

Advocacy Practices in Ohio MCHES and CHES Health Educators

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Abstract

The purpose of this study was to determine the type and level of public policy involvement and perceptions regarding public policy involvement of Certified Health Educator Specialist (CHES) and Master Certified Health Education Specialist (MCHES) registered in Ohio. A four-page instrument was mailed to a population sample of 385 CHES and MCHES Health Educators registered in Ohio from the National Commission for Health Education Credentialing (NCHEC) database. A three-wave mailing procedure resulted in a 45.7% response rate. Almost half of the health educators indicated they had not participated in activities to influence public policy in the past two years. Voting was the most frequent public policy activity (94.6%). These findings demonstrate an opportunity for professional health organizations to influence members and provide training and resources so that they can become more active public policy advocates. Organizations should tailor advocacy opportunities to the target population.

Introduction

The field of health education is concerned with improving the health status of the public and developing education strategies to promote the health of individuals and communities. Both individual and community health can be improved with policies that foster an environment that supports and encourages health. Health educators can influence health by being involved in advocating and supporting health related

policies. Advocacy is considered a professional and ethical responsibility of health educators (Tappee, Galer-Unit, 2001).

The National Commission for Health Education Credentialing (NCHEC) includes advocacy as a professional responsibility for health educators, including advocacy as a competency for their Certified Health Education Specialist (CHES) and Master Certified Health Education Specialist (MCHES) exams. The responsibility includes communicating and advocating for population health and the profession of Health Education (National Commission for Health Education Credentialing, 2014). Newly updated competencies for MCHES health educators include an even greater focus on advocacy, indicating the increased significance of this responsibility.

If health educators used advocacy to influence public policy, it could significantly improve health status. There are many instances within public health and health education where advocacy has played a critical role in translating research into policy or practice and in changing public opinion. For example, between the 1950's and 2014, health educators and other public health professionals played an important role in reduction of smoking rates through their advocacy activities. In 1961, the American Cancer Society, the American Heart Association, the National Tuberculosis Association, and the American Public Health Association wrote a joint letter to President Kennedy, urging him to establish a commission to address the increasing evidence of health hazards associated with smoking. Due to their efforts, the Surgeon General's report in 1964 was a landmark report that linked smoking and lung cancer. This advocacy measure also shifted public opinion. In 1958, a survey found that 44% of American believed smoking caused cancer, but in 1968 after the Surgeon General's report 78% believed smoking caused cancer. Another example of advocacy influencing policy is "The Truth" campaign, which was launched by Legacy, a public health organization. This campaign was the largest national youth smoking prevention campaign that used television commercials to counter messages from the tobacco industry. "The Truth" campaign was successful, preventing 450,000 teens from starting to smoking from 2000 to 2004 and saving between 1.9 billion and 5.4 billion dollars in medical care costs to society (Robert Wood Johnston Foundation, 2014). The role of health educators in reducing smoking rates is just one example of how advocacy can help improve the health of the community through their influence on public opinion and legislation.

While there are professional expectations and documented public health successes achieved through advocacy efforts, past research suggests advocacy is not a priority for many health educators (Holtrop, Price, Boardley, 2000). Previous national research found that a large percentage of health educators (36%) reported involvement in two or fewer public policy activities, of which voting was the most frequently reported

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public policy activity (Holtrop, Price, Boardley, 2000). In this study, the most frequently cited barrier was a lack of time (Holtrop, Price, Boardley, 2000). A similar study was conducted with health commissioners and 69% of respondents reported that they were not involved at all in public policy (Thompson, Boardley, Kerr, Greene, Jenkins, 2009).

In Ohio, state health education professional organizations, such as Ohio Society for Public Health Education (OSOPHE) and Ohio Public Health Association (OPHA), also have promoted and encouraged involvement with advocacy efforts through establishment of advocacy committees and emphasis on advocacy related topics at conferences. Advocacy involvement is included in OSOPHE's mission and is promoted financially through mileage reimbursement for members who attend Ohio-based advocacy events (Society for Public Health Education, 2014). OPHA, a broader organization including other public health professionals, has promoted advocacy through events such as National Public Health Week and has encouraged members to educate political leaders, raise awareness, and encourage support from the general public for health problems in Ohio (Ohio Public Health Association, 2015).

The purpose of this study was to assess advocacy involvement of health educators in Ohio. Additionally, the study describes the public policy activities performed, perceived benefits and barriers to advocacy activity, perception of effectiveness of advocacy, and knowledge related to public policy.

Methods

The University of Toledo's Institutional Review Board approved the study. A cross-sectional survey research design was used in this population study. The NCHEC Board of Commissioners permitted access to the MCHES and CHES database.

Instrumentation

For the study, public policy was defined to be "any activity such as laws, regulations, or funding enacting by governmental entities". A previously validated instrument in health policy research with health educators was used. The previous instrument indicated a medium to high ($r > 0.6$) correlation coefficients (Holtrop, Price, Boardley, 2000). The current instrument was updated to include one question pertaining to the Affordable Care Act.

A four page, 22-item survey instrument using constructs from the Health Belief Model (Rosenstock, 1974) and Transtheoretical Model's Stages of Changes (Prochaska & DiClemente, 1984) was used. Advocacy involvement was assessed with one question, *What advocacy and public policy activities have you participated in during the past 2 years (check all apply)?* Responses included a range of 17 advocacy activities, including a space for participants to write activities not included. Two questions were based on the Health Belief Model addressing the constructs of perceived benefits and perceived barriers to advocacy and public policy (Janz & Becker, 1984). Participants were provided with 15 barriers and 10 benefits, including an 'other' option, and asked to check all that apply. Cronbach's alphas for the barriers and benefits items were .720 and .368, respectively.

Additionally, a question based on the Transtheoretical Model (Prochaska & DiClemente, 1984) assessed participants' stage of change for involvement in public policy. The question asked participants, *How would you rate your current involvement in public policy?* Responses were matched to the stages of change precontemplation, contemplation, preparation, action, maintenance, and relapse. Responses included "I am not actively trying to influence public policy", "I am planning to learn more", "I am planning to be more involved in the next 30 days", "I have actively been involved within the past 6 months", "I have been involved in influencing public policy and will continue to do so", or "I was actively involved in public policy but no longer do so".

Three questions separately asked about knowledge of the process of public policy, effectiveness of public policy, and involvement in public policy with responses ranging from 1-5 with 5 being very knowledgeable, effective, or important, respectively. One follow-up question asked participants whether their involvement in public policy was as a health education professional or a citizen, taxpayer, or parent.

Two questions asked participants if they had received any information or training on advocacy or changing public policy and if so, a list of possible places where the training was listed and participants were instructed to check all that applied. Additionally, one question assessed participants' confidence in performing various advocacy activities (self-efficacy) on a scale of no confidence to great confidence (1-5). Another question measured opinions on the amount of impact a list of advocacy activities would have on a local or regional level. Common advocacy activities were listed and participants rated their impact on a scale of no impact to great impact.

As mentioned previously, one question asked participants about the impact of the Affordable Care Act on health educators from no impact to great impact. Demographic variables collected included age, sex, race/ethnicity, marital status, education level, certifications, primary profession, years as a health educator, area of employment, and employment setting.

For additional content validity, experts in the area of health education reviewed the instrument. The expert reviewers were asked to determine whether the questions could adequately assess CHES and MCHES health educators' public policy involvement. Minor wording changes were made to strengthen the instrument.

Subjects

A population sample (n=385) of Ohio CHES and MCHES health educators was obtained from the National Commission for Health Education Credentialing (NCHEC). Each mailed envelope consisted of a hand-signed cover letter, survey and self-addressed and stamped return envelope. The return envelopes were marked with a unique three number code to identify non-respondents and reduce the potential for double responses. Non-respondents to the first mailing were sent an additional mailing two weeks later. A final third mailing was sent to non-respondents of the prior mailings.

A total of 385 surveys were mailed to a population sample of Ohio MCHES and CHES health educators. Thirteen mailings were returned as undeliverable. Of the 372 surveys mailed and received, 176 (45.7%) were answered and returned, forming the sample for analyses. Table 1 shows the

Table 1.

Demographic Characteristics of the Analyzed Sample

Variables	%	N
Gender		
Female	93.2%	164
Male	5.7%	10
Race/Ethnicity		
Caucasian (white)	89.2%	157
African American	7.4%	13
Asian or Pacific Islander	1.1%	2
Hispanic	0.6%	1
Native American	0.6%	1
Other	0%	0
Employment Setting		
College/university	25%	44
Government (including public health)	23.3%	41
Hospital/medical setting	21%	37
Private company	10.2%	18
Other	9.7%	17
Currently unemployed	5.7%	10
Community based outreach	5.7%	10
Elementary/secondary school system	3.4%	6
Voluntary health agency	2.3%	4
Self-employed	2.3%	4
Health maintenance organization	0.6%	1
Highest Level of Education		
Master's	60.2	106
Bachelor's	27.3%	48
Doctoral	11.9%	21
Education Specialist	0.6%	1
Certification		
CHES	84.7%	149
MCHES	14.2%	25
Primary Profession		
Other	51.7%	91
Health Educator	47.7%	84
Area of Work		
Urban	44.9%	79
Suburban	34.7%	61
Rural	18.2%	32

*Note: Data reflect respondents. Missing values were excluded from the descriptive statistics. Percentages do not total 100% due to rounding.

demographic characteristics of the sample.

As indicated by Table 1, the sample consisted of predominantly females (93.2%) and Caucasians (89.2%). The average age of the sample was 37.6 years with a range from 22 to 72 years. Of those working in government, most were working at a local level (75%). There was no statistically significant difference ($p>0.05$) in public policy involvement type by employment setting (government vs. not government). The majority of the sample (84.7%) were CHES certified, but analyses showed there was no statistically significant difference in public policy involvement by certification type ($p>0.05$). Results show that 51.7% of CHES and MCHES indicated that health education is not their primary profession. Primary professions included administration, nursing (RN and BSN), university faculty, epidemiology, elementary/secondary education, grants, fitness/wellness, physical therapy, and research analyst. For those working full time as a health educator, years of experience ranged from 1-42 (10.55 ± 8.9 years), while part time years ranged from 1-23 (5.4 ± 5.0 years).

All data analysis was performed using SPSS 19 for Windows statistical software package. Descriptive statistics, including frequencies, means, and standard deviations were used to describe demographic characteristics, level, and type of involvement in public policy. A dichotomous measure of level of public policy involvement was created and validated using the Rasch model (Andrich, 1988, Bond & Fox, 2007). The Rasch model arranges survey items on a scale according to difficulty, or how likely respondents are to endorse the survey item. Additionally, a person measure is created, a quantitative measure of a person's attitude (Bond & Fox, 2007). The survey item difficulty and person measure are measured on the same scale and allows researchers to determine meaningful differences in difficulty between survey items. Chi-square was used to investigate the relationships

between demographics and level of public policy involvement.

This study was delimited to health educators credentialed by NCHCEC and registered in Ohio. The data collection included self-reported data, which may result in over- or under-reporting based on the nature of the survey. Respondents may have been more interested in advocacy and public policy and therefore represent more involved health educators in advocacy than non-respondents. Also, respondents may have answered the questionnaire with responses that were socially desirable, such as being more involved in advocacy activities. The questionnaire may have failed to adequately provide all advocacy activities as options and participants may have not remembered or written additional advocacy activities performed in the 'other' response. These limitations should be considered when interpreting study results.

Results

Public Policy Activities

On average, respondents were involved in 3.6 public policy activities ($0-13 \pm 2.6$). Voting was the most reported public policy activity with 94.6% of the sample indicating that they voted. Other highly reported items were contacted a public official or their office (50.6%), used social media or public events to address policy issues (41%), and provided policy-related information to consumers and other professionals (39.8%). Activities that were rarely reported include testified at formal hearing (1.8%), served as elected/appointed public official (1.8%), volunteered for public official (2.4%), took part in protest/demonstration (3.6%), and drafted legislation/regulations/developed resolution (5.4%). Table 2 provides a breakdown of all activities reported.

The Rasch analysis was used to transform the dichotomous responses into an interval-level measure so that differences

Table 2.

Percentage of Respondents Reporting Involvement in Each Activity

Advocacy Activity	% responded yes	n
Voted in an election	89.2%	15
Contact a public official or their office	47.7%	84
Provided policy-related information to consumers or other professionals	39.8%	70
Used media (including social media) or public events to address a public policy issue	38.6%	68
Participated in an advocacy committee or coalition that takes action to influence public policy issues	29.5%	52
Attended Advocacy Summit/Advocacy type summit	29.5%	52
Gave money to a campaign or for a public policy concern	21.6%	38
Personally met legislator or his/her staff concerning advocacy issues	17%	30
Provided reports, consultation, research, or other such assistance to a public official in support of or opposition to a public policy issue	15.3%	27
Analyzed policies and/or made recommendations about them to a public official	11.9%	21
Worked on a campaign for a candidate or proposal	6.8%	12
Drafted legislation, regulations or developed a resolution	5.1%	9
Took part in a protest or demonstration regarding a public policy issue	3.4%	6
Testified at a formal hearing	1.7%	3
Served as an elected or appointed public official	1.7%	3

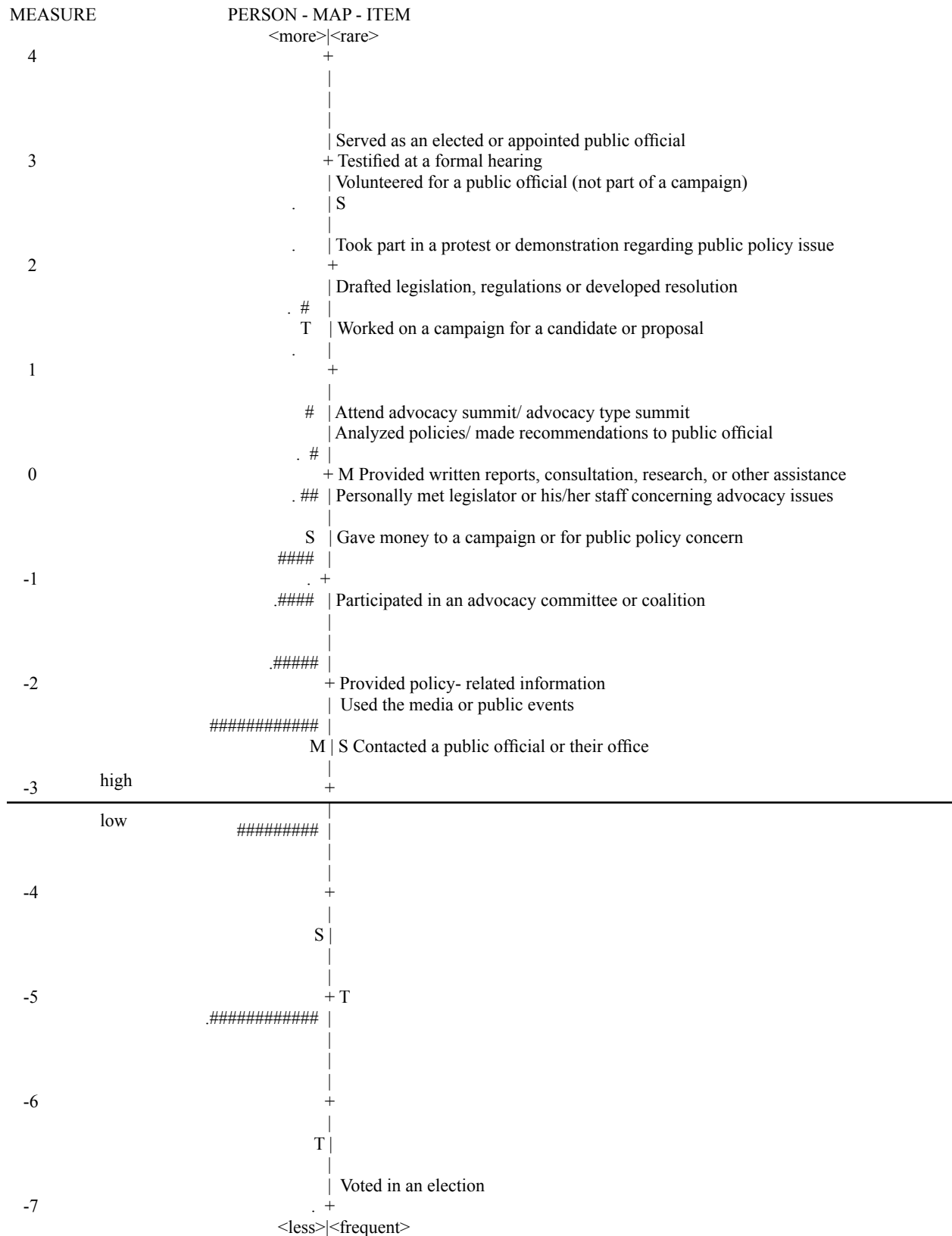


Figure 1. *Rasch Analysis of Involvement*. Each # represents three respondents. Each . represents one to two respondents. Distinctions among the labels “low” and “high” were based on visual breaks along the continuum and added to aid the reader in interpreting the variable.

Figure 1 is the person–item map, which portrays both persons and activities on the same unidimensional scale. The right side of the map displays the advocacy activities, such as “contacted a public official or their office” and are based on the responses to the question assessing participant’s advocacy activities. The left side of the map displays the number of people that checked the corresponding item to the right and every item below. Activities at the bottom of the scale, such as “voted in an election” were activities that were not difficult for participants to check (ie. frequently checked by respondents) and represent a low level of public policy involvement. Alternatively, activities at the top of the scale, such as “served as an elected or appointed public official” were difficulty for participants to check (ie. rarely checked by respondents) and represent a very high level of involvement. There are two statistically significant groups among our sample, indicated by the line on Figure 1. The two groups include - those that only participate in very low level public policy activities (the persons below the line) and those who are very involved in public policy activities, including high level activities (the persons above the line). These groups are distinct statistically and theoretically. The figure visually displays that most of the respondents are near the bottom of the scale, displayed by the symbols representing participants on the left side of the map, indicating that of the health educators who are active in public policy activities are performing “low” scale activities, such as voting.

Current Involvement in Public Policy Activities

When asked about current involvement in public policy activities using the Transtheoretical Models Stage of Change (Prochaska & DiClemente, 1983), 44.9% of participants

were in the precontemplation stage of change (ie. not actively trying to influence public policy). While 21.0% of participants indicated they were planning to learn more (contemplation) and 2.8% were planning to be more involved in public policy in the next 30 days (preparation). Other participants (7.4%) were in the action phase having been actively involved in public policy within the past 6 months and 22.9% of participants were in the indicated they have been involved in public policy and will continue to do so (maintenance). A small number of participants (2.8%) were in the relapse stage, meaning they were actively involved in public policy but no longer do so. A few participants checked two responses, precontemplation and relapse.

Approximately 40% of respondents indicated they were not involved in influencing public policy in the past 2 years. When asked about how they were involved (as a health education professional and/or citizen/taxpayer/parent), approximately 40% were not involved, 41.4% involved as health education professional, and 35.1% were involved as citizen/taxpayer/parent. About 15% of the sample indicated they were involved as both a health education professional and citizen/taxpayer/parent. Of respondents who are active in influencing public policy, respondents indicated on a scale of 1-5 a mean involvement level of 2.65 ± 7.5 .

Barriers and Benefits of Public Policy Activities

The most common response for barriers to involvement in public policy were: busy with other priorities (71.6%), lack of money/resources (29%), not familiar with legislation/regulatory process (25.6%), and can’t be involved due to employment (22.7%) (see Table 3).

Table 3.

Barriers to Public Policy Activities

Barriers	% responded yes	n
Busy with other priorities	71.6%	126
Lack of money or other resources	29%	51
Not familiar with the legislation/regulatory process	25.6%	45
Can’t be involved due to employment	22.7%	40
Not confident that I could advocate effectively	19.3%	34
Lack of access to key individuals	19.3%	34
Frustration with the process	17.6%	31
Confronting others with opposing viewpoints/large funds/influence	15.3%	27
Lack of support from other	12.5%	22
Policy makers’ attitudes/values are inconsistent with my attitudes/values	11.4%	20
Takes too long to see a difference	6.3%	11
There are no barriers	5.7%	10
Probably won’t make a difference	4.5%	8

The mean barriers reported was 2.6±1.7 barriers. The mean number of benefits reported was 5.8±2.6. Common benefits reported were improving health/welfare of the public (85.7%), creating public awareness (78.9%), improving a situation/issue in the community (74.9%), and affecting many people at once (74.3%) (see Table 4).

Confidence in Performing Advocacy Activities

When asked about confidence (self-efficacy) to perform public policy activities at a local or regional level, participants indicated they were most confident voting in a public election (M=4.76, SD±.735), being a resource for a public officer/policy maker (M=4.36, SD±10.335) and providing policy-related info to consumers (M=4.11, SD±7.32).

Knowledge, Effectiveness, and Impact of Public Policy Activities

When asked about rating their knowledge of the process of public policy, participants rated their mean level of knowledge (1-5 scale with 5 being very knowledgeable) as 2.78±1.1. When asked how effective public policy is in changing public health behaviors, participants indicated that it was not highly effective or ineffective. Most respondents had received information or training on advocacy or changing public policy (65.9%) and the majority of information came from sessions at a conference (60.3%), college coursework (57.9%), workshops/webinars (57.9%), and professional colleagues (46.3%).

In the printing of the survey, an incorrect scale for impact of various advocacy activities was printed. The question asked about opinion of impact, while the scale rated confidence. Therefore, the results of this question are not interpretable.

Affordable Care Act

The majority of participants thought the Affordable Care Act would have either a moderate influence (36.4%) or great influence (30.7%) on health education practitioners.

Discussion

Advocacy is an important professional responsibility per NCHEC. However, almost half of the health educators in Ohio indicated they had not participated in activities to influence public policy in the past two years. Additionally, MCHES health educators were no more involved in advocacy activities despite an increased focus on advocacy in NCHEC’s responsibilities for MCHES health educators.

It is encouraging that 21.0% of the health educators indicated they were planning to learn more about public policy, yet half of the sample is only performing very low level advocacy activities, such as voting. This presents an opportunity for professional health organizations to influence these individuals by providing training and resources so that they can become more active public policy advocates. Health educators need to be presented with opportunities to increase their advocacy activity in “low” to “medium” activities. If “high” level activities are encouraged, such as running for public office, this may be too large of a jump in activity and will not likely result in behavior change. By tailoring the advocacy opportunities offered, it may increase the likelihood that health educators participate.

On average, respondents indicated more benefits to public policy involvement than barriers, yet many in the sample were not actively involved in public policy. This suggests that benefits may not be driving behavior and that reducing barriers might be key to involvement. Additionally, the Cronbach alpha for benefits was low ($\alpha=0.368$), suggesting that the responses contained heterogeneous constructs. Due to the low Cronbach alpha, any results about benefits of public policy should be interpreted with caution.

The most frequent barrier (“not enough time”) is of particular importance. Many participants had only completed public policy activities that did not take much time such as voting or contacting a public official. Perhaps in order to increase advocacy among health educators, activities need to be quick and easy.

Table 4.

Benefits to Public Policy Activities

Benefits	% responded yes	n
Improving the health or welfare of the public	85.2%	150
Creates public awareness	78.4%	138
Making a difference in other’s lives	76.1%	134
Improving a situation or issue in my community	74.4%	131
Affecting many people at once	74.3%	130
Changing social norms	65.9%	116
Being able to get involved/participate	43.8%	77
Potential to get or direct limited resources (funding or staffing)	39.2%	69
Increasing the compliance to the issue	37.5%	66

Thus, to improve the measure, items eliciting involvement such as 'reading and discussing public policy initiatives' could be added to the scale to fill in that gap. This would also provide more precision of measurement for those respondents who cluster at that lower level involvement by allowing more differentiation of involvement.

Implications for Health Education

Health educators in Ohio need to be presented with opportunities to increase their advocacy activity in "low" to "medium" public policy activities. For example, most of the target population is currently voting as their primary advocacy activity. Therefore, promotion of understanding current public policy issues and write letters to their legislators might be an appropriate target activity. Perhaps in order to increase advocacy among health educators, activities need to be quick and easy, since the most frequent barrier was lack of time. One idea might be increased use of social media, with organizations such as OPHA and OSOPHE sharing emails or Facebook posts that can easily be forwarded or reposted. Providing templates or fact sheets for health educators to use in constructing a letter to the editor or letters to their representatives might be another idea.

Only 24.8% of respondents obtained information on advocacy or changing public policy from professional journals. Health journals are an untapped mechanism for promoting advocacy. Additionally, many respondents indicated they received on-the-job information through colleagues or job-related functions, such as conference sessions or college coursework. These should continue to be venues through which information is distributed. Within the profession, colleagues should be encouraged to promote advocacy by peers and administration.

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