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Health Educators' Perspectives on Black and Latin@ College Students' Health Literacy

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MA, Kean University, 2017

BS, Bloomfield College, 2010

Dissertation Submitted in Partial Fulfillment

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Abstract

Emerging adulthood is a critical life stage when participation in higher education can facilitate the transition of young individuals into adulthood and independence. The barriers associated with low health literacy levels are higher among racial or ethnic groups facing health inequalities, including those enrolled in higher education institutions. The purpose of this basic qualitative study was to explore how health educators promoted the health literacy of Black and Latino emerging adult college students. The theoretical framework was based on Bandura's social cognitive theory. Eight health professionals who served to promote health literacy across diverse college campuses and different states in the United States were interviewed. The interviews were coded manually to identify overarching themes from the health promotion practices and experiences noted by those engaging in college health promotion. Results showed higher education health professionals promoted health literacy by focusing on cultural awareness, using diverse strategies to engage their students, and seeking out internal and external supports to benefit their students' health literacy levels. The results may promote social change by increasing college health professionals' knowledge and practices to promote the health literacy of Black and Latino emerging adult college students.

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Dedication

"De una sola gota" se ha llenado el mar, se han multiplicado las razas, los lenguajes, las costumbres, y las vivencias. Soy producto de gente fuerte, obstinada, y determinada a vivir la vida hasta que Dios disponga. Gracias a los antepasados, los que vivieron una vida digna y esforzada para que yo llegara a este momento. Gracias a los cruzaron fronteras, mares, y culturas, su legado continúa. Dedicado a mis abuelos, Juan Brown, Cruz Grey de Brown, Melida Maria Castillo de Williams, y Alberto Elias Williams Larmoni. Valoro tanto haber crecido conociéndolos. Y a pesar de que algunos no estén, siguen presentes pues por ellos y su amor aquí estamos. Ojalá y sigamos siendo familia de amor, paz, y fe.

Gracias, mamá y papá, Eloisa Brown Grey y Rafael Elias Williams Castillo, por hacer prevalecer la importancia de la educación en nuestro hogar. Gracias por los principios, y el sacrificio de dejar atrás un país, una cultura, una lengua, y un entorno conocido para dárnoslo todo. Gracias por ser padres entregados y correctos, pues mejor ejemplo no ha habido ni habrá. Gracias a mi hermano Will Williams Brown y hermana Heidy Williams Brown por ser fuentes de fe y motivación. Que Dios continue dándoles salud, para que me sigan acompañando toda la vida. Que Dios los guie y les otorgué todos los sueños que aun tengan por cumplir.

Remember to dream big, Matthew and Grace. I love you more than words would ever say. May you glow and go even higher than this with God and family as your fuel! Thank you, Nelson Malta, for sticking with me through this and beyond. You are my guardian angel on earth, my friend, and a husband handpicked by God for me.

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Chapter 1: Introduction to the Study

Health literacy affords a person the ability to control their health, make decisions on disease prevention, and seek health-related information or health care (Bröder et al., 2019; Malloy-Weir et al., 2016). Many adults in the United States have basic to low health literacy, which may cause anxiety, an inability to manage their health through preventive practices, financial strain, and higher risk of dying from health-related issues (Boyle et al., 2017; Cutilli et al., 2018; Palumbo, 2017). The barriers associated with low U.S. health literacy levels are higher among racial or ethnic groups facing health inequalities (Hicken et al., 2018; Rikard et al., 2016). College students' health literacy is an understudied topic as limited studies reported findings about the health literacy levels of young adults while they attended college (Barsell et al., 2018; Joseph et al., 2016; Mackert et al., 2017; Rababah et al., 2019; Sukys et al., 2017). College studentsinclined to seek informal health literacy information from family members, friends, and online resources (Chen et al., 2018; Kam et al., 2018; Shreevidya, 2020; Yoo & De Choudhury, 2019). Lower health literacy among college students may negatively impact their academic experience and ability to balance stress and responsibilities (Joseph et al., 2016; Sogari et al., 2018; Wyatt et al., 2017).

The college journey may be a good time to develop healthy lifestyles and healthy behaviors as traditional students transition between adolescence and adulthood (Barsell et al., 2018; Lederer & Oswalt, 2017). The health literacy of racial and ethnic emerging adult college students is an underresearched topic, especially as it relates to students' racial and ethnic experiences and health risk behaviors associated with their racial and

ethnic identities (Asad & Clair, 2018; Bailey et al., 2017; Blume & De Fina, 2017; Carrington, 2019; Levin-Zamir et al., 2017; Malan et al., 2020; Rababah et al., 2019; Uysal et al., 2019). Racial minority students are an underserved and misrepresented demographic group across higher education institutions (Grawe, 2018; Jackson & Sherman, 2018; Loveland, 2018; Strayhorn, 2018, 2019; Wolf, 2017).

Cutilli et al. (2018) and Rikard et al. (2016) noted that Black and Latino adults' health literacy was lower than other groups, and that racial health inequalities and limited English language proficiency negatively impact health literacy. A few studies noted how college health educators promote health literacy for Black and Latino emerging adult college students, and fewer studies showed the incorporation of cultural relevance to increase health equity in their practice with racial minority students as noted by Rikard et al. (2016). I explored how health educators promote Black and Latino emerging adult college students' health literacy.

In this chapter I provide the introduction and historical perspective to my study. The background section summarizes current research on college students' health risk behaviors, risk factors associated with the cultural background of college students belonging to racial minority groups, and limitations on available research on college health educators' perspectives of the current landscape of health education in higher education. The problem statement addresses a gap in the literature by focusing on the underresearched topics of college health educators' promotion of Black and Latino students' health literacy. The purpose section explains my intent to learn how college health educators addressed the health needs of Latino and Black emerging adult students.

The research question provides the inquiry my study attempted to answer. The theoretical framework section explains how the theory selected to frame my study. In Chapter 1, I also address the nature of the study, the scope, the limitations, and how this study may contribute to positive social change.

Background

Poor health literacy is associated with risky health behaviors and higher health-care-related costs (Boyle et al., 2017; Levin-Zamir et al., 2017; Palumbo, 2017). Researchers noted the importance of increased attention on health equity and health literacy promotion for marginalized students because they face barriers to seeking health care and have higher mortality rates (Joseph et al., 2016; Levin-Zamir et al., 2017; Loan et al., 2018; Rikard et al., 2016; Rosario et al., 2017). Study findings suggested the need to focus on racial health inequality and social determinants of health, such as health literacy for racial minority students because these factors were found to negatively impact their higher education experience (Daniel et al., 2018; Franklin, 2016; Museus et al., 2015).

Risk factors impacting diverse college students elicited responsiveness from higher education institutions across the United States (Avci et al., 2018; McLennan, 2019; Stolzenberg et al., 2019). However, when compared to other college students, those in the Black and Latino groups have disproportionate access to early health risk prevention, may lack access to health care, and may lack basic amenities such as food and shelter while pursuing their degrees (Goldrick-Rab et al., 2017; Hallett & Crutchfield, 2018; Rababah et al., 2019; Rosario et al., 2017; Wyatt et al., 2017). Higher

education institutions have an increased awareness of the impact of students' health literacy on academic success and the barriers faced by racial minority students (Healthy People 2020, 2018; Logan & Siegel, 2017). Institutions must be knowledgeable of students' primary health literacy motivators so that culturally relevant health promotion efforts can be enacted (Jackson & Sherman, 2018; Kim & Kim, 2018; Ridner et al., 2016). Cultural and familial factors play a role in health promotion, and Black and Latino emerging adult college students' academic performance is influenced by health literacy (Gurung, 2019; Isik et al., 2018). As health promotion leaders, college health educators who promote meaningful health literacy efforts for Black and Latino students are positioned to support positive changes in academic outcomes and health promotion practices on college campuses (Lederer & Oswalt, 2017; Miller, 2016).

Adams et al. (2018) analyzed how the Affordable Care Act influenced the health of adolescents and which groups of adolescents received the services. Adams et al. found that more attention and inclusion efforts into health and well-being, including preventative health measures, increased racial minority underserved youths' health gains after the Affordable Care Act was passed by the U.S. government. The current study addressed how college health educators consider health literacy promotion for Black and Latino emerging adult college students. The literature supported collaborative efforts by key stakeholders to address cognitive, social, and emotional needs among racial minority college students through a multidisciplinary approach with the goal of increasing health literacy (Newell, 2016). Collaborative health-promoting stakeholders include local public health community agencies, student leaders, college faculty, health educators, and staff

from student services departments. Although Newel (2016) recommended that leaders in health promotion develop multidisciplinary groups within student affairs departments, this might be a difficult task because most student support services are siloed in specific focus areas such as health and well-being and diversity and inclusion departments.

Subject matter experts have encouraged innovative student support service initiatives by college health educators to enhance student well-being and success (Amnie, 2018; Ciotoli et al., 2018; Mackert et al., 2017; Newell, 2016). Data confirmed health literacy disparities among diverse racial and ethnic groups, such as food inequality, homelessness, lack of education, lack of health care, and other factors referred to as social determinants of health (Healthy People 2020, 2018). Culturally specific changes to health promotion take time and face power limitations to implementation, prompting researchers to learn more about health educators' professional practice and self-efficacy beliefs (Amnie, 2018; Castillo-Montoya, 2017; Lyson, 2020; Martinez et al., 2018; Zamani-Alavijeh et al., 2019; Zareban et al., 2018). Further insight could be gleaned by institutions sharing best practices regarding diversity inclusive health promotion efforts employed by college educators to positively impact students' health literacy (Batterham et al., 2016; Gibson et al., 2016). My study focused on how health educators promote the health literacy of Black and Latino traditional college students.

Quality improvement efforts are informed by what information health educators consider when constructing interventions to address the health literacy of Black and Latino students (Calamidas & Crowell, 2018; Calvo, 2016; Gibson et al., 2016; Rosario et al., 2017). There was a gap in the literature at the time of the study pertaining to what

information health educators use to inform best practice efforts in addressing the health literacy needs of Black and Latino traditional college students. My study added to the body of knowledge and helped fill the gap regarding how college health educators promote Black and Latino emerging adult students' health literacy across the United States.

Problem Statement

I explored the low health literacy of Black and Latino emerging adult college students and how health educators promote health literacy for these populations in the United States. Emerging adulthood is the critical life stage when participation in higher education facilitates the transition of young individuals to adulthood and independence (Wood et al., 2017). Warnick et al. (2019) asserted that colleges should focus on the beliefs, needs, and opinions of emerging adults when developing practical healthpromoting initiatives because college marks a crucial time in life when the health literacy of students may be improved. Ciotoli et al. (2018) championed a call to action for college health leadership to include in their missions a call for interventions for better college health promotion. Ciotoli et al. noted the need to improve current practices calling for "better care, better health, and increased value—goals closely linked to students' wellbeing, learning, and success" (p. 634). Improved health literacy and health equity across college campuses are persistent public health concerns (Rosario et al., 2017). There is an underlying stigma associated with having poor health literacy knowledge, and young college students often hide issues to avoid this stigma (Chen et al., 2018; DeBate et al., 2018; Mackert et al., 2017).

Mackert et al. (2017) advised that college health promotion efforts such as health education campaigns must target young college students transitioning to adulthood who are learning to be responsible, are experiencing life changes, and are making health-related choices for the first time. Mackert et al. focused on current college health literacy approaches and encouraged best practices by adapting tools that measure health literacy among college students. Mackert et al. noted that college students from specific racial and ethnic minorities had lower health literacy than White students. Taylor et al. (2019) explained that lower level socioeconomic status is associated with food insecurity, and racial health disparities expose students to a higher risk of dying from chronic health complications. Taylor et al. encouraged higher education initiatives that promote student well-being, provide comprehensive on-campus programs for health learning, and address sociocultural factors.

There is a gap in the research regarding how health educators promote health literacy and college health education equity for racial minority students who identify as Black and Latino (Avci et al., 2018; Azzopardi-Muscat & Sørensen, 2019; Batterham et al., 2016; Gibson et al., 2016; Rosario et al., 2017). Research on health education and health promotion that focused on college students' health literacy excluded racial minority populations (Rababah et al., 2019). Limited research documented college health educators' perspectives on health promotion efforts (Logan & Siegel, 2017). Research is needed to learn what procedures, policies, and efforts are employed by college health educators to promote health literacy (Logan & Siegel, 2017) for racial minority populations. Health promotion should be embodied by the leaders whom students follow

and respect on their college campuses (Eifert et al., 2017). The health literacy promotion methods used by college health educators need to be studied to understand how they impact racial minority and emerging adult college students (Eifert et al., 2017; Lederer & Oswalt, 2017).

Challenges associated with the health literacy of college students who identify as Black and Latino are alarming and more complex than any other racial minority group (Rababah et al., 2019; Rosario et al., 2017). Black and Latino students in higher education require more culturally based approaches because they grapple with inequalities afflicting their well-being while pursuing their degrees (Carey, 2018; Felder et al., 2019; Sanchez & Awad, 2016). Limtation of proper racial and ethnic representation in college health data poses barriers to health-promoting efforts (Jackson & Sherman, 2018). I explored health educators' health-promotion approaches for Black and Latino emerging adult college students.

Purpose Statement

The purpose of this basic qualitative study was to learn how health educators promote the health literacy of Black and Latino emerging adult college students. Researchers reported the need for more studies on health education addressing college students' needs as they transition into more adult responsibilities (Wood et al., 2017) to determine best practices. According to Martinez et al. (2018), health education initiatives can be useful when they encourage preventive health behaviors and demonstrate a powerful way to obtain engagement from young adults when using their voices and insights into their communities' lived experiences.

Schillinger et al. (2018) posited that college students' health education literacy is dependent on the content presented in public health announcements focused on public health initiatives. Schillinger et al. noted that achieving the best impact on student health education occurs when the messaging is relevant to their culture and community needs. I explored how college health educators promote health literacy for Black and Latino college students to promote positive social change. The results of my study may increase college health professionals' knowledge and practice through a self-efficacy lens and the use of self-management strategies for best practice in health promotion (see Conrad et al., 2019; Lederer & Oswalt, 2017). Information on Black and Latino emerging adult college students' cultural experiences and challenges helped inform how health educators develop improvement efforts and address health equity in higher education (Rababah et al., 2019).

Research Question

The research question for my study was: How do health educators promote Black and Latino emerging adult college students' health literacy?

Theoretical Framework

Bandura's (1977, 1986, 2004) social cognitive theory (SCT) was used to frame this study. Efforts to motivate students to learn more about health in higher education institutions are impacted by their communities, their cultural practices, their social foundation, and their beliefs (Bandura, 1977, 1986; Barsell et al., 2018; Grier-Reed & Williams-Wengerd, 2018). Bandura (1997) postulated the idea of self-efficacy, or a person's belief in their ability to achieve desired goals and the factors that impact

behaviors known as triadic reciprocal determinism, which account for the individual's social, internal, and external influences on goal achievement. Bandura (2002) explored social development in the context of culture and asserted that humans behave individually and collectively and attain personal development according to their sociocultural experiences.

The ideals for inclusion, consideration, and objective observation are considered attributes to social change by noting significant factors to consider when aiming to understand attitudes, beliefs, and experiences shaping how individuals behave (Bandura, 2004). SCT guided the exploration of how health educators interpret their ability to promote students' health literacy improvement in ways that considered encouragement for change and the factors influencing positive behavioral change for health literacy for two racial minority groups (see Bandura, 2004; Beauchamp et al., 2019). The concepts from Bandura's SCT aligned to research that addressed the intent to achieve behavioral change and to convey the goal of best practice and quality improvement for health promotion (Beauchamp et al., 2019).

Nature of the Study

To answer the research question, I conducted a basic qualitative study using semistructured interviews. Patton (2015) asserted that qualitative methodology is used to discover how groups and individuals attribute meaning to social phenomena. I explored health educators' perceptions about how they practice health literacy promotion of Black and Latino emerging adult college students. I interviewed participants until I reached

saturation of data after eight interviews to answer the research question. I analyzed the interview transcripts and coded the data for emergent themes.

Definitions

The following terms informed my study through definitions that provided meanings and context:

Best practice: Best practice involves applying the best available resources and information to achieve individuals and institutional goals. Understanding best practices in college health promotion can inform health educators when addressing outcome improvements (Eifert et al., 2017).

Emerging adults: Emerging adulthood is the critical life stage when education and other goals transition young individuals into adulthood and independence (Wood et al., 2017). For my study, an emerging adult was considered a traditional student between the ages of 18 to 25 (see Mushonga & Henneberger, 2020).

Ethnic/*racial minority*: These terms describe non-White people within the U.S. population (Isik et al., 2018). Isik et al. (2018) noted that "ethnic minority is an ethnically defined group that is significantly smaller than a dominant other ethnically defined groups within the population" (p. 2).

Health educators (leaders): Sharma (2016) noted that "health education professionals facilitate modification of health behaviors" (p. 7) and are a vital part of the public health workforce. These are individuals who dedicate time to increasing health promotion and literacy within their institutions.

Health literacy: Nutbeam et al. (2018) described health literacy as "the possession of literacy skills (reading and writing) and the ability to perform knowledge-based literacy tasks (acquiring, understanding, and using health information) that are required to make health-related decisions in a variety of different environments (home, community, health clinic)" (p. 902). Rudd (2015) defined health literacy as the "capacity to obtain, process, understand, and use health information" (p. 7).

Health promotion: Whitehead (2018) noted that "health education is a component of health promotion" (p. 41) and health promotion involves the provision of information, creation of strategic ways to increase health literacy, and innovation for new technologies that assist these actions. Health promotion involves empowering communities, institutions, social groups, and individuals to desire better health for themselves.

Racial health inequity: Discrepancies reflected on affordability, access, and quality of health services that some social and cultural groups have over others (Milburn et al., 2019). Racial health disparities typically afflict racial minority populations more than others and are considered social determinants of health (Healthy People 2020, 2018).

Assumptions

I assumed that college health educators who agreed to participate in my study would provide accurate information to the best of their knowledge relevant to their role. The final assumption was that health-promoting leaders were aware of the social and cultural barriers of Black and Latino students as they evolve into adulthood.

Scope and Delimitations

The study participants were health educators serving in U.S. higher education institutions, and the study focused on how those college health educators promoted health literacy for Black and Latino emerging adult college students. The areas of specialization in which these health educators were employed focused on health and wellness programs, or student support services offered within student affairs departments. This study did not address health literacy promotion for racial minority emerging adults outside of the college setting.

This study focused on the perspective of health educators employed at higher education institutions across the United States. An in-depth analysis of how college health educators inform interventions aligned to cultural factors to promote Black and Latino students' health literacy may support best practices to drive social change and student success. The study focused on Black and Latino students' health literacy as emerging adults. These groups were chosen from research that encouraged further improvement to their academic achievement in higher education experiences impacted by their health and cultural/racial identities (Carey, 2019; Mushonga & Henneberger, 2020; Rababah et al., 2019; Rocio et al., 2017). Results were delimited by data collected from health educators working at U.S. universities.

Limitations

This study focused on college educators. I interviewed college health educators from a limited number of U.S. higher education institutions. This study had a small

sample size. The results cannot be generalized to all college health educators. Researchers must use caution when transferring the study's results.

I did not report on emerging adults outside of higher education institutions. Emerging adults outside of higher education institutions face higher risks for inequalities, lower health literacy, and poverty due to a lack of education; they are harder to reach for health promotion studies and reflect higher recreational substance use and other risky health behaviors (Healthy People 2020, 2018; & Simons-Morton et al., 2016) and were exempt from my study. A limitation expected for my study was limited access to health educators due to the COVID-19 pandemic (see Steinberg et al., 1996), insecurities with the research process, and lack of motivation amid balancing role responsibilities. To mitigate these challenges, I recruited as far and wide as possible within the United States using available health educator associations such as the American College Health Association (ACHA), the National Commission for Health Education Credentialing, LinkedIn, and social media posts.

Significance

My study's findings may increase understanding of how college educators promote Black and Latino emerging adult college students' health literacy. As stated by Taylor et al. (2019), the academic success of racial minority students depends on the schools' focus on well-being and well-developed research-based initiatives that promote health efficacy. Policies that promote the attainment of well-rounded educational experiences suggest improvement of U.S. students' attendance, academic achievement, retention, and graduation rates through best practice methods and assessments on school

climate (Beauchamp et al., 2019; U.S. Institute of Research, n.d.; & Rodericks et al., 2018). Calamidas and Crowell (2018) noted that health promotion is essential to reinforce college students' positive health behaviors. Calamidas and Crowell also noted that students' health practices are typically influenced by their social and cultural networks.

My study results may inform ways to improve existing health education promotion among Black and Latino emerging adult college students in higher education institutions. Positive social change may result from the findings of my study being used to close the gap in the literature related to my research topic. This study may positively influence community health when health educators align cultural health practices relevant to students' racial and ethnic identity in health literacy promotion (see Asad & Clair, 2018; Calvo, 2016; Chang, 2019; Hicken et al., 2018; Marks & Garcia, 2018; Patel et al., 2016; Rikard et al., 2016; Warnick et al., 2019; Wolf, 2017; Yang et al., 2016; Zhu et al., 2019). The improvement of health literacy and equity among racial minority students within college support services provides an opportunity for positive social change (Sørensen et al., 2018). Improved health literacy in higher education is a promising goal (Richter et al., 2020). My study results may inform key stakeholders of best practices to impact positive social change and add to the literature from the perspectives of health educators (see Logan & Siegel, 2017; Schloemer & Schröder-Bäck, 2018).

Summary

This chapter introduced the topics relevant within higher education aligned to the current literature in the introduction and background sections. I evidenced a need to increase health literacy for Black and Latino emerging adult college students in the

problem and purpose statements. I also delineated the research gap in the problem statement and noted the connection between the theoretical framework and the research question I sought to answer. I noted the study's scope and limitations. This first chapter's cited literature indicated that health literacy is vital for promoting health among emerging adult college students. In Chapter 2, I synthesize literature related to the problem and gap in the literature and note the strategies used to find pertinent research studies on the topic. A discussion of the theoretical framework and connection to my study is also provided in the next chapter.

Chapter 2: Literature Review

The purpose of my basic qualitative study was to learn how health educators promoted the health literacy of Black and Latino emerging adult college students. Young college students typically are not proactive in seeking formal health education from the institutions they attend (Gagnon et al., 2017). Some college students feel stigmatized by seeking health-related help while on campus, and this is magnified in students of racial minority descent (Kam et al., 2018; Shreevidya, 2020; Wei et al., 2018). Many Black and Latino students' evidence poor health literacy, and barriers to their health literacy may be associated with their racial identities (Kam et al., 2018; Rosario et al., 2017).

In this chapter, I describe the theoretical framework and analyze the empirical literature that supported the research problem. I provide the scholarly databases I accessed through the Walden Library and the search strategies and keywords I used to gather articles. In providing empirical evidence, I sought to support the importance of the social problem by addressing the literature gap regarding college health educators' roles and how they promote health literacy among Black and Latino students.

Literature Search Strategy

The following databases were used to search for literature that supported the research topic: Educational Resource Information Center (ERIC), Education Source, Google Scholar, ProQuest Central, SAGE Journals, and Scholar Works. Keywords and phrases I used to find research articles included but were not limited to *U.S. health literacy, Black health literacy, Black and Latino student health, college health beliefs, college health educators, college student health, college students' health knowledge,*

college health literacy, college health promotion, emerging adult, higher education, health inequality, health literacy, college well-being, Latino health literacy, minority college students, and *minority college student health*.

Challenges experienced during the search for information included finding empirical articles fewer than 5 years old. Also, some articles were not empirical but were of value for understanding the research problem and were from peer-reviewed journals. I used these resources because of the paucity of empirical studies related to the research problem and gap in research. Academic journals searched to find relevant literature and inform my study included the following: *Journal of U.S. College Health, Journal of Higher Education Research and Development, Journal of Higher Education Health, Journal of Racial and Ethnic Health Disparities, Journal of Student Affairs Research and Practice,* and *Journal of Social Science and Medicine*. Although these journals were explored to learn more about the research topic, little information was found regarding educators' perspectives and experience with health literacy of Black and Latino college students as emerging adults, thereby confirming the gap in the literature.

Theoretical Framework

The theoretical framework was based on the concepts postulated by Bandura (2004). SCT stemmed from earlier theorists' works on social psychology, learning, and behavioral theories (Bandura, 2004; Barone et al., 2012). SCT focuses on motivation and cognitive aspects of social psychology (Barone et al., 2012). Balbay and Doğan (2015), building from the SCT, explained the following principles are associated with human learning, behavior, and cultural influence: (a) Culture and social interactions influence

learning, (b) humans learn through interaction, and (c) social interactions become internalized. These three principles from Vygotsky's (1978) theory of learning and behavior align with SCT principles about how people see the world, how they interpret it, and how their interpretation affects learning and behaviors. Barone et al. (2012) claimed that Mead was one of the original contributors to developing the modern psychological beliefs, concepts, and pragmatic contributions of the SCT. Barone et al. and Ryan (2018) claimed Mead's work provided the foundation for the understanding that personal experiences that come from social interactions and cultural experiences shape the socialization of individuals, their learning, and their views of their personal identity.

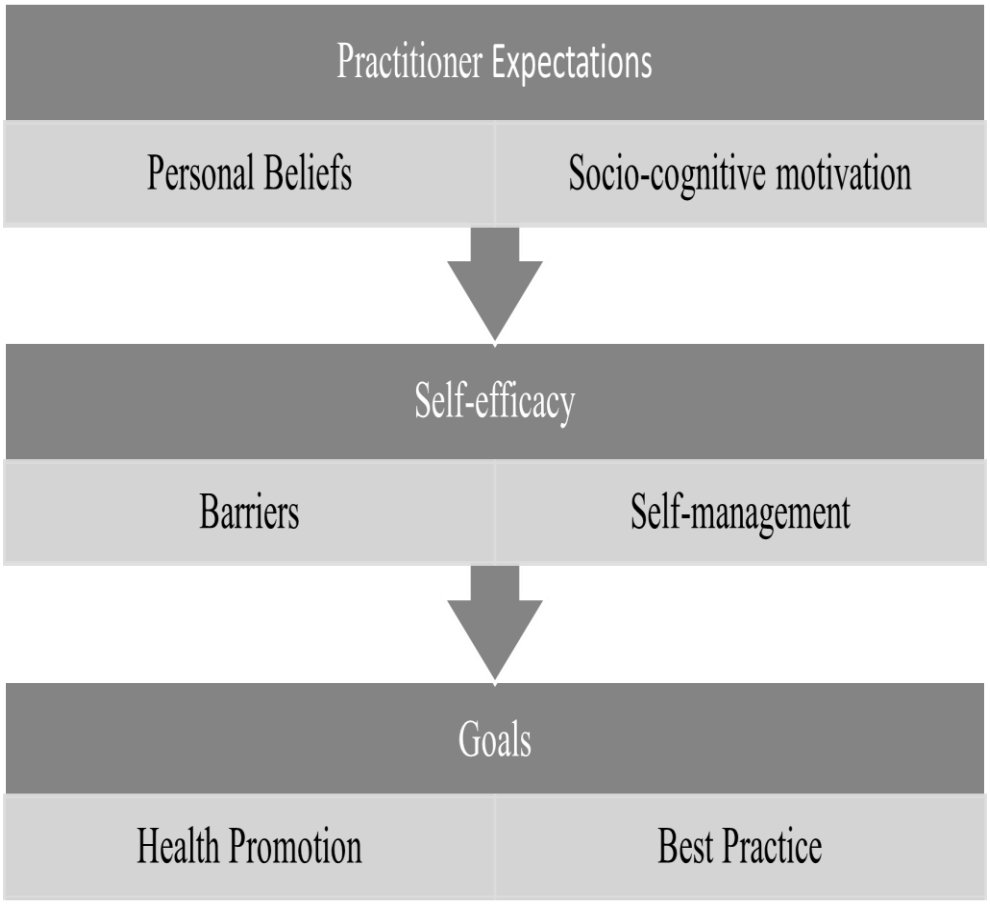
My study was grounded in the theoretical concepts of Bandura's (2004) SCT, as these concepts have been applied to health promotion and health education (Bandura, 2004; Barone et al., 2012; Schunk & DiBenedetto, 2020). SCT makes the connection between behaviors and social environments and has been applied in health promotion to learn best practices and to evaluate how social influences relate to personal behavior (Bandura, 2004; Schunk & DiBenedetto, 2020; Schunk & Usher, 2019). Bandura encouraged evaluating what is already known about health promotion to motivate disease prevention and health management and stated that "self-efficacy beliefs shape the outcomes people expect their efforts to produce" (p. 145). Aligned to my study, Bandura considered and examined what helps and hinders tailored public health promotion from the perspective of self-management and best practice promotion by practitioners. Bandura explained that an individual's health behaviors are influenced by social-cognitive motivators to reach goals, overcome barriers, and get back to homeostasis when

challenges arise. Bandura postulated that behaviors are directly affected by the social components of an individual's life, and explained how practitioners manage all of this while promoting self-help and better health management to their patients.

Figure 1 illustrates how Bandura (2004) explained the possibility of achieving positive behavioral change in health promotion efforts via practitioner self-efficacy, self-management, and consideration of how social and cognitive factors influence goal achievement. According to Bandura, the U.S. Public Health Service in relation to health promotion is like the SCT and overlaps in the use of self-efficacy. Bandura explained that in both the health belief model from the U.S. Public Health Service and the SCT, what influences individuals internally and externally helps predict health behaviors, even though outcomes might differ from predictions. Bandura highlighted that the health behavior model is not specific to "change health behavior" (p. 146). Rather, the model distinguishes the influence of social-cultural beliefs regarding health behaviors to determine future "health habits" (p. 146). In summary, the SCT is useful for understanding health promotion to encourage individuals' self-efficacy and personal desire to change.

Figure 1

Health Promotion From the Perspective of Practitioners Who Self-Manage May Improve Best Practice and Better Patient Health Management



Note. Adapted from Bandura, 2004.

Bandura (2004) shared examples of how effective health promotion practices targeted to specific community needs can work when properly educating the community to become self-efficacious in managing and preventing health comorbidities. These examples provided a foundation for understanding how college health educators could promote health and effect positive social change to improve Black and Latino students' health literacy. Callero (2013) discussed the power of cultural capital in shaping a

person's attitudes, actions, behaviors, and beliefs related to interactions within their environment, economic status, and familial association. Cultural capital stems from the same concepts on learning and behavior as the theoretical underpinnings of SCT, which highlights the values and connections to the individual's social and cultural wealth (Callero, et al. 2013).

SCT provides three focused concepts of observation, known as triadic reciprocal determinism, which focuses on an individual's self-efficacy (Balbay & Doğan, 2015). Balbay and Doğan (2015) encouraged understanding of the motivation behind racial minority students' learning and the beliefs that shape educators to achieve their educational goals. Balbay and Doğan supported the assumption that SCT can support inclusive health promotion to evaluate the cultural beliefs that influence student behaviors and the factors that influence health educators to promote health. Given the relationship between health promotion and SCT, I explored environmental factors that shaped educators' personal practices, how health educators self-managed in their pursuit of health promotion, and their motivation to influence students' health behaviors through the promotion of health literacy.

Bandura (2004) posited that the "knowledge of health risks and benefits creates the precondition for change" (p. 144). Health promotion through health literacy may provide students with an opportunity for improved health fostered by the knowledge to make better health decisions. Omar et al. (2019) asserted that self-efficacy in higher education leadership roles must have a strong basis for motivation, stem from

experiences, and support the needs of students served with a focus to meet goals as delineated by institutional missions.

Literature Review of Related Key Factors

In this review of empirical research related to the research problem of lower health literacy among Black and Latino College students, I analyzed research related to the following areas: health literacy among racial minority college students, initiatives for college student support, college students' health behaviors, stigmas, help-seeking behaviors, and limited health literacy. Additionally, I analyzed research related to the diverse needs of racial minority college students as emerging adults, student affairs and college health organizations, and college health educators' role related to the gap in the literature.

Health Literacy Among College Students from Racial and Minority Groups

Lower health literacy is a problem among racial and ethnic minority students in higher education and across the United States as compared to their White counterparts (Hicken et al., 2018; Rababah et al., 2019, Rickhard et al., 2016). Sukys et al. (2017) found evidence of lower health literacy among college students, limited skills for disease prevention, and the need for health promotion strategies. Lower health literacy of Black and Latino college students as emerging adults is a public health concern, and researchers supported further study of the matter. Mackert et al. (2017) and Rababah et al. (2019) noted disparities in college health literacy levels, increased health risks, and the need to support students' success when they belong to racial minority and ethnic groups. Sogari et al. (2018) found college students' health behaviors have social and individual factors,

eating habits are poor, and students require supportive initiatives that consider their input. Schwitzer et al. (2018) and Reuter et al. (2019) found that college students have diverse needs such as physical and emotional health, which can hinder or help their educational success. Increased health literacy offers support for young students' health, and researchers have sought to find a link between better health, decreased risks, and academic achievements.

Lack of information and changing consensus on what it means to be healthy perpetuate unhealthy habits often learned and embraced by the desire to reach an ideal health path (Chen et al., 2018). These factors influence students' nutritional health behaviors and their ability to practice prevention (Dumitrescu et al., 2016; Juvinyà-Canal et al., 2020; Reuter et al., 2019). Racial and ethnic minority students may face life-altering risks and barriers associated with how they see the world and receive health information (Glanz, 2017). Uysal et al. (2019) and Vamos et al. (2016) noted significant differences between college students' health literacy based on gender, as male students often evidenced lower health literacy than female students. Ridner et al. (2016) concluded that another factor influencing health is college students' wellness, which is also lower among students who identify with nonheterosexuality sexual orientations.

Various surveys and assessments for health literacy were used to understand student literacy (National College Health Assessment, Next Generation Health Study, Health Literacy Questionnaire, and Youth Risk Behavior Survey). Although many studies confirmed racial health disparities among young adults and children, the results lacked consistency in guidelines to inform college leaders on the best health promotion practices

that are sustainable and universal across higher education institutions (Dolezel et al., 2018; Eifert et al., 2017; Mann et al., 2018; Rababah et al., 2019; Simons-Monrton et al., 2017). There was a lack of information regarding how college health-promoting individuals become leaders in student wellness and health literacy promotion.

Initiatives for College Students' Support

Barsell et al. (2018), Oberne et al. (2020), Rababah et al. (2019), Rosario et al. (2017), Schillinger et al. (2018), and Sukys et al. (2017) concluded that college health literacy and health promotion efforts warrant improvement for Black and Latino students' health, and that lower health literacy among these two racial and ethnic groups of college students is a public health concern. Sykes and Wills (2018) concluded that through health literacy-focused research, the ability to answer questions affords an opportunity for "improvement" and the "development of future interventions" (p. 3). A paucity in health literacy research results in an inability to design effective ways to implement health literacy changes appropriate to populations such as college students (Sukys et al., 2017).

Although various student support services address diverse college student health needs, such as mental health resources, tobacco cessation, and health and wellness programs, collaborative efforts are encouraged to improve college students' health in more accessible ways (Yoo & De Choudhury, 2019). Sukys et al. (2017) asserted that communities could be developed when building health literacy. De Wit et al. (2018) noted that community health initiatives improve health literacy, supporting diverse entities' collaboration for health promotion efforts. Mann et al. (2018) reported that effective health promotion is too great a challenge for one entity to address and evidenced

the need for collaborative efforts to assist students and their communities. Gordon et al. (2016) examined the use of the visual methodology within health care practices across organization work practices and asserted that bettering public health education should be a collaborative effort from diverse professionals.

The National Institute of Health (2017) assessed the health risk behaviors of young adults ages 10–24 years across the United States and analyzed a total of 14,765 responses from the 2017 National Youth Risk Behavior Survey (YRBS). The YRBS has collected data on youth risk behaviors across the United States since 1991 and has included racial minority YRBS data from across urban school districts since 1995. Six priority health behaviors include (a) behaviors that contribute to unintentional injuries and violence, (b) tobacco use, (c) alcohol and other drug use, (d) sexual behaviors related to unintended pregnancy and sexually transmitted infections including human immunodeficiency virus infection, (e) unhealthy dietary behaviors, and (f) physical inactivity. These focus areas are used to track physical inactivity and successfully yielded information for students' evidence-based health literacy initiatives as they transitioned from childhood to adolescence and adulthood (NIH, 2017). The National Institute of Health (2017) YRBS results also noted "significant health disparities" (p. 2) stating that health literacy for a smooth life cycle transition proved lower among those identified by sex, race/ethnicity, grade in school, and sexual minority status.

Schillinger et al. (2018) analyzed whether increased health literacy through public service announcements (PSAs) and The Bigger Picture (TBP) advertisement positively influenced civic engagement, norm change, and advancement in the health literacy of

minority young adults. Through surveys and focus group analysis, they determined that PSAs brought about social activation in minority youths and influenced their interpretation of the PSAs related to their cultures. Socioeconomic barriers faced by minority groups with limited access to healthy food and drink increased the risk for developing chronic health conditions, such as type 2 diabetes. The authors suggested further investigation is needed focusing on cultural context to improve minority youth's public health literacy and PSA interpretation.

College Health Literacy Initiatives

A critical factor specific to minority emerging young adults is their access to equitable health literacy in education. This was postulated by Mann and Lohrmann (2019), who noted that college health education professionals focused on advancement for "effective school health education," (p. 842) and policy development in higher education requires an understanding of socio-cultural needs and barriers students face. Rikard et al. (2016) conducted a quantitative analysis of the 2003 National Assessment of Adult Literacy Survey data. The study used participants aged 18 and older and noted that health literacy is higher amongst those who can speak English. Rikard et al. reported that socioeconomic advantages and health literacy are related to health risk prevention. Health risks were typically higher in minority groups with higher comorbidities, higher risks for chronic diseases, and higher mortality rates. Rikard et al. further noted that better health findings were correlated to higher education and higher household income, and minorities reflected the lowest income level within the U.S. population.

American higher education institutions have implemented ways to support health and well-being with sustainable approaches. Oakwood University, in Huntsville, Alabama, is a religious grounded institution known for its historically Black foundation. The institution set a goal to become the healthiest U.S. campus with its Healthy Campus 2020 initiative in partnership with the U.S. Department of Education. The institution began assessing incoming college students in 2015. It offered health management assessments to students and provided them with annual health evaluations and a health transcript to maintain throughout their college careers (Dalrymple & Pollard, 2020; Oakwood University, 2020). A quantitative study by Dalrymple and Pollard (2020) concluded that focused curricular interventions positively impacted college students' health. Research by Isik et al. (2018) suggested that preventive health measures offer the potential to favorably influence health practices when policies are tailored to specific populations' needs.

College Students' Health Behaviors

Risky health behaviors for young students occur when they neglect emotional challenges and physical health issues while in college (Simon-Morton et al., 2016). Poor habits can turn into inadequate nutrition routines for college students, poor judgment, substance abuse or dependence, and poor mental health are other behaviors that may continue into adulthood (Henry et al., 2018; Reuter et al., 2019; Stok et al., 2018). Sogari et al. (2018) highlighted that competing demands, thirst for adventure, and learning about the world may hinder young students from maintaining their health while in college.

Black and Latino emerging adult college students emulate behaviors and form identities influenced by their personal beliefs, social environment, and ethnic descent (Barsell et al., 2018; Grier-Reed & Williams-Wengerd, 2018). As a result, they need relevant and equitable health promotion practices from college health educators (Bailey et al., 2017; Bauman et al., 2019; Hicken et al., 2018; Isik et al., 2018; Jackson & Sherman, 2018). Barsel et al. (2018) examined health risk behaviors and noted benefits of self-efficacy use to support health literacy promotion for college students. Assessing a willingness and awareness to consider students' culture needs to be evaluated through a self-efficacy lens. Institutional understanding of emerging adult students' identity and their culture is associated with student success when transitioning to college and positively affects their sense of belonging (Lee & Goldstein, 2016).

Stigmas, Health-Seeking Behaviors, and Limited Health Literacy

Stigmas, lack of proactive help-seeking behaviors, and limited health care literacy raise concerns about college students' health in the following ways: studies noted that a distinctive barrier to emerging adults achieving health literacy is their limited ability to navigate and afford health care while in college (Carrington, 2019; James et al., 2020). Other studies suggested that college students might be limited by stigmas associated with limited knowledge on the health care system and resources available to them (Kam et al., 2018; Mackert et al., 2017; Noonan et al., 2016). Noonan et al. (2016) discussed that African Americans are the least healthy ethnic group within the country and attributed the prevalence of this ethnic group's racial health inequality to the historic misfortunes of slavery and lack of socioeconomic equity they endured for over 400 years.

According to Adegboyega et al. (2020), disparities exist between the knowledge, resources, and accessibility of college students' health care services. They noted issues such as financial stressors, transition of cultural perspectives, and different health care systems concerning students who came from abroad to study at a U.S. higher education institution. Given the racial and ethnic intersectionality of my intended study's target population, it is relevant that all Black and Latino students being served in higher education institutions might not be native-born Black and Latino students. Thus, health literacy promotion for specific ethnic groups must consider what factors, such as health care accessibility, knowledge, and efficacy, apply within students' racial and ethnic experiences while attending college.

Nobles et al. (2019) conducted an online questionnaire at a public university to evaluate college students' health insurance literacy as part of a mixed-method study. They found that confusing terminology and the inability of students to thoroughly understand health insurance plans posed the risk of delaying these college students from pursuing optimal health. They concluded that higher education institutions must recognize the "deficiency in students' health insurance comprehension" to prepare tools and pedagogical approaches to meet students' health literacy needs (pp. 477- 478). James et al. (2020) also surveyed college students to learn health insurance knowledge as well as self-efficacy and recommended more student education efforts to increase students' use of health care services.

While there are other risks related to racial health disparities and service gaps for minority students, Paez and Mallery (2014) noted that limited health insurance

knowledge risks could be deadly for Americans. Four years earlier, Vernon et al. (2007) asserted that limited health literacy is costly to Americans as implications of low health literacy affect finances and impose burdens for generations to come. Calling for national health policies and reforms, they noted that barriers associated with limited health literacy include lack of appropriate care and stigmas associated with not knowing where to get appropriate care. They also noted fears and a lack of effective communication between health care professionals and patients. These assertions align with Palumbo's (2017) research noting that stressors related to limited health literacy result in expensive medical services, increases risks of death, and contributes to America's inability to practice preventive health equitably. Ciotoli et al. (2018), Henry et al. (2018), Hicken et al. (2018), Nobles et al. (2019), and Rikard et al. (2016) urged for inclusive health literacy education efforts. They discussed considerations from national studies and assessments for the U.S. population, confirming that limited health affordability and lack of health equity must be improved to address college health promotion.

College students depend on educators' support to improve attendance, achievement, retention, and graduation rates through best practice methods reflected in school climate (Banks & Dohy, 2019; Knight & Duncheon, 2020). Baldwin et al. (2017) asserted that "…holistic wellness contributes to student success, and the cultivation of wellness is a valuable institutional commodity" (p. 2). Thus, an analysis of how college health educators promote health literacy could support internal review efforts and positively influence Black and Latino college students' health literacy promotion services.

College Health Literacy Promotion

Literature supports the existence of barriers to health promotion practices within college campuses (Schwitzer, 2002; Schwitzer, 2009). Torres (2017) stated that addressing health promotion in diverse institutions, such as educational settings, offered the opportunity to shape healthy behaviors and prevent toxic ones. These authors highlighted the work by researchers in Latin America who support increased health promotion by focusing on schools as vital parts of the public health education system. Kumar and Preetha (2012) found that health promotion can influence global health via strengthening community education, an increase in advocacy, and promotion of preventive practices when addressing socio-cultural factors that go beyond the scope of health care systems' educational efforts.

Other studies highlighted the need to increase health literacy promotion among minority emerging adults, calling to focus on diverse students' needs (Gibson et al., 2016). Lederer and Oswalt (2017) and Mackert et al. (2017) found that college is an optimal time for an emerging adult to receive health literacy information. Sykes and Wills (2018) explained that personal growth is achieved with "self-esteem," and this can be built into ineffective health literacy initiatives "outside of formal school" (pp. 3-5). Whitehead (2018) asserted that effective health education requires health promotion practitioners to be purposeful with their efforts to increase health literacy. As leaders, college health educators affect positive social change within health and wellness programs by promoting students' health literacy aligned with a sensitivity to students' cultural needs (Batterham et al., 2016; Schwitzer, 2002).

Ciotoli et al. (2018) asserted the need for Quality Improvement (QI) in students' learning experiences through health care education; and noted the call for action by diverse professionals at a 2015 health symposium with participants from 88 higher education institutions. Increased health literacy offers support for young students' health, and studies have sought to find a link between better health, decreased risks, and academic achievements (Rodericks et al., 2018). Health-promoting efforts are vital for emerging adult students to help them develop and maintain health consciousness while balancing newfound freedom, increased responsibilities, and changes in social and emotional lifestyles (Simons-Morton et al., 2016a). O'Donnell et al. (2015) highlighted factors influencing health promotion programs and the effectiveness for the desired change. He emphasized connecting the health promotion initiatives with content that interests the audience. Thus, health literacy can positively influence students' health behaviors when addressed with resonating information by college health educators (Lefebvre & Palmedo, 2017).

College Health Disparities

Students who experience racial health inequalities and identify with specific ethnic and cultural beliefs might face difficulty maintaining their academic goals (Bornschlegl et al., 2020). College students in the United States reflect low health literacy knowledge with even lower racial health equity reported among minority students (Avci et al., 2018; Mackert et al., 2017; Rababah et al., 2019). Innovative and inclusive solutions are needed to support a more comprehensive health literacy program. Batterham et al. (2016) stated that practitioners, health service managers, policymakers, academics,

and consumer groups need to understand and measure health literacy to comprehend how health literacy strengths and limitations can vary within different populations. Batterham et al. pointed to health literacy promotion best practices with a need to focus on students belonging to racial and ethnic minority groups.

Many studies confirm the need for increased health literacy for specific minority groups of students within college campuses (Auld et al., 2020; Baik et al., 2019; Dawkins-Moultin et al., 2018). Minority emerging adult college students may experience diverse challenges specific to their community's health and socioeconomically complex issues (Calvo, 2016; Chang, 2019; Marks & Garcia, 2018; Rikard et al., 2016; Wolf, 2017; Yang et al., 2016; Zhu et al., 2019). Thus, a social change opportunity might emerge from my study if health educators offer insights into their roles and share how they promote health literacy in culturally appropriate ways (Bauman et al., 2019; Newell, 2016). McClain et al. (2016) examined the impact of racial stressors on college students' health and well-being. They found that Black college students face higher stress levels, anxiety, and isolation more than any other ethnic group. A study by Jackson and Sherman (2018) noted the prevalence of limited data on college students' health, with Black and other minority students being misrepresented in college studies data. They attributed limited outreach and lower enrollment of Black college students as a contributing factor and suggested more engagement efforts to obtain more representative data from Blacks and other minority students across college campus studies.

Hicken et al. (2018) highlighted structural racism issues in health that prevent minority groups from being serviced equitably. The study noted limited information from

an analysis of racial discrimination prevalence within health-promoting services. The study called for institutional analysis on policies and processes to include the cultural perspectives of the people they serve. They also found value in considering the lived experiences of Blacks, Latinos, and other immigrants/ethnic minorities concerning health, education, housing, food, and work environment. The researchers sought to understand institutional consciousness about racial health inequality, and what efforts motivate policies and institutional actions across sectors. Minority emerging adult college students' racial health inequalities remain a barrier to equitable health education (McClain et al., 2016). This problem could pose a barrier to health promotion efforts as educators need to possess the skills and capacity to address diverse students' needs relevant to their cultures and ethnicities. Wolf (2017) posited that health professionals have a vital role in promoting health equity to diminish the effects of health inequalities.

Diverse Needs of Racial Minority Emerging Adult College Students

Emerging adult students transition to major life epochs and shape their adulthood footprint in college years (Arnett, 2014). Joseph et al. (2016) found that age and school year has a relative effect on health literacy perception and knowledge for college students. Wyatt et al. (2017) found that poorly documented young/first year students' health affects their performance, and poor mental health and limited resources pose increased risks to college students. Andrews and Westling (2016), and Healthy People 2020 (2018) found that social determinants of health, such as lower health literacy, food insecurity, and lower income, expose minority adult college students to higher comorbidity and high mortality rates associated with chronic disease development. Black

and Latino college students are part of historically marginalized community groups that need careful consideration for health equity engagement to aid barriers relevant to their socio-cultural identities (Schneider et al., 2006). A review of research on health literacy by Fleary et al. (2018) noted that health literacy and health behaviors of young college students require increased support for best practice within higher education institutions. Thus, supporting need for research to inform how college health professionals assist the learning and promotion of optimal health for minority college students (Mushonga & Henneberger, 2020; Rababah et al., 2019; Rosario et al., 2017). Avci et al. (2018) alerted that health professionals in college should be cognizant of the existence of a "subpopulation" of underserved minority college students who reflected limited health literacy, which impacted their "decision-making" and access to appropriate health (p. 186).

A study by Taylor et al. (2019) found that other factors perpetuating the inability to continue education correlate with poverty and food insecurity amongst young adults. Based on their student sample, most ethnic minority students attending public colleges live in poverty. Food insecurity is linked to lower academic achievements; thus, minority young adults could benefit from college initiatives tasked with reducing food insecurity. The authors suggested that food assistance programs in public higher education schools increase minority students' well-being. Students transitioning from high school lose free and reduced lunch access in college, which may contribute to health literacy barriers of students belonging to at-risk groups. Calvez et al. (2016) conducted a study at Texas University and surveyed students about their food insecurity. Their study concluded that

students facing limited access to fresh and affordable food negatively impacted their academic success and overall health.

Zhu et al. (2019) asserted that racial health disparities expose racial/ethnic minorities to a higher risk of developing/dying from severe chronic health risks and chronic conditions such as diabetes. They noted the need for preventive health education efforts with an intensified focus on vulnerable population members from minority groups. Thus, further inquiry into the health education initiatives that promote cultural meaningfulness and relevance to minority college students is needed. According to Martinez et al. (2018), health education initiatives that encouraged preventive health demonstrated a powerful way to obtain student engagement and their insights of lived experiences within their communities.

Limited knowledge from research studies confirmed that college health practices related to the diverse needs of minority students who are not native-born are needed. Research studies are needed to inform how culturally inclusive approaches may include help with acculturation, issues of institutionalized racial discrimination, language barriers, and making sense of U.S. health practices relevant to their lived experiences (Asad & Clair, 2018; Gagnon et al., 2017; Gibson et al., 2016; Mackert et al., 2017). Lederer and Oswalt (2017) and Mackert et al. (2017) found the college years of an individual's life are crucial for health literacy education and lifelong wellness formation to achieve optimal health outcomes.

Student Affairs and College Health Organizations

Higher education student affairs departments manage health and wellness programs across colleges. As explained by Akens et al. (2019), student affairs professionals help students develop "self-efficacy" and "self-preservation" by teaching the importance of wellness and pursuing student-centered initiatives to promote engagement and socialization on campus. Akens et al. explained that these professionals' roles were shaped by "postmodern beliefs" and a focus on diversity for inclusion across college campuses (pp. 6-9).

In the last century, studies reported consideration for college students' health issues and how they impact the academic experience, which advanced the need for supportive services on campuses (Patrick et al., 1992). A gap in the literature is identified for studies focusing on the college health educators' role as they support health education promotion and equity. Since the phrase "Mans Sana in Copore Sano," (p. 256) college health services began to emerge in the first universities. This motto, "a healthy body for a healthy mind," (p. 256) is dated to the 1800s and evidences the importance of college students' health to academic success (Turner & Hurley, 2002; Turner & Hurley, 2014; Wood, 2016).

Turner and Hurley (2002; 2014) discussed college student affairs' historical underpinnings and student support services at the national and international levels. They documented the creation of gymnasiums and medical infirmaries within U.S. higher education institutions. Turner and Hurley related that acknowledging and implementing diverse practices coincided with women and minorities' admission to college campuses

in the mid-1970s. They further noted the significant influence that the typhoid epidemic had in associating college students' health with national health initiatives for infectious disease prevention, creating national associations, health initiatives, and in 1920, formation of the American Association of College Health Education (ACHA) based in the U.S. The college health services primal leaders were medical personnel such as doctors and nurses. These authors explained that health education within college campuses began to include mental health personnel and certified public health professionals at the turn of the 21st century. Patrick et al. (1992) related the scope and typical emphasis area for "student health services" available, which include "medical, psychological, and health promotion" (p. 257).

When discussing historical landmarks of college health promotion, health literacy, and well-being, the following organizations are influential: The Council for the Advancement of Standards in Higher Education (CAS, n.d.), the American College Health Association (ACHA), and the National Association of Student Affairs Administrators in Higher Education (NASPA), which support and provide resources for U.S. higher education institutions and their leaders. These organizations follow the Center for Deceases Control (CDC) and Prevention's guidelines and framework to promote health literacy within college campuses (Epperson, 2012; Lederer & Oswalt, 2017). These entities encourage college health leaders to learn about the social determinants of health or social factors that influence students' belonging to ethnic/racial minorities (Healthy People 2020, 2018; Logan & Siegel, 2017; Rudd, 2015). ACHA has provided standards to guide higher education best practices and provide hiring guidelines

and training to develop health-promoting educators since 2001 (ACHA, 2019, Zimmer et al., 2003).

Jackson and Sherman (2018) argued against the American College Health Association's (ACHA) claims of inclusivity in their student health studies and reports. They noted that students' racial/ethnic data is misrepresented within some of ACHA's college health reports and that their omissions perpetuate service disproportion within college health services. Jackson and Sherman further justified a need for internal college health reviews to become more socially conscious and competent. NASPA, in collaboration with NIRSA and ACHA, dedicated efforts towards health promotion through an annual report called Health and Wellbeing in Higher Education: A Commitment to Student Success (NIRSA, 2019). The 2019 statement affirmed that well-being within higher education evolves when diverse cultural views on health and language yield better health promotion. This finding encourages college health professionals to foster a culture for inclusion within college campuses.

Early studies on multicultural teaching and learning by Abrahams and Troike (1972) advised educators to account for their students' cultural differences and attribute meaning to their teachings that eliminates personal bias. Factors influencing college students' health behaviors are ever-changing, and knowledge on how college health educators increase health promotion needs continued development (Kim & Kim, 2018). Student affairs and health and wellness services should enhance inclusiveness amongst all student groups (Best College Reviews, 2017), impact college experiences with culturally inclusive services, and increase health literacy promotion efforts by health

educators as leaders in college health promotion (College and University Health Services, n.d.).

College Health Educators' Role

College health educators may be public health professionals with essential training on health promotion and education, registered nurses, or doctors depending on size, location, student need, and composition of the college or university (Butler & Veeser, 2002; Crihfield & Grace, 2011; Farrell & Ellis, 1994). Limited studies explained how health educators promote students' health literacy, supporting the need for further research to address the gap in the literature. Lambert et al. (2014) confirmed a lack of literature about health professionals' perceptions of health literacy practices and promotion. Their study found that some health professionals lacked basic knowledge of health literacy related to the barriers faced to provide needed services to specific ethnic groups.

Conrad et al. (2019) and Logan and Siegel (2017) advised on the need for making sure college health educators are prepared to support students with health wellness and self-efficacy skills. Baldwin et al. (2017) found that while many organizations, like the ACHA, encourage student wellness and conducted studies and developed standards to recommend greater support for students, there was a lack of inclusiveness in their recommendations to aid the practice of college health promotion. Steinberger et al. (1996) delineated the importance of inclusive practices in college health education research. They noted researchers' inability to gain buy-in from educators who feared retaliation from their workplaces impacts the trustworthiness of research findings.

Steinberger et al. highlighted the need to present research participation as an opportunity to share expertise in health education. The recommendations from earlier researchers evidence the need for college health educators to continue education and capacity building for their profession (Davidson, 2008).

Since 1997, through the National Survey on Health Education, ACHA has gathered data on health educators across the country (Zimmer et al., 2003). However, most studies on health education and health promotion used quantitative methodology, and offered limited results on college leaders' experiences, their professional approach to practical health promotion, and discussions on equitable health services for minority students. Thus, research is needed to inform how health educators' approaches help with acculturation, issues of institutional racial discrimination, language barriers, and the lived experiences of Black and Latino emerging adult college students (Asad & Clair, 2018, Gagnon et al., 2017; Gibson et al., 2016; Mackert et al., 2017). Factors influencing the role of college health educators require further exploration through studies and literature documenting their perspective. Focus on best practice, and institutional support to Black and Latino students, and barriers associated with social determinants of health such as poor health literacy, are also under-researched topics. Predicting behavior, understanding cultural background, places of origin, and socio-emotional circumstances encouraged the development of effective ways to promote college students' well-being (Ridner et al., 2016). The knowledge of these factors, or social determinants, of health in college students can create sensitivity and effectiveness for health promotion (Ciotoli et al., 2018).

It is advised that college health educators consider how students' cultural and ethnic differences influence their likelihood to seek help for their physical or mental well-being (Avci et al., 2018; Despues & Friedman, 2007; Schwitzer, 2009). Institutions must know students' primary health literacy motivators in college health initiatives so that culturally relevant health promotion efforts can be enacted (Bandura, 2004; Jackson & Sherman, 2018; Kim & Kim, 2018).

Summary and Conclusions

Chapter 2 included recent and seminal studies that support research related to students' college health education through the critical history of student support services. My literature search strategy and theoretical framework sections were documented with alignment to the social problem. The literature review included supporting evidence of the social problem and analysis of the research that supports more research for this topic. In Chapter 3, I describe the rationale for the research design and my role as a researcher. I also provide the description of my intended study's methodology, including participant selection logic and recruitment, the data collection and analysis plan, steps I took to increase trustworthiness, and ethical considerations.

Chapter 3: Research Method

The purpose of this basic qualitative study was to learn how health educators promote the health literacy of Black and Latino emerging adult college students. In this chapter, I describe the methods I undertook to recruit participants. I also describe my role as the researcher, explain my data analysis plan, and describe how I reported my research findings. Additionally, the ethical considerations for my study are described as well as strategies to increase trustworthiness.

Research Design and Rationale

I sought to answer to the following research question: How do health educators promote Black and Latino emerging adult college students' health literacy? Based on my intent to explore the perspectives and practices of college health professionals, the use of a basic qualitative design was appropriate. The research question guided the choosing of a basic qualitative design, as well as how data were to be collected and analyzed (see Merriam & Tisdell, 2015). The qualitative research process provides a systematic way to measure experiences and perceptions (Patton, 2015). Using a basic design, I conducted one-to-one semistructured interviews (see Saldaña, 2016). Patton (2015) asserted that with the discovery of meaning via qualitative inquiry, the use of lived experiences, the explanation of the context of the problem, and the understanding of functions and practices, new knowledge and can be achieved in a basic design. Because of the alignment of these methodological purposes with the purpose of my research, I chose the basic qualitative design to answer the research question. Babbie (2016) and Patton noted that what is learned from a study's participants about their experiences may help inform

their field of professional practice. Interviewing facilitated the collection of data from the rich perspectives of the participants (see Babbie, 2016; Saldaña, 2016). My study was based on the constructivist assumption (see Caelli et al., 2003; Merriam & Tisdell, 2015) that it is valuable to understand how participants view their world, environment, and practices.

Role of the Researcher

My role as the researcher included recruiting participants and collecting data from them via recorded interviews, as well as coding the data. Acknowledging that everyone, including myself, holds personal beliefs and opinions on a problem, I used journaling to minimize and manage personal bias while seeking answers to the research question, as suggested by Patton (2015). A journal also complemented the one-on-one interviews and facilitated some triangulation of the data (see Kalu & Bwalya, 2017; Ortlipp, 2008). Having beliefs and assumptions is normal; however, minimizing them helps promote ethical practices (Burkholder et al., 2016).

My biases may have been related to being a racial minority doctoral student who has had to manage chronic health conditions while pursuing my degrees. I worked as a public health professional in a health care organization. I did not have any professional or personal relationship or any managerial power over my study participants. I sought to objectively portray participants' experiences and perspectives with the information they provided, the experiences they described, and the practices they shared with me as I sought to answer the research question.

Methodology

In this section, I describe the selection criteria for recruiting participants, explain how I recruited participants, and describe the instrumentation and the plan for data collection. I also share my plan for analyzing the collected data. I followed Maxwell's (2009) suggestions that researchers must describe how their approach aligns with the study's purpose and how the methods are applied when designing a qualitative study.

Participant Selection Logic

The target population of participants in this study included counselors, nurses, health educators, or doctors who

- served in the role of health educator and any other role to promote health literacy to Black and Latino emerging adult college students and
- worked in student affairs/student support services departments and served in their role for at least 1 year.

To reach data saturation of the research topic, I aimed to recruit between eight and 10 college health educators. As noted by Guest et al. (2006), in qualitative research data saturation can be reached via interviewing 12 participants, and six participants could provide sufficient variability.

I recruited participants using publicly accessible contact information from university websites and social media. Because potential participants belonged to professional development organizations such as ACHA and the National Commission for Health Education Credentialing, I was able to recruit participants by finding their contact

information through these association's websites. I also recruited from the Society for Public Health Educators, as well as states' certifying public health associations.

I sent written invitations to prospective participants explaining the study's purpose. I informed them of the provision of a $25 dollar e-card to thank them. I explained my intent to conduct in-depth semistructured interviews with open-ended questions (see Appendix) designed to solicit health educators' personal insights on their professional practice and their experience with health literacy promotion to college students (see Jacob & Furgeson, 2012; Patton, 2015; Ravitch & Carl, 2016).

Malterud et al. (2016) noted that health educators might fear research participation due to fear of retaliation from institutions where they work and lack of time due to the nature of their work. Lack of time posed an accessibility risk for the current study amid the COVID-19 pandemic (see Campbell et al., 2020). I aimed to mitigate these barriers by recruiting from diverse schools in different states and by providing informed consent about the confidentiality of this study.

Instrumentation

The interview questions (see Appendix) were designed to provide extensive feedback or to gain in-depth insights into the participants' perceptions and experiences (see Ravitch & Carl, 2016). Patton (2015) discussed a pragmatic approach for interview questions designed to elicit answers about participants' experiences and behavior, their opinions and values, their knowledge, their background, and their demographics. Using this pragmatic focus, I hoped to learn how health educators did their job, what health literacy promotion practices they used, and how their personal beliefs were affected

through their student interactions. The interview protocol also included probing questions to elicit more information if needed (see Dikko, 2016). To respect the qualitative inquiry process, I did not ask questions that may have posed risks to the participants, that might have been subjective or leading, or that might have been embarrassing to the participants (see Ravitch & Carl, 2016). Despite participants' modest risk when participating in studies, my aim was to gain their trust. To ensure trustworthiness, I sought to develop questions that were objective in their design (see Patton, 2015). To further ensure trustworthiness, I asked my chair and committee member to review the interview questions and used them in practice interviews before the data collection process.

Participant Recruitment

No recruitment or data collection occurred until I received institutional review board (IRB) approval from Walden University. Walden University's approval number for this study was 07-01-21-0290594. Once eligible persons agreed to participate, I thanked them for their interest and explained the next steps in the process. I scheduled the interview and provided each participant with an interview guide containing the interview questions. The consent form contained details of confidentiality, commitments, risks, and participation expectations. Participants who agreed to be interviewed signed the consent form electronically. Participants were informed of their right to withdraw from the study at any time without fear of reprisal. The interview guide included the invitation letter for recruitment.

Data Collection

Due to COVID-19 restrictions, I conducted interviews virtually via Zoom or Google Meets because both had recording options. I allotted 60 to 90 minutes per interview, although I expected some interviews to be approximately 45 minutes. I masked names with respectful pseudonyms for participants' confidentiality (see Allen & Wiles, 2016), and identifiable demographic information was not included in the study. Participants were asked to be in a comfortable and private space, and I was in a private space for the recording. At the beginning of the interview, I reiterated that the interview would be confidential, and that the participant had the right to withdraw without risk of repercussion at any time. Participants were also able to skip any question they were uncomfortable answering by saying "next question." As a researcher observer, I strove not to react to answers that might have been alarming or in opposition to my beliefs. I remained objective by managing involuntary reactions (verbal and nonverbal) in a way that did not inadvertently lead the participant in any direction (see Seidman, 2012). I fostered participant feedback to questions by creating a "relaxed environment" (Seidman, 2012, p. 78) and asking the questions with care not to lead or influence the respondent. I also sought to avoid stressful interviews by building rapport with the participant through trustworthy behavior and demeanor. Before ending the interview, I asked participants if they had any more information they wanted to share and told them that I would inform them if a follow-up interview was needed. I reiterated the study's confidentiality commitment, told the participant to feel free to reach out to me with any questions and

concerns, and closed the interview by thanking the participant before ending the virtual meeting.

I thanked participants for their time with a $25 dollar e-gift card. Transcriptions were shared via email with each participant (transcript checking) for review, feedback, and accuracy before I began data analysis. Participants had 5 business days to make any desired changes to the transcripts and send them back to my email address. If nothing was returned after 5 business days, I assumed that the participant had accepted the transcript as correct. I will secure the data for 5 years in a locked box at my home that only I have access to (see Charmaz & Thornberg, 2020; Creswell & Poth, 2016; Hernandez et al., 2016; Patton, 2015). Data will be destroyed after 5 years of the study completion, per IRB regulations.

Data Analysis Plan

I reviewed the interviews by listening to the recording while checking the transcript to ensure accuracy. I also reviewed my research journal to maintain objectivity. I coded the data manually using first and second level coding (see Saldaña, 2016). Coding helps researchers with the attribution of units of meaning and provides an opportunity to label standard information derived from participants' shared insights and experiences during the data collection process (Miles & Huberman, 1994; Patton, 2015; Saldaña, 2016). I looked for connections between participants' responses and the research question (see Rubin & Rubin, 2012).

I organized the data in a table using identifying colors for first and second level codes and possible themes. If there were too many codes to easily identify themes, I

sorted the codes into categories and then looked for a smaller number of themes to emerge from the codes. I used direct quotes to support central themes that emerged from the interviews (see Halcomb & Davidson, 2006). Patton (2015) warned that researchers should not include their personal inferences different from the participant's perspective on the phenomenon. I also removed identifiable participant information such as names, gender, and demographic information.

Issues of Trustworthiness

Credibility

To ensure credibility, I conducted research and presented findings without inconsistency based on the college health educators' interviews. I transcribed the participants' recorded interviews. The recorded interviews were replayed as many times as needed and read against the transcript to ensure accuracy. Transcripts were shared with the participants for transcript review. Maintaining a reflective intent through the data analysis process helped me manage and reduce possible bias. Journal entries of my experience were used to ensure credible research was produced and that valid representation was evidenced, as I intended to objectively document information shared by participants.

I met the triangulation requirements for trustworthiness by interviewing more than one health educator from U.S. universities. I used my research journal to describe the different higher education institutions, their settings, and their geographical regions (see Fusch et al., 2018). My methodological approach aligned with my research question, literature review, and theoretical framework (see Creswell & Poth, 2016).

Transferability

To ensure triangulation, I interviewed health educators from diverse higher education institutions from several regions to obtain rich insights into the study's phenomenon. Interviewing people who fulfilled the health educator and other health-promoting roles across several higher education institutions offered the opportunity to gain participant variation. Participants shared diverse perspectives about the institution's culture, the missions they followed, and the populations they served, which could inform daily practices. My research results may inform future research on college health educators and the practice of college health educators outside of my recruitment area.

Dependability

Kalu and Bwalya (2017) noted that a study must contain a relevant design and knowledge used in diverse settings to conduct ethical and trustworthy research. By conducting ethical research and producing universally understood results, I achieved external validity. During the data analysis, I represented results that could be universally interpreted and duplicated by others seeking to further the study in a different setting, location, or with a different data set (Merriam & Tisdell, 2015).

As a reliable researcher I ensured that the data collection process was impeccable. I maintained dependability by securing the participants' confidentiality. I scheduled individual virtual meetings with the participants to maintain their confidentiality from other participants. I provided different meeting identifications and passwords for each participant to avoid confidentiality violations during virtual meetings (Hancock, 2019). I intended to rule myself via the institution's academic and ethical requirements and related

any questions to my doctoral committee, academic advisors, academic mentors, and help from the center of research quality resources provided by Walden University to ensure dependable and sound research methodology application.

Confirmability

A source of confirmability and neutrality was in the use of the researcher's journal. I noted the experiences lived as the researcher during the research process, and what I learned from participants. I also intended to note any possible problems or obstacles faced in the recruitment, data collection, and data analysis process while documenting what I learned on how to avoid such issues in the future, and how I intended to overcome them. I reflected on beliefs and biases that rose and documented them to separate them away from the study results. The participants' backgrounds, perceptions, observations, interactions, and relevant research information were also noted in the research journal.

Ethical Procedures

The following ethical procedures plan was contingent upon Institutional Review Board (IRB) approval from Walden University. The participants were not contacted, and no part of the data collection was done before obtaining IRB approval. Once approved I began participant recruitment and scheduling of interviews. My intent was to objectively report on what was learned, and to interpret information as accurately as possible. I was careful to mitigate bias and repress personal beliefs during the reflective process of the data analysis, and refrain from using subjective language and personal inferences when documenting the data results.

Human participants were treated with respect, and their confidentiality was protected. If participants were unwilling to proceed with the study and did not wish to continue to be interviewed, they had the right to leave or request the interviewer to end the interview process. As the researcher, I would have thank the participant and reiterate that participation was voluntary and free or reprisal. I reiterated the confidentiality and consent agreement to build trust rapport at the beginning of the interview. To further preserve the confidentiality of the collected data for participants, I maintained the transcriptions and data in a flash drive in a personal lockbox in my home for five years. After 5 years, the data will be deleted, and printed copies would be destroyed.

Summary

In this chapter, I described my research design rationale, my role as the researcher, my recruitment strategy, the data collection and analysis plans, and how I intended to produce ethical work. In the role of the researcher section I disclosed possible bias, identified ways to minimize bias, and ways to mitigate any potential issues. By delineating details and steps in the section of issues of trustworthiness, I addressed validity, reliability, transferability, and intent for objectivity in the research process.

Chapter 4: Results

The purpose of this basic qualitative study was to learn how health educators promote the health literacy of Black and Latino college students as emerging adults. To understand perspectives and practices among those who promote college health education on campuses, I conducted semistructured virtual interviews using open-ended interview questions designed with the research question in mind. In this chapter, I describe the setting, participant demographics, data collection process, data analysis, the trustworthiness of the findings, and the results.

Setting

Because of the COVID-19 pandemic and the need to socially distance, interviews were conducted via Zoom with participants from eight different institutions of higher education. The setting for data collection included participants' choice of a quiet and private space for a confidential conversation, as well as my own private setting. I did not have any conflict of interest with the participants, and no prior professional or contractual relationship existed with the participants before or during recruitment.

To recruit participants, I emailed 123 health promotion professionals from 36 higher education institutions via their publicly available email addresses, LinkedIn pages, and Facebook posts. I also sought participants via local state organizations for public health professionals. Challenges in recruiting included scheduling limitations after work and some potential participants responding they were interested in the study but cautioned their time was compromised with the COVID-19 pandemic due to their responsibilities to manage safety regulations for on and off-campus students. Because of

challenges recruiting participants, I got approval from Walden University's IRB to modify my study criteria to accommodate more health promotion roles, including those who promoted health and wellness such as a nurse, doctor, counselor, or health educator at any U.S. college or university.

The most successful outreach sources were LinkedIn and Facebook postings, with 15 potential participants expressing their desire to participate, 10 committing to being interviewed, and five of the 15 failing to show or not agreeing to reschedule. Two of those 10 who agreed to interview were ineligible community health nurse practitioners who had no experience working on a college campus. To the remaining eight participants, I offered flexibility to interview them during lunch breaks, in the evenings, or during the weekends. Most participants agreed to meet during the workweek after they left work, two met with me over a weekend, and the last interview occurred during a lunch break. I accommodated rescheduling requests, but after not hearing from some participants for several weeks and after reminders were sent, I stopped reaching out to unresponsive potential participants.

Demographics

Of the eight participants, I interviewed four individuals who identified as women and four who identified as men. Four participants identified as Black and Latino racial and ethnic group members, one identified as an immigrant Asian American, and three identified as White individuals. They were all college graduates, and four of them were enrolled in continuing education activities, including a certificate program, a master's program, and a doctoral program. From their descriptions, I surmised that all eight

participants were in different professional and personal stages of life. They also worked at eight large private and state universities.

When recruiting participants, I was able to reach only one individual with the title of health educator. Other participants currently or recently held roles with diverse titles regarding promoting health and health literacy. The ones who left the formal health educator role worked promoting health on college campuses, and others went to work in high schools doing similar work with different titles. For confidentiality, participants' names were masked with a numerical pseudonym (Participant 1, Participant 2, etc.) that did not represent their participation order or gender. I used gender-neutral pronouns in the results section to further ensure confidentiality. Table 1 shows the pseudonyms, public or private institution status, and participants' roles.

Table 1

Participant Demographics

Pseudonym	Institution type	Former/current role
Participant 1	Public state university	Assistant director of student support services
Participant 2	Private university	Certified health educator
Participant 3	Public university	Mental health counselor and peer field supervisor
Participant 4	Private university	Education and student support services director
Participant 5	Private university	Program assistant for student wellness and health promotion
Participant 6	Public university	Assistant health promotion worker mental health faculty
Participant 7	Public university	Public health nurse, program director of health promotion program
Participant 8	Public university	Campus recreation/fitness coordinator

Data Collection

My data were collected via recorded interviews that started in July 2021. I continued to recruit and concluded interviews by October 2021. Although I aimed to interview between eight and 10 participants, I reached data saturation after eight interviews. As I conducted interviews and reviewed my notes, I began to note some commonalities within responses. After the sixth interview, I realized participants shared evidence of similar ways to promote health literacy, and by the eighth interview, I realized I had reached data saturation as no new information to my questions was elicited.

Consent was obtained from each participant prior to scheduling interviews. I communicated via phone calls, text messages, and emails to determine whether

prospective participants met the inclusion criteria. I also discussed and reviewed the consent form with each participant and sent a copy to them to review before we set up the interview. At the beginning of each interview, I reiterated that the interview would be confidential and that participants had the right to withdraw from the study without risk of repercussion at any time. I reminded participants that interviews were being recorded and that I would not divulge their personal information or share their transcripts in the final study document. Each participant was provided with a private Zoom link and password. Each interview was recorded and lasted between 60 and 90 minutes. To ensure confidentiality, I met with participants in a private space and asked participants to do the same. Participants were able to skip any question they were not comfortable answering by saying "next question." All participants answered all interview questions. I informed participants that I was taking notes in my research journal.

Following Seidman's (2012) advice for effective data collection practices, I opted to elicit answers by creating a "relaxed environment" (p. 78) and asking the questions using "smiles" (p. 90) and expressions, with care not to lead the respondent to answer questions. Once participants informed me that they understood the purpose of the study, consented to participate, and did not have further questions, I asked the first exploratory question to get to know them and build rapport. During the interviews, some participants had children come and seek their attention, and I offered to stop the interview or continue another day. All participants were given the flexibility to stop and take breaks as needed during meetings. Some excused themselves for short periods of time and returned to their

interview after leaving their children to be attended by partners and spouses, and some had pets they had to tend to during the meetings.

All participants answered the 11 questions asked, as well as some probing questions. There was no need to request follow-up interviews because participants provided expansive information to answer each question and provided rich content regarding their roles and college health promotion experiences. I ended each interview by asking if there was anything else they would like to share that I may have not asked about and thanked them for their time and for sharing their insights with me. Some participants added more context to the answers they had already provided and offered information about the resources and health promotion programs they provide on campus. There were no extra insights provided on topics I did not ask about. To thank them for participating in the study, I provided participants with a $25 gift card. Participants were asked if they preferred the thank you gift to be sent via email or text to accommodate their preferences.

To ensure I captured participants' interviews accurately, interviews were recorded via Zoom and transcribed manually as well by using a software program. The interview transcripts were checked and rechecked alongside the recording to ensure the accuracy of the transcription. I shared transcripts with participants for transcript review after completing each interview. Participants were told to review their transcripts, make any changes desired, and return them to me within 5 business days. Some participants replied and thanked me, three replied with minor grammar changes, but most did not reply after 5 business days, in which case I assumed they were not interested in making changes to the transcripts.

Data Analysis

I began the data analysis by color coding the transcribed interviews. The hand-coded data revealed initial recurring words that helped me group the codes into the following initial categories: insights on practice and beliefs, insights on professional and personal experiences, insights on cultural awareness, insights on student-focused practices, and insights on overall health promotion activities and outcomes of their practice across their diverse campuses. Participants' answers and candid anecdotes helped me further categorize the initial codes into themes.

Another part of my data analysis included the use of a data analysis software. The software analysis provided recurring words, but I preferred to proceed with hand-coding as I became submerged in reading and learning from participants' words and making notes to highlight trends in the data as I coded by hand. As I reread the data to find connections and themes among all eight participants, the initial number of recurring words and phrases from my hand-coding analysis was 32.

With themes beginning to emerge from categorizing the initial codes, I went back to my data to read more about the context of the codes. I compared the interviews and reviewed my research journal to achieve triangulation. Further analysis of the interviews provided explanations about participants' field/career, student interactions, practices, and health promotion strategies that helped me answer the research question of how these participants promoted health literacy for Black and Latino students with the following three themes: culture-focused promotion practices, use of diverse engagement strategies,

and internal and external stakeholder collaboration (see Table 2.) There were no discrepant data.

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Table 2

Codes and Themes

Code	Theme
Personal view of health/upbringing	Culture-focused promotion practices
Institutional support	
Student focus	
Ethnic health beliefs	
Sociocultural status	
Student-focused	Use of diverse engagement strategies
Improved strategies	
Financial impact	
Disposition to learn/try	
Current interests	
Food gift cards	
T-shirts	
Institutional policies	
Institutional composition	
Guiding principles	
Personal view of cultures	
Desire to learn	
Role autonomy	
Years in role	Internal and external stakeholder
Health promotion beliefs	collaboration
Use of uncommon terminology	
Professional experiences	
Health promotion	
Training opportunities	
Managerial support	
Theory versus practice	
Personal view of cultures	
Knowledge/perspective on theories	
Interactions with diverse students	
Collaborative involvement	
Community organizations	
Professional development institutions	

Evidence of Trustworthiness

To conduct ethical research, an investigator must respect participants, follow protocols delineated by the IRB, and meet ethical research standards of qualitative research. I maintained evidence of trustworthiness in my research by applying criteria and providing descriptions with in the sections for credibility, transferability, dependability, and confirmability.

Credibility

To ensure credibility, my research was guided by the research question, the literature review, and conceptual framework throughout the data collection process (see Ravitch & Carl, 2016; Twining et al., 2017). I asked participants the same questions in the same order that were designed to elicit answers to address the research question. Interview questions were vetted by my doctoral committee members, and I conducted practice interviews with community health educators and family and friends who were not participants in my study. Their participation helped me finalize the interview questions as I reflected on the effectiveness of the questions to answer the research question.

As a listener during the interviews, I did not react to answers that might be alarming or in opposition to my beliefs. I remained neutral, so I did not negatively impact the integrity of the inquiry process (Seidman, 2012). After the interviews, I transcribed and double-checked the transcriptions to ensure consistency between recordings and transcriptions. Consistency in the data collection practice was also maintained by encouraging transcripts checks with the participants after each interview. Only three of

my interview participants shared grammatical revisions to their transcripts, four of the participants expressed no interest in making corrections but thanked me for sharing, and one did not answer my email, which noted that after 5 business days with no response, I would assume the participant had no interest in correcting the transcript. I also helped establish credibility by interviewing diverse college health promoting professionals from diverse schools across several different states.

Transferability

To maintain the qualitative criteria and ensure truthfulness in the presentation of the results of this study (Noble & Smith, 2015), I followed a careful and consistent plan for recruitment, data collection, and data analysis as described in Chapter 3. I made my research study more transferable by providing lengthy quotes so readers could discern better if the results had applicability to their setting or research problem. I also worked to ensure that if this study was replicated by future researchers, they could do so via the descriptions of the process I followed.

Dependability

I worked to establish rapport through informed consent by leading a guided conversation with my line of questioning, and by reminding interview participants of my commitment to confidentiality. Participants appeared comfortable enough to share freely and candidly. I served as the data collection instrument and utilized a journal to document the research process and to manage bias (Ortlipp, 2008). Participants were made aware I would take notes during interviews. These journal reflections were used as part of my triangulation process along with discussions with my doctoral committee members. I was

committed to the study's integrity by ensuring the ethical research protocols delineated in Chapter 3 were followed.

Confirmability

I documented my feelings and the steps I took during the interviews in my research journal. After the interviews, I reviewed my notes to add my interview reflections. Once I transcribed interviews, I compared my notes and the transcripts. This practice helped me ensure confirmability of the findings by reflecting on possible bias regarding health promotion practices as shared by participants and important points to consider during the interview process.

Results

The results of the data analysis brought about the following three emergent themes to address the research question regarding how health educators across different U.S. higher education institutions promoted Black and Latino emerging adult college students' health literacy. From the collected data, I learned that health educators promoted health literacy by being culturally focused on their promotion practices, by using diverse engagement strategies with the students, and by seeking out support via internal and external stakeholder collaboration. Overall, participants commented on the status of their college campus' health promotion efforts and the opportunities in their practice. Some participants expressed being happy with their campus health promotion practices, the resources they had, and the teaching styles they employed to engage Black and Latino students in the most comprehensive way possible. Other participants noted the limitations of their practice and roles, while others noted gaps, and others mentioned

opportunities for growth within their campus. Some expressed they had role autonomy and were able to customize their educational practices to meet the needs of students. Others highlighted limited role autonomy that exacerbated their inability to properly support Black and Latino emerging adult students as their institutions were focused on generalized practices for health literacy education and promotion.

Theme 1: Culture Focused Health Promotion

The data were richest in describing this first theme. Some professionals noted they were self-aware about their limitations to connect to students' personal and cultural needs. Others noted they could personally relate to the cultural needs and experiences of Black and Latino students at their college campuses. Some stated they began to change their teaching habits, outreach efforts, and used more resources in hopes of being more culturally sensitive. Based on participants' responses to questions about barriers to promoting health to these two populations of learners, health educators noted these students might come from diverse cultures with needs unique to their ethnic experiences. Such needs included support with language barriers, as some Black and Latino students migrate from different parts of the world and might speak languages different than English. Other participants shared that those who belonged to Black and Brown ethnicities and identified as part of a minoritized sexual orientation required more support to help them better receive health literacy education that could be applicable to their lives.

To express their cultural experience and cultural awareness, participants utilized words and phrases such as "meaningful," relevant information," or "meet students where

they are at," and statements such as "some students might see health a little bit different," or "I may need to seek more appropriate supports." Some participants yearned for the possibility to provide more equitable support to Black and Latino students when promoting health literacy, such as Participant 2, who stated:

> I am of their cultural background; they need barriers broken, taboos to be explained, and relatable ways to educate based on limited knowledge students might obtain on sexual health, knowledge on how to assert consent for sex, and other things. Such as how do they [Black and Latino college students] could pursue wellbeing from the perspective of some of their parent's authoritative cultural practices religions, as well as their ability to learn beyond limited knowledge from parents who might be illiterate and from poor socio-economic backgrounds.

Participant 3 shared: "As a White person, I realize I have limitations to be able to provide shared life experiences. So, I try to find resources and support for them [Black and Latino emerging adult college students] via culturally specific campus organizations."

Regarding the college health literacy initiatives by these diverse professionals, Participant 7 expressed their focus on:

> Talking to the students within their culture and understanding the things, the food that we eat, as people of color. Talking to them about specific things they can only describe in their native language is another one. At times I am the only health promotion person that can communicate with them…I also teach new, healthier ways to cook the foods we eat. So, I promote health by listening and

> educating them, as not every member of one culture might have all the answers about the cultural eating habits of each home or ethnicity.

Participant 2 noted the limited health literacy of Black and Latino students regarding "sexual health limitations directly related to their parent's practices, and cultural beliefs." This participant also noted a need to "practice health literacy in a way to build confidence" so students may get past the stigma of help-seeking and beyond the shame to ask questions during some public health forums on campus. Participant 2 expressed hope to prevent negative and long-term impacts on [students'] sexual and physical health that could be preventable via the education they [health educators] provide. Participant 3 addressed the dichotomy some institutions have between the use of funds and allocation of health services to students versus the need to support students equitably and the abilities or limitations that some health educators may face due to the composition of the institutions they work for. This participant explained that

> it is impossible [for institutions] to accommodate the needs of the student … and be able to afford it. They say they do it on paper, but research and collected data of actual health literacy and lived experiences of students note I need to do more to help. I lean on local culturally exclusive organizations to gain that buy-in and be able to better engage the specific cultural needs of these students.

These participants' experiences point to their desire to be culturally sensitive and some limitations in their institutional systems' ability to afford individualized support for Black and Latino students. College health promotion professionals are invested in helping to improve students' health literacy through education and breaking silos by reaching out

to diverse resources as described in the ways they promote culturally sensitive and specific health literacy for Black and Latino emerging adult college students on their campuses.

When asked about the cultural awareness preparation participants have available to them to support Black and Latino emerging adult college students, participants shared they receive cultural awareness workshops required by university compliance offices and that some of them willingly seek out training in cultural awareness to stay relevant to the conversations on students' needs. For instance, Participant 6 expressed:

> You know, I seek out conferences. I am also part of national associations that meet periodically. Because it is not always about covering topics that are relevant to me [as a health educator], but to them [Black and Latino students], I think. On top of that, to have an understanding of the challenges of navigating school, navigating the workforce, seeking what constitutes success and professionalism, and the pressure to achieve all that. You know, it is disproportionately harder for students of color.

These participants expressed diverse students need different supports to be provided when teaching health literacy and that each student's socio-cultural background affects the way information is taught and received regarding health literacy promotion. For instance, Participant 4 said

> We have students [who are] first-generation, students who are predominantly underrepresented minorities, persons of color, and most were female. It is not the case for most educational clusters in the United States, but I was one of the only

> White people in the administration, which was a good thing- I think that would talk about promoting health literacy to different cultures and people of different backgrounds. I believe you need a consensus that you've helped to craft not just experts and professionals in the field, but also people from that culture … people that have that experience.

Theme 2: Use of Diverse Engagement Strategies

Participants expressed they use diverse strategies to engage students while promoting health literacy within their campuses, such as intentionally motivating students through healthy conversations about their physical health and eating habits. Several participants expressed they sought to encourage better sleep habits, as well as physical activity promotion via discussions about their students' emotional health. Incentives were brought up by all participants while answering questions about engagement strategies that worked best. Many shared the challenge of engagement related to students not being required to attend health promotion events or educational activities outside of their academic program requirements. Thus, they used incentives to include self-help journals, intimate care products, condoms, food gifts cards, pizza, or free food in general, and T-shirts to drive student attendance and interests.

Participant 3 stated: "I like to build rapport by engaging these specific students via cultural specific groups they belong to. Some of these organizations may be Greek-lettered organizations for Black and Latino or student engagement organizations within their cultural groups." Participants noted that part of their roles and responsibilities might hinder the way they are or are not able to tailor their health literacy promotion. For

instance, not many are able to customize health literacy promotion in ways that drive equity for Black and Latino students with consideration for their unique lived experiences, diverse health practices, or needs with healthy behavior building for those emerging adults on their college campuses. Participant 5 shared:

> I consider my Black students might be in college for the first time trying to find their place. I would encourage them to get their colon checks and share with the older men in their community. By explaining the stats of cancer risks in their population, I would also discuss the economic challenges of my Black students compared to their White counterparts on campus. I would discuss opportunities to make changes now they have better access to foods, as some come from places that have food deserts, and several burgers and fried chicken food spots are more commonly available than healthy food markets. These were just my practices, which were not always representative of what the school had me teach with a generalized approach. That's just what I saw the students needed.

One participant stressed the importance to reevaluate the way health-promoting professionals on campus are being taught to apply theories and beliefs learned in their professional development such as the health belief model or self-efficacy awareness. They noted that while many individuals begin with the inspiration to do good, and do no harm by their practice or beliefs, bureaucratic limitations, as well as limited knowledge of cultural awareness, may risk health-promoting professionals or college health educators' ability to relate to Black, Latino students, or any other student belonging to marginalized

groups. Participant 2 shared how they see things from another lens to try and best support Black and Latino students with their specific sociocultural needs:

> In my work, I met a teacher from a Latin American country that became one of my students [who] walked here [to the United States] pregnant. She was college-educated, but it was horrible there, this was going to be her better life. I had to figure out her culture and where she was coming from because everybody said, "well, that's just stupid" [that the student migrated and went through that pregnant]. But she walked by night, slept during the day where she found a safe place and fed herself along the way with fruits and vegetables."

This participant continued sharing about the differences they observed between one student group to the next and the behaviors that shaped their health. This participant added that the help needed by those students who may experience things like "food insecurities" on their campus was great as many might assume that the college student population is wealthy. This participant also expressed these assumptions are "far from the truth" as some students struggle financially to the point, they may struggle choosing between paying for food or other basic needs versus affording their education. Participant 2 added that the campus deals with situations like students with "domestic violence, abuse of drugs, alcohol, and have eating disorders." They continued saying:

> You really must focus on nutrition; you really must be careful that you're not triggering somebody when doing exercise kiosks, as we have those students that are sneaking in the gym and doing 6 hours of cardio and like coming down to a skeleton. So that's where I think my nursing hat kind of comes into play.

The same participant further explained that having cultural awareness challenges such as general views of one culture by saying, “Then I look at health literacy in a way that takes it one step beyond; sometimes you cannot assume all African Americans have high blood pressure, this is just a wrong assumption.”

Participants’ intent behind their health literacy promotion practices was expressed as they described how they plan educational activities to promote health on campus. Also, by how they described helping their students by giving them gift cards to supermarkets and to campus cafeteria meals via grants they applied for as they knew some students face hunger. Their intent and good nature were also evidenced through participants’ outreach efforts and diverse strategies employed to try and teach health literacy and better health habits to Black and Latino emerging adult students with chronic health conditions and poor management while on campus. Some of these strategies included the discussions on specific beliefs the students had on using pre-and post-surveys to gauge students’ knowledge on health literacy and the possible impact they might have had on student post-teaching sessions. Other strategies included the use of incentives in the form of food cards, t-shirts, and the provision of meals during educational events to encourage participation and student engagement in health-promoting teaching sessions, health-promoting campaigns, and health literacy enhancement activities taught and designed by these participants. As noted by Participant 7:

> I made it fun; we always had food, as it really gets the students there. Realistically, college students are mostly saving all their money for vodka and

> skip their meals. I would do a grocery tour, sometimes I would just record it, or I'd have the students go and pick me out this list of stuff, and would always spend, you know, $10 to $20, and have food to last them for several days. For some of the bigger events, if we had 10 different topics, we would visit each table, get a stamp and then put it in for a gift card for the bookstore or some healthy food place on Main Street. A lot of times, [the incentive used] was just a small gift card for a big event, and you could get them to attend. It was all very cheap incentives. Because we typically haven't had a budget. In the last 30 years that I've been doing this, I try to do it as economically as possible. So just something as easy as $15, the bookstore gets a good benefit.

Participants noted their health promotion efforts resulted in an overall improvement in health for some students, yet they noted further needs to support Black and Latino students with centralized teaching approaches, incentives, culturally relatable health literacy education, and coordination of better resources and supports by the institutions they belonged to is still an ask for some of the study participants. Other participants noted that before they could attempt at teaching meaningful health changes that may impact students' overall health, participants had to self-reflect on engaging students within the context of what their college experience looked like when they came from Black and Latino ethnic backgrounds. As evidenced by Participant 8's engagement efforts, health-promoting professionals are a significant force for change. Participant 8 shared:

> I train [the students to look at] women's self-view of athletic practices and exercise needs of one culture based on food intake, sedentary lifestyle, and their status within a predominantly White institution (PWI). As a person of color, in the past 2 years, I've been there trying to change the narrative. Fortunately, I have a dual role. So that means I get to be in the classroom, and I've taught a popular format that allows me to formulate relationships. I have been intentional about partnering or going into different student organizations and letting them know, "Hey, did you know there was an instructor of color in Campus Recreation, and I am that person." So, inviting students to come along and check out the class. I've had Black and Brown girls in my class, it was such a delight, and for me, that connection is not just in the classroom. I connected with them outside of the classroom, and even now that they've gone away to different universities, we keep in touch with each other.

This participant shared making connections to their students beyond normal activities to promote students' fitness, and overall well-being would have been difficult if the participant only cared to use generalized institutional approaches to health promotion. The participant explained they believed in the importance of connecting to their students to enhance trust-building and student engagement.

The eight health promotion professionals I interviewed shed light on several aspects of their health education systems where they tried to improve the lives of their students. They explained some of the systematic barriers the students face in their communities as well as when trying to access help while pursuing higher education.

Some made a clear differentiation between the realities of students on campus and students that commute to school, while others expressed concerns for the accessibility to needed health resources and general supports that their students face while pursuing their education. Some of the keywords and phrases used to describe the circumstances and challenges some of their students are facing included “ethnic health beliefs,” “chronic health diagnostics,” “limited health knowledge,” “limited resource access,” “barriers to health,” and “fears.” Participants discussed some of the ways they practice health promotion to support students despite all of this.

Participant 2 shared their insights on the Black and Latino students served in their health promotion practice. The same group of students who the health educator described as carrying “so much shame” about accessing services on campus. This health educator related on circumstances where their students were harassed when aiming to access Planned Parenthood (PP) services over the weekends when the college campus clinic is closed. They added that some of the students use PP as an alternative to avoid being labeled or judged if they seek out help on campus. This participant shared how political discords caused the segmentation of services and how the campus location where this educator works is in a remote area, away from most services that students need to access. Participant 2 continued by sharing:

> A lot of the kids don’t have access to health classes in high school. They start taking most of the health classes in college. A lot of these students have a lot of different preconceived notions, and a lot of our kids are into, how do I say this? The miseducation of music. I want to say that this is because the music that

> they're listening to does not really talk about women's empowerment. [The music they listen to is] more like women being used to divide or to get with a guy for power, and getting purses, and shoes, and things like that. So just to break out of those things, I teach about sexual health, self-care, and wellness, about things that affect their generations and cultures. So, I find myself breaking these things down and helping them break from the stigma they live with regarding their sexual health.

Additionally, Participant 1 shared that when framing the ways, they teach about health and their health literacy efforts, this participant used strategies that help relate to their students even if their initial encounters are not focused on health promotion. The participant may meet students at career fairs, student organization events, and social gatherings sponsored by their student affairs department. When asked about ways they supported Black and Latino emerging adult college students, this participant shared they considered being student focused and recognizing diverse socio-economic challenges when designing health promotion plans. Participant 1 added:

> I would say framed in terms of, like we don't directly, talk about building their health literacy, but we're talking about identifying some of these factors that are impacting their ability to feel motivated or successful in and outside of the classroom. And I think so much of that is important to focus on, emotional or social health literacy; even if we're not talking about it in those terms, a lot of what we're helping students do is achieve that health literacy. So, they make those

> sustainable changes in their own lives to improve, feel successful, feel confident while they're going through their [educational] programs.

Participants noted the design of the programs and curriculums being used for health promotion is important to build equity and inclusion. Participant 3 noted:

> What I will say is that it's the leadership [that] matters, one, and the resources available matter. Also, the allocation of resources mixed with the rationale of the why we do things, why we allocate or don't allocate. So, I'm in that kind of that trifecta is the comfortable formula of promoting health for me. When you create things from the bottom up, you have a locus of control that's unprecedented. Typically, you'll see things like retention and attrition go up and persistence and retention too. That is because you focus on your student population's needs…they feel valued. They are not just a body in the seat. They are a person, and that part of the whole education structure is what you want to build; you want educators that treat these people, like people, number one, and number two, you got to let them [students] know that they are and will be able to do something amazing for themselves.

The educators I interviewed reported they spend a lot of time shifting focus, shifting strategies, and trying new ways to approach and relate to students purposefully. Their practice was not only based on required deliverables from their institutions but also on personal goals and personal experiences with their students and the rapport they built. They reported they gain their students' trust by becoming sources of support, barriers

breakers, and social change agents that seek to make things move for the benefit of those they serve. Participant 6 offered:

> [the school where I work offers] school-wide programming, universally open to all students. And this could be workshops, or info sessions, or kind of skill-building sessions that focus on broad topics, a lot of them career-related. But we also have done a series of academic and more student focus topics like stress management and advocacy … time management, academic and study skills, and I think, a lot of discussions around work-life balance, or school life balance that I think, talk a lot about these self-care strategies to incorporate elements of health literacy.

Participant 5 talked of the sessions where they taught health literacy to students, which necessitated a component of good and attentive listening skills to pick up nuances about the students' culture and eating habits. This participant shared how they traveled as a former military person and picked up knowledge about diverse cultures, which they found helpful to use when relating their health literacy teaching with students of color.

Participants shared when they have role autonomy, that within itself is a blessing for their role and for the students, having the ability to craft health literacy efforts with their students' needs in mind. The educators demonstrate cultural awareness in the design of their programs by highlighting that they de-stigmatize the students and build their confidence despite where they come from and what they are going through. The educators reported they build the students' confidence and, in turn, seek to make long term impacts on their students' overall health.

Theme 3: Internal and External Stakeholder Collaboration

From the interviewed health educators, I learned about their strengths, what practices they believed are opportune for enhancement or change, and the sources of support fueling their health promotion efforts. While some of the participants might have been humble in sharing their personal difficulties in reaching their goals for health literacy promotion; I found their self-awareness to be strong and perceptive as they sought to do no harm. These health educators sought to enhance their skills by seeking out conferences, by becoming members of local, statewide, and countrywide organizations, as well as by reaching out to their leadership for support by becoming certified in their field, and by continuing their education to remain current in the best practices being used to support student health promotion on their campus.

Participant 1 shared: "…to support students' overall well-being and again, take that approach that in order to be the best public health professional you can be, you also must honor your own health and your own boundaries." Additionally, Participants 3 and 4 shared that their leadership was a source of support as the educator can shape and re-share their program in ways they saw fit without opposition. Participant 8 noted they can request professional development beyond the annual conferences they attend for student support services and health promotion. Participant 5 expressed:

> One conference impacted me recently, specifically focused on implementing DEI [diversity, equity, inclusion] practices within Career Services centers at the schools of public health. I try to seek out the training whenever I can, but it's something that I, by no means, am an expert in. So, I really appreciated the

> workshop for breaking down where to start because I know that's something I especially have struggled with. I find myself getting overwhelmed at times, knowing that there's so much we could be doing, there's so much more we could do to tailor for our various student groups. I don't always have that confidence. But that's not always, you know, an excuse either. So, I think that training really helped me.

Participant 6 highlighted their feelings about the professional formation they are restricted to fulfill this role and the gaps they found in the educational system. They shared that as a byproduct of mental health, and as a former student of health promotion, there were resources they [this participant] did not find related to the current practices they have to apply to support all students. Participant 6 shared:

> I am a bit skeptical about the ability to advance knowledge from what I learn in a textbook when I serve my fellow Black and Brown kids. I helped create programs on campus that focused on inclusivity and social responsibility. Some of the examples I used to teach students social responsibility came from actual situations on campus. Promoting their health more inclusively was hard. To be honest with you, it was very hard; it is like a 50 to 60% [of the student population] that's White. Then there was also a large Asian population of about 20%, and then the Black and Brown kids on our campus are the minority in terms of student demographics. I'll be frank with you, the Black population, the Latino population, at first, they weren't really recognized. Just like the veterans, it took a lot for them to recognize us as veterans. I had to change the culture, the mindset of what we're

looking forward to doing. And I did a lot of advising with some of the Latino programs to gain buy-in.

Participant 6 expressed they had a vision for what they thought their campus would be when they first began to work there. Then they had to find creative ways to advance their knowledge and the knowledge of other health-promoting entities on campus that would also influence the students. Thus, they developed "train the trainer" programs for student interns at the student health offices. Participant 6 shared that they used veteran offices, commuter student engagement offices, and the diverse leadership organizations within student affairs to host events that helped make a systematic shift in their school. They also shared that the institution was not ready to support Black and Latino students' health literacy promotion equitably. All 8 participants asserted to their disposition to learn from diverse resources and informed how often they consult with their leadership and are supported by their managers to seek out help from organizations and social resources that support health promotion. Some also discussed that while they sought continuing education resources to support their practices, only a few of these resources focused on health promotion equity and inclusion, as most resources focused on helping them maintain role administrative responsibilities. Another participant shared that they wished more relevant educational resources and conference to help them support students with their diverse needs were available more often during the year, as some conferences and educational opportunities may be offered at times during the year when participants might not be able to take time away from their daily responsibilities and might miss the opportunity to attend as often as they wish.

Summary

All eight participants expressed their aim to improve the overall health of their students and the health literacy outcomes of Black and Latino students to promote equity and improvement of practices that serve those with disproportionate needs within their campuses. To best represent their thoughts to the best of my ability, I used direct quotes and examples of the type of work they do as they shared with me. I began by sharing the setting, the demographics of participants, the data collection practices, and data analysis practices. I also described steps I took to meet the criteria for trustworthiness. The chapter ended with a description of the three emergent themes: health educators promoted health literacy by being culturally aware, health educators promoted health literacy for Black and Latino emerging adult students by using diverse engagement strategies and practices to build healthy habits, and health educators supported students' health literacy by seeking internal and external stakeholder collaborations to support their health literacy promotion goals. The next and final chapter includes interpretations of the collected data, connections of my study finding to the literature review, the limitations, recommendations for future research, and possible implications of the results for positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

In a basic qualitative study, I conducted semistructured interviews with college health educators in the United States to learn how health educators promote the health literacy of Black and Latino college students as emerging adults. My study participants provided perspectives on their practices, beliefs, and ways they overcame challenges while pursuing their goals to promote health literacy for Black and Latino college students as emerging adults. These were the three themes that emerged from the analyzed data:

- Theme 1: culture focused promotion practices
- Theme 2: use of diverse engagement strategies
- Theme 3: internal and external stakeholder collaboration

In this chapter, I provide my interpretations of the results, noting connections of my study findings to the literature review. I share the limitations and possible implications of the findings, and recommendations for future research regarding how college health educators promote health literacy for Black and Latino college students as emerging adults.

Interpretations of the Findings

The findings confirm studies and theories associated with health promotion. Bandura's (2004) SCT was used as the conceptual framework to learn college health educators' experiences and their health promotion practices within the college campuses where they work. I interpret my findings to describe the ways health educators promoted

health in relation to the conceptual framework and the literature. I note what philosophies participants used, what trends emerged from the analyzed data, and what institutional challenges participants faced carrying out the duties and responsibilities of their health educator roles. I relate the considerations for future research with recommendations on ways to improve college health promotion practice.

Interpretations Considering the Conceptual Framework

The theory I used for my conceptual framework was Bandura's (2004) SCT. Bandura explained how health promotion is aided by socio cognitive beliefs of applying practices that consider environmental barriers, cultural needs, self-efficacy skills, listening skills, learning skills, and self-management skills used for disease prevention. This theory resonated with the results of my study, which showed college health educators promoted health literacy shaped by their personal beliefs, social interactions, and the way they saw the world. Participants applied self-efficacy practices that encouraged goal achievement, self-management to pursue best practices, and understanding learning styles and social components of learning to achieve the best health promotion outcomes for their students.

Health promotion professionals evaluated how students received the education provided based on their cultural upbringing and beliefs. My study's results are consistent with those by Chen et al. (2018), Schreevidya (2020), and Yoo and De Choudhry (2019) who suggested that the endemic cultural practices of Black and Latino students derive from their cultural experiences with environments, their family, and community practices. Some of the cultural practices expressed by current participants included how

food is prepared, differences in food preferences, as well as nutritional choices that embodied students' cultural backgrounds. These practices differ from the cultural practices of non-Black and non-Latino students. The SCT model helped me explain the connections with the teaching styles, goals, and outcomes that health promotion professionals used to apply self-efficacy practices and learn about their students via social interactions as asserted by Barone et al. (2021) and Balbay and Dogan (2015).

Bandura (2004) discussed good practice in health promotion as evidenced by health educators who applied self-efficacy beliefs for the purpose of disease prevention outcomes. Health educators who used professional and personal experiences influenced what types of motivation and learning outcomes they obtained because of their health literacy promotion to these two racial groups. This was also evident in the participants' use of self-management and motivational strategies to support health promotion as discussed by Schunk and DiBenedetto (2020) who noted connections for health promotion between culture, learning, and social environment.

The findings of my study confirm Bandura's SCT tenets via the responses from the participants. In the first theme, I related some of the ways participants reflect cultural awareness and apply knowledge of their Black and Latino students' needs as shared by participant 2 by "meeting students where they are at" and aiming to enhance their health literacy via "relatable conversations," connection to resources, and comprehensive educational practices. In the second theme, I noted that to engage students and overcome barriers, health educators such as participant 7 used incentives to attract students to participate and displayed self-efficacy and positive motivation to engage their students

"respectfully" and to "encourage healthy habits." In the third theme, health educators evidenced self-awareness regarding areas for opportune growth in themselves and the institutions they work for. Health educators sought continuing education resources and managerial supports to make their practice more inclusive and equitable.

Participants related ways they overcame environmental barriers to support student health literacy promotion needs by pointing students in the direction of services inside and outside of their college campuses. Regarding environmental barriers identified, the limitation on adjustment to students' needs for individualized health promotion practices to Black and Latino students posed a hurdle that some participants could not change as this was tied to the financial and structural composition of their institutions. Participants noted, however, that it is a standard practice to have some sort of support to emerging adult students, but not a targeted approach to help emerging adult students who also identified as Black and Latino students. Participants noted the desire to change some policies and departmental organizations of their student health departments to make their health promotion on campus more relevant and directed to racial health needs. Other participants shared that having leadership support to adjust their health literacy promotion and being relatable to students' cultural and ethnic health needs helped them meet their goals for disease prevention and health behavior building of their students. Participants' ability to deal with barriers was evidenced by their self-determination to overcome challenges and to achieve their goals. This was also evidenced in the tenets of triadic reciprocal determinism of the SCT, which notes that a person's beliefs in the ability to achieve goals are tied to behavioral factors as well as internal and external factors that

might influence goal achievement. Devi et al. (2017) discussed the application of the tenets in Bandura's SCT for health promotion efforts, including self-efficacy, which showed that educators who self-managed were efficient in managing factors that posed barriers and were creative in setting goals beyond those barriers to achieve desired goals.

The behaviors and self-efficacy of health-promoting professionals were evidenced by those who expressed being aware of their limitations when belonging to a different race than those they served, in addition to institutional limitations. Considering diverse nuances of their students' lives afforded the participants the opportunity to relate as they engaged the students in discussions about health and personal life habits that affect overall health practices. Participants considered students' learning styles, language barriers, and literacy limitations based on cultural upbringings when designing their health promotion activities, classes, individual interactions, and large-scale events.

Supported by Bandura's SCT, health promotion practices that seek to influence disease prevention, formation of healthy habits, and reflection on self-efficacy by both health promoters and those they serve are evidenced by awareness of the social influences to health outcomes. Results showed that health literacy promotion efforts in higher education institutions were done via acknowledgment, assessment, and provision of resources that can positively impact the social determinants of health and the lived experiences on health behaviors of racial minority (Healthy People 2020, 2018). Results also showed that determinants of health attribute disparities to the lives of students from particular social groups because their socioeconomic status, environment, and other social factors may negatively influence their ability to achieve their desired health goals.

Interpretation Related to Empirical Literature

The social problem of limited health literacy by college students (Joseph et al., 2016; Sogari et al., 2018; Wyatt et al., 2017) and the gap in the literature related to limited knowledge on how health educators promote health in college (Barsell et al., 2018; Logan & Siegel, 2017; Rababah et al. 2019) are detailed in the literature review for my study. In this section, I interpret how my findings regarding health educators' experiences relate to the literature as study participants discussed the cultural needs and disparities of racial minority college students, strategies for college health literacy promotion engagement, and the promotion of health literacy by educators and diverse student supports internally and externally.

Theme 1: Culture-Focused Promotion Practices

The findings by Chen et al. (2018), Shreevidya (2020), and Yoo and De Choudry (2019) on limited health literacy were supported by current results that participants are knowledgeable about the needs of Black and Latino students who come to their college campus with misinformation about the best way to support their health. Participants reported their students faced socioeconomic barriers, had poor eating habits, practiced poor sexual health practices, and acknowledged that some students adhered to very strict cultural beliefs. Participants' insights are consistent with the findings of Sogari et al. (2018) who noted that college students' health habits were a source of concern and offered an exploratory opportunity for improvements in health promotion.

Current participants found it important to be culturally sensitive, to seek the best ways to support students' learning styles in health literacy promotion, and to use

motivating practices to help students implement better health habits, consistent with the findings of Callero et al. (2013) regarding awareness of cultural wealth as a valuable driver of equity. The college health literacy initiatives of these participants evidenced connections to previous studies that highlighted the importance of personal knowledge and the impact that cultural awareness has on the ability to impact students' health behaviors, especially students from lower socioeconomic backgrounds who might also face language barriers (see Asad & Clair, 2018; Gagnon et al., 2017; Gibson et al., 2016; Mackert et al., 2017).

Strayhorn (2018, 2019) noted challenges faced by Black students related to their struggle with feeling welcomed when transitioning into a college setting. Some of my participants shared Black and Latino students carry shame about seeking help, their humble socioeconomic backgrounds, the neighborhoods they come from, and the personal traumatic experiences that may keep them from feeling welcomed in some of the predominantly White institutions they attend. Participants indicated that some students are afraid to seek health-related help for fear of being judged or having the information negatively impact their educational journey. Participants used culturally focused health promotion practices to support their students while aiming to diminish their fears.

Results showed that health educators applied strategies to overcome their professional obstacles and their students' obstacles when promoting health literacy on their respective college campuses. These strategies included one-to-one meetings with students to build capacity and confidence and to help their students with individualized

health concerns while promoting trust in confidentiality. Current participants also supported their students by developing classes and discussions on topics of basic sexual health, incorporating healthy food habits into their daily routines, and well-being management skills such as breathing exercises to be used throughout the day. Sogari et al. (2018) discussed the challenges of responding to college students' eating habits, their use of substances, and the effective application of theoretical models to support the shaping of health behaviors using motivational practices. Fleary et al. (2018) agreed that those motivational practices and other health literacy promotion practices were achieved by being inquisitive about students' needs. Fleary et al. also noted health literacy promotion improvements when health educators consider the health behaviors or habits of their students. Furthermore, Fleary et al. encouraged educators to learn these habits, form relationships, and incorporate the students' perspectives on personal health and cultures.

Theme 2: Use of Diverse Engagement Strategies

My study participants had extensive experience concerning their Black and Latino emerging adult college students' needs as they sought to make their students feel welcomed and listened to the way they engaged and communicated with students. Participants shared they individualized how they reached out to their students by engaging students at social events and at general on-campus activities. By inserting health promotion discussions of general well-being and physical health at on-campus career fairs, on-campus cafeterias, libraries, and commuter student lounges, participants found relatable ways to form meaningful connections with these students. There, the

participants would discuss health literacy interests and concerns with their students in relaxed environments to learn of their needs.

Participants made their health promotion practice more informative to ensure students were not turned off to the subject, aiming for their students to feel seen and supported. Participants learned that other creative ways to encourage student participation included the use of incentives, connections to relevant information, and connections to resources from outside of their school. Participants' findings are consistent with findings of Conley et al. (2012) who asserted the importance of making significant connections and purposeful engagement with first-year college students to secure and enhance their sense of belonging and their emotional wellness. Current participants who made changes to their teaching styles reported they were able to use resources within their campuses and were able to make changes to their roles and health promotion activities. Their new practice was student focused and centered around the specific needs of students on campus. This practice is consistent with the work of Sukys et al. (2017) who noted that college health promotion practices should change to represent the needs of the populations being served.

My study participants, who indicated they had role autonomy, sought to create safe spaces for their students, to lessen their help-seeking stigma, and to help students feel a sense of belonging despite being part of a minority racial group, and despite any cultural or language barrier faced by their students. This connects to findings by DeBate (2018) who asserted help-seeking stigma among college students is best combated with the use of motivation strategies, and behavioral skills to develop rapport, and engage

college students. When considering professional self-management practices, self-efficacy, and desires to achieve goals, the findings related these professionals were impacted by diverse nuances affecting Black and Latino emerging adult college students. Specifically, health educators' responses showed that intent to support students may be difficult to achieve due to competing with institutional demands, and the institutions' generalized, as opposed to student-focused, application of health promotion best practices. Conversely, these participants also found ways to offset the effect of their institutional limitations, by developing relatable communication styles and encouraging students to feel welcome to come to them (participants) with questions and concerns to maintain engagement. A connection was also found within literature noting that personal behaviors are influenced by social and cultural aspects of a student's lives, which in turn demand personalized approaches to health promotion, as root resource for motivation and goal achievement (Schunk & DiBenedetto, 2020; Schunk & Usher, 2019).

Results showed that some participants expressed feeling pressured by their institutions to provide the same blanketed support to their students, which did not properly allow them to connect or relate with Black and Latino students. Furthermore, other participants shared feeling more supported and successful while working for institutions that allowed them to bring specific cultural and ethnic-centered support to the students they served, which was positively evidenced in their levels of student engagement. Additionally, participants who engaged their Black and Latino students, shared they had better health literacy reception and believed they positively impacted their student's academic experience. This is consistent with works by Strayhorn (2018)

who suggested that institutional efforts that engaged students to make them feel a sense of belonging supported students' educational success.

Theme 3: Internal and External Stakeholder Collaboration

Participants found support from diverse organizations on campus that they could count on to collaborate for outreach events to connect and meet the needs of students' health literacy. Yoo and De Choudhury (2019) shared collaborative efforts supported the improvements to college health promotion with the goal of inclusivity. Mann et al. (2018) warned that institutions would be challenged to effectively promote health literacy without the support and collaboration of more than one entity.

Participants sought to partner with Black and Latino student campus clubs, first year student experience program faculty, sororities, and fraternities to help these two groups of students learn about the best ways to support their wellbeing by hosting mindfulness and yoga classes. Additionally, participants promoted health literacy to Black and Latino emerging adult students by encouraging them to embrace changes to their physical health, eating habits, and overall care while pursuing academic degrees. The use of on-campus organizations to connect with students was supported by Audrey et al. (2006) who asserted that informal and peer-supported connections were found effective to drive public health campaigns as students tend to trust their peers more than conventional college health professionals.

Most participants shared different examples about challenges faced when trying to support their students, which stemmed from their inability to control situations within their roles and responsibilities, including lack of resources specifically targeted to these

two cultural groups. By listening to students' needs and seeking out opportunities to show students the attention they sought during difficult conversations, participants made meaningful connections, which they noted: "lasted beyond the students' graduations". Participants reported that they connected with students outside of the classroom individually and confidentially to build rapport and respect their students' needs for privacy and confidentiality. Bailey et al. (2017) and Bauman et al. (2019) also encouraged equitable health promotion practices that took into consideration the needs for inclusion and inclusive practices for Black and Latino students when they first arrive to college campuses, to offset inequalities, combat limited health literacy, and improve poor health habits.

Participants believed understanding students' needs was a strength, as they were self-aware that students' limited health literacy posed risks for food insecurity and limited access to other basic needs were examples of social determinants of health. Participants shared Black and Latino students struggle to stay on their academic journey in comparison to other racial or ethnic groups due to these challenges. Taylor et al. (2019) shared that factors of poor health, limited access to basic needs, poverty, and food insecurity forced students to end their higher education journeys before completion. Consistent with the findings of Joseph et al. (2016), Sogari et al. (2018), and Wyatt et al. (2017), participants reported that Black and Latino students face a higher level of stressors in their academic experiences due to limited health literacy and other pressing social-economic barriers they experience while pursuing an education.

Participants' understanding of underlying social complexities affecting the health or access to health of their students was high. This was evidenced as participants sought to fill gaps in the learning needs of their students by encouraging students to take advantage of free resources on campus that would advance their health, such as checkups by medical personnel on campus when the student lacked healthcare coverage. Other participants supported students overcoming socio-cultural barriers like limited access to healthy foods by encouraging students to participate in "supermarket runs" or events, where the participants provided small amounts of money to students, so they could buy healthy foods.

Previously mentioned activities also offered an opportunity where participants could discuss budgeting and affordability of the most needed nutritional products with the students who attended these types of educational events. Participants shared they believed they could support students by partnering with the events that provided basic life skill formation, and they took the opportunity to address health risk habits with discussions at these events. Barsel et al. (2018) discussed ways health risk behaviors of diverse populations could be assessed and supported through self-efficacy and through practices that demonstrated cultural awareness and willingness to support cultural diversity.

Participants shared outside resources with their students such as their local social services offices for the homeless and food resources. They informed students about local hospital and community clinics charity health programs to build their health literacy skills about health care coverage and additional services students could afford while in school. Adegboyega et al. (2020), noted that disparities exist between the knowledge, resources,

and accessibility of college students' health care services due to limited health care systems literacy, which could be aided through focused and intentional educational practices. Nobles et al. (2019) and James et al. (2020) encouraged more student education efforts about diverse health care systems available, increased knowledge on insurance language and plans, and encouraged higher education institutions to be cognizant of students' deficiency in understanding how to best pursue their optimal health while on college campuses. Consistent with statements by participants, Goldrick-Rab et al. (2017) mentioned some college students battled inequalities such as homelessness and food insecurity and encouraged further support and investigation across higher education institutions, by policy makers, and by educators.

Participants supported students by being aware of systematic barriers like loss of healthcare and consistent medical follow-ups for emerging adult college students as they transitioned from high school to college, and into adult medicine. Participants found support in continuing education resources for themselves when they lacked knowledge of specific ways to help. Davidson (2008) indicated the value of continuing education supports to health educators who sought to improve college health promotion. Conrad et al. (2019), and Logan and Siegel (2017) supported continuing education and proper training as they alerted health educators must be prepared to support students with health wellness and with self-efficacy skilled practices.

Participants offered feedback about creative ways they increased follow-up meetings with students after discussing difficult topics. They shared they self-manage, and schedule time in their calendars to call students back to follow up with them via

phone, or they make appointments for follow-ups before students leave their offices, and they also try to discuss anticipated completion dates for health goals with their students. Participants shared these were sometimes their best health promotion efforts, which helped them best support students who would “typically go unnoticed and underserved”. Consistent with calls to action by Fleary et al. (2018), higher education institutions are encouraged to consider the health risk behaviors of their young college students to effectively model their best practice efforts. Isik et al. (2018) noted strengths in practices and policies that increased preventive health efforts that favorably supported specific population’s needs.

Avci et al. (2018) encouraged health educators to be cognizant and proactive to the needs of existent subgroups of students who are underserved. My study findings confirmed others’ results regarding the needs for added support to Black and Latino students at higher education institutions. My study findings bring into perspective an extension on the results of studies that recommended increased support to Black and Latino college students’ needs. My study also extends to the findings of others who encouraged additional attention to students when they arrive to campuses and adds the unique value of the two populations’ needs for better health promotion by health educators in higher education institutions. While studies made the suggested focus on health inequalities for Black and Latino students, based on my review of literature no study also included the needs to evaluate the needs of Black and Latino students who are also emerging adults. My findings discussed how emerging adult college students have specific needs for special attention to their health habits. The risky health habits of

emerging adult students are an addition to the health inequalities that Black and Latino students face by virtue of their racial and ethnic experiences, which is the innate finding of this study, and my contribution to the body of knowledge.

Limitations of the Study

There were several limitations to this study such as the small sample size, eight health educators. While the participants provided rich experiences related to their profession, it is important to consider whether the results might differ with a larger sample size, another type of institution, such as 2-year institutions, and if participants identified with other demographic aspects from those I interviewed. The findings may not be transferable to the experiences of doctors who promote health literacy on college campuses as I was unable to interview any of the on-campus doctors due to their focused support to the COVID-19 health crisis.

My results are also limited to the perspectives of one person holding the role of health educator, and seven health promotion professionals who did not hold that specific title but promoted health under the umbrella of student support services departments. The study findings are limited to the participants' feedback regarding their general college health promotion efforts towards college students. While participants were interviewed regarding emerging adult college students, the study does not reflect their professional impact on older students.

While my study focused on college health literacy promotion to emerging adult college students, the study did not solely address campus issues in depth such as substance use, student attrition related to health barriers, overall physical health, or

promotion of mental health awareness to college students. My study focused on learning about the perspectives of universal health literacy promotion practices to Black and Latino emerging adult students by health educators that relied on the participants' experience with several aspects of health including preventive sexual health, mental, physical, nutritional health, and support with substance use concerns.

Recommendations for Future Research

Future research is needed to explore the post-college impact of health educators' practices on the health behaviors and health literacy of their college graduates. More research is required to examine health educators' promotion efforts for women or male-identified students among Black and Latino students, and those who identify with a different sexual orientation to learn the scope of their support for health literacy promotion. While sexual orientation was not the focus of my study, participants shared that they adjusted their practices and strategies when their participants identified with another sexual orientation other than heterosexual. Thus, suggesting there is a need for future research that explore these different practices, and the potential for support to that population their results might offer. Future studies should also seek to learn how health literacy promotion efforts to emerging adult college students influenced the lives of college graduates. Future research should explore how these health promotion practices helped the long-term health of their students as alumni as they continued communicating post-graduation.

Implications

My study adds to closing the existing gap in research on how health educators promote health literacy to emerging adult college students from Black and Latino cultural and ethnic groups. New knowledge was obtained from the information shared by my participants related to the ways educators support health literacy on their campus. Based on my study's results, my first recommendation is that cultural and ethnic diversity be honored when promoting college health. To promote health literacy to Black and Latino students, the use of evidence-based practices is encouraged to support their specific population health needs. Increased learning regarding the perspectives of college health educators, their beliefs, and their impact on Black and Latino college student health literacy was evidenced through my research study results as participants discussed their self-efficacy skill applications, which has important implications for positive social change. The goal of this study was to add to the body of knowledge regarding health promotion efforts on college campuses and how health educators supported a culturally inclusive health literacy promotion practice that influenced Black and Latino students' experiences.

This is supported by the SCT as mentioned by Bandura (2004), and by the literature encouraging the culturally relevant support of Black and Latino students noted by Lederer and Oswalt (2017). The study participants were self-aware in their culturally relevant health education practices, chose to incentivize students in relatable ways, and sought to promote racial health equity through listening, outreach, and learning best practices in support of Black and Latino students' health.

Participants noted that while their pedagogical practices and strategies seemed to be small and incremental, in the long run, they perceived their extended relationship with some of their students beyond graduation evidenced positive influences on their students' lifestyles. Participants further explained that health literacy promotion efforts should begin in high school and continue as students transition to adulthood with their first years in college. Health educators engaged with the emerging adult college students while being aware that their students struggled with cultural limitations, struggled with personal decisions on their nutrition, and dealt with continued pressure to participate in the use of drugs and alcohol.

As asserted by Bauman et al. (2019) and Newell (2016), a social change opportunity emerges from health educators learning insights directly from those they serve. The participants who are health educators shared they learned about their students, and their roles and self-reflections on how they promote health literacy in culturally appropriate ways. My study results may offer contributions to the development of best practices for those who desire to advance their professional practice and optimize the outcomes for their population of learners. Based on the results of my study, higher education institutions are encouraged to consider more student-focused teaching practices and self-management, as reflected in Theme 1, rather than generalized practices that ignore the cultural needs of students.

Participants shared their work on applying self-efficacy in their role and activities for health promotion, as reflected in Theme 2, which strengthened their engagement efforts. The results of my study showed that health educators aimed to change their

practice, and to motivate other college health professionals to support students' health literacy in more comprehensive and culturally relatable ways as their strategies for engagement.

Finally, participants shared their practice was supported by external and internal stakeholders, as reflected in Theme 3, which included direct managerial support, collaborations with internal organizations to encourage cultural outreach activities, and external collaborations to help students reach their cultural health goals.

Conclusion

In this chapter, I presented an interpretation of the findings in light of the conceptual framework and empirical literature. I also discussed the limitations of my study. I shared my recommendations for future research, and the implications for positive social change through the study's participants perspectives on health promotion practices that support Black and emerging adult college students' health literacy.

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Appendix: Interview Questions

Research Question (RQ): How do health educators promote Black and Latino emerging adult college students' health literacy?

Theoretical Framework: Bandura's (2004) social cognitive theory.

Interview Questions	Relevant Literature	Theoretical Framework
1. Tell me a little bit about yourself. *Possible Probing Questions:* a. How long have you been a college health educator? b. What are the duties and responsibilities within your role? c. What organizations have you worked for prior to the current one?		
2. Tell me about some of the ways you promote health literacy within your campus. 3. Explain some of the ways you promote health literacy for Black and Latino emerging adult college students? *Possible Probing Questions:* a. Tell me of some of the guiding principles or assumptions you have that help you achieve this? b. Are there specific indicators or role requirements to help you achieve this? c. What engagement strategies do you use to get them to increase their self-	Self-efficacy is used as a strong base for motivation and outcome achievement (Omar et al., 2019). Inclusive health literacy promotion practices consider cultural wealth a valuable component for equity (Callero, 2013). Barsel et al. (2018) examined health risk behaviors and noted the	Bandura (2004) noted that practitioners who self-manage and use motivation in their self-efficacy approaches encourage best practices in health literacy promotion. Triadic reciprocal determinism, a part of the SCT, is used to learn about the motivation behind what shapes learning and behaviors to achieve goals (Balbay & Dogan, 2015; Bandura, 2004).

management when promoting health literacy? *Probe explicitly for 'improving self-efficacy" if they do not mention it. make sure you have probes to match each of the sources you've carefully added in columns 2 and 3. They don't' just 'justify' the question but give you backup for probes. 4. Tell me about challenges you have encountered related to the promotion of health literacy for Black and Latino emerging adult college students. 5. Tell me about what opportunities or support systems assist you in your job related to the promotion of health literacy for Black and Latino emerging adult college students? *Possible Probing Questions:* a. What resources do you have? b. Who can you rely on to help with problems? 6. Tell me about your opportunities for professional development. *Possible Probing Questions:* a. Tell me when you last attended a professional development session. What was the topic? b. How did you apply what was	benefits of self-efficacy use to support health literacy promotion for college students. Avci et al. (2018) alerted that health professionals in college should be cognizant of the existence of a "subpopulation" of underserved minority college students who reflected limited health literacy, which impacted their "decision-making" and access to appropriate health (p. 186). Institutions must be knowledgeable of students' primary health literacy motivators so that culturally relevant health promotion efforts can be enacted (Jackson & Sherman, 2018; Kim & Kim, 2018; Ridner et al., 2016). Black and Latino college students are marginalized and need careful consideration for health equity	Bandura (2004) noted similarities between the health belief model and social cognitive theory used to analyze external and internal influences on practice and behavior prediction for health promotion.

learned to your professional practice? c. How are you compensated (self-cost, paid day of work, pay for conf and day of work, etc.)? 7. How does the ethnic culture of the student effect the promotion of health literacy? *Possible Probing Questions:* a. What supports your practice with Black students? b. What supports your practice with Latino students? 8. What is your experience with addressing health literacy promotion in pairs or groups as compared to one-to-one interactions? *Possible Probing Questions:* a. How is communication enhanced or decreased with pair or group discussions as compared to 1:1 discussion? b. What other communication tools do you use	engagement to aid barriers relevant to their socio-cultural identities (Schneider et al., 2006). An individual's culture and social interactions influence learning and become internalized. (Balbay & Doğan, 2015). Belief shapes an individual's behavior. (Barrone et al., 2012; Ryan, 2018). Yoo & De Choudhury (2019) found that in student support	

for health promotion? 9. Tell me about challenges related to Black and Latino students with language barriers? *Possible Probing Questions:* a. What teaching aids do you use? b. How do you enhance communication? c. How to assess that the student understands what was taught? 10. Tell me what you identify as opportunities to reach Black and Latino students with language barriers? 11. Does a student's gender influence or impact how health literacy information is taught/delivered?	services, collaborative efforts are encouraged to improve college students' health in more accessible ways.	