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From deficit to action: rebuilding policy and advocacy capacity in the public health workforce

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Abstract

Federal health policy protections and health-related funding are being eroded, yet policy windows exist at every governmental level to improve the public's health. To strengthen health policies, restore lost funding, and maximize emerging policy windows, the public health workforce must be prepared to advocate for policy and systems change. Evidence suggests that the public health workforce is ill-prepared to do so. In this article, we introduce 3 compelling indicators from the National Board of Public Health Examiners that further illustrate a lack of workforce policy and advocacy expertise, including poor domain scores on a national certification exam, a dearth of related continuing education submissions and offerings, and low self-reported rankings for policy and advocacy-related job tasks. We then offer 6 approaches to improving workforce policy and advocacy expertise. Addressing this problem is key to rebuilding our public health infrastructure, reducing health care inequities, and improving health outcomes.

Key words: health policy; policy advocacy; National Board of Public Health Examiners; CPH; NBPHE; public health workforce; training; health professional education.

Key Points

- The public health workforce must be prepared to advocate for policy and systems change. Evidence shows that public health professionals are not "advocacy-ready".
- We introduce 3 compelling indicators from the National Board of Public Health Examiners that further illustrate a lack of workforce policy and advocacy expertise and preparation.
- We offer 6 approaches to improving workforce policy and advocacy expertise. Addressing this problem is key to rebuilding our public health infrastructure, reducing health care inequities, and improving health outcomes.

Introduction

Since the end of the COVID-19 pandemic, long-standing health policy protections and the broader safety net have been degraded, and confidence in public health systems is at an all-time low.[1] More recent federal policies, with stated goals of increasing governmental efficiency, have eliminated entire divisions and staff positions charged with improving the health of Americans;[2] cancelled scores of grants, halting important public health research;[3,4] replaced experienced public health leaders with political allies;[5] and spread disinformation about the effectiveness and safety of evidence-based interventions like vaccination.[6] Federal actions have also increased state costs, which may result in further cuts to safety net programs. Together, these policy developments have significantly weakened the public health infrastructure and will likely contribute to poorer health outcomes and stalled health equity progress in the coming years.

And yet, policy windows still exist to improve Americans' health. For example, 12 states have successfully received waivers from the US Department of Agriculture to eliminate sugary drinks or sweets from SNAP food packages. Studies suggest that these changes alone could significantly reduce obesity, dental caries, and type 2 diabetes incidence rates.[7,8] In addition, 26 states have enacted secure firearm storage or access prevention laws, which are associated with decreased firearm injury and death, proving that public health progress can be made in both politically blue and red states.[9,10]

Sound policy leads to better health outcomes

Sound public health policy has historically served as the bedrock of a healthy society. Key frameworks such as the World Health Organization's 12 Essential Public Health Functions and the Centers for Disease Control and Prevention (CDC)'s 10 Essential Public Health Services support this observation,

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with the latter citing Policy Development as 1 of 3 domains of an effective public health system.[11,12] The CDC framework suggests that public health practitioners should know how to, "create, champion, and implement policies, plans, and laws" as well as know how to "utilize legal and regulatory actions" to equitably improve the health of Americans. The ability to influence, enact, and implement effective health policy through advocacy efforts is so important to improving health that both the Council on Education for Public Health (CEPH), the accrediting body for public health higher education, and the Council on Linkages Between Academia and Public Health Practice (Council on Linkages), a national public health workforce improvement collaborative, have adopted policy and advocacy-related competencies.[13-15] As such, we use the terms policy advocacy, policy-change efforts, and public health advocacy in this article interchangeably.

The public health workforce may not be prepared to advocate for health policy improvements

Given that sound public policies are critically important to improving health outcomes, the public health workforce should be strongly equipped with the requisite knowledge and skills to advocate for the policy and systems changes that will rebuild public health and maximize current policy window opportunities.

However, existing literature suggests that the workforce is not "advocacy-ready". Despite the CEPH advocacy teaching requirement, Schneider et al.[16] found that public health advocacy curricula offered by accredited public health schools and programs may inadequately prepare students to participate in and/or lead policy advocacy efforts. Only 7% of reviewed course syllabi prioritized advocacy skill instruction and less than half included content and/or skills most often associated with policy-change advocacy efforts. Though a widely accepted definition of public health advocacy does not yet exist, the literature suggests that successful advocates strategically use distinct skill sets from the policymaking, coalition-building, policy communication, media advocacy, community organizing, lobbying, equity, and policy fundraising categories.[15-18]

A recent 50-state scan by the Public Health Law Network (PHLN) concluded that the public health workforce is skittish about policy advocacy and that practitioners have difficulty distinguishing between advocacy and lobbying, of which the latter may be discouraged and/or limited by local tradition and/or law.[19] Krasna analyzed public health job postings and found that policy and advocacy skills are rarely required by public health employers.[20] Moreover, 40% of public health department employees identified policy engagement as a training need in the 2024 Public Health Workforce Interests and Needs Survey (PH WINS), making this the second-highest training need nationwide.[21]

New indicators add further evidence of workforce policy and advocacy skill deficits

This article introduces 3 indicators of concern based on data from the National Board of Public Health Examiners (NBPHE). These new indicators further expose vulnerabilities in student and workforce policy advocacy preparation that must be addressed.

NBPHE administers the "Certified in Public Health" (CPH) credential and, since 2008, has certified over 10 000 public health professionals from more than 95 countries. Over 50% of CPH candidates are alumni of CEPH-accredited schools and programs of public health, and the remaining 50% tested through student or work experience criteria. CPH candidates self-report a wide variety of expertise, including epidemiology (18%), general public health (17%), health education (9%), public health practice (8%), and health policy (7%).

To obtain CPH credentials, professionals must sit for an exam that covers material from 10 public health domains (see Figure 1). Additionally, credentialed professionals must report at least 30 continuing education (CE) credits every 2 years to keep their certifications current. To date, CPH professionals have submitted more than 500 000 CE hours.

The CPH exam development process includes multiple layers of expert review and rigorous testing. Each year, trained volunteers draft new questions based on their area of expertise. These questions are subsequently reviewed by subject matter experts and re-evaluated before they can be included in a new test form. The NBPHE also conducts annual item analysis using unscored "beta" questions to assess difficulty, clarity, and discrimination—ensuring only high-performing questions are used for scoring. In addition, the NBPHE periodically performs bias analyses to identify questions that may disadvantage certain groups and takes corrective action to promote fairness.

Indicator #1—CPH exam policy and advocacy domain exam scores are the lowest

Of the 10 domains, CPH exam takers have fared worst in the Policy and Advocacy domain every year since 2019. Between 2019 and 2023, scores for the "Policy in Public Health" domain ranked lowest, with a mean percentage score of 63.95%, meaning that respondents correctly answered only 64% of exam questions related to this domain (see Figure 2). Policy-related domain scores have decreased by nearly 7% since 2019. In 2024, based on a job survey-guided domain refresh, "Policy in Public Health," along with other domains, was realigned, resulting in the new descriptor for this content, "Policy and Advocacy". In 2024, the "Policy and Advocacy" domain score remained the lowest, with CPH candidates answering 56.6% of domain questions correctly. This was consistent across all CPH candidates regardless of their achievement of a public health degree or years of professional experience.

Indicator #2—Policy and advocacy continuing education submissions are lacking

To remain Certified in Public Health, professionals must complete at least 30 CE credit hours every 2 years. Like many other occupational certifications, individuals can earn credits for teaching or taking online or in-person courses and workshops, attending conferences, writing or reviewing manuscripts, relevant volunteerism, and other activities. However, of the 172 850 activities submitted for recertification since the credential's inception, only 6.3% included the word "policy" or "advocacy" in the activity description.

It is unclear why so few CE activities submitted seemingly included policy or advocacy concepts. It is possible that CPH credentialed professionals are not interested in these activities or that CE activities may include policy or advocacy-related content without identifying those exact

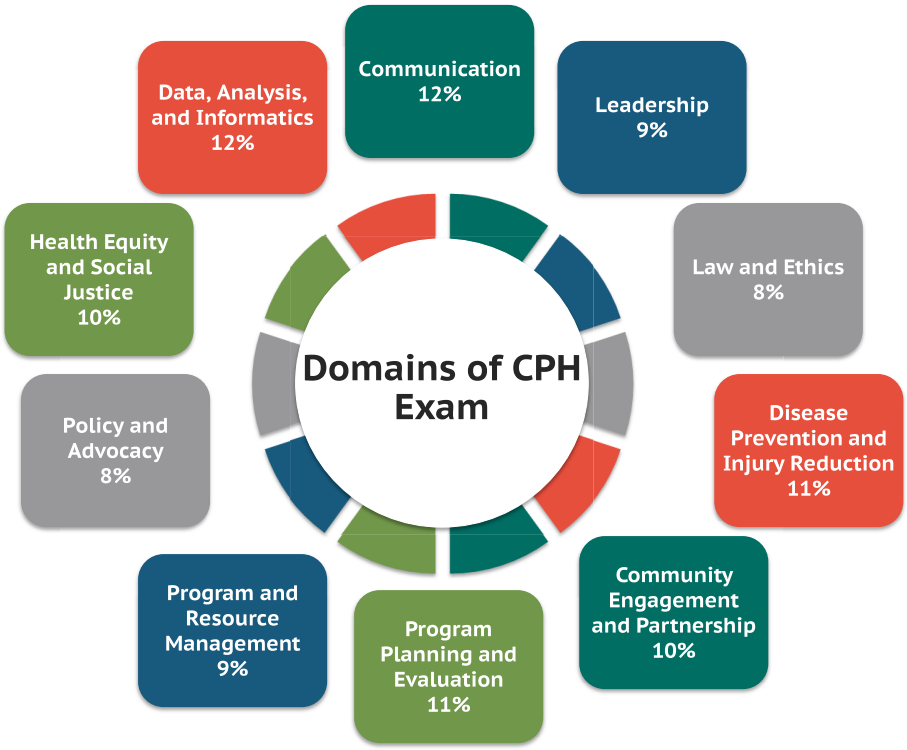

Figure 1. Domains of the CPH exam and percentage of exam questions. Source/Notes: SOURCE [National Board of Public Health Examiners, 2025].

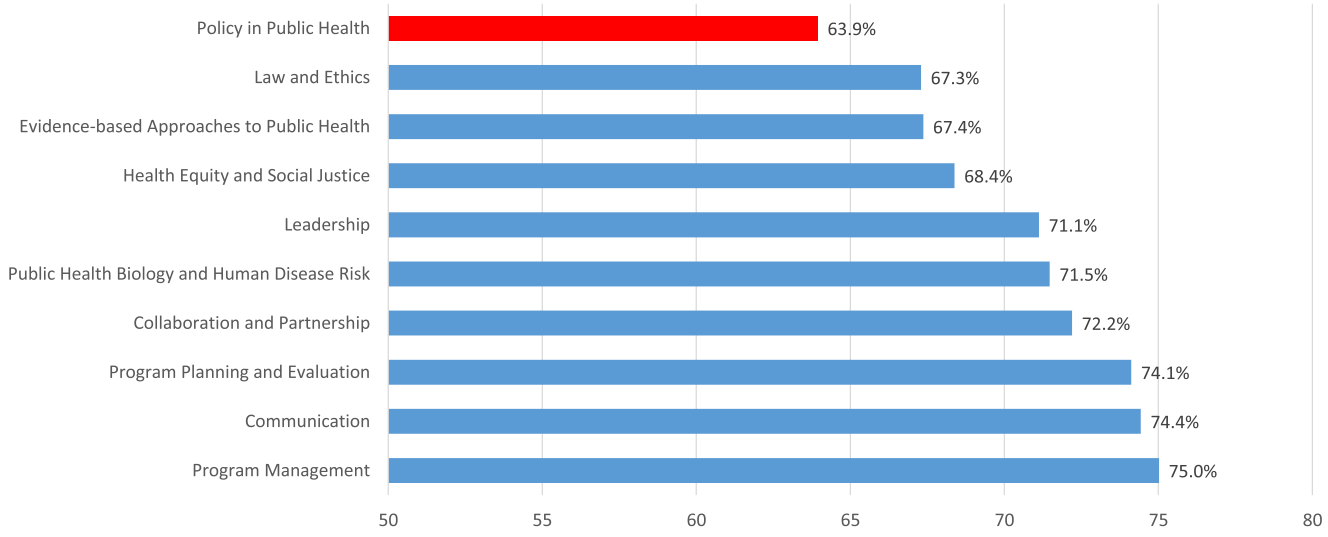

Figure 2. Mean CPH exam scores by domain (2019-2023). Source/Notes: SOURCE [Authors' analysis of data from NBPHE's CPH Certification Exam, 2019-2023].

words in the description. This variance may also be related to the lack of availability of policy and advocacy-related CE. For example, the CPH website recommends several CE resources, including the CPH Activity Finder, a filterable list of activities with information on providers, formats, credits and more.[22] As of September 2025, the CPH Finder included 399 overall records. Policy and advocacy activities are included under the overall topic "health policy and management." A search for activities using this topic yielded 19 results, comprising 4.8% of total activities included in the tool. Upon closer examination, only 5 results (1.3%) pertained to policy or advocacy. Another CE resource is the TRAIN Learning Network that lists over 5195 CE activities.[23] A TRAIN search using the subject "Policy/Planning" yielded 308 records. Of these, 127 activities or 2.4% of total offerings directly pertained to public health policy. Furthermore, 45 activities, or less than 1% of total offerings, directly addressed policy advocacy. These results may also be influenced by search timing, an inadequate search strategy, and/or search interface complexity. A more thorough investigation as to whether policy and advocacy

Table 1. Lowest 10 ranked job tasks for criticality and frequency.

Task	Domain	Combined score (Rank out of 103 tasks)
Identify the role of international health regulations in promoting and protecting public health	Law and Ethics	2.25 (103)
Implement a community health assessment and community health improvement plans	Program and Resource Management	2.35 (102)
Establish goals, timelines, funding, and partnerships for the implementation of policy initiatives	**Policy and Advocacy**	**2.47 (101)**
Analyze the feasibility and expected outcomes of policy options	**Policy and Advocacy**	**2.49 (100)**
Analyze political, social, and economic policies for their impact on health outcomes	**Policy and Advocacy**	**2.56 (99)**
Design policies and programs that ensure equitable distribution of health resources with attention to diversity, systemic racism, and discrimination	**Policy and Advocacy**	**2.57 (98)**
Use informatics principles and methods in the design and implementation of data systems	Data and Informatics	2.60 (97)
Navigate the governmental policy-making process	**Policy and Advocacy**	**2.62 (96)**
Identify risk and protective factors or unintentional and intentional injury	Disease Prevention and Injury Reduction	2.70 (95)
Develop a community health strategy and plan based on needs and resource assessments	Program Planning and Evaluation	2.73 (94)

Source/Notes: Authors' analysis of data from NBPHE's Job Task Analysis (2022). Policy and Advocacy domain job tasks are **bolded** for emphasis.

training opportunities are widely available and/or discoverable is warranted.

Indicator #3—NBPHE's job task analysis indicates that policy and advocacy job tasks are seen as least important and least often performed by public health professionals

To ensure the CPH exam questions accurately reflect current public health job tasks, the NBPHE routinely conducts job task analysis (JTA) surveys. Every 5-7 years, the JTA measures the criticality and frequency of tasks which are each assigned to 1 of 10 domains. JTA scores are categorized by employment type, job seniority, degrees earned, areas of job expertise, and sociodemographic variables. In 2022, NBPHE conducted a JTA, which yielded 2091 valid responses.[24] The respondents represented a wide variety of academic and professional backgrounds and considerable diversity in terms of citizenship, geographic location, race, ethnicity, and gender. Seventy percent of respondents reported graduating from a CEPH-accredited school or program and 39% reported having earned their CPH.

None of the 10 most critical or frequent job tasks, on average, fell within the Policy and Advocacy domain.[24] Further, most tasks that were rated low in both frequency and criticality were from the Policy and Advocacy domain. Accordingly, Policy and Advocacy ranked last in criticality and frequency overall in 2022 (see Table 1). Though the 2014 JTA domains differed, Kurz et al. reported that the Advocacy domain tasks ranked second-to-last in importance.[25]

Out of 103 tasks, policy and advocacy tasks integral to advancing social change, advocating for the health of communities, and analyzing policies scored near the bottom in terms of criticality and frequency.

Summary

Public health practitioners, who, by obtaining the CPH credential, illustrate their overall mastery of public health concepts and competencies, seemingly come into the CPH exam less prepared to engage in policy and advocacy activities compared to other areas. Only a fraction of the CE credits they later submitted for recertification are policy and/or advocacy-related. In addition, in a recent job task analysis, public health professionals from a range of academic and professional backgrounds ranked policy and advocacy-related tasks among the least critically important and least often performed.

We add the indicators above to several others found in the literature. It is increasingly clear that the field is not prioritizing policy and advocacy knowledge and skills development in formal academic public health training and subsequent workforce continuing education. It may be that policy and advocacy workforce training activities are limited and/or not widely available. Moreover, the PHLN report's conclusion that public health professionals are skittish about participating in or leading advocacy efforts is an observable result of our lack of attention to this growing field deficit.

Challenges remain but pathways for improvement exist

Improving public health outcomes and reducing health inequities require a skilled workforce with a thorough understanding of health policy and advocacy strategies to improve health. A new approach to equipping both the next generation of practitioners and more experienced workers with policy and advocacy knowledge and skills is sorely needed. We suggest the following 6 responses:

1. **Improve public health advocacy and policy instruction in accredited schools and programs of public health.** The Lerner Center for Public Health Advocacy at the Johns Hopkins Bloomberg School of Public Health (Lerner Center), along with several leading national partners including NBPHE, American Public Health Association (APHA), Association of Schools and Programs of Public Health (ASPPH), Association of State and Territorial Health Officers (ASTHO), CEPH, Council on Linkages, de Beaumont Foundation, Public Health Foundation (PHF), and the Society for Public Health Education (SOPHE) launched the Public Health Advocacy

Consensus Task Force (PH-ACT) in 2024. Led by a national advisory committee, PH-ACT is working to define public health advocacy, identify the essential advocacy skills that should be taught to public health students, and provide guidance to public health schools and programs on how to improve their advocacy instruction. This work is informed by consensus-building activities, including research, town halls, and focus groups. Additional information can be found on the PH-ACT website.[26]

2. **Embed health policy and public health advocacy into academic and student culture.** Lack of academic administrator and institutional support, as well as funding for policy change efforts, are frequently cited as barriers to effective teaching and course development, faculty participation in policy change work, and/or faculty research related to advocacy efforts.[19,27]

   Institutional rules regarding participation in health policy campaigns can be unclear, difficult to navigate, and/or highly discouraging to faculty who want to engage in these efforts. Tenure and promotion processes give more weight to research activity over practice-based work, including public health advocacy campaign involvement.[27,28] Moreover, departmental or institutional rapid funding to support policy advocacy research is often limited or non-existent. Public health school and program leaders could better prioritize public health advocacy efforts to ensure that public health faculty, students, and alumni are equipped with the skills they need to advocate for the public's health, irrespective of their professional role. Institutions should reform the tenure and promotion process to include incentives for participating in and/or researching policy advocacy efforts, provide faculty training and support to enhance their own advocacy knowledge and skillsets, and raise/distribute rapid funding for policy advocacy research projects. To maximize student mastery of policy advocacy skills, public health schools and programs should require that students pass a policy advocacy course and embed experiential policy advocacy activities into curricular content. For example, faculty could provide course credit for outside-of-class policy advocacy engagement, participate with students in advocacy trainings like SOPHE's Advocacy Summit that culminate in Congressional visits, and offer extracurricular activities like the Activist Labs run by 2 prominent schools.[29,30] Together, these steps could greatly improve public health advocacy instruction, add to the advocacy research base, and yield more advocacy-ready public health practitioners.
3. **Offer low-cost policy advocacy training, policy resources, technical assistance, and networking opportunities, and make them more widely available through trusted partners.** Given the elimination of many federal offices that previously provided policy and advocacy-related training, other community institutions must fill the gap. Several, including the Lerner Center, ASPPH, APHA, SOPHE, and others, offer annual or semi-regular policy advocacy workshops that often include a day of congressional visits. SOPHE, for example, has conducted its Advocacy Summit for more than 25 years. Yet, many of these training activities require registration, travel, and associated costs that are prohibitive for many, especially in the current economic climate. State and local public health associations should consider providing regional, lower-cost trainings and opportunities for public health professionals to practice their new policy advocacy skills. In addition, many non-public health-focused advocacy training organizations (eg, Midwest Academy, Highlander Center, Training for Change, etc.) could be good sources for further skill development.
4. **List health policy and advocacy trainings through trusted directories.** An informal analysis showed that existing public health training directories include relatively few policy and/or advocacy-related trainings. Trusted entities should market and disseminate policy-related activities in TRAIN, CPH Finder, and other prominent national training directories.
5. **Prioritize policy and advocacy-related training for state and local health department employees.** State and local health department employees often have a strong civic presence and a connection to local policymakers that others in the field may lack. They can advocate and be important drivers of policy change if given sufficient support, even if local laws or customs prevent them from lobbying. Lobbying is just one important component of public health advocacy, though the 2 terms are often conflated.[16,19] As PHLN suggests, public health workers are unsure how to navigate the rules of advocacy-related engagement.[19] There are many examples, however, of local health departments whose employees have successfully engaged in policy advocacy efforts in collaboration with community partners.[31]

   Trusted training entities should work with public employee groups like ASTHO and the National Association of County and City Health Officials to offer low-cost, accessible, policy advocacy training to this essential sector of the public health workforce.
6. **Personally engage in policy advocacy efforts at the federal, state, and local levels.** Public health professionals must personally engage in public health advocacy efforts to build a reimagined and more effective public health system. At a minimum, we must:
   - reconnect with our personal passion for public health;
   - use our expertise to further engage in debate and discussions in the public sphere using all available tools of influence, including social media;
   - better communicate how sound public health policies and public health funding directly matter to families and communities;
   - identify and partner with effective community organizations to advance sound policy;
   - consistently counter disinformation when it arises; and
   - connect with policymakers to offer our viewpoints and become trusted resources through constructive relationship building and information sharing.

By heeding the indicators and changing our approach, we can reimagine, reinvent, and rebuild public health to enact better health policy, improve public health outcomes, and eliminate inequities. By doing so, we may also make inroads towards re-establishing trust in the public health system.

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Supplementary material

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Conflicts of interest

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Notes

1. Kearney A, Sparks G, Hamel L, Montalvo J, Valdes I, Kirzinger A. KFF tracking poll on health information and trust: January 2025. San Francisco (CA). KFF. Updated January 28, 2025. Accessed September 13, 2025. https://www.kff.org/health-information-trust/kff-tracking-poll-on-health-information-and-trust-january-2025/
2. Assistant Secretary for Public Affairs (ASPA). Fact sheet: HHS' transformation to make America healthy again. U.S. Department of Health and Human Services. Updated April 2, 2025. Accessed September 13, 2025. https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html
3. Hwang I, Huang J, Anthes E, Migliozzi B, Mueller B. The disappearing funds for chronic diseases, global health, vaccine research. *New York Times*. Updated June 4, 2025. Accessed September 13, 2025. https://www.nytimes.com/interactive/2025/06/04/health/trump-cuts-nih-grants-research.html
4. Rabin R, Hwang I. Trump Administration scraps research into health disparities. *New York Times*. Updated August 13, 2025. Accessed September 13, 2025. https://www.nytimes.com/2025/08/13/health/nih-grant-cancellations-dei.html
5. Kanno-Youngs Z, Haberman M. How the Trump-Kennedy alliance is pushing the boundaries of public health. *New York Times*. Updated August 29, 2025. Accessed September 13, 2025. https://www.nytimes.com/2025/08/29/us/politics/trump-kennedy-alliance-vaccines.html
6. Hughes R, Rosenbaum S. Vaccine policy in crisis: Secretary Kennedy dismisses entire advisory committee on immunization practices. Health Affairs Forefront. Updated June 11, 2025. Accessed September 13, 2025. https://www.healthaffairs.org/content/forefront/vaccine-policy-crisis-secretary-kennedy-dismisses-entire-advisory-committee
7. Basu S, Seligman HK, Gardner C, Bhattacharya J. Ending SNAP subsidies for sugar-sweetened beverages could reduce obesity and type 2 diabetes. *Health Aff (Millwood)*. 2014;33(6):1032-1039. https://doi.org/10.1377/hlthaff.2013.1246
8. Choi SE, Wright DR, Bleich SN. Impact of restricting sugar-sweetened beverages from the supplemental nutrition assistance program on children's health. *Am J Prev Med*. 2021;60(2):276-284. https://doi.org/10.1016/j.amepre.2020.08.023
9. KFF. States with firearm laws designed to protect children. San Francisco (CA). 2025. Accessed September 13, 2025. https://www.kff.org/state-health-policy-data/state-indicator/firearms-and-children-legislation
10. Lee LK, Fleegler EW, Goyal MK, et al. Firearm-related injuries and deaths in children and youth: injury prevention and harm reduction. *Pediatrics*. 2022;150(6):e2022060070. https://doi.org/10.1542/peds.2022-060070
11. World Health Organization. Application of the essential public health functions: an integrated and comprehensive approach to public health. Geneva: World Health Organization. 2024. Accessed September 13, 2025. https://iris.who.int/bitstream/handle/10665/375864/9789240088306-eng.pdf?sequence=1
12. Centers for Disease Control and Prevention. 10 essential public health services. CDC Public Health Professionals Gateway. Updated 2020. Accessed September 13, 2025. https://www.cdc.gov/public-health-gateway/php/about/index.html#cdc_program_profile_program_impact-10-essential-public-health-services-revised-2020
13. Council on Education for Public Health. MPH foundational competencies. Washington (DC): Council on Education for Public Health. 2016. Accessed September 13, 2025. https://media.ceph.org/documents/D2_guidance.pdf
14. Council on Linkages Between Academic and Public Health Practice. Core competencies for public health professionals. Washington (DC): Council on Linkages Between Academic and Public Health Practice. Updated 2021. Accessed September 13, 2025. http://www.phf.org/corecompetencies
15. Hearne S, Jernigan DH. Who will advocate to keep the public healthy? Establishing competency-based advocacy training for the public health field. *J Public Health Manag Pract*. 2024;30(1):3. https://doi.org/10.1097/PHH.0000000000001839
16. Schneider GE, DiOrio A, Asada Y, Hearne SA. Charting the advocacy landscape: a qualitative content analysis of syllabi in public health graduate education. *J Public Health Manag Pract*. 2024;30(3):325-335. https://doi.org/10.1097/PHH.0000000000001889
17. Hines A, Jernigan DH. Developing a comprehensive curriculum for public health advocacy. *Health Promot Pract*. 2012;13(6):733-737. https://doi.org/10.1177/1524839912457682
18. Cohen BE, Marshall SG. Does public health advocacy seek to redress health inequities? A scoping review. *Health Soc Care Community*. 2017;25(2):309-328. https://doi.org/10.1111/hsc.12320
19. Dang Q, Kappagoda M, Waugh E, Zellers L. The state of state-level public health advocacy: Findings and implications from a 50-state scan. Edina (MN): The Network for Public Health Law. Updated October 2023. Accessed September 13, 2025. https://www.networkforphl.org/wp-content/uploads/2023/10/PH-Advocacy-Scan-Summary-Final-October-2023.pdf
20. Krasna H. Employer demand and desired skills for public health graduates: evidence from job postings. *Am J Public Health*. 2024;114(12):1388-1393. https://doi.org/10.2105/AJPH.2024.307834
21. Hearne S, Schneider GE. From skittish to skilled: policy engagement needs to be our superpower. *J Public Health Manag Pract*. 2026;32(1S):S7-S9. https://doi.org/10.1097/PHH.0000000000002288
22. National Board of Public Health Examiners. CPH Activity Finder. Arlington (VA): National Board of Public Health Examiners. n.d. Accessed September 13, 2025. https://nbphe.connect.prolydian.com/ce-activity-finder
23. Public Health Foundation TRAIN. TRAIN Learning Network. Washington (DC): Public Health Foundation TRAIN. n.d. Accessed September 13, 2025. https://www.train.org/main/welcome
24. Kurz RS, Foster A, Bowen LM, Bender K. Perceptions of criticality and frequency of tasks by the public health workforce, 2022. *J Public Health Manag Pract*. 2025;31(2):E126-E133. https://doi.org/10.1097/PHH.0000000000002068
25. Kurz RS, Yager C, Yager JD, Foster A, Breidenbach DH, Irwin Z. Advancing the certified in public health examination: a job task analysis. *Public Health Rep*. 2017;132(4):518-523. https://doi.org/10.1177/0033354917710015
26. Lerner Center for Public Health Advocacy. Public Health Advocacy Consensus Task Force (PH-ACT). Baltimore (MD): Johns Hopkins Bloomberg School of Public Health. n.d. Accessed September 13, 2025. https://publichealth.jhu.edu/lerner-center/public-health-advocacy-consensus-task-force-ph-act
27. Carter A, Dorfman L, Iton T, Snyder H. Public health advocacy must be taught. Health Aff Forefront. Updated February 7, 2022. Accessed September 13, 2025. https://www.healthaffairs.org/content/forefront/public-health-advocacy-must-taught
28. Israel BA, Coombe CM, Cheezum RR, et al. Community-based participatory research: a capacity-building approach for policy advocacy aimed at eliminating health disparities. *Am J Public Health*. 2010;100(11):2094-2102. https://doi.org/10.2105/AJPH.2009.170506

29. Boston University School of Public Health. Activist Lab | SPH. Boston (MA): Boston University School of Public Health. n.d. Accessed September 13, 2025. https://www.bu.edu/sph/practice/activist-lab/
30. University of South Florida College of Public Health. Activist Lab. Tampa (FL): University of South Florida College of Public Health. n.d. Accessed September 13, 2025. https://health.usf.edu/publichealth/activist-lab/overview
31. Freudenberg N, Franzosa E, Chisholm J, Libman K. New approaches for moving upstream: how state and local health departments can transform practice to reduce health inequalities. *Health Educ Behav*. 2015;42(1 Suppl):46S-56S. https://doi.org/10.1177/1090198114568304