

# POSITION PAPER ON ADVOCACY IN PUBLIC HEALTH

March 2004

## Introduction

This paper arose out of concerns and discussions amongst people working in public health providers.<sup>1</sup> It is the result of a number of meetings and other communication to identify issues of concern that we wish to bring to the attention of the Minister of Health and Government agencies concerning recommendations in the *Report on Contracts with NGOs – Compliance with Public Service Standards* (the Hunn/Brazier Report).

It is noted that:

The Hunn/Brazier Report said “a clear distinction must be made in contracting with NGOs between the legitimate function of information gathering and the inappropriate and unacceptable activity of lobbying...A distinction between information provision and lobbying is essential...advocacy falls into the middle ground between information and lobbying...There is a narrow line in a political context between advocacy and lobbying. It is the issue of advocacy that can draw the Ministry close to the area of lobbying... The only way to avoid this situation [loss of public confidence in political neutrality by the Ministry] being an ever present risk to the Ministry and a continuing management concern is to avoid contracting for any ‘advocacy’ role on health and disability issues. Instead the Ministry should be specific about the services it contracts providers to deliver and ensure that those services are confined to supplying specific evidence based information as distinct from the more generic ‘advocacy’.” (p 9 and 10).

It is further noted the report recommended that:

The Ministry should draw up guidelines for future contracting with NGOS that:

- explicitly exclude lobbying activities
- cease the use of the word 'advocacy' in contracts and substitute a precise statement of the services being purchased
- ensure that services purchased are specific to information provision activities
- ensure that Ministry staff receive instruction and training on the avoidance of lobbying requirements and on substituting advocacy with more precise expectations. (p 4)

## Use of the word advocacy in contracts.

This paper focuses on the recommendation that the MOH cease the use of the word 'advocacy' in contracts.

---

<sup>1</sup> This paper was compiled by the Health Promotion Forum of New Zealand/Runanga whakapiki ake i te hauora o Aotearoa, based on discussions at meetings, other communications and feedback on drafts. The Forum is a

We strongly recommend the Ministry of Health does not take the step of ceasing the use of the word 'advocacy' for the following reasons.

1. The term 'advocacy' has been internationally recognised and adopted as a core and legitimate element in health promotion to improve the health of individuals, families, communities and whole populations. It is an integral aspect to the Ottawa Charter for Health Promotion 1986 which informs public health practice in Aotearoa-New Zealand, as noted in MOH strategic plans and frameworks. It is recognised in law as the duty of the Ministry of Health and District Health Boards to undertake health promotion.
2. Advocacy is one of the three major strategies for health promotion identified in the Charter:

*Advocacy* for health to create the essential conditions for health  
*Enabling* all people to achieve their full health potential  
*Mediating* between the different interests in society in the pursuit of health

3. These strategies are supported by five priority action areas as outlined in the Charter :
  - Build healthy public policy
  - Create supportive environments for health
  - Strengthen community action for health
  - Develop personal skills and
  - Reorient health services.
4. The importance of advocacy in achieving health has been restated in the four subsequent World Health Organisation conferences on health promotion (Adelaide, Sundsvall, Jakarta and Mexico).
5. Advocacy was seen as important by Ministers of Health, including a representative from New Zealand who signed the Mexico Ministerial Statement for the Promotion of Health (Fifth Global Conference on Health Promotion, Mexico City, June 5-9, 2000). They said (pg 3):

*“Advocacy is an important tool and includes lobbying, political organization and activism, overcoming bureaucratic inertia, identifying a champion for the cause, enabling community leaders and mediating to manage conflict.”*

6. Lobbying and advocacy are often publicly used interchangeably. The Hunn/Brazier report has suggested the two can be confused and therefore it would be better to remove the word advocacy altogether from contracts.
7. However advocacy as an internationally recognised concept, process and tool of the professional health promotion and allied occupational fields has specific technical meanings . From a professional public health perspective they are not interchangeable.
8. Health promotion is defined as the process of enabling people to increase control over their health and thereby improve their health. It has been noted that:

*“a healthy society is defined not only by morbidity but also by well-being, and the degree to which the society protects and advances cherished shared values like democracy and equity. These qualities in turn facilitate and advance the health and well-being of individuals and societies. Policy advocacy in health*

*visible and direct determinants of morbidity, but also of advancing the healthy society which creates the conditions both for reduced morbidity and enhanced well-being. The Ottawa Charter takes yet an additional step. Advocacy for healthy public policy does seek to alter policies in order to achieve identified health and well-being outcomes. But it is also about changing the means by which policy is made, [emphasis in original] in particular by: • advancing democratic values • empowering people as participants in the polity • facilitating the capacities of communities and vulnerable populations to make their needs and interests known • increasing peoples' participation more substantively in processes allocating societal resources and values among its members.”<sup>2</sup>*

9. Carlisle<sup>3</sup> suggests there are two main goals underpinning health advocacy:  
“...that of protecting people who are vulnerable or discriminated against; and that of empowering people who need a stronger voice by enabling them to express their needs and make their own decisions.”
10. The first goal involves advocacy on behalf of (involving protection). The second goal involves advocacy with (emphasising strategic partnerships, facilitational roles, capacity building). These activities are considered health promoting in themselves because they support increased participation and other aspects of the processes involved in health promotion. In short, undertaking advocacy is integral to the practice and processes involved in health promotion.
11. Public health advocacy is often used to refer to the process of overcoming major structural (as opposed to individual or behavioural) barriers to public health goals.<sup>4</sup> These barriers include political philosophies that devalue health and quality of health at the expense of economic outcomes; political and bureaucratic opposition or inertia to health promoting legislation, regulation and policies; opposition to participation of consumers in health care planning; marketing of unsafe and unhealthy products often by transnational corporations of immense influence and wealth; the pervasiveness of racism and sexism, expressed through institutional values, personal attitudes and behaviours.
12. In Aotearoa-New Zealand Te Tiriti o Waitangi has paramount relevance to health promotion. Honouring and operationalising the articles of Kawanatanga (governance) Tino Rangatiratanga (Maori control and self-determination) Oritetanga (equity) and the principles of protection, partnership and participation requires public health organisations and practitioners to use the skills, knowledge and values of advocacy to ensure that Maori health-related aspirations are achieved and the disproportionate negative health related statistics suffered by Maori are turned around.
13. WHO notes that advocacy can take many forms, including: • the use of the mass media and multi-media • direct political lobbying • community mobilisation through, for

---

<sup>2</sup> McCubbin, M. Labonte, R., Dallaire, B. (2001) Advocacy for healthy public policy as a health promotion technology. Centre for Health Promotion (online archives). Available: <http://www.utoronto.ca/chp/symposium.htm>.

<sup>3</sup> Carlisle, S. (2000) Health promotion, advocacy and health inequalities: A conceptual framework, Health Promotion International, 15, 369-376.

example, coalitions of interest around defined issues. It can take place in many settings and on many issues.

14. To remove the word advocacy from public health contracts will mean public health practitioners will be prevented from undertaking an essential element of their professional practice. An analogy is preventing surgeons from using particular surgical instruments or procedures in their profession.
15. Suggestions for substitutes to the word advocacy that have been suggested by the Hunn/Brazier Report include that the MOH “ensure that those services are confined to supplying specific evidence based information as distinct from the more generic ‘advocacy’.”
16. This position does not take into account the breadth and depth of advocacy processes as a tool of health promotion necessary to support the development and implementation of policy for the public good.
17. Advocacy cannot be equated to ‘supplying evidence based information’. This is a very limited interpretation in the Hunn/Brazier Report.
18. The word advocacy must be retained in public health contracts because it is a legitimate essential tool, in theory and practice, for health professionals and citizens to engage in as part of the process of increasing control over the determinants of health.
19. Advocacy and lobbying have different meanings as noted below. We believe these differences can be accommodated in decisions on wording of contracts which will meet Ministry concerns about political neutrality, but which will not result in removing the word advocacy.

## Definitions

### *Advocacy:*

- (1) Plead for, defend; recommend, support (policy etc).<sup>5</sup>
- (2) A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.<sup>6</sup>
- (3) The use of tools and activities that can draw attention to an issue, gain support for it, build consensus about it, and provide arguments that will sway decision makers and public opinion to back it.<sup>7</sup>

### *Lobbying:*

Seek to influence (members of legislature), get (bill,etc) through, by interviews etc in lobby; solicit support of (influential person), frequent lobby of legislature, solicit members’ votes.<sup>8</sup>

---

<sup>5</sup> The Concise Oxford Dictionary, 1982. Seventh edition. Edited J.N. Sykes

<sup>6</sup> Report of the Inter-Agency Meeting on Advocacy Strategies for health and Development: Development Community in action. WHO, Geneva, 1995.

<sup>7</sup> Rice, 1999, cited in Nathan et al, 2002. Closing the gap: building the capacity of non-government

We wish also to make the following points.

20. It has been stated by the MOH that it is 'business as usual' while further consultation and discussion takes place on this issue. Providers have reported variable interpretations from MOH officials on what activities they are able to undertake around advocacy. For example, a provider was advised not to send MPs a letter bringing to their attention 'evidence based' results from recent health related national surveys. Uncertainty around this issue raises logistical, administrative, and power issues. This puts a strain on the funder/provider relationship and the ability to effectively undertake contracted roles. We are concerned that this untenable situation will continue if advocacy is removed from contracts. It may result in counterproductive, increased risk. It will be logistically and administratively difficult for providers to have to check what specific activities may be acceptable. 'Seizing the moment' in advancing a health issue may be lost as responses are waited upon, significant time and energy will be consumed which would be better expended on undertaking the work on behalf of the public. The MOH risks being charged with censoring work and being an agent of social control.
21. In contested policy areas such as alcohol, tobacco, and food, public health interests find themselves engaged in public conflict with commercial vested interests. The latter have significantly more resources, often global, to present their views, push for change or the status quo and attempt to discredit the work of public health organisations. There are many examples of this that can be provided.
22. To continue with the current risk averse approach and ban the word advocacy, which refers to a class of activities, puts both the class of activities and the organisations and people that undertake them, under a cloud. It puts them in a position of having to defend their lawful activities.
23. We are concerned that vested interests and their political supporters will not be slow in taking advantage of this current uncertain environment to attack public health work. We acknowledge that public health agencies must be accountable for the quality of the work they do on behalf of the public good. Nevertheless, given the contested nature of some of that work, its potential impact on the financial interests of private industries and the tactics used by some vested interests, we are concerned that in the current environment significant public health resources will have to be diverted to dealing with these tactics. Some public health organisations have reported an increase since November 2003 of comments and articles in the business media questioning the validity of their funding and general work.
24. The contested nature of evidence, knowledge and approaches to improve health is an ongoing aspect of the democratic policy making territory. It will never diminish.
25. We ask that agencies such as the Ministry of Health publicly acknowledge and welcome this as part of a healthy and robust democracy. We ask they publicly defend the role of public health organisations in undertaking advocacy.
26. The *Framework for Relations between the Ministry of Health and Health/Disability NGOs* mentions under 'Communication' that "NGOs will aim to assist the MOH in understanding the key issues and trends affecting NGOs, share information and research with the MOH and provide NGO intelligence for input into policy

assist the MOH in policy development; provide feedback on the impact of policy on the consumer; provide access to NGO grassroots networks and advise the MOH on how consultative arrangements with NGOs are working. It will be impossible for NGOs to effectively fulfil these functions if they are restricted in what they can do in relation to advocacy.

27. The advice that the Ministry can only contract what it can do itself raises questions on what is the extent of the funding and operational role of the Ministry in society and how it sees the purpose and role of agencies outside of government. It contradicts the statements made in the Framework for Relations between the Ministry of Health and Health/Disability Non-Government Organisations. This states “NGOs (independent community and iwi/Maori organisations) are considered to bring a value to society that is distinct from both government and the market. The Framework recognises that NGOs contribute in many and varied ways, to the development of healthy social environments and healthy communities. The MOH will work to ensure its relationship with health/disability NGOs is nurtured and protected.” This implies NGOs are valued because they provide something (services, information, access to community constituencies) that the MOH cannot itself undertake. We suggest the advice is untenable both philosophically and practically.
28. On the one hand, public health organisations (both NGOs and DHB public health units), are often asked by the Ministry for advice and other help in developing policy. This may be via writing submissions on the release of discussion/consultation documents. It may be by providing direct advice in working parties, meetings, personal discussions and to meetings of government officials and other stakeholders.
29. On the other hand, such organisations may now find themselves in a position of only being able to respond when asked by the Ministry, rather than having the freedom to bring matters to the attention of the MOH, politicians, and other policy makers. This is simply not acceptable in a democratic society and compromises the duty of care the MOH, public health services and others undertake on behalf of and with the people of Aotearoa-New Zealand.
30. The work of public health staff employed by District Health Boards is also specifically affected by this current issue. For example, Medical Officers of Health employed by public health units in DHBs have statutory duties to publicly raise health risks and undertake appropriate action. This ability to speak out and advocate on behalf of the public may become compromised.
31. Community based public health providers are reliant on building a relationship of trust and standing with community members, so they can act on their behalf in raising and negotiating on public health issues. This relationship will be compromised if their community of interest perceives community views and expertise will not be heard, due to uncertainty over what is permissible for organisations to undertake around advocacy.
32. Local government sector representatives have noted they have significant and valuable working relationships with many NGOs and other public health providers, which assist them to discharge their legislative duties around care and protection of their citizens. Limits on the ability of NGOs and other service organisations to provide advice, initiate or support action and provide an important bridge with local

## **Undertaking advocacy to improve public health outcomes: dimensions and evidence**

A story often told in public health circles as a metaphor for public health action concerns people rescuing people who have fallen in a river. Eventually, wondering why so many people keep falling in the river, someone goes up stream to find out why. Effort is then put in 'upstream' to prevent this happening.

The goals of advocacy often involve changing 'upstream' economic, structural and environmental influences on health, such as bringing in laws making it compulsory that cars have seatbelts, rather than on efforts focused 'downstream' on treating people's injuries or persuading individuals to change health-related behaviours.

Carlisle<sup>9</sup> suggests there are two main goals underpinning health advocacy:

"...that of protecting people who are vulnerable or discriminated against; and that of empowering people who need a stronger voice by enabling them to express their needs and make their own decisions."

The first involves advocacy on *behalf of* (involving protection)

The second involves advocacy *with* (emphasising strategic partnerships, facilitational roles, capacity building).

### **Some examples of advocacy to improve the health of people**

#### **Maori communities taking action on young people and drugs**

While participating in the Community Action on Youth and Drugs Project (CAYAD) several Maori communities, worried about the health consequences of cannabis use for their young people, drew on their strong kaupapa Maori approach and their local experience to challenge government departments, parliamentary committees and funders. They challenged them to go beyond predominant drug education and 'Band-Aid' solutions and to "think outside the square box" in addressing drug issues. They came together to present a comprehensive and complementary perspective on cannabis issues to national government consultation hearings on mental health and cannabis. Project workers tapped into a variety of community forums and used media advocacy to provide accurate information and present a range of perspectives on underlying societal risk conditions, risk factors and behaviours associated with the uptake of cannabis. Some sought consensus on drug-free places such as early childhood and school centres, sports and social events and activities such as driving. They generated discussion of harm reducing practices for dealing with cannabis in both specific and general contexts, covering cannabis policy as well as broader issues such as alienation from the land, language and values, and reconnection with tikanga. They assisted local schools to become more aware of and increasingly receptive to alternative options such as diversion rather than using suspensions for cannabis use. Holistic health programmes based on tikanga were introduced as well as specialised school programmes for youth/families in need of support and guidance. Joint school/community projects were organised, such as

---

sports and cultural events, lunch-time and school holiday programmes and school/community murals with tikanga-based health messages.<sup>10</sup>

### **Local community action on housing and child health**

A group of Pacific women selected the advocacy issues of housing and child health and undertook a child health and safety survey of 42 local Housing New Zealand houses. The release of the survey findings at a public meeting resulted in widespread media coverage of the issues and some action by Housing New Zealand to remedy the problems. The action was part of a participatory action research project looking at how members of marginalised groups could increase their role in policy work/advocacy on underlying determinants of health and well-being. It also looked at the role of community based organizations and community workers in such a process. In developing their group, members shared their own stories with an emphasis on culture, identity and difference. This storytelling was an empowering process invaluable as a method of building personal and group power, which then enabled the group to challenge the institutional power of the housing agency.<sup>11</sup>

### **Helping put obesity issues on the national health agenda in New Zealand**

An early objective for Agencies for Nutrition Action (ANA) formed in 1995 by organizations working in the nutrition and health arena, was to address obesity in the community. Its collaborative advocacy efforts aimed to raise awareness about the issue among media, government and the community. The development of two papers, on obesity in New Zealand and on associated health care costs, helped with this. Appearing before a government advisory committee and organising an intersectoral national forum with the food industry, media, physical activity and education groups and Maori and Pacific peoples to explore weight issues were two other activities. Regional forums, a regular newsletter and website were also set up. ANA received praise from government policy makers for its initiative and contracts to undertake its work. An outcome was the inclusion of obesity issues, for the first time, in national health goals and targets developed in 1998 by the Ministry of Health.<sup>12</sup>

### **Encouraging and working with local governments on food and nutrition issues**

In Australia, four case studies of food and nutrition policy at the local level looked at the role of public health professionals in presenting data on food and nutrition issues to local government. These data highlighted problems and issues experienced by local residents such as limited access to food retail outlets, poor quality fruit and vegetables, high food prices in economically depressed areas and populations with high nutritional needs such as older residents and people with HIV/AIDs. Policy committees were then formed within the local governments and with health and other sectors. Public health professionals made strategic use of their advocacy skills to stimulate and support policy action, including gathering local data, ensuring the agendas, report writing and minute taking side of the policy committees functioned efficiently and working in partnership alongside the organizations. In two cases councils adopted food and nutrition policies. Initiatives included support for school breakfast programmes, community gardens and food safety education for food vendors. Important factors for the policy process were supportive environmental conditions in the local

---

<sup>10</sup> Conway, K. Tunks, M., Henwood, W. Casswell, S. (2000) Te Whanau Cadillac - A Waka for Change. Health Education and Behaviour, Vol 27 (3):339-350

<sup>11</sup> Williams, L. Labonte, R. O'Brien, M (2003) Empowering social action through narratives of identity and culture. Health Promotion International, Vol 18(1), pp 33-40.

government, influential individuals and groups and use of information to inform the policy process.<sup>13</sup>

### **Thirty years of action to prevent tobacco related harm in Australia**

Since 1970, Australian tobacco control advocates have made significant gains in advertising bans, pack warnings, mass reach campaigns, civil disobedience, smokeless tobacco, banning of small 'kiddie' packs, tobacco tax, replacement of industry sponsorship and clean indoor air. Two case studies on promoting smoke-free indoor air and banning tobacco advertising provide information on strategies and outcomes. Most advocacy efforts have been driven by professionals within NGOs and dedicated advocacy offices set up explicitly to pursue these objectives. They took the recommendations of early expert reports on reducing the tobacco epidemic and the results of relevant local policy-relevant research and advocated for changes to be adopted. As they began to set the agenda for tobacco control reform, community support for action began to rapidly grow.<sup>14</sup>

---

<sup>13</sup> Yeatman, H. (2003) Food and nutrition policy at the local level: key factors that influence the policy development process. *Critical Public Health*, Vol 13(2) pp 125-128.