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Tobacco Control Policy Advocacy Attitudes and Self-Efficacy Among Ethnically Diverse High School Students

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This study applied self-efficacy theory to assess empowerment to advocate on behalf of tobacco control policies. The Youth Tobacco Survey with added policy advocacy self-efficacy, attitudes, and outcome expectations scales was given to 9,177 high school students in Texas. Asians showed the lowest prevalence of experimentation and current smoking, followed by African Americans. Anglo-Europeans had higher rates of current smoking. Latino male students had the highest experimentation and current smoking rates. Policy advocacy self-efficacy was higher among African Americans. Latinos scored lowest. Asians had the highest level of approval for tobacco control policies. African Americans had the highest scores in policy advocacy outcome expectations, followed by Asians and Latinos. Anglo-Europeans scored lowest. Students who had never tried smoking had the highest scores in all three scales, with a decreasing trend as the frequency of smoking increased. Associations with smoking status remained significant when controlling by gender and ethnicity.

Keywords: tobacco control; policy advocacy; disparities; empowerment; youth; high school students

Most early tobacco prevention programs focused on passing information to teenagers about the harmful long-term health effects of cigarette smoking. This approach often increased students’ knowledge, and some interventions showed attitude changes, but most resulted in little or no change in smoking behavior (Killen, 1985). Later interventions added an important focus on peer pressure resistance skills and

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tobacco marketing awareness (Evans, Farkas, Gilpin, Berry, & Pierce, 1995; Feighery, Borzekowski, Schooler, & Flora, 1998; Schooler, Feighery, & Flora, 1996; Tobler, 1986). Many of these programs showed significant reduction in the incidence of youth tobacco use (Botvin, Baker, Dusenbury, Tortu, & Botvin, 1990; Flay, 1985; Killen, 1985; Killen et al., 1988; Rundall & Bruvold, 1988), but the effects tended to be only temporary (Flay et al., 1989; Hansen, 1992).

It has become increasingly clear that to achieve sustainable behavior change, intervention strategies must include the target audience’s social context (Link & Phelan, 1995; Macintyre, Maciver, & Sooman, 1993; Millstein, Nightingale, Petersen, Mortimer, & Hamburg, 1993; Wills, Pierce, & Evans, 1996). With tobacco use, for example, environmental influences must be addressed. Policy advocacy training may give adolescents long-lasting capacity to transform their societies. It may also make behavior change more durable as youths have an opportunity to organize their ideas in a coherent manner, to prepare to defend them, and to infuse all their passion into achieving societal change (Bandura, 1996; Pittman, 1991). In addition, to enhance self-efficacy, tobacco control policy advocacy training per se may help adolescents modify their perceived norms and attitudes toward tobacco.

Self-efficacy expectations are important determinants of behavior (Bandura, 1996), and those related to resisting peer pressure have widely been associated with expectations of future smoking and actual smoking behaviors (Shegog et al., 2005; Winkleby et al., 2004; Winkleby, Feighery, Altman, Kole, & Tencati, 2001). However, very little has been published in the scientific literature about tobacco-related advocacy self-efficacy expectations and their relationship to tobacco use. A recent study by Winkleby et al. (2004) reported that high school students exposed to a tobacco advocacy training program were less likely to smoke, especially those categorized by the researchers as regular smokers (consuming at least 1 pack per week), compared with the no-intervention control group. Participants also showed significant increase in their advocacy self-efficacy expectations, but researchers did not report the relationship between the change in efficacy expectations and smoking behavior. Investigators defined advocacy self-efficacy expectations as the perceptions of ability to perform specific advocacy actions such as conducting background research; making presentations to school administrators or community store owners; surveying school or community members about a tobacco issue; or working with the media, police, or schools on a tobacco-related issue. The Advocacy Self-Efficacy Expectations Scale consisted of eight items and had a Cronbach’s reliability alpha of .83.

In a study with nearly seven thousand 10th graders in California published in 1999, Unger et al. found that support for antitobacco policies was highest among nonsusceptible never-smokers and lowest among current smokers. The authors also reported that support for tobacco control policies was significantly associated with psychosocial predictors of tobacco use, as well as with intentions to perform advocacy actions against tobacco use. However, although several youth tobacco prevention studies and interventions have included policy advocacy components (Chaney, Jones, & Galer-Uniti, 2003; Ribisl et al., 2004; Unger et al., 1999), descriptions of the relationship between feeling politically empowered (policy advocacy-specific self-efficacy) and cigarette-smoking behaviors are difficult to find in the recently published literature.

Empowerment is a construct with several dimensions, which may be interpreted in several different ways. Some definitions refer to power as a characteristic or structure (e.g., knowledge; Lips, 1991). Max Weber (1946) proposed that power exists within the context of a relationship between people or things. According to Weber, power does not
exist in isolation nor is it inherent in individuals. Therefore, if power is created in relationships, power and power relationships can change. In this context, empowerment, defined as a social process that helps people gain control over their own lives, at the individual, community, and societal levels, by acting on issues that they define as important, is paramount to the reduction of disparities (Friere, 1970).

Feeling disempowered may be a consequence of educational and economic disparities that prevent individuals from possessing the skills and sense of capacity to bring change to their communities and to society in general, and even realizing that it is possible for individual and collective action to effect change. The political passivity of many is not due to laziness or lack of interest but to the overwhelming dimension of a power relationship in which they find themselves. Unfortunately, feeling disempowered perpetuates and expands disparities by maintaining the status quo and exposing these individuals to greater risks, further exacerbated by inequalities in access to care.

Social disparities help shape the likelihood of behavior problems. Tobacco use is a problem that both reflects and widens the health disparity gap. Individuals with lower educational attainment, blue-collar jobs, lower income, and a higher number of life stressors are more likely to become smokers than those who are better educated, have better employment, and are more likely to have a stronger social support system (Chuang, Cubbin, Ahn, & Winkleby, 2005; Chyou, Nomura, Stemmermann, & Kato, 1993; Lindstrom & Ostergren, 2001; Montemery et al., 2001; Sorensen, Gupta, & Pednekar, 2005). Poor people have more difficulty gaining access to effective cessation aids and suffer more often from associated problems that reduce the likelihood of successfully quitting (e.g., depression, other mental health problems, and alcoholism; Agency for Healthcare Research and Quality, 2005). In addition, smoking typically negatively affects their health, adding handicaps and increasing the need for health care services that most lack to begin with. Consequently, tobacco use is one of the most representative expressions of social disparities in general and health disparities in particular.

According to social cognitive theory, individuals act greatly depending on the interaction between the environment and the person’s expectations both of performance (self-efficacy) and outcomes (Bandura, 1986, 1996). This study applies self-efficacy theory to empowerment to take political action—in this case, action on behalf of tobacco control public policies. It is important to note that, in this article, the term political is used to indicate participation in, relating to, or dealing with the structure or affairs of government or the state (Simpson & Weiner, 1989) and not any affiliation to a particular doctrine.

As part of the evaluation of the Texas Tobacco Prevention Initiative (McAlister et al., 2004; Meshak et al., 2004), the present study measured the association between tobacco control policy advocacy self-efficacy expectations and cigarette-smoking behavior, and the relationship to gender and ethnicity among high school students in Texas. We defined policy advocacy as individual and group actions to influence public policies by writing and/or speaking in person or by other medium in support of an issue at a societal level. Tobacco control policy advocacy was defined as actions to support public policies to reduce tobacco use or exposure to environmental tobacco smoke. Examples are writing letters to a local newspaper in support of a clean indoor air ordinance, writing or talking to elected officials about increasing taxes on tobacco products, and collecting signatures for a petition to ban tobacco advertisement in sports facilities. Self-efficacy expectations related to policy advocacy were defined as the feelings that an individual may have related to his or her capacity to take political advocacy actions.
METHOD

A self-administered scannable questionnaire was given to students in eight east Texas high schools during the spring of 2003. The survey instrument was based on the standard Youth Tobacco Survey (Centers for Disease Control and Prevention [CDC], 2004), and a series of tobacco control policy advocacy questions were added after extensive pretesting. The policy advocacy questions involved three scales: (a) attitudes toward tobacco control policies, (b) tobacco policy advocacy self-efficacy, and (c) tobacco policy advocacy outcome expectations.

The Attitudes Scale included five questions with Likert-type responses ranging from strongly support to strongly oppose. The questions asked for participants’ approval of policies such as stronger laws to prohibit selling or passing tobacco to minors, more limits on the people allowed to smoke, raising taxes on tobacco products, and providing funding for tobacco prevention education and for cessation programs. The Self-Efficacy Scale included six questions with a response range from 0 (I definitely cannot do it) to 10 (I definitely can do it). The questions asked how capable participants felt taking specific policy advocacy actions, including “gathering all the necessary information,” “writing letters to elected leaders,” “meeting elected leaders at their offices,” “writing letters to newspaper editors,” “defending their opinions even when someone disagrees with them,” and “keep insisting even if it is hard to see results.” The Outcome Expectations Scale included eight questions about expected social outcomes and expected efficacy of advocacy actions, also with Likert-type response options. Questions referred to such outcomes as “my parents will be proud of me if I write a letter to an elected official,” “my friends will respect me if I write a letter to an elected official,” “elected leaders will read what I write,” “elected leaders will think about what I write,” “my parents will be proud if my name is in the news,” and “my friends will respect me if my name is in the news.” Response options ranged from strongly agree to strongly disagree.

Quality control and questionnaire scanning were performed by a specialized company. Data were analyzed using SPSS 13.01. Factor analysis with Varimax rotation and Cronbach’s alpha reliability analysis were performed on each of the scales. F tests were used to analyze differences in scale scores by age, gender, and ethnicity, as well as by smoking status.

RESULTS

A total of 9,177 students took the survey, with slightly more female students participating (51.1%). Most students were between 15 and 17 years of age, with only 6% being 14 and 17% 18 or older. Thirty percent of the students described themselves as Anglo-European, 28% as African American, 19% as Hispanic or Latino, and 23% as other or mixed ethnicity. Table 1 shows the prevalence of lifetime smoking (ever having tried a cigarette) and current smoking (having tried a cigarette in the past 30 days) by gender and ethnicity. Asian girls showed the lowest prevalence of ever having smoked (experimentation) and current smoking, with approximately one quarter of participants (25.6%) having experimented with smoking and less than 7% being current smokers. Half of the African American girls had experimented with cigarettes (47.7%), and just more than 1 in 10 (11.9%) reported current smoking behavior. Latina girls had the highest rate of experimentation (54.6%) and the second highest current smoking
Table 1. Prevalence of Lifetime and Current Cigarette Smoking by Gender and Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Lifetime Cigarette Smoking</th>
<th></th>
<th>Current Cigarette Smoking</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>Anglo-Europeans</td>
<td>687</td>
<td>51.6</td>
<td>645</td>
<td>48.4</td>
</tr>
<tr>
<td>African Americans</td>
<td>592</td>
<td>47.7</td>
<td>649</td>
<td>52.3</td>
</tr>
<tr>
<td>Hispanic Latino</td>
<td>466</td>
<td>54.6</td>
<td>387</td>
<td>45.4</td>
</tr>
<tr>
<td>Asian</td>
<td>210</td>
<td>25.6</td>
<td>609</td>
<td>74.4</td>
</tr>
<tr>
<td>Other</td>
<td>85</td>
<td>57.8</td>
<td>62</td>
<td>42.2</td>
</tr>
<tr>
<td>Total</td>
<td>2,040</td>
<td>46.4</td>
<td>2,352</td>
<td>53.6</td>
</tr>
</tbody>
</table>
rate (18.7%). Anglo-European girls had the second highest rate of experimentation (51.6%) and the highest current smoking rate (25.3%).

Similar to the girls, Asian boys had the lowest prevalence of ever trying a cigarette (39.6%). Although African American boys showed experimentation rates higher than Asians (47.7%), current smoking rates were almost the same for both groups (17.8% vs. 17.6%, respectively). Nearly two thirds of Latino boys (64.4%) had experimented with cigarettes, and about 1 in 3 reported current smoking (31.7%), the highest rates of all groups. Cigarette experimentation among Anglo-European boys was the second highest (54.5%), and their current cigarette use (30.7%) was almost the same as for Latino male students.

Factor analysis showed only one main component for each of the three scales. Cronbach’s alpha reliability coefficient for the Attitudes Toward Tobacco Control Policy Scale was .84, with scores ranging from 0 to 20, a mean of 13, and a standard deviation of 5.2. The Policy Advocacy Self-Efficacy Scale had a Cronbach’s alpha reliability coefficient of .89, a minimum score of 0 and a maximum of 60, a mean of 36, and a standard deviation of 15. For the Outcome Expectations Scale, Cronbach’s alpha was .91, scores ranged from 0 to 24, the mean was 16, and the standard deviation was 5.5.

Table 2 shows the scale scores according to gender and ethnicity. The one-way ANOVA showed statistically significant differences among each ethnicity/gender group for each of the scales. Coefficients (F) were 15.9 (p < .01) for intergroup differences in the Tobacco Policy Advocacy Self-Efficacy Scale, 25.9 (p < .01) in the Tobacco Policy Attitude Scale, and 48.5 (p < .01) in the Policy Advocacy Outcome Expectations Scale. Scores for the Self-Efficacy Scale were generally more positive among female students, with African American girls showing significantly higher scores than the other girls. Among male students, African Americans also showed the highest self-efficacy scores, followed by Anglo-Europeans and Asians. Latinos had the lowest scores of all gender/ethnicity groups. Only African American boys and girls were always above the mean for the entire sample. Anglo-Europeans were slightly below the mean, and Asians and Latinos were consistently below the mean.

Similar to the self-efficacy expectations, female students scored generally higher than male students in the Attitudes Toward Tobacco Control Policy Scale. The highest level of approval among female students was among Asians, with no difference among the other groups. Asian male students also had the highest approval scores, followed by African Americans. Both groups were above the mean, whereas Anglo-Europeans and Latinos were below the mean, with no significant difference between them. In terms of the Policy Advocacy Action Outcome Expectations Scale, African American female students had the highest scores, followed by Asians and Latinas. Anglo-European girls had the lowest scores and were the only female students below the mean. Among male students, African Americans also had the highest scores, followed by Latinos. Asians and Anglo-European boys scored below the mean, with the latter scoring lowest, similar to their female counterparts.

Students who described themselves as of “other” ethnic origin showed some of the highest rates of cigarette use and similarly lowest scores in the scales. Unfortunately, the number of students in this group was often too low, and the differences with other groups did not reach statistical significance.

There were significant differences in scale scores according to smoking status, as shown in Table 3. Students who had never tried smoking had the highest scores in all three scales, significantly above those who had experimented with smoking and established smokers. Table 3 also reflects a decreasing trend in the scores of the three scales.
<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Tobacco Policy Advocacy Self-Efficacy Scale</th>
<th>Attitudes Toward Tobacco Policies Scale</th>
<th>Policy Advocacy Outcome Expectations Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female M 95% CI</td>
<td>Male M 95% CI</td>
<td>Female M 95% CI</td>
</tr>
<tr>
<td>Anglo / other Europeans</td>
<td>1,307 37.4 36.7-38.2</td>
<td>1,199 34.4 33.5-35.3</td>
<td>1,301 13.4 13.1-13.6</td>
</tr>
<tr>
<td>African Americans</td>
<td>1,164 39.5 38.7-40.3</td>
<td>1,103 36.8 35.9-37.7</td>
<td>1,157 13.2 12.9-13.5</td>
</tr>
<tr>
<td>Mexican / other Hispanics</td>
<td>810 37.0 36.1-38.0</td>
<td>730 32.6 31.5-33.7</td>
<td>806 13.1 12.7-13.4</td>
</tr>
<tr>
<td>Asian</td>
<td>799 36.9 36.0-37.8</td>
<td>780 33.2 32.2-34.2</td>
<td>795 14.8 14.5-15.1</td>
</tr>
<tr>
<td>Other</td>
<td>139 38.2 35.8-40.6</td>
<td>124 33.2 30.1-36.4</td>
<td>138 11.7 10.8-12.7</td>
</tr>
<tr>
<td>Total</td>
<td>4,219 37.8 37.4-38.3</td>
<td>3,936 34.5 34.0-34.9</td>
<td>4,197 13.5 13.3-13.6</td>
</tr>
</tbody>
</table>
Table 3. Self-Efficacy, Attitudes, and Outcome Scales Scores by Smoking Status

<table>
<thead>
<tr>
<th>Smoking Status</th>
<th>n</th>
<th>M</th>
<th>95% CI</th>
<th>M</th>
<th>95% CI</th>
<th>M</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never tried a cigarette</td>
<td>4,414</td>
<td>38.0</td>
<td>37.5-38.4</td>
<td>14.4</td>
<td>14.3-14.5</td>
<td>16.5</td>
<td>16.4-16.7</td>
</tr>
<tr>
<td>Have tried a cigarette at least once</td>
<td>4,215</td>
<td>34.3</td>
<td>33.8-34.7</td>
<td>11.3</td>
<td>11.1-11.5</td>
<td>15.1</td>
<td>14.9-15.3</td>
</tr>
<tr>
<td>Current smoker</td>
<td>1,765</td>
<td>30.6</td>
<td>29.9-31.4</td>
<td>8.7</td>
<td>8.5-8.9</td>
<td>13.4</td>
<td>13.1-13.7</td>
</tr>
<tr>
<td>Smoke 1 to 19 days per month</td>
<td>1,008</td>
<td>32.5</td>
<td>31.6-33.4</td>
<td>9.9</td>
<td>9.6-10.1</td>
<td>14.7</td>
<td>14.4-15.0</td>
</tr>
<tr>
<td>Smoke more than 20 days per month</td>
<td>749</td>
<td>28.2</td>
<td>26.9-29.5</td>
<td>7.1</td>
<td>6.7-7.5</td>
<td>11.6</td>
<td>11.1-12.1</td>
</tr>
<tr>
<td>Current daily smoker</td>
<td>563</td>
<td>27.6</td>
<td>26.1-29.2</td>
<td>6.7</td>
<td>6.3-7.2</td>
<td>11.1</td>
<td>10.4-11.7</td>
</tr>
<tr>
<td>All groups</td>
<td>8,604</td>
<td>36.2</td>
<td>35.8-36.5</td>
<td>12.9</td>
<td>12.8-13.0</td>
<td>15.8</td>
<td>15.7-15.9</td>
</tr>
</tbody>
</table>
as the frequency of smoking increases. These associations did not change and remained significant when controlling by gender and ethnicity.

DISCUSSION

This study reveals some important issues in smoking prevalence among high school students of diverse ethnic origins. Anglo-European girls and boys in this study reported experimenting with and currently using cigarettes at the highest rates. In fact, Anglo-European girls showed the highest rates of current smoking, surpassing even Asian and African American boys. Comparably low rates for Asian girls have been reported in other studies, as well as lower prevalence for African American boys and girls (CDC, 2005; Schepis & Rao, 2005). In addition, Latinos, who were believed to have traditionally low smoking rates (citing protective cultural factors), presented the highest rates of cigarette use among boys. Even Latina girls, who in previous studies had shown the lowest prevalence, reported rates of current smoking 3 times higher than Asian girls and 1.5 times higher than African American girls. These results agree with other data obtained by our research team in South Texas (Chalela, Velez, & Ramirez, 2005) and with other recent studies that show increasing rates of experimentation with cigarettes at ages earlier than other children and either an increase in current smoking among Latino children or a lower rate of decrease than for other racial/ethnic groups (CDC, 2002).

Increased rates of experimentation among Latino youths suggest a future increase in the proportion of established smokers, unless effective programs are developed to address this problem before Latino children become addicted to tobacco. Given the rapid growth of the U.S. Latino population, it is possible to predict a directly related increased raw number of Latinos who smoke and, consequently, an increase in the number of cancer patients of Latino origin in the years to come. Because Latinos are negatively affected by a health care access gap, the mere anticipation of larger numbers of cancer cases is of concern. Yet, if Latinos also increase their rates of smoking, we can expect a substantial rise in the incidence of cancer among this population, which, paired with lack of health care coverage, poses a dramatic challenge. Leaving unattended the increased rates of smoking experimentation among Latino children may prove to be an extremely disturbing health disparity in the making.

Based on social cognitive theory (Bandura, 1986, 1996), empowering youths to advocate for public policy requires them to have favorable attitudes toward tobacco control, expect to be capable of taking action, and have positively biased outcome expectations. Anglo-European students in this study showed lower approval for tobacco control policies, but they still felt capable of taking action to transform the system. Interestingly, they showed the lowest confidence in the response of the system to their advocacy actions. On the other hand, African Americans reflected the strongest approval for tobacco control policies, higher advocacy self-efficacy, and higher confidence in the response of the system. Latinos and Asians had the lowest approval rate for policies, lowest self-efficacy, and average outcome expectations. The strong association between smoking and lower approval of tobacco control policies, lower self-efficacy, and lower outcome expectations for advocacy actions suggests that feeling empowered to take action on behalf of tobacco control policies is related to remaining smoke-free. The fact that most nonsmokers had high scores in all scales also suggests the projection of a healthy and politically active cohort, and an eventual group of empowered citizens willing to advocate on behalf of public health. However, although this was a cross-sectional
study and no causal inferences can be made, the association between the feelings of disempowerment and smoking behavior are of concern. This association may be especially troubling in the case of Latino male students, given their apparent lack of interest and low-efficacy expectations, particularly considering the previously discussed risks of their increased experimentation with smoking. Also, the apparent pessimism of Anglo-European teenagers must be addressed when dealing with tobacco prevention. On the other hand, the favorable complex of attitudes and expectations of African Americans and, to some extent, Asians is encouraging and bodes well for these communities.

**IMPLICATIONS FOR PRACTITIONERS**

Practitioners engaged in youth tobacco control efforts may wish to consider public policy as a key area of emphasis. Revealing the tactics of the tobacco industry may help to develop positive attitudes toward tobacco control policies among young people. In addition, use of positive reinforcement and participatory learning strategies, such as encouraging policy advocacy actions (e.g., writing a letter to an elected official), may provide useful tools for improving outcome and performance expectations. Including policy advocacy training in all youth programs likely will not only help solidify healthy behaviors but also aid public health efforts by having empowered advocates in the community when these young people mature.

It is important to further explore the apparent disenchantment that Anglo-European students showed toward the system. If they continue to have weak expectations about the benefits and possible success of their advocacy actions, they may alienate themselves from the political process as adults. Although Anglo-Europeans have traditionally been considered the group in power, closing disparity gaps should by no means result in disempowering them. It is also necessary to find culturally sensitive ways to address the higher experimentation with tobacco shown by Latino students as well as the best strategies to empower them to advocate for societal change to reduce the health disparities that affect their communities.

To truly contribute to closing the disparity gap, health promotion programs for youths must go beyond the traditional knowledge, attitude, and behavior modification model. In addition to promoting healthy behaviors, empowering young individuals to transform the system involves helping them understand the complexity of policy making and the political process, the extent of influence that powerful individuals and corporations have on policy makers, and the true value of citizen participation in the process. Young people also need to learn the skills necessary to present and advocate on behalf of their causes and to access or create tools to counterbalance the power of influential entities. Above all, they need to feel that they can bring about change when they are well prepared, persistent, and innovative. Because youths typically possess a wealth of energy, persistence, and creativity, empowering them is simply helping them redirect some of their innovative ability and stamina toward seeking societal changes to reduce disparities. This will help create a favorable environment to sustain behavior change and leave these young people a legacy that far exceeds public health (i.e., tobacco control) and that they will carry well into their adult lives. A person who feels capable of taking actions that can eventually transform society through public policy has already breached a fundamental barrier for political empowerment.

Although empowerment and policy advocacy have been included in many public health programs over the years, particularly in poor countries, more research is needed...
to find the best means of incorporating these elements into traditional health promotion programs in the United States. Because empowerment and advocacy are essentially political processes and, as such, highly dependent on culture and social interactions, further investigation is also needed to learn how specific population groups perceive and use available and newly designed tools for education, training, and facilitating advocacy.

References


