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The Potential of Partnerships for Health Advocacy and Policy Change: The Legacy of the Partnership for the Public's Health Initiative

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Introduction

Starting in the late 1980s, the Institute for Medicine began calling for greater involvement of public health professionals in the development of public policies affecting health (Institute of Medicine, 1988, 2003; Institute of Medicine, Gebbie, Rosenstock, & Hernandez, 2002). Since that time, the concept of harnessing policy advocacy for community health improvement has been featured in the *American Journal of Public Health* (2003), and a variety of community health improvement efforts have focused on policy and systems change strategies (Cheadle, Senter, et al., 2005; Community Intervention Trial for Smoking Cessation, 1995; Conrad et al., 2003). With the growing recognition that public health departments have an obligation to work collaboratively with the communities they serve, community-based participatory research and advocacy capacity building have received increased attention

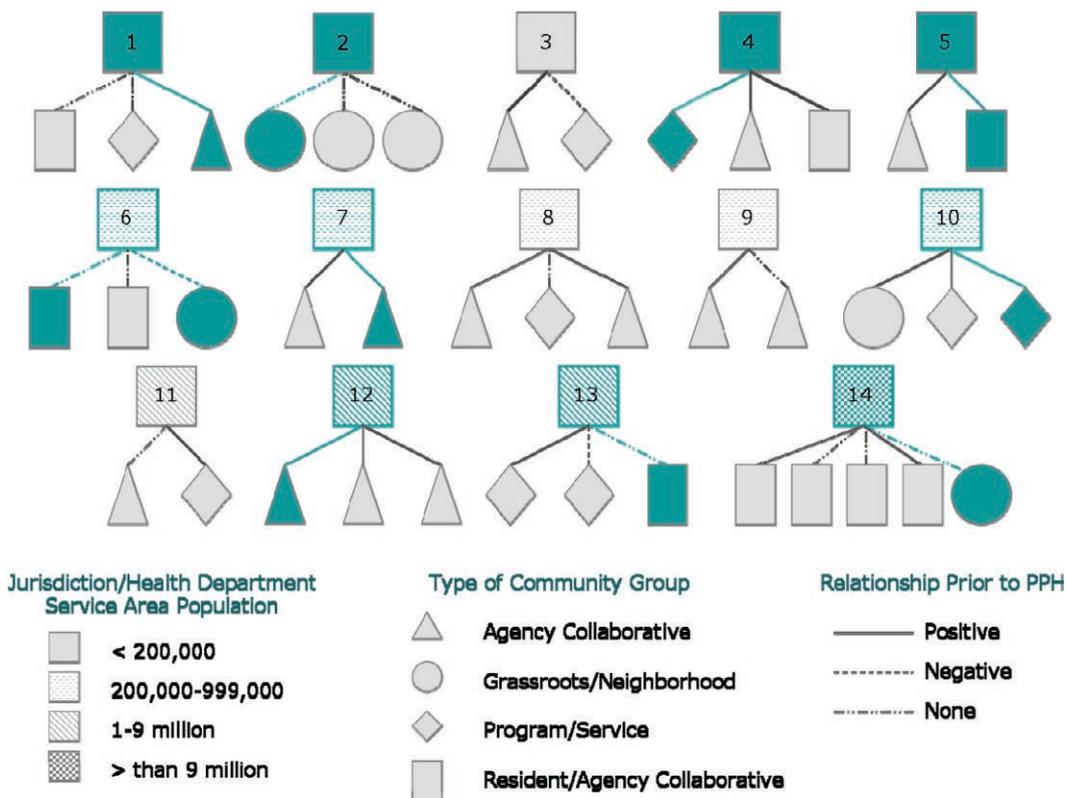
Key Points

- This article reports on a study of 11 partnerships between public health departments and community organizations that were funded by The California Endowment to support advocacy and organizing to improve health outcomes in the communities.
- The evaluation examined the sustainability of the partnerships as well as the policy and advocacy work of the organizations.
- Almost 90 percent of the activities in policy change and community capacity building was sustained, whereas partnership and health department capacity building activities were the least likely to be sustained.
- The policy change legacies at the community level were strong and included empowerment of community members, the creation of healthier environments, increased access to services, and increased focus on health by local governments.

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This manuscript was written by a team from Center for Community Health and Evaluation (CCHE). CCHE designs and evaluates health-related programs and initiatives throughout the United States. Much of CCHE's experience comes from its evaluation of multi-site community-level interventions with an emphasis on implementation and outcomes. CCHE specializes in matching evaluation strategies to the needs of stakeholders, including the community, program staff, clinicians, and policy-makers. Highly interdisciplinary, CCHE has designed health promotion interventions, evaluated both large and small health-related initiatives, organized national conferences, and published widely. Formerly the evaluation team of the Group Health Community Foundation, CCHE is now part of the Group Health Research Institute.

FIGURE 1 Descriptive Diagram of PPH Partnerships (Partnerships Selected for Legacy Evaluation in Color)



(Bassett, 2003; Minkler, Blackwell, Thompson, & Tamir, 2003).

An important advantage that policy and system change strategies offer is the potential to address environmental factors and create lasting improvement in health without requiring direct or continuing funding. Policy changes also have the potential to directly and indirectly affect a broader population and individuals who might not be reached by traditional service provision or health education campaigns. For example, ensuring that cities have sidewalks and safe public parks has the potential to impact a broader segment of the population than does providing direct health service to obese individuals. Despite the acknowledged potential role of health advocacy in improving population health, few large-scale evaluations have sought to document the contributions that funding initiatives can make toward building public advocacy skills within communities and supporting policy change efforts. Nor

have they examined the longer-term legacy of support of advocacy and policy efforts. In this article, we look at the scope and legacy of one funder’s efforts to promote and maintain health improvement through partnerships between health departments and community groups, with an emphasis on advocacy and policy change. Eleven partnerships were studied three years after funding for a large-scale initiative (the Partnership for the Public’s Health) ended. Results describe (1) the extent to which building the capacity of health departments and community groups to jointly advocate for policy change led to sustained work in health advocacy; and (2) the policy-related legacies of the initiative.

Methods

Original Initiative and Evaluation (2000–2004)
 The Partnership for the Public’s Health (PPH) was a \$40 million, five-year initiative funded by The California Endowment (TCE) to develop partnerships between California communities and

local health departments. Fourteen county and city health departments and 39 local community groups were funded under the PPH Initiative. The goals of the PPH Initiative were (1) to strengthen the capacity of communities to engage residents to act on their own and in partnership with health departments and other institutions to protect and improve the community's health and well-being, (2) to enhance the capacity of health departments to respond to community-based and community-driven priorities, (3) to create sustainable partnerships between communities and health departments, (4) to promote and define mutual responsibility for improving community health, and (5) to develop state and local policies that support and sustain local capacity to improve community health. Each local partnership was funded for a total of four years. Each health department partnered with two to five separate community groups within its jurisdiction. Funding was allocated separately to the community groups and the health department. Community groups received approximately \$80,000 per year, and health departments received between \$150,000 and \$180,000 per year, depending on the number of community groups with which they had partnerships. Figure 1 illustrates the diversity of the original 39 partnerships and highlights the 11 partnerships that are the focus of this article (the 11 selected for the legacy evaluation — that is, legacy partnerships — are highlighted in color; see the Legacy Evaluation subsection).

Health department and community group partnerships were expected to create an action plan that included activities in each of five major PPH goal areas mentioned above. The evaluation documented the activities of each partnership in detail to assess its level of progress. Methods used to assess that progress, as well as the findings and lessons learned from this original evaluation, have been presented previously (Cheadle, Hsu, et al., 2008).

Legacy Evaluation (2007–2008)

To better understand the longer-term impact of the initiative, TCE funded an evaluation to assess the enduring models, sustained practices, and best practices that emerged from PPH (i.e., a legacy evaluation). A key aspect of this evalu-

ation was to determine the extent to which the original work in the five goal areas was sustained and whether PPH had contributed to new work aimed at improving the health of communities. Because the legacy evaluation was intended to identify models and best practices, 11 of the 39 partnerships were selected for study based on several criteria, the most important of which was having achieved high levels of progress during the initiative. Other criteria included geographic distribution, representation of diverse ethnic communities, and variation in size and type of health department. Site visits were conducted that included interviews with representatives of both grantees from each of the 11 partnerships (community groups and health departments), as well as observation of a partnership meeting when possible. Interview participants were asked

TCE funded an evaluation to assess the enduring models, sustained practices, and best practices that emerged from PPH.

to describe in detail the status of all activities that were listed in the final case study from the original evaluation. They also were asked to comment more generally on the legacy of the PPH Initiative for the health department, the community group, the partnership, their community, and the state as a whole. For the purposes of this evaluation, *partnership* was defined as the relationship between one community group and one health department ($n = 11$). *Sustainability* was defined as continuation of specific grantee activities, including continued support of policy and systems changes that were made during the initiative and the extent to which these changes remained intact or evolved.

Evaluation Framework

From 20 years' experience evaluating complex community health initiatives, the evaluation team learned that experimental designs and an exclusive focus on long-term outcomes produced results that were confounded by environmen-

tal variables and often overlooked important progress occurring in communities. As a result, we have developed methods for evaluating these types of health improvement efforts that we believe permit a richer understanding of what takes place in complex, dynamic community settings (Cheadle, Beery, et al., 2003; Cheadle, Hsu, et al., 2008; Cheadle, Senter, et al., 2005). Our approach centers on the development of logic models and case studies. The logic models are used to identify intermediate indicators, and case studies are designed to monitor those indicators. The identification of relevant indicators involves detailed discussions with the program stakeholders regarding how the program is intended to work. Depending on the construction of the overall logic model, the intermediate indicators can include program accomplishments and activities. Often, as is the case with the PPH Initiative, tracking accomplishments and activities is the best means to assess program effectiveness.

Tracking accomplishments and activities is the best means to assess program effectiveness.

For the original PPH Initiative, the evaluation team created logic models for both the entire initiative and each partnership. Detailed information was collected about each partnership based on a standardized case-study template. The five goal areas provided the overarching structure for these case studies, with each partnership identifying and describing its major activities/accomplishments. Because each partnership created an action plan based on the needs of its own community, there were no common intermediate indicators that applied across all partnerships. Therefore, we focused on examining the type, quality, and quantity of activities and/or accomplishments that occurred in each goal area. For the purposes of this article, we refer to all these items as “activities.” Analysis of partnership activities was used to assess progress toward partnership-specific and overall initiative goals

during the original evaluation. We continued our examination of partnership-generated activities in the five goals areas (including policy) during the legacy evaluation.

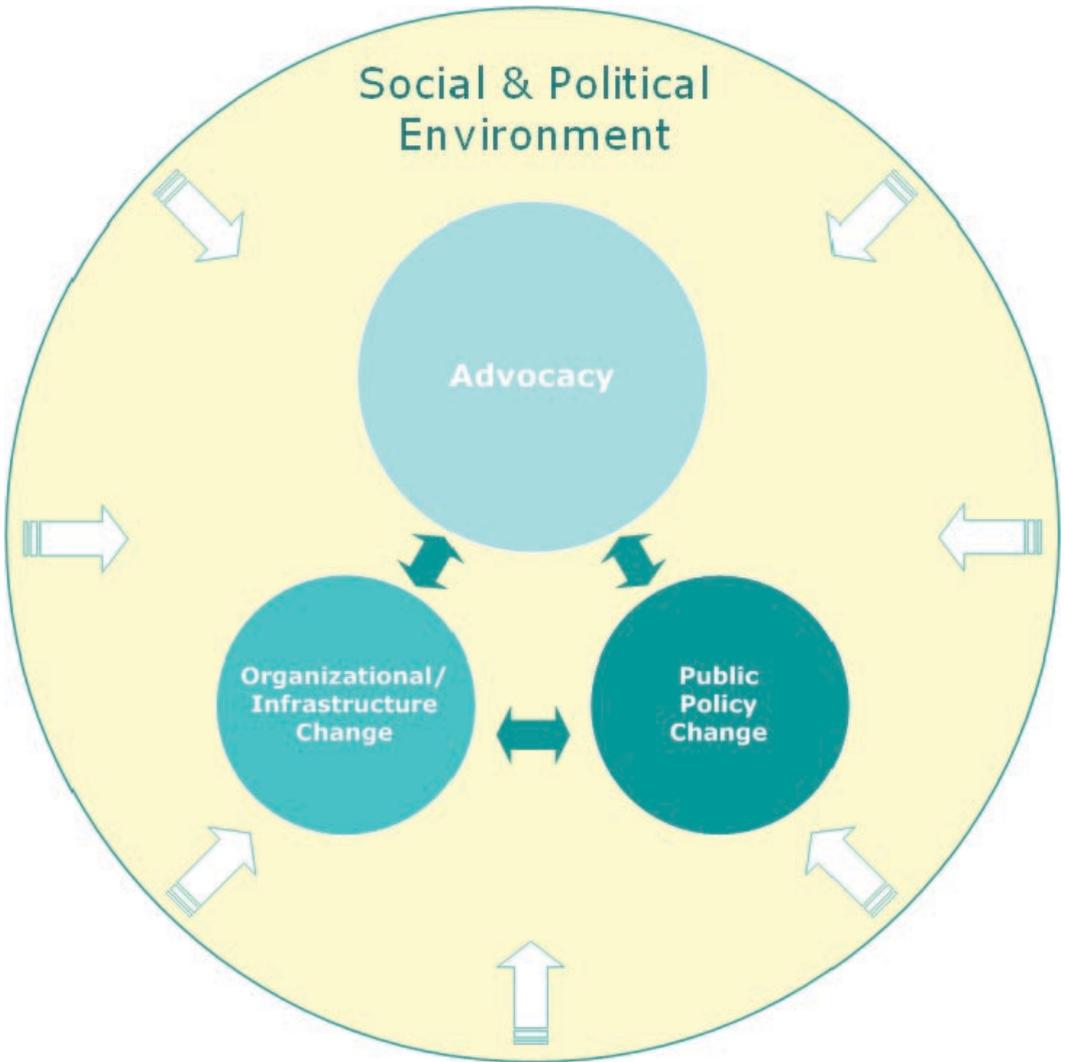
Policy Framework

To augment our standard evaluation framework, we also examined the literature on policy and evaluation and developed a conceptual framework for the PPH Initiative policy activities. Policy change is a field that is wide-reaching and complex. Several key scholars in the area of political science and policy analysis have suggested that policy change is not the result of rational and linear processes, but involves a wide range of activities and events that can be unpredictable, nonlinear, and at times paradoxical (Kingdon, 1984; Polsby, 1985; Stone, 2002). Most of these analyses have been conducted on national-level policies, yet assessing advocacy and policy change at the local level can be equally challenging.

A number of frameworks have been developed for mapping the trajectory of policy change and identifying the specific strategies that can be used to create policy change. Ottoson et al. (2009) described a science-policy-public spectra model that demonstrates how public awareness, policy change activities, and science parallel and complement one another. This model identified concrete activities that may occur in the course of policy change, including describing the problem, researching the causes and consequences, developing awareness, mobilizing, reframing the issue, and framing the policy. Grantmakers in Health’s monograph “Funding Health Advocacy” (2005) provides a three-stage progression that includes problem definition, advocacy, and implementation. Within these broad categories, the monograph identifies a number of specific strategies, including research and analysis, solutions identification, stakeholder engagement, community organizing, building the advocacy capacity of diverse stakeholders, coalition building, lobbying, public education, and evaluation.

For the purposes of our analysis we chose a relatively streamlined conceptual model for examining the policy activities that were reported during

FIGURE 2 Policy Change Framework.



PPH by the legacy partnerships. Our framework for conceptualizing policy change included three domains — advocacy, organizational/infrastructure change, and public policy change (see Figure 2). Within this framework (1) *advocacy* included all activities that were aimed at influencing decision makers (Innovation Network, 2008), including those activities identified by Ottoson et al. (2009) and Grantmakers in Health (2005); (2) *organizational/infrastructure change* included any changes made to policies within private or public organizations and improvements in the community infrastructure (primarily administrative or bureaucratic in nature but with lasting effects

on organizational practice or the built environment); and (3) *public policy change* included the passage and/or creation of new local ordinances, laws, or public policies, as well as changes to or increased enforcement of existing ordinances, laws, or public policies. Although the key vector for change is from advocacy activities to either organizational or public policy change, we recognized that these efforts do not always occur in a linear fashion (Kingdon, 1984; Stone, 2002). In some cases, organizational policies may reinforce or influence public policy. In other cases, public policy or failed attempts to change public policy may catalyze new types of advocacy efforts. Also,

we would expect that most of the partnerships' policy-related activities would include advocacy efforts, given that organizational/infrastructure or public policy change is almost always preceded by some advocacy work. Finally, the model acknowledges that there are many events occurring in the social and political environment that can positively or negatively affect policy changes efforts, which means policy changes rarely can be attributed solely to the advocacy efforts of one organization or partnership.

Analysis

Our analysis for this article focused on three strategies for examining the data. First, we examined the sustainability of partnership activities. Next, we examined the policy activities using the policy framework. Finally, we analyzed the qualitative data for information about the legacy of the PPH Initiative on the partnerships' current capacities and the broad impact of PPH participation on advocacy and policy-related issues.

Within the five goal areas, health department capacity building was the most prevalent activity.

Data regarding partnership accomplishments were analyzed by systematically compiling and coding qualitative descriptions of sustainability and then conducting quantitative analyses on the sustainability codes. All partnership activities documented at the end of the original PPH Initiative were first identified. Then, based on data collected for each activity during the legacy evaluation, each activity was assigned a sustainability score: 1 (*activity not sustained*), 2 (*activity sustained at a lower level than at the end of the PPH Initiative*), 3 (*sustained at same level*), or 4 (*sustained with increased activity*).

For the analysis of the advocacy and policy-related activities, we developed a coding scheme to categorize all policy activities by the components of the policy framework (described earlier). In cases

where an activity had begun as advocacy but had progressed into one of the other two categories after the initiative ended, the original code was used.

During the legacy evaluation, we collected additional qualitative data on several other topics such as legacy of PPH, changes in community context, technical assistance needs, and recommendations. For this article, we describe the legacy and challenges, because they are most relevant to advocacy and policy change. All qualitative data (e.g., detailed site visits, notes, and observations) were analyzed using immersion/crystallization analytical methods to identify key themes in the data. Immersion/crystallization emphasizes detailed examination of qualitative data to identify patterns and connections (Borkan, 1999). For all coding (sustainability, policy framework, and qualitative), two team members independently coded the data and then met to compare and reconcile differences. Atlas.ti, a software package designed for analysis of qualitative data, was used to aid this process as needed.

Results

Sustainability — All PPH Goals

In order to provide a comparative context for the PPH policy work, we examined the overall sustainability of activities in all five goal areas. This analysis was aimed at testing whether the policy activities were, as the literature suggests, more sustainable overall and to determine whether there were patterns in these data that might inform our understanding of the policy activities in light of trends in the other goal areas. Among the 11 partnerships, a total of 323 activities were identified at the end of the original initiative. Among those 323 activities, more than 85 percent ($n = 278$) had enough information available to assign a sustainability score (Table 1). Reasons for not being able to assign sustainability scores included lack of detailed program information on the activity, lack of knowledge among program staff about the activity, and lack of time during the site visit interviews.

Within the five goal areas, health department capacity building was the most prevalent activity (25 percent of all activities), whereas policy/system change and partnership work were less

TABLE 1 Status of PPH Activities Three Years Postfunding (n = 278)

Sustainability score	1	2	3	4	Total (%)	Not sustained %
	Sustained (not)	Sustained (some)	Sustained (same)	Sustained (increased)		
Goal area						
Capacity building—community	3	7	28	20	58 (20.9)	5.2
Capacity building—health dept.	11	13	30	15	69 (24.8)	15.9
Capacity building—partnership	4	10	26	10	50 (18.0)	8.0
Health improvement	7	20	20	9	56 (20.1)	12.5
Policy and systems change	2	3	33	7	45 (16.2)	4.4
Total	27	53	137	61	278	
	9.7%	19.1%	49.3%	21.9%	100.0%	

Note. PPH = Partnership for the Public’s Health Initiative.

prevalent (accounting for 16 percent to 18 percent of all activities). Of all activities, half (49 percent) were sustained at levels similar to those reported when the original funding ended. Examples of activities that continued included a teen support group, annual updating and distributing of a wellness guide, and leadership trainings for parents in the community. One-fifth (21 percent) of partnership activities had increased in scope and scale since initiative funding ended. Examples of program activities that increased included health departments’ expansion of the use of Mobilizing for Action through Planning and Partnership or MAPP (a health system assessment tool developed by the National Association of County and City Health Officials (NACCHO)), expansion of neighborhood action groups (from five to 10), acquisition of land to expand social and health services, and expansion of an after-school program. Less than 10 percent of all the documented activities at the end of the initiative were not sustained at any level three years later.

When the analysis was limited to partnership activities that had increased or stayed the same (top

two categories of the four-point sustainability scale) and stratified by partnerships (No. 1 to No. 11), sharper contrasts emerged (Table 2). Almost 90 percent of the work in policy change and community capacity was sustained (89 percent and 85 percent, respectively), whereas partnership capacity building activities and health department work were the least likely to be sustained (53 percent and 60 percent, respectively). Among individual partnerships, three (No. 2, No. 4, and No. 11) were able to successfully sustain the majority of their PPH-initiated efforts; these same partnerships also had the fewest number of activities listed from the original evaluation. In contrast, two of three partnerships that during the original evaluation reported the most activities (No. 1 and No. 10) had the lowest sustainability rates (about 50 percent).

Partnerships varied in their ability to sustain specific types of activities within the five goal areas. For example, one partnership (No. 9) planned and implemented almost one-third of all the documented community capacity-building work (12 of 50 activities) — all of which was sustained

TABLE 2 Activities Sustained by Goal Area and Partnership: “Same” or Increased” (*n* = 198)^w

Goal Area	Community capacity building	Health department capacity building	Partnership collaboration
Partnership 1	2 (4) ^a	0 (4)	5 (5)
Partnership 2	7 (8)	3 (3)	4 (4)
Partnership 3	6 (6)	4 (4)	1 (4)
Partnership 4	5 (5)	6 (6)	3 (3)
Partnership 5	3 (4)	6 (7)	2 (4)
Partnership 6	2 (2)	4 (4)	5 (8)
Partnership 7	4 (7)	3 (5)	1 (8)
Partnership 8	4 (4)	1 (5)	3 (5)
Partnership 9	12 (12)	5 (6)	1 (4)
Partnership 10	3 (5)	2 (4)	1 (7)
Partnership 11	2 (2)	2 (2)	3 (3)
Total Sustained	50	36	29
Total attempted	(59)	(60)	(55)
% Sustained (same/increased)	84.8%	60.0%	52.7%

^a number in () = total activities.

at follow-up; two partnerships (No. 1 and No. 10) planned and implemented approximately a third of all the documented health improvement work (13 of 41 activities) — almost none of which was sustained (two of 13 activities) during the follow-up period. These differences are likely due to variations in the partnerships’ capacities and interest.

Sustainability — Policy

The policy change work completed by partnerships at the end of the three-year follow-up period is highlighted in Table 3. Based on the conceptual framework, we developed nearly a half (42 percent) of all the policy work that was categorized as advocacy. Forty percent of the work was categorized as organizational/infrastructure change, and 20 percent qualified as public policy change work. Only five of the 45 (11 percent) individual advocacy and policy activities were not sustained at the same level or at an increased level compared with the score at the end of the origi-

nal initiative (rated 1 or 2 on the sustainability scale). Eight partnerships had activities that were considered organizational/infrastructure change, and seven partnerships reported activities that qualified as public policy change. Table 4 provides detailed descriptions of the policy change activities from three example partnerships, along with the sustainability code and the policy framework category assigned to each activity.

Among the partnerships, examples of activities coded as advocacy included the convening of a roundtable on juvenile justice, seeking assistance from the Environmental Protection Agency to address diesel emissions, developing state legislation to address rural ambulance service, ensuring resident participation in MAPP, building relationships and awareness among local officials, and training residents to advocate for themselves around specific issues. Organizational/infrastructure change included creating internal policies within the health department to facilitate

	Health improvement	Policy change	Total sustained	Total attempted	Sustained %
	1 (7)	7 (7)	15	27	55.6
	4 (4)	5 (5)	23	23	100.0
	5 (11)	4 (5)	20	30	66.7
	5 (5)	5 (5)	23	24	95.8
	3 (3)	1 (3)	15	21	71.4
	7 (8)	2 (2)	20	24	83.3
	1 (4)	6 (6)	19	34	55.9
	4 (6)	2 (3)	14	23	60.9
	7 (8)	2 (2)	25	32	78.1
	1 (6)	6 (7)	13	29	44.8
	3 (3)	1 (1)	11	11	100.0
	41	41	198	278	71.2
	(65)	(46)	(278)		
	63.0%	89.1%	71.2%	25.3%	

advocacy work, getting an air-quality monitoring station put in the community, increasing street lighting, changing school vending machine policies, creating a new city park, and establishing a community advisory board in the health department. Examples of public policy changes included new garbage and solid waste policies, a county measure banning the growth of genetically modified organisms, a city ordinance requiring retailers to have a license to sell tobacco products, and city policies mandating the availability of simultaneous translation at city council meetings.

Policy Legacy

During site visits, participants also were asked to comment on the legacy of the PPH Initiative for each partner/grantee (health department and community group), the partnership, and the community as a whole. The concept of legacy goes beyond the sustainability of specific activities to explore how the relationships and capacities built during the PPH Initiative contributed to and

shaped subsequent work. Many of the reported legacies related to building advocacy capacity and promoting policy change.

All 11 participating community groups reported that advocacy capacity was built during PPH. Several of the PPH community groups indicated they had not considered working on advocacy and policy change before the PPH Initiative, but they had since shifted their priorities to make this a major focus of their work after recognizing the potential for long-lasting and widespread impact. One community group reported that it had “strong community members positioned and trained to advocate for community policy preferences.” Another group member reported, “We learned that advocating and fighting are not the same thing.”

Advocacy capacity for health department grantees did not emerge as a major legacy theme, but several health departments did report increased

TABLE 3 Policy Activities by Type and Partnership (*n* = 45)

Type of policy	Advocacy	Organizational and infrastructure change	Public policy change	Total (%)
Partnership 1	2	1		3 (6.7)
Partnership 2	2	3	1	6 (13.3)
Partnership 3		1	1	2(4.4)
Partnership 4	2	3	1	6 (13.3)
Partnership 5	1			1 (2.2)
Partnership 6	1		2	3 (6.7)
Partnership 7	1		1	2 (4.4)
Partnership 8	3	3	1	7 (15.6)
Partnership 9		4	1	5 (11.1)
Partnership 10	4	1		5 (11.1)
Partnership 11	3	2		5 (11.1)
	19	18	8	45
% by area of policy	42.0%	40.0%	18.0%	(100.0%)

understanding and/or ability to engage in health advocacy. One health department stated that a legacy was “understanding the need to engage city government and county government.” Another legacy of the PPH policy work for health departments was internal policies changes.

Many of these changes were aimed at increasing the health department’s ability to engage and work in collaboration with the communities. These organizational policy changes also helped facilitate new partnerships with other communities and organizations. They also contributed to overall change in the culture of the health department that supported a community-based approach and strategies that focused on environmental factors rather than individual behavior change interventions. Finally, four health departments reported an increase in the capacity of the communities to advocate for public health issues and for the health department. For example, one health department experienced a precipitous drop in a key funding stream that would have required dismantling several regional offices that had been established recently in outlying areas.

When the cuts and planned changes were announced, the community advocated for preserving the regional offices, resulting in the county providing additional funding to the health department. A health department representative stated:

Our partners really advocated for us to keep our regional offices open. We do have that support for serving people in those communities. We have a commitment that is very clear and concrete. The longer we are there, the more outcry the community we would have if we were to leave.

Another health department trained residents how to advocate for services. This activity was described by the health department:

We explained primary care vs. tertiary care vs. emergency care. We looked at the fiscal reality of the business of running a clinic. Explaining that not going to an appointment took one away from someone else. They truly saw what was going on. We were able to teach them how to advocate for additional hours.

For other health departments, building this constituency was an unexpected outgrowth of partnering. For example, one respondent noted:

We have allies in the community that will come with us to talk to [the] city council. How we work with each is more of a partnership now than a handout type of relationship. That really stands out in our work.

At the partnership level, four partnerships specifically reported that one partnership legacy was increased advocacy capacity. The most prevalent legacy theme for partnerships was improved relationships and the continuation of the partnership, which are essential for supporting future advocacy and policy change work. These relationships give each partner access to additional resources (e.g., funding, data, community members) that bolster policy change activities. One community member reported:

There were some health department staff that didn't know us and now they seek us out and we partner in different venues. It is more intentional now. We see them as a resource and they see us as a resource.

The policy change legacies at the community level were strong and included empowerment of community members, the creation of healthier environments, increased access to services, and increased focus on health by local governments. Eight of the 11 partnerships reported that PPH contributed to "resident empowerment." Key aspects of empowerment were increased ability to advocate for the community's needs and increased education. In the words of one respondent: "Our grass-roots community has become a pretty sophisticated . . . PPH contributed to that. We have become pretty powerful. We make stuff happen." Another respondent stated: "Improved knowledge of community members is an important legacy. This gives us power. We can advocate for ourselves."

Healthier neighborhood environments were reported by 10 of 11 PPH partnerships. These changes were often the result of advocacy work and sometimes involved organizational/infra-

structure changes and/or public policy change. We divided these changes in two topical areas, the first of which was safety, including neighborhood beautification and clean up, partnerships with law enforcement to decrease criminal activity, improvements to streets and crosswalks, and prevention of street crimes such as prostitution. The second topical area, healthy eating and active living, encompassed an increase in the availability of healthy food and the creation of parks and recreational facilities.

An increase in access to health-related services was another community legacy related to advocacy and policy change activities. These changes included opening community health clinics, providing dental services in underserved communities, increasing hours for mental health clinics, and providing mental health care in multiple languages.

"Improved knowledge of community members is an important legacy. This gives us power. We can advocate for ourselves."

Members of a number of partnerships stated that their local government officials — mostly at the city level — had an increased recognition of both the importance of addressing health issue through local policy and the impact that local policy can have on creating healthier communities. Through the knowledge and capacities developed during PPH, partnerships were able to demonstrate the ways that health is interwoven with other city government projects and activities and create opportunities for integrating a health perspective into local policy making. One respondent explained:

People are starting to tie in the issues in a much different way than I've ever seen. Even our city manager was saying the other day, "You know a couple of years ago at a conference somebody told me that I was go-

TABLE 4 Partnerships' Policy Activities — Example of Three Legacy Partnerships (Original and Legacy)

	Original description	Legacy description	Policy framework category	Sustainability code
Partnership 3: Policy activities				
1)	Developed a policy statement that promotes community collaboration in all decision-making about future development; statement was approved by the Board of Development and applies to all agencies that serve the county.	Policy has been institutionalized. The county transportation agency has adopted a formal policy that all community groups must be consulted for input on any new development project; additionally, the partnership has a clear role articulated in the city's 30-year general plan for economic development.	Public policy change	4
2)	Health department developed a new basic health care program to cover residents.	Policy sustained	Organization/ infrastructure change	3
Partnership 4: Policy activities				
1)	Continued development of relationship with the state assembly member's field deputy.	The new field deputy is now a member of the community group.	Advocacy	4
2)	Tracked and responded to social and environmental issues related to nearby airport layoffs due to 9/11. As a result, the airport developed a "Good Neighbor Policy" to address noise pollution issues. The airport agreed to work with the community group to implement the modernization plan.	Policies and plan in place. Now working on getting residents training and access to airport jobs. Trying to make sure residents are at the front of the line.	Organization/ infrastructure change	3
3)	Formed a garbage disposal district, which resulted in improved solid waste disposal.	Completed and sustained. Used as a model for other communities.	Public policy change	3
4)	Improved lighting on central thoroughfare.	Completed and sustained	Organization/ infrastructure change	3
5)	Developed a policy requiring the partnership to conduct all business in both English and Spanish.	Practice continues	Organization/ infrastructure change	3
6)	Organized the community to successfully advocate against the closure of a rehabilitation services and fitness center at a local hospital.	Through further advocacy the fitness center became part of the YMCA	Advocacy	3

TABLE 4 continued

	Original description	Legacy description	Policy framework category	Sustainability code
Partnership 6: Policy activities				
1)	Developed AB911 and the Emergency Services Act to address the lack of a secure ambulance service. Then, in partnership with the local hospital and hospital association, they lobbied for access to a county set-aside rider that would bring in funding.	AB911 did not pass. They are still working with the ambulance providers to get additional funding.	Advocacy	2
2)	Successfully passed a county measure to ban the growth of genetically modified organisms (County Measure H passed in March 2004).	County ban is still in place.	Public policy change	3
3)	Passed a tobacco ordinance that requires all vendors to be licensed to sell tobacco products. The ordinance also states that the license could be revoked for selling to minors.	Ordinance is enforced: If you are underage and you buy tobacco from a store and are caught with it, the store will lose its license to sell tobacco. This was one of the first cities with such an ordinance in place.	Public policy change	3

Note. Lists all activities for each partnership that were included in the analysis; activities from the original evaluation for which there were insufficient data to analyze were excluded.

ing to have to worry about obesity as a city manager and I went ‘ugh . . . I can’t control what people do.’” And now it has clicked for him how what the city does, does have an impact.

Challenges

Policy work — though having a potential for long-term, sustainable change — came with a number of challenges for the PPH partnerships. Policy-related challenges identified by respondents included building and maintaining trust in collaborative relationships and the steep learning curve for health departments to do community-based work. Another challenge for some health departments was navigating the local political environment and determining what role public health professionals could play in advocacy and policy work. Community partners also required significant training in advocacy skills. During the PPH Initiative, the

policy and systems change goal area was the slowest to develop and the area with the least activities. This appeared to be due to partnerships needing to develop both the capacity and relationships necessary to undertake policy change work.

To illustrate the types of advocacy capacity it is possible to build in these types of partnerships, Table 5 contains a case study from one of the PPH partnerships that made notable progress in the area of policy change.

Discussion

Limitations

All the data from this evaluation were obtained via self report. Self-reported data are known to contain bias of various kinds, including positive response bias, differences in recall, and interactions between the program and the individual.

TABLE 5 Descriptive Case Study**South Bay Partnership: Building capacities in advocacy and policy change**

Formed in 1997, the South Bay Partnership (SBP) was originally created as a regional response to substance abuse and violence in San Diego, CA. As a result of several funding opportunities, including Partnership for the Public's Health (PPH), the partnership found it needed to shift its approach away from traditional service provision toward a community advocacy model. PPH allowed SBP to intensify its community mobilization work and legitimized the group in the eyes of the community members with whom it worked. Key to this was what the SBP director calls a "people's victory" that resulted from advocacy targeted at agency practice.

For SBP, that victory was mandating simultaneous Spanish translations of city council meetings in National City and Chula Vista to allow for broader community participation that better reflected the ethnic and cultural makeup of the community. At the time of the legacy evaluation, this policy had been sustained. All city council meetings in National City had simultaneous translation available, whereas in Chula Vista the service was available upon prior request. Another important mobilization effort was aimed at preventing a smoke shop from opening between a teen recovery center and a popular ice cream parlor. The smoke shop did not open in that location. SBP leadership attributed the prevention of the smoke shop's opening to the partnership's greater capacity to move their priorities forward and successfully advocate.

SBP's advocacy also targeted broader policy goals to improve the overall quality of life in the community. In doing so, SBP came to be viewed by community members, policy makers, and government officials as the "go-to" group for health policy advocacy. As a result, they were invited to participate in the development of a General Plan for land use and planning, allowing SBP to have a voice in land use and transportation decisions that contributed to the overall health and safety of the community. Specific policies that resulted from adoption of the General Plan included (1) encouraging the development of parks, open space, and pedestrian walkways for physical activity; (2) providing adequate lighting for streets, park, recreation facilities, sidewalks and bike paths; and (3) promoting access to healthy foods through opportunities such as farmers' markets. SBP's advocacy work with the city of Chula Vista also contributed to a number of other organizational and public policy changes, including accommodations for breastfeeding mothers working in city facilities, the creation of a new park, the revitalization of several other parks in the city, and a 100 percent healthy food policy for all city-owned vending machines. The SBP partnership illustrates the great potential for health advocacy that is possible when partnerships are provided with the time and resources to build their advocacy capacity and learn to engage the community in policy change work.

Additionally, there have been a number of initiatives implemented in California that involved a strong community focus for public health and/or took a population health approach toward addressing chronic disease and health equity; therefore, it is difficult to isolate and differentiate the results of PPH from other funding initiatives. The sampling strategy we used to identify partnerships for inclusion in the legacy sample also introduced bias; findings from this group of partnerships can not be generalized to all PPH partnerships or other community studies involving partnerships. Despite this limitation, our evaluation provides valuable insights regarding the possibilities for promoting health advocacy through community-based partnerships.

Finally, the data on sustainability only apply to activities that either occurred or were started

during PPH funding. They do not include new policy work that developed after PPH but was a result of the capacities built during the initiative. Therefore, a partnership may have advocated for only one policy issue during PPH and then addressed several additional policies issues after the conclusion of the initiative. The new issues would not have been reflected in our sustainability data. The result is that this particular analysis may under-represent the full legacy of the PPH policy work.

Conclusions

The findings from this legacy evaluation suggest that the majority of work started during the PPH Initiative continued three years after funding ended for the 11 partnerships included in the legacy evaluation. When analyzed in relationship to the initiative goal areas, policy change had the

fewest number of reported activities. However, policy change activities were more likely to be sustained than were activities in other goal areas. Sustainability across all five goal areas appeared to be positively associated with having a lower number of activities.

Focusing on the policy change goal, we found that the majority of activities were in the areas of advocacy or organizational/infrastructure change. The fact that advocacy activities were the most numerous is not surprising, because most, if not all, policy work would logically begin with the types of activities included in our definition of *advocacy* (defining the issue, research, engaging stakeholders, training stakeholders to advocate). That there were a similar number of organizational/infrastructure changes is more notable, indicating that many partnership reported that their advocacy had resulted in tangible changes that could be sustained over time. Many of these changes were made in health departments to support a community-based approach to health improvement, including policy change. Much has been written about the resources and momentum required to restructure these organization in ways that increase community engagement and focus on the social determinants of health rather than on traditional public health (Beyers et al., 2008; Hofrichter, 2006; Prentice & Flores, 2007; Satcher & Higginbotham, 2008), suggesting that organizational/infrastructure change can have important impacts on community health. Likewise, the creation of new parks and improved lighting on streets has a tangible and lasting effect on communities.

One-fifth of the accomplishments were considered public policy changes. It is unclear whether this figure is high or low given the time frame of the initiative and the resources the partnerships were able to invest in their policy work. However, considering that PPH funding was provided for only four years (one planning year and three years for implementation) and that each community had a unique set of policy issues, the ability to achieve any public policy change within that time frame appears promising. Furthermore, during the three years that partnerships had for imple-

mentation of their plans, they were required to work on all five goal areas so that their attention and resources were split among many priorities.

Although there were many positive accomplishments in the policy area during PPH, it was clear from discussions with partnership members that they struggled with policy work. In contrast to the other goal areas outlined in the PPH Initiative, policy work usually started last and progressed at the slowest pace. The challenges often were associated with lack of effective models, lack of precision about program goals, and lack of experience with advocacy and policy change. At the same time, it was apparent that the required focus on policy by the PPH Initiative resulted in a greater understanding of the value and utility of policy as an effective strategy in community health improvement.

Focusing on the policy change goal, we found that the majority of activities were in the areas of advocacy or organizational/infrastructure change.

Based on the findings presented in this article and our experience in working with the PPH partnership over an extended time frame, we offer three key lessons:

Partnerships are effective vehicles for promoting policy change. Bringing together the health department and the community group to work together allowed each of the partners to contribute a unique set of resources and capacities. The result was that health departments were able to engage communities in public health issues and to learn to respect and value the local knowledge that community leaders can bring to public health. Community groups, on the other hand, received access to data, knowledge, political connections, and training resources that enhanced their ability to advocate for changes

designed to improve the health of their communities.

Developing the capacity to work on policy change takes time. Partnering around policy change requires the development of a new set of skills for both health departments and communities. Health departments must learn to work collaboratively and to respect the local knowledge and insights that community members bring to the table. Community groups often need to start from scratch when it comes to advocacy, learning what policy is, how it is made, and how to speak to policymakers. Also, the partnership needs time to develop a stable relationship and gain experience working together.

The creation of new parks and improved lighting on streets has a tangible and lasting effect on communities.

Policy work has the potential to result in sustained changes that have broad impacts on health. Because policy changes generally affect the environments in which we operate on a day-to-day basis, they are powerful vehicles for change. Furthermore, once in place, these types of changes are usually sustained through institutional mechanisms and do not require outside funding. In PPH, we saw that more than half of the policy activities were considered organizational/infrastructure changes and public policy changes. These were changes such as new street lights, the creation of a garbage collection district, and tobacco ordinances that will have long-term, widespread effects on the community.

In these days of the epidemic spread of chronic diseases such as Type 2 diabetes, asthma, and heart disease, it is imperative that we move beyond trying to change the behaviors of individuals. We also need to change the environments that encourage and perpetuate unhealthy behaviors. In other

words, we need policy changes that will reshape our communities into healthier places to live. PPH provided unique insights into the potential benefits and challenges of funding partnerships between health departments and communities and building the advocacy capacities of these partnerships. The initiative also highlighted the potential for using these types of partnerships to develop grass-roots advocacy for health. We hope that these findings can provide a comparison point for evaluating other community-based health advocacy work and that the examples presented in this article can help inform future funding initiatives, offer models to emulate and adapt, and inform the development of best practices.

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