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Advocacy skills are essential for the public health practitioner. Recognizing this need, two statewide public health organizations partnered for a series of advocacy trainings. Outcomes included an increased competence for such advocacy as providing expert testimony, writing position papers, forging stronger relationships with policy makers, and committing to ongoing advocacy. An increase in statewide initiatives also included a legislative scorecard, development of a model advocacy network by voting districts, advocacy policy for associations, fact sheets for legislators on pending public health issues, a new university advocacy course, and advocacy action by two associations' members to reach common goals. The trainings and subsequent initiatives provide a template for organizations and individuals to build advocacy skills and increase the role of public health professionals in setting state public health policy.

Keywords: *advocacy training; public health advocacy; policy development*

Public health advocacy is increasingly identified as a way to systematically alter public health policy and infrastructure (Christoffel, 2000). Although the use of advocacy as an intervention strategy has been repeatedly cited as crucial to effectively address health disparities among populations, increase social justice, and inform public health decisions with science and experience (McLeroy, Bibeau, Steckler, & Glanz, 1988; Schwartz, Goodman, & Steckler, 1995; Wallack, Dorfman, Jernigan, & Themba, 1993), it is not typically a component of health educators' preparation and training (Goodhart, 2002). In fact, the Institute of Medicine's (1988) landmark report, "The Future of Public Health," noted that whereas public health workers have adequate technical preparation in specific fields, many lack training in management, political skills, and community organization and diagnosis, all of which "are essential for leadership in complex, multifaceted public health activities." A decade after the Institutes of Medicine's report, leaders in the field of health education are still making the case for increasing competency and skills of public health educators in the advocacy arena (Allegrante, Moon, Auld, & Gebbie, 2001; Wooley, Ballin, & Reynolds, 1999; Gielen, McDonald, & Auld, 1998). Despite this, knowledge does not always equal action: A gap may exist between what public health practitioners concede is important and what they actually do in practice.

Public health policy may sometimes be developed without input from the public health community or from the constituents it serves. As Wallack et al. (1993) noted, policy and political agendas often continue to respond to issues of profitability or special interest rather than to public health issues of health and well-being. The change in focus from disease as a personal problem to health as a social issue requires increased understanding and commitment by public health advocates. Improving health by making changes in the environment requires participation in the policy process, yet the public health community frequently focuses efforts on education rather than using its resources to change regulations and legislation. As a result, despite the essential services performed by public health practitioners, legislators and policy makers often have little or no knowledge or appreciation of public health and its functions (Wallack & Dorfman, 1996).

To achieve meaningful results, a high level of advocacy skill is necessary before public health practitioners can achieve social change (Wallack & Dorfman, 1996).

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By providing skills training and calling the public health community to action, professionals can mobilize to take a proactive role in developing public health policy. The New Jersey Society for Public Health Education (NJ SOPHE) and the New Jersey Public Health Association (NJPHA) developed several initiatives to enhance their members' skills and confidence in incorporating advocacy into their professional lives while also establishing and building working relationships with legislators and policy makers. Guided by health education principles to build individual and organizational competencies and the diffusion of innovation theory, these organizations worked to bridge the gap between knowledge and action among practitioners. Their initiatives included organizing annual advocacy trainings, inviting legislators and policy makers to association membership meetings, recognizing sound policy initiatives with organizational awards, creating a statewide legislative network, developing a public health legislative scorecard, and training constituent groups to relate their personal stories to policy makers. Additional activities included coordinated use of advocacy techniques such as meeting with legislators, writing position papers and editorials, providing expert testimony, strengthening relationships with policy makers, and building coalitions.

As Rogers (1983) stated, "Diffusion is defined as the process by which an innovation is communicated through certain channels over time among members in a social system" (as cited in Glanz, Lewis, & Rimer, 1997, p. 271). In this case, advocacy action (the innovation) is being encouraged through training and by example (the channels of communication) to public health practitioners (members of an identified social system). The practice of advocacy action was considered innovative because it had not been undertaken in a comprehensive and systematic way among the public health organizations and practitioners throughout the state.

Following the innovation-development process described by Rogers (1983), the following two-fold problem was identified: (a) a lack of confidence among practitioners in taking on advocacy projects and (b) doubt that individual advocacy actions could have an impact. Through informal interviews with colleagues and a survey of public health preparation programs in the state, most practitioners reported feeling ill-prepared to be "public health advocates" and few, if any, academic programs offered coursework in public health advocacy (Goodhart, 2002). Skills training and demonstration of advocacy principles were identified as the best means for preparing advocates for advocacy.

The trainings were developed to reflect noted characteristics of successful diffusion of innovation efforts (Kolbe & Iverson, 1981), specifically addressing concerns about complexity, relative advantages, and minimal risk. Real life testimonials that were familiar to the public health community in New Jersey, such as the implementation of local tobacco control ordinances and lobbying for increases in state aid, were presented and participants were provided with ample time for applying principles to these issues.

This article provides a "how-to" guide for health education practitioners by showcasing five initiatives undertaken by health educators in New Jersey to promote the use of advocacy.

ADVOCACY TRAINING FOR PUBLIC HEALTH PROFESSIONALS[1]

A review of traditional programs for health educators and other public health professionals reveals a substantial lack of training in advocacy theory and practice. In fact, a recent survey of public health and health education programs in New Jersey conducted by one of the authors found only two of the eight offered a course on advocacy and only three others indicated including core advocacy concepts elsewhere in their curriculum (Goodhart, 1999).

Recognizing this as a challenge and opportunity, NJ SOPHE and NJPHA collaborated in 1998 to develop what has become a series of advocacy training workshops for public health professionals. This joint effort was significant for several reasons. First, it marked the first time these two public health organizations came together to work toward a common goal that capitalized on the strengths of each group. Second, this specific focus helped each organization identify its own advocacy priorities and subsequently develop advocacy action plans. Third, organized, multidisciplinary, statewide training in public health advocacy had not been offered before to New Jersey's public health community.

NJ SOPHE and NJPHA set out to provide public health practitioners with knowledge and competency in basic advocacy principles and the motivation to make

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advocacy an ongoing component of their professional activities. The trainings provided participants with an understanding of advocacy's role in public health, skills for effective advocacy, application of advocacy principles to public health issues, and opportunities for collaboration with new partners (see Table 1).

Although each training had individual goals, the planners took great care to build the goals and objectives for each succeeding session on previous sessions.

Part 1: Amplifying Our Voices: Training for Public Health Advocacy

The goals of the inaugural workshop were to

- provide public health professionals with an overview of advocacy skills needed to influence public health policy,
- identify the principles of effective advocacy,
- describe the role and importance of advocacy in public health practice,
- apply advocacy principles to a defined public health issue, and
- encourage participants to create advocacy action plans with other public health colleagues.

The day began with an overview of key principles of advocacy (see Table 2) using a general approach that could later be applied to specific public health issues. This approach can be used any time a group or an individual wishes to make a change.

Practical methods for implementing advocacy practices were discussed by several of the invited guests but were also contributed by attendees who were surprised to discover that they were in many ways already practicing many of the principles previously described. A representative of national SOPHE illustrated these principles in action through SOPHE's efforts to change a proposed rule by the Department of Labor and Commerce to recognize "health educator" as a distinct occupational classification. An attorney for the New Jersey Group Against Smoking Pollution presented a case study describing how grassroots efforts were responsible for tobacco control policies in certain towns.

In the afternoon, participants applied newly discovered advocacy skills in small groups, addressing specific topics of interest including comprehensive school health education, funding for public health, adolescent substance abuse, tobacco control, managed care, licensure and/or certification, and envi-

TABLE 1
Training Content

Session	*Principles and Skills Presented*
Part 1: Amplifying Our Voices: Training for Public Health Advocacy	Overview of advocacy Demonstration of advocacy skills and techniques Development of topic-specific action plans
Part 2: Amplifying Our Voices: Training for Public Health Advocacy	Overview of advocacy; demonstration of skills (repeat) How to influence policy Understanding the political system Identification of pending public health policy issues Dialogue with legislators, policy makers, and lobbyists
Part 3: Advocacy and You: Perfect Together	"Advocacy 101" Presentation of New Jersey's public health agenda Discussion with legislators moderated by news anchor
Part 4: A Public Health Advocacy Dialogue	Current public health law in New Jersey Proposed new public health practice standards Dialogue with legislators, policy makers, and lobbyists Call to action by president's council

TABLE 2
Key Advocacy Principles

Advocacy Steps	*Level of change*	
Defining the Problem	Individual level (e.g., behavior)	Policy level (e.g., access, product safety, regulatory, manufacturing, and so forth)
Identifying the cause	Gap in information	Gap in power to change policy
Making strategic choices	What do you want?	(Objective)
	Who can give it to you?	(Your audience)
	To whom do they listen?	
	Who can give it to them?	
	What do they need to hear?	(Message)
	Who do they need to hear it from?	(Messenger)
	How can we get them to hear?	(Method)
Building coalitions as needed	Individuals affected and community members	Public and private organizations as partners

ronmental issues. Evaluative reports from the small groups demonstrated application of advocacy principles. The groups framed their issues, analyzed the power structure, identified strategies for persuading those in power, and identified resources such as funding, materials, data, and allies (individuals, groups, organizations, and coalitions available to help). Groups then designed a five-step action plan with specific, realistic steps to solve the problem.

Participants received a packet of information with materials on the legislative process in New Jersey and "how to" sheets describing ways to contact policy makers, provide expert testimony, work with the media, build coalitions, and access key Web sites. The packets also contained resource lists with contact information for organizations involved in advocacy work. In addition, exhibitors from various state and national organizations were recruited to provide information and resources that could support attendees' individual advocacy efforts.

Part 2: Amplifying Our Voices: Training for Public Health Advocacy

Based on evaluation and feedback from the first program, Part 2 was designed as an "advanced" training to introduce more sophisticated advocacy techniques and to offer a forum where public health officials and health educators could interact with New Jersey policy makers.

First-time attendees attended an overview session of public health advocacy prior to the start of the program and were introduced to important advocacy principles and strategies. The session also served as a review for attendees from Part 1. First timers received a detailed packet that contained handouts from the previous training as well as additional resource materials.

A representative from the American Public Health Association began with principles of public health advocacy. She discussed the legislative process, how to prepare for a legislative visit, effective communication, and follow-up. All public health professionals were encouraged to communicate, educate, and support their policy makers. Attendees learned they could provide expertise on local programs, make connections with constituents in their districts, and work collaboratively with other local and national groups to strengthen their message.

The Commissioner of New Jersey's Department of Health and Senior Services spoke about new public health initiatives and suggested ways in which participants could contribute to the process. A panel of five state assembly members and two controversial lobbyists led an energetic discussion on what it takes to influence health policy in New Jersey. One of the lobbyists had represented the tobacco companies during the tobacco lawsuit and provided a perspective on how large firms influence policy. Legislators encouraged participants' support, advised them about the types of constituent action that would help their legislative initiatives, and indicated they need current factual information on emerging health policy issues in a clear, concise, easy-to-read format so they can educate potential opponents about pending legislation. They encouraged public health professionals to develop public health fact sheets to aid them in this quest.

The rest of the training provided a unique experience because key policy makers, legislators, and controversial lobbyists shared their viewpoints on policy making and offered tips for working with legislative offices. The invited panelists discussed strengths and weaknesses in the political system, pending public health policy issues, and action steps for practitioners. It was evident from the panel discussion that legislators encouraged public health support.

Participant evaluations suggested open dialogue with legislators was eye-opening, effective, and empowering. Comments repeatedly cited by participants indicated they felt increased comfort in communicating with state legislators and they expressed intentions to pursue further advocacy opportunities. Participants suggested further training should include how to provide expert testimony, build grassroots support, and research timely advocacy opportunities. Most important, attendees indicated they believed ongoing dialogue with elected and appointed officials was crucial if they were to have an impact on policy.

Part 3: Advocacy and You—Perfect Together

A third advocacy training was held in the spring of 2000. "Advocacy and You—Perfect Together" encouraged expanded use of effective advocacy skills, provided advanced skills training in advocacy techniques, and continued the dialogue with both elected and appointed state officials.

Again, an "Advocacy 101" session was planned for the first hour of the day for first-time attendees. Presenters discussed the role and importance of advocacy in public health practice, principles of effective advocacy, how to overcome barriers in advocacy efforts, and specific advocacy methods and resources. Presenters emphasized that anyone can be an advocate, and as in previous trainings, participants were surprised to learn that they probably had already participated in some advocacy work and were highly capable of "doing" advocacy.

The Presidents of NJ SOPHE, NJPHA and the New Jersey Health Officers Association (NJHOA) welcomed attendees. The inclusion of this third public health organization was itself an advocacy success, as increasing numbers in an advocacy coalition can generate better outcomes. This was also the start of the New Jersey Public Health President's Council,[2] a coalition of the presidents of each of the state's seven public health organizations who joined together with the intent of having a single, stronger, and more effective voice on public health issues.

A well-known lobbyist addressed the process of providing testimony to legislative committees and discussed how to create effective delegations. As a current lobbyist, she applied her professional experiences and insights to current health issues. Several other practitioners provided their perspectives on developing advocacy and policy initiatives.

The State Commissioner of Health highlighted recent public health successes and challenges within the state, followed by a legislative panel discussion moderated by a well-known local television news anchor. The planning committee used this opportunity to actively engage the media in the training because media advocacy is increasingly important (Wallack et al., 1993). The legislative panel, consisting of four members of the state assembly, a state senator, and two senior representatives from the state department of health, came prepared to speak about certain pressing public health issues. The panel addressed topics that had been previously identified through inquiries via the various listservers of the New Jersey public health community, namely, gun control, tobacco, public health infrastructure, *Healthy New Jersey 2010*, and emergency preparedness. After providing brief comments, panel members answered specific questions on the issues from the attendees. A former legislator, offering additional insight into the policy-making process, summarized the panel's remarks.

The third training also provided a forum for NJ SOPHE to release two position papers: one on the need for a statewide patients' bill of rights and one on the allocation of monies from the tobacco settlement. The development of these papers was the result of requests for information on pending public health issues from legislators who participated in the previous training. The release of these papers during the third training was an opportunity to further highlight the importance of public health practitioners in policy design to legislators.

As in the previous year, evaluations showed that the interaction with the panel was the most appreciated segment of the day. Participants indicated they continue to benefit from advocacy training through reinforcement of existing knowledge and as an impetus for advocacy action. In fact, when asked in evaluations what future advocacy steps the attendees would take, many participants described specific actions they had taken, including joining their local boards of health, writing their local legislators, and becoming more vocal about public health issues.

Part 4: A Public Health Advocacy Dialogue

A public health advocacy dialogue focused on ways to sustain a productive discourse among state policy makers and public health experts while identifying key public health issues for potential action. In addition, representatives from the various public health associations unveiled "New Jersey's Public Health Agenda," a list of public health priorities established by the newly formed Public Health President's Council.

Part 4 began with a unified message on the importance of public health advocacy from the Public Health Presidents' Council, a coalition that included NJ SOPHE, NJPHA, the New Jersey Health Officers Association, the New Jersey Association of County Health Officers, the New Jersey Environmental Health Association, the New Jersey Association of Public Health Nurse Administrators, and the New Jersey Local Boards of Health Association. As stated previously, this new council was the direct result of collaboration by the public health community on advocacy efforts initiated in this program.

Part 4 of the training also provided information on current public health law in New Jersey and anticipated changes needed to implement new public health practice standards. The Commissioner of Health provided a call to action for public health professionals around several initiatives, including tobacco prevention and control. Again, a member of the press received topic-specific information prior to the legislative dialogue he moderated. This time, gubernatorial candidates joined state senators and assembly representatives. Participants actively engaged panelists in strategies to improve public health.

Evaluations once again highlighted participants' eagerness to engage in advocacy activities and their desire to continue this program. Participants also cited the experience of speaking with legislators as the most fulfilling part of the day. Including the gubernatorial candidates also was a coup, as that generated more media attention for the event and, consequently, for public health.

Outcomes of Advocacy Trainings

Self-reports and activities undertaken by participants suggest the successful diffusion of advocacy as a new innovation within New Jersey's public health community. Participants from the first training reported in their evaluations that on average, their knowledge of advocacy was raised 2 points on a 5-point scale after the training. In addition, all participants were able to identify at least one way their practice would change as a result of the course (e.g., will incorporate advocacy into the course I teach, will visit my representative because I feel more confident, will look beyond individual behavior and focus more on policy strategies, or will make a regular practice of writing to my legislators).

Of participants attending Advocacy Training 2, 81% reported that the training would be *very beneficial* or *mostly beneficial* (1 = *no benefit*, 5 = *very beneficial*) in their practice. When asked what their next advocacy action would be, respondents mentioned higher level advocacy strategies such as providing testimony to the Senate Health Committee, joining their local board of health, writing an editorial for a statewide newspaper,

and going before their mayor and town council to advocate for increased funding for their health department.

At Advocacy Training 3, 68% of participants indicated that the training was *very beneficial*. When asked what knowledge or skills were acquired from the training, top responses were creating and/or using a legislative score card, understanding the legislative process, and the ability to understand legislators' constraints and personal preferences for contact.

Increased advocacy work was measured by tracking participant's specific activities. All participants were asked to send copies of letters and testimony to the NJ SOPHE and NJPHA advocacy committees and to report on their activities through association newsletters and at future trainings. Additional measures of increased advocacy at the organizational level included several initiatives (see Table 3).

Training in public health advocacy is a necessity for state-of-the-art public health practice. These trainings provided participants with an understanding of advocacy's role in public health practice, skills for effective advocacy, application of advocacy principles to public health issues, and opportunities for collaboration with colleagues and beginning an open dialogue with elected and appointed officials. The trainings described in this article may serve as a template for any organization wishing to build public health advocacy skills and increase the role of public health professionals in setting public health policy.

TABLE 3
Organizational Advocacy Activities

Advocacy Activities	*Organization*
Development and dissemination of an annual public health scorecard	NJPHA
Holding of a press conference on an advocacy issue	NJPHA
Establishment of a coordinated model for a statewide advocacy network based on voting districts	NJ SOPHE
Provision of expert testimony at the Assembly and Senate Health Committee hearings	NJ SOPHE, NJPHA, NJHOA
Training constituent groups to testify before legislative committees	NJ SOPHE member
Development and publication of position papers on issues including needle exchange, sole domestic partner benefits, patients' bill of rights, comprehensive tobacco prevention and reducing firearm injury	NJ SOPHE, NJPHA
Development of fact sheets for legislators on pending public health issues	NJ SOPHE, NJPHA
Development of a policy statement and process for increased advocacy activities	NJPHA
Institution of an advocacy course at the state university	NJPHA member
Funding of a public health mini grant to survey legislators on public health issues	NJ SOPHE, NJPHA
Creation of a student advocacy internship	NJPHA
Commitment to future collaborative advocacy action to reach common goals	NJ SOPHE, NJPHA, NJHOA
Implementation of a media advocacy training	NJHOA
Stronger relationships with state policy makers and legislators	NJ SOPHE, NJPHA, NJHOA

NJPHA = New Jersey Public Health Association; NJ SOPHE = New Jersey Society for Public Health Education; NJHOA = New Jersey Health Officers Association.

Creating a Legislative Scorecard

Legislative scorecards provide a snapshot of the voting trends of lawmakers on selected bills. These scorecards are being used by organizations across the United States as part of their advocacy agendas and to hold legislators accountable for their decisions. A nonpartisan scorecard provides factual and reliable information about public policy and elected officials' stance on important public issues. In addition, individuals who are provided with the information included in the scorecard may be able to participate more effectively in the policy-making process.

NJPHA recognized the importance of tracking and publishing legislators' votes and developed an annual statewide scorecard in 1999. The five key stages of development were looking over other organizations' legislative scorecards, creating a policy agenda, identifying and tracking key legislation, gaining the approval from the board, and disseminating the results to the public.

An undergraduate student intern developed the first NJPHA scorecard. Because health policies span a wide range of issues, problems, and opportunities, clearly identifying interests and narrowing the focus to a manageable number of bills was important. A small committee of NJPHA members volunteered to identify public health issues and narrow which bills to consider. Their decision was based on the following factors: existing positions of the association (such as support for universal health care and needle exchange), current issues the association was involved with (such as tobacco), and other salient public health bills taken up by the state legislature.

The information needed to identify and track related legislation was easily found on the Internet (in New Jersey at http://www.njleg.state.nj.us), making this process extremely efficient. Records for key bills were collected and reviewed for consideration by the committee (who used criteria adopted from the American Public

Health Association to decide which votes to include in the scorecard). The criteria included the overall importance to public health initiatives and the NJPHA political agenda, the closeness of the vote (eliminating legislation that was passed or defeated nearly unanimously), and the amount of publicity and media exposure that the vote received.

The timing for disseminating the scorecard to the public should be well thought out and based on specific objectives. Some organizations inform the public of candidates' views by distributing their scorecards during the election season. Use care at this time to position the scorecard as an educational rather than lobbying tool. Our scorecard was unveiled at the March advocacy training sessions. The scorecard helped participants familiarize themselves with both the issues and the panel of legislators. New Jersey legislators received their personal copies, and the scorecard was also posted on the NJPHA Web page for public review. A press conference was used to release the second annual scorecard. In addition, a Power Point presentation was prepared for the North East Public Health Leadership Institute scholars (contact goodhart@rci.rutgers.edu for more information).

Creating a scorecard has several risks, such as misinterpreting the intent of a bill or a vote (e.g., a good idea being opposed by a legislator if it did not include enough funding or go far enough in its recommendations) and errors in scoring (e.g., scoring someone absent or not voting as a "no" vote). The scorecard should clearly identify how to interpret the votes or the scores—the NJPHA scorecard translated votes into scores supporting or opposing the NJPHA position and with a supporting rationale to help the reader.

NJPHA supervised student interns during 1999 and 2000 to develop an annual legislative scorecard. The tool is powerful for identifying legislative allies and alerting the legislature about public health. Eventually, these public health organizations hope to alert the legislature ahead of time on the public health bills being tracked and to have the opportunity to provide input during the actual bill-drafting process.

NJPHA distributes its scorecard to legislators, media, and NJPHA members and encourages members to become actively engaged in the health policy-making process. To be effective advocates, individuals must have information about the issues and their legislators' views on those issues. Although the information gathered is time-consuming, it is imperative that public health organizations work together to concentrate their resources to develop this information and make it public.

Key lessons learned included the need to triple check the scorecard for complete accuracy, the importance of being nonpartisan in the development and presentation of the scorecard, and the value in releasing this tool as a vehicle to help support those legislators who scored well, gaining public recognition for supporting public health.

CREATING A STATEWIDE LEGISLATIVE NETWORK

Altman (1994) wrote that one of the most important principles in public health advocacy is inclusion of a broad array of many representatives from a community to achieve the best chances for success. This concept was used in the development of a grassroots movement to call legislative attention to the need for an increase in cancer research funding.

In September 1998, the March to Conquer Cancer was held in Washington, attracting more than 6,000 cancer survivors, advocates, celebrities, and health providers from throughout the country. In an effort to gain widespread attention to this critical event so it would have an impact in New Jersey as well, more than 20 state public, nonprofit, corporate, and community-based organizations formed a coalition to create an effective and meaningful network to reach state policy makers. The objective was simple: to bring a consistent, clear message to all 40 state senators and 80 members of the assembly requesting support for increased funding for cancer and to invite the legislators to attend a march on Trenton 1 week prior to the national march, which the New Jersey Coalition was organizing.

To reach all legislative districts in the state, the advocacy committee of NJ SOPHE worked with the American Cancer Society and the Cancer Institute of New Jersey to identify members and concerned citizens in each legislative district. Names were matched by district to identify "teams" of two to four advocates who were to call and/or visit their legislator during a specified 6-week period. All participants were provided with contact information for other advocates in their district and were encouraged to connect with each other to make group visits. All advocates received an instruction packet that included contact information for their district representatives, a scripted message, information on NJ SOPHE and the Cancer Institute of New Jersey, fact sheets on cancer in New Jersey, information on the March to Conquer Cancer, and an invitation to attend the Trenton rally.

Volunteers agreed to contact one or more of their local legislators, deliver specific materials, and document their experience to the organizing committee. During the 6-week period, a total of 41 advocates reached 85% of the legislators through personal visits, letters, or telephone calls. Outcomes of the visits were recorded and used for future planning for other statewide initiatives. Participants noted the comfort and confidence they felt in making the visits because they were well prepared with a scripted message, had a single, specific issue to discuss, and had others with whom to make the visit. Participants who did not visit their legislators were polled to identify the barriers that prevented them so these issues could be addressed in future advocacy network initiatives.

Although logistically time-consuming, this method presents an effective way to mobilize an entire state

around specific public policy issues. As a result of this project, NJ SOPHE and NJPHA began asking for members to indicate their legislative districts on their annual membership form to facilitate matching members with their districts. The network remains intact for future advocacy initiatives.

DEVELOPING GRASSROOTS ADVOCACY INITIATIVES WITH CONSTITUENT GROUPS

As public health professionals build individual advocacy skills and impact public policy, they have the opportunity not only to advocate for those who need better policies but also to extend advocacy by empowering members of the public at large to become their own advocates (Blaine et al., 1997; Wooley et al., 1999). When current services or regulations do not provide appropriate protection, it is the people who are directly affected who can be the most powerful advocates for change.

The following example describes how potential advocates were identified and trained to advocate more effectively on behalf of people with Alzheimer's disease (AD). Individuals who participated learned how to define policy issues and articulate their needs and the needs of individuals with AD. Opportunities were identified for participants to voice their needs before state legislators.

A letter describing the goals of a statewide Alzheimer's association coalition was distributed to state respite coordinators, AD support group leaders, volunteers, and members of three chapters of the Alzheimer's Association. The letter outlined the lack of community resources available to families caring for loved ones with dementia. Facts about the prevalence of AD in the state, the lifetime cost of health care for someone with AD, research about the burdens AD caregivers faced, and the success of other caregivers in advocating to increase funding for AD research at the national level were included.

An advocate profile form encouraged individuals to become Alzheimer Association advocates. Respondents identified the number of years they had been caring for someone with AD and described their primary concerns about providing care. The respondents identified the community-based and long-term services they had used. Caregivers were asked to write or phone their legislators, testify before legislative committees, and tell their stories to the press. Caregivers who responded became part of the coalition's advocate database.

These new advocates received alerts asking them to contact state legislators about important legislation expanding services for family caregivers. Alerts included the address and phone numbers of key legislative committee members, bill numbers, and bulleted information about the impact the new legislation would have on caregiving families and communities. Advocates were urged to respond to the alerts within a specific time period.

The coalition learned there was an opportunity to testify at public hearings before a new advisory council on elder care created by the governor 2 months after the initial letter and profile were distributed. The council's charge was to gather and evaluate information on the needs of senior citizens and those caring for them. A letter describing the council's purpose and the opportunity for caregivers to testify at council hearings was sent to all advocates in the database. Information included how to ask legislators for services, how to share personal stories, and the impact of those stories on changing legislation.

The sample testimony included a formal greeting to the council, the name and city of the person providing the testimony (caregiver), the caregiver's relationship to the person being cared for, services used (respite, adult day care, home health service, and nursing home care), and in what ways those services were helpful. The form also asked advocates to describe additional services that could help them with their caregiving. Advocates were encouraged to write down their own personal experiences on the form and bring the form with them to the hearings.

Acknowledged barriers to providing testimony were addressed by providing the opportunity for advocates to practice testimony with AD staff members, arranging for transportation to hearing locations when needed, and by identifying "buddies" for advocates so they would not feel isolated. In addition, the value of testifying in effecting policy change and in providing additional resources was underscored. The self-efficacy of caregivers was increased when advocates were provided with an opportunity to practice their stories with their "buddies."

A total of 21 caregivers testified about services needed by AD caregivers at three elder care council public hearings. The testimonies were powerful, succinct, and unified in their requests for increased community-based programs to help families continue caring for loved ones at home. These testimonies were shared with the governor, who proposed a 3-year, $60 million plan to provide new community-based senior initiatives.

A few months later, success of the testimony before the elder care council and news of the governor's initiatives were shared with advocates along with a request to encourage other advocates to testify at public hearings before the joint budget and appropriations committee of the state senate and state assembly. Advocates received a new request to testify about new senior initiatives. Advocates were again asked to identify initiatives that would be useful to them as caregivers. Another 20 caregivers testified at the budget hearings. The senior initiatives were passed by the joint budget and appropriations committee and approved by the state senate and state assembly.

Alerts continue to serve as cues to action. The success achieved in expanding services has empowered advocates who now recognize the impact of personal testimony. Advocates continue to share their experiences with other caregivers, and the number of active AD advocates has tripled within 1 year.

Methods used to identify caregivers, increase their advocacy skills, and encourage them to participate in the legislative process can guide other health professionals in increasing advocacy in underserved populations.

ASSOCIATION ADVOCACY IN ACTION: POSITION PAPERS, EDITORIALS, AND PROVIDING EXPERT TESTIMONY

Professional association members can serve as "technology transfer" as they use their public health skills in other organizations with which they are involved. An NJPHA member was a member of the New Jersey HIV Prevention Community Planning Group, which advises the New Jersey State Department of Health and Senior Services on effective interventions and priority target populations for HIV prevention every year. Although this community planning group recommended needle exchange as a top intervention priority for HIV prevention annually, the commissioner and governor never accepted the community planning group's recommendation.

Because public health associations are politically neutral and can be seen as authentic experts in their professional area, they are important voices for such public health issues as needle exchange. The NJPHA member on the HIV Prevention Community Planning Group asked NJPHA to support needle exchange as a position. The board considered the issue, had an informative discussion, and decided to do so. This was the second in a growing number of positions on key issues for NJPHA, and it was seen as another way of getting more visibility and credibility for the association.

The position paper was drafted based on the considerable literature available and was approved at the next board meeting. Now NJPHA, an objective association committed to public health, had a position advocating for needle exchange and for decriminalizing syringe possession.

Creating a position on an issue was an important start as it educated NJPHA members and pushed the board to take a stand. NJPHA's second step was joining a coalition—in this case, the New Jersey Harm Reduction Coalition—to help focus and amplify its voice on the issue. NJPHA, realizing that it could not advocate alone on this issue, joined forces with others advocating for the same cause. NJPHA has since decided to act on only a few priority advocacy issues each year and sign on or join with other coalitions for important issues on which they are unable to take the lead. As such, NJPHA is more likely to focus on what will not happen if they do not do it themselves.

Because the board wanted to publicize the new position, the position paper was reworked into an editorial and sent to the major newspapers in the state. Timing was crucial because legislation was pending on needle exchange (S 453) and syringe availability (without prescription in specific instances, S 267) at that time.

Through an NJPHA member's employment at a public university, the position paper was reviewed by the public information office, who helped rewrite the editorial to be concise, focused, and timely. In fact, the news service even faxed this editorial to almost every newspaper in the state (all but one because that one demands exclusivity and will not print an editorial printed in any other newspaper). NJPHA also requested and received their fax list of media editors, so now NJPHA can directly send other editorials on their own behalf. Several newspapers printed the editorial. One, in fact, had juxtaposed this editorial with that of the governor's, who had an opposing view on the same issue. Soon after, a radio station contacted NJPHA for a studio interview.

The NJPHA board wanted to get as much exposure for the position as possible, as it was the board's role to educate the public and policy makers about public health and about the association. Once the editorial was printed, copies of the editorial were sent to state elected officials and the chair of the Senate Health Committee. This gave both the issue and the association good publicity.

Not long after the editorials were printed, the chairman of the Senate Health Committee called to invite NJPHA to provide testimony at their upcoming committee hearing on the pending legislation, saying they "wanted the public health perspective." This is exactly the exposure and relationship NJPHA wants with policy makers. (The bills have since progressed through committee but unfortunately did not get posted for a full vote before the legislative session ended. Since then, one of the original sponsors died, but another has sponsored the bill in the current session.)

As part of NJPHA's advocacy coalition work, the association now makes a point to include policy makers, legislators, and newspaper editors as panelists in its programs and conferences. An NJPHA annual award is given to a selected media person every year. For example, 2 years ago, a special president's award was given to the two senators who sponsored the needle exchange legislation to show support, strengthen the relationship, and increase visibility for them and the issue.

Experiences such as these can give the inexperienced professional the confidence to articulate public health positions important to them and to respond to advocacy alerts distributed electronically. NJPHA and NJ SOPHE have since developed positions and editorials on sole domestic partner benefits in the workplace, gun safety, patients' rights, reproductive health, and comprehensive sex education. Members are urged to correspond regularly with their state and federal legislators either

by letter or e-mail, whichever the legislator prefers. Health educators are further encouraged to connect their perspective with their own professional experiences and to include resources and offer additional information. In addition, modifying these letters to legislators and sending them as letters to the editors of local newspapers is another mechanism to inform readers of a public health education view without much extra effort (Altman, 1994).

Lessons learned include the importance of building relationships with groups and coalitions who also support the same issues to amplify this issue while conserving resources, using professional associations as a neutral voice on a community issue, and speaking out together. Giving specific examples of messages along with advocacy alerts on specific bills and the recommended actions steps and targets is also helpful.

DISCUSSION

Advocacy is an important strategy for advancing the health of the public (Schwartz et al., 1995). Health educators in one state, New Jersey, recognized the need to strengthen the skills and confidence of their public health educators.

Public health advocacy trainings strengthened participants' skills, created important dialogue on policy issues, and built relationships with policy makers, especially legislators. The trainings provided a model for advocacy strategies and tactics and introduced resources (from experts to readings and Web site sources) for participants to draw upon. Public health professionals learned that their voice is credible and needed but often silent.

Professional associations were encouraged to articulate their positions on key public health positions and to communicate these positions to policy makers (to inform and stimulate policy) and to the press (to educate the public). An important lesson learned was that the media welcomes such editorials and letters to the editor.

NJ SOPHE and NJPHA developed several specific initiatives as a result of the advocacy trainings presented, as follows:

- A nonpartisan legislative scorecard used a tool to track key public health legislation, hold legislators accountable for their votes, and alert legislators that the public health community is watching. The ultimate goal is to be welcomed as a partner in crafting public health legislation.
- A legislative network was created to deliver a consistent constituent message to the legislature overall. Hearing from constituents is important to legislators. A consistent message is a powerful persuader.
- A specific constituency was organized to provide testimony to the state legislature. An appropriations increase attests to the value of this strategy. An educated and empowered constituent base carries much weight with policy makers.
- Individual accomplishments included drafting fact sheets and writing to local newspapers about key public health issues as well as becoming more involved in statewide professional advocacy efforts.
- Public health professionals can, indeed, make a difference in the policy arena with adequate skills, confidence, motivation, and support. An organized professional association working in partnership with like-minded organizations becomes a powerful tool for influencing policy. The methods and resulting initiatives described in this article can be used as a template for any organization to build public health advocacy skills and increase the role of public health professionals in shaping public health policy.

CONCLUSION

Health educators are challenged to recognize that advocacy is an integral part of practice regardless of role or work setting. Some health educators are already doing advocacy work; too many more are not.

Take small steps, such as joining the local and national professional associations. Support their advocacy efforts by writing letters to policy makers and the media. Join their advocacy committees to help craft positions and promote advocacy actions.

Become active in the democratic process. Learn whom your elected and appointed policy makers are. Develop relationships with these people. Communicate your views and share information with them. Consider running for office (from your local school board or board of health to higher elected or appointed offices). Support other health educators who do.

Infuse advocacy into your workplace programs and practices whenever appropriate. Facilitate advocacy skill building with your communities, constituents, and colleagues.

NOTES

1. The information in this section provides a descriptive overview of several advocacy training sessions conducted in New Jersey that may be suitable for replication. Specific information and materials on planning and conducting such workshops may be obtained by contacting the authors.

2. The Public Health President's Council includes presidents or past presidents from the New Jersey Society for Public Health Education, the New Jersey Public Health Association, the New Jersey Health Officer's Association, the New Jersey County Health Officer's Association, the New Jersey Environmental Health Association, the New Jersey Association of Public Health Nurse Administrators, and the New Jersey Local Boards of Health Association

REFERENCES

Allegrante, J. P., Moon, R. W., Auld, M. E., & Gebbie, K. M. (2001). Continuing education needs of the currently employed public health education workforce. *American Journal of Public Health*, *91*, 1230-1234.

Altman, D. (1994). *Public health advocacy, creating community change to improve health*. Palo Alto, CA: Stanford University Press.

Blaine, T. M., Forster, J. L., Hennrikus, D., O'Neil, S., Wolfson, M., & Pham, H. (1997). Creating tobacco control policy at the local level: Implementation of a direct action organizing approach. *Health Education and Behavior*, *24*, 640-651.

Christoffel, K. K. (2000). Public health advocacy: Process and product. *American Journal of Public Health*, *5*, 722.

Wooley, S. F., Ballin, S., & Reynolds, S. (1999). Partners for advocacy: Non-profit organizations and lobbyists. *Health Education Monograph Series*, *17*(2), 45-48.

Gielen, A., McDonald E., & Auld, M. E. (1998). *Health education in the 21st century: A white paper*. Rockville, MD: Health Resources and Services Administration.

Glanz, K., Lewis, F. M., & Rimer, B. K. (Eds.). (1997). *Health behavior and health education: Theory, research, and practice* (2nd ed.). San Francisco: Jossey-Bass.

Goodhart, F. W. (1999). Adapted from Approaches to advocacy for health educators. *The Health Education Monograph Series, Eta Sigma Gamma*, *2*, 26-28.

Goodhart, F. W. (2002). Teaching advocacy to public health students: How and why. *Health Promotion Practice*, *3*, 341-346.

Institute of Medicine. (1988). *The future of public health*. Washington, DC: National Academy Press.

Kolbe, L. J., & Iverson, D. C. (1981). Implementing comprehensive school health education: Educational innovations and social change. *Health Education Quarterly*, *8*, 57-80.

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly*, *15*, 331-337.

Rogers, E. M. (1983). *Diffusion of innovations* (3rd ed.) New York: Free Press.

Schwartz, R., Goodman, R. M., & Steckler, A. (1995). Policy advocacy interventions for health promotion and education: Advancing the state of practice. *Health Education Quarterly*, *22*, 421-426.

Wallack, L., & Dorfman, L. (1996). Media advocacy: a strategy for advancing policy and promoting health. *Health Education Quarterly*, *23*, 293-317.

Wallack, L., Dorfman, L., Jernigan, D., & Themba, M. (1993). *Media advocacy and public health: Power for prevention*. Newbury Park, CA: Sage.

Wooley, S. F., Ballin, S., & Reynolds, S. (1999). Partrners in advocacy: Non-profit organizations and lobbyists. *Health Education Monograph Series*, *17*(2), 45-48.