact injury and fatality rates from motor vehicle crashes (Rivara, Thompson, & Cummings, 1999).

Advocacy is a professional responsibility and competency and health educators need to be competent in advocacy skills and strategies (Tappe & Galer-Unti, 2001). Advocacy skills should be a core skill developed in all future health educators. Advocacy skill development starts in pre-professional programs through integration into coursework and service-learning activities (Tappe & Galer-Unti, 2001). Although most instructors believe teaching advocacy skills are important, those who instruct pre-service students may also need to more fully develop their personal advocacy skills and capacity through trainings or more experience in advocacy efforts (Radius, et al., 2008; Thompson, Kerr, Dowling, & Wagner, 2012). Political advocacy educational interventions seem to improve college student advocacy skills and expectations for advocacy participation (Beaumont, Colby, Erlich, & Torney-Purta, 2006). It is recommended that pre-service students develop expertise in policy-making, lobbying, and media advocacy strategies (Hines & Jernigan, 2012), and most pre-service programs do include advocacy education (Radius, et al., 2008). Once students transition to professionals, they should maximize their advocacy skills as part of their professional development through in-service, trainings, and workshops; as well as experience and participation in advocacy activities (Tappe & Galer-Unti, 2001). In a previous study, many practicing public health educators reported conducting advocacy; however, as a skill set, it needed to be improved upon (Holtrop, et al., 2000; Allegrante, Moon, Auld,

& Gebbie, 2001). Advocacy is considered a core competency to develop a strong global health promotion workforce (Barry, Allegrante, Lamarre, Auld, & Taube, 2009). Policy change takes high levels of advocacy skill; however, many health educators lack training and preparation in advocacy-related competencies (Caira, Lachenmayr, Sheinfeld, Goodhart, Canciolosi, & Lewis, 2003).

Health educators are challenged to become involved in a variety of advocacy activities and strategies, both as individuals as well as members of professional associations (Galer-Unti, et al., 2004). Changing laws, policies, and regulations is often the aim of advocacy efforts, and higher education and professional health associations have the duty to collaborate with grassroots community health organizations to advocate for evidence-based changes (Chapman, 2004). Professional health associations and organizations include members who are credible experts in their fields. These groups are in a strong position to voice their positions on health issues to policy-makers (Caira, et al., 2003). Therefore, professional health organizations are now placing more emphasis on advocacy as support for an issue or policy change. Policy change can be enhanced by professional organization backing (Galer-Unti, et al., 2004). Some professional health organizations and groups have trained their members in advocacy principles through conferences (e.g., Health Education Advocacy Summit), workshops, meetings, and continuing education; building grassroots networks to increase their capacity and chances for successful initiatives (Caira, et al., 2003).

Eta Sigma Gamma National Health Education Honorary, a member of the Coalition of National Health Education Organizations (CNHEO), recently added an Advocacy Committee as a new ad hoc committee in order to more effectively promote environmental and policy changes that its membership deemed important. Stronger and more powerful arguments can be advanced to achieve advocacy outcomes when greater numbers of individuals come together to promote change. The goal of advocacy efforts by professional associations is to educate association members, professionals, and the public about the important public health issues (Matthews, 2012). By including members' input in deciding advocacy issues for a professional organization, it allows for their contributions as well as their accountability.

When other health-related professionals were surveyed about their advocacy activities and perceptions, many similarly stated that advocacy efforts were important to them and to their professions. For example, adolescent medicine physicians reported that legislative advocacy in their medical specialty was essential, and that they were highly involved in a variety of advocacy efforts and priorities (McPherson, 2009). In addition, nurses with higher levels of political participation and more work experience possessed stronger attitudes toward advocating for health care issues (Barrett-Sheridan, 2009). Experienced, lay community health workers were more often involved with advocacy initiatives if they were employed by a non-profit group, received training in the past, and perceived themselves as community leaders (Ingram, Sabo, Rothers, Wennerstrom, & deZapien, 2008). As health educators who often collaborate with partners such as these, advocacy skills are imperative in helping to promote change among individuals and communities.

Purpose

The purpose of this study was to determine in which types of advocacy activities members of Eta Sigma Gamma (Gammans) currently participate, their rating of their personal advocacy skills and capacity, as well as their opinions on advocacy priorities for Eta Sigma Gamma.

Methods

Sample

During fall 2013, a convenience sample of all (2661) current members of Eta Sigma Gamma (the National Professional Health Education Honorary) with active electronic mail accounts during 2012-2013, was invited three times through electronic mail and website announcement to participate in a survey of their health advocacy activities, perceptions, and priorities. Eta Sigma Gamma members include professionals active in the profession of health education who hold a degree in the field as well as students majoring in health education and related disciplines with a grade point average of 2.7 or above (Eta Sigma Gamma National Health Education Honorary, 2013). After Institutional Review Board approval and respondent consent was obtained, the survey was distributed. Two hundred eighty six respondents completed the survey. The response rate was 10.75% (n=286) of those with active electronic mail accounts. While this response rate was somewhat low, it is congruent with similar online surveys that have been published in the literature (Cook, Health, & Thompson, 2000). In addition, an a priori power analysis using a 70/30 split with a .05 confidence level determined that there was adequate power reached to conduct statistical testing.

Instrument

The Eta Sigma Gamma Advocacy Priorities Survey was developed to measure health advocacy activities, perceptions, and priorities of respondents. Respondents were asked to rate their frequency of advocacy activity participation; barriers to that participation; their level of personal advocacy skill; and to list advocacy issues they perceive as priorities for Eta Sigma Gamma.

This instrument has been utilized in various forms in several studies and has been validated for its psychometric properties (Thompson et al., 2009; Holtrop et al., 2000). In previous studies, stability/ reliability testing yielded correlations of .6 and factor analysis for self-efficacy and efficacy-expectations constructs demonstrated strong factor loading. Additionally, the Cronbach alpha for the two factors was .85 and .79, respectively. In the current study, the instrument was reviewed by an expert panel of health education advocacy professionals, revised, and then pre-and post-tested with a convenience sample of health educators. Ten health educators currently working in community/public health in the Midwest and East Coast who were former, but not current Gammans, pretested the survey for format, readability, word order, and answering process. Internal consistency and scale reliability of the instrument was tested using Cronbach's alpha measure. The reliability statistics test was performed using all 19 variables, and then only the 12 variables related

to advocacy activities. Cronbach's alpha was .766 and .744 respectively, indicating acceptable reliability.

The survey contained five sections: Gammans' health advocacy activities (12 items ranging from joining a mailing list to visiting a policymaker); Gammans' ratings of barriers to participation advocacy activities (seven items on perceived barriers); Gammans' ratings of personal advocacy skills and capacity (four items, including whether advocacy was a personal or professional responsibility, the importance [seriousness] of advocacy for health educators, self-efficacy in influencing public health policy, and to what extent professional organizations should be advocating for health issues); Gammans' opinions on advocacy priorities for the organization (three open-ended items asking respondents to generate their top health priorities for Eta Sigma Gamma to pursue), and respondent demographics (e.g., number of years involved in Eta Sigma Gamma, status). Several types of sub-scales were utilized in the survey such as: Likert, open-ended, descriptive, and dichotomous.

Procedures

The Eta Sigma Gamma National Office was contacted during summer 2013 to acquire the electronic mail addresses of all current members of Eta Sigma Gamma during 2012-2013 and to place an announcement in the fall electronic newsletter posted on the Honorary's website inviting members to participate in the survey. A pre-invitation electronic mail was sent early fall 2013 to all potential respondents alerting them that a survey about advocacy priorities would be sent. The electronic survey (using Survey Monkey) and accompanying cover letter, including consent form, was sent to all members with a valid electronic mail address in mid-September 2013, and an electronic mail was also sent to Chapter Advisors to remind their students to participate. To help protect respondent confidentiality, identification code numbers and password-protected computer files were used. Another electronic mail reminder was sent in early October as well as an announcement made at the Honorary's national fall conference to encourage members to participate in the survey. During the first phase of the survey, 124 Gammans responded. During mid-October, a follow-up survey with reminder was sent to non-respondents. During this second phase, 162 Gammans responded. When a sample (every fiftieth non-respondent; n= 47) of those Gammans who did not respond at all to the survey were contacted by electronic mail at the beginning of November, none responded to the follow-up.

Analysis

SPSS Statistics for Windows, version 21.0 (IBM Corporation, 2012) software was used to perform analyses. Descriptive statistics calculating frequencies and percentages of the answers to each quantitative question were performed. In addition, frequencies and percentages of Gamman status as a professional, undergraduate student, or graduate student were calculated. The frequencies and percentages of the respondents' current certification status as CHES/MCHES were also calculated.

Cross-tabulation and Pearson Chi-square tests were then performed to check for differences in responses between Gamman status and the quantitative questions. These analyses were also conducted between certification status and the quantitative questions.

Results

Respondent Demographics

Almost half (48.3%) of those who responded to this survey question reported that they were Gamman undergraduate student members, while 28.7% were Gamman professional members, 19.6% were Gamman graduate student members, and 13.5% did not answer this question. The majority (74.8%) were not MCHES/CHES-certified.

Health Advocacy Activities

Respondents were asked twelve questions regarding their health advocacy activities. The answers were rated on a scale from 1-5 as "not frequently", "somewhat frequently", "neutral", "frequently", and "very frequently". The results were summarized in Table 1.

The cross tabulation by professional or student status and each of the above questions were performed and is summarized in Table 2. The cross tabulation by CHES/MCHES membership and these advocacy activities questions is summarized in Table 3. Pearson Chi-square test was also performed to check for significant difference between groups. However, due to the small sample size, many cells did not have the minimum count to perform this test and the results are not reported.

Participation in Advocacy Activities

When asked whether or not they perceived any barriers to health educators' participation in community/public health education advocacy, most (60.0%) stated that they did perceive barriers. Of those who indicated barriers, lack of money (65.3%), lack of time (63.5%) and lack of advocacy training (60.0%) were rated as top concerns. Other concerns included a lack of advocacy experience (55.3%), lack of professional recognition/support to participate in advocacy activities (53.2%), and lack of progress on issues/frustration with process (40.4%) (See Table 4). Most other comments focused on workplace setting and type of employer (i.e., governmental agency, public school, federal grant) as a specific barrier limiting or perceived as limiting advocacy activities, as well as cultural barriers and the effect of advocacy activities on personal reputation.

Rating of Their Personal Advocacy Skills and Capacity

When asked if advocacy in Community/Public Health Education is a personal issue, a professional responsibility, or both, the vast majority responding to this question reported it was both a professional and personal responsibility (87.1%), followed by professional responsibility (12.2%), and personal issue (0.7%), with seven (2.4%) not answering the question. Results of cross tabulation by professional or student status showed that 87.7% of Gamman professionals, 84.7% of

Table 1.

Frequency of Participation in Legislative Advocacy Activities, Specifically Related to Community/Public Health Education

	Percentage (n=)					
	Not frequently	**Somewhat frequently**	**Neutral**	**Frequently**	**Very frequently**	**Did not respond**
Getting on the mailing list of an advocacy group	43.7% (125)	17.8% (51)	14.3% (41)	13.6% (39)	8.0% (23)	2.4% (7)
Voting in an election	18.9% (54)	11.9% (34)	11.5% (33)	23.4% (67)	31.8% (91)	2.4% (7)
Speaking to groups or individuals about a health policy issue	34.3% (98)	22.0% (63)	10.5% (30)	19.9% (57)	9.8% (28)	3.5% (10)
Working on a coalition to promote a policy	49.9% (134)	19.2% (55)	15.7% (45)	10.8% (31)	4.9% (14)	2.4% (7)
Donating money to a cause/issue/ organization	27.3% (78)	23.1% (66)	14.3% (41)	22.7% (65)	11.2% (32)	1.4% (4)
Writing/calling a policy-maker	57.0% (163)	19.2% (55)	9.4% (27)	9.4% (27)	2.8% (8)	2.1% (6)
Visiting/educating a policy-maker	66.4% (190)	11.9% (34)	10.1% (29)	6.3% (18)	2.1% (6)	3.1% (9)
Providing testimony	70.3% (201)	10.5% (30)	9.8% (28)	4.9% (14)	2.4% (7)	2.1% (6)
Lobbying	74.8% (214)	7.7% (22)	8.7% (25)	4.9% (14)	1.0% (3)	2.8% (8)
Attending rallies	66.1% (189)	15.0% (43)	10.5% (30)	4.5% (13)	0.3% (1)	3.5% (10)
Writing an Op-Ed or newspaper article on a health policy issue	72.0% (206)	10.8% (31)	7.7% (22)	5.2% (15)	1.4% (4)	2.8% (8)
Using media advocacy for policy change awareness	50.7% (145)	18.2% (52)	11.2% (32)	12.9% (37)	5.2% (15)	1.7% (5)

(n=286)

Gamman undergraduate students, and 94.6% of Gamman graduate students viewed advocacy both a professional responsibility and personal issue. Similar results were found for cross tabulation based on CHES/MCHES status, with 86.9% of those who were not CHES/MCHES certified and 89.8% of those who were CHES/MCHES certified viewing advocacy both a professional responsibility and personal issue.

Comments addressed the difficulty in advocating for one stance professionally, but another stance personally

When asked how important advocacy skills are for Community/Public Health Educators, the majority (92%) stated that it is "important" or "very important." Results of cross tabulation by professional or student status showed 93.8% of Gamman professionals, 93.4% of Gamman undergraduate students, and 100% of Gamman graduate students viewed advocacy skills as either "important" or "very important" for Community/Public Health Educators. Similarly, cross tabulation by CHES/MCHES status showed 91.6% of respondents who were CHES/MCHES certified and 95.7% of respondents without CHES/MCHES certification selected either "important" or "Very Important" in regards to the importance of advocacy skills for Community/Public Health Educators.

Table 2.

Cross tabulation by professional or student status and advocacy activities questions

		Percentage (n=)		
Advocacy activity	**Status**	**Not frequently/ Somewhat frequently**	**Neutral**	**Frequently/ Very frequently**
Getting on the mailing list of an advocacy group	Professional Undergraduate Student Graduate Student	55.1%* (43) 66.4% (91) 65.5% (36)	7.7% (6) 20.4% (28) 10.9% (6)	37.2% (29) 13.1% (18) 23.6% (13)
Voting in an election	Professional Undergraduate Student Graduate Student	13.9% (11) 44.9% (61) 23.6% (13)	6.3% (5) 14.0% (19) 14.5% (8)	79.7% (63) 41.2% (56) 61.8% (34)
Speaking to groups or individuals about a health policy issue	Professional Undergraduate Student Graduate Student	61.5% (48) 57.8% (78) 56.4% (31)	7.7% (6) 24.8% (20) 3.6% (2)	30.8% (24) 27.4% (37) 40.0% (22)
Working on a coalition to promote a policy	Professional Undergraduate Student Graduate Student	61.5% (48) 57.8% (78) 56.4% (31)	16.0% (13) 17.8% (24) 9.1% (5)	24.7% (20) 11.9% (16) 16.4% (9)
Donating money to a cause/ issue/organization	Professional Undergraduate Student Graduate Student	39.5% (32) 59.9% (82) 51.8% (29)	13.6% (11) 16.1% (22) 8.9% (5)	46.9% (38) 24.1% (33) 39.3% (22)
Writing/calling a policy-maker	Professional Undergraduate Student Graduate Student	64.6% (51) 86.9% (119) 78.6% (44)	11.4% (9) 8.8% (12) 5.4% (3)	24.1% (19) 4.4% (6) 16.1% (9)
Visiting/educating a policy-maker	Professional Undergraduate Student Graduate Student	74.0% (57) 83.1% (113) 87.5% (49)	15.6% (12) 10.3% (14) 1.8% (1)	10.4% (8) 6.6% (9) 10.7% (6)
Providing testimony	Professional Undergraduate Student Graduate Student	84.6% (66) 83.9% (115) 80.4% (45)	9.0% (7) 10.9% (15) 5.4% (3)	6.4% (5) 5.1% (7) 14.3 (8)
Lobbying	Professional Undergraduate Student Graduate Student	86.1% (68) 84.6% (115) 85.5% (47)	6.3% (5) 11.0% (15) 5.5% (3)	7.6% (6) 4.4% (6) 9.1% (5)
Attending rallies	Professional Undergraduate Student Graduate Student	87.2% (68) 83.7% (113) 81.8% (45)	9.0% (7) 11.1% (15) 10.9% (6)	3.8% (3) 5.2% (7) 7.3% (4)
Writing an Op-Ed or newspaper article on a health policy issue	Professional Undergraduate Student Graduate Student	84.6% (66) 86.8% (118) 83.6% (46)	7.7% (6) 8.1% (11) 7.3% (4)	7.7% (6) 5.1% (7) 9.1% (5)
Using media advocacy for policy change awareness	Professional Undergraduate Student Graduate Student	69.6% (55) 70.8% (97) 71.4% (40)	11.4% (9) 10.2% (14) 12.5% (7)	19.0% (15) 19.0% (26) 16.1% (9)

*Percentage of professionals, undergraduate students, and graduate students (n=286)

Table 3.

Cross tabulation by CHES/MCHES membership status and advocacy activities questions

		Percentage (n=)		
Advocacy activity	**Status**	**Not frequently/ Somewhat frequently**	**Neutral**	**Frequently/ Very frequently**
Getting on the mailing list of an advocacy group	CHES/MCHES Not CHES/MCHES	56.1% (32) 65.2% (137)	3.5% (2) 17.1% (36)	40.4% (23) 17.6% (37)
Voting in an election	CHES/MCHES Not CHES/MCHES	16.1% (9) 35.5% (75)	0.0% (0) 14.2% (30)	83.9% (47) 50.2% (106)
Speaking to groups or individuals about a health policy issue	CHES/MCHES Not CHES/MCHES	67.9% (38) 56.9% (119)	3.6% (2) 12.0% (25)	28.6% (16) 31.1% (65)
Working on a coalition to promote a policy	CHES/MCHES Not CHES/MCHES	66.7% (38) 68.2% (144)	8.8% (5) 17.5% (37)	24.6% (14) 14.2% (30)
Donating money to a cause/ issue/organization	CHES/MCHES Not CHES/MCHES	40.0% (24) 55.2% (117)	10.0% (6) 14.6% (31)	50.0% (30) 30.2% (64)
Writing/calling a policy-maker	CHES/MCHES Not CHES/MCHES	66.7% (38) 81.6% (173)	7.0% (4) 9.4% (20)	26.3% (15) 9.0% (19)
Visiting/educating a policy-maker	CHES/MCHES Not CHES/MCHES	77.2% (44) 82.3% (172)	7.0% (4) 11.0% (23)	15.8% (9) 6.7% (14)
Providing testimony	CHES/MCHES Not CHES/MCHES	87.9% (51) 82.0% (173)	1.7% (1) 11.4% (24)	10.3% (6) 6.6% (14)
Lobbying	CHES/MCHES Not CHES/MCHES	89.5% (51) 84.3% (177)	0.0% (0) 10.5% (22)	10.5% (6) 5.2% (11)
Attending rallies	CHES/MCHES Not CHES/MCHES	93.0% (53) 82.3% (172)	1.8% (1) 12.4% (26)	5.3% (11) 5.3% (3)
Writing an Op-Ed or newspaper article on a health policy issue	CHES/MCHES Not CHES/MCHES	91.2% (52) 84.3% (177)	0.0% (0) 9.5% (20)	8.8% (5) 6.2% (13)
Using media advocacy for policy change awareness	CHES/MCHES Not CHES/MCHES	73.3% (44) 69.5% (146)	5.0% (3) 12.4% (26)	21.7% (13) 18.1% (38)

(n=286)

Table 4.

Perceived Barriers to Health Educators' Participation in Community/Public Health Education Advocacy

	Percentage (n=)
Lack of time	63.8% (108)
Lack of advocacy training	60.0% (102)
Lack of advocacy experience	55.3% (94)
Lack of money	65.3% (111)
Lack of professional recognition/support to participate in advocacy activities	52.2% (91)
Lack of progress on issues/frustration with process	40.4% (69)

Note. Respondents could check all that applied

Respondents were also asked to rate their level of advocacy skill to influence health policy to promote health. The scale used included "not competent," "somewhat competent"" "neutral," "competent," and "very competent." About 40% responded as "competent" or "very competent." Results of cross tabulation for this item varied greatly based on professional or student status, as well as CHES/MCHES certification. The majority of Gamman professionals rated their level of advocacy skill as somewhat competent or competent (75.3%), while only 38.8% of Gamman undergraduate students stated they were competent or very competent. Similar results were found for Gamman graduate students with only 41.9% stating they were competent or very competent. Cross tabulation based on respondents' CHES/MCHES status also revealed varying levels of self-reported advocacy skill. For respondents who were CHES/MCHES certified, the majority rated their advocacy skill levels as "somewhat competent" or "competent" (75%). Only 41.3% of respondents who were not CHES/MCHES certified reported that they were competent or very competent. When asked to what extent professional community/public health organizations should be responsible for advocating for environmental or organizational changes in order to achieve a health goal, a little over half of the respondents (52.1%) noted that professional organizations should be responsible or very responsible. Similar results were found based on CHES/MCHES certification.

Opinions on Advocacy Priorities for the Professional Eta Sigma Gamma

Respondents were asked what the top three general health or campus health issues that Eta Sigma Gamma should pursue (e.g., smoke-free campuses, quality/daily school health and physical education), and the issues/themes ranked as first priority by the 252 respondents who answered this question centered on smoke-free campuses and communities (30.2%), followed by nutrition and healthy eating concerns (15.9%), and school health and physical education (9.9%). The issues/themes ranked as second priority by the 244 respondents who answered this question noted nutrition and healthy eating (20.9%), followed by smoke-free campuses and communities (11.5%), and school health and physical education (11.1%). The issues/themes ranked as third priority by the 218 respondents who answered this question focused on nutrition and healthy eating concerns (18.3%), followed by school health and physical education (10.1%, 22/218), substance abuse prevention (10.1%), and physical activity and preventive health practices 10.1%) (Table 5).

Discussion

A convenience sample of current members of Eta Sigma Gamma responded to a survey asking them to assess their health advocacy activities and perceptions as well as list their advocacy priorities for the organization. Results indicated that even though respondents rated advocacy as being a high priority for health educators in their professional and personal lives, the majority often did not engage in many of the listed activities, including: writing/calling a policy maker, visiting/educating a policy maker, providing testimony, lobbying, attending rallies, writing an op-ed or newspaper article on a health policy issue, and using media advocacy for policy change awareness. In fact, when combining the respondents' answers of "somewhat frequently" and "not frequently," the only advocacy task that Gammans participated in with a majority of respondents was voting. It should be noted, however, that only 18.9% (n=54) of respondents self-reported to be "not frequent" voters. Because the proportion of student respondents approached 70%, these results should be interpreted with caution. Undergraduates have not finished training, and graduate students may not have had previous undergraduate training in health education. Student respondents may not have had the opportunity to actively practice the advocacy skills they may be learning about in the classroom depending on the level of service-learning or community involvement required in their school curricula.

For example, results showed that the majority of Gamman respondents do not participate in advocacy activities, regardless of Gamman rank. When respondents were divided between their status as professionals, graduate students, and undergraduate students, however, undergraduate students were the least likely to report that they "frequently" or "very frequently" participated in most advocacy activities. They were, on the other hand, more likely to attend rallies than professional Gammans, and more likely than graduate student Gammans to use media advocacy for policy change awareness (of which they were just as likely to perform this advocacy activity as professional Gammans). As most pre-service programs include advocacy education (Radius, et al., 2008), it may be advisable to use active-learning or service-learning strategies to allow more hands-on, advocacy skill practice for this group. Because their experience seems to include rallies and media advocacy, possibly using those activities as awareness strategies when training undergraduates to conduct advocacy activities on the college campus, for example, would be an appropriate first step or introductory activity.

When comparing the frequency of advocacy activities among Gammans of MCHES/CHES or no CHES status, results indicated that with the exception of attending rallies for which both Gammans of MCHES/CHES and those without CHES had the same response, MCHES/CHES were more likely to "frequently" or "very frequently" participate in advocacy activities. Consistent with the literature, many practicing health educators do seem to participate, at least moderately, in advocacy activities (Holtrop, et al., 2000; Allegrante, Moon, Auld, & Gebbie, 2001; Radius, et al., 2008; Thompson, et al., 2009). Those with professional certification could have likely graduated from a health education program where those skills were taught and assessed, or those with more years in the field would have more opportunity through their jobs to conduct advocacy activities. On the other hand, because of the large proportion of student respondents, the undergraduates and possibly many of the graduate students had not yet obtained professional certification, thus, the distinction.

Respondents also indicated several reasons for the lack of participation in advocacy activities including lack of: time, advocacy training, advocacy experience, money, professional recognition/support, and progress on issues. Low levels of involvement in political advocacy are seen across all college-age young Americans (Beaumont, et al., 2006), therefore,

Table 5.

Opinions On Advocacy Priorities For the Professional Organization

Priority 1

Topic/Issue	Percentage (n=)
Smoke-free campus/community; tobacco cessation	30.2% (76)
Nutrition/healthy eating/vending/obesity prevention	15.9% (40)
Quality School Health/Physical Education	9.9% (25)
Disparities, access to care, insurance; health equality	8.3% (21)
Comprehensive school health education; school health	7.1% (18)
Sexuality education, STI/STD/HIV, reproductive health	7.1% (18)
Mental health, stress management, suicide prevention	6.3% (16)
Physical activity, exercise	2.8% (7)
ATOD prevention; drug abuse	2.8% (7)
Health promotion, college health	2.4% (6)
Environmental health	2.0% (5)
Screening, immunizations	1.6% (4)
Billing/funding for disease prevention	1.2% (3)
Other responses: Oral health, Homelessness, Health literacy, Pedestrian safety, Diabetes, Advocacy for the profession.	0.4% (1)

(n= 252)

Priority 2

Topic/Issue	Percentage (n=)
Nutrition/healthy eating/vending/obesity prevention	20.9% (51)
Smoke-free campus/community; tobacco cessation	11.5% (28)
Quality School Health/Physical Education	11.0% (27)
Sexuality education, STI/STD/HIV, reproductive health	8.2% (20)
ATOD prevention; drug abuse	7.8% (19)
Comprehensive school health education; school health	6.1% (15)
Disparities, access to care, insurance; health equality	4.9% (12)
Physical activity, exercise	4.5% (11)
Advocacy education/social determinants	4.5% (11)
Mental health, stress management, veterans' health	4.1% (10)
Chronic disease prevention/health promotion/health issue awareness	3.7% (9)
Environmental health	3.3% (8)
Safe driving/motor vehicle crashes	2.9% (7)
Reimbursement/funding for prevention education	2.5% (6)
Crime/violence	1.2% (3)
Aging health	0.8% (2)
Infectious disease/vaccination	0.8% (2)
Maternal/child health	0.8% (2)
Other responses: Women's health, Health careers, Parking	0.4% (1)

(n= 244)

Table 5 cont.

Priority 3

Topic/ Issue	Percentage (n=)
Nutrition/healthy eating/disordered eating/obesity prevention, nutrition education	18.3% (40)
Quality School Health/Physical Education	10.1% (22)
ATOD prevention; drug abuse, underage drinking	10.1% (22)
Physical activity, Exercise, Preventive health practices	10.1% (22)
Smoke-free campus/community; tobacco cessation	7.8% (19)
Mental health, stress management	7.3% (16)
Sexuality education, STI/STD/HIV, reproductive health	6.9% (15)
Disparities, access to care, insurance; health equality	5.0% (11)
Crime/violence, bullying	4.1% (9)
Comprehensive school health education	3.2% (7)
Environmental health, built environment	3.2% (7)
Advocacy/policy	2.3% (5)
Bike/pedestrian safety	1.4% (3)
Worksite health	1.4% (3)
Maternal/child health	0.9% (2)
Health literacy/literacy	0.9% (2)
Other responses: Cancer, Promoting health education profession, Oral health, Homelessness, Driving/highway safety, Health/financial literacy, Cultural competence, Men's health	0.5% (1)

(n= 218)

many barriers are to be expected. With a majority of student respondents, it would be anticipated that lack of training, experience, and money would possibly be barriers.

There are some important implications from this study for student and professional Gammans as well as for professional organizations such as Eta Sigma Gamma. Because students need to develop advocacy skills and expertise as part of their core health education skill set (Hines & Jernigan, 2012;), advocacy education needs to be fully integrated into the curriculum through both didactic and experiential learning activities and events (Tappe & Galer-Unti, 2001) in multiple courses and levels of courses. To overcome some of the barriers reported, more emphasis on skill acquisition in lower level course work can be introduced. Application of skills in simulated and then real advocacy situations can then be emphasized and reinforced in higher level coursework. Students need to prioritize their funds, too, and take responsibility for becoming involved in any extra-curricular advocacy education experiences or opportunities that become available.

Because advocacy is a professional responsibility and competency (Tappe & Galer-Unti, 2001), those professionals not frequently involved in advocacy activities should seek out additional training through professional development activities to become more comfortable with the skills and competencies. Professional health associations, too, need to emphasize advocacy skill improvement for their memberships to assist in more strongly urging health policy changes (Galer-Unti, et al., 2004). Specifically, as a national organization involved with CNHEO, Eta Sigma Gamma must continue to be involved in advocacy work and skill improvement for its membership, especially student members, including focusing on those advocacy priorities listed by Gammans in this study.

Programs focusing on advocacy competencies and behaviors may improve undergraduate political activity and possible future activity (Beaumont, et al., 2006). Keeping in mind reported barriers to lack of participation in advocacy activities, especially for students, Eta Sigma Gamma can provide additional trainings at low-cost, on-line projects that can be easily integrated by faculty into the curriculum or co-curriculum, or programs that can be combined with professional development activities Gamman professionals are already doing such as webinars, seminars, or articles for MCHES/ CHES credits in The Health Educator. It may also benefit Gammans if the National Board and National Office advertised potential advocacy education and advocacy opportunities presented by other professional health education organizations that align with reported advocacy priorities to increase both organizations' capacity for success on key health issues (Caira, et al., 2003).

Limitations

Conducting studies using Survey Monkey are usually quick to conduct, very cost-effective, and can reach many respondents in a short period of time. There is strong evidence that web-based tests can be used effectively to collect data, especially in certain populations with Internet access and high rates of use (McCabe, Boyd, Couper, Crawford, & D'Arcy, 2002). However, this study presents some limitations including a nonrandom sample of only those with active electronic mail addresses who were invited to participate in the study. Moreover, out of 2661 dues-paid members of Eta

Sigma Gamma who were invited to participate in this survey, only 286 persons responded with a 10.75% response rate. This low response rate presents a nonresponse bias which affects both the reliability and the validity of the study as, typically, online surveys yield lower responses than traditional mail surveys (Cook, et al., 2000). This low response rate may limit the generalizability of our study results. Usually, only those with strong opinion of the subject will respond to the survey whereas those who are less motivated or do not have incentive would not participate causing the study to be biased, thus the results are weaker and less generalizable. This study attempted to address the issue of nonresponse as researchers sent frequent reminders to respondents to encourage them to participate in this study. The survey was also self-reported data, and thus, there may be a chance that advocacy involvement was under or over-reported. The monothematic nature of the survey may also compromise the validity of the findings. Lastly, the use of a mostly closed-items instrument may limit the opinions and perceptions expressed in the findings of this study.

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