Health Education Advocacy For Health Initiatives: Political, Program, and Practice Actions

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Abstract: Health educators have much to be excited about if the debate and legislation on healthcare continues to focus on prevention. The potential of resources and jobs would be a boon for the profession not to mention further legitimacy for practitioners. Without question health education advocacy efforts helped in some respects to push the prevention agenda but was it enough and was it at the right time? This article seeks to discuss advocacy in health education in the political, program and practice arenas and calls for advocacy as a health education skill to be more ingrained into the fabric of the profession.

"Nero fiddled while Rome burned."
Tacitus, 64 AD

INTRODUCTION

There was panic in the streets the year socialized medicine came to town. The country, trying to emerge from an economic downturn and having elected a new democratic president, was split on what was real and what was rumor and innuendo. Media reports had the president accused of being a socialist and that big government would soon control the medical establishment and how citizens could use it. The year of course was 1934 and President Franklin D. Roosevelt was in his first year in the White House. In one of his famous fireside chats, FRD stated:

> "A few timid people, who fear progress, will try to give you new and strange names for what we are doing. Sometimes they will call it 'fascism,' sometimes 'communism,' sometimes 'regimentation,' sometimes 'socialism.' But, in so doing, they are trying to make very complex and theoretical something that is really very simple and practical…I believe that what we are doing today is a necessary fulfillment of what Americans have always been doing – a fulfillment of old and tested American ideals." (June 28, 1934)

Years later President Truman would urge congress to pass a national health insurance program, followed by various iterations of healthcare reform from Presidents Johnson, Nixon, Clinton and Obama. The moral of this for health educators is that often times there is nothing new under the sun and it should be anticipated that positioning for evolving health initiatives is as much a part of our professional ethos as design, implementation and evaluation – the 2009 healthcare debate has kept us ever mindful of that. This article will continue important discussions in the field on advocacy and provide a relative discussion concerning health educations efforts using political, practice, and programming actions given current competency areas, skill sets and the profession's maturation.

CURRENT NATIONAL HEALTH INITIATIVES

The political landscape around 2009's debate and crafting of healthcare reform provides a practical starting point for this article. From a health education and health promotion perspective the national visibility given to the notion of prevention is exciting. For example, in a September 22, 2009 column under the heading *Preventing Diseases Before They Happen,* U.S. Department of Health and Human Services Secretary Katherine Sebelius wrote "… health reform must make health care more than just sick care. Real health reform must also improve the health of our nation by investing in critical prevention and wellness initiatives that help keep Americans healthy and out of the hospital in the first place". Seeing the language of health education at the highest levels during these remarkable times should be cause for validation of many of the efforts of the profession over the last few decades – The Role Delineation Study and resulting competency areas including the Competencies Update Project

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(CUP), the inclusion of Health Education as a Standard Occupational Classification (SOC) within the Bureau of Labor Statistics, and one would think, the positioning of health educators to reap potential benefits, (i.e., jobs), of a health reform bill that stresses appropriation for prevention and wellness initiatives. Now, more than ever, are health educators best positioning themselves relative to these and future health initiatives? According to Carlisle (2000), two historical goals underpin health advocacy—protection of the vulnerable and empowerment of the disadvantaged. Carlisle argues that in recent years, health advocacy has increasingly sought a role in the development and implementation of healthy public policy at the local, national and global level. As such, the notion exists that advocacy for health fulfils two functions: as a form of practice and as a useful strategy for a discipline which has to be self-promoting as well as health-promoting in order to survive in a competitive political environment.

POLITICAL ACTION

The World Health Organization (1998) defines advocacy for health as a "combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems for a particular health goal or program". In terms of political action, health educators align professional practice with the Responsibilities and Competencies of Health Educators; particularly relevant in this case is Responsibility VII - Communicate and Advocate for Health and Health Education (2006). Entry-level skills include being able to analyze and respond to current and future needs in health education that influence decision-makers. One example where this responsibility seemed appropriate to position the field was during the crafting of the Healthy Workforce Act of 2009 (S. 803/ H.R. 1897). If passed, The Healthy Workforce Act would offer a tax credit to businesses that have comprehensive employee wellness programs. As well, it would credit up to $200 per employee for the first 200 employees and up to $100 per employee, thereafter. Most importantly, companies would be eligible for the tax credit by establishing programs that raise health awareness among employees, encourage employee behavioral changes, and prompt employee participation through an incentive. The wording in this bill calls for "evidence-based research and best practices, as identified by persons with expertise in employer health promotion and wellness programs." In this regard health educators would be best served by contacting the offices of the authors of the bill as well as their state elected officials to advocate for health educators as the most qualified professionals to act as persons with expertise in health promotion and wellness programs. But the profession is always better served by advocating early in the process to have wording specific to health educators in the crafting of the bill. Strategic use of professional groups that have a history of advocating for health education such as:

- Coalition of National Health Education Organizations
- American Public Health Association
- Society of Public Health Education
- American Association for Health Education

and other organizations to position health educators become more powerful proactively rather than reactively.

Clearly articulated for the profession on the Health Education Advocacy (HEA) website (2009), political action, or advocacy for health education is a "critical competency of the health education specialist and an essential strategy in profession-wide efforts to foster improvements in individual and population health in all settings". The HEA goes on further to stress building effective political alliances with Congressional representatives and other policymakers as critical to strengthening and expanding the resource base for behavioral/ social sciences research, health education programs and practice, professional preparation in health education, and workforce employment.

PROGRAM-BASED ACTIONS

In 2005 many institutions of higher education began to hear about the Spellings Commission. Convened by then Secretary of Education Margaret Spellings to better understand higher education's accountability to student's performance, learning and achievement, it focused on assessment of learning outcomes and objectives. It required many college departments, health education included, to drill down to what was being taught; essentially did coursework leading to degree articulate with standards and competencies established for the that profession and what processes were in place to guide learning outcomes. From a health education perspective this can be seen as a chance for positioning curriculum revision to better serve students of health education in terms of the changing political landscape. Historically, this has not been easy – Robert Diamond, President of the National Academy of Academic Leadership, wrote in 2006 "Assessment and accountability are viewed by many as evils to be avoided rather than as tools for improving what they do or the quality of their institution". Reasons to consider assessment of program-based actions to facilitate positioning for health initiatives include:

- Helps identify if new course(s) are needed,

i.e., Advocacy in Health Education.
- Allows instructors to see if competency areas are being taught (or not) that best reflect established competencies.
- Determine if program is merely a collection of classes or a cohesive curriculum aimed at creating comprehensive and critical thinking pathways in graduates.
- Reflects if internships, etc are creating appropriate opportunities for student engagement.

Other reasons show that it is time to legitimize advocacy in the profession as a systematic, scholarly pursuit aimed at building a scientific knowledge base for the field. Chapman identified this challenge in 2001:

> "Few postgraduate courses in public health place anything but passing attention on how to advance or advocate the policy implications of research. Public health advocacy remains barely a sub-discipline within our field. Unlike medical psychology, education, sociology, anthropology, economics, biostatistics or epidemiology, advocacy has no journals dedicated to critical analysis of its methods, wins and losses. It has few textbooks and even fewer recognized training programs. Every branch of public health can point to the critical role of advocacy in translating research into policy, practice and sea changes in supportive public opinion; the relative neglect of both the skills and analysis of advocacy is remarkable given its achievements".

In response to Chapman's challenge, Tappe, et al (2007) found significant positive relationships between health education faculty members' perceptions of the importance of advocacy and their competence to teach advocacy, their own professional preparation in advocacy, their advocacy-related teaching experiences, and their participation in advocacy activities at the local, state, and national levels, and provided learning experiences and curriculum strategies to fold in to both undergraduate and graduate learning. In 2009, Tappe et al, again articulated further substantive rationale, strategies, and resources for inclusion in professional preparation programs. As with the possible paradigm shift in systematic national healthcare, growing evidence suggests that health education advocacy as a curricular standard is moving further along the continuum.

PRACTICE-BASED ACTIONS

Twenty years ago, Dr. Halfdan Mahler the then Director-General of WHO said that public health needed to move into positive and active advocacy for health. One of the significant obstacles to progress he considered was that the political will and the intersectional action necessary to create the healthy environments are sadly lacking in many countries. Caira, et al (2003) voiced similar concerns that while the health education profession is making strides in institutionalizing advocacy, as a skill it is still gaining a foothold and may not be practiced as much as it is preached.

This year marked the 11th Advocacy Summit held each year in Washington DC. Its purpose is to immerse health educators in the political system by training selected participants in specific legislative issues important to the profession and allowing them the opportunity to speak directly to elected officials and key opinion leaders. The Advocacy Summit reflects probably the most visible representation of a practice based action in health education. While similar trainings may be going on in other venues, the Summit has grown to be an "event." The Summits beginning may have had to do with the publication of the 1995 document "The Health Education Profession in the 21st Century: Setting the Stage." (13) One of the focal points of the document, in answer to the question "Where do we want to be in 10, 20, 30 years", involved the recognition of advocacy as an active part of the *practice* of health education, not just the profession. In ensuing years, objectives set to measure advocacy efforts revealed that most organizations that represent health education have in place advocacy guidelines and recommendations and are working hard to raise the level of engagement in this area.

The Competencies Update Project (CUP), begun in 1998, has been a similar ongoing effort to assess the practice of health education competencies across multiple levels (Entry, Advanced 1, Advanced 2). All these efforts clearly emphasize that recognition of advocacy efforts has galvanized the profession into swimming in the same direction, but much more work needs to be done to truly institutionalize advocacy efforts into practice. Only 5 years ago, Chapman (2004) maintained that advocacy remained a 'Cinderella branch of public health practice' with insufficient attention given to its development through university programs, text books and journals."

We are living in exciting times, both as a country and as a profession. It seems some good will come of the healthcare debate and legislative efforts and the profession of health education will certainly benefit. In hindsight though, will we be asking ourselves if we did enough to help *position* the legislation with our advocacy efforts, will the ultimate aims of health education result in the inclusion of prevention and

wellness efforts currently being discussed and will those aims ultimately result in more jobs and more legitimization for health educators?

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