Intent to Advocate Before and After a Health Education Workshop

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Abstract

This pilot study evaluated the influence of an advocacy training workshop sponsored by an Eta Sigma Gamma chapter affiliated with a large university in the Midwest. The theory of planned behavior (TPB) was utilized as a framework for assessing participants' intentions to participate in advocacy. Participants completed pre- and post-test surveys to assess intent to advocate. Multiple linear regression was executed to determine the extent to which participants' attitudes, subjective norms, and perceived behavioral control predicted their behavioral intentions to advocate. Only perceived behavioral control significantly predicted participants' behavioral intentions to advocate, $p = .009$. Dependent *t*-tests showed that mean post-test scores were significantly lower than pre-test scores for attitudes toward advocacy ($M = 11.59$, $M = 7.41$), subjective norms ($M = 16.21$, $M = 13.11$), and behavioral intentions ($M = 18.55$, $M = 13.50$). There was no significant change for perceived behavioral control ($M = 37.65$, $M = 36.35$). Participants' knowledge of the advocacy process was associated with greater involvement in advocacy ($M = 5.10$, $M = 6.15$). Findings from this pilot study suggest that participants' perceptions regarding their capacity for advocacy influenced their intentions to engage in the process. Findings also indicate that the training workshop improved participants' knowledge of advocacy, but not their intent to advocate.

Introduction

In addition to developing programs and fulfilling other key responsibilities, health educators are increasingly involved in advocacy, a process devoted to acting on behalf of individuals in need of resources and skills to support their health. Health educators can serve as instruments of change working closely with individuals and communities to facilitate the advocacy process (McKenzie, Neiger, & Smeltzer, 2005).

Advocacy has been defined as an attempt to influence decisions that affect the health and welfare of vulnerable individuals who lack power (Sosin & Caulum, 2001). In other words, an advocate is a person who asserts or argues for a particular cause. Advocacy provides an opportunity for influencing the manner in which the public and policy makers think about and act on policies that affect health. Despite common misconceptions about advocacy requiring special mentalities and skills, advocacy can be performed by anyone who has a desire to affect change for individuals, families, communities, organizations, and other targeted entities (Legislative Consultant, Illinois Rural Health Association, personal communication, October 15, 2004). Those who engage in advocacy activities exercise their rights to participate in the democratic process (American Public Health Association, 1999).

There are many ways to be an active health advocate without making personal visits to policy makers. Writing letters to policy makers can be very effective in influencing the outcome of a piece of legislation. Health educators can inform policymakers about the impact a particular bill would have on them, their community, and their state. Utilizing media coverage is one of the best ways to gain the attention of decision makers. The media also can be used to publicize community or state level public health events. Speaking at town/public board meetings has the potential to impact the policymaking process. Citizens who understand the needs of their community and the ramifications of policy decisions on the health and well-being of their community are essential to the success of any advocacy effort. Finally, coalition building is one of the most effective vehicles for generating grass-root support for a public health issue. Coalition building involves activating local support through community mobilization around an issue, and voicing the support to policymakers (American Public Health Association, 1999). Unfortunately, few health educators are actively involved in the advocacy process (Tappe & Galer-Unti, 2001).

The ability to advocate for personal, family, and community health represents an essential skill for a health literate individual and an integral part of the health education process. Advocating for health-related issues, needs, and resources is not only a requisite skill, but also a responsibility of health educators. According to the National Commission for Health Education Credentialing, Inc. (2000), even entry level health educators have the responsibility of communicating health and health education needs, concerns, and resources. The competency-based framework for

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graduate level health educators further expanded the responsibilities to incorporate health advocacy (NCHEC, 1999). For health educators to promote health literacy, advocacy must be included in the process (Tappe & Galer-Unti, 2001).

Health educators have the skills and expertise, as well as the credibility to present information about a wide array of health issues. Educators may not know the specifics of every health policy, but they can speak broadly about the importance of prevention, surveillance, data, and sound science (American Public Health Association, 1999). Health educators can be found in a variety of settings, such as schools/universities, healthcare organizations, community health agencies, and worksites. These different settings allow for many opportunities to advocate for and educate others on health-related issues. Advocacy can involve interaction with legislators, legislative assistants, school administrators, school board members, private sector leaders, parents, community members, and/or faculty and staff members. Advocacy interactions can be planned or incidental; occur with one person or a group; and take place during a meeting, through the media, or at a public forum. Because of the potential impact of successful advocacy, health educators must be prepared to leverage every opportunity available (Birch, 1995).

The success of health education programs depends, in part, on the ability of health educators to influence the actions of politicians. Politicians tend to support programs they feel are of greatest value to their constituents; they are not expected to know the value of community-based health education programs, unless health advocates are able to make compelling cases for such programs. Therefore, politicians depend on advice from those who have legitimate expertise such as health educators. The decisions that legislators make have such a powerful effect on health education that legislative advocacy can be viewed as a direct extension of the education process (Huntington, 2001).

Research has highlighted the need for health educators to master advocacy skills (Tappe & Galer-Unti, 2001). Moreover, the American Public Health Association (APHA), the Society for Public Health Education (SOPHE), and other professional organizations have collaborated to support advocacy education and skill development among health educators (APHA, 1998). Despite widespread recognition of the importance of advocacy and national initiatives to develop advocacy skills among health educators, no research exists to address factors that contribute to health educators' intentions to participate in advocacy activities.

This pilot study was designed to examine the effectiveness of an advocacy training workshop in relation to health educators' attitudes, social norms, levels of perceived control, and behavioral intentions. The workshop, sponsored by an Eta Sigma Gamma chapter, addressed advocacy, lobbying, the law-making process, implications for health educators, methods for communicating with legislators, and tobacco control as an example

Theoretical Framework

The instrument for this study was developed using constructs from Ajzen and Fishbein's Theory of Planned Behavior (TPB) (Fishbein & Ajzen, 1975; Glanz, Rimer, & Lewis, 2002). The TPB is a value expectancy theory that focuses on the value attached to a behavioral outcome or attribute. In essence, humans are rational beings who make decisions about engaging in a behavior as result of the value associated with the behavior (Glanz, Rimer, & Lewis, 2002).

The TPB focuses on predicting human behavior through behavioral intention. Behavioral intention is predicted by three constructs–attitudes toward the behavior, subjective norms, and perceived behavioral control (Glanz, Rimer, & Lewis, 2002). With regard to advocacy, attitude toward the behavior is contingent upon perceptions regarding the role that advocacy plays in one's professional life and the extent to which advocacy makes a difference in the lives of the people one serves. The key norms for advocacy come from beliefs and motivation to comply with the desires of supervisors/bosses, co-workers/colleagues, and top level administrators. Control issues surrounding advocacy include available resources, influence of stakeholders, knowledge of the advocacy process, workplace environment, available time, influence from organizations, level of advocacy training, and political atmosphere at work.

Methods

The workshop consisted of lectured-based presentations, an open forum, an interactive discussion, and PowerPoint presentations. Guest speakers consisted of representatives from the Illinois General Assembly, Southern Illinois University Public Policy Institute, Illinois Rural Health Association, and the American Lung Association.

The morning session of the workshop addressed two major issues in advocacy including the use of media and advocacy versus lobbying. The afternoon session incorporated input from state representatives regarding what is important to legislators. Finally, the guest speakers focused on the process of advocacy utilizing tobacco control as an example.

Sample

Fifty-four individuals participated in the advocacy training workshop and completed pre-tests including 44 (81.5%) females and 10 (18.5%) males. The initial sample consisted of participants from the following work settings: (a) clinical (1, 1.9%), (b) school (12, 22.2%), (c) community (10, 18.5%), (d) university (18, 33.3%), (e) other (6, 11.1%), and (f) multiple settings (7, 13.0%).

Twenty-two participants completed post-tests including 14 (63.6%) females and 8 (36.4%) males. The final sample consisted of individuals associated with the following work settings: (a) school (4, 18.2%), (c) community (4, 18.2%), (d)

university (10, 45.5%), (e) other (1, 4.5%), and (f) multiple settings (3, 13.6%).

Instrumentation

The research questions for this pilot study were as follows: (a) Do participants' attitudes, subjective norms, and perceived behavioral control significantly predict their behavioral intentions to advocate?; (b) Does a significant difference exist between participants' attitudes toward advocacy before and after the advocacy training workshop?; (c) Does a significant difference exist between participants' subjective norm before and after the advocacy training workshop?; (d) Does a significant difference exist between participants' perceived behavioral control before and after the advocacy training workshop?; and (e) Does a significant difference exist between participants' behavioral intentions to advocate before and after the advocacy training workshop?

Prior to developing the instrument for this pilot study, the investigators conducted elicitation interviews among potential participants of the advocacy training workshop. Questions incorporated in the elicitation interviews were reviewed by an assistant professor of health education (see Figure 1). The investigators contacted three graduate students, two representatives from community agencies, and two representatives from a local university for telephone interviews. Responses to the elicitation interviews were synthesized and a formal instrument was developed based on constructs from Ajzen and Fishbein's Theory of Planned Behavior (TPB) (Fishbein & Ajzen, 1975; Glanz, Rimer, & Lewis, 2002). Specifically, survey items assessed participants' attitudes about the importance and influence of advocacy, perceptions about their support for advocacy involvement from individuals in the workplace (i.e., subjective norms), perceptions about factors that influence their capacity to affect change through advocacy (i.e., perceived behavioral control), and behavioral intentions to participate in advocacy-related activities.

Attitude

1. What role has advocacy played in your professional life?
2. Describe your perceptions toward advocacy (i.e., How do you feel about advocacy?).
3. Do you believe that doing more advocacy work will improve the lives of those you work with? Why or why not?

Subjective norm

1. By becoming involved in advocacy, what individuals or groups do you feel will support or hinder your efforts? Please explain.
2. How have your advocacy efforts been affected by individuals within your workplace?

Perceived behavioral control

1. What factors do you believe have facilitated your ability to participate in advocacy activities?
2. What barriers do you believe have hindered your desire to advocate?

Figure 1. Elicitation Interview Question

Content and face validity for the instrument was confirmed by two health education professors skilled in instrumentation. Internal consistency/reliability estimates were conducted for each subscale of the instrument using data from the pre-test. Results were as follows: (a) attitudes toward advocacy (.71), (b) subjective norms (.89), (c) perceived behavioral control (.74), and (d) behavioral intentions (.82).

Responses to individual survey items were formatted according to a 7-point Likert-type scale. For example, participants were asked to rate the extent to which they agreed (7) or disagreed (1) with the statement, "Advocacy plays an important role in my professional life." Total scores were generated to measure participants' attitudes toward

Table 1

Results of the Multiple Regression Analysis

Predictors	â	*t*	*p*
Attitudes	-.118	-.840	.405
Subjective norms	.160	1.125	.266
Perceived behavioral control	.401	2.741	.009*

* $p < .05$

advocacy, subjective norms, perceived behavioral control, and behavioral intentions to advocate.

Data Collection

Data for this pilot study were collected on two separate occasions. Participants completed pre-tests during the registration process on the day of the advocacy training workshop. Participants reviewed cover letters indicating that their participation was both voluntary and anonymous. By completing the survey and revealing their email address on the instrument, participants agreed to be contacted for completion of a follow-up survey. The follow-up survey (i.e., post-test) was administered to participants approximately four months after the advocacy training workshop. Participants received an initial email message and two subsequent follow-up messages. Each message contained a link to the survey. Participants who failed to respond to the email survey received hard copies of the instrument through the mail. The response rate for the post-test was 40.7% (n = 22). Pre- and post-tests were matched through participants' email addresses.

Data Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 11.0. A multiple linear regression analysis was used to examine the extent to which participants' attitudes, subjective norms, and perceived behavioral control predicted their behavioral intentions to advocate. The multiple regression analysis was based on participants' responses at pre-test (N = 54). The data were normally distributed and thus, dependent t-tests were used to compare mean responses to survey items before and after the advocacy training workshop. The Bonferroni procedure was applied to minimize Type I error for dependent t-tests. Alpha levels were adjusted to .0125.

Results

Results from the multiple linear regression analysis indicated that the linear combination of predictors (i.e., attitudes, subjective norms, and perceived behavioral control) was significantly related to the total score for behavioral intentions, F (3, 45) = 3.94, p = .01. The sample multiple correlation coefficient was .46, indicating that approximately 21% (R^2 = .21) of the variance of the total score for behavioral intentions was explained by the linear combination of predictors.

Table 1 presents results indicative of the strength of the individual predictors. Only one predictor was statistically significant—perceived behavioral control, p = .009. Perceived behavioral control accounted for 18% of the variance of the total score for behavioral intentions, while the other variables (i.e., attitudes and subjective norms) contributed only 3%.

Table 2 shows results from the dependent t-tests. Mean post-test scores were significantly lower than the pre-test scores for attitudes toward advocacy, t (21) = 4.194, p = .000; subjective norms (i.e., encouragement from and compliance with selected entities), t (21) = 2.798, p = .011; and behavioral intentions to advocate, t (17) = 3.369, p = .004. Results also indicated that there was no statistically significant difference between the mean pre- and post-test scores for perceived behavioral control (i.e., factors that support or hinder participation in advocacy), t (19) = .832, p = .416. The data also revealed that upon completion of the workshop, participants' knowledge of the advocacy process was more likely to support their involvement in advocacy.

Conclusions

Several conclusions can be drawn from this pilot study. First, findings suggest that only factors that influence participants' capacity to engage in advocacy efforts (i.e., available resources, influence of stakeholders, knowledge of advocacy process, workplace environment, available time, influence from organizations, level of advocacy training, and political atmosphere at work) influenced their intentions to advocate. Consequently, health educators should seek to address these factors through collaboration with employers, community agencies, and professional organizations. Health educators also must coordinate workshops and other continuing education activities that enhance perceived behavioral control.

A second conclusion from this pilot study was that a single workshop characterized by presentations and discussion is insufficient in improving participants' attitudes toward advocacy, subjective norms, perceived behavioral control, and behavioral intentions. Nonetheless, knowledge of advocacy can positively affect individuals' perceptions about their involvement in the process. Based on these conclusions, efforts must be made to bridge the gap between advocacy knowledge and practice. For example, continuing education seminars that incorporate role plays, scenarios, and other interactive activities could be organized to promote the practice of advocacy among health educators.

Interestingly, the vast majority (81.5%) of participants who chose to attend the workshop were females. However, there was a greater response rate for the post-test among males (80.0%). The post-test response rate for females was 31.2%. These findings support a need to explore gender differences related to interests and behaviors toward advocacy. It also should be noted that almost half (45.5%) of individuals who completed the post-test were affiliated with a university setting. These individuals might not have had opportunities for professional involvement in advocacy despite their avid interests in the process.

Several limitations restricted the researchers' ability to generalize findings and conclusions about the study. First of all, the study design was non-experimental and all measures relied on self-report. Thus, the extent to which participants provided socially desirable responses was not fully known. Secondly, the total sample size and low response rate from participants limited the type of data analyses

Table 2

Survey Questions and Results of Dependent t-tests

Constructs	Pre-test	Post-test	*t*-test	*p*-value
Attitudes				
Please rate the extent to which you agree or disagree with the following statements (scale: 1 = strongly disagree to 7 = strongly agree).				
1. Advocacy plays an important role in my professional life.	5.45 (1.06)	3.86 (2.01)		
2. Advocacy makes a difference in the lives of the people I serve.	6.14 (.71)	3.55 (2.70)		
Total	11.59 (1.56)	7.41 (4.67)	4.194	.000
Subjective Norms (Normative Beliefs)				
Please indicate the degree to which the following entities are likely to discourage or encourage your involvement in advocacy (scale: 1 = very likely to discourage to 7 = very likely to encourage).				
1. Supervisor/boss	5.36 (1.53)	5.09 (1.09)		
2. Co-workers/colleagues	5.50 (1.06)	3.86 (2.05)		
3. Top level administrators	5.18 (1.53)	6.18 (1.44)		
Subjective Norms (Motivation to Comply)				
Please indicate how likely you are to comply with the desires of each entity (scale: 1 = not likely to comply to 7 = very likely to comply).				
1. Supervisor/boss	5.45 (1.54)	3.73 (2.07)		
2. Co-workers/colleagues	5.27 (1.35)	3.55 (1.92)		
3. Top level administrators	5.64 (1.29)	3.82 (2.15)		
Total	16.21 (3.45)	13.11 (4.29)	2.798	.011
Perceived Behavioral Control				
Please indicate how much each of the following factors support or hinder your participation in advocacy (scale: 1 = very likely to hinder to 7 = very likely to support).				
1. Resources available	4.00 (1.56)	3.10 (1.59)		
2. Influence of stakeholders	5.15 (1.23)	3.35 (1.70)		
3. Knowledge of advocacy process	5.10 (1.80)	6.15 (1.42)		
4. Workplace environment	5.10 (1.48)	6.15 (1.14)		
5. Available time	4.30 (2.00)	2.90 (1.97)		
6. Influence from organizations	4.45 (1.73)	5.90 (1.77)		
7. Level of advocacy training	4.75 (1.55)	3.20 (1.61)		
8. Political atmosphere at work	4.70 (1.34)	5.60 (1.03)		
Total	37.65 (6.89)	36.35 (4.00)	.832	.416
Behavioral Intentions				
Please indicate the likelihood of your participation in each of the following advocacy-related activities within the next 6 months (scale: 1 = very unlikely to 7 = very likely).				
1. Providing testimony before a state/federal legislative body	2.88 (2.06)	1.88 (1.11)		
2. Writing a letter/sending an email message to a legislator	6.24 (1.52)	3.35 (2.23)		
3. Making a telephone call to a legislator	5.35 (2.03)	2.82 (1.74)		
4. Presenting information to a local governing body	4.78 (2.05)	5.50 (2.33)		
Total	18.44 (6.42)	13.50 (4.61)	3.369	.004

conducted by the researchers. Thirdly, there is a possibility that participants were overwhelmed with information about the complexity of the advocacy process. Therefore, some participants' interest in advocacy declined. Fourthly, the workshop focused mostly on advocacy at the state level as opposed to the local level. There is a possibility that participants were expecting more information about advocacy at the grass roots level. Consequently, the content of the workshop did not necessarily meet the needs and skills of participants. This study involved only one workshop in an anticipated series of advocacy training workshops. Lastly, the workshop did not include hands-on activities for engaging participants in the advocacy process.

Participants were given an opportunity to evaluate the workshop by completing a form and providing written comments. Despite its limitations, participants' comments about the workshop reflected their acknowledgement of the importance and relevance of advocacy in health education.

This pilot study provided planners with insights for improving future advocacy-training seminars and an instrument to measure the effects of training on advocacy involvement. Essentially, those planning advocacy training seminars should incorporate hands-on activities that enhance participants' self-efficacy, emphasize the impact of advocacy at the local level, and focus on participants' special interests and work settings. Getting health educators involved at the grass roots level of advocacy seems to be a favorable approach for developing skills and gaining confidence towards advocacy activities. Those planning workshops also should measure effect. The TPB may provide a framework for measuring this effect.

Advocacy is an important aspect of health education. One of the key responsibilities of a health educator is to advocate for health-related issues at local, state, and federal levels. The need for advocacy is becoming increasingly recognized by health educators within school, university, clinical, community, and worksite settings. Health educators must overcome barriers for participating in the advocacy process and strive to become a voice for the people they serve.

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