Marilyn Wise

The role of advocacy in promoting health

The social determinants of health are now well established (Marmot, 1999; Keating and Hertzman, 1999; Antonovsky, 1996). Individuals' and communities' decisions in relation to health are shaped by and responsive to the environments (social, economic, and physical) and circumstances in which the decisions are being made (Macintyre and Ellaway, 1999; Hawe, 1998; Westphal, Arroyo and Castro-Albarran, 2000). The stories outlined in the publication *Voices of the Poor* (World Bank, 2000) highlight, graphically, the multiple and interacting ways in which poverty limits individuals' and communities' life chances and health choices. It is of major concern therefore, as we enter the 21st century, that health promotion is able to contribute, actively, to action that addresses these social determinants – at global, national and local levels. The demands are great and the stakes are high. It means engaging in the processes of policy-making and implementation across a range of sectors, working more deliberately to influence broad social and economic policy with the intention of creating conditions for health.

One of the first issues this raises for health promotion is to understand why and how to contribute actively to the policy decisions that influence environments, social norms, and behaviours. To date, health promotion has contributed very actively in many countries to policies that govern access to alcohol by young people, the right to own a gun (or not), the right to drive, tobacco advertising or the sentencing of young offenders. These are, on the whole, recognised as health promotion or public health issues. It is expected that health promotion researchers, practitioners and administrators be engaged in efforts to influence such policies.

However, the social determinants of health mean it is becoming equally important to engage in broader social and economic policy development and implementation. Here the legitimacy of the role of health promotion is much less well established and the challenges are greater. Nonetheless, if it is to be possible to reduce unfair inequalities in health it is vital that we engage in the processes that determine the goals of such policies and the strategies they recommend. Strengthening advocacy for social and economic policy that promotes the health and well-being of populations, and that ensures a sustainable environment are major challenges for health promotion as we enter the 21st century.

Why is this important to contemporary health promotion?

If we accept that physical, economic and social environments determine peoples' access to healthy choices and that these environments are created by decisions made by individuals, organisations and governments, then it is essential that people concerned to promote the health and well-being of populations and individuals be engaged in making these decisions – either directly, as participants "at the table" or indirectly, by providing information, and building constituencies (in communities and organisations) to support preferred courses of action.

This requires health promotion leaders, practitioners and researchers to develop the tools and skills necessary to ensure our active participation in or contribution to the decisions that, ultimately, create social, economic and environmental conditions for health.

Chapman and Lupton (1994) identified barriers to achieving public health goals:

- political philosophies that devalue health and quality of life at the expense of economic outcomes;
- political and bureaucratic opposition or inertia to health promoting regulatory provisions and policies, and to the participation of consumers in planning for health;
- the marketing of unsafe and unhealthy products, increasingly by transnational corporations of immense political power and wealth;
- the pervasiveness of cultural values such as racism and sexism, which find expression in institutional values and personal attitudes and behaviours relevant to public health issues.

Plainly such barriers can be overcome only by engaging in the processes used by our own organisations and governments to set goals and to make and implement policies and programmes. It means employing the processes and mechanisms that are used to influence and create policy in our societies and in organisations across all sectors.

What is advocacy?

Advocacy is an act of pleading for, supporting, or recommending a course of action (The Macquarie Dictionary, 1981). Westphal, et al, (2000) pointed out that the term requires a semantic reconsideration for the Iberian-American and use the following definition: *To advocate means to defend, speak in favour of someone or something, sustain a cause against outside interests, defend an idea. An advocate is someone who performs activities or negotiations aiming to achieve something for someone, to exert the power of doing something on behalf of someone, groups, communities, or society as a whole* (Chapela, 1994).

Kaufer (2000) defined advocacy as *the application of information and resources (including finances, effort, and votes) to*

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effect systemic changes that shape the way people in a community live, and public health advocacy is advocacy that is intended to reduce death or disability in groups of people.

As a health promotion strategy, advocacy is a process for bringing about change in society. It is a process to overcome structural (as opposed to individual or behavioural) barriers to achieving public health goals (Chapman and Lupton, 1994). Public health advocacy employs the methods of political advocates to bring about changes in the systems that influence the health and well-being of populations. It aims to change the legislative, fiscal, physical and social environments in which individuals' knowledge and attitudes are developed and expressed, and in which behaviour changes take place (Chapman and Lupton, 1994). But in itself, public health advocacy is, essentially, a political process that aims to influence political decisions about the distribution of society's resources.

How is advocacy different from public education or social marketing?

Some of the difference lies in the goals of public health advocacy, and those of public health education or social marketing. In addition, the methods used by advocates are different than those used by educators or social marketing campaigns, although the media through which much public health advocacy occurs are used to achieve the goals of all three strategies.

Wallack provided a very clear explanation of the difference between media advocacy and a social marketing campaign. He points out that traditional forms of mass media intervention in health promotion (often, paid advertising campaigns), *emphasise the "information gap", which suggests that health problems are caused by lack of information on the part of individuals with the problem or at risk.*

Public education campaigns are then designed to fill the information gap. Here the problem is presented as an individual's problem, and the solution is for individuals to take action (on their own). Wallack (1998), commenting about a public education campaign against illicit drug taking in the U.S., said: *The partnership ads insist that the drug problem is your problem, not the government's. The ads never question budget allocations or the administration's emphasis on [law] enforcement over treatment... If there are mitigating reasons for drug use - poverty, family turmoil, self-medication, curiosity - you'd never know from these ads. The partnership ads laud volunteerism, self-discipline and individualism, precisely the values that resonate with the American people. And the partnership strategies meet with little resistance because they are consistent with a victim-blaming orientation toward public health.*

He suggests that media advocacy, on the other hand, focuses on the "power gap" where health problems are viewed as a lack of power to define the problem and create social change. The target of media advocacy is to close the power gap by attempting to motivate broad social and political involvement rather than changes in personal health behaviour.

However, it is not inherently the case that media advocacy aims to reduce the power gap. That is, it would be entirely possible to imagine media advocacy being used to propose or justify such a public education campaign and the actions it recommends. However, McKinlay and Marceau (2000) suggest that a public health advocate is much more likely to use a sociopolitical rather than a biomedical paradigm to guide analysis of problems, and their determinants. It is also much more likely that a public health advocate will identify solutions that focus on political, legislative and social action rather than on individual behaviour change. However, although it is more likely, it is not an absolute given.

What are the components of an effective public health advocacy campaign?

As is true of so much health promotion work, public health advocacy is neither the domain of a single person, nor, even a single organisation - important though it is to have high profile leaders or champions engaged in the advocacy work. Rather, multiple actions are required by multiple people and organisations if public health advocacy is to succeed.

An effective public health advocacy campaign requires:

• **Information** about public health problems and their causes or determinants, and about effective solutions or responses. It is important that any course of action being advocated has a high probability of achieving its intended outcomes. It is also important that the intended outcomes are clearly identified.

However, it also requires extensive information about key organisations or groups or individuals that have a stake in the issue. It is such information that can be used to build alliances, that can help to frame counter (or supporting) arguments, and that can help develop policy that is more likely to be effective.

Finally, information is needed about policy-development and implementation processes. There are formal frameworks that are used by political science and in policy studies, but it is not yet clear that health promotion practitioners and researchers are working with these overtly.

• **Health professionals** are important in establishing an agenda, or in proposing courses of action. Health professionals often have high levels of credibility among the public, the media and politicians - credible sources of information (McGuire, 2001).

• **Skilled professionals** and administrators working within the health sector (and other sectors) to influence the processes and methods used by organisations to make decisions regarding goals, priorities, resource allocation, and staffing, for example.

Bureaucrats play crucial roles in translating the agenda of public health into the language and thinking of the government of the day. Traditionally, the centrality of this role has been neglected. Yet as history shows, using rhetoric and language that engage vital actors and legitimate particular actions is essential to successful policy implementation (Hawe, Wise and Nutbeam, 2001).

• **Partnerships or coalitions** with key stakeholders. These might be individuals or organisations. They might be among government sectors; they might be

between government and the private sector. Such partnerships are critical to the success of health promotion, in particular, because most of the decisions affecting the health of individuals and communities are made by and in sectors other than health.

• **Champions or leaders** to draw public and political attention to the issue and proposed solutions. These people must be particularly skilled at working with the mass media, but ideally, they must have skills in negotiating directly with multiple stakeholders, including politicians, community and business leaders and individuals.

• **Community educators and organisers** to build widespread, community support for action to address an issue, for generating solutions, and for then supporting proposed changes in policy or programming or resource allocation. The Internet has contributed enormously to the capacity of many individuals to participate in action to influence the decisions of government or business or community agencies. But it is only one of the many different ways in which communities network within and beyond countries (Wellman, 1999).

•**Journalists** to engage community attention, to initiate and encourage debate about both the problem and suggested solutions. Building good relationships with journalists in a variety of media is important for effective public health advocates.

• **Lawyers and political analysts/ advisers** provide political and legal advice and expertise in drafting new legislation, regulations or policy, or in revising existing policy. Again, developing relationships is a key to ensuring successful outcomes.

• **Research,** including market research, to identify problems, test solutions, and to assess the "readiness" of communities to take action on a given public health issue and/or to adopt proposed solutions.

• **Evaluation** to assess the effects of different components of the activity and to measure impact and outcomes.

[This list is based on a model developed by Kaufer, 2000].

Effective public health advocacy, therefore, draws on the knowledge, skills and methods of a wide range of disciplines and occupations. At its most effective, a public health advocacy campaign includes each of the components listed, above. It is rare, however, for these to work systematically or in a predetermined sequence. The reality of working to bring about social change is that it is time consuming, messy and impossible for one person or organisation to control. It is also the case that bringing about policy change is, often, a long-term undertaking.

Does it work?

Governments (and organisations) tend to adopt policies only in a climate of public readiness, using the principle that governments (or organisations) should not move far from what is perceived to be public opinion (Carr-Gregg, 1993).

Experience shows over and over again that scientific evidence on its own is not sufficient to bring about changes in policies, programmes and services to ensure that they are conducive to health. A political decision to, say, add fluoride to the water supply, or to control the ownership of guns may depend only peripherally on the quality and consistency of the scientifically-derived evidence presented in its favour.

The task for public health advocates is fundamentally involved with efforts to shift public and political opinion towards the advocates' preferred position, to the point where the desired political action becomes compelling, and inaction a political liability (Chapman and Lupton, 1994).

The examples below have been drawn largely from Australian experience in the use of public health advocacy to achieve changes in policy and in the delivery of programmes or services by a wide range of public agencies and private and community organisations. It is not intended to imply, however, that all successful examples have been in Australia. Rather, the examples are intended to illustrate how advocacy has "worked" at local, state, and national levels to influence decisions in favour of the health and well-being of populations.

While the examples point to significant achievements, the issues have been relatively non-controversial. Advocacy has been necessary to achieve these changes but opposition was relatively limited. However, there are also examples of effective advocacy in relation to much more sensitive and controversial issues including, for example, changes in the laws relating to gun ownership, or in the laws relating to the distribution of needles or syringes for injecting drug users.

Sun protection

The gradual adoption of comprehensive, state-wide sun protection programmes for children (in particular) has been one example of the successful use of advocacy to complement programmes of community education (using social marketing) and community mobilisation. Evidence of the relationship between high rates of skin cancer and sun exposure (particularly at young ages) was used to develop a mass media advertising campaign (Slip, Slop, Slap) that ran from 1985-1995. The voluntary adoption of sun protective practices by individuals has been gradually supported by changes in policies across a range of sectors (e.g. education, local government, and the private sector), physical environments (e.g. shade in parks, schools, swimming pools), and industry practices (e.g. protective clothing, increased sun protection factor in sunscreen, reduced taxation on sunscreen products) – all the result of public health advocacy carried out by parents, public health professionals, dermatologists, unions, and many others.

A combination of direct political advocacy (lobbying), information-giving to the community (but particularly parents) and the creation of community demand (for sun protective products and environments) has resulted in significant changes in attitudes and behaviours in regard to sun protection, and some encouraging signs of reductions in the incidence of melanoma in people aged less than 65 years (Carter, Marks and Hill, 1999; National Health and Medical Research Council, 1996).

Road safety

In Australia the death rate from road traffic crashes declined from a peak of

30.4 per 100 000 people in 1970 to 11.1 per 100 000 in 1994. This decline was achieved despite the fact that the amount of road travel almost doubled over the same period (National Health and Medical Research Council, 1997).

The Royal Australasian College of Surgeons was one of the earliest groups to advocate for action to reduce road crashes in the 1970s, placing the issue firmly on the public and political agenda.

Over the subsequent two decades, advocacy by other professional groups (e.g. the Institute of Municipal Engineering), parents groups, the motor vehicle insurance industry, and families of victims of road deaths has resulted in significant changes to legislation, to enforcement, to road and motor vehicle design and engineering, and to the quality and focus of public education campaigns.

The success of action to improve road safety has been the combined effect of multiple strategies. Advocacy (using the mass media and direct political lobbying) has played a key role – alongside public education, community mobilisation and changes in health care services.

It is of concern to find that in the last two years, deaths from road traffic crashes have begun to increase – causing significant concern among politicians, community members and road safety professionals.

What does advocacy do?

It is possible to identify clear examples of the effectiveness of public health advocacy – measured by success in changes in laws, organisational policies, and in environments, particularly the physical environment.

• Sets the agenda
In the first instance, public health advocates create widespread visibility for an issue. The mass media are critical partners in this – alerting people to research that has identified potential or actual public health problems. The more coverage a topic receives in the media, the more likely it is to be a concern to the public and to opinion leaders. Media are also a vehicle for gaining access to politicians, legislators, community leaders and corporate executives.

• Shapes the debate
This is crucial for effective public health advocates. The issues here are to ensure that the problem is defined as social and environmental – and hence, that the solutions are also social and environmental change. It is here that there is often a clash of values – between people who accuse the "nanny state" of reducing personal choices and people who believe that it is necessary for the state to play a significant role (in addition to business and individual organisations) in shaping the conditions in which populations and individuals live and work.

The debate about illicit drug use in most countries is an example of the failure of public health advocacy to shape perceptions of the causes or determinants of the problem and hence, of potential solutions. Individuals almost exclusively frame the use of illicit drugs as one of "personal choice". It is almost never framed as a wider social or economic problem.

Shaping or framing the debate is a critical skill of effective public health advocates. Being able to counter opposing views, being able to provide alternative ways of understanding the causes of public health problems, and being able to develop partnerships with other potential beneficiaries are all critical to the success of public health advocacy.

•Advances policy
In addition to pointing out problems and their "causes" or determinants, and in addition to informing and shaping public debate about these, effective public health advocates must also have the ability to propose policy solutions. This means engaging in the political process – in the process of decision-making about the goals and intended outcomes of government or organisational policy, and in deciding on the allocation of resources to support these.

What are conditions for success?

Public health advocacy is more likely to be effective when based on:

• A recognised constituency
Most effective public health advocacy occurs when the advocate has the backing of a significant, credible, respected constituency. The public, politicians, and other organisations and sectors are more likely to be persuaded by the arguments of, for example, a Public Health Association or a National Heart Foundation, than those of an individual.

Such constituencies may be formed specifically to address the issue. In Australia the Coalition for Gun Control was able to draw together disparate groups to form a formidable constituency arguing for gun control, while several of the major non-government organisations continue to support a coalition to support action on smoking and health (ASH).

Public health advocacy contributes to:

• Building community agreement that an issue is a priority for action and that the proposed solutions are acceptable
The purpose of setting an agenda is to establish widespread community agreement that this is, indeed, an issue that merits significant government (or organisational) attention. The greater the level of community agreement that an issue should be addressed, the greater the likelihood that organisations and governments will act.

Conversely, where there is not widespread community agreement, it is difficult (or impossible) to implement new policies or changed programmes. The Domestic Relations Bill developed in Uganda to reform laws and regulations related to marriage met with such negative public reaction that it was likely that it would need to be withdrawn (Davies, 1999).

• Empowered communities
The likelihood of positive action being taken to address a public health problem is much greater when communities speak for themselves about problems and solutions. Effective public health advocacy is dependent upon the active engagement of the widest possible range of community members and organisations.

• A feasible solution
While it would be useful if there was always incontrovertible evidence that proposed solutions to public health problems are likely to have the desired outcomes, this is rarely available. The notion of "what constitutes evidence" is,

itself, contested (Nutbeam, 1999; Chapman, 1993); while in a democracy particularly, the perspectives and interests of many different groups must be balanced (Gaughwin, 1998; Lupton, 1998; Chapman, 1998). A feasible solution is not necessarily based only on, for example, epidemiological evidence. Rather, it is likely to be negotiated on the basis of many the many different types of "evidence" used by politicians, and managers when making policy decisions.

Mechanisms and methods used by public health advocates

Mass media, in most cultures, are unparalleled vehicles for setting public and political agendas. In our society, public media are irreplaceable as a mechanism for moving a problem to a solution (Otten, 1992).

It is, indeed, the case that mass media are critical to the effectiveness of public health advocates. The power of "talk back radio" in particular, to engage in debate with communities about problems and solutions, to solicit reaction to proposed policy changes, and to engage the attention of politicians and community leaders is well recognised.

However, there are many other mechanisms through which advocacy occurs - public meetings, personal and professional networks, petitions and newsletters, public events, and telephone trees are all ways of setting agendas, debating solutions, and advancing specific proposals.

In recent years, the Internet has become a powerful medium through which individuals and organisations that were, previously, often unable to participate in the policy-development process, are now able to act collectively and to exercise some power over decision-making by organisations such as the World Trade Organization (globally) or a national government (as in the introduction of genetically-modified food into commercial food production in Australia).

In effect, effective public health advocates use every method possible to inform, persuade, and motivate communities, senior administrators, and politicians to act to protect or promote the health of the population.

Advocacy, ethics and equity

Of the three major strategies for promoting health, advocacy tends to be the least well used. Becoming effective public health advocates means understanding the purposes of advocacy. It requires mastery of the methods and tools of advocacy, particularly, the use of the mass media. However, effective advocacy is not simply a set of technical skills to be learned and used. It also requires understanding on the part of advocates of their roles in relation to the values and goals of the community or society on whose behalf they/we are advocating. It is important to recall that the goals of health promotion are, themselves, ideologically and politically determined (Seedhouse, 1999).

The use of advocacy in promoting the health of populations is based on the understanding that the determinants of health are "socially constructed" - that is, the distribution of society's resources is not random, but is, rather, the result of the decisions of governments, organisations (public and private), communities and individuals. The methods or mechanisms used for public health advocacy are the same as those used by all groups in society to further their interests.

For public health advocates this raises the significant question - whose interests are we serving? Is it the responsibility of public health advocates to set the public health agenda? Or should we follow (rather than lead or influence) the public's expressed needs? To what extent have we been given a mandate to propose solutions to public health problems - or to propose particular solutions?

There is danger that the values of public health advocates and health promotion practitioners dominate too much in public health (Mooney, 2000). However, there is also a strong argument for public health advocates to ensure that the public is well informed about public health issues and potential solutions, and to contribute to the debate about the specific solutions that are to be adopted (Chapman, 2000). There are no simple answers to these issues. It is a reminder, however, of the responsibilities of public health advocates and of the goal for advocacy to become the tool of empowered communities (Labonte, 1999).

In conclusion

Advocacy is a powerful strategy for promoting health. It has been demonstrated that it is possible to engage in political processes to bring about positive changes in the policies and environments that, in turn, shape people's and populations' access to healthy choices. However, the successes to date have been linked with specific public health issues or problems.

There has been much less success in using advocacy to reduce inequalities in health - to influence the policies and practices of governments, private sector and non-government organisations, and international organisations to create conditions for health. This is a huge challenge for health promotion in the 21st century. This concern with inequality is shared by many sectors other than health - agriculture, education, environment, transport, and social welfare, to name but a few. But to date it has proven difficult to form and maintain the partnerships needed to work together to advocate for goals and decisions that promote and protect the health and well-being of populations. There are encouraging signs, however, of such partnerships developing. The IUHPE, is, itself, exploring ways to collaborate with a wide range of agencies to influence the goals and methods of the World Trade Organization, for example.

In addition, the essentially political nature of health promotion and public health has been obscured by an emphasis on gathering evidence - first, evidence of the relationship between population health status and social, economic and environmental conditions, and second, evidence that it is possible to improve the health of populations using the methods and tools of health promotion and public health. The quest for evidence is and will remain a vital thread of health promotion activity. However, it is clear that it is necessary to return to the political roots of public health and to re-engage in the political process if we are to truly achieve our goal of putting fences at the top of the cliff instead of driving the ambulances at the bottom.

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Election of the IUHPE global board of trustees membership for 2001-2007

Every three years in accordance with the IUHPE's Constitution and Bye-laws, the General Membership of the IUHPE elects members of the Board of Trustees. For the first time, this voting process is currently taking place by post in order to provide each member with an equal opportunity to elect the members of the IUHPE Board, which in turn elects the IUHPE President and administers and governs the IUHPE between sessions of the General Assembly. **A consultation of the General Membership shall be valid if a quorum of at least 20% of the membership reply and vote.**

As all members have been informed, according to our constitution and bye-laws, ballot papers must reach the headquarters by **June 18, 2001.** Therefore, we urge all members who have not voted yet to vote now and mail their ballot paper without delay. We must reach a participation rate of at least 20% of the General Membership to avoid paralysing the structures and governance of the IUHPE. **Please vote today!**

In order to facilitate this process, we are offering IUHPE members alternative methods of voting. If you are prepared to accept that your vote will not be completely secret, you may vote electronically by downloading the ballot paper from the IUHPE Global Website at http://www.iuhpe.nyu.edu/whatsnew/ballotpaper.doc and sending it as an attachment to the Executive Director at iuhpemcl@worldnet.fr. You may also print out the ballot paper and vote by fax (33-1 46 45 00 45). In either case, your completed ballot paper will be kept confidential to the IUHPE Executive Director. Upon receipt, she will register your vote in the same way as if it had come by post and will place it in the sealed boxes at IUHPE Headquarters until the voting process is complete.

When voting electronically or by fax, **please indicate the name of the member (individual or institutional).** Should you have any questions during this process, we remain available to provide any further information that you may need (iuhpemcl@worldnet.fr).