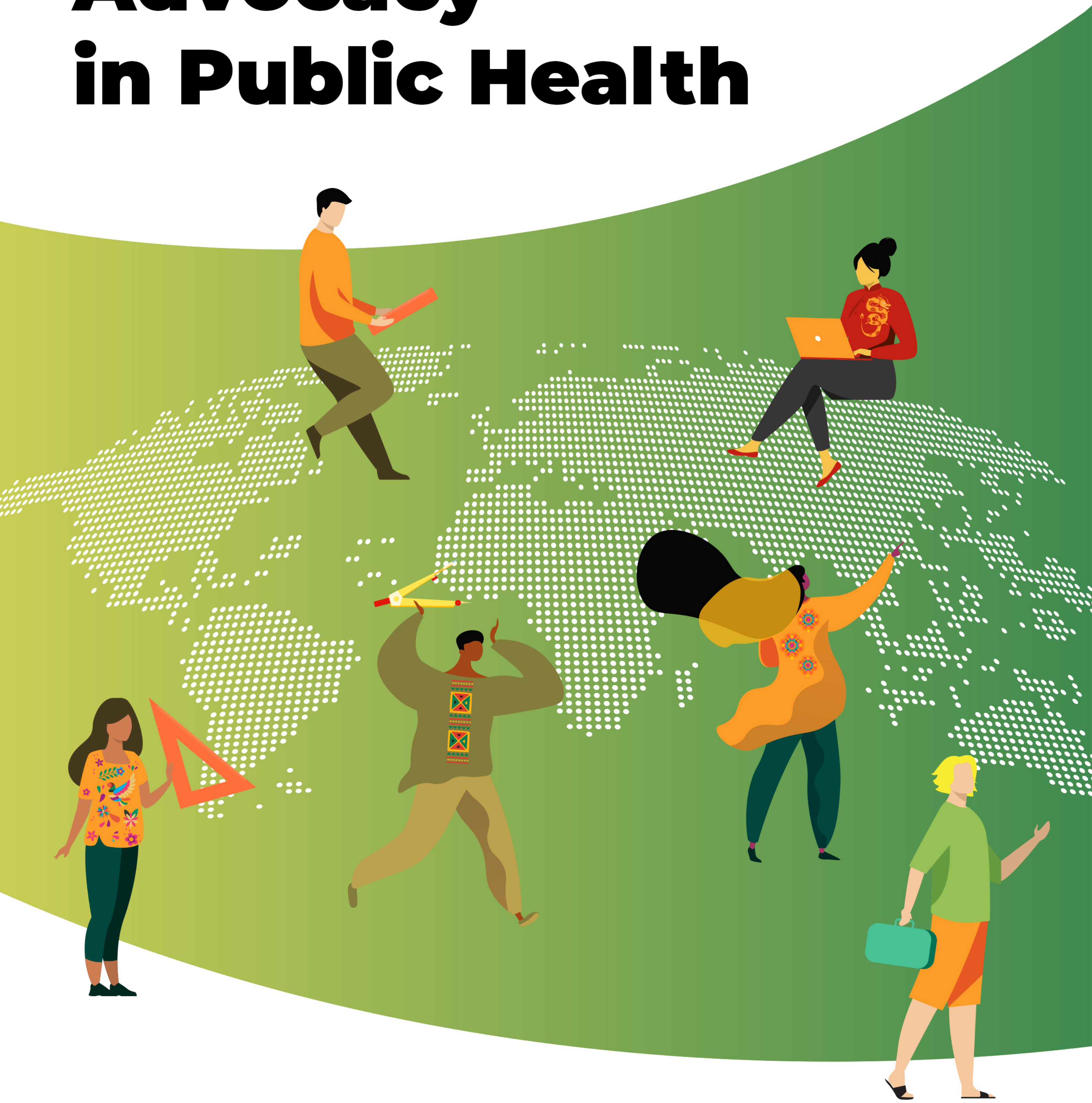
Casebook on Advocacy in Public Health



WFPHA World Federation of Public Health Associations

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ISBN E version: 978-84-09-27984-5

Produced by the World Federation of Public Health Associations (WFPHA), Geneva, Switzerland.

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1202 Geneva, Switzerland
https://www.wfpha.org

Funded by the Global Health Research Group at the University Miguel Hernández de Elche (UMH), Alicante, Spain.

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AKNOWLEDGEMENTS

Marta Lomazzi at WFPHA for her support in the coordination of the preparation and launch of the Casebook.

The editorial committee for their valuable oversight and dedication to the peer reviewing of the cases.

Technical editing by Manuel González-Moro Tolosana.
Digital design by Daniella Zlotogoura, SPARQ.

How to cite this document:

World Federation of Public Health Associations (2021). Casebook for Advocacy in Public Health. Geneva, Switzerland: WHPHA

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RIGHTS AND PERMISSIONS

GOAL OF THE CASEBOOK

The goal of the Casebook is to assist National Public Health Associations and other actors to improve their capacity of influence on national public health policies through advocacy efforts.

Specifically, the Casebook aims:

(1) to increase knowledge and capacity to develop and implement advocacy strategies in order to improve population health at local, regional, national and international levels and

(2) to inspire the development of curricula and other training material to support instruction, debate, dialogue and action to strengthen advocacy efforts.

The WFPHA promotes the use of the Global Charter for the Public's Health in order to improve the practice of public health around the world. The Charter considers Advocacy, together with Governance, Information and Capacity, as key enablers/functions of Public Health. Unfortunately, the study and teaching of advocacy and their application to improve population health remains neglected in many countries.

Increasing the capacity for advocacy can have positive effects on population health by stimulating healthy policies for implementation in both the public and private sectors.

In addition, a more developed public health evidence-based research base on advocacy can help focus public health efforts globally and assure public health strategies are placed higher on the political agenda of countries.

CONTENTS

FORWARD

The World federation of Public Health Associations attaches paramount importance to public health advocacy as an essential function to improve the health of populations. Many public health interventions that depend on public policy decisions are only possible through high advocacy capacity.

Several national associations have identified the need for examples of good practice in public health advocacy and knowledge about barriers to implementation and strategies to address them. The WFPHA Policy Committee therefore decided that a collection of actual cases of health advocacy would be useful. WFPHA now has the possibility to publish this book which gathers initiatives on public health advocacy from countries in several continents.

The Casebook of Public Health Advocacy includes two introductory chapters that address the essentials of public health Advocacy and frame advocacy within the key actions of public health associations.

Eighteen experiences from the five continents are described. The contributions of multiple authors address challenges that are very much on the public health agenda of the 21st century. Actions on sustainable investment in well-being and equity in health, the need for universal access to health protection and promotion, permanent issues such as exposure to dangerous chemical and physical risks or tobacco control are considered in these cases. Some authors focus on specific health problems, others on vulnerable groups and still others on global challenges.

Overall, a wide range of examples of public health advocacy are provided, identifying organisational strategies, difficulties and barriers to their implementation and highlighting the importance of active involvement of public health professionals in working with communities to promote public health.

The final chapter considers the role of advocacy within health policy formulation and reviews the remaining challenges facing the public health community in strengthening and making advocacy actions more effective. It will be necessary to invest in advocacy research, but it is also necessary, as a precautionary principle, to develop advocacy actions at all levels for global health advocacy and promotion as soon as possible.

Walter Ricciardi, President of the WFPHA

01 WHAT IS PUBLIC HEALTH ADVOCACY?

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Key words: Public Health Advocacy, Critical Friend, Kotter Plus

ABSTRACT

Introduction

Public health advocacy may be defined as the deliberate process of using knowledge and evidence to support or argue in favour of a cause, policy or idea in order to influence decision makers and public opinion to deliver better population health outcomes. The most apparent advocacy practice is to influence politicians and bureaucrats, in the traditional and social media and to influence powerful stakeholder groups.

Aims for public health advocacy

However, advocacy does not sit in isolation. Public health advocates work towards healthier individuals and communities with the intent of leaving no one behind. Johns Hopkins Bloomberg School of Public Health summarises public health as not just about "Protecting health, Saving lives", but doing so "Millions at a time" (Johns Hopkins, 2020).

Kicking goals in public health advocacy

Prior to the turn of this century people were living longer, healthier lives in both developed and developing nations (Lomborg, 2002). The factors driving this are often beyond the healthcare fraternity. The social determinants of health are now well understood by public health professionals. However, a significant challenge is understanding how to influence determinants such as climate change, poverty, unhealthy commodities as well as countering the industries that drive them (Marmot, 2008).

The Challenge

Therefore, understanding the practice of public health advocacy and learning from others has become a key role, not just for public health professionals, but for all of those who seek healthier communities and a healthier world.

INTRODUCTION

Some countries have been much more successful than others at handling the COVID-19 pandemic. This pandemic throws a spotlight on politics as a key determinant of the public's health. Quite simply, public health is political. In accepting the political nature of public health, it is incumbent on public health professionals to influence politics for better health outcomes. This need to influence political outcomes underpins public health advocacy.

The aims of public health are much more clearly understood by the general public following the advent of the COVID-19 pandemic. Surprising to many is how key politics and economics is to public health. Even more striking is the impact that public health has in terms of socio-economic status and vulnerable groups of people. In this pandemic, the vulnerable include those who are less healthy through such factors as socio-economic status, age, indigeneity, smoking, overweight or race. The simple aim of public health as demonstrated through this pandemic is, as far as possible, to reduce sickness and death.

Reducing morbidity and mortality in their communities or throughout their nations has been an absolute goal of leaders in some countries such as Taiwan, New Zealand and Australia. However, even those countries still wrestle with other causes of ill-health and early death such as tobacco, alcohol and other drug use, diet-related disease, preventable injury, anti-biotic resistance, reluctance to immunise, other infectious diseases and climate change preparedness.

To successfully tackle the causes of preventable disease the World Federation of Public Health Associations has developed the Global Charter for the Public's Health (The Charter) (WFPHA, 2016) (Lomazzi et al., 2016). The Charter identifies "protection, prevention and health promotion" as the key elements of effective public health policy.

Public health kicking goals

Where governments have implemented, and continue to invest in protection, prevention and health promotion, there is a greater likelihood of better health outcomes. Unfortunately, prior to the COVID-19 pandemic, investment in public health as a percentage of health funding has been declining over the last decades (OECD, 2017) (Figure C1-1). Although Canada spent over 6.2% of the health budget on prevention, the average OECD expenditure in 2017 was less than 3%. Additionally, where governments have worked to deliver on their own commitments to the UN Sustainable Development Goals (SDGs), they are also contributing to prevention, protection and health promotion.

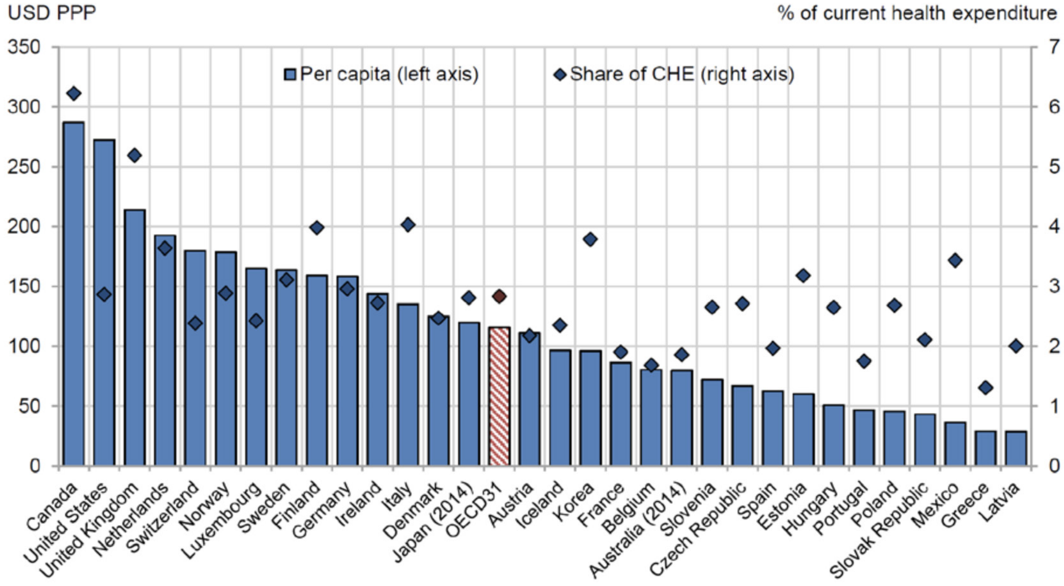

Figure C1-1: Prevention expenditure per capita as a share of current health expenditure, 2015

Source: OECD Health Statistics 2017

In addition to protection, prevention and health promotion identified in The Charter as the key ‘services’ that underpin public health, there are ‘enablers’ to facilitate the delivery of those key services. The enablers include: information, governance, capacity and advocacy (Figure C1-2). In the era of ‘fake news’, it may be preferable to think in terms of ‘accurate’ information, as well as ‘good’ governance, capacity ‘building’ and ‘effective’ advocacy.

Under the heading of advocacy, The Charter includes: “leadership and ethics; health equity; social-mobilization and solidarity; education of the public; people centred approach; voluntary community sector engagement; communications and sustainable development". Each of these is important in that they identify approaches and key areas of focus. However, advocacy does not sit in isolation. Whilst The Charter calls on governments "to take into account the impact of social, environmental and behavioural health determinants, including economic constraints, living conditions, demographic changes and unhealthy lifestyles", there is still a need for a clear understanding of what is meant by public health advocacy.

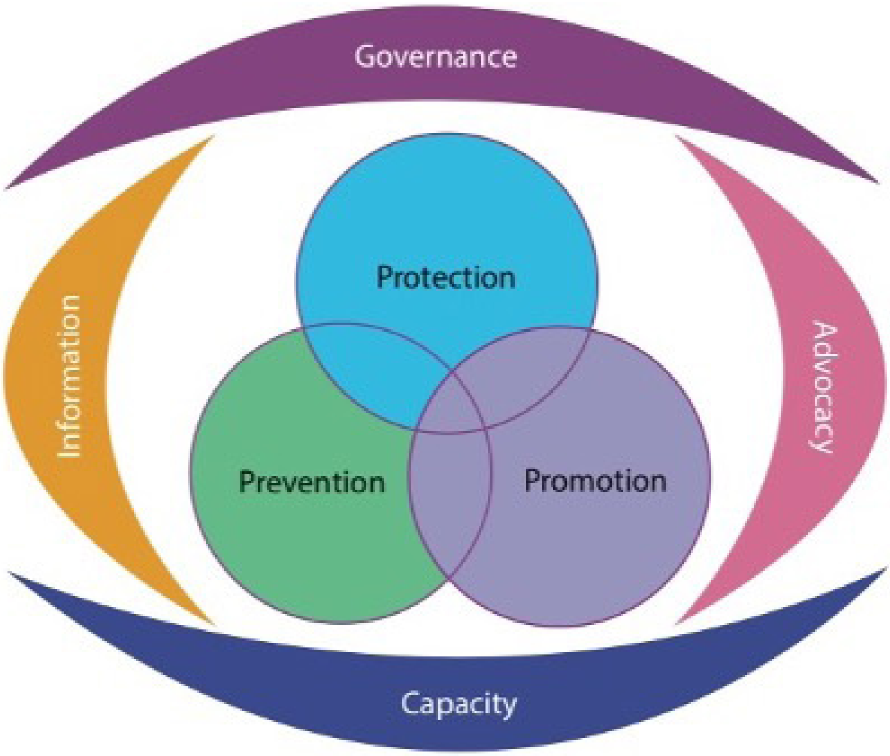

Figure C1-2: The Global Charter for the Public's Health (WFPHA 2016)

Public Health Advocacy

Public health advocacy may be defined as the deliberate process of using knowledge and evidence to support or argue in favour of a cause, policy or idea in order to influence decision makers and public opinion to deliver better population health outcomes. The most apparent public health advocacy practice is to influence politicians and bureaucrats, in the traditional and social media and to influence powerful stakeholder groups (Moore, 2020).

Health advocacy has also been defined as "the act of supporting or arguing in favour of a cause, policy or idea. It is undertaken to influence public opinion and societal attitudes or to bring about changes in government, community or institutional policies" (Daube, 2009).

The necessity of public health advocacy emerges when an individual, a group or a network of individuals recognises a need to improve particular health outcomes. This might be through a need to change policies or structural arrangements. It might be a need to change management practices with regard to cultural and social norms, opinions or consensus. Advocacy needs to focus on change, moving from one issue, concern or management system to another.

It is important to distinguish this type of advocacy from advocacy at a personal level where the advocate seeks a better deal for someone, for example, with a serious medical, physical or mental health disability. As with the difference between medical treatment focussed on the individual and public health which is focussed on populations, public health advocacy also focusses on improving the health of populations rather than being focussed on an individual.

Change is fundamental to public health advocacy

To frame this concept a slightly different manner, public health advocacy is about seeking change, requesting, or even demanding, of others that they modify their approach from pursuing one course of action to pursuing another. Often the change not only challenges the way things are currently done, it also challenges entrenched thinking, privileges and advantages of some over others. The notion of 'change' is fundamental to this type of advocacy work. In explaining "How to Change the World", political scientist, Gene Sharp, has identified nearly two hundred actions for non-violent advocacy (Sharp, 1973). A summary of the list is available through the Albert Einstein Institution (Albert Einstein Institution, 2020).
Understanding public health advocacy in terms of the change

process opens a different paradigm. John Kotter remains a leading thinker in change management, as it applies to business management. He argues “we have learnt an enormous amount in the past decade about the kinds of structures and capabilities that create powerful enough basis to launch and sustain big change” (Moore et al., 2013). However, change is not easy as was identified centuries ago by one of the first political scientists, Nicolo Machiavelli, who stated “And it ought to be remembered that there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success than to take the lead in the introduction of a new order of things” (Machiavelli 1952). Seeking change in the context of politics and bureaucracy led to Kotter’s theories and provided motivation to examine if these techniques might also apply to the type of change management that is the role of the public health advocate.

The key element of Kotter’s eight steps to provide leadership in change management work quite well in application to public health advocacy. The most important factor, compared to other approaches to public health advocacy, is that it provides a sequential framework. However, from experience it seemed to me that there were two more important steps that applied specifically to public health advocacy work. The development of ‘Kotter Plus’ as a ten step framework for planning or evaluating public health advocacy followed.

The ten step plan is as follows:

Step 1: Establishing a Sense of Urgency
Step 2: Creating the Guiding Coalition
Step 3: Developing and Maintaining Influential Relationships
Step 4: Developing a Change Vision
Step 5: Communicating the Vision for Buy-in
Step 6: Empowering Broad-based Action
Step 7: Be Opportunistic
Step 8: Generating Short-term Wins
Step 9: Never Letting Up
Step 10: Incorporating Changes into the Culture

“Being opportunistic is identified as Step 7. However, as important as a strictly sequential approach is to effective advocacy, a sequential approach would be contradictory to the notion of being opportunistic. A time, a place, a catalyst or a media story may provide an opening for an opportunity to influence. The “elevator pitch” is practiced in lectures or workshops in public health advocacy at the Public Health Advocacy Institute of West Australia and they provide an illustration of the importance of being opportunistic (Public Health Advocacy Institute of WA, 2020).

Although the ten step plan provides guidance for planning or evaluating public health advocacy, it works within a series of broader concepts of what is meant by public health advocacy. The notion of the ‘critical friend’ is basic to success. Of all the tools available to the public health advocate, building constructive working relationships is one of the most important. The ‘critical friend’ is not just about building a relationship with those in power. It is much broader and requires, even from the very early steps, efforts to ensure that the guiding coalition is based on strong foundations. This requires colleagues to develop a shared vision for change based on evidence and, as such, requires respectful critical analysis between colleagues. In following the ten steps, whether seeking to communicate the vision for buy-in (where strong relationships with media are critical) to empowering broad based action – positive relationships simply underpin successful health advocacy.

The phrase ‘critical friend’ has been invoked as a key concept for encouraging a better understanding of public health advocacy, and deliberately chosen for its dual meaning. Initially, the intention of using this term was to encourage people to understand the importance of maintaining an appropriate engagement, where possible, with those in power. Politicians are used to being criticised. The main role of the official opposition is to double-check, look critically and hold the government to account. A minister invariably faces a person from the opposition with the specific responsibility to criticise where possible – this is usually the shadow minister, but will also regularly include cross-bench politicians. However, when blind criticism is offered without acknowledging achievements or good intent, it simply destroys relationships and undermines the chances of a constructive approach.

The other meaning of ‘critical’, however, is also very important and can be a crucial component of advocacy. It is significant if the relationship built by a public health professional with those in power allows influence that is a key, or a critical part of the adoption of policy objectives. Understanding the exercise of power, understanding how politics works and being effective within the context of being persuasive depends on being a critical friend.

CONCLUSION

Early definitions of public health advocacy came particularly from those who were challenging governmental approaches to tobacco policy. Simon Chapman’s early suggestions on advocacy were focussed particularly on media, “public health advocacy is the strategic use of news media to advance a public policy initiative, often in the face of opposition” (Chapman, 2015). Today this definition may seem too narrow as, although Chapman’s definition deals with the important aspect of media and oppositional resistance, it lacks the broad coverage of many other aspects of advocacy that are identified in the “Kotter Plus” ten step plan.

There is also the irritation factor for the public health advocate that explains Chapman’s need for to “grow a rhinoceros hide”. Michael Pertschuk explains, “advocates are unabashed tellers of truth to power…. They may often be irritating and difficult, but they churn up our collective conscience and annoy us into action” (Daube, 2017).

Public health is political. It is not easy being a public health advocate. However, when the need for change is understood to ensure healthier populations, it is a public health responsibility to stand up and make a difference.

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DECLARATIONS

Competing interests: The Author is a member of the Policy Working Group of the World Federation of Public Health Associations

Funding: The author received no specific funding for this work.

02 MAKE ADVOCACY AN ESSENTIAL PUBLIC HEALTH FUNCTION

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ABSTRACT

Advocacy is rarely listed explicitly as an essential public health function (EPHF). This, despite the fact that individual/collective and organizational advocacy for healthy public and private sector policies, regulations and practices over the past several decades has had a major impact on human health. National public health associations (PHAs) and the World Federation of Public Health Associations (WFPHA) have played a significant role and exerted considerable influence over the past few decades by advocating for policies, programs and practices that protect, promote and improve the public's health and address health equity. Given the important contribution advocacy plays to prevent illness and injury, promote health and health equity and protect and safeguard human health, this article makes a case to include advocacy as an EPHF.

Key words: Advocacy, public health associations, essential public health functions

ADVOCACY FOR THE PUBLIC'S HEALTH

Although dated, the definition of advocacy offered by Wallack and his colleagues is, in my opinion, the best to date:

"… a catch-all word for the set of skills used to create a shift in public opinion and mobilize the necessary resources and forces to support an issue, policy, or constituency … advocacy seeks to increase the power of people and groups and to make institutions more responsive to human needs. It attempts to enlarge the range of choices that people can have by increasing their power to define problems and solutions and participate in the broader social and policy arena." (Wallack et al., 1993).

Advocacy is a deliberate pro-activist process to promote, plead or defend a cause or point of view, to shape opinion and action, to influence others to shift their perspective and position on an issue, to counter misinformation, and to legitimize an issue. Advocates use strategic actions to influence people, organizations, enterprises, governments and their decisions. It goes well beyond simply communicating a point of view. As Chapman and others point out, advocacy is a political process[1] often carried out in the face of opposition to create social change and to shift power relationships, (Chapman, 2001). The effectiveness of an advocacy campaign is influenced by a myriad of factors and influences often beyond the control of the advocate (WHO, 1986; Chapman, 2004; Moore, 2013).

Advocacy within the EPHF framework

The concept of essential public health functions, or EPHF as they became known, can trace its origin to the Ottawa Charter for Health Promotion (WHO,1986). The Charter defined several core functions for health promotion (one of the three 'domains' of public health as defined at that time, the other two being disease and injury prevention and health protection), which, by today's standards, are essential public health functions. These included building healthy public policies, creating supportive environments

[1] The term 'political process' refers to a process wherein the proponents transmit their position on an issue as a means to influence policy/practice and resource allocation decisions that affect the public within political, economic, socio-cultural and institutional/organizational systems. It is not restricted to partisan politics at the governmental level.

for the public's health, strengthening community engagement and action for health, helping to enable people develop a wide range of life skills, and reorienting health services to support the needs of individuals and communities for healthier lives.

The Ottawa Charter also identified advocacy for health – perhaps the first time within the global public health arena – as an important enabler for achieving better health and health equity. Prior to that point in time, advocacy was rarely mentioned in articles, papers and reports about public health functions and services.

The majority of key documents published by public health bodies during the final decade of the 20th century and the first decade-and-a-half of the 21st century that define the nature and scope of essential public health functions do not identify explicitly advocacy as either an EPHF or an enabler for EPHFs. The EPHF frameworks developed and published by the World Health Organization (WHO,1998), the Pan American Health Organization (PAHO) in 2002 (PAHO, 2008), and by the US Centers for Disease Prevention and Control (CDC, 2013) (the three most cited EPHF frameworks) make no mention of 'advocacy' nor identify a role for advocacy within public health.

Although one finds the term within Essential Public Health Operations (EHPO) 9 of the WHO Regional Office for Europe's EPHF framework (2012), its focus is limited to encouraging and supporting community efforts to demand better access to and quality of health services (WHO Regional Office for Europe, nd.). It does not present advocacy as a means by those involved in public health to address the wider socio-economic, political, ecosystem and commercial determinants of health; nor does it describe a role for individuals and organizations/groups working within the public health domain as pro-active change agents. Passing reference to advocacy is as well made in the White Paper released in 2010 that redefined the delivery of public health services in the United Kingdom, citing the public policy advocacy role played by the non-governmental UK Faculty of Public Health (one of that country's two public health associations) (UK Department of Health and Social Care, 2010).

It wasn't until 2006 that WHO, in a guide related to chronic diseases, explicitly recognized advocacy as an important tool for and within public health (WHO, 2006). In 2009, a joint European Centre for Disease Prevention and Control (ECDC) and European Public Health Association (EUPHA) report acknowledged the role of public health professionals in advocacy, stating that "public health professionals have a major responsibility to act as advocates for public health at all levels of society" (European Centre for Disease Prevention and Control, 2009). That being said, both the WHO guide and the ECDC/EUPHA report are silent as to what skills and competencies public health advocates need other than identifying 'good strategic communications' as important.

There were two exceptions; the EPHF frameworks developed respectively by the Ministry of Health Services of the Canadian province of British Columbia in 2005 (BC Population Health and Wellness Branch, 2005) and the Public Health Agency of Canada (PHAC) in 2008 (PHAC, 2008). In the former, advocacy is identified explicitly as an EPHF. The BC framework states categorically that public health professionals require special training for advocacy, although it does not specify the skills, competencies or training required. The EPHF framework developed by the PHAC defines 36 core competencies organized under 7 essential functions, one of which is 'partnerships, collaboration and advocacy'. It further stipulates that public health practitioners should be able to "advocate for healthy public policies and services that promote the health and well-being of individuals and communities … and reduce inequities in health status and access to health services". As with the BC report, the PHAC framework does not identify the skills and competencies needed by public health practitioners to become effective advocates.

Advocacy and Public Health Associations

Advocacy has been and continues to be a core function of public health associations (PHAs). In response to a survey of its national PHA members around the world conducted by the World Federation of Public Health Associations (WFPHA) in 2011 and again in 2014, respondents identified advocacy as a core organizational function for public health associations (WFPHA, 1992; Chauvin et al., 2016).

PHAs play an important role in representing civil society's voice for healthy policy and practice within both the public and private sectors. In their role as civil society advocacy organizations, public health associations convene diverse actors around the table and generate research, the results of which are used to support the formulation of policies and strategies; they represent the wide-ranging points of view of their members, and voice an independent, evidence-based, politically non-partisan perspective on issues that affect the public's health (CPHA, 2009).

Several public health associations have long-standing traditions as advocacy organizations. For example, the Canadian Public Health Association (CPHA) traces its advocacy efforts back to its establishment in 1910. During the association's formative years, its members advocated through briefs, position papers, letters, meetings, and articles in the Canadian Journal of Public Health for action to be taken by government authorities on a wide range of issues affecting the public's health at that time, including water supply, sanitation, industrial effluent in rivers, infectious disease control (in particular tuberculosis, syphilis and cholera), and the promotion of green spaces in the country's emerging and expanding urban areas and playgrounds for children (CPHA, 2010). CPHA remained the country's primary advocate on public health issues over the next century and beyond, counting among its advocacy achievements the establishment of a federal ministry of health (1944), publicly funded and universally accessible public health and health care services during the 1950s and

1960s, vigorous advocacy for tobacco control beginning in 1959 and continuing through to the present day, the adoption of an ecosystem approach to human health beginning in the 1970s, and attention and action on the social determinants of health in the 1980s and 1990s (CPHA, nd).

In recent years, CPHA advocated for enhanced gun and firearms control, the banning of the mining, transformation, export and utilization of asbestos, full access to health care services for refugees who arrive in Canada, the legalization of cannabis and decriminalization of other psychoactive substances, access to safe and supervised injection sites (which saw CPHA argue against the federal government before the country's Supreme Court), improved health and social services for Canada's Indigenous Peoples, addressing systemic racism and its impact on human health, and action on climate change (CPHA, nd). Several other national PHAs, among them the American Public Health Association (APHA), the Public Health Association of Australia (PHAA), the Royal Society for Public Health (RSPH-UK), the Public Health Association of New Zealand/Kahui Hauora Tumatanui, and the European Public Health Association (EUPHA), maintain well-documented archives about their advocacy efforts and accomplishments covering a wide range of issues affecting the public's health. (APHA, nd; PHAA, nd; RSPH-UK, nd; EUPHA, nd).

Advocacy campaigns and actions are not restricted to public health associations located in higher-income countries. PHAs in many lower- and middle-income countries, including Vietnam, Uganda, Tanzania, Cuba, Haiti, Romania, South Africa, and Bosnia & Herzegovina, played leadership roles in tobacco control advocacy, calling for strict tobacco products' marketing and sales, bans on smoking in public areas, and smoke-free hospitals and health facilities. Several PHAs in Africa, Asia and Latin America focused their efforts on advocating for enhanced public health education and training, better occupational health services, the prevention and control of both infectious and non-communicable diseases, and the quality of and access to essential public health services such as immunization and maternal-newborn and child health services[2]. Still others focused their efforts on water supply and sanitation and solid waste disposal. Some associations championed politically unpopular causes, such as the prevention and treatment of HIV and AIDS, access by women to a full slate of reproductive health services and better access to essential medicines (CPHA, 2009; CPHA,2010).

Several PHAs advocated for measures to address climate change, race and location as critical determinants of health, universal health care and sustainable health development. Some called for and successfully lobbied their national health authorities and governments to enhance pandemic preparedness protocols and to adopt the International Health Regulations following the SARS epidemic in 2002-2004. In 2020, PHAs in several countries are advocating for the application of evidence-based measures to prevent and control the transmission of the SARS-CoV-2 virus.

In 1992, predicated on the advocacy efforts and successes of several of its long-standing members, the WFPHA for the first time included advocacy as a core function within its five-year strategic plan (WFPHA, 1992). The aim was to enhance the federation's capacity to influence policies at the global level (in particular, within WHO) and, simultaneously, encourage and support national public health associations to do the same at the national level, with their respective national Ministries of Health.

Advocacy remains an essential function within the WFPHA as reflected in subsequent organizational strategic plans (WFPHA, 2007; WFPHA, 2013). It continues to be as a core WFPHA function today – with a shift in focus from assisting member associations in their national advocacy capacity efforts and capacity building to the WFPHA's own capacity to influence global-level policies and norms/standards to improve population health and health equity

[2] Beginning in 1986, CPHA provided financial and technical assistance, through funding support by the Government of Canada, to national PHAs in low- and middle-income countries to strengthen their organizational capacity. One of the elements of what became known as the Strengthening of Public Health Associations (SOPHA) Program, which ended in 2012, was to build advocacy capacity within national and regional PHAs to influence policies and practice within and outside of the health sector. Their advocacy campaigns and achievements are documented in the SOPHA Program's annual reports, archived at CPHA.

(WFPHA, 2018). In 2016 the Federation published the Global Charter for the Public's Health, a framework wherein advocacy is one of four enabling determinants that support the achievement of essential public health functions (WFPHA, 2016).

Moving ahead

The world's public health community has, over many years, and continues to utilize advocacy to influence thinking, decision-making and action around policies and practice within both the public and private sectors to promote, safeguard and improve human health and to achieve health equity. In the case of the PHA movement at national, regional and global levels, advocacy is a core function.

Public health professionals and practitioners play an important role in public health advocacy. Whilst people employed within the public/government sector might be restricted from and reticent to participate directly in advocacy efforts, their personal viewpoints and opinions can be voiced through the advocacy efforts of civil society organizations to which they belong, such as national professional associations (for example, medical, dental, nursing and other health discipline associations) and PHAs. Based on the achievements of PHAs, their members, for the most part public health professionals and practitioners, are active participants in their organization's advocacy efforts.

Although the concept of advocacy is absent from or mentioned obliquely within the EPHF frameworks published by some key public health bodies, it is, for all intents and purposes, a core function within public health. While no explicit mention is made of advocacy within the WHO's original EPHF framework, it would appear that WHO now recognizes advocacy as an important tool, as evidenced through the publication of the WHO advocacy guide to address chronic diseases and the promotion of advocacy as a means to achieve increased immunization coverage and universal health care. Several countries now accord a visible role to advocacy within their national EPHF frameworks.

My call to public health colleagues around the world: let’s advocate for the incorporation of advocacy as an essential public health function or at the least as a critical enabler for EPHF as proposed by the WFPHA. And at the same time, let’s advocate for advocacy to be recognized as a competency for public health practitioners.

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DECLARATIONS

Competing interests: None to declare.

Funding: This article was written without remuneration.

Acknowledgements: The members of national public health associations around the world whose advocacy efforts have had and continue to have a positive impact on human health and health equity.

CASE 01

MAKING THE CASE FOR SUSTAINABLE INVESTMENT IN WELL-BEING AND HEALTH EQUITY: A PRACTICAL GUIDE FOR ADVOCACY

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Key words: sustainable investment, health equity, evidence-informed policy, advocacy for health

ABSTRACT

Evidence shows that current investment policies and practices are unsustainable and often result in high costs to people, communities, the economy and the planet. To tackle the current increasing social, economic and environmental challenges and create a more inclusive and equitable society, there is a need for evidence-informed and sustainable solutions and innovative approaches for policy action and investment prioritisation. The WHO CC on Investment for Health and Well-being has developed a Guide that facilitates the development of evidence-informed, context-tailored advocacy reports to enable healthy policy- and decision-making across different sectors, levels of government and country settings. The Guide supports to prevent disinvestment in health, increase investment in (public health) prevention and mainstream cross-sectoral investment to address the wider determinants of health and equity, driving sustainable development and prosperity for all. The Guide takes a step-by-step approach with relevant practical tools and resources on how to review, synthesize, design and communicate public health and health economics evidence into policy and practice. Essential elements of the Guide are the health economics approaches, methods and tools to build the case for investment; showing the burden and costs of inaction in parallel with available sustainable solutions, which bring health, social, economic and environmental benefits (returns on investment). Politicians, policy and decision-makers are challenged to make a more sustainable use of resources, balancing short- and long-term needs and priorities, for the wellbeing and prosperity of current and future generations. Investing in health and understanding its value and interdependence with sustainable development – as an outcome, as well as a prerequisite, is critical to achieve this.

INTRODUCTION

Populations and communities face ongoing increasing social, economic and environmental challenges. Urgent action is needed to address these in a sustainable way. Evidence shows that current investment policies and practices ('business as usual') are unsustainable and often result in high costs to people, communities, the economy and the planet (Dyakova et al., 2017). This has become even more evident as communities deal with the impact of COVID-19. Strong political commitment and action at all governance levels and across all sectors is needed to shift the ever more limited resources towards sustainable economies and nations to achieve healthy and prosperous lives for present and future generations (Brown et al., 2014; Dyakova et al., 2017). To accomplish this, it is widely recognised that there is a need for evidence-informed solutions and innovative approaches for policy action and investment prioritisation (Dyakova et al., 2017). This is reflected in various international agendas. The *United Nations 2030 Agenda for Sustainable Development* advocates for working in transformative ways to achieve sustainability (United Nation's General Assembly, 2015). The *WHO European Roadmap* (World Health Organization Regional Committee for Europe, 2017) to implement the *Sustainable Development Goals* and the *WHO European Health Equity Status Report (HESR)*[1] *Initiative* view health as an investment rather than an expense (WHO Regional Office for Europe, 2018). The *Global Charter for the Public's Health* views health as a vital component for sustainability and equity, achieved through evidence-based decision making and advocacy as core function (World Federation of Public Health Associations, 2016).

In 2016, Public Health Wales, the national public health institute for Wales, identified the need to develop an advocacy resource to inform sustainable investment in (public) health and well-being. As a result, the *'Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales'* (hereafter referred to as the *'Making a Difference'* report was developed (Dyakova et al, 2016).

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[1] "The WHO European Health Equity Status Report initiative (HESRi) is being developed as a mechanism to promote and support policy action and commitment for health equity and well-being in the European Region. Specifically, the HESRi aims to shift political and policy focus from describing the problem to capturing progress and enabling action to increase equity in health." https://www.euro.who.int/en/health-topics/health-determinants/social-determinants/health-equity-status-report-initiative

The report showed the burden and costs associated with ill health and inequity in Wales, together with available sustainable policy and practice solutions. It advocated for sustainable investment in health and well-being through evidence-informed solutions, bringing savings, returns and added value to communities, society, the health sector and the wider economy. For example, the '*Making a Difference'* report synthesised evidence showing the (social) return on investing in specific public health interventions such as physical activity or violence prevention interventions. It was identified that supporting and investing in active transport strategies such as increasing cycling and walking in urban areas will save £0.9 billion over 20 years for the National Health Service (NHS) in Wales. Further, evidence presented in the 'Making a Difference' report shows that "a multi-agency approach sharing and using Emergency Department data saves £82 to society per £1 invested (in Cardiff, associated with a reduction in hospital admissions for violence)."

Following from the report, the need to develop a guide on how to translate and communicate health economics evidence in a way that can be used for (public health) advocacy purposes and facilitate the transmission of evidence, was identified. The Guide has been intended for a wide audience. It aims to help key stakeholders, advocates for health and equity, civil servants and other health and non-health professionals who have a role in informing, influencing or shaping national and subnational policy and practice. This can include public health agencies/institutes, governmental departments, evidence review departments and policy and government advisory services.

CASE

Building on the successes of the *'Making a Difference'* report and gathering further evidence and lessons from other countries, the WHO Collaborating Centre on Investment for Health and Well-being (WHO CC) has developed the *'How to Make the Case* *for Sustainable Investment in Well-being and Health Equity: A Practical Guide'* (hereafter referred to as the Guide) (Dyakova et al., 2019). The Guide is making the case for decision/policy-makers to view public health as an investment rather than an expense. It is also linking and aligning with the *European Health Equity Status Report Initiative* (WHO Regional Office for Europe, 2018), exploring and advocating how to invest in health equity and its wider determinants.

The Guide has the following aims:

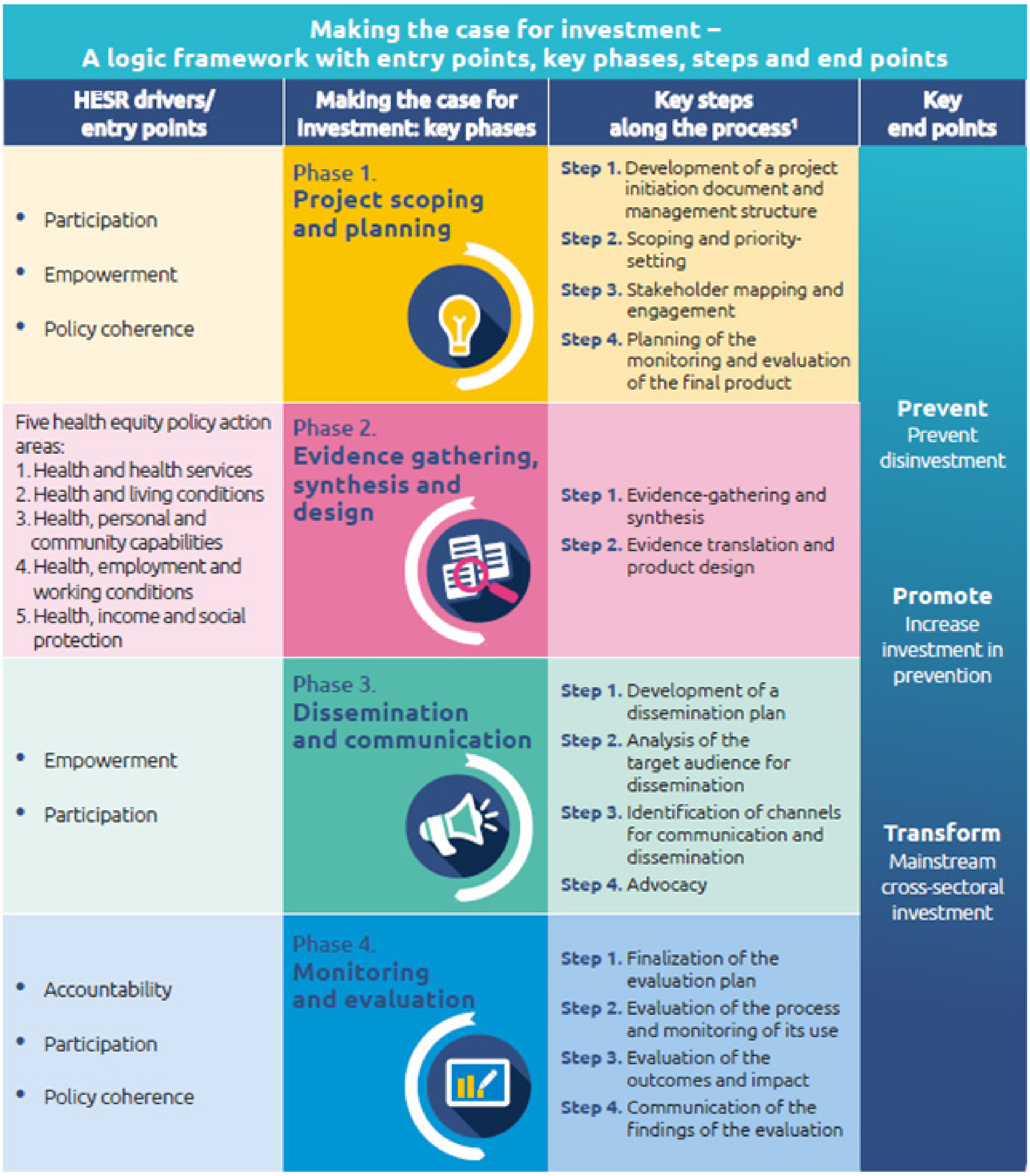
1. To facilitate the development of evidence-informed, context-tailored advocacy reports and other relevant documents and tools to enable healthy policy- and decision-making across different sectors, levels of government and country settings.

2. To support capacity and skills for making the case and advocating for investment for well-being and health equity

The Guide helps users to develop evidence-informed reports to:
Prevent disinvestment in health; Increase investment in prevention (public health); and Mainstream cross-sectoral investment to address the wider determinants of health and equity, driving sustainable development and prosperity for all.

The Guide was developed through a mixed-methods approach. This included an evidence review, wide stakeholder engagement, international multi-sectoral expert consultation and peer review. It is based on the theoretical knowledge-to-action framework (Graham et al., 2006). Through this process relevance of the Guide and transferability across sectors, contexts, settings and countries was ensured.

The Guide outlines four distinctive, though interrelated phases of making the case for investment in well-being and health equity (Figure 1-1). It takes a step-by-step approach with relevant practical tools and resources on how to review, synthesize, design and communicate public health and health economics evidence into policy and practice.



Making the case for investment –
A logic framework with entry points, key phases, steps and end points

HESR drivers/ entry points	Making the case for investment: key phases	Key steps along the process¹	Key end points
• Participation • Empowerment • Policy coherence	Phase 1. **Project scoping and planning**	**Step 1.** Development of a project initiation document and management structure **Step 2.** Scoping and priority-setting **Step 3.** Stakeholder mapping and engagement **Step 4.** Planning of the monitoring and evaluation of the final product	**Prevent** Prevent disinvestment **Promote** Increase investment in prevention **Transform** Mainstream cross-sectoral investment
Five health equity policy action areas: 1. Health and health services 2. Health and living conditions 3. Health, personal and community capabilities 4. Health, employment and working conditions 5. Health, income and social protection	Phase 2. **Evidence gathering, synthesis and design**	**Step 1.** Evidence-gathering and synthesis **Step 2.** Evidence translation and product design	
• Empowerment • Participation	Phase 3. **Dissemination and communication**	**Step 1.** Development of a dissemination plan **Step 2.** Analysis of the target audience for dissemination **Step 3.** Identification of channels for communication and dissemination **Step 4.** Advocacy	
• Accountability • Participation • Policy coherence	Phase 4. **Monitoring and evaluation**	**Step 1.** Finalization of the evaluation plan **Step 2.** Evaluation of the process and monitoring of its use **Step 3.** Evaluation of the outcomes and impact **Step 4.** Communication of the findings of the evaluation	

Figure 1-1: A Logic Framework with entry points, key phases, steps and end points guiding the reader through the process of developing an evidence-informed advocacy document to make the case for sustainable investment for health and well-being.

Phase 1. Project scoping and planning.

A clear question outlining the policy/health area(s) for investment must be identified at the beginning of the project, guided by the five policy action areas and the aims to prevent, promote and transform.

Initial project scoping and planning are essential, taking account of and aligning with the national or local context to ensure policy coherence.

Early stakeholder mapping, engagement in participation and accountability are key to the success of the project, empowering various decision-makers and the public.

Phase 2. Evidence gathering, synthesis and design.
A clear evidence search, review and synthesis protocol is a necessary product to develop.

It is essential to consider the economic and social argument for investment along the five HESR policy action areas, including the commercial determinants of health and equity.

The evidence should be synthesized and then translated into a concise and easy to understand product, tailored to the target audience and context.

The use of different formats, including visuals, is key to increasing the impact of the product. A multi-disciplinary team of professionals is required to develop a high impact product.

Phase 3. Dissemination and communication.
The dissemination plan should be tailored to the needs and preferences of the target audience.

An advocacy plan is required to engage with the target audience, aid their understanding, ‘buy-in’ and use of the product, and to enable empowerment of the relevant stakeholders.

Analysis of and adaptation to the political context is essential to maximize uptake and application.

Phase 4. Monitoring and evaluation

A detailed evaluation plan with indicators of success is essential and should be developed at the outset of the project to facilitate and ensure accountability.

Monitoring of the outputs and outcomes of the plan is a continuous process, which should start shortly after publication of the product.

Targeted stakeholder involvement and feedback are key in the evaluation process to ensure wide participation and policy relevance.

Essential elements of the Guide are the health economics approaches, methods and tools to build the case for investment; showing the burden and costs of inaction in parallel with available sustainable solutions, which bring health, social, economic and environmental benefits (returns on investment).

The Guide was developed as a full online interactive version (https://phwwhocc.co.uk/wp-content/uploads/2020/07/How-to-Make-the-Case-Guide.pdf), as well as a PDF summary (https://phwwhocc.co.uk/wp-content/uploads/2020/07/How-to-Make-the-Case-Summary.pdf).

The four phases of the Guide link well with several components of the *Global Charter for the Public's Health* (World Federation of Public Health Associations, 2016). For example, the function to provide information to improve the public's health and minimize health inequities, goes in line with Phase 2 of the Guide to gather and synthesis evidence to enable advocacy for healthy policy and decision-making for sustainable development. Another key function as outlined in the *Global Charter for the Public's Health* is prevention of disease and promotion of public health, one of the main aims of the Guide is to 'increase investment in (public health) prevention. The Guide presents itself to be a valuable resource to achieve the aims of the *Global Charter for the Public's Health*.

DISCUSSION

Politicians, policy and decision-makers are challenged to make a more sustainable use of resources, balancing short- and long-term needs and priorities, for the well-being and prosperity of current and future generations. Investing in health and understanding its value and interdependence with sustainable development – as an outcome, as well as a prerequisite, is critical to achieve this.

Making progress towards healthy prosperous lives for all requires systematic and sustainable action, including scaling up and adapting what works, and generating new solutions, alliances and tools that break down the barriers to progress. We already have good instruments to describe the problem. We urgently need appropriate know-how to develop and implement solutions and to enable a coordinated approach to advocacy and real life application. This Investment Guide, developed by the WHO CC at Public Health Wales, provides a useful framework and resource to empower decision-makers to take better-informed decisions and transformative action.

During the initiation and development phase of the *'Making a Difference'* report and the Guide, the project team has encountered several challenges and was able to learn from those for future projects. Please see table 1-1 and 1-2. The tables are not an exhaustive list but provides and insight into the process and rationale of the cause of action during the development of both products. The Guide has been widely disseminated nationally and internationally and it is already used as a skills building tool in public health seminars. An example of its practical use, is helping to build capacity for advocacy in sustainable health investment through a skills building seminar at the European Public Health Conference 2019. It is also planned to develop training resources and skills building webinars, tailored to the needs and priorities of different countries and contexts. The Guide supports advocates for health and equity who have a role in informing, influencing, engaging or shaping policy and practice to develop better advocacy tools for sustainable investment in health equity and well-being. The Guide aspires to improve the uptake of evidence for good practice in decision- and policy making and can be used to mobilise and tailor evidence.

Table 1-1: Challenges and lessons learned during the process of the development of the 'Making a Difference' report

Challenges	**Lessons learned…**
The report had a *broad scope*, allowing the inclusion of a variety of different public health related topics (including harmful behaviours such as alcohol and substance misuse but also physical activity and economic and social inequalities)	The report was developed to inform the newly elected Welsh Government in 2016, this demanded for a broad scope of the document to provide relevant and sufficient information to decision-makers. The project team kept in regular contact with the stakeholder group and consulted topic experts along the development process of the report to include the most relevant and up to date evidence to draw key conclusions.
Broad/ diverse target audience (such as decision/policymakers, specialists and non- public health specialists)	The project team made the decision to keep the scope of the document wide and not go into too much detail. This allowed the coverage of a variety of public health related topics ('no deep dive') and inform a variety of different stakeholders. Even though the report was broad, the number of topics was limited based on the priority areas of the key target audience. In order to incorporate the most important information for the target audience, the draft version of the report was circulated for feedback at 3 stages during the development. Prior to this stakeholder prioritisation mapping was undertaken to balance confronting priorities. Key messages were developed and phrased in a way that were applicable to a variety of the target audience and different contexts. The project team also decided to develop another follow-up report ('*Driving Prosperity for All through Investing for Health and Well-being: An Evidence Informed Guide for Cross-sector Investment*', 2019)[1] which mapped identified public health actions to improve health and well-being and reduce inequalities against different key stakeholders and their responsibilities.
The project team identified and synthesized a *large body of evidence* (this resulted from the broad scope and the diverse stakeholder group including local, national and international government representatives, directors of Public Health, clinical managers and budget holders but also topic experts) and had to work against a very *tight deadline*.	It was decided to only include 'high level' documents and evidence such as systematic reviews, excluded were primary data sources.

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[1] Dyakova et al. (2019). Driving Prosperity for All through Investing for Health and Well-being: An Evidence Informed Guide for Cross-sector Investment. http://www.wales.nhs.uk/sitesplus/documents/888/PHW-Prosperity-for-all-report-%28Eng-web%29.pdf

Table 1-2: Challenges and lessons learned during the process of the development of 'the Guide'

Challenges	Lessons learned…
The Guide includes *all elements of (public health) advocacy* to communicate effectively to the target audience	The project team decided to keep the different phases of the Guide broad and not to go into depth but include the most relevant and up to date key messages from the respective areas of interest.
Broad target audience and diverse stakeholder group as well as informant environment (including WHO, EuroHealthNet and other international experts with different priority areas such as from evidence synthesis from Health Intelligence colleagues or colleagues focusing on public health decision making processes)	The team undertook a stakeholder mapping exercise, this allowed for a more relevant and timely outcome. A wide consultation process with several rounds allowed to capture and incorporate most recent and robust evidence. The Guide is also the first product under the WHO CC workplan, which is closely linked to the programme of work and priorities of the WHO EURO Region. The project team decided to have practical examples and tools incorporated into the Guide to support (practical) understanding and usage of different stakeholders.
Adjusted direction and took decision to add a health equity lens to the Guide and link to HESRi due to a change of leadership of main stakeholder (change of direction of collaborating WHO office workplan)	A broad stakeholder group and involvement of topic experts helped to incorporate suggested changes and find relevant evidence and gain understanding of health equity. It also helped, that no tight deadline was agreed upon at the start which allowed for flexibility in the approach.

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DECLARATIONS

Competing interests: There are no competing interests.

Funding: All costs have been covered by Public Health Wales, the WHO Collaborating Centre on Investment for Health and Well-being. No external funding received.

Authors’ contribution: Anna Stielke has been responsible for writing the case study. Kathryn Ashton Brown has reviewed and contributed to the case study. We confirm that all authors have read and approved the final manuscript.

Acknowledgements: We would like to thank Professor Mark A Bellis (Director of the WHO Collaborating Centre on Investment for Health and Well-being) and Christine Brown (Head, WHO European Office for Investment for Health and Development, Venice, Italy); as well as the International Health team of the WHO Collaborating Centre on Investment for Health and Well-being for their support.

CASE 02

LOCAL EXPERTS AND GLOBAL EVIDENCE: CATALYSTS FOR POLICY CHANGE IN THE PHILIPPINES

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ABSTRACT

Our contribution to the passage of a child restraint law in the Philippines demonstrates the importance of helping local experts share their stories and amplify each other's messages, on the foundation of global best practices and evidence. This is particularly relevant for national public health associations, which combine national expertise and prestige with a global network.

The Child Safety in Motor Vehicles Act (SB 1971), signed into law in February 2019, was the country's first mandatory child restraint law. Health advocates in the Philippines had identified the issue as a priority, but the general public was largely unfamiliar with the problem and its solutions. To change this dynamic, Bloomberg Philanthropies invited our organization, the Global Health Advocacy Incubator (GHAI), to join of a group of partners and stakeholders that included the Global Road Safety Partnership and the World Health Organization. Our role was to help local partners build their capacity for advocacy and conduct a successful policy change campaign.

The lessons we've learned are applicable to many other situations. Local experts are the best leaders for helping their countries adopt health policies to improve outcomes on a broad scale, even if they're not already addressing those particular issues. We also learned that collaboration is key to identifying the applying the lessons that have already been learned in other places, and to building on the capacity of local organizations while leveraging the complementary strengths of in-country partners.

INTRODUCTION

An advocacy campaign in the Philippines contributed to the passage of the country's first mandatory child restraint law in 2018. The campaign was led by Filipino civil society organizations that supported local experts and other stakeholders to share their stories and amplify each other's messages alongside global evidence and best practices. These organizations' experiences and ultimate success are relevant for national public health associations, which combine national expertise and credibility with a global network.

The Child Safety in Motor Vehicles Act was passed in December 2018 and signed into law in February 2019 (Republic Act Nº 11229, 2018). Many countries still lack such laws, even though road traffic injuries are the leading cause of death for 5-29 year-olds globally, and car seats can reduce the risk of death in a crash for small children by up to 80 percent (FIA Foundation, 2009).

Health experts in the Philippines had identified the issue as a priority, but the general public was largely unfamiliar with the problem and its solutions. To change this dynamic, Bloomberg Philanthropies invited our organization, the Global Health Advocacy Incubator (GHAI), to join a group of partners and stakeholders that included the Global Road Safety Partnership (GRSP) and the World Health Organization. GHAI supports civil society organizations that advocate for public health policies that reduce death and disease, across health issues and in diverse political systems. Our role was to support local partners to strengthen their capacity for advocacy and conduct a successful policy change campaign.

Road safety is a global issue. There are more than 1.35 million deaths and up to 50 million injuries on the road every year, and Bloomberg Philanthropies has determined that “Nearly 85% of the world's countries lack adequate laws to counter the growing rates of traffic deaths and injuries” (Bloomberg Philanthropies, 2020).

Advocates and experts around the world are addressing this problem, including many who aligned around the United Nations Decade of Action for Road Safety 2011-2020, which called on governments to take action on capacity building, safe drivers, safer vehicles, safer infrastructure and post-crash response (World Health Organization [WHO], 2020). GHAI supports road advocates in Bangladesh, China, Colombia, Ecuador, India, Mexico, Philippines, Tanzania, Uganda and Vietnam, and formerly supported activities in Russia and Thailand.

The campaign in the Philippines illustrated advocacy's role as an enabler of health services and outcomes. It shows how advocacy can advance all three objectives of the Global Charter for the Public's Health: encouraging work across sectors of society, planning and implementing strategies for better health outcomes, and ensuring a comprehensive approach to tackling threats to health (World Federation of Public Health Associations [WHFPA], 2016).

CASE

Prior to the passage of RA 11229, the Philippines had already passed laws addressing four out of the five behavioral risk factors – speed, use of seatbelts and helmets, and drink driving – but did not have a law mandating the use of child restraint systems (CRS). However, the number of road crashes in nation's capital region Metro Manila had been in an upward trend for the past decade, averaging 262 road crashes daily (Metropolitan Manila Development Authority [MMDA], 2015). Meanwhile, automotive sales reached milestones in 2016 and 2017, with passenger cars making up almost 40% of the share (Autoindustria.com, 2016). Thus, civil society identified a need to pass a law to address the policy gap in an attempt to further protect children from increasing road crashes.

GHAI and our local partners faced multiple challenges to securing passage of a child restraint law. From the beginning, the issue was low on the government's list of priorities, and there was no real public demand for political leaders to take on the issue. One example of this lack of prioritization was that there was no available disaggregated data on the number of children involved in road crashes—which also made it harder to build a case for making the issue a priority. In addition, child restraints contradicted the norm: caregivers preferred to hold young children in their arms, which provided them with a sense of physical security—so much so that addressing this belief eventually became a focus of the campaign. The resistance to car seats was apparent from the numerous focus group discussions and public consultations that advocates conducted throughout the campaign.

Local leadership would be critical to the campaign's success. Fortunately, the Philippines has a strong tradition of civil society engagement. When the project began, no organizations were advocating for a national child restraint policy, but many had relevant public health and safety experience. GHAI and GRSP surveyed the landscape to identify seasoned public health advocates who recognized a need to expand their expertise to include road safety, and GHAI supported these local leaders in building a coalition of committed stakeholders.

This process included guided self-assessments for organizations to evaluate their strengths across multiple domains: policy analysis stakeholder mapping, advocacy communications, coalition building, campaign planning, and monitoring and evaluation. GHAI used these assessments to develop trainings through workshops, technical assistance and online training. For example, in October 2017, GHAI launched its social media accelerator program, which helps organizations increase engagement on digital platforms. This program was supplemented with a digital content and design training. Through structured exercises, the accelerator program helped organizations go from a combined total of 7,097 followers on Facebook to 300,000 followers and from 206 monthly engagements (comments, post sharing, etc.) to an average of 100,000 monthly engagements.

The next step was to conduct a thorough analysis of the political and media environments that would shape the legislative process. The analysis helped the advocates identify key legislators to approach and to develop a strategy for working with other stakeholders relevant to the campaign. The political map that resulted, with the information needed to bring tailored messages directly to elected representatives, was incorporated by local organizations into an integrated campaign plan.

In the Philippines, civil society can directly propose legislative bills to lawmakers for the latter to author and file. To maximize this opportunity, advocates proposed a draft bill to the identified legislative champions. The bill contained global best practices on CRS.

In order to maintain the commitment of elected representatives throughout the legislative process, the coalition knew it would be critical to demonstrate public support. GHAI helped the coalition develop a communications strategy that would provide support to policy initiatives, generate coverage by news media and position coalition members as the leading voices on road safety advocacy. GHAI also sponsored qualitative and quantitative research and message testing with focus groups to measure message effectiveness for key audiences.

Policymaker Engagement

There was no indication that a CRS bill would be introduced or adopted without the encouragement and support of advocates, the offer of technical assistance, and the emergence of public awareness. Based on the political map, advocates identified and approached three legislators. These were Congressman Cesar Sarmiento, Congressman Michael Velarde, Jr. and Senator Joseph

Victor Ejercito. Advocates presented the idea of the legislation to them as an easy and effective way to reduce child road deaths and injuries.

The lawmakers were selected based on a combination of their relevant leadership positions and past interest in road safety. Rep. Sarmiento was Chair of the House Transportation Committee. Sen. Ejercito was Chair of the Senate Health Committee and Vice-Chair of the Public Services Committee, and he was a motorcycle enthusiast who had authored road safety laws in the past.

To gain the legislators' trust and confidence, the coalition demonstrated their credibility as experts. Advocates presented the legislators with a draft of their proposed bill and provided the staff with the data and evidence needed to support it. When the staff needed information the advocates didn't have, they worked with local and global experts to obtain it.

The legislators also needed to be assured that the public would support the measure. Advocates were proactive and transparent in sharing both positive and negative feedback from the public and possible solutions for addressing it.

The coalition further strengthened their relationships with legislators by engaging them in awareness campaigns for their colleagues. This helped the political leaders see themselves as champions of the issue and facilitated additional collaboration. For example, the bill's sponsors attended a ribbon-cutting ceremony to open the first of four photo exhibits advocates placed in the Senate and House of Representatives buildings. The ribbon-cutting ceremony to open the first House event was attended by the legislative champions.

This consistent engagement paid off. Under the leadership of Rep. Sarmiento, in May 2016 the House Transportation Committee issued a Transportation Policy Framework in that recommended the adoption of a national law on child restraints, while Rep. Velarde filed a relevant legislation.

Advocates present throughout committee hearings and Technical Working Group sessions as expert speakers. They also provided data and studies during legislative debates and provided answers to difficult questions posed to the legislative champions. As a result of their engagement, legislators adopted recommendations from the advocates throughout the deliberations, and the Explanatory Notes filed with the bills cited data the advocates provided. The bills' leads also acknowledged the advocates' roles during their privilege speeches and media appearances.

The legislators had a deadline: 14 December 2018, when both houses of Congress would recess for the Christmas holiday. The next year, 2019, was an election year, when passing the legislation would be much more complicated. The bill passed the House of Representatives on 6 February 2018 with a unanimous vote, but it took until 8 October for the Senate to pass its version—again, unanimously. Then, both bills had to be aligned, because different language had been added to the two versions. Members of the advocacy coalition followed up with legislative staff to consolidate the language and attended congressional reconciliation meetings. The final legislation passed out of the Bicameral Conference Committee Hearing in November 2018 and was unanimously approved by both Houses on 12 December 2018. Comments from legislators indicated that the information and facilitation provided by the advocates was instrumental in shepherding the bills through the process. The President subsequently signed the measure on 22 February 2019.

Media Advocacy

Local organizations used media to build awareness of the need for a child restraint bill. Members of the coalition developed information education campaign materials across various platforms. GHAI funded a paid media campaign that began in November 2017 and continued throughout 2018. It included ads on television and in leading newspapers, Filipino celebrities recording public service announcements and civil society organizations making the morning show circuit on television and radio. In all, the media campaign reached 95.3 million people through TV and radio, based on viewership ratings reports.

GHAI partnered with Probe Media Foundation to conduct a fellowship program to ensure that journalists understood the child restraint bill and why it had been introduced. The fellowship program contributed to a steady release of stories related to CRS. Probe also conducted a workshop to prepare coalition members to speak with the press. This training was especially useful for live TV and radio interviews that GHAI facilitated for its partners.

GHAI organized two press conferences during the advocacy campaign. These generated stories that aired on primetime news shows and were published in leading newspapers. Policymakers used the data presented in the press conferences to explain the need for a of child car seat law during congressional debates. On 19 March 2019, civil society organizations hosted an additional press conference to announce the bill's passage. Sixty people attended, with journalists representing CNN Philippines, six domestic television stations and all major newspapers. Conversations with members of Congress and senators provided anecdotal confirmation that media coverage provided them the space they needed – and perhaps even some pressure—to ensure the bills' passage.

All these efforts helped Filipino parents understand the need for a CRS law. The impact was evident in social media engagement, where there was a significant decrease in comments questioning the reason for a law. The importance of the media campaign was further confirmed by an executive of the biggest mall in the Philippines, who shared in a meeting that there was an influx of parents inquiring about and buying child car seats even though the law's implementation wasn't set to take place until 2021.

DISCUSSION

Several factors contributed to the campaign's success. First, the political map allowed advocates to identify and work with legislators who could move the bill through Congress and explain it to the public. The campaign also benefited from the advocates' ability to demonstrate their role as credible and reliable experts able to share both local and international evidence. Having strong support from civil society, who were able to show that the bill addressed a public concern, made it easier for the legislators to champion the measure. As the advocacy campaign won goodwill, some legislators also seemed to see the bill as an opportunity to elevate their own personal and political profiles.

The lack of disaggregated data about child road deaths posed a challenge. Advocates responded by drawing on the available literature and data from other countries. They also included improved data collection, and other activities to address policy and practice gaps, in the draft legislation.

To address the fact that there was low public awareness about the issue at the beginning of the campaign, advocates packaged the legislation as "low-lying fruit" that could save lives without competing with other government priorities that had grabbed public attention. At the same time. media campaigns increased public understanding of CRS and the associated bills.

Because public knowledge was low at the start of the campaign, and financial and human resources were limited, advocates had to choose their media engagements strategically. Media activities were planned to align with events that would already generate attention, such as Road Safety Week during the month of May and key stages in the legislative process.

Knowledge of CRS was also low at transportation agencies, which would be responsible for implementing a new law and whose advice legislators were likely to seek. Advocates helped familiarize the agencies with CRS and build their technical capacity, particularly on implementation and standards, by drawing on the expertise of foreign counterparts and tailoring it to be relevant to the local context. Advocates also arranged training opportunities for agency officials and included a one-year transition period in the law to allow for public education as well as capacity-building for local enforcers.

CONCLUSION

The Philippines' success shows that local experts are the best leaders of campaigns supporting policies to improve health outcomes in their countries. The Child Safety in Motor Vehicles Act is already having an impact globally. The advocacy approaches applied in the Philippines were adapted by organizations in India, where more than 400 people die on the roads every day. Indian organizations supported the passage of the Motor Vehicles Amendment Act, which mandates child safety restraints among other road safety measures and was signed into law on 9 August 2019.

National and local civil society will determine whether their countries are prioritizing evidence-based public health policies. Global networks can share evidence and best practices, but most importantly, they can support local leadership.

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DECLARATIONS

Competing interests: The authors have no competing financial or non-financial interests.

Funding: The authors wrote this article while employed by the Global Health Advocacy Incubator. The project described in the article was funded by Bloomberg Philanthropies (as noted in the text).

Authors' contribution: ABR, MET and AJE each contributed to the writing and reviewed the manuscript.

Acknowledgements: This article drew on information provided by Sophia San Luis (ImagineLaw) and Evita Ricafort (ImagineLaw).

CASE 03

ADVOCACY FOR INTEGRATING HEALTH IMPACTS IN CLIMATE CHANGE NEGOTIATIONS

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Key words: climate change, environment, health diplomacy, global health

ABSTRACT

Climate change has important health impacts, while they will be felt everywhere in the world, they will disproportionately affect the most vulnerable regions furthering global inequities. Action on climate change touches upon all functions of public health from prevention and promotion through to protection.

This case focuses on the health sector advocacy in the United Nations Framework Convention on Climate Change (UNFCCC) negotiations leading to the Paris Agreement in 2015. It highlights the challenges in finding the right communication approach towards other sectors and in building capacity and governance structures within public health to engage in a complex international political process. It describes the outcomes relevant for health in the Paris Agreement, the outputs from health sector advocates over the years that have followed, as well as current opportunities for continued engagement.

Advocacy effort by the health sector transitioned from health focused asks to environmental asks expected to have the greatest impact on health. On-the-ground negotiations were supported by the well-timed release of scientific evidence supporting the health asks as well as rapidly policy analyses of negotiation texts and national commitments.

This case illustrates the importance of adapting messaging to context and target audience when in intersectoral fora. The challenges faced in uniting heterogenous organizations behind a single messaging and the ever-growing diversity of health and climate activism with its popularization through movements such as Fridays for Future, the Global Climate Strikes, and Extinction Rebellion.

INTRODUCTION

Climate change is recognized as having important health impacts and the importance of protecting health is acknowledged in the first article of the United Nations Framework Convention on Climate Change (UNFCCC), the international institution which first gave us the Kyoto Protocol and in 2015 the Paris Agreement (United Nations, 1992). The World Health Organization (WHO) estimates that between 2030 and 2050, climate change will cause an additional 250 000 deaths yearly (WH0, 2018), and while those impacts will be felt everywhere in the world, they will disproportionately affect the most vulnerable parts of the world furthering global inequities (WHO, 2018).

This case focuses on the health sector advocacy in the United Nations Framework Convention on Climate Change (UNFCCC) negotiations leading to the Paris Agreement in 2015 (UNFCCC, 2015b). UNFCCC negotiations are the political fora where countries, often through environmental and foreign affairs diplomats express their interests and the challenges they face in addressing the global anthropogenic climate change. It is a difficult diplomacy space for health focused organizations given the highly technical nature of some of the issues discussed, as well as the protracted negotiations which often take many years from conceptualization to policy decision.

This case highlights the challenges in finding the right communication approach towards other sectors and in building capacity and governance structures within public health to engage in a complex international political process. It describes the outcomes relevant for health in the Paris Agreement, the outputs from health sector advocates over the years that have followed, as well as current opportunities for continued engagement. Action on climate change touches upon all functions of public health. While we aim to take a health promotion approach through climate change mitigation, we also work on prevention when increasing the resilience of public health and healthcare systems through climate change adaptation. Unfortunately, climate impacts are already felt around the world and we now must deal with problems such increasing extreme weather events with a health protection approach. Climate change thus exemplifies a complex global health challenge: it is a problem that is multifaceted, that requires intersectoral action and international collaboration to be addressed.

CASE

The negotiations pertaining to the Paris Agreement were conducted by the Ad Hoc Working Group on Durban Platform for Enhanced Action (ADP) under the UNFCCC. The ADP met five times in 2015 concluding in Paris just prior to COP21 where the historical Paris Agreement was adopted. The presence of health advocates was minimal during those negotiations despite the recognition of the importance of this political agreement to protect health from climate change (Campbell-Lendrum et al., 2018). Only three health groups systematically attended all negotiation meetings: the World Health Organization (WHO), the World Medical Association (WMA), and the International Federation of Medical Students' Associations (IFMSA).

Most civil-society health advocates who were engaged had experience in local public health, in global health, and climate change, but no significant experience in international law and in translating health messaging for other sectors. Thus, advocacy efforts evolved significantly during that year as the joint experience of the group increased. Initially, efforts were unrefined and focused on getting the word "health" inserted in as many places as possible in the negotiation text. Despite this crude approach, the efforts initially seemed successful: leveraging past and new alliances with negotiators, the health advocates systematically managed to have some of the suggested health language included in the negotiated drafting text at the end of each ADP session. However, as the co-chairs of the ADP re-worked the text between meetings, those sections would, most often, end up being removed and the health sector would be set back to square one by the beginning of the next meeting (United Nations Framework Convention on Climate Change, 2015a, 2015c). After a few iterations of this fruitless process, the need to review the strategy was identified. This lead to a gradual transition from health-specific asks to environmental asks which would have the greatest impact: in short, the health sector gradually recognized that the Paris Agreement was not a health treaty (despite having often been lauded as such) but rather an environmental treaty with crucial importance for health.

This transition in strategies is exemplified by the evolution of advocacy and communication tools produced by the health community over the course of that year. At the first two meetings, the only tool used by health advocates were rapidly produced briefing papers with strong health background evidence, numerous concrete policy asks for negotiators, but a poor bridge of the two. Nevertheless, in June of that year, The Lancet Commission on Health and Climate Change produced its 2015 report titled "Health and climate change: policy responses to protect public health" (Watts et al., 2015) and provided the elements necessary to start translating health advocacy into environmental negotiator language.

That report highlighted climate change's potential to "reverse the health gains from economic development" and pointed out the co-benefits that could be gained across multiple sectors form rapid action. It was followed by the release of the first WHO UNFCCC Health and Climate Change Country Profiles (WHO, 2015) which identify climate hazards and their associated health risks specifically for each country, present opportunities for co-benefits to health from climate mitigation at the global level, and highlight which climate policy measures are already implemented and which could be further developed in each setting. Building on the lessons learned, a small group of health advocates worked to produce a yet more focused evidence-base to inform advocates at COP21. They conducted a rapid analysis of the Intended Nationally Determined Contributions (INDC), the voluntary national emissions reduction targets set by each Party under the Paris Agreement (Wiley, et al., 2015). This analysis evaluated the inclusion of health-related language in the INDC submitted before November 30th, 2015 for 184 Parties which had done so. Furthermore, the language was analyzed to differentiate which INDCs addressed health issues under their mitigation strategies and which under their adaptation strategies and negotiating groups analyses were performed. This offered all health advocates working on the negotiation of the Paris Agreement concrete guidance of where to focus final influencing efforts and brought to light which parties might have a more favorable view of engaging with the health sector.

In short, over the course of a few months, the health sector advocacy strategy was re-focused calling for:

- a 1.5-degree target for the climate treaty: the one most compatible with protecting the health of current and future populations;

- the inclusion of loss and damages i.e. the impacts that originate both from slow onset impacts including for example changes in sea level or extreme events and which include impacts on life, health, displacement and human mobility and thus affect health both directly and indirectly through a number of health determinants; while also continuing to support a few asks for the inclusion of health in very specific locations of the negotiation text and for specific reasons articulated in language understandable by an environmental sector representative.

This change of focus was possible because of a constant critical appraisal of past activities and the perseverance of a few individuals who provided continuity to the health sector civil society groups. It was further strengthened by timely data on the political positioning of Parties with respect to health in their INDCs.

Image 3-1
Late night meeting of health advocates during COP21 to discuss the state of negotiations and strategies for further influence.

Image 3-2
Public action by youth and climate advocates at the Ad Hoc Working Group on the Durban Platform for Enhanced Action (ADP) of the UNFCCC in Bonn to illustrate the negative health impacts of climate change and that failure to act on climate change has health consequences for people everywhere on the planet

DISCUSSION

This case illustrates the importance of adapting messaging to context and target audience when in intersectoral fora and remains relevant today as public health professionals continue engaging in the intricacies of the negotiation process of the UNFCCC and are still often disappointed by the lack of integration of their message in outcome documents.

Intersectoral health advocacy is challenging because of the necessity to identify key areas of influence in a sector other than one's own, then to translate health evidence into language readily understandable and convincing for experts of fields who not only work with a different terminology and knowledge base but also have a different conceptualization of reality and prioritization of values. These challenges are further exacerbated when considering the fact that the health climate change advocacy groups are themselves not homogenous but range from organizations representing health professionals for whom climate change advocacy is only one small mandate to grassroots organizations founded by civil society members uniquely to do advocate on climate change and health issues.

Nevertheless, it is noticeable that the climate and health constituency has significantly matured over the years and that past lessons have been integrated into current work. Since 2016, the Lancet Countdown on Health and Climate Change report (Watts et al., 2019) tracks yearly an ever-growing set of indicators of climate change and health action, and report launches serve as a regular opportunity to evaluate progress and prompt decision makers to take further actions.

The WHO has continued expanding it technical publications which focus on climate change and health policy including through the expansion of the WHO UNFCCC Health and Climate Change Country Profile Project in its 2019-2020 cycle, (WHO, 2019) and the production of the COP24 Special report on Health & Climate Change (Campbell-Lendrum et al., 2018). Additionally, solidifying long standing collaborations with health and climate NGOs, the WHO established in 2019 a formal partnership with civil society organizations through the WHO-NGO Working Group on Climate Change which aims to better align global advocacy efforts (World Health Organization & The Global Climate and Health Alliance, 2019). For numerous years up to then, the WHO had engaged with colleagues from various civil society organizations in preparation for and during UNFCCC meetings, namely co-organizing the Global Climate and Health Summit since 2013 and numerous other activities.

The WHO-NGO Working Group currently represents an innovative model of global collaboration between WHO and civil society and will hopefully pave the way for other similar collaborations in other fields. Finally, while the historically strong actors remain engaged, the health community now has stronger coordination with the increasing advocacy role that the Global Climate and Health Alliance is playing both during physical meetings of the UNFCCC and year-round through virtual coordination.

Climate change advocacy now attracts a more diverse group of actors as it has gained more mainstream recognitions through movements such as Fridays for Future, the Global Climate Strikes, and Extinction Rebellion. While health can serve as a meaningful lens to those advocates, the diversity of perspectives makes it yet more challenging in having a meaningful message. Nevertheless, efforts are currently underway by the WHO-NGO Working Group on Climate Change to make use of these lessons learned in order to frame engagement on timely issues such as the healthy recovery from the COVID-19 pandemic and the review of the Nationally Determined Contribution to the Paris Agreement. Those efforts build on years of experience of the organizations and individuals which are leading change and would likely not have been possible without the challenges previously encountered described in this case.

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DECLARATIONS

Competing interests: No competing financial interests.

Funding: This works has not been externally funded.

Acknowledgements: I wish to acknowledge the many colleagues who dedicate a lot of time and effort, very often voluntarily, to the cause of climate change which currently poses an existential threat to humanity. I also wish to acknowledge the organizations which have offered me a platform to engage in global diplomacy on this topic, namely the IFMSA and the WMA.

CASE 04

ADVOCACY ROLE OF A EUROPEAN NETWORK OF PUBLIC HEALTH RESIDENTS - THREE CASE STUDIES

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Key words: Public Health; Advocacy; Internship and Residency; Motivation; Health Workforce; Capacity Building; Staff Development; Sustainable Development

ABSTRACT

The European Network of Medical Residents in Public Health (EuroNet MRPH) is a network of national associations of professionals enrolled in public health residency programmes in European countries. Founded on the need to share information on training programmes, its activities soon exceeded information exchange and now include multinational research projects, facilitation of internship placements, regular meetings, collaborations with international and national public health organisations and, last but not least, advocacy work in the field of public health workforce development.

Three examples of EuroNet's advocacy work, on national and on the European level - presented here - provide a snapshot of different profiles of needs, approaches and results to specific issues faced by residents around Europe, highlighting the advocacy activities involved. EuroNet MRPH empowers medical residents and provides them with a platform where they can collaborate, innovate, exchange good practices and address issues they are facing during their training process. Based on our experience, an association or a network of associations can offer a flexible platform, a community of practice that facilitates capacity building and transfer of good practices, often accomplished through advocacy.

INTRODUCTION

The European Network of Medical Residents in Public Health (EuroNet MRPH) is a network of national associations of professionals enrolled in public health residency programmes around Europe. Since its official establishment in 2011, the network grew to 10 member associations (countries) around Europe (Figure 4-1), now representing over 4,000 public health residents, medical doctors and early career professionals of other educational backgrounds.

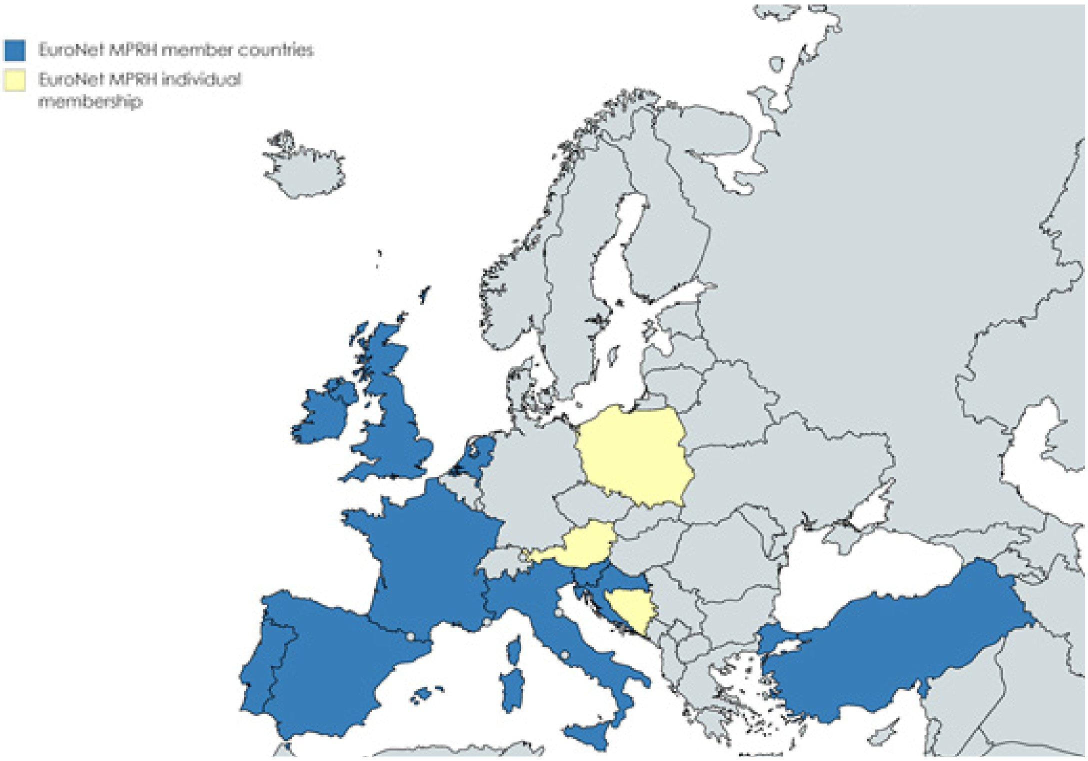

Figure 4-1: Map of member countries with national associations of public health residents and countries with individual membership in EuroNet MPRH.

EuroNet MRPH was founded as a network to share information on training programmes in different European countries. The activities of the network soon exceeded information exchange and now include multinational research projects, facilitation of internship placements, regular meetings with lectures and workshops on various professional and scientific topics, collaborations with international and national public health organisations and, last but not least, advocacy work in the field of public health workforce development.

The value created by EuroNet MRPH can be assessed through its role as an advocacy platform for the advancement of public health medical training, but also as a Community of Practice (CoP) (Wenger, 1999). CoPs are collective learning structures that develop spontaneously and are characterised by their domains, communities that constitute them and practices of their constituents. It is the third CoP element that greatly adds to the value of EuroNet MRPH where public health medical residents engage in a variety of activities from academic research to the implementation of health promotion strategies.

Below we present three cases, on both European and national levels, where EuroNet MRPH played an important advocacy role.

Figure 4-2: Logo EuroNet MPRH.

CASES

Case #1: Participation in development of a core competencies framework for the public health workforce in the European Region (2018)

In order to develop a strong public health workforce in Europe, WHO Europe's Coalition of Partners started a new work stream in 2018 with the goal of creating a core competence framework for public health training, an accreditation system for public health professionals (WHO-ASPHER, 2020) and a roadmap for public health professionalisation (Czabanowska et al., 2020). The Association of Schools of Public Health in the European Region (ASPHER), an independent organisation that promotes public health training and education, took the leading role in this work, putting a special focus on recognizing and highlighting the views and opinions of young public health professionals within the scope of the profession. Given EuroNet's work with early career public health professionals in Europe and previous collaborations, ASPHER invited EuroNet representatives to attend and actively contribute to the Coalition's work (ASPHER, 2018). This unique opportunity allowed for pooling of experiences and ideas from multiple young public health professionals to be integrated into a potentially important operational and strategic set of documents that directly influence careers of EuroNet members. Representing young public health professionals was only possible through an organised network such as EuroNet, enforcing the notion of collective action as a key element of advocacy. It additionally proved that networking is a useful tool with which the early career professionals could be involved in decision-making processes, and be able to have their voices heard (ASPHER, 2017).

Case #2: Participation in establishing the Association of Public Health Residents of Slovenia (2016) and redevelopment of the national residency training experience monitoring tool (2019)

Slovenia is a country with a small population and a consequently scarce public health workforce. With less than 15 public health residents, there was no perceived need to organise a formal association Slovenia. In 2016, public health residents from Croatia, who at the time were already involved in EuroNet MPRH, presented their activities to the Slovenian colleagues. Since establishing an association was conditional to joining EuroNet MRPH, the Slovenian public health residents decided to follow this route. After starting an association and joining EuroNet, they actively participated in several of Network's activities, such as forming a Europe-wide working group dedicated to researching the residents' learning environment and working conditions (Vidovic et al., 2018). Slovenian residents later used experience from the working group when the Committee for Education and Training of Resident Physicians of the Medical Chamber of Slovenia announced the plan to update the tool for monitoring residency training experiences. Based on the input from the Slovenian public health residents Committee updated the monitoring tool that is now being used by all residents physicians across Slovenia (Prosen, 2019).

Case #3: Participation in keeping the funding for the MSc, as part of the residency programme, in Spain (2016)

In 2016, the inclusion of the Superior Course in Public Health became a point of conflict in the National Commission of the Spanish Preventive Medicine and Public Health residency program. As a key element of the residency programme with a duration of at least 900 hours, the course constitutes the foundation of public health specialist training and offers residents the opportunity to enrol in an official master's degree in public health. While a sector within the commission defended the inclusion of the course, others vowed for its reduction or elimination. Members of the Spanish Association of Public Health Medical Residents (ARES MPSP) developed a strategy to make a case for maintaining the MPH as a fundamental part of the training programme, enabling future public health professionals to access tuition-free higher education. This initiative resulted in the "Homogeneity of the European Public Health Residency Training" study (González-Rubio et al., 2019), a six-question survey developed in collaboration with members of ARES MPSP and distributed among EuroNet MRPH membership in a number of European countries. Its aim was to characterize the disparities present among the public health residency programmes across Europe. The results became an advocacy tool for the advancement of quality and homogenised public health training in Europe. In seven of the nine participating countries, completion of a MPH was a compulsory element of the training programme.

Only in two of these seven were residents to cover the cost of tuition. These findings became an integral argument in the defence of a balance in the specialty's competencies, securing the MPH as a key element of the Spanish training program and ensuring its equivalence to its European counterparts. The work carried out by EuroNet MRPH continues to play a role in 2020 in some Spanish regions where the legitimacy of residents' access to an MPH is still disputed by local authorities.

DISCUSSION

The work that EuroNet MRPH has accomplished so far has empowered medical residents and provided them with a platform where they can collaborate, innovate, exchange good practices and address issues they are facing during their training process. Thus, the Network has successfully contributed with its advocacy activities to public health workforce development both on national and international level. Presented activities are integral to sustainable development of public health as a profession - advocacy and capacity building are core functions of a resilient public health system (Lomazzi, 2016). As is evident from the cases the Network enables early-career professionals to contribute and advocate for systemic changes. By presenting a majority of public health residents in Europe the Network is identified as a relevant stakeholder on the European cross country level (Case #1) and by functioning as a CoP it allows for exchange and development of new models and tools to address public health (workforce) challenges at the country level (Cases #2 and #3).

The Network has taken advantage of every opportunity to be a part of the debate in a variety of public forums and through participation in programmes such as Young Forum Gastein (YFG), Young Physician Leaders (YPL), and EUPHAnxt (Vis & Ivankovic, 2016). Because the Network is composed mainly of associations of medical doctors enrolled in public health residency training, problems, and also opportunities, were identified that are specific to medical educational background. Despite this, as seen in EuroNet's participation in the development of the core competencies framework, the network's activities have the potential to positively impact the advancement of other public health professionals. In the past few years, a variety of non-medical professionals such as anthropologists and lawyers have become part of the network's CoP.

Differences among training programmes were one of the main reasons the network was established, but it was the similarities (in training programmes and our outlook of public health as a field of work) that allowed us to be successful in our endeavours. By learning about public health residency programmes and practices in other European countries, we were able to develop an advocacy toolkit that significantly impacted the educational landscape in several EuroNet MRPH member countries. The Network was central to our work as it presented a space where we could exchange our experiences, ideas and aspirations. The inquisitiveness about new and better ways to develop public health competencies that fuelled our activities is certainly not limited to residents represented by the Network. Early-career public health professionals with other educational backgrounds face challenges and opportunities related to their professional development similar to those faced by residents active in EuroNet MRPH.

Workings, as well as the advocacy role, of a network, such as EuroNet, do not come without challenges. In a voluntary, practically budget-less organisation, a lot relies on the motivation of individual members that are willing to take leading roles and initiatives. Membership is time-bound, because most members finish their residency in four or five years. Also, our autonomy is a double-edged sword, which limits our impact on the cross county international level, where many other networks of young professionals operate while being tethered to a senior network (e.g., YFG, YPL, EUPAnxt) and therefore get premier access to the activities of the mother organisation.

Based on our experience, an association or a network of associations can offer a flexible platform, a community of practice that facilitates capacity building and transfer of good practices, often accomplished by advocacy.

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DECLARATIONS

Competing interests: The authors declare that they have no conflict of interest.

Funding: The author(s) received no specific funding for this work.

Authors' contribution: All authors contributed equally to this work

Acknowledgements: We would like to thank all our EuroNet MRPH colleagues and friends.

CASE 05

PATIENT ADVOCACY AS A POWERFUL TOOL FOR PUBLIC HEALTH: CASE OF THE GLOBAL PATIENT SOLIDARITY DAY MOVEMENT

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Key words: patient advocacy, patient engagement, patient safety, IAPO, Patient Solidarity Day

ABSTRACT

Patient advocacy has been considered but is not well researched in the scientific literature and policy frameworks. It is an important change agent in health policy, as it brings the voice of those affected by the illness or condition. Among the many patient-led advocacy efforts, one that gained significant momentum over the past years is the Patient Solidarity Day (PSD). Started by few patient organisations around the African continent in 2011, the PSD initiative has become a global movement for raising awareness about patient-centred healthcare being critical in many countries worldwide. Within a decade, the locoregional initiative of several organisations gained international dimension expanding to nearly 50 countries on all continents through activities of over 170 patient organisations.

PSD, as a regular patient advocacy activity of the International Alliance of Patients Organisations and its 286 member organisations is just one example of how interest on patient engagement in every step of the policy and decision making processes and policy implementation can be generated – towards ensuring equal access to healthcare, health equality and solidarity, leaving no one behind.

Patient advocacy brings unique knowledge and expertise to the health advocacy, enabling access for decision makers to specific experiences of their citizens and electorate. It thus has to be considered and used as a valuable resource in policy-making, and be embedded in decision-making processes at local, national and global levels. Its institutionalisation can be one of the new models and skill sets "to address new and re-emerging public health challenges within the different socio-economic realities around the world, varying political capacities and new political entities" (Global Charter for the Public's Health).

INTRODUCTION

The patient voice is a very important change agent in health policy and health system design (Sehmi, 2016). The power of patient advocacy within the entire spectrum of health advocacy efforts lies with the direct participation and experience of those affected by the illness or condition (Wong-Rieger, 2017). Over the years, patient advocacy had evolved from small issue-driven groups' engagement with local media outlets to globalized movements across same or similar issues, addressed as high as global health agenda venues (Wong-Rieger, 2017). The possibilities of internet and social media have further boosted these efforts (Obar et al., 2012).

Although slowly gaining increased attention, patient-led advocacy is not well researched and documented in the scientific literature and policy frameworks, especially in low- and middle-income countries. Among the many patient-led advocacy efforts (Markman, 2008; Milevska Kostova et al., 2008; Rothman, 2011), one that gained significant momentum over the past several years is the Patient Solidarity Day (PSD), aimed at raising awareness about the importance of patients' involvement as part of multi-stakeholder teams in planning and implementing strategies for safe patient-centred healthcare. The challenge was laid down in the Global Charter for the Public's Health, acknowledging that many public health policies remain vertical and that the lack of effective multisectoral approach has a detrimental impact on populations' health. The Charter calls for new models and skill sets "to address new and re-emerging public health challenges within the different socio-economic realities around the world, varying political capacities and new political entities" (Lomazzi, 2016), and PSD represents one such innovative model.

Patient safety is an issue long debated in the political circles, but due to its complexity, very rarely it gained consensus for global action. In addition, as health is a sovereign issue of the states, which remain central to national policy decision-making and implementation (Ricci, 2009), it is very difficult, especially in low- and middle-income countries to raise an issue, such as patient safety, higher on the political agenda without international influence or resolution. The endorsement of the Resolution WHA55.18: Quality of care: patient safety in 2002 (World Health Organization [WHO], 2002) was pivotal in recognizing patient safety as 'a fundamental principle of every health system', and placing high hopes into government's action on 'establish[ing] and strengthen[ing] science-based systems, necessary for improving patients' safety and quality of health care, including the monitoring of drugs, medical equipment and technology' (WHO, 2002). But the reality faced by patients was slow progress and low investments in safer or higher quality care. In addition, standardisation of safety and lack of universal indicators for measuring quality have posed additional challenge to the efforts. With the emerging global economic crisis of the mid 2000s, the patient safety has soon fallen behind on implementation.

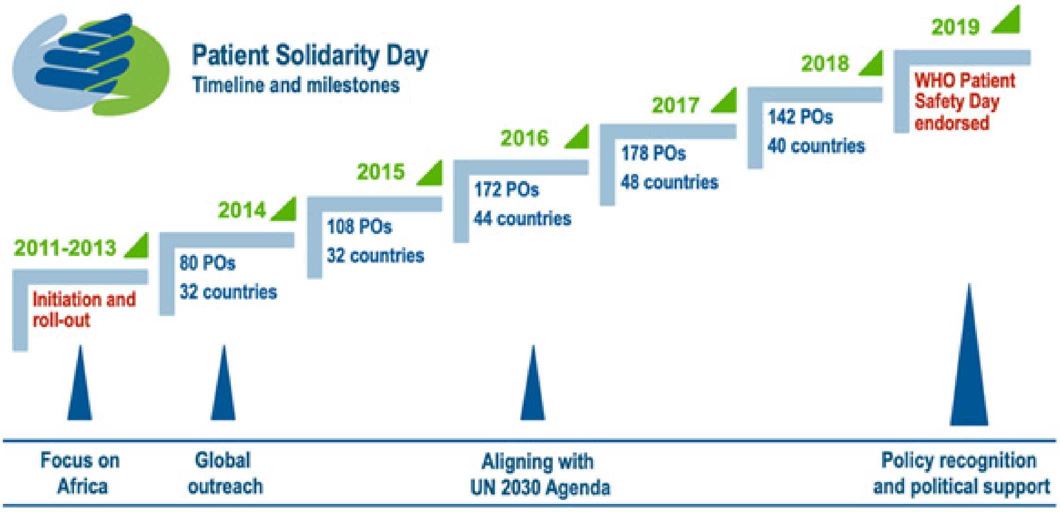
In order to bring safety and quality of care back on the political agenda, patients initiated advocacy activities using media and mass advocacy tools, including public events, workshops, media interviews, social media campaigns, petition signing and so forth. In parallel, patient advocates transmitted the patients' voice in high-level meetings and events, making presentations and delivering policy statements. In 2019, the resolution WHA72.6: Global action on patient safety was adopted (WHO, 2019), through which 193 WHO member states renewed their commitments to safer healthcare, making patient safety an essential component for strengthening health care systems in order to achieve universal health coverage.

CASE

The Patient Solidarity Day (PSD), in the first week of December, was started in 2011 (Figure 5-1) as an initiative of the Morris

Moses Foundation (MMF) a member of the International Alliance of Patient Organisations (IAPO) from Kenya, in an attempt to use patient advocacy to highlight the importance of patient safety and the need for strengthening patient-centred healthcare systems in Africa (IAPO, 2020).

Figure 5-1: Patient Solidarity Day timeline and milestones



IAPO which collaborates closely with MMF recognized the importance of this initiative and developed a strategy to expand the movement and support it beyond the efforts of few local organisations. IAPO's strategic approach had two distinct components: i) top-down advocacy, through supporting PSD activities of its members at a national level; and bottom-up advocacy, through channelling the PSD messages of patients worldwide and presenting them in high-level policy meetings and venues. IAPO's assets for taking such approach were: firstly, its membership base of over 270 patient organisations from 70 countries representing more than 50 disease areas, and secondly, its official relations status with the World Health Organisation (WHO), enabling IAPO to articulate the patient voice in the regional and global events where health agenda is discussed and decided.

In 2013, the movement spread across the entire African continent, under the theme to “improve lives through patient-centred healthcare”, aiming to raise awareness of the important role patients’ organizations play in ensuring patients are well-informed to make effective healthcare decisions. 17 IAPO members from 10 countries in Africa celebrated and supported the event. That year, PSD got its first decision-makers’ support when the Ministry of Public Health of Cameroon signed the IAPO Declaration on Patient-Centred Healthcare (IAPO, 2020).

Applying its advocacy strategy, in 2014, under the theme: “We need to unite to ensure all people, across the world, have fair and equal access to quality healthcare”, IAPO expanded the movement beyond the African continent; 80 organizations from 32 countries supported the day, through community-based events, policy meetings, social media interactions and crowdsourcing of patient voices, as well as academic papers and opinions to attract scientific and policy community attention (Aggarwal, 2014; Sehmi, 2016). Alongside national and local events (Images 5-1), media and mass advocacy tools were used for increasing outreach of the PSD messages and patients’ voice (https://www.facebook.com/PatientSolidarityDay/).

Images 5-1: National and local Patient Solidarity Day events

(Source: IAPO archive)

In 2015, 108 organizations across 32 countries supported PSD2015 declaring healthcare is a human right. Patients and representatives marched in defence of their rights, lobbied politicians, provided free health screenings and stood together in solidarity (Images 5-1). The campaign reached over 100,000 people via social media and dozens wrote articles and blog posts to mark the occasion. In 2016, IAPO gathered 172 organizations from 44 countries under the UN 2030 Agenda and SDG-aligned theme: “Leave no one behind: Sustainable patient-centred universal health coverage by 2030”.

In 2017, under the theme: “Globally Empowered Patients: Power through Knowledge” the movement accelerated to include 178 organizations from 48 countries organising events such as hospital leafleting sessions, student advocacy workshops, international webinars, writing blogs and articles, and sharing key messages via social media all in effort to advancing empowerment through knowledge. In 2018, 142 organizations from 40 countries took part in calling for safe medication and healthcare for all, through conducting awareness lectures on patient safety in colleges, district marches, capacity building workshops for patient group leaders, movie screenings, school debates, leafleting sessions and essay competitions. Other alliances, such as the NCD Alliance, EURORDIS and World Hepatitis Alliance joined, supporting the cause and disseminating the messages across their members and policy makers of the necessity and importance of patients’ involvement and engagement in creating better and safer care.

In the global policy arena, IAPO was also pursuing its agenda to gain political support and accelerate the achievement of safe patient-centred healthcare. Staff, board members and representatives of IAPO member organisations participated in high-level events and presented statements at the World Health Assembly (WHA) and the WHO regional committee meetings in AFRO, EURO, SEARO, PAHO, EMRO and WPRO regions. In 2015, PSD gained official endorsement and support from the WHO

Regional offices in Africa and Western Pacific regions. Finally, the highest recognition of advocacy efforts came in May 2019, at the 72nd WHA with the adoption of the resolution WHA72.6: Global action on patient safety (WHO, 2019), through which 193 WHO member states committed to recognize patient safety as a health priority in health sector policies, and endorsed the establishment of 17th September as the World Patient Safety Day. In 2020, WHO started a consultative process to develop a Global Patient Safety action plan until 2030, involving patient organizations in all bodies and working groups related to the process.

DISCUSSION

Patient advocacy has been considered but not well researched and documented in the scientific literature and policy frameworks. PSD is just one example through which further interest on patient engagement in every step of the policy and decision making processes and policy implementation can be generated – all towards ensuring equal access to healthcare, health equality and solidarity, leaving no one behind.

Started by patients' organizations around the African continent, the PSD initiative has soon grown to be a global movement for raising awareness about safe patient-centred healthcare being critical in many countries worldwide. The success of this advocacy effort can be measured through the recognition and endorsement of the World Patient Safety Day, and the commitment of the World Health Organization to prepare and implement a Patient Safety Decade Plan 2020-2030 (Dhingra, 2020).

However, gaining political commitment at a global level is not a sufficient warranty for implementation, especially since health remains a national sovereign matter. As a result, patient safety and care quality remain Achillean heel of many health systems. It is up to the vision of the government - or in its lack, of the empowerment and advocating abilities of the civil society – how much of the avoidable harm will be prevented. Unfortunately, in many low- and middle-income countries the civil society and patient organizations remain the only driving force towards safer care. And yet, as often there are no independent funding mechanisms for the civil society, in many of these countries the sustainability of patients' organizations is largely confined to the support provided by the pharmaceutical and medical devices industry. Such legacy often undermines the trust, reduces the strength of the patient voice in policy-making and brings ethical issues and bias on the table.

Patient advocacy brings unique knowledge and expertise to the health advocacy, enabling access for decision makers to specific experiences of their citizens and electorate. It thus has to be considered valuable resource in policy-making, and is embedded in decision-making processes at local, national and global levels. The advantage of such institutionalization of patient advocacy is to bring to national attention patients' interests and needs and allowing the national patient alliances to rally behind patient-centred universal health coverage. Such strategy has been successfully used by disease-specific patient groups to highlight awareness about their disease and to rally support from various stakeholders.

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DECLARATIONS

Competing interests: None to declare.

Funding: IAPO's activities on Patient Solidarity Day were funded through organization's core funding, which is provided as unrestricted grants from the pharmaceutical and medical devices industry. To the best of authors' knowledge, activities related to the celebration of Patient Solidarity Day on national and local levels were funded from own funds of the participating patient organizations.

Authors' contribution: NMK wrote the manuscript; RD and KS provided data and guidance; KAV, EL and YW provided comments. All authors read and approved the final manuscript.

Acknowledgements: The authors would like to thank all IAPO members in the Africa region and worldwide for initiating and continuing the Patient Solidarity Day, as well as all individual patients who by joining PSD have contributed to making the patient voice heard.

CASE 06

IMPLEMENTING NATIONAL HEALTH PROMOTION POLICY: ADVOCACY IN TWO REGIONS OF BRAZIL

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Key words: Health Promotion, Public Policy, Advocacy

ABSTRACT

This case study reports advocacy practices experienced by university lecturers, researchers, undergraduate, and graduate students, as well as workers in the health sector linked to the Thematic Group on Health Promotion and Sustainable Development (HPSD Group) of the Brazilian Association of Collective Health (ABRASCO) in the processes of building health promotion policies in two states in Brazil.

These advocacy actions are more necessary than ever due to the constant changes of stakeholders and the context of fiscal austerity that hinder the sustainability of such policies. One of the main advocacy actions was to expand the implementation of the National Health Promotion Policy to the other government levels. The country's continental dimensions make it difficult to formulate policies that take into account the different realities of each region. The two Brazilian states that are the object of the analysis, Minas Gerais and Goiás, show very different general contexts.

The methodological strategy sought to analyze the health promotion actions experienced by participants of the policymaking process. These actions made it possible to identify values, guidelines, and priority themes for a state policy.

Advocacy proved to be important because there was no common view on health promotion among members of institutionalized intersectoral working groups in the State Health Secretariats, non-governmental organizations (NGOs), State Health Councils (CS), universities, etc.

INTRODUCTION

The public policy formulation is permeated by the engagement of different actors, aiming, in general terms, to translate the theory into real-world actions. This case study reports advocacy practices experienced by researchers linked to the Thematic Group on Health Promotion and Sustainable Development (HPSD Group) of the Brazilian Association of Collective Health (ABRASCO) in the processes of building health promotion policies in two states in Brazil. This country has continental dimensions, which makes it difficult to formulate public policy that takes into account the different realities of each region.

The HPSD Group brings together professors, researchers, undergraduate and graduate students, and health sector workers who, in an integrated way, seek to contribute to the production and translation of knowledge about health promotion. One of its main advocacy actions is to increase the use of the National Health Promotion Policy - NHPP (Rocha et al., 2014). The reasons for the need of advocacy actions include the constant changes of stakeholders and the fiscal austerity context (Akerman et al., 2019; Labonte, 2016) that make difficult the sustainability of the policies. The NHPP was initially published by the Brazilian Ministry of Health in 2006 and revised in a participatory process conducted throughout 2013 (Rocha et al., 2014).

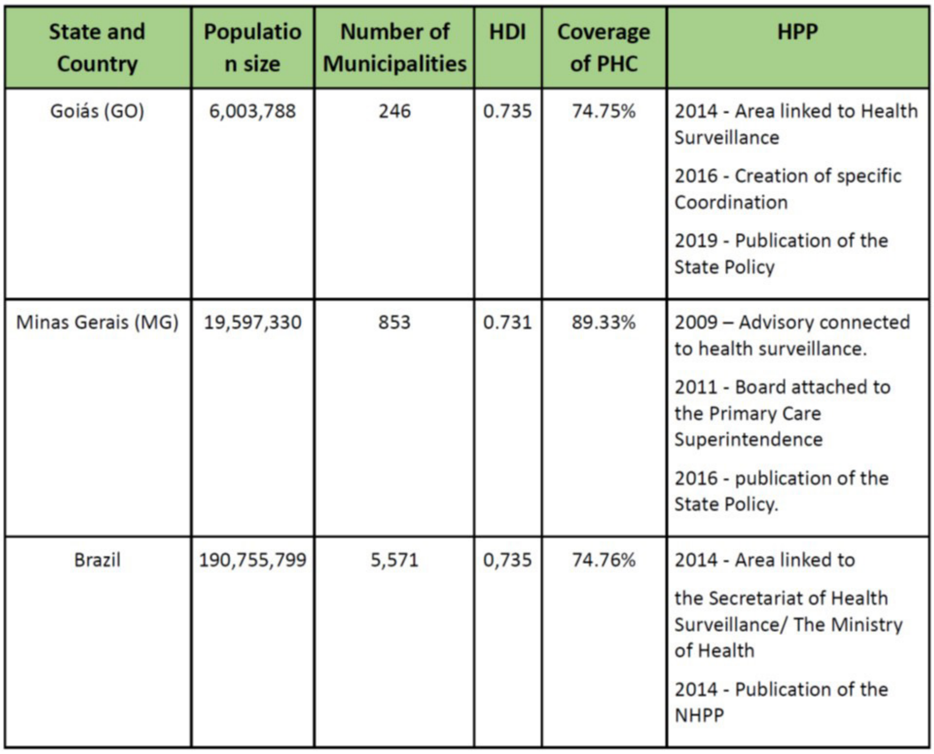
The revised NHPP version was published in 2014 and aims to promote equity and improve conditions and ways of living (Brasil, 2018). Its main principles are: equity, social participation, autonomy, empowerment, intersectoral and intrasectoral actions, sustainability, holistic view and territory focus. The members of HPSD Group contributed to the revision process by guiding the methodological approach and by preparing the final text for the policy (Rocha et al., 2014). The NHPP revision involved different strategies such as workshops, research, and writing meetings, many of which included workers from State Health Departments.

All those actions led the States to feel the necessity of formulating their own State Health Promotion Policies. This case study reports the experience of Goiás (GO) and Minas Gerais (MG), two Brazilian states with published Health Promotion Policies. In both initiatives, professors linked to the HPSD Group participated in the formulation of State Policies. The members of HPSD Group contributed as experts on the theme and literature reviews, pointing out connections of local, national and global debates and also sharing the conduction of advocacy actions as Carlisle (2000) calls this co-participation and co-responsibility actions with the population in the local contexts.

CASE

The two analyzed Brazilian states have quite different contexts. Table 6-1 summarizes social, demographic, health coverage information and Health Promotion Policy publication for the states and for Brazil (Ibge, 2019; Brasil, 2019).

Table 6-1: Characteristics of Goias, Minais Gerais and Brazil related to population size, number of municipalities, Human Development Index (HDI), coverage of Primary Health Care (PHC) and information regarding the Health Promotion Policies (HPP), 2019.



State and Country	Population size	Number of Municipalities	HDI	Coverage of PHC	HPP
Goiás (GO)	6,003,788	246	0.735	74.75%	2014 - Area linked to Health Surveillance 2016 - Creation of specific Coordination 2019 - Publication of the State Policy
Minas Gerais (MG)	19,597,330	853	0.731	89.33%	2009 – Advisory connected to health surveillance. 2011 - Board attached to the Primary Care Superintendence 2016 - publication of the State Policy.
Brazil	190,755,799	5,571	0,735	74.76%	2014 - Area linked to the Secretariat of Health Surveillance/ The Ministry of Health 2014 - Publication of the NHPP

Source: Instituto Brasileiro de Geografia e Estatística (2019); Brasil (2019).

The process of state policy formulation was inspired by the methodology adopted in the NHPP review (Rocha et al., 2014). The methodological strategy started at reflecting on health promotion actions experienced by workshop participants. Those actions allowed to identify values, guidelines and priority themes for a state policy. The analysis presented here was carried out considering the convergences and singularities of the process. The convergence analysis was conducted based on four categories: political/institutional scenario, methodology, actors and institutions involved, and final products.

The political/institutional scenario was favourable for the debate and implementation of the state health promotion policies by articulating this theme with agendas, initiatives and pacts undertaken by state governments, such as the Plan for Confronting Chronic Diseases in Minas Gerais and the strategy for implementing the 2030 Agenda/Sustainable Development Goals in Goiás. Despite this, advocacy was important because there was not a common vision about health promotion among the members of institutionalized intersectoral working groups in the State Health Departments, non-governmental organizations (NGOs), State Health Councils (SHC), universities etc. That created difficulties to define the roles and attribution of each sector. The advocacy actions included seminars, regionalized workshops with intrasectoral participation, intersectoral writing workshops, expert presentations, and debate and approval meetings with SHC and intrasectoral collegiates with regional representations (CIB). The participation in those advocacy actions triggered regional commitment and the development of networking in order to permanently mobilize and strengthen health promotion in the different regions of the states.

The first step to build the state policies was the official recognition of these intersectoral groups. After that, the State Health Promotion Policy text was also approved by the SHC. The SHC is a formal forum where representatives of civil society, managers, users and workers of the Unified Health System (UHS) debate and approve actions and policies linked to the health sector. In the national context, the publication of the new version of the PNPS and the call for its implementation in the different Brazilian territories led to the opportunity for dialogue with the administrations of the State Departments.

The design of the policies formulation followed a bottom-up strategy through intra and intersectoral workshops held in different regions of the states. It is important to highlight that the entire policy-making process was kept in line with the UHS principles of decentralization and social participation. Another guiding principle was the dialogue between the knowledge coming from the practices of the workshop participants with the scientific evidences in the field of health promotion. In both states the workshops started from a survey and debate of the participants' local experiences with health promoting actions in order to identify principles, values and themes, which served as subsidies for the state policy drafts.

The intersectoral actions were promoted by involving health institutions and workers of central, regional and municipal levels, as well as representatives from other municipal departments, social movements and universities. As a final product, both experiences built a state policy text that unified guidelines, principles and values listed in the NHPP with the principles, values and themes derived from the reports of the regional intrasectoral and the intersectoral workshops. This analysis also identified singularities of the processes summarised in Table 6-2.

Table 6-2: Singularities in the Process of Building State Health Promotion Policies in the States of Minas Gerais (MG) and Goiás (GO).

Item	**State Health Promotion Policies**	
	Minas Gerais (MG)	**Goiás (GO)**
Working Process	A survey of Health Promotion actions was carried out in the 28 Health Regions prior to the workshops.	An exhibition of experiences on health promotion was held concurrent with the workshops. Health promotion actions were reported, making it possible to map more frequent practices and themes.
Number of Activities	39 Activities: – 01 Intrasectoral Workshop. – 01 Intersectorial Workshop. – 01 Workshop with representatives of the 28 Health Regions. – 35 workshops in 28 Regional Health Offices across the State – - 01 Systematization Workshop at the central level at the end of the process (Campos et al., 2017).	10 Activities: – 01 Intersectorial Workshop with social movement representatives held in Goiânia, capital of the state. - 01 State Seminar. - 07 Workshops, one for each health macro-regional of Goiás (Southwest, Centre-Southwest, Centre-North, Centre-West, and Northeast) conducted with intrasectoral participation (in 2 workshops, representatives of health councils also participated). - 01 Systematization Workshop at the central level of State Department of Health.
Number of Participants and Location	Number of participants: - Intrasectoral Workshop: 44 - Intersectorial Workshop: 66 - Workshop with representatives of the Regional Health Offices: 55 - Workshops in the Regional Health Offices: 966 participants from 852 municipalities (99, 88% of the total state, n = 853 municipalities) - Systematization Workshop: 26 The first three workshops and the systematization workshop. were held in Belo Horizonte, capital of the State of Minas Gerais, at the State Department of Health. The other 35 workshops were held in the 28 regional health Offices.	Number of participants - Intrasectoral workshop with representatives of regional health: 242 participants, linked to 97 municipalities in Goiás (39% of the total state, n = 246 municipalities) - Intersectorial Workshop: 25 - Systematization Workshop: 15 - Seminar: 80 people. The Seminar, one intrasectoral, the intersectorial and systematization workshops were held in Goiânia, capital of the State of Goiás. The other intrasectoral workshops were held in health regions of the State (Southwest, Centre-Southwest, Centre-North, Centre-West, and Northeast).
Articulation with Equity Policies	Articulation at the Intersectoral Workshop, with the participation of several State Secretaries of Minas Gerais.	Health Equity Policies Coordination involved since the beginning of the SHPP Goiás building process.
Publication Format	A Resolution based on the intrasectoral collegiate agreement, which approved the State Health Promotion Policy (Minas Gerais, 2017).	An ordinance published by the State Health Department (Goiás, 2019).

DISCUSSION

The term “advocacy”, which is used in the Global Charter (World Federation of Public Health Associations [WFPHA]; WHO, 2016) is immersed in a polysemy of meanings. Carlisle proposes a conceptual framework for the practice of advocacy based on performance levels, goals that guide action and the role played by the actors involved. Its practice can be analysed from domains of activity - causes (policy/structure) or cases (individual/groups) and the desired goals - empowerment or protection/prevention (Carlisle, 2020). These elements are not opposites, but a continuum of practical advocacy action that is permeated by other aspects such as the philosophy (co-worker or expert status) and the type of representation (Carlisle, 2000; Germani & Aith, 2013) highlight its democratic dimension in health promotion for bringing integration between the diversity of knowledges, including scientific evidence.

The analysed cases are inserted in the context of policy structure and the performance of the different actors was based on a practice of co-working. The dialogue of scientific and general knowledges was fundamental for a final health promotion policy text that connected the broad theoretical health promotion field with the local context. The experience of SHPP was based on collaboration and democratic dialogue creating opportunities for individual and collective empowerment.

These processes can also be explained by what Cohen and Marshall define as aspects connected with advocacy. In the construction stage, the SHPP focused on the health protection/promotion dimension (Cohen & Marshall, 2017).

As evaluation aspects, it can be highlighted that the focus on the negotiation with stakeholders and the empowerment of workers were fundamental to guide the official publication as a result of this methodological decision. Another result is the feeling of belonging and co-responsibility of the different individuals towards the constructed policy, bringing them to a more active and defensive action of the policy in the implementation and monitoring stage. The singularities of the SHPP processes are connected with the different paths used for promoting collaborative social participation, related to what Santos reports as participatory democracy (Santos, 2002).

We finally highlight two learned lessons. First, the use of a participatory approach seems to have contributed to the sustainability dimension of policies as state strategies for health promotion. Second, the appropriation of policies as an intersectoral and intrasectoral construction, as well as their official publication allowed its implementation, even in a context of administrative changes.

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DECLARATIONS

Competing interests: No conflict of interest

Funding: The authors recieved no specifc funding for this work.

Authors' contribution: All authors contributed in the same way in the chapter. All authors read and approved the final manuscript.

Acknowledgements: Acknowledge to all the employees of the State Health Department involved in the construction of State Policies

CASE 07

THE STRUGGLE FOR ADEQUATE FINANCING OF UNIVERSAL HEALTH SYSTEM IN BRAZIL

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ABSTRACT

Since the enactment of the 1988 Federal Constitution that established health as a right for all, substantial advances have occurred in Brazil. Indeed, the creation of the Unified Health System (SUS) led to a significant expansion of services. This expansion was mainly funded by the resources from the municipalities, as successive federal governments since 1990 have only maintained spending levels.

In April 2012, 60 entities, under the leadership of the National Health Council, created the National Movement for Public Health, which, in 18 months, managed to collect 2,146,670 voter signatures in support of a Popular Initiative Bill (PIB) that established the obligation for the Union to invest at least 10% of its current revenues in SUS. The reach of this number of signatures for a parliamentary bill – the largest in the country's history - was the result of a big effort from the entities involved, notably from the Minas Gerais State Assembly and the Catholic National Confederation of Bishops of Brazil, which were able to reach different segments of the population in all regions of the country. Formally handed over to the president of the National Congress on August 5, 2013, the PIB were not approved by the congressmen. On the contrary, on December 15, 2016, the National Congress approved a constitutional amendment, that froze public spending, including in the health sector, for 20 years.

This advocacy process taught that, at least in Brazil, we need to renewal the operating mechanisms of representative democracy in order to have parliaments and governments more sensitive to the people's aspirations.

INTRODUCTION

Since the enactment of the 1988 Federal Constitution that established health as a right for all, substantial advances have occurred in the health sector in Brazil. In fact, during the period 1990-2015, the public health network, especially primary care, was expanded, increasing access to medical visits. The expanded prevention actions, especially vaccination, reduced communicable disease morbidity and mortality. Overall age-standardized mortality rates fell by 34%. Life expectancy at birth increased from 68.4 years to 75.2 years (Souza et al., 2018).

This expansion of the Unified Health System (SUS, in its Portuguese acronym) was mainly funded by the contribution of resources from the municipalities and states. Indeed, while in 2000 the federal government accounted for 60% of total health spending and states and municipalities accounted for 18.5% and 21.5% respectively, in 2017, the Union's participation declined to 43.2% and state and municipal spending increased to 25.7% and 31.1% (Piola et al., 2018).

It is noteworthy that Brazil is a country that invests few public resources in health. In 2017, they were only 4% of GDP or US $ 303.96 per capita. Already committing large proportions of their budgets to SUS, states and municipalities cannot increase health investments. Therefore, the Union would need to expand the investments. However, successive federal governments since 1990 have only maintained spending levels.

SUS underfunding has limited further expansion of health services and hindered the improvement of healthcare quality. Large cities have failed to achieve an adequate coverage in primary care. Smaller cities have failed to implement specialized services. SUS has not significantly invested in education programs for health professionals nor has been able to build integrated health services, which would only be feasible with the allocation of new resources by the Union. Lack of federal funding has also directly affected equity, as the Union usually plays an important role in reducing inequalities, investing in less favoured regions resources raised in more favoured ones.

As they perceived the inequity, insufficiency, and poor quality of health services, civil society's organizations decided to mobilize ordinary people to push for greater federal investment in the health care system. Civil society is well represented in the National Health Council (NHC), a collegiate and deliberative body of SUS, part of the structure of the Ministry of Health, whose mission is to monitor health policies and to take the demands of the population to the government.

In April 2012, the NHC launched a movement, which, in 18 months, managed to collect 2,146,670 voter signatures (more than 1% of the country's electorate, distributed in all 26 states) in support of a Popular Initiative Bill that, if approved by the Parliament, would oblige the Union to invest at least 10% of its gross current revenues in SUS, which led to it becoming known as Health + 10 Movement.

This text describes the case of the Health + 10 Movement, identifies its key steps, and discusses the lessons learned. Considering advocacy an enabler function of public health systems, this case is an example of social mobilization, voluntary community sector engagement, and strategic communication. Indeed, it demonstrates that the development of public health requires political engagement, use of social networks, identification of political leverage points and steerage of public health agendas through different political environments, as highlighted by the Global Charter for the Public's Health (World Federation of Public Health Associations [WPHA],2016).

THE CASE OF THE HEALTH + 10 MOVEMENT

The beginning of the movement dates back to 2011 when non-governmental organizations and municipal health authorities determined that President Roussef, in the first year of her term, was responsive to demands for more investment in healthcare. They decided to fight for the regulation of constitutional amendment n. 29, already part of the Constitution since 2000, which were scheduled to be voted by congressional representatives in September 2011. Approved in 2000, the CA-29 established minimum floors for the application of budgetary resources in health actions and services, but did not define what were considered "health actions and services", allowing many governments to include in this item expenses related to environmental sanitation or housing. The regulation, therefore, aimed to determine that the minimum floors mentioned in CA-29 refer exclusively to expenses incurred within the scope of SUS. Led by the National Health Council, the entities carried out various activities, including meetings with the minister of health and the delivery of flowers to the President, seeking government support for the regulation of Amendment 29 that would provide new resources to SUS (Rede Humaniza SUS, 2011).

When the National Congress voted the regulation, however, it did not include a minimum floor of mandatory health expenditures from the federal government, frustrating social activists and health authorities. Nevertheless, the new Law n. 141, enacted in January 16 2012, determined a small increase in the Unified Health, System's expenditures, making it illegal to book expenditures outside the SUS as health expenditures.

This partial defeat, four months before the formal launching of the Health + 10 Movement, led to an important change in strategy. Instead of advocating for the government to act, this partial defeat led civil society entities to mobilize citizens to sign a Popular Initiative Bill which obligated the federal government to spend at least 10% of its gross revenue into the SUS. In April 2012, the NHC formalized this initiative, naming it as Health + 10 Movement. The Health + 10 Movement resulted not only from the struggle for the regulation of Constitutional Amendment n. 29 that ended with the approval of Law n. 141, but also from an important mobilization of the National Confederation of Bishops of Brazil (CNBB, in its acronym in Portuguese). Throughout 2011, CNBB had been discussing the theme of its annual Fraternity Campaign for the next year. Under the theme chosen, “That health is spread over the earth” (Bible: Ecclesiastical, c. 38, v. 8), the Fraternity Campaign aimed to promote the defense of SUS and to claim for its fair functioning; and qualify the community to demand the application of public resources with transparency, especially in health (CNBB, 2012).

The convergence of purposes between the Fraternity Campaign and the National Health Council favoured CNBB’s active engagement in Health + 10 Movement. Undoubtedly, it was a key step in the advocacy process, as later experience has shown that no one contributed more to the collection of signatures than the CNBB, which collected 865,000 signatures (Conselho Nacional de Saúde, 2013).

Another important step was taken when the Health + 10 Movement decided to articulate state legislative assemblies, sending coordinators to talk to deputies in all states of the country. In practice, this strategy worked particularly well in the state of Minas Gerais, where the president of the legislative assembly was a champion of the health cause and led hundreds of mayors and local political leaders to collect signatures for the Popular Initiative Bill. In total, the Minas Gerais Assembly collected 615.986 signatures (Assembleia Legislativa de Minas Gerais, 2013).

In its beginning, in 2012, the signature collection process proceeded slowly. Only CNBB had been able to mobilise its grassroots organizations. In the middle of 2013, however, a demonstration against the increase in bus tickets in São Paulo sparked a wave of protests in many cities against the political establishment, in general, and the federal government, in particular. Among other subjects, the poor quality of SUS health services was emphasized to the point that the President Roussef launched a program to expand quickly the provision of medical services. No doubt, this situation contributed to accelerate the signature collection process, strongly motivating all members of the National Health Council.

In fact, from July 2013, the 72 entities that make up the NHC - half of them representatives of health services' users - mobilized their bases in a hand-to-hand work to collect signatures for the Popular Initiative Bill. This general mobilization was the final key step that allowed the Health + 10 Movement to reach 2,146,670 voter signatures, far exceeding the minimum of 1,5 million needed to present the Popular Initiative Bill.

Formally handed over to the president of the National Congress on August 5, 2013, the Popular Bill passed through several congressional committees until it was transformed into a Constitutional Amendment Proposal (CAP n. 1/2015) that was approved in the first round on March 22, 2016, by the plenary of the Chamber of Deputies, with 402 votes in favour and only 1 vote against.

Meanwhile, with government support, Congress passed another constitutional amendment, establishing a slow and progressive increase in the minimum mandatory floor of resources to be applied by the Union in the SUS. In practice, this new amendment prevented the continuation of the CAP n. 01/2015 voting process. At this time, the impeachment of President Roussef was triggered, with a new government taking office by August 2016. This new government forwarded and the National Congress approved, on December 15, 2016, another constitutional amendment (CA n. 95/2016), that froze the public spending, including in the health sector, for 20 years.

Not surprisingly, the media did not play a supportive role in the advocacy process. The mainstream mass media (the newspaper, radio and television networks) never divulged the existence of the Health + 10 Movement, except when they reported the handing of the popular bill to the congressmen after the end of signature collection. This was expected behaviour for the mass media in Brazil since it is a powerful and unregulated economic oligopoly. The media committed to neoliberal policies, having strong links to other corporations as health insurance companies who are important media advertisers and staunch opponents of proposals to strengthen healthcare public systems.

What are the Lessons Learned?

Reflecting on the six-year advocacy process for expanded health care in Brazil leads us to one conclusion and some lessons learned. The conclusion is that the goal was not achieved in this case after six years, and the new money was not forthcoming due to the political opposition from the social elite through its representatives in the government, the Parliament and the media.

The lessons learned are four.

First, the success of advocacy depends, more than anything, on the harmony between the initiatives of the social organizations and the aspirations of the population. The signature collection process is complex, as it requires approaching people in their homes or workplaces and getting several minutes of attention, necessary to explain the purpose and procedures of the initiative, in addition to registering the voter registration number. It is not possible to get people's attention if the problem addressed is not seen, from the beginning, as relevant by the person addressed. The success of the Health + 10 Movement, therefore, is a consequence of this strong identification of the voter with the purpose of the movement.

Second, to reach more than 1,5 million voters, it is necessary to overcome the lack of information disclosure by the big media. Although there is some initiative in Brazil of digital newspapers that allows hope about independent media, its reach is limited. Moreover, 42% of Brazilians do not have access to internet (State of Connectivity 2015, 2016). So, to reach out people, the Health + 10 Movement relied on a decentralized structure of social networks. The Catholic Church has a comprehensive network, spread across hundreds of community ecclesial organizations, that was the central pillar of signature collection. Also the states' legislative assemblies are able to overcome the silence of the media, reaching local leaders in their communities.

Third, the experience showed that the actual protagonists of the advocacy actions for public goods or interests are social movements. In fact, infinitely more important than the contribution that any individual may have made as leaders of the movement was the collective involvement of the NHC and its members, CNBB and legislative assemblies.

Finally, the advocacy process revealed that there is a democratic deficit in the political representation system in Brazil that makes the government less sensitive to the people's aspirations. In fact, the immense support for this Popular Initiative Bill as well as opinion polls (Instituto Locomotiva, 2020; Congresso em Foco, 2014), indicate that health is a priority for the population, while, once in parliament and in the executive branch of government, politicians do not give priority to health. It is also reflected in the difference between the composition of the parliament and of the population. If Brazil were a large-scale representation of its Parliament, it would be a country of white, highly educated and wealthy men. From the point of view of descriptive representation, saying that Parliament is a reflection of Brazilian society is simply not true (Oliveira, 2015).

IMPLICATIONS FOR POLICY, PRACTICE AND RESEARCH

The lessons learned have some implications. In the political dimension, they make it clear that it is necessary to renew the operational mechanisms of representative democracy in order to allow representation in Parliament and the Executive that reflects the diversity of Brazilian society in terms of gender, race / ethnicity and economic status. Limiting private financing of electoral campaigns and democratizing the media so that all candidates, from different political matrices, can convey their views are important strategies for renewing these mechanisms.

In the practical dimension of advocacy, the lessons learned imply that it is essential to invest in broad unity among the various actors committed to the cause of the universal right to health, leaving aside secondary differences. Only this unit can create capillary mobilization networks, capable of overcoming the silence of the oligopolistic media and reaching the entire population, especially users of public services, most interested in strengthening the SUS. To forge this unity, the best strategy will probably be to define a political program with common and consensual objectives among people who defend health as a right".

Finally, there are at least two implications for scientific research. The first stems from the lessons learned showing that little is known about the practice of advocacy itself. In this sense, researchers could support social movements in a process of self-reflection on the effectiveness of their activities and the possibilities for improvement. The second implication refers to the evidence that it is necessary to better understand the processes of social communication, especially when it is intended to reach and involve different audiences, in order to strengthen health awareness.

In short, all these implications are challenges, but also opportunities in the struggle for the universal right to health. It is hoped that this analysis on the Health + 10 Movement can contribute to face the challenges and seize the opportunities.

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DECLARATIONS

Competing interests: The authors were actively involved in the leadership of the reported case, the Health +10 Movement.

Funding: The authors recieved no specific funding for this work.

Authors' contribution: LES, ALO and RFS discussed and outlined the text. LES wrote the drafts. ALO and RFS revised the drafts. Everyone approved the final version.

CASE 08

RESEARCH IN ACTION: NON-DISCRIMINATION IN MEDICAL EDUCATION

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ABSTRACT

LGBTIQ people and people living with HIV/AIDS (PLWHA) face difficulties in accessing health services due to homophobia among health professionals in Turkey. Therefore, health professionals' training becomes the target for interventions to ensure equal access to quality care and solidarity. Upon two consecutive news stories in the media about the denial of care of transsexual patients by medical doctors in 2015, we designed an action research activity.

The objectives of the study were to explore the level and dynamics of homophobia and HIV/ AIDS discrimination in medical education and provide guidelines for developing non-discriminative communication skills among medical students distributed by medical students as leaders and peer-educators. Design, data collection and analysis of the project have been conducted together with researchers and a group of students. The students attended a comprehensive training program covering discrimination and health, qualitative and quantitative research methods, leadership skills and video-activism. After conducting a survey with 524 medical students in three medical schools, we obtained medical curricula and teaching materials for content analysis. We conducted 7 focus group interviews and 18 in-depth interviews with medical students. Our findings indicated that homophobic attitudes were common among medical students and the curricula lacked LGBTIQ health concepts. The students have conducted a series of recordings with LGBTIQ people, sex workers and PLWHA that developed into a twenty-minute long documentary. The research findings and the documentary film have created a valuable opportunity for creating a change in medical curricula and advocacy.

INTRODUCTION

LGBTIQ people and people living with HIV/AIDS (PLWHA) experience many difficulties in accessing health services due to the common homophobia and hostility existing among the health professionals in Turkey (Göçmen & Yılmaz, 2017). Discrimination in healthcare services is both an ethical problem and human rights concern worldwide. The United Nations addresses the need to eliminate discrimination as part of Sustainable Development Goals as “ensuring equal opportunity and reduce inequalities, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard” (UN, 2015). Therefore, healthcare services as well as the training of health care professionals is appropriate for interventions to ensure equal access to quality healthcare and solidarity with the disadvantaged populations.

Our project is based on two consecutive news stories in media. One of them is about the insult and loathing of a transsexual patient by a medical doctor. The medical doctor posted the photograph of the patient on his social media accounts with the caption “People usually find a kitten on the doorstep but look what I have found!”. Following the post, the medical doctor received a punishment from the High Honor Board of Turkish Medical Association (KAOS-GL, 2019). The second news story was about a transsexual patient who was denied the care she needed after her transition surgery by an obstetrician. The obstetrician stated that “She does not approve her condition” and asked the patient to leave (Medimagazin, 2014). Such incidents are not rare in the health care system of Turkey which motivated us to examine the medical education. There are many studies on the discriminatory beliefs and attitudes that local medical students have during their medical training (Varol et al., 2016; Yertutanol et al., 2018) as well as globally (Obedin-Maliver et al., 2011; Phelan et al., 2017; Lehmann et al., 2018).

As a group of researchers in coordination with the NGOs, we designed an action research. The objectives of the study were to (a) explore the level and dynamics of homophobia and HIV/AIDS discrimination among the medical students, (b) evaluate the medical curriculum and its discriminative content, (c) provide guidelines for developing non-discriminative communication skills among medical students, and (d) train a peer leader group among the medical students who would be advocating for non-discriminative medical education. These objectives represent the two areas of The Global Charter for the Public's Health namely services (protection, prevention, promotion) and functions (governance, capacity, advocacy, information) (World Federation of Public Health Associations [WFPHA], 2016). Three medical schools in Istanbul (Istanbul University School of Medicine, Acibadem University School of Medicine and Koç University School of Medicine) and four NGOs namely Positive Living Association, Lambda-Istanbul, LISTAG (Families of LGBTIs in Istanbul), BirIZ (Association of Trace in Individual and Community Mental Health), SPoD (Social Policy, Gender Identity, and Sexual Orientation Studies Association) took part in the project. Istanbul University School of Medicine Ethical Committee approved the study.

CASE

The project started with several medical students initiating a dialogue on human rights and discrimination against LGBTIQ people in healthcare services using the above-mentioned news as a gateway. Their initial effort then transformed into an action research project. The project had three main pillars.

1. Training: Thirty-five medical students volunteered to be part of the project activities and enrolled in a training program to improve their knowledge on human rights, the root causes of discrimination and to develop their skills for qualitative and quantitative research methodology and advocacy techniques. Training sessions were planned in two sections. First training session took place in a remote hotel out of Istanbul, which allowed the group members to get to know one another by spending more time together and to build social bonds. There were infectious disease specialists, the members of LGBTIQ organizations and the family members of LGBTIQ people. We used roleplay and psychodrama techniques to raise awareness on human rights and discrimination among the participants. The second training session focused on the mixed method study design and advocacy techniques. Participants had attended lectures and practice sessions on survey design, interview techniques, coding and content analysis. A documentary-film director joined the sessions to introduce photo-voice techniques by using mobile phones and shared skills on effective use of social media for advocacy purposes. Therefore, the volunteers had the opportunity to improve their leadership skills along with video documentary and video-activism methods.

2. Needs assessment: We designed a mixed method study for needs assessment. For the quantitative part, we conducted a survey including Hudson-Ricketts Homophobia Scale along with socio-demographics. 524 students from three medical schools participated in the survey. The level of discomfort reported by the medical students in the survey was 15% and 30% for homosexual and transsexual patients respectively. Male students significantly reported higher levels of homophobia than females and the percentage significantly decreased among the students having a LGBTIQ acquaintance.

For the qualitative part, we conducted 10 focus group interviews and 15 in-depth interviews. The aim was to explore the attitudes among medical students. All of the interviews were conducted by a professional interviewer and was accompanied by two students as assistants. Another inquiry was an assessment of the discourse analysis of the teaching materials used in the curriculum with the objective to identify the discriminatory use of language. For the discourse analysis of the transcripts, the coding was performed by the students and there was also a discourse analysis of the teaching materials. Our findings from the interviews matched with the survey results showing that the female students had a positive attitude towards LGBTQI people. While there were no explicit bias or discomfort stated by the participants our analysis indicated some forms of implicit bias based on heterosexist and heteronormative judgements. Nevertheless, none of the participants stated that they would refuse providing service to LGBTQI people giving reference to equality clause of medical ethics. Discourse analysis of the teaching materials indicated that while there was no obvious discriminatory language in medical education, there was not enough content to provide students with the knowledge and skills about sexual orientation, and how to meet the health needs of LGBTI people.

3. Advocacy: Based on the evidence we have collected; the advocacy activities were designed accordingly. Our advocacy aimed (a) to raise awareness on the necessity to increase the LGBTIQ health content in the curriculum for the medical education professionals; (b) raise awareness among medical students on the discriminatory practices and human rights violations committed by the medical doctors in healthcare services; and (c) familiarize medical students with the expectations of LGBTIQ people from the health care workers.

Thanks to the video-documentary training at the beginning of the project, medical students have conducted a series of recordings with LGBTIQ people, sex workers and PLWHA who had volunteered to participate in the process. NGOs working in this particular field have facilitated the engagement of participants. Recordings were shot at the places preferred by the participants. The interview questions included open ended questions to explore the experiences of the participants in the healthcare services, their interactions with physicians and their recommendations for medical students. The students also edited the recordings with the support of a documentary director and developed a twenty-minute long documentary-film.

Since 2015 we have been using the documentary-film and the report for our needs assessment to raise awareness in various medical education events and public health conferences. We have also organized know-how workshops for the medical educators with a goal to introduce our methodology and discuss the findings of our research along with common barriers, solutions and potential collaborations.

The research findings and the documentary film have created a valuable opportunity for creating a change to the medical curricula. Since 2015 partnering medical schools have expanded their curricular content by including sexual orientation and LGBTIQ health needs tutored in collaboration with NGOs. In addition, we, as academic researchers, NGO members and medical students, have been communicating the outcomes in different venues including the National Conference on Medical Education, European Public Health Conference 2018 and in various workshops organized in medical schools through the initiative of medical students. The Turkish Medical Association also hosted two of our workshops in two different cities with the students and medical professionals. The next phase of our plan is to prepare a textbook for medical schools in Turkey providing guidance for developing non-discriminative content in medical education and non-discriminative communication skills among medical students as well as ways of integration into curriculum.

Figure 8-1: The logo of the Non-Discrimination in Medical Education Project. It is designed by medical students based on the initial letters of original Turkish name of the project as Ötekilestirmeyen Tıp Egitimi

DISCUSSION & IMPLICATIONS

Taking into consideration the sociocultural and political environment of Turkey, discrimination based on sexual orientation either in a direct or indirect way has existed for many years in many people and institutions (Yuzgun, 1993). Traditional gender roles have a huge impact in everyday interaction of the people as well as their perceptions in the society. People in Turkey are highly conservative and patriarchal, and many people support that the male dominant culture where women depend mostly on men (Kandiyoti,1995). Therefore, these discriminatory perceptions lead to human rights violations and hate speech that targets LGBT people (ILGA-Europe, 2019).

Medical students are also highly affected by these perceptions. However, it is possible to train them to deal with these. Such an endeavor is not easy and requires advocacy to create change in the established structures of the medical curricula in many medical schools. Our work has a special methodological approach to counter discrimination against LGBTIQ people in health services. We focused on medical education as one of the root causes of discrimination and built up an action research in collaboration with medical students. The goal was to initiate change based on evidence and innovative ways of activism. Having medical students as a partners, we were able to analyze the results of the mixed method study for the needs assessment in medical education. The perspectives of medical students shed light on the gap and allowed us to build our action plan. Secondly the medical students used photo-voice techniques to create a documentary film to discuss the discrimination practices by medical doctors against LGTBIQ people in health care services and on what were the expectations of LGBTIQ people from the medical doctors. Since then, this video material has been used in more than five medical schools. The methodology used in this project can also be adapted to address diverse human rights violations and the discriminatory language throughout the trainings in health care workers. The involvement of the students also makes the process an interactive and creative one.

We have witnessed that our struggle created a dialogue of human rights in medical practices. It allowed students to assess and act on what seems to be unknown to be known by using multidisciplinary, innovative and evidence-based approaches. The participation of LGBTIQ people including sharing their health care experiences via their own personal accounts provided the ground for discussion of differences. Lastly, the whole process demonstrated that it is crucial to allow ourselves to welcome those differences which should not be neglected in medical training.

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DECLARATION

Competing interests: Authors declare no competing interests.

Funding: The project was funded by Open Society Foundation.

Authors' contribution: SK (Project administration, Funding acquisition, Conceptualization, Supervision); IK (Conceptualization, Quantitative analysis, Writing original draft); HN (Conceptualization, Qualitative analysis); YNY (Conceptualization; qualitative interviews); OFB (Conceptualization); DDN (Conceptualization); IS (Conceptualization, Trainer); DM (Conceptualization); GTY (Conceptualization, Qualitative analysis)

Acknowledgements: Authors would like to thank all the medical students volunteering to work in this project. Authors also would like to thank to NGOs that took part in the project, namely Positive Living Association, Lambda-Istanbul, LISTAG (Families of LGBTIs in Istanbul), BirIZ (Association of Trace in Individual and Community Mental Health), SPoD (Social Policy, Gender Identity, and Sexual Orientation Studies Association)

CASE 09

CLAIMING SEXUAL AND REPRODUCTIVE HEALTH RIGHTS FOR WOMEN DURING PREGNANCY, LABOUR, AND POSTPARTUM ACCORDING TO SOCIAL STATUS BOGOTÁ COLOMBIA 2018

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Key words: Reproductive Rights, Advocacy, Social Class, Pregnancy, Childbirth, Postpartum Period

ABSTRACT

Obstetric Violence (OV) is a public health problem that is made worse by the economic context of the Colombian health system. This case analyzes the struggles that a pregnant woman faces in the receipt of health services in Bogotá where there are structural barriers to assuring the right of a respectful and healthy delivery. The advocacy activities discussed in this case include: research of information concerning sexual and reproductive rights, interviews with experts about risks in pregnancy, linking to social networks of women who have suffered violence in the receipt of health services, participation in legislative roundtables to prevent OV. and collaboration in a radio program to promote respect for rights. Public health projects in the future should include the evaluation of advocacy actions in order to strengthen the power of women in politics and social movements.

INTRODUCTION

Social status is a relevant classification in public health that accounts for inequalities and inequities in the health care system (Rocha et al., 2014). Patients with higher incomes and private insurance in Colombia, which is among the 15 most unequal countries in the world (World Bank, 2018), are more likely to access “second level” health services, emergency care and disease prevention (Garcia-Subirats et al., 2014).

The Colombian health system works under the policies of globalized neoliberalism (Labonté R et al., 2007; Pinilla et al., 2017), where the concept of profitability prevails. Currently, health institutions are under-funded (Colombian Association of Hospitals and Clinics, 2018), obstetrics-neonatology services are closed (Bejarano-Daza et al., 2017), and there is a deficit of supplies such as beds and ambulances (Colombian Ministry of Health, 2018) and corruption is rampant (Semana, 2019).

Women in pregnancy, labour, and postpartum are victims of obstetric violence (OV) which is gender-based violence. With respect to health services, they suffer from discrimination, retaliation, silencing, lack of confidentiality in the care process, and disrespect for decisions made about their bodies (Santiago et al., 2018). Therefore, it is necessary to formulate advocacy actions to protect sexual and reproductive rights from a feminist position (Bedoya-Ruiz et al., 2020).

In this context, research was conducted in order to support women in maternity care in Bogotá city. This case discusses the steps taken by the lead author in the fieldwork to advocate for women’s rights during pregnancy and birth.

CASE: THE STRUGGLE FOR A NATURAL DELIVERY IN THE CONTEXT OF A COMMERCIALIZED HEALTH SYSTEM.

The strategies used in advocacy are consistent with the conceptual framework of the global charter for public health (World Federation of Public Health Associations, 2016), including some components of governance (public health legislation), information (research), prevention (quality health care), advocacy (inequalities), and defence (mobilization).

During her first pregnancy, Juliana (name changed to protect her identity), intended to use the private health care service in order to have the opportunity of a natural delivery. However, this was not possible due to medical reasons that she considered were not articulated in the consent process and violated her rights in the context of the low-risk pregnancy. In her second pregnancy, the ultrasound diagnostic detected the need for the second caesarean operation because “the child was big”. The health care personnel did not explain what this implied or the probability of her having a poor outcome, which would give her a different option.

Consequently, the medical definition of “a large baby” and what type of probabilities for different birth outcomes were related to various birth weights (Fonseca., 2014; Henderson et al., 2014) were studied to understand the options. In addition, the risks of having a natural delivery after experiencing a caesarean operation (Medline Plus, 2018; Odent, 2004) and theoretical aspects associated to a physiological childbirth (El parto es nuestro, 2011) were identified.

The viewpoints of obstetricians who support natural childbirth were collected in interviews and compared with the findings from a literature review. The lead author clarified the medical terms that women did not understand and provided documented information related to rights and duties in the health system (Congreso de Colombia, 2015), such as the right to have a second opinion in the care process and reject non-consensual institutional practices.

In addition, support networks were contacted to promote women's rights during pregnancy, labour, and the postpartum period (National Movement for Sexual and Reproductive Health in Colombia, 2020). This allowed contact with doulas and midwives who have experience in natural childbirth and have been mobilized as a group against OV.

Supported by this information on childbirth, after having a caesarean operation in her first pregnancy, Juliana decided to have a natural childbirth. However, at the end of the pregnancy, the obstetrician scheduled the caesarean arguing the child could not fit through the pelvis. The woman decided not to attend the programmed surgery and looked for other care alternatives.

Despite paying for social security, Juliana pays for her own health insurance from a company that did not guarantee her rights in the birthing process. As a result, she had to pay additionally for a doula (Uribe et al., 2009) who taught her movement techniques to fit the baby and recommended another obstetrician. After facing this intimidating event, she managed to have a natural birth performed in a private hospital in personalized and safe conditions that guaranteed quality health care.

Women from disadvantaged social classes depend on informal work and are not entitled to the same opportunities as Juliana. In the public sector, policing and control occur through prolonged waits in the streets, queues, hunger, stigmatization, and penalties where mandatory public health programs are not respected. Induction of labour with synthetic oxytocin is mandatory because one cannot expect the natural rhythm of a woman in the middle of overcrowding and outmoded health institutions. There are no supplies for peridural analgesia, or any other alternatives to reduce pain, such as those proposed by doulas and midwives, since "humanized" childbirth in the urban context is a social class privilege and not available to many poor or disadvantaged women who suffer from social and health inequalities in pregnancy, labour, and postpartum.

Given her experiences with the health system, the lead author joined the National Movement for Sexual and Reproductive Health in Colombia (MNSSRC) and began work in the legislative roundtables to construct a bill to provide humanized natural childbirth through an interdisciplinary approach (Congreso de Colombia, 2018).

Additionally, in collaboration with the MNSSRC, an event was organized at a public university to discuss options for better childbirth options for all women. Healthcare providers who opposed OV regulation (obstetricians as association) (Opinion and Health, 2017) provided information about the barriers faced in practicing their profession under economic market conditions. Several experiences of violence in health services were also highlighted which were important for engaging women in advocacy. Pictures of members of MNSSRC, wearing T-shirts supporting women's rights in childbirth, were posted on social networks. In addition, advocacy included participation in radio programs, discussing aspects related to OV prevention (SOS Mama Radio Program, 2019), and collaborative meetings with women's groups (tribes).

In order to evaluate the action taken, research participants were interviewed and expressed the need to link public health research to the processes of advocacy and citizen participation due to the transforming impact on people´s lives. The research results were also evaluated by academic experts who were not involved in the advocacy process.

The advocacy actions undertaken within the MNSSRC faced two challenges: (1) how to seek consensus on common issues among people who think differently about reproductive justice, and (2) how to show the importance of articulating how the structural aspects of the Columbian health system impact sexual and reproductive health choices and outcomes.

DISCUSSION

A citizen oversight investigation showed the inefficiency of the Republic Congress of Colombia (Veeduria Ciudadana Colectivo “Trabajen Vagos”, 2019). In this context, the “humanized” birth bill and others were declined and filed away. Other attempts to reform the Colombian health system to improve health care quality have also failed due to opposition from private health companies (El Espectador, 2013).

Before declining the “humanized” birth bill, it had already been approved in two legislative debates (Congress of the Republic of Colombia, 2018). Although it could be viewed that the MNSSRC participation in the bills were defeats, much was learned about how advocacy could help women. The compilation of all the judicial sentences related to the violation of women’s rights in the health care services established a “care track” for women who need it.

The construction of social movements is a complex process that requires time and funding. In this respect, there has been no evaluation of the advocacy actions carried out within the movement. Given this limitation in this case, it is important to design projects that can be evaluated in the future. A quantitative survey of women to clarify their experiences during childbirth could be used to measure the implementation of “humanized” care and propose new interventions.

Organizations are needed to support women’s rights in pregnancy, labour and postpartum. This assistance requires comprehensive support if legal action is required. In Mexico, these advocacy strategies have been developed (Grupo de Información en Reproducción Elegida, 2015) and can be replicated in other countries. It is also important that the actions within the movements for reproductive justice the possibility of women’s political participation, with access to power positions that allow them to make decisions in favour of the protection of their rights.

IMPLICATIONS FOR POLICY, PRACTICE, AND RESEARCH.

International policies promote the reduction of maternal mortality (ONU, 2015). However, it is difficult to implement these policies in low-income countries in the context of social inequities and the precariousness of public health institutions (Das, 2016). This implies that international public health organizations must adopt a social and political perspective that impacts on women's rights (Fassin et al., 1992) and additionally improves quality of care and promotes equity in women's reproductive health outcomes.

Safeguarding women's rights in pregnancy, labour, and postpartum implies considering structural conditions, including training, that affect the Colombian health system. Tax reforms for public health financing require civil society strategies to protect public resources, prevent corruption, and consolidate health services outside of economic market policies.

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DECLARATIONS

Competing interests: All authors state that they have no conflict of interest.

Funding: Colciencias and CES University of Medellín

Authors' contribution: All authors participated in the conception, project design, analysis, data analysis, critical review and approval of the final version. Libia A. Bedoya-Ruiz performed the data collection and the initial writing of the document. All the authors take responsibility and guarantee all the aspects that are included in the paper. This chapter made part of the doctoral training process of L.A. Bedoya-Ruiz in the PhD in Public Health at CES University.

Acknowledgements: women and health personnel who participated in the research. Arka foundation, Apapachoa Organization, National Movement for Sexual and Reproductive Health in Colombia, Criarte Tribe, Secretary of Health Bogotá, SOS Mamá. Radio Program, Marcelo Amable, Alfredo Maya, Mónica Saenz for their contribution from the Social Sciences, CES University of Medellín and Colciencias for the financing.

Diálogos sobre parto respetado y violencia obstétrica para la construcción de paz

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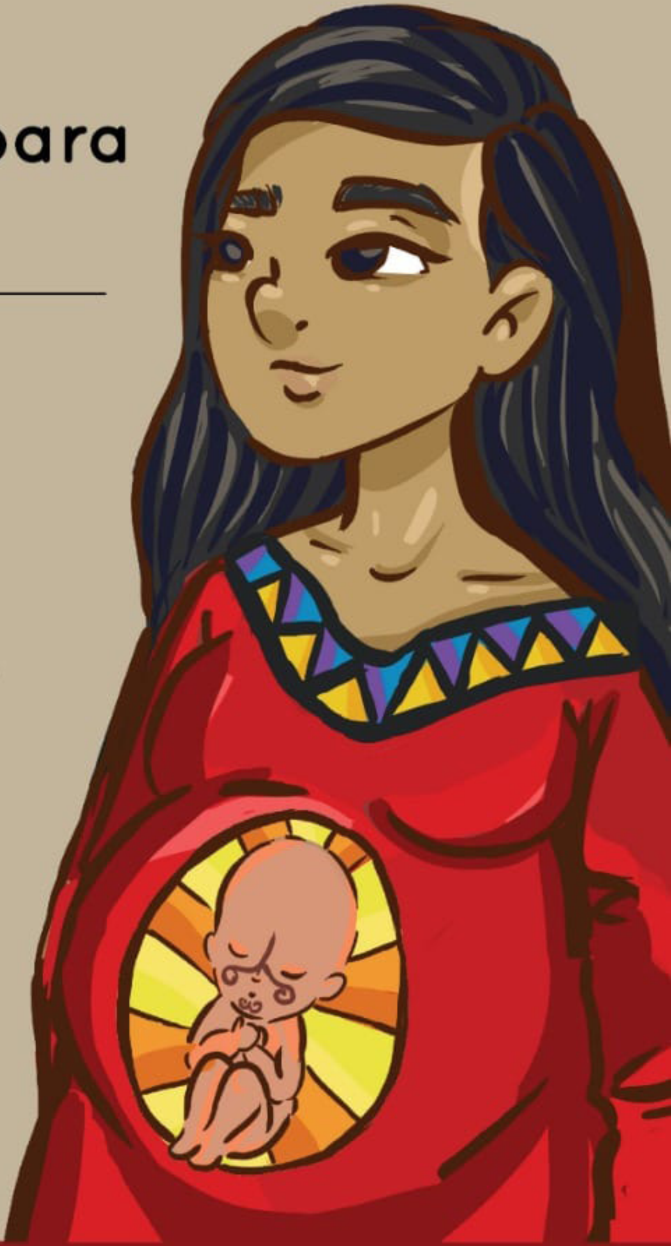
PRIMER ENCUENTRO INTERSECTORIAL MOVIMIENTO NACIONAL POR LA SALUD SEXUAL Y REPRODUCTIVA



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CASE 10

FIGHTING ANTIMICROBIAL RESISTANCE THROUGH AWARENESS-RAISING, PARTNERSHIPS AND MULTI-STAKEHOLDER INVOLVEMENT

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ABSTRACT

Antimicrobial resistance (AMR) has become a recognized threat to prevention and treatment of bacterial infections globally. Inappropriate use of antibiotics is one of the main drivers of the emergence and spread of AMR.

This case describes how the expert-initiated efforts to improve antibiotic prescribing and use have instigated policy attention and political commitment to address this significant threat to public health and health systems, and how it has grown into a sustainable long-term government-supported initiative. The case is described from the perspective of three distinct phases, targeting different advocacy elements: i) initiating interest among professional and expert communities; ii) gaining momentum of the endorsed AMR strategy; and iii) institutionalisation of antimicrobial stewardship. Whole-of-society approach, improved communication and coordination in bridging the knowledge gap between population and health professionals is the right approach putting them on the same side of fighting AMR. As much as communication skills are essential and inseparable part of modern medicine, this communication need to develop beyond patient-doctor relationship and be constantly aligned with the patient's needs. The active involvement of professionals, policy and decision makers, the international expert and donor community, civil society and citizens in joint coordinated action is critical for successfully setting a pathway towards establishment of a sustainable system for rational antibiotic use and AMR containment. The multi-stakeholder involvement and fostering partnerships as a dominant paradigm embedded in the Global Charter for the Public's Health, is just one example of how limited-resource settings can also effectively contribute in the fight of public health threats towards achieving the goals of the global health agenda.

Key words: antimicrobial resistance, rational antibiotic use, awareness-raising, health policy, partnerships and multi-stakeholder involvement

INTRODUCTION

The accidental yet revolutionary discovery of antibiotics transformed medicine and approaches to treating communicable diseases and saving lives. However, antibiotic (AB) use contributes to antimicrobial resistance (AMR), and antibiotic misuse in particular accelerates this process (Zarb et al., 2010). According to the literature, almost half of all antibiotics used in human healthcare can be considered inappropriate (Cecchini et al., 2015). Since there is an established link between levels of antibiotic use in humans and AMR (Costelloe et al., 2010), one of the main strategic directions in the fight against AMR is to optimize antibiotic use through antibiotic stewardship (WHO, 2015b). Although not specifically addressed in SDG targets, AMR is included in paragraph 26 as one of the key global health challenges the world needs to address in the next decade (Jasovský et al., 2016; UN, 2015). Healthcare providers act as gate-keepers for AB therapy, which is why successful containment of AMR relies on their responsible prescribing and dispensing, as well as on patients' compliance.

In Macedonia, excessive antibiotic consumption can be attributed to both the supply side, including: empirical prescribing due to lack of resources for diagnostics, non-adherence to clinical guidelines, and non-prescription dispensing, as well as to the demand side, including patients' pressure on providers and self-medication (Milevska-Kostova, 2017). Forms of antibiotic misuse include unjustified use in non-bacterial infections (Angelovska et al., 2016), excessive prescribing and inadequate selection, dosage or duration of antibiotic therapy (Milevska Kostova et al., 2020).

To address the issue, in 2008, a group of clinicians, microbiologists, pharmacists and civil society representatives joined their expertise with the main objective to gather global and local evidence, analyse policy options and advocate for putting AMR and antibiotic consumption surveillance higher on the political and policy agenda in the country (Boshevska & Panovski, 2015).

The dominant paradigm was to use the whole-of-the-society approach through fostering partnerships and multi-stakeholder involvement for ensuring success in tackling health threats posed by the rapidly increasing AMR, aligned with the objectives of the Global Charter for the Public's Health (Lomazzi, 2016).

The presented case describes how the expert-initiated efforts to improve antibiotic prescription and use to reduce AMR have instigated policy attention and political commitment to address this significant threat to public health and health systems, that has grown into a sustainable long-term government-supported initiative (Figure 10-1).

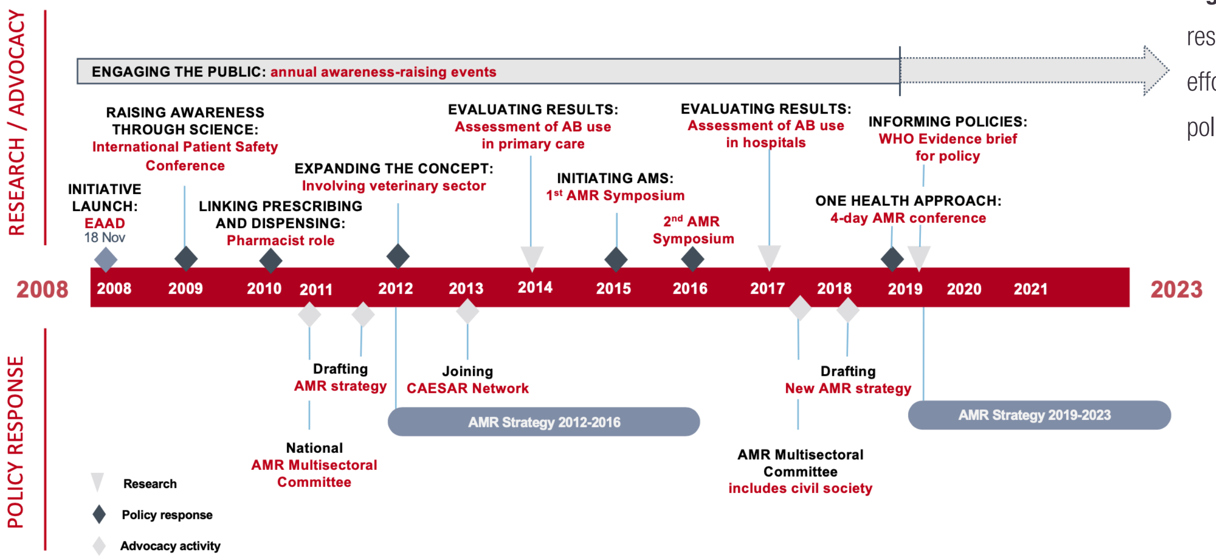

Figure 10-1: Timeline of research and advocacy efforts and the resulting policy outcomes

The announcement of the European Antibiotic Awareness Day (EAAD) by the European Centre for Disease Control and Prevention (ECDC) in 2008 prompted a group of Macedonian clinicians, microbiologists, academics and civil society members to gather and discuss how to use the existing professional engagement for triggering political commitment in addressing the antimicrobial resistance (AMR). The global economic crisis was already shaking the world, and expanding investments in public health priorities, including AMR was not foreseen in any government's agenda (Karanikolos et al., 2013).

Shaping it as a commitment to the EU accession, the expert group succeeded in organizing a celebration of the first EAAD with high-level presence including minister of health, directors of the Institute of Public Health and the medicines agency (then Drug Bureau), and presidents of professional chambers and associations (Pharmaceutical Chamber of Macedonia and Macedonian Medical Association). The political commitment was verbalized, but no direct actions were taken (Figure 10-1).

The following three years, the expert group has taken an approach of initiating interest among the wider expert and professional community, in an attempt to create a critical mass that would support and further expand the advocacy efforts. A number of professional seminars and educational events were conducted: in 2009, as collaboration with Studiorum think-tank - international patient safety conference with experts and patients from 20 countries in Central and Eastern Europe and Central Asia; in 2010, in collaboration with the Faculty of Pharmacy – educational workshop for community and clinical pharmacists; and in 2011, under the auspices of Medical Faculty-Skopje and Institute of Public Health - one-day seminar for physicians and nurses. To gain public support, in addition to the above, public awareness-raising events were organized, ensuring national and local media coverage. All events were accompanied by posters, flyers and brochures, translated and adapted from the WHO and ECDC resource materials (Studiorum, 2012).

As a result, in 2011, the Ministry of Health established a Multi-sectoral Committee for Antimicrobial Resistance (MCAMR), marking the first action of political commitment and the start of the second phase of the advocacy case: gaining the momentum in the AMR fight.

During the next few years, AMR activities have significantly intensified. In 2012, MCAMR developed, and the Government adopted the first national Strategy to fight AMR 2012-2016

(Boshevska & Panovski, 2015). The same year, the approach was expanded to veterinary medicine, through educational workshop in collaboration with the Faculty of Veterinary Medicine-Skopje. In 2013, expert community made a request through the Ministry of Health for WHO technical assistance to join the Central Asia and European Surveillance of Antimicrobial Resistance (CAESAR) Network, established for countries in Europe that are not part of the European Antimicrobial Resistance Surveillance Network (EARS-Net) (WHO, 2020).

In 2014, MCAMR embarked on a larger-scale campaign involving ten public events with 700+ participants from over 70 healthcare institutions in 21 municipalities with physicians from different specialties, pharmacists, hospital administrators, students, patient associations and general public around the issue of rational antibiotic use. The aim was two-fold: to initiate further policy changes for more stringent control of antibiotic prescribing and dispensing in primary care, as well as for establishment of antibiotic use surveillance system in hospitals. In addition, two major studies were conducted on the appropriateness of AB use in primary care and on the magnitude of AB use in hospitals. Every year, the public awareness-raising events continued, further enriched with a short video aired daily for one month on most national and local TV stations (WHO, 2013).

The findings from the studies and the tacit knowledge of professionals suggested it was time to move forward into operationalisation of measures for rational AB use, leading to the third phase of the advocacy case: the institutionalisation of antimicrobial stewardship (AMS).

In 2015, starting with the first Massive Open Online Course (MOOC) was organized in collaboration with WHO and Stanford University (Studiorum, 2015; WHO, 2015a), a series of similar activities were undertaken in order to prepare the health workforce for the introduction of AMS in hospitals. Main partners were the

Centre for Family Medicine – Medical Faculty, the Association of Family Medicine Specialists – Respiratory Group, the International Primary Care Respiratory Group (Studiorum, 2016), and ESCMID Study Group for AMS (ESGAP, 2017). In 2019, an Evidence brief for policy on AB use in hospitals, developed under WHO programme, recommended three interventions: revision of clinical guidelines; and establishment of AMS teams and AB surveillance system in hospitals (Milevska Kostova et al., 2020). The AB surveillance system was established for public hospitals, and the other two interventions have been added to the new AMR strategy 2019-2023, that was adopted by the Government in October 2019.[1]

DISCUSSION

Successful advocacy assumes gathering evidence and opening dialogues through collaborative efforts, public engagement and political commitment toward a joint goal (Lomazzi, 2016), that have been employed in Macedonia for addressing the growing public health threat from AMR. The undertaken approach can be observed from the perspective of three distinct phases, targeting different advocacy elements: i) initiating interest among professional and expert communities; ii) gaining momentum of the endorsed AMR strategy; and iii) institutionalisation of antimicrobial stewardship. It is not by chance that this approach was taken; one of the main challenges faced by the experts was to attract attention of policy makers amidst other pressing public health issues during times of global financial crisis (Karanikolos et al., 2013). Thus, creating a critical mass from the professional community and patients as a first step contributed to the success in raising AMR higher on the policy agenda and institutionalisation of efforts through adopted strategy and action plan.

Whole-of-society approach, improved communication and coordination in bridging the knowledge gap between population and health professionals is the right approach putting them on the same side of fighting AMR. As much as communication

[1] National Strategy for control of AMR with action plan 2019-2023, available at: http://zdravstvo.gov.mk/wp-content/uploads/2020/01/Nacionalna-strategija-za-AMR-so-AP-za-e-vlada-30.09.2019-NOV-TEKST.pdf

skills are essential and inseparable part of modern medicine, this communication need to develop beyond patient-doctor relationship and be constantly aligned with the patient's needs (Ewers et al., 2017).

Joint efforts involving government, academia and civil society over a timespan of over one decade, resulted in creation of a multisectorial committee and endorsement of a strategy to fight AMR. The active involvement of professionals, policy and decision makers, the international expert and donor community, civil society and citizens in awareness-raising, joint actions and improved communication and coordination in fighting AMR was crucial for successfully setting a pathway towards establishment of a sustainable system for rational AB use and AMR containment.

The described case on expanding knowledge and strengthening partnerships and multi-stakeholder involvement can be applied to a number of public health issues and services, especially those that directly affect public's health and where public engagement in particular is pivotal for ensuring compliance and success. It is also a good example of how limited-resource settings can effectively contribute in the fight of this worldwide public health threat towards achieving the SDGs and the goals of the global health agenda.

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DECLARATIONS

Competing interests: None to declare.

Funding: The activities described in the case were implemented using both financial and in-kind contributions from different institutions including: World Health Organisation, Ministry of Health, Institute of Public Health, Medical Faculty at the University “Ss. Cyril and Methodius”, University Clinic for paediatric diseases - Skopje and Studiorum think-tank.

Authors’ contribution: Authors’ contribution: NMK wrote the manuscript, GB and KS provided comments. All authors read and approved the final manuscript.

Acknowledgements: The authors would like to thank Prof Nikola Panovski, Institute for Microbiology and Parasitology, Medical Faculty, Skopje, Jovanka Kostovska and Biljana Celevska, Ministry of Health of the Republic of Macedonia, Kristina Hristova, Health Insurance Fund of Macedonia, Governing board members of the Studiorum think-tank, all members of the National multisectoral committee on antimicrobial resistance, and all other stakeholders who contributed to the fight against AMR in the country.

CASE 11

THE USE OF SOCIAL MEDIA IN CURBING ANTIMICROBIAL RESISTANCE IN NIGERIA

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Key words: Social Media, Students, Advocacy, Antimicrobial Resistance, Antimicrobial Stewardship, Nigeria

ABSTRACT

Antimicrobial Resistance (AMR) is a global public health threat. The role of health promotion and advocacy in creating awareness among the populace cannot be deemphasized. Education and awareness raising are the primary tools to change people's behaviour and tackle antimicrobial resistance. Our advocacy project aimed at improving the public understanding of AMR for a period of 100 days in Nigeria. From 2 February to 13 May 2019, we carried out an awareness-based project using community outreaches and social media to raise awareness on AMR. In this casebook chapter, we share our story, lesson learned, and inferences from the advocacy actions.

The key targets of the awareness are to correct misconceptions regarding antimicrobial use, informed populace on the threat of AMR, to increase people's commitment to fighting AMR, to engage healthcare professionals in the fight against AMR, and to influence healthcare leaders to prioritize AMR in their political agenda. Student-led efforts should be encouraged in the fight against AMR because of their capability to disseminate the information to hard-to-reach people and wider communities. Healthcare professionals should be actively involved in providing information regarding AMR. It is also worthy to note that social media is still a power tool to raise awareness regarding the quest to curb AMR and it should be maximized to reach more people.

INTRODUCTION

Antimicrobial Resistance (AMR) stands as a giant threat to advances already made in modern medicine which rely heavily on the effectiveness of antimicrobials (Fair & Tor, 2014; Jasovský et al., 2016; Naylor et al., 2018). In 2019, AMR was listed by the World Health Organization (WHO) as one of the top ten threats to global health (WHO, 2019). The threat remains a major global public health concern (Ferri et al., 2017; Tuyishimire et al., 2019). The role of health promotion and advocacy in creating awareness among the populace about the threat and their much-needed roles in the fight against AMR cannot be deemphasized (Kumar et al., 2012). It has also been well-documented that one of the major tools of global health policy to change public behaviour and tackle AMR is public awareness (Haenssgen et al., 2018; Lomazzi et al., 2019; Mathew et al., 2019). Additionally, the growing increase in multidrug-resistant organisms have increasingly potentiated the need for nationwide interventions towards reducing the mortality and economic burden accrued to AMR (Oloso et al., 2018).

According to the World Health Organization, “Antimicrobial resistance occurs when microorganisms such as bacteria, viruses, fungi and parasites change in ways that render the medications used to cure the infections they cause ineffective” (WHO, 2017). High levels of resistance have been reported worldwide, currently responsible for at least 700,000 deaths per year globally (Jasovský et al., 2016). It is estimated that by 2050, AMR will cause 10 million deaths per year (Tagliabue et., 2018), with a high proportion of these deaths potentially occurring in Africa. The global economic implications of AMR by 2050 could be up to 100 trillion USD (Founou et al., 2017). By making it difficult to treat even simple infections, AMR also has the potential to take us back to the pre-antibiotic era, where soldiers died from war wounds that got infected. Hence, resulting in increased mortality and morbidity due to infections, increased healthcare costs and prolonged hospital stay (Naylor et al., 2018).

Nigeria has been facing numerous public health challenges including infectious diseases for over a decade ago (Njidda et al., 2018; Adebisi et al., 2020) and most recently, COVID-19 (Akande-Sholabi & Adebisi, 2020). Hence, it is alarming that resistance to drugs commonly used to treat these infections have been reported (NCDC 2017a). For instance, data from Nigeria National Action Plan for Antimicrobial Resistance (2017-2022) showed non-typhoidal Salmonella (NTS) had the following resistance: nalixidic acid (0-100%), chloramphenicol (36-100%), cotrimoxazole (0-100%), ampicillin (50-100%), amoxicillin (0-90%), gentamicin (0-89%), ciprofloxacin (0-30%), ofloxacin (0-20%) and tetracycline (0-100%) (NCDC, 2017b). As a means of curbing the menace of antimicrobial resistance, the World Health Assembly adopted a global action plan on AMR in May 2015 and encouraged member states to develop a national action plan on AMR. Nigeria developed her national action plan (NCDC, 2017b), using a “one health” approach in which five strategic objectives were identified which include: Broaden awareness and knowledge base of AMR through effective communication and educative tools, conduct AMR surveillance and research using “one health” approach, ensure tripartite sectors complies with Infection Prevention and Control protocols, support antimicrobial stewardship and regulate access to antibiotics and drive research to determine the cost of AMR and develop novel antimicrobials and diagnostics.

CASE

We carried out 100 Days Awareness on Antimicrobial Resistance towards broadening awareness and knowledge base of the public regarding AMR through social media sensitization and community outreaches. Prior to the period of the awareness, there had been some grassroot advocacy efforts to increase awareness regarding AMR from government and non-governmental organizations. However, our project is unique in that we championed a nationwide awareness on AMR which was completely ran and managed by students. This was possible through partnership with many student organizations including Pharmaceutical Association of Nigerian Students, Nigeria Medical Students' Association, Nigeria University Nursing Students Association, Nigeria Association of Microbiology Students, Nigeria Medical Laboratory Science Students' Association, and other student bodies in the country. Another uniqueness of the project is that students with no background in healthcare also took part in sharing the AMR promotional materials throughout the 100 days of the awareness. In this casebook chapter, we share our story, lesson learned, and inferences from the advocacy.

The 100 days awareness on antimicrobial resistance was started and ran by a team of students from Nigeria to support the fight against antimicrobial resistance. Antimicrobial resistance is an increasing concern in modern world. It is becoming essential and obvious that students and professionals need to work together towards curbing AMR. From 2 February to 13 May 2019, we carried out an awareness-based project using community outreaches and social media to raise awareness on AMR. The key targets of the awareness were to correct misconceptions regarding antimicrobial use, inform the populace about the threat of AMR, to increase people's commitment to fighting AMR, to engage healthcare professionals in the fight against AMR, and to influence healthcare leaders to prioritize AMR in their political agenda.

The project primarily leveraged on social media and messaging platforms such as LinkedIn, Facebook, Twitter, Instagram and WhatsApp with daily post of case studies, infographics, videos and other contents aimed at sensitizing the public about AMR and at the same time project the message to increase commitment towards fighting AMR. Community outreaches in some regions of the country were also carried out. To ensure accuracy and reliability of the information, the promotional materials used during the project were gotten from the websites of these organizations: World Health Organization, ReAct: Action Antibiotic Resistance, the Alliance for the Prudent Use of Antimicrobials, Public Health England and the Global Health Education Consortium among others. The number of students and professionals that shared the promotional materials kept on increasing on daily basis which further increased the number of people we were able to reach.

In addition, to monitor impact and reach of the AMR messages, Talkwalker social media analytics (hashtag tracker) was used to monitor the reach of the #100DaysAwarenessOnAMR on Facebook and Twitter. For the period of 100 Days, the hashtag enabled tracker recorded 800,000 potential reach with over 200,000 engagement on Facebook. The tracker also revealed 2 million potential reach with over 100,000 engagement on Twitter within the period of the awareness. A survey carried out amongst the project volunteers that posted the promotional materials on their WhatsApp story revealed that an average of 100 persons viewed them. Other campaign participants also leveraged Instagram and LinkedIn to promote the awareness.

It is well-documented in literature that commitment to curb AMR and spread the message increase with increase in knowledge about the threats of AMR (Haenssgen et al., 2018). This is evident in that after the 100 days period of the awareness several professionals, students and the public signed up for to become frontline fighters (ambassador) for AMR through peer education and community awareness initiatives. This provides an opportunity worth exploring for AMR advocacy and other public health advocacy.

We also created opportunities for the public to ask questions regarding AMR. As students engage in these processes, they undoubtedly encounter topics where no reliable information is available to them. In such cases, resource materials were also shared to equip students with the required knowledge to respond correctly to such questions. This project is not only aimed at creating awareness, it is also an opportunity for students to gain confidence and increase their knowledge base on antimicrobial resistance. Additionally, due to the fact that we leverage social media for the advocacy, students, and professionals from other countries such as United Kingdom, United States, Tanzania, Ghana, South Africa, Morocco, Rwanda, and Zimbabwe among others, also joined us in sharing the AMR promotional materials.

DISCUSSION

We believe the awareness program has instilled the much-needed attention that AMR deserved among students and other individuals who are the potential leaders in the healthcare space in the years to come. The Nigeria Centre for Disease Control, the Royal Society of Tropical Medicine and Hygiene, AB Global Health Initiative, Ducit Blue Solutions, Pharmacostory Health Awareness Initiative, and Global Health Focus among many other organizations in the space of global public health acknowledged our efforts in the fight against AMR. This project reiterated the much-needed roles students can play in advancing public health awareness on major health issues globally and also revealed voids in the general public knowledge of AMR. Furthermore, it brought to light how powerful social media can be as a tool to increase public attention to an advocacy cause. Even though, the actual impact of the advocacy efforts would be difficult to measure, the enthusiasm of the students, reach of the promotional materials and public engagement show the goals of the advocacy was achieved.

However, this advocacy effort is not without its challenges. Duration of the advocacy initiative was a challenge, reaching more people would have been possible if the awareness program lasted for longer time. In addition, lack of funding also posed a challenge during the course of the advocacy effort. Therefore, it is important to prioritize support, including funding opportunities for students who are passionate about health promotion. Once students have attained a baseline understanding of an advocacy initiative at the local, community, national and international level, they can help educate fellow students and their immediate community towards improving the understanding of public health advocacy cause including AMR. Limited knowledge regarding rational prescribing of antimicrobials among healthcare professionals was also identified. Even though we were able to circumvent the knowledge barrier regarding AMR among students by providing resource materials, it is still another challenge that is worth mentioning.

Social media remain an essential tool towards improving public health advocacy. Students and generally the young population are positioned to leverage these platforms to relay public health information. Additionally, the versatility of students in use of digital technologies for advocacy is worth exploring. Therefore, students are powerful in the fight against AMR. In addition to promoting change using social media, students can play a key role as educators and advocates in their local and immediate communities. The first step to fulfilling these functions is learning local patterns of AMR and receiving the needed support in championing their own initiatives.

Students can educate their online community by writing opinion pieces, championing awareness initiative and informational articles that discuss the growing problem of antimicrobial resistance and highlight its local manifestations. Initiatives specifically outlining steps for community members to limit the spread of resistance will be most applicable to community audience. If we sight antimicrobials as an essential global public good, a powerful agent whose effectiveness belongs not to an individual person or institution, but to the whole society, then with innovative approaches and efforts coupled with effective policies, we can effectively curb AMR. These realities must of course be balanced with the benefit of antibiotic use to the individual patient.

CONCLUSION AND RECOMMENDATIONS

This advocacy initiative reiterates the roles students as well as leveraging social media can play to advance AMR advocacy in Nigeria and globally. Some of the lesson learned and practical implication of this advocacy effort include:

1. Healthcare professionals should be actively involved in providing information regarding AMR. The misconception surrounding antimicrobial resistance is not uncommon among healthcare professionals. It is therefore essential that training on AMR and evidence-based prescribing is included into healthcare students' curriculum. In addition, a general course can be inculcated into non-healthcare students' curriculum on AMR and its threat to global health.

2. Student-led efforts should be encouraged in the fight against AMR because of their capability to disseminate the information to hard-to-reach people and wider communities. Versatility of the students should be leveraged upon to increase public understanding of AMR.

3. It is also worthy to note that social media is still a powerful tool to raise awareness regarding the quest to curb AMR and it should be maximized to reach more people.

4. Collaborative interventions between the grassroot, private and governmental bodies towards reducing the burden posed by AMR remain essential.

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DECLARATIONS

Competing interests: Yusuff Adebayo Adebisi, Adeola Bamisaiye, Damilola Quazeem Olaoye and Awolola Timileyin Omolayo are winners of the 2018 Innovate4AMR Global Competition organized by ReAct-Action on Antibiotics Resistance , International Federation of Medical Students' Associations (IFMSA) , the Johns Hopkins IDEA Initiative, the World Health Organization (WHO) and South Centre Geneva. All the authors are advocates for antimicrobial stewardship.

Funding: The authors receive no financial support for the research and authorship of this article.

Authors' contribution: Yusuff Adebayo Adebisi conceived the study. Yusuff Adebayo Adebisi, Adeola Bamisaiye, Damilola Quazeem Olaoye, Aishat Jumoke Alaran, Don Eliseo Lucero-Prisno III and Awolola Timileyin Omolayo participated in the search for literature and writing of the manuscript. All authors contributed to revising the final manuscript for submission. All the authors approved the final manuscript.

Acknowledgements: We appreciate all the project volunteers and AMR Changemaker Team for their unwavering support and commitment towards advancing public health advocacy to curb AMR.

CASE 12

ADVOCATING FOR A COMPREHENSIVE CARE AND CONTROL OF CHAGAS DISEASE IN MADRID, SPAIN

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ABSTRACT

Chagas disease (CD) is an anthropozoonosis from the American continent that has become global through migration flows. Current estimations are 6 million infected humans worldwide, of whom 30%–40% either have, or will, develop organ involvement, being the cardiac one the main cause of death from CD. Vector-borne transmission is the most common route in endemic countries, but other transmission routes have more impact in non-endemic countries (specially mother-to-child transmission), where CD still represents a major public health concern. Spain is the non-endemic country with the highest burden of CD within Europe, even though Spain has no national legislation requiring screening of pregnant women coming from CD-endemic areas. In the Madrid region, the overall prevalence among pregnant women from CD endemic areas is around 3%, with a congenital transmission rate estimated in Spain of around 3.5%.

The Working Group on Chagas disease of Madrid was built up in 2016 with the aim to improve the status of CD in this region at all levels through research, action and advocacy, taking initiatives for reducing healthcare and communication barriers among migrants. The main aim of the group is, together with advocating and involving policy makers in the process, to promote and establish officials protocols for systematic CD screening among risk groups, specially pregnant women and women of childbearing age faithfully following the motto "zero vertical transmission". More than 120 professionals of both social and healthcare fields are involved at this point in the group. These advocacy actions and their results may encourage professionals from other regions or countries to replicate similar initiatives.

INTRODUCTION

Chagas disease (CD) is a potentially fatal zoonosis caused by the protozoan parasite *Trypanosoma cruzi* (T. cruzi). According to the World Health Organization (WHO), between 6–7 million infected humans are estimated (WHO, 2015), mainly in Latin-America where the disease is endemic. In endemic areas, vector-borne transmission through triatomine bugs is the most common way of infection. The transmission routes through blood transfusions, organ transplantations and mother-to-child transmission are less common routes although they are of increasing importance, particularly in non-endemic countries (Pérez-Molina & Molina, 2017).

Mainly due to migratory movements, Spain has become the second non-endemic country with the highest burden of CD, with 75% of the total confirmed cases in Europe (Requena-Mendez et al., 2015). There are between 50.000 and 55.000 Latin Americans estimated to be infected with T. cruzi in Spain, being around 60% of them women of reproductive age (Navarro et al., 2012; Requena-Mendez et al., 2015). Although it has been demonstrated the cost-effectiveness of implementing CD screening among pregnant women and at primary care level in non-endemic areas (Imaz-Iglesia et al., 2015; Requena-Méndez et al., 2017), approximately 95% of the estimated cases remain undiagnosed (Basile et al., 2011) and up to 50% of congenital cases (Howard et al., 2014).

Underdiagnosis’ causes are diverse: population at risk’s lack of knowledge about CD, fear, stigma, barriers to healthcare access; healthcare professionals’ lack of training in global health and cultural diversity; and insufficient public health measures to address the challenge of detecting and controlling this emerging Neglected Tropical Disease (NTD) (Forsyth et al., 2019; Requena-Méndez et al., 2014; Romay-Barja et al., 2019).

Spain, despite representing a model for non-endemic countries concerning CD transmission control at blood banks and organ transplant units (Requena-Méndez et al., 2014), remains lacking a national protocol for screening and clinical management of this disease. The region of Madrid, where the country's capital is located, has proportionally the largest population coming from Latin-America and it is by far one of the regions with more barriers (structural, psychosocial, and clinical) for CD patients (Romay-Barja et al., 2019).

Screening and control programs for congenital CD implemented in other Spanish regions (Catalonia, Galicia, Valencia, Andalusia) or in endemic countries have been shown to improve diagnosis (Alonso-Vega et al., 2013), adequate follow-up of patients and specially early diagnosis among women of childbearing age and pregnant women. There is huge evidence that treatment in risk groups can prevent vertical transmission (Murcia et al., 2013) and can cure children with congenital infection (Altcheh et al., 2011; Soriano-Arandes et al., 2016). With the current available evidence, not diagnosing on time and having cases of vertical transmission of CD in Spain incurs in malpractice and should be corrected as soon as possible.

In the Madrid region, the overall prevalence among pregnant women from CD endemic areas is 2.8% (Navarro et al., 2020), with a congenital transmission rate estimated in Spain around 3.5% (Lucas & Barba, 2009). Despite these data, Madrid still lacks legislation for standardized screening of pregnant women from endemic areas and follow-up of their children.

THE CASE

The Working Group on Chagas disease of Madrid (WGCD) was set up in 2007. After publishing a couple of protocols with scientific recommendations (Flores-Chavez et al., 2011), CD continued to be neglected in the region for another decade. The resulting lack of a CD screening strategy, lack of public policies focused on NTDs, and a large number of barriers faced by the migrant population at risk of CD, the WGCD was reestablished in 2016. It was reactivated with the aim of raising CD awareness among health professionals, reducing healthcare and communication barriers among migrant population, improving care of CD patients and above all, establishing systematic CD screening among risk groups, especially pregnant women and women of childbearing age, to contribute to the goal of “zero vertical transmission”.

The main actions of the WGCD and its results are presented within the functions that compose The Global Charter for the Public’s Health (Lomazzi, 2016), as follows:

INFORMATION: Creating scientific evidence and raising awareness about CD

Between January 2011 and December 2016, a multi-centre cross-sectional retrospective study was performed in 8 hospitals (the main healthcare centers attending pregnant women in the region; in order to assess the prevalence of CD among pregnant women coming from T. cruzi endemic areas. Around 11,000 pregnant women were screened for CD. The average screening rate was 38%. A total of 309 CD cases were confirmed and up to 94% of them were in women from Bolivia (J.M. Herrero-Martínez et al., 2019).

The results of this study and the current situation in our region were shared through several channels, including the below-mentioned conferences on CD, national and international meetings (“X National Conference of the Sociedad Española de Medicina Tropical y Comunitaria (SEMTSI),” n.d.; “XVIII Congress of the Sociedad Española de Salud Pública y Administración Sanitaria (SESPAS) & XXXVII Scientific Meeting of the Sociedad Española de Epidemiología & XIV Congress of the Associação Portuguesa de Epidemiologia,” n.d.).

Regarding social actions and mobilization, the WGCD supported CD community-based actions and educational campaigns adapted to at-risk migrants. These actions were coordinated by NGOs and public institutions (Navarro et al., 2017).

The WGCD also supported the federation of CD patients' associations (FINDECHAGAS) to request the World Health Organization to designate 14th April as "World Chagas Disease Day", which was designated during the 72nd World Health Assembly on May 2019 in Geneva ("World Chagas Disease Day", 2019).

ADVOCACY: Overcoming barriers for the required legislation

Some additional actions were taken by the WGCD to support the creation of scientific evidence and transmit it to the policymakers. Three of these actions are highlighted: (1) further review and unification of data about CD screening coverage among pregnant women, with a final product of a manuscript to be published in an international scientific journal, (2) the promotion (together with the National Centre of Microbiology) of the unification of serological screening techniques, and (3) the design of richly illustrated material tailored for primary healthcare and gynecology-obstetric providers.

Through the celebration of monographic conferences about CD and the striking data collected by the group, the WGCD aimed at raising awareness among the scientific community of the region. Additionally, the group also intended to draw the attention of regional political leaders and policy makers to the conspicuous neglect of CD in their region. On 11th April 2018 the first Conference on Chagas disease of Madrid took place, with around 100 people in attendance. Since the conference, with the additional effort of contacting all the public healthcare centres in Madrid to raise awareness among their staff, the WGCD members increased by 50% from the 30 members at its reactivation in 2016. Currently, more than 120 professionals of both social and healthcare fields are involved in the WGCD; these include midwives, gynecologists, pediatricians, microbiologists, general practitioners, cardiologists, internal medicine specialists and sociologists. This multidisciplinary representation of most of the healthcare centres in the region represents an opportunity for advocacy action.

Two private meetings of the core of the WGCD and policymakers in Madrid were held in 2018 and 2019 to discuss the short-to midterm feasibility of developing protocols and specific legislation. After the first steps, the WGCD could count on facilitating agents (public health technical staff and policymakers) within the regional government, who arranged the abovementioned meetings. The results of these meetings concluded with the political willingness to implement an official CD screening protocol for at-risk pregnant women. The fact of gathering information and presenting scientific evidence to the political decision-makers represents itself an overcome barrier and an advocacy action. Through a Twitter account (@chagas_gt), the WGCD aims at raising awareness about CD, promoting scientific knowledge and advocating for CD patients' rights.

CAPACITY: Teaching and training the healthcare workforce

The WGCD consists mainly of healthcare professionals of almost all public hospitals (25 out of 26) of the region and their primary health areas, the Centre of Blood Transfusion of the region of Madrid, and both the National Centre of Microbiology and the National Centre of Tropical Medicine of the Instituto de Salud Carlos III. The WGCD is also collaborating with NGOs devoted to migrants from CD endemic countries, Latin-American community health workers and CD patient's associations from outside of Madrid (the region of Madrid is still lacking such an association).

At every working meeting of the group, members are encouraged to carry out informative sessions and local guidelines in their healthcare centres, and offer them live and remote sustained support to achieve this goal.

Considering the data revealing low CD screening among pregnant women, the WGCD started to train midwives about CD in the last quarter of 2019. The first training was performed in November 2019 with a group of 43 midwives. The initiative was very well welcomed and evaluated by participants. The evaluation of the initiative could not be completed due to the COVID-19 pandemic, as post-training questionnaire was planned to be taken by March 2020.

GOVERNANCE: Meeting the challenges of institutionalization of CD policies

The final objective of the WGCD was to implement regional public health legislation that ensures the early detection and holistic treatment of CD patients, with a special focus on women of childbearing age. The meetings with the policymakers in Madrid have not yielded tangible results to date. The Spanish Ministry of Health was planning to officially draw up a CD regulation included in a global protocol for prevention of vertical-transmission diseases to be applied throughout the Spanish territory in 2019. The WGCD has been informed that, despite the COVID-19 pandemic, the shaping of the national protocol is ongoing.

DISCUSSION

In the absence of political support and official protocols in Madrid, the organization of health professionals from different disciplines and hospitals has been key to conducting a study that shows the high prevalence of CD in Latin-American pregnant women in Madrid, and the urge of implementing protocols to facilitate systematic screening and treatment prior to upcoming pregnancies, as well as early diagnosis and treatment of the newborn with congenital infection. The WGCD estimated that there would be about 1,900 infected pregnant women in Madrid, and we would be detecting less than 15% of them. Additionally, the screening rate was extremely heterogeneous in time and location (Taylor, 2020; Herrero-Martínez et al., 2019). The most important lesson learned by the WGCD is that creating scientific evidence and translating it to the policymakers is crucial to perform advocacy actions.

Several meetings have been held with the region's public health authorities showing our findings, obtaining a commitment from them to assess the implementation of an official CD screening protocol for pregnant women. Unfortunately, these steps have been stopped due to the current COVID-19 pandemic, which has led to the political resignation of some health authorities ("Available www.euroweeklynews.com/2020/05/08/" n.d.) as well as the complete shutdown of any health action outside the COVID-19 emergency. The current pandemic also hindered the WGCD promotion actions, like the midwives' training evaluation and the celebration of our biennial CD Conference. Sadly, professionals devoted to NTDs are relatively used to see how these entities are not usually prioritize by policy makers, as CD and other NTDs remain far from be controlled and comprehensively cared (Calleri et al., 2019).

One fact that could be a positive sign of our initial informative and advocacy functions, is the participation in the group of healthcare staff belonging to practically all public hospitals in the region. The implementation of the WGCD has allowed multiple awareness-raising tasks to be carried out among professionals of 25 hospitals and three institutions, making the disease and its impact known by gynecologists, pediatricians and midwives among others (as well as the implementation of local protocols with their collaboration). The impact of these actions has not been assessed yet.

Another remaining challenge is the involvement of more primary healthcare professionals. Incorporating community health workers and primary healthcare professionals, including midwives, into the WGCD is crucial to detect and overcome some structural barriers of the healthcare system (Iglesias-Rus et al., 2019). The future healthcare professionals need to be trained and sensitized about CD and other NTDs, as their current level of knowledge is not adequate (Ramos-Rincón et al., 2020; Roger et al., 2017). Thus, students and residents from medicine and other healthcare disciplines have been encouraged by the WGCD to attend and participate in CD conferences. Nevertheless, the low number of medical residents involved in the WGCD to date (up to 5%) highlights that there is much work to be done.

Among the benefits of this advocacy strategy, we must add that improving care in a neglected disease such as CD, allows at the same time to sensitize and improve knowledge in other NTDs that share common risk factors and characteristics. This is the case, for example, of strongyloidiasis, which co-infection rate can rise up to 22% in migrant population in Spain (Salvador et al., 2019; Ramos-Sesma et al., 2020).

In summary, the past 5 years of work have taught us that the fight against NTDs must be a multidisciplinary and coordinated work. Healthcare professionals should demand public policies and official protocols, aligned with EMTCT Plus framework (EMTCT Plus, 2017), in order to:

- reduce structural and healthcare access barriers for CD population at risk
- regulate access to diagnosis and treatment for CD patients
- eliminate congenital CD in our country.

Finally, we believe that a measure to be implemented in order to overcome one of the main barriers faced by NTDs (healthcare professionals' lack of knowledge and awareness about these entities) should be to include a specific training in the academic programs of Nursing, Medicine, Midwifery and health management degrees, among others. To achieve this goal, it would be crucial to be on the agendas of the ministries of health and education, in order to make them aware of the importance of the problem we are facing and to implement a global health approach. It would be also desirable to periodically evaluate the level of compliance of the protocols once they had been implemented. Thus, errors and gaps could be amended in a timely and dynamic manner. It will also be essential to continue working with patients on their knowledge of the disease and to support "expert patient" programs, together with health education campaigns.

During the recent experience with the COVID-19 pandemic we have learned that society should get involved in generating empathy, knowledge, trust and a sense of community. We should keep on avoiding the stigmatization of anything that seems strange or foreign to us because in health, as in other areas, the most important is not to leave anyone behind, especially when talking about vulnerable groups.

This case study shows that the abovementioned objectives are reachable and that the key recipe for its achievement contains much effort, a long and sustained cooking time on a generous basis of political willingness and a human rights-based approach.

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DECLARATIONS

Competing interests: The authors have declared that no competing interests exist.

Funding: This study has not received any financial support

Authors' contribution: MN and ET made the main contributions to conception, design the manuscript and drafted the article; JMHM, MN, ET, ICA, MCM and PMR participate in data collection; JMHM, MN and ET revised critically the manuscript for intellectual content. All authors reviewed the final manuscript.

Acknowledgements: This paper reflects the advocacy work of the more than 100 health professionals who make up the WGCD and whose names can be found on the website: https://www.smmc.es/chagas. To all of them, thank you. Special thanks to the promoters of the WGCD in 2007, represented by its coordinator Dr Juan Cuadros. We would also like to thank the Sociedad Madrileña de Microbiología Clínica (SMMC) for their support.

CASE 13

HAZARDOUS WORKERS AND THIRD-PARTY RISK. THE ADVOCACY ACTION OF THE LA.R.A. GROUP

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ABSTRACT

In addition to the traditional chemical, physical, biological, and psychosocial hazards, in the workplace, we must also include everything that derives from the presence of a worker who, due to his/her physical or mental health conditions, does not perform in a standard way, and endangers the health and safety of third parties.

The LaRA group, since its establishment in 1999, is responsible for defining the practices through which it is possible to protect the health and safety of hazardous workers and that of third parties, without harming the civil rights of workers.

This study group composed of doctors of various disciplines, bioethicists, jurists and representatives of workers and employers, has produced numerous consensus documents and procedures, developed research tools and participatory methodologies, and stimulated the implementation of policies for the prevention of risk caused by hazardous workers and the promotion of their recovery. The advocacy action over the years has concerned workers with infectious or psychiatric diseases as well as those suffering from addiction; occupational categories at greater risk for third parties such as health or police services; as well as companies, scientific societies and public administrations.

Key words: impairment; workplace; alcohol addiction; drug addiction; psychiatric disease; workplace violence; disability management; policy

INTRODUCTION

The prevention of work-related injury and disease has been traditionally based on the identification, measurement, and control of chemical, physical, and biological environmental risk factors. However, workers themselves may also represent a potential hazard for colleagues and clients.

At some point in their lives, on account of physical or mental illness resulting from deterioration due to ageing or the loss of motor skills, workers may be unable to carry out their tasks efficiently and with adequate safety protection levels for third parties. Other impairing diseases include psychiatric and psychosexual disorders, neurological/cognitive deficiency, physical illness, alcohol and drug addiction, incorrect behavior due to fatigue, sleepiness, and/or distress.

The great variety of conditions that can determine impairment and consequent risk for third parties makes it impossible to quantify exactly the size of the phenomenon, which may however be very relevant. If we consider doctors, a category that enjoys a better level of health than the general population (Carpenter et al., 1997), but whose judgment is critical to patient health, we must estimate that roughly 10-15% per cent can be impaired at some point of their career by alcoholism, drug abuse, senility or disabling disease (Boisaubin & Levine, 2001). An intervention is certainly necessary.

Solving this problem poses an ethical dilemma, since the legitimate interests of all stakeholders must be taken into consideration. The sick worker’s interests include career expectations, his/her role in organization, the right to privacy, and the right to freedom from discrimination. The client’s interests include protection from harm, the right to autonomy, and the right to informed choice. The interests of society include maintaining effective and affordable public services with sustainable resources, as well as the benefits and burdens of any agreed policies.

Traditional ethics that are concerned with the relationship between individuals, have failed to find an acceptable solution to these complex issues. Our research has therefore focused on this ethical dilemma at an organizational level.

The La.R.A. (LAvoratori Rischiosi per gli Altri - Study group on Hazardous Workers) was set up in Italy in 1999 to study how the health and safety of sick workers and that of third parties could be protected without damaging the civil rights of workers.

This Group is made up of a number of experts such as doctors from different specialties, jurists, bioethicists, and representatives of employees and employers. It is independent and receives no funding. It organizes conferences and produces consensus documents and publications on specific topics concerning hazardous workers.

La.R.A. action is taken according to the following general procedure: 1) a kick-off meeting, in which the numerous members of each group (30-45 experts who represent all possible points of view) define the specific objective and timing of the action; 2) a thorough review of the literature to compare different guidelines and an analysis of relevant experiences in different countries; 3) a series of subgroup meetings and emails to exchange documents in order to progressively elaborate and edit a joint document containing practical suggestions for addressing the topic; 4) a final meeting to approve the agreed document; 5) the dissemination of results by means of conferences and scientific papers; 6) the monitoring of effects (an analysis of variations in the literacy of researchers and stakeholders), through an assessment of whether companies have applied specific policies.

The following is an example of the action taken by the LaRA Group in relation to healthcare workers (HCWs) who have periodically been the focus of numerous specific activities.

CASE

Occupational medicine is founded on both scientific and legal principles, since all procedures must be based on evidence and all acts must be permissible by law.

Italy is currently subject to more than 300,000 national laws. Over 1,000 of these deal with employment. Italy is the only country in the world where the prevention of occupational health and safety risks is regulated by criminal law. Another substantial difference between Italy and other countries is the distinction made between occupational medicine and legal medicine. In Italy both of these medical branches issue fitness-for-work certificates (with the same name), although these differ considerably in meaning and comply with different laws.

The first task of the LaRA group was to produce a Consensus Document (Magnavita et al., 2001) establishing the difference between these “fit-to-work assessments”, and the way in which they could be applied in keeping with the civil rights of workers.

The criteria on which the occupational physician bases his/her judgement are well known, since occupational doctors from several countries are in agreement on how to protect workers from potential damage caused by exposure to occupational hazards. The Occupational Health Physician -OHP (‘competent doctor’ according to Italian law) - can impose restrictions or limitations on work activities. The OHP’s assessment is based on the job performed at the time of medical examination, on the risks contained therein, and on eventual modifications to the job or work environment. On the contrary, when work capacity needs to be assessed, a medico-legal evaluation of fitness for work is performed by a medical board. In such cases, an assessment is made of the ability of the doctor, or nurse, that is valid for an occupational lifetime. These two “fit-to-work” judgments have very different functions: one is preventive, the other involves social security interests. The action of the LaRA group was designed to effectively define this difference and inform healthcare companies of the correct way to use the two certificates. The effort to increase the literacy of executives has entailed the typical difficulties of all these types of tasks: the need for a continuous commitment, especially by occupational doctors and corporate forensics, to explain to top managers and middle managers the subtleties of Italian legislation and the correct ways of applying the law. We can say that this continuous effort is not yet complete.

The LaRA Group also addressed the question of evaluating infectious diseases in HCWs (Magnavita & Sacco, 2002; Magnavita et al., 2003; Magnavita & Puro, 2003; Puro et al., 2004). A comparison was made of relevant guidelines in different countries to establish common proposals. The multidisciplinary nature of the group enabled it to tackle the ethical dilemma arising from the legitimate rights of the various parties involved. The group's proposal was that companies should adopt a common policy that would be communicated to workers before cases of infectious diseases occurred.

Subsequently, the LaRA group also studied the question of mental health problems in HCWs (Sacco, 2005; Magnavita, 2005; Magnavita et al., 2006). Firstly, the group identified typical cases that had occurred in a number of healthcare companies and analysed the procedures adopted in each case. A survey of practices followed in other European and non-European countries was then carried out in order to compare the course of action.

In 2008, the topic of behavioral manifestations was addressed with the drafting of a Consensus Document on workers with alcohol and drug problems (Magnavita et al., 2008; Magnavita & Santoro, 2009). In the following years, members of the group tried to implement a specific policy in each healthcare company. To define a proactive addiction prevention policy, the first step in each company was to identify the "key people", that means the most representative workers (eg, expert workers, union representatives, head nurse, managers, etc.), and invite them to a meeting where the problem was discussed. At the end of the meeting, everyone was invited to respond to an anonymous specific validated questionnaire (PAD, Policy for Alcohol and Dependence) containing a choice on the main points of the policy. The results of the questionnaire were analysed and presented in a second meeting, in which the possible solutions were discussed. Key people were then invited to reply to the same anonymous questionnaire again. This repeated Delphi method always promoted the confluence of opinions towards shared solutions. A participatory policy could thus be produced and implemented, overcoming the tendency to disengage from the problem and to remain passive (Magnavita et al., 2009).

In Italy, the Regions are responsible for healthcare activity and are allowed to make autonomous decisions regarding application procedures. This leads to problems of coordination. In 2014, the LaRA group dedicated a Consensus Document to the need for coordinating policies on alcohol-related problems in various parts of the country (Magnavita et al., 2014).

Over the years, the LaRA group's proposals for developing participatory research on problems concerning workers' health and safety have provided concrete solutions.

The manual handling of patients is undoubtedly one of the most important issues related to the health, safety and productivity of HCWs and, consequently, patient safety and quality of care. In 2007, during the European campaign "Lighten the weight", the group received an award for encouraging the application of participatory ergonomic intervention in some hospital companies. 2008 saw further appraisal of the group's work on the part of the Italian Ergonomic Society.

The LaRA group has also focused on participatory techniques for the older worker, earning recognition for its methodology in the 2016/17 European campaign "Healthy and safe work environments for all ages".

In industrialized countries, a highly negative outcome of healthcare impairment is attributable to medical errors. These are the result of a number of variables that include the health condition and organizational wellbeing levels of HCWs. The LaRA team studied two particular problems that can increase errors: workplace violence (Magnavita 2011., Magnavita & Heponiemi 2012., Magnavita., 2014, Magnavita et al., 2020) and sleep deprivation (Costa et al., 2013; Garbarino et al., 2014; Magnavita et al., 2019). Moreover, the Group made a specific analysis of how the issue of impaired physician is treated in different countries (Magnavita, 2006).

Finally, in some companies, the group's proposal of implementing a policy of dealing with problems in a participatory way (Magnavita, 2007) has resulted in the creation of a Committee for the improvement of occupational situations (Comitato per il Miglioramento delle Situazioni Occupazionali, Co. Mi.S.O.). This has the task of determining the best ways of guaranteeing not only worker and patient health and safety, but also respect for civil rights.

In connection with previous research on occupational fitness in workers with blood-borne infectious diseases, the group is currently engaged in defining criteria for the protection of vulnerable workers during the Covid-19 pandemic and in promoting virtuous behavior even in asymptomatic workers who may be unwitting carriers of the infection.

DISCUSSION

Over the years, the LaRA's research on the occupational approach to the problem of third-party safety, and on the attention social media give to this phenomenon, has encouraged companies to prevent the occurrence of serious cases in the workplace by developing a policy for hazardous workers based principally on a bottom-up participatory model. In some companies, interdisciplinary committees for the management of critical cases have been set up.

The strengths and weaknesses of the LaRA group's advocacy experience and the results obtained have been compared to other EU and non-EU countries, with particular regard to the question of the impaired HCW. Many years after the start of the LaRA group's activity, few companies have implemented a policy for impaired HCWs. Most companies do not have a proactive policy and only act after the impairment has produced damage. Furthermore, in some countries, including Italy, there is no national policy on this topic (Magnavita, 2006). The positive results achieved in virtuous Italian companies and the positive experiences of other countries need to be disseminated. The agenda for future action is constantly under discussion within the group.

More generally, the advocacy action of the LaRA group on the management of hazardous workers has obtained evident results. Twenty years ago, the topic was virtually untreated on any level. Today many scientific societies and institutions have this theme on their agenda. For example, the objective of protecting the health of third parties is the basis of national or regional laws on vaccination requirements for HCWs and of the National Vaccination Prevention Plan. Article 32 of the Italian Constitution, "The Republic protects health as a fundamental individual right and collective interest" is now also read in the sense of protecting the health of third parties. The concept of identifying and treating workers who could endanger the health of others has gradually become part of the common cultural heritage.

The action model described above, that envisages the involvement of all stakeholders, has already been implemented in other productive sectors affected by this topic such as law enforcement and transport services. However, this method can also be applied to other contexts (job placement of "vulnerable" workers, gender differences in occupational settings, prevention of occupational diseases and accidents at work, etc.).

In the police forces, the activities carried out over the years have led to the creation of guidelines for health surveillance, which have been issued under the aegis of the Italian Society of Occupational Medicine (Pira et al., 2016a, b) and have been applied in the Italian Police.

In road transport activities, the group has addressed the problem of undiagnosed pathologies that can endanger driving safety. A campaign of investigations, called “check stop”, with the offer of free medical visits to truck drivers parked in hub stations, made it possible to identify the problems associated with the risk of road accidents: sleep deprivation (Guglielmi et al., 2016), obstructive sleep apnea (Garbarino et al., 2016), insomnia (Garbarino et al., 2017). The accumulated scientific evidence has led to the participation of the Ministry of Transport and workers’ organizations in a national campaign for the prevention of risky pathologies for third parties in professional drivers (Garbarino et al., 2018).

A health promotion action, with the screening and treatment of sleep respiratory disorders, and of the associated cardiovascular and psychiatric problems, was also carried out in small industry, trade, and service companies (Garbarino & Magnavita, 2014).

IMPLICATIONS FOR POLICY, PRACTICE, AND RESEARCH

The most important lesson to be learned from the authors’ experience is that the management of occupational health issues requires the constructive contribution of all parties (employers, workers, health technicians, etc.).

The inclusive choice, actively seeking and rehabilitating the hazardous/impaired worker, has extraordinary advantages over the traditional behavior of ignoring the problem until it becomes too serious to be solved. The LaRA group is committed to ensuring that this principle is present in all health and safety actions in the workplace. Health promotion and disability management are the pillars for the construction of the concept of total worker health. The Group's next task will be to adopt indicators for assessing the effectiveness of advocacy interventions, since this could be useful both for evaluating the strengths and weaknesses of the advocacy experience, and also for comparing results obtained in different occupational sectors.

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DECLARATIONS

Competing interests: None declared

Funding: The author(s) received no specific funding for this work.

Authors' contribution: NM conceived the manuscript and drafted it; AS and GDL discussed the synthesis and contributed to the final manuscript. Everyone has participated in the group's activities from the beginning to the present day.

Acknowledgements: We thank Ms. EA Wright who revised the language.

CASE 14

THE PROHIBITION OF THE USE OF ASBESTOS IN COLOMBIA: HOW THE ACTIVE MOBILIZATION OF VICTIMS OF DISEASES CAUSED BY ASBESTOS AND OTHER STRATEGIES BROUGHT ABOUT CHANGE

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ABSTRACT

After over a decade of significant public health education and political advocacy to eliminate the use of asbestos in Colombia, this case study highlights the processes and experiences in the development and enactment of the "Ana Cecilia Niño Law", named after a noted public communicator and victim of asbestos, that prohibited the use of Asbestos in Colombia which provided needed health protection for the residents of Colombia. Scientific journalism, the use of social networks, education of a broad range of civil society organizations and government officials, the expansion of strategic allies and most importantly, the strong mobilization of victims and relatives of diseases caused by asbestos applied essential political pressure and greatly served as key complementary strategies that led to a successful passage of the law.

This case study, using the principals of the Global Charter for the Public's Health, summarizes the unique dynamics of this community-based advocacy initiative, its key public and private actors, social media platforms, and its trajectories, strategies and lessons learned that overcame major industry and political barriers in the creation of this new national law that took effect on January 1, 2021 to improve and protect the public's health.

Key words: Advocacy, Community Mobilization and Participation

INTRODUCTION

Asbestos, a Greek word meaning inextinguishable, made from silicate materials has been known to be used for over 4000 years. In the early 20th Century, Austrian Ludwig Hatschek invented a process to combine asbestos fibers with cement to produce a material in building construction with multiple applications. Hatschek named the product Eternit and sold its patent to companies around the world (Kazan-Allen, 2006). By the early 1960's, studies in South Africa linked the inhalation of chrysotile (white) asbestos micro fibers to mesothelioma, a severe form of lung cancer (Wagner, 1960; Selikoff, 1964; Newhouse, 1965). Asbestos fibers could be released into the air of buildings and inhaled by construction workers and residents. By 1970, asbestos was classified as a human carcinogen by the International Agency for Research on Cancer (IARC) (Sawanyawisuth, 2017).

Today, an estimated 125 million workers are exposed to asbestos estimated to cause more than 107,000 deaths annually from asbestos-related mesothelioma, asbestosis, and lung, larynx and ovarian cancer (World Health Organization [WHO], 2018; WHO, 2014; WHO, 2006). In Colombia, 320 people die each year from asbestos-related diseases and 50% of all occupational cancers are caused by asbestos (General Secretariat of the Senate of the Republic of Colombia, 2017). As of 2019, sixty-six (66) nations had banned asbestos use (Asbestos.com, 2020).

In June 2019, Colombia, after twelve years and seven failed legislative attempts by a diverse coalition of actors led by the Ana Cecilia Niña Foundation (Ana was a noted journalist who died from asbestos exposure), an eighth legislative initiative, entitled the Ana Cecilia Niño law was finally approved by a unanimous 140-0 House vote banning all uses of asbestos to take effect on January 1, 2021 (Republic of Colombia, 2019).

This was the result of persistent action by scientists, academics, environmentalists, politicians, media leaders, and especially non-governmental organizations that actively engaged community members, particularly victims of the negative health effects of asbestos joined the cause. The key role national journalist Ana Cecilia Niño and her husband, Daniel Pineda, was reflected in the commitment and testimony of love through which they knew how to promoted collective action for the common good (Ana Cecilia Niño Foundation, n.d.). Advocacy is one of the key functions to improve population health according to the Global Charter for the Public's Health (World Federation of Public Health Associations, 2016). This article, describes various advocacy actions involving community sector engagement, social mobilization and people centered approaches and presents the story of these protagonists of change in Colombia and summarizes the unique dynamics of this public health advocacy initiative, its key actors, its trajectories, strategies and lessons learned in the creation of this new national law to improve and protect the public's health.

CASE

Asbestos context in colombia

Colombia has been an asbestos consumer for 77 years under the premise of "controlled use" and an asbestos producer for 42 years, replicating industrial and mining practices from Europe and North America, with an average consumption of 20,000 tons per year (Ossa, 2014). This occurred despite warnings of isolated scientific and institutional voices during the 1980's and 1990's.

By the turn of the century, Colombia passed Resolution 935 in 2001 creating the National Commission for Occupational Health and in 2008, passed Resolution 1458 creating an Asbestos section in the Commission on chrysotile asbestos and other fibers.

Since 2007, seven bills were submitted to the Colombian Congress that were either withdrawn, postponed or not approved as the powerful asbestos industry lobby argued that there was insufficient evidence of negative health effects to consider prohibiting its use. The asbestos industry strongly disputed the growing science of the serious health risks of asbestos and politicized the science with tactics similar to the tobacco industry decades earlier by hiring their own scientists to dispute the data and argued that the industry could self-regulate asbestos use to reduce risk to industrial workers.

Public attitudes and increased regulation began to turn at the end of the last decade. By 2011, Resolution 007 was adopted under the leadership of the Colombian Ministry of Health and Social Protection that developed a framework for the regulation of chrysotile asbestos. Publications by Colombian researchers Maria Fernanda Cely-Garcia and Juan Pablo Ramos-Bonilla and the work of Guillermo Villamizar, a known social artist and art critic, and Director of the Colombia Without Asbestos Foundation used simple, easy-to-understand, language explaining the science behind the health risks of asbestos, raised the general public's collective consciousness, and mobilized various actors around a campaign to ban asbestos from Colombia (Cely-Garcia, 2012; Villamizar, 2012, Villamizar & Camero, 2019).

An individual helps ignite a movement

In 2014, Ana Cecilia Niño was diagnosed with mesothelioma. As a result, Ana and her husband, Daniel became activists on banning the use of asbestos in Colombia. Ana and Daniel had lived for 17 years near an Eternit plant in the city of Sibaté, near the capital city of Bogotá and became acutely aware of the health risks of asbestos.

With the assistance of lawyer, Camilo Araque Blanco, Ana Cecilia and Daniel promoted a variety of pressure strategies through national communication and legal channels that also included a human rights complaint that reached the Inter-American Commission on Human Rights of the Constitutional Court of Colombia (Ana Cecilia Niño Foundation, n.d.).

Awareness and educational strategies were implemented through the media, social networks and direct contacts with key actors. To reach the general public, the major national television station, CARACOL, and its media journalist, Marcela Pulido, provided important information about the issue, with local political advocacy to prohibit the use of asbestos and most importantly, provided specific stories and impactful visuals of victims and their families (Pulido, 2019). Examples included interviews with high-risk industrial workers who worked in mines and factories discussing their concern or their work environment, and caregivers of family members suffering from asbestos exposure expressing their love for the people they care for. In addition, a major virtual signature campaign in support of banning asbestos was developed by The Ana Cecilia Niño Foundation via its Hagamos Eco + platform, the environmental group, Greenpeace Colombia, and Change.org Colombia resulting in a large community response with close to 200,000 online signatures directly to Colombian Congressional representatives (Ana Cecilia Niño Foundation).

Sadly, in January 2017, Ana Cecilia Niño passed away due to mesothelioma. This event was publicized nationally and further motivated the various organizations supporting a ban on asbestos, putting increased pressure on Colombia’s political and economic leaders.

A national call to action

A bill to ban asbestos, authored by Senator Nadia Blel Scaff with 19 co-sponsors was presented for debate in August of 2017. The initiative was named the “Ana Cecilia Niño Law” as an honor to a key leader of the movement, Colombia Without Asbestos, on behalf of the victims of asbestos (General Secretariat of the Senate of the Republic of Colombia, 2017). Hearing consistent emotional constituent appeals via social media such as Twitter from the victims of asbestos and the impact on their lives and those of their families personalized the health data that had been presented to lawmakers over the past several years.

To enhance the advocacy effort, Networks and the Collective Action Observatory at Rosario University in Bogotá, led by Professor Juan Carlos Guerrero, provided an analysis of the previous Congressional legislative discussions about the proposed "Ana Cecilia Niño Law" (Guerrero, 2017). This made it easier to communicate with undecided representatives to become initiative allies.

During 2018 and early 2019, discussions were held with the President of the Colombian House of Representatives and Daniel Pineda, Guillermo Villamizar and Hernando Nieto, Founding President of the Colombian Public Health Association (CPHA) as an increasing number of members of Congress had agreed to support the ban after receiving a wealth of scientific evidence and hearing from a large number of their constituents over the past couple of years. The CPHA wrote and disseminated a policy document summarizing the documented evidence, highlighting Colombian reports calling for an asbestos ban, and the strong national community support for the legislation just before the crucial vote in Congress in the spring of 2019, (Colombian Public Health Association, 2017, 2019).

The bill was finally approved by the Colombian Congress of the Republic and signed by the President on June 11, 2019 that would officially ban the use of asbestos on January 1, 2021 (Pulido, 2019). Attached is a timeline highlighting key actors and actions in the creation of the Ana Cecilia Niño asbestos law (Figure 1).

DISCUSSION

The growing scientific evidence of the health effects of asbestos for nearly two decades had not been sufficient by itself to ban asbestos in Colombia. The formation of strong community empowerment and social mobilization were necessary as emotional ties and intelligence enhanced outcomes in the political arena. The Colombian Public Health Association played an important supportive role in advocating for healthy policies, as it exercised its voice by contributing scientific evidence and fostered meeting spaces for strategic actors.

Exercising advocacy from the facilitating functions of the Global Charter of the Public's Health is possible if one recognizes the overlap that exists between the services and functions proposed in it, especially in this case, between community health promotion and education, primary prevention and environmental health. As the Charter states, "to realize the potential of healthy global citizenship that supports economic growth and development, equity and stability, there is an urgent need for genuine political awareness, and commitment and leadership for supporting public health in a global public health system" (World Federation of Public Health Associations, 2016).

Advocacy processes are highly effective if empowerment is generated with direct participation of those affected and multiple civil society actors join the initiative. The use of social networks, game theories and strategic analysis of actors and scenarios are areas of interest for both practice learning and research. The approval of a law does not constitute an end point, but rather the beginning of a series of struggles to guarantee the subsequent required regulations, and budget allocations for effective implementation of a public health policy.

A true social mobilization from different academic, scientific, artistic, civil, institutional, media and political sectors allowed the culmination of a coalescing task in the final debate that prohibited asbestos use in Colombia. That same critical mass will play a definitive role so that the law is translated into a tangible reality.

The lessons learned from this case will have implications for future public health advocacy initiatives in Colombia in such areas as environmental health and justice to reduce the use of glyphosate to spray crops, regulating hydraulic fracking, enhancing security and violence prevention, guaranteeing access to healthcare for all including our indigenous populations as a fundamental right, and improving systematic and community responses to future global infectious disease threats such as COVID-19.

Box 14-1: Timeline of Key Advocacy Actions and Actors for Case Study on the Prohibition of Asbestos in Colombia

Year(s)	Actions/Key Actor(s)
2005-2019	A Class Action lawsuit against the use of asbestos in Colombia was filed against the asbestos producers in the state of Cundinamarca (capital city of Bogotá) on the basis of human rights. The action was not settled until 2019 before the law to prohibit asbestos throughout the country was passed.
2007-2016	With growing scientific evidence linking asbestos with respiratory diseases, seven legislative bills were submitted to Colombia's Congress to prohibit the use of asbestos before the final bill was passed in 2017.
2011	Resolution 007 was adopted under the leadership of the Colombian Ministry of Health and Social Protection that developed a framework for the regulation of chrysotile asbestos
2012	Scientific publications by researchers Maria Fernanda Cely-Garcia and Juan Pablo Ramos-Bonilla on asbestos in Colombia and its effects on industrial workers was published and the work of Guillermo Villamizar draws national media attention
2013	Andrés Hoyos national radio shows highlighted the story of a widow of a man who died from mesothelioma due to asbestos exposure
2014	Major academic conferences were held on Environmental and Occupational Health highlighting-health data and specific cases of Colombians suffering serious respiratory illnesses and deaths due to asbestos exposure. Asbestos in Colombia: A Silent Enemy by Ossa, et.al. was published and received significant media coverage. Guillermo Villamizar hosted Art and Science Interactions and Politics Fair includes visual impact of Colombians' exposure to asbestos and gains media attention. El Tiempo, Colombia's leading newspaper interviewed a representative of the Asbestos Lobbying Association who claimed that chrysotile asbestos was safe and did not lead to respiratory illnesses. Reaction at the Fair was strongly negative and received media attention. Ana Cecilia Niño was diagnosed with mesothelioma after having lived near an Eternit plant for 17 years as a child and young adult.
2015-2016	Increased coalition building to support a national movement to prohibit asbestos use. The Ana Cecilia Niño Foundation, Greenpeace Colombia and change.org Colombia, collaborated on a major national social media signature campaign to prohibit asbestos that generated nearly 200,000 signatures that were submitted directly to members of Congress and highlighted in national media.

Box 14-1: cont. Timeline of Key Advocacy Actions and Actors for Case Study on the Prohibition of Asbestos in Colombia

Year(s)	Actions/Key Actor(s)
2016	The Organization of American States (OAS) International Commission on Human Rights files a lawsuit against the asbestos industry.
2017	Ana Cecilia Niño passed away from mesothelioma. Her death received national media attention and served as a major catalyst for the movement to ban asbestos. Colombia's National Cancer Institute and the Ministries of the Interior, Health, Labour, and Environment conducted major conference with international speakers on the use of asbestos and the need for strong legislative prohibition action to reduce health risks of workers and residents. The Ana Cecilia Niño bill to ban asbestos in Colombia is introduced in the Senate for debate by Senator Nadia Blel Scaff with 19 co-sponsors. The Colombian Public Health Association in its second year joins the national movement and develops a policy document in support of a bill to ban asbestos.
2018	The Ana Cecilia Niño Bill is approved by the Colombian Senate and is sent to the House for debate.
2019	The National Medical Association and the Colombian Public Health Association along with other health, science, and legal organizations participate in a conference on the medical and legal aspects of the proposed ban on asbestos. Publishing and dissemination of Networks Observatory and Collective Action (ORAC): Attempts to Ban the Use of Asbestos in Colombia, Part 2, 2019, by Rosario University that summarized in detail the collective advocacy effort to ban asbestos in Colombia. The book, Asbestos in Colombia highlighting asbestos industry lobbying of Colombian Congressional members was published and distributed to House members of Congress. The House unanimously approved the Ana Cecilia Niño Law that banned all use of asbestos in Colombia by Jan. 1, 2021 and was signed by President Duque.

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DECLARATIONS

Competing interests: The authors declare that they have no competing or conflicting interests.

Funding: Sources of funding for this research include: (or report no sources of funding)

Authors' contribution: Hernando Nieto is the principal author of this manuscript and corresponding author. He developed the initial and corresponding drafts of the manuscript focusing on the historical and public health significance of the advocacy case study for Colombia's nationwide prohibition of the use of asbestos in building construction.

Daniel Pineda provided key perspectives and examples of the engagement of Colombian citizens who directly and indirectly experienced the negative health impact of the use of asbestos for the "story" of the case, serving as President of the Ana Cecilia Niño Foundation.

Guillermo Villamizar provided historical information and evidence in Colombia and globally as President of the Colombian Foundation without Asbestos.

Robert Simmons organized the evidence and the case study and provided translation from Spanish to English and overall editing of the manuscript.

Acknowledgements: To Ana Cecilia Niño for inspiring the development of the anti-asbestos movement in Colombia and the telling of this public health advocacy story

To the thousands of Colombian victims of respiratory illnesses and deaths and their families as a result of the use of asbestos for over 70 years

To the organizations and people of Colombia who actively participated in social mobilization and commitment to prevent future generations from inhaling asbestos fibers and thereby improving the public's health

CASE 15

HEALTHCARE IN THE PRISONS: THE CASE OF SUB-SAHARAN AFRICA

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ABSTRACT

Globally, prisons have a turnout of communicable diseases significantly higher than general population. This affects the prisoners, prison staff, and in turn the general public. This makes prison health a public health imperative. Prisons in Sub-Saharan Africa are in a deplorable state. Living conditions are poor, translating to negative health consequences. Overcrowding, poor sanitary conditions, poor ventilation, lack of safe spaces, lack of protection from physical and sexual violence, absence of appropriate clothing, food and good health care, are evident in these prisons. The UN Declaration of Human Rights, 1990, emphasizes the right of prisoners to receive healthcare equivalent to that available to the national community amongst other rights. This has only been achievable in many resource rich countries. Most prison reforms in sub-Saharan Africa have been tied to activism efforts of non-governmental organizations, which consistently push for a fairer justice system and strong political will to upturn barriers instituted by poor legislations. This case study describes and assesses how these private organization, advocacy groups and government initiatives can be streamlined to promulgate incisive action and transformation of health in sub–Saharan African prisons.

INTRODUCTION

Prisons all over the world are fraught with significant challenge of providing quality health and safe spaces for incarcerated people. The health of incarcerated people in prisons tends to affect the health of general population due to the reintegration of inmates into their previous communities on release (Enggist et al., 2014). They are at a higher risk of infectious diseases due to the close confinement and overcrowding present in the prisons. Tension among inmates which promote sexual and physical abuse, unprotected sex, rape, and other unsafe practices fueling the risk of sexually transmitted infections, HIV, hepatitis, and other infections is a further concern (Van Hout & Mhlanga-Gunda, 2019). Improving prison health is therefore a public health imperative to ensure social justice and preservation of human rights.

Prisons in sub-Saharan Africa are in a deplorable state. Living conditions are poor, translating to negative health consequences. Overcrowding, poor sanitary conditions, poor ventilation, lack of safe spaces, lack of protection from physical and sexual violence, absence of appropriate clothing, food and good health care, remain evident in these prisons (Schönteich, 2015; Van Hout & Mhlanga-Gunda, 2019). This is due to major delays in the justice system processes and the high rate of remand of pretrial detainees (Soyombo, 2019; Todrys & Amon, 2012).

Global public health is increasingly directed towards health promotion and improvement of health and living status. To this effect, the World Federation of Public Health Associations developed a global charter for the public's health, a major component of which is advocacy (Lomazzi et al., 2016). This drive is evidenced by an increasing level of political will, as well as government organisations and public health practitioners' efforts to improve health in prisons.

There is an increasing need for the vindication of the health status of people in sub Saharan African prisons and those in remand. To achieve growth, development, equity, and stability across prisons globally, prison health reforms are crucial (Woodal & Dixey, 2015).

Prison reforms in sub Saharan Africa have been tied to activism efforts of non-governmental organizations, civil society groups and investigative journalism, which consistently push for a fairer justice system and stronger political will to reverse poor and unfair legislation. In this case study, we describe and assess how these private organizations, advocacy groups and government initiatives are being implemented to promulgate incisive action and transformation of health in sub-Saharan African prisons.

CASE

The advocacy actions described herein: strategic litigations, policy framework reviews, penal reforms and investigative journalism aimed to highlight problems associated with prison services and/or change prison policies, standards and laws to support adequate healthcare and prison conditions to promote humane and fair treatment, improving health of all prisoners.

Strategic Litigation and Advocacy to Transform Prisons

The use of strategic litigation to develop and vindicate the health rights of incarcerated people has been well documented in sub Saharan African countries notably South Africa, Zimbabwe, Namibia, Malawi, among others (Bukurura, 2002). This was instrumental in tackling issues such as overcrowding, health inequalities and unnecessary pretrial detention. Litigations in South Africa were aimed at making health service more accessible to incarcerated people as well as providing parole for medical reasons when necessary, especially in situations where prison medical facilities were not equipped to handle such cases (Keehn & Nevin, 2018). Cases such as *Van Biljon v Minister of Correctional Services,* 1997; *Stanfield v Minister of Correctional Services*, 2004;

Du Plooy v Minister of Correctional Services, 2004; *EN and others v Government of Republic of South Africa and others,* 2006; *Lee v Min of Correctional Services,* 2012; *Sonke Gender Justice v Government of Republic of South Africa,* 2016 are notable wins (Keehn & Nevin, 2018).

The Department of Correctional Services (DCS) in the 1997 case of *Van Biljon* and the 2004 cases of *Stanfield* and *Du Plooy* respectively denied access to medical parole and certain treatments for prisoners by neglecting already existing policies. The DCS argued that the treatment sought was not at par with what was obtainable statewide. The court however held that the DCS bears a higher duty of care to the prisoners since it incarcerated them. The court in the case of *EN & others, 2006* ruled that such treatments by the DCS were cruel, inhumane, or degrading, and against prisoners' human rights to dignity and healthcare.

Some of the improvements brought about by the Sonke Gender Justice, 2016 case included no sharing of beds by inmates and inmate blankets washed regularly. DCS also expedited the filling of staff vacancies for both custodial and health care staff in order to improve safety and security of detainees, increase access to health services and permit more frequent exercise (Keehn & Nevin, 2018).

These litigations aided the quick action of the South African government and DCS to resolution of arching issues within the prison health care system and improve care. There was also the adoption of new guidelines on tuberculosis and HIV by the department of health as well as establishing a task force within the prisons to guide implementation (Keehn & Nevin, 2018). Though being successful in tackling the narrow issues via the widespread media attention, protests and policy reforms as evidenced especially in the case of Lee v Minister of Correctional Services, the overcrowding levels in prisons remained marginally unaddressed.

The success of litigations of cases such as *Conjwago v Minister of Justice, Legal and Parliamentary Affairs and others* 1992 in Zimbabwe is also evidenced in other parts of sub Saharan Africa (Bukuruma, 2002). This success led to better training for prison guards and other personnel to ensure preservation of health rights and provision of health promoting services.

Whilst successful cases helped track narrow issues and influence policies on a broader scale, litigations can only succeed in the presence of aiding legislation. In the face of poor policies, strategic litigations are therefore bound to fail. Lack of awareness on prison conditions also mean that most cases of violation and inhumane treatment are not even heard.

Legislation, Policy Framework and Penal Reforms

Civil rights groups and organizations such as the Detention Justice Forum (Keehn & Nevin, 2018), Penal Reforms International, (Bukuruma, 2002) and African Prisons Project have served as an organizing mechanism to coordinate advocacy actions for incarcerated people. Other actors supporting penal reform include community human right advocates, civil society organizations and coalitions of previously incarcerated people (Sarkin, 2018).

Legislations and policy frameworks in Namibia reflect the values of the United Nations Standard Minimum Rules for the treatment of prisoners (Oxche, 2006). The 1998 Prisons Act and its implementation in Namibia has earned the country its reputation for model prisons' practices. The Prisons Act followed the establishment of the Ministry of Prisons and Correctional Services in 1995, now a part of the Ministry of Safety and Security (Oxche, 2006), had specialized directives with objectives targeted towards more humane treatment of offenders as well as prioritizing their health care.

To develop a better framework, the Canadian Department of Correctional Services were invited to better enhance implementation and to identify gaps and improve prison efficiency. The provision of this technical assistance led to the institution of new objectives to provide safe custody with emphasis on health care, sanitation, shelter, rehabilitation amongst others. This has also informed the adoption of milder punishments and implementation of parole and community service for minor punishments as seen in Uganda also (Schönteich, 2015). The Justice Law and order sector initiative of Uganda in 1999 brought about expediting trials and improved administration of justice. Prison crowd levels were reduced as pretrial detainees dwindled in numbers.

United Nations Office on Drugs and Crime (UNODC) and drug policy organizations such as the Africa's Students for Sensible Drug Policy and the International Drug Policy Consortium are constantly working with top officials of government agencies, prison officials and criminal justice agencies to ensure that being in prison does not nullify one's right to healthcare and health. UNODC also provides technical assistance to member states on request, in addition to provision of numerous policy documents that serve as instruments relevant to policy reforms.

Women prisoners in Sub Saharan Africa prisons constitute about 4% of the total sub Saharan Africa prison population and have increased 22% in recent years (Van Hout & Mhlanga-Gunda, 2018). Some of the challenges facing female inmates include physical and sexual abuse, food insecurity, lack of sanitations (including toiletries and sanitary wears), and limited access to health care services which exacerbates spread of infectious disease such as HIV and tuberculosis. The African HIV in Prisons Partnership Network, which was established as an outcome of the 2009 the African Declaration of Commitment for HIV and AIDS (PTS&C in Prisons) continue to work towards improving women prisoners health and health needs (Van Hout & Mhlanga-Gunda, 2018).

Investigative Journalism

In 2019, an investigative journalist reported the deplorable state of Ikoyi Maximum Prison in Nigeria, which reflected the conditions in prisons in most other SSA countries. The reporter identified corruption as a major deep-rooted problem which results in severe consequences on the health status of prisoners. Of note is the high level of inmates' access to sex workers and illicit drugs, sodomy of young and vulnerable inmates, and prevalence of congestion (Soyombo, 2019). A 320 square meters cell could sometimes house as many as 16 inmates while the facility of 800 inmate capacity operating at greater than 3000 inmates, about 2500 of which being pretrial detainees. Even with the new legislation, Nigerian Correctional Services Act 2019, prison wardens still exercised inhuman treatment on inmates, predisposing them to negative health outcomes (Soyombo, 2019). Whilst this effort by the investigative journalist led to increase in public attention and government to state of issues including healthcare services in Nigerian prisons, it is still early to determine success.

Media advocacy and widespread coverage have in the past proven successful in engineering policy change and implementation of better practices (Keehn & Nevin, 2018). The report by Soyombo led to the Comptroller General of the Nigerian set up a panel to investigate the claims. A major limitation the approach of investigative journalism faces in Nigeria is the ploy by authorities to silence journalists either by intimidation or outright prosecution on trumped up charges.

In summary, actions by advocacy organizations and coalitions, investigative journalism and case reports have shown the deplorable conditions in the prison system and called for wide public discourse to enhance advocacy efforts in the country towards improving health in the prisons. These advocacy actions to change prison conditions have been met often with insufficient action by the government to make changes to improve prison conditions. Putting a spotlight on the situation conversely opens the opportunity for action and investment by well-funded non-governmental organisations, activist groups, and legislators.

DISCUSSION

Criminal justice reforms and respect for human rights of incarcerated people are the bedrock for achievement of public health equity as it relates to prison populations (Todrys & Amon, 2012). It is key to have these in place to assist bridging the gaps existing in health service access afforded sub-Saharan African prison populations when compared to general population.

Strategic litigations have been proven to alleviate the problems associated with most narrow legal health issues, informing the need to employ litigation even more. Civil society groups, nongovernmental organisations, activists including health practitioners and lawyers can work even more closely with incarcerated people to ensure greater access to care and to embody their stories to champion even greater actions. New litigations could also be used to call up problems in prison health systems enabling effective handling.

The UN Sustainable Development Goals emphasizes the treatment and right protection of incarcerated people as human right instruments. Legislations have gone ahead to translate to positive improvements in Namibia (Oxche, 2006). This is in no small part due to implementation. In other countries where legislations already exist, there is increasing need for enforcement of same. The UN Standard Minimum Rules for Treatment of prisoners should also be put in consideration as well as recommendations for fundamental human rights (Reid, 2012; UNODC, 2011). It is essential that Sub Saharan Africa governments, national prison policy makers, international human rights organizations, donors and partners, and NGOs collaborate and advocate for prison health policy reform to ensure no-one is left behind as recommended by UN Sustainable Development agenda (Van Hout & Mhlanga-Gunda, 2018) .

All these instruments have been used to achieve positive gains and can be further improved upon. Political will, funding from governments and international organizations alike are significant needs for transforming the health care status of prisons in sub-Saharan Africa. Progressive legislation, provision of constitutional safeguards viz-a-viz implementation, health promotion, increased funding and an improved legal framework are prospects for improvement of sub Saharan prisons as it concerns health.

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DECLARATIONS

Competing interests: The authors declared no conflict of interests

Funding: The authors receive no financial support for the research and authorship of this article.

Authors' contribution: Yusuff Adebayo Adebisi conceived the study. Nelson Ashinedu Ukor led the writing of the manuscript with support from Aishat Jumoke Alaran, Yusuff Adebayo Adebisi, Don Eliseo Lucero-Prisno III and Alumuku Iordepuun Micheal in the search for literature and writing of the manuscript. All authors contributed to revising the final manuscript for submission. All the authors approved the final manuscript.

CASE 16

PLAYING THE MULTILEVEL GAME: SUCCESSFUL TOBACCO CONTROL ADVOCACY IN A FEDERAL SYSTEM

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ABSTRACT

Tobacco control provides a good case study for public health advocacy. A wide range of conflicting interests is structured around this issue: public health interests on the one hand (second-hand smoke protection, rising health costs, and youth protection) and economic interest on the other hand (tobacco industry, restaurants, and advertisement industry). This case analyzes tobacco control advocacy in federal Switzerland, a country known for its particularly weak regulation on the matter. The study focuses on advocacy activities aimed at advancing the agenda on the smoking ban, advertisement restrictions, and the ban on tobacco sales to minors. We underline that structural protection is difficult to achieve because economic lobbies are well organized at the national level. However, in a federal system, the subnational government units are able to advocate for tobacco control regulations from the bottom. We found that the Swiss cantons successfully used three types of advocacy strategies. Infra-political advocacy includes nonregulatory actions aimed at setting up structural protections at the local level, on a voluntary basis and in consensual settings (i.e., playgrounds, sports areas), in the perspective of a future regulatory change. Political advocacy directly intends to change the regulation through strategical actions within the political game. Finally, para-political advocacy aims at enhancing tobacco control by improving the actual enforcement of existing regulation. This typology shows the interplay and complementarity between these different advocacy types, which go beyond the classical idea of advocacy as a voicing activity limited to the political arenas.

Key words: tobacco control; federalism; multilevel governance; bottom-up change; framing strategies.

INTRODUCTION

Tobacco consumption was identified by the World Health Organization as one of the leading causes of avoidable deaths and a major global public health challenge. Various conflicting interests exist around the issue: general interest concerns (second-hand smoke, youth protection), economic concerns (hospitality, tobacco, and advertisement industries), and the political representation of these interests. This makes tobacco control a textbook case for studying public health advocacy. This chapter is based on a comprehensive study of the tobacco control policies of 14 subnational states in the Swiss federal system. The study was conducted between 2012 and 2019 and includes 157 in-depth semi-structured interviews with key players (civil servants, NGOs, private sector), 601 self-evaluation reports, field observations, and a context analysis.

The focus of the chapter is structural prevention: the smoking ban, advertisement restrictions, and the ban on tobacco sales to minors.

Despite having signed the Framework Convention on Tobacco Control,[1] Switzerland has a weak tobacco control policy and has not implemented these international guidelines yet. In the 2019 Tobacco Control Scale of the European Cancer Leagues, Switzerland had the second-to-last rank out of 36 countries.[2] Several factors account for this weakness. First, Switzerland is not part of the European Union, the member states of which have recently made some progress regarding tobacco control. Second, Switzerland is deemed “the land of the tobacco industry”[3] because it hosts the headquarters of several tobacco conglomerates and has a tobacco-growing tradition. Third, political lobbying remains strongly unregulated in Switzerland, which makes the political arenas permeable to industry interests. Finally, liberal economic tendencies are politically well represented, which discourages the adoption of bans and restrictions.

[1] https://www.who.int/fctc/en/

[2] https://www.europeancancerleagues.org/tobacco-control-scale/ [retrieved July 23, 2020]

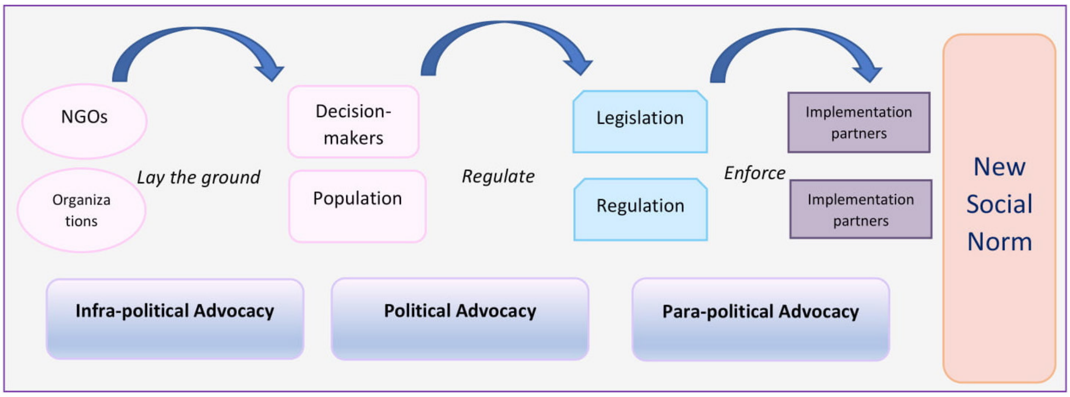
[3] https://www.swissinfo.ch/eng/lobbying_switzerland--the-land-of-the-tobacco-industry/44449446 [retrieved July 23, 2020]

Tobacco control is therefore difficult to advance on the national stage. However, a strong bottom-up dynamic has been initiated in subnational states in the past few years. In the Swiss federal system, the states bear an important part of healthcare costs, which explains their interest in tobacco control. They also have considerable public health prerogatives, which allow them to regulate on tobacco control. Finally, not all states have tobacco lobbying in their territory, which facilitates policy innovation at this level. The first significant regulations were adopted at the state level, driven by nongovernmental organizations (NGOs), public health organizations and administrations. These local experiments cleared the path for policy transfer processes among states (Mavrot, 2017).

Public health advocacy plays a crucial role in mobilizing public opinion, translating scientific evidence, and triggering political change (Asbridge, 2004). Often, advocacy addresses the structural determinants of health by aiming at global regulations, beyond individualist health perspectives. However, as in Switzerland, advocacy might be hampered by strong industry lobbying at the national level. In such cases, federal systems offer "multiple venues" for advancing public health agendas (Studlar, 2010).

In the following, based on the example of tobacco control in Switzerland, we present three types of advocacy. Political advocacy involves classical advocacy directly aimed at convincing politicians to adopt a policy. Infra-political advocacy includes all preliminary activities aimed at preparing public opinion and the decision-makers for a later change, through the introduction of small-scale interventions. Para-political advocacy encompasses policy enforcement activities. Figure 16-1 illustrates the advocacy continuum between these three types and Table 16-1 provides an overview of the strategies they comprise.

Figure 16-1: Infra-political, Political and Para-political Advocacy



CASE: POLITICAL, INFRA-POLITICAL AND PARA-POLITICAL ADVOCACY

Political advocacy usually refers to communication activities directed toward politicians to encourage them to undertake legislative, regulatory, or funding changes (Braun, 2003). Tobacco control advocacy in Switzerland provides four interesting lessons regarding this type of advocacy. First, whereas national politicians might be far from reach for health organizations, our case study shows that NGOs have better access to their local representatives in the national parliament. Most countries—with centralized and federal systems—have an electoral system ensuring regional representation in the national chamber(s). Because of the importance of the local electoral clientele for politicians and of proximity effects, targeted advocacy by local NGOs toward their own states' representatives can prove more effective than centralized advocacy at the national level. Second, two states successfully developed a poll strategy for convincing politicians. Local health organizations commissioned a population survey (opinions on advertising restrictions for tobacco products, support of the smoking ban in bars and restaurants before its adoption), to show politicians that the population was more supportive of bans than they were. This strategy reduced the risks and uncertainty politicians perceived regarding adopting a progressive stance. The media were actively used to broadly publicize the results of the population surveys to challenge politicians in the open. Third, while most of right-wing parties usually do not support bans, NGOs actively tried to build bridges with Christian right-wing parties on tobacco control issues. Such alliances were successful for bans of cigarette sales to minors when the issue was framed as a matter of youth protection. Fourth, varying the scale of advocacy in a multilevel system also proved to be effective. Facing inaction at the national level on the issue of cigarette sales to minors, one state prepared a regulatory reform (a system of licenses for selling points for a stronger monitoring of compliance with the law) and actively promoted the reform among neighbor states. This process is still ongoing, but if the policy were adopted in other states, it would enhance its outreach and coherence because bans make more sense at the supra-state level. By upscaling the issue, the state attempted to create an intermediate regulatory level between the state and the nation at the regional level.

Table 16-1: Overview of Advocacy Strategies in Tobacco Control

Infra-Political Advocacy	Political Advocacy	Para-Political Advocacy
Bottom-up diffusion of the non-smoking norm at the sub-regulatory level	Local lobbying of national politicians	Sensitization internships for implementation partners
Incentive systems for voluntary change	Population surveys to show the opinion gap between politicians and citizens	Issue-framing for implementation partners (e.g., law and order)
Targeting of consensual settings (e.g., sports) and target groups (e.g., children)	Youth protection framing	Issue-extension (e.g., temporary events)
Satisfaction surveys	Issue upscaling at the regional level	Enforcement mix (information, support, warnings, and rewards)

When health organizations sensed that the public and politicians were not ready for a direct regulatory change, they used infra-political advocacy strategies. Although less spectacular, such strategies can be highly efficient in the middle term. Various states successfully initiated sub-regulatory innovations, laying the foundation for subsequent regulatory reform. In a pioneer state, a parliamentary bill called for an outdoor smoke-free policy on bar and restaurant terraces, thus provoking a political controversy. To better set the stage for this change, the local tobacco control organization launched several initiatives aimed at softly disseminating smoke-free policies, but at a level on which regulatory change was not necessary. The organization implemented incentive systems involving information sheets, ashtrays, and boards in strategic places where the acceptance of an outdoor smoke-free policy would be higher: children's playgrounds, bus stops, and sports areas. The political debate on the bill is still ongoing, but this strategy helped normalize the outdoor nonsmoking norm through positive social pressure and voluntary renunciation. An important aspect of law changes also lies in their consolidation a posteriori. In a state where the newly enforced smoking ban in the hospitality sector was criticized because of outdoor noise pollution, an NGO organized a survey to show that 84% of the population nevertheless supported the ban (Zürcher et al., 2017). Again, the results were actively presented in the local press to counter the negative framing of the smoking ban.

Finally, the health organizations also implemented para-political advocacy activities, aimed at enhancing the enforcement of structural prevention. Here, the advocacy targets are implementation partners whose collaboration is needed. In some states, tobacco control regulation was poorly implemented, with a lack of controls and sanctions. Advocates had to convince implementation partners such as work inspectorate, police forces, or the food and hygiene inspectorate of the importance of regulations. In one state, an internship was organized for the police forces within the food safety administration to sensitize them to the importance of properly enforcing the smoking ban. In another state, a former public health official newly employed with the police worked to frame the smoking ban as a law and order duty, to convince the police to implement controls in their daily routine. In other states, the police were convinced to extend the smoking ban controls to festivals and temporary events to enhance the coherence and comprehensiveness of law enforcement. Regarding the ban on sales to minors, a complex combination of measures was implemented. It included test purchases, the publication of their results in the press, and communication with selling points through different means: an official warning or congratulatory letter from the health department, a police visit to remind business owners of the law, free trainings for sales personnel, and a certificate of compliance for law observers.

DISCUSSION

This case study presented three types of public health advocacy. The combination of these three types of advocacy allowed for significant tobacco control progress in Swiss states. Political advocacy directly aimed at decision-makers includes traditional information activities, but also subtle games within multilevel governance (e.g., creating a regional scale of action, targeting national politicians at the local level), framing activities (e.g., youth protection vs. bans and restrictions), and strategies with politicians and electorates (e.g., population surveys). Infra-political advocacy is a longer-term strategy that lays the foundation for future regulatory change (e.g., bottom-up dissemination of the smoke-free norm) or consolidates it afterward (e.g., a satisfaction survey). Para-political advocacy includes activities aimed at convincing implementation partners to enforce the law. Indeed, the proper implementation of existing laws is a permanent challenge in policy fields where behavior and technology constantly evolve. For instance, the tobacco industry is currently attempting to bypass second-hand smoke regulations with its new generation of products such as heat-not-burn cigarettes (Auer et al., 2017), which calls for constant vigilance to maintain high public health standards.

Advocacy is one of the pillars of a future global and sustainable health policy, as pictured in the Global Charter for the Public's Health (Borisch et al., 2018; Lomazzi, 2016). Advocacy is a complex endeavor that encompasses a wide array of activities ranging from lobbying to counseling, testifying, ensuring enforcement, bringing suits, and publishing evidence (Christoffel, 2000). The task is challenging because it aims at convincing politicians to adopt potentially unpopular policies such as taxes (Jahiel & Babor, 2007). In this context, one of the key tasks of public health advocates is to create a win-win situation for policymakers (Chapman, 2004). Another key lesson is to take advantage of multilevel systems such as federal states. Multilevel settings offer various opportunities to advance a cause through horizontal policy learning among states (Mavrot, 2017) and bottom-up diffusion (Mavrot & Sager, 2018).

However, there are many barriers to the advocacy of structural and efficient public health policies: political short-termism, concurring economic interests, the tendency to blame individuals for unhealthy behaviors (Farrer et al., 2015), industry lobbying, and the potential dependency of health organizations on public funding—and therefore on political authorities. Overcoming these hurdles requires the combined action of public agencies—which hold significant means of state action—and independent NGOs—which have autonomy of action and are free to express critical views—to ensure a significant public health impact.

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DECLARATIONS

Competing interests: No competing interests.

Funding: The data is drawn from a research project conducted by the Universities of Bern and Luzern, which received funding from the Tobacco Control Fund of the Swiss Federal Office of Public Health (a public agency).

Authors' contribution: The author conceptualized and wrote the article.

Acknowledgements: The author would like to thank her colleagues on the project from which the data was retrieved, Fritz Sager and Susanne Hadorn from the University of Bern, Switzerland

CASE 17

ADVOCACY FOR TOBACCO CONTROL IN LEBANON: LESSONS LEARNED TO ADVANCE PUBLIC POLICIES AGAINST ALL ODDS

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Key words: Tobacco control policy, framework convention on tobacco control, evidence based policy, partnerships

ABSTRACT

In 2011, six years after Lebanon ratified the Framework Convention on Tobacco Control (FCTC), the legislature passed the first ever comprehensive tobacco control law – Law 174. The law conformed to three pillars of evidence-based policy: Non smoking public places, bans on all forms of advertisement and promotion, and larger textual warnings, with a recommendation for pictorial warnings on all tobacco products. The passage of the law was a result of a concerted advocacy campaign led by a coalition of like-minded individuals and organizations that combined their skills and competencies to be most effective. The coalition included academics – particularly the American University of Beirut Tobacco Control Research Group (TCRG) - that brought forth the most recent research conducted globally and locally; governmental bodies including the National Tobacco Control program in the Ministry of Public Health that has a mandate to create environments conducive to tobacco prevention and control; non-governmental organization with influence on the ground and experience in programmatic implementation; and local media. Our case study will use an advocacy framework and functions of the Global Charter for Public Health to describe strategies and tools applied in pushing for the passage of Law 174, and subsequently for its implementation and enforcement. The case study will describe critical aspects of the advocacy campaign that influenced its success including the credibility of the academic research team; challenges to passage and subsequent implementation including disagreement and fragmentation of the advocacy groups, conflict of interests and values; pushback by industry and its representatives; as well as partisanship and lack of political bargaining. Lessons learned for other low and middle income countries will be shared.

INTRODUCTION

In Lebanon, 43.2% of adult males (aged 25-64 years) and 33.8% of females are current tobacco smokers; and 32.3% and 20.5% of adult males and females respectively currently smoke cigarettes (WHO, 2013). Youth tobacco use is high; 34.8% of 13-15 year olds were regular waterpipe tobacco smokers in 2011 (WHO, 2012). Yet, tobacco control was not considered a priority in Lebanon. The Framework Convention on Tobacco Control (FCTC) was ratified in 2005. Prior to that, Lebanon had: a law requiring the placement of warning labels on cigarette packs and tobacco advertisements (1983) and an administrative decree banning smoking in public places (1993) which was never enforced. Several factors affected this lack of prioritization of tobacco control including the civil war (1975-1990), all subsequent political events (up until 2011) (BBC, 2017); as well as the interference of the tobacco industry (Nakkash, 2007; Nakkash & Lee 2008, 2009).

In 1998, as part of the World Health Organization country program, a National Tobacco Control Program (NTCP) was established within the Ministry of Public Health (MOPH). The NTCP has never been adequately funded and its directors have not always been committed to tobacco control. In 1999, academics at the American University of Beirut (AUB) formed a multidisciplinary research group, the Tobacco Control Research Group (TCRG), with a mission to promote public health by producing and disseminating evidence-based tobacco control research (AUB Tobacco Control Research Group-About us, 2020). Members of the TCRG carefully documented determinants of tobacco use, tested interventions, analyzed waterpipe toxicant smoke, assessed economic impact, and evaluated policies (AUB Tobacco Control Research Group-Research, 2020).

In 2003, in the wake of continued evidence of the high prevalence of tobacco use in Lebanon, two tobacco control laws were proposed by parliamentarians. The first focused on imposing total bans of advertisement and sponsorship; while the second was more comprehensive and included smoking bans in public places and health warning labels. Despite Lebanon's ratification of the FCTC in 2005, efforts to move towards a national tobacco control policy were decelerated by the assassination of Prime Minister Rafik Hariri that year. Four years later, tobacco control activities at the national level were re-accelerated by the NTCP, supported by a Bloomberg Global Initiative grant (Tobacco Control Grants, 2009). These activities, including a national media campaign on the dangers of second hand smoke, and the continued research evidence provided by the TCRG brought national attention to tobacco control and resulted in a bourgeoning non-smoking culture in Lebanon (Nakkash et al., 2018). Within this window of opportunity, a new draft tobacco control law, endorsed by the NTCP, the MOPH and the head of the Parliamentary Health Committee, was brought forth to the parliament. The law was not fully in line with the FCTC, therefore, a concerted advocacy campaign began to strengthen the law prior to passage. In what follows, we describe the story of the passage of Law 174. The story highlights many of the services and functions of the Global Charter for Public Health (GCPH). Although primarily a story of sustained advocacy, its success was dependent on (i) information; (ii) governance; and (iii) capacity.

CASE

The aim of the advocacy campaign was to ensure that the proposed law conformed to the evidence-based recommendations of the FCTC. The stakeholders included the TCRG, supportive media outlets, Non-governmental organizations (NGOs), the NTCP, and some parliamentarians. Opponents included front organizations for the industry (including advertising companies and the hospitality sector), the multinational tobacco industry, the Regie - Lebanon's tobacco industry, and some media and parliamentarians. We use the Bloomberg Advocacy Incubator framework (Advocacy Incubator) to describe the process that led to the passage of Law 174.

The framework suggests thirteen iterative steps.

1. Gather background information: TCRG members were well informed of the global evidence outlined in the FCTC. When analyzing the draft law proposed, they found it to be deficient in several ways (Nakkash et al., 2018). Research by TCRG members continued to document the reality of tobacco use and interventions in Lebanon, including tobacco industry practices.

2. Set clear policy objectives: The policy objectives of the advocacy campaign were to ensure that the proposed draft law conformed to FCTC policy recommendations: a complete smoking ban in indoor public places, a comprehensive ban on advertising, and the use of pictorial health warning labels covering at least 40% of the front and back of cigarette packs (Nakkash et al., 2018).

3. Build strong partnerships: The TCRG formed a coalition with the media, civil society groups, the NTCP and others. Each partner had a unique contribution to the campaign. Briefly, TCRG members coordinated the advocacy campaign; and through lobbying for the policy, became policy entrepreneurs. Media channels uplifted the advocacy campaign through intense coverage. The NTCP helped frame tobacco control nationally. Two non-governmental organizations, Indyact and the Tobacco Free Initiative (TFI), were expert in advocating for social issues and were able to name and shame allies of the tobacco industry in a way no other players could.

4. Know the political landscape: The right mix of coalition partners facilitated the understanding of the political landscape. A power analysis - of position vis-a-vis the draft law and potential power to influence its passage - began early in the campaign and was updated throughout as positions of policymakers changed. Awareness of tobacco industry practices and tactics in Lebanon was used to control their influence; e.g., by highlighting the violation to article 5.3 of the FCTC, the coalition managed to get the tobacco industry out of the parliamentary deliberations (Nakkash et al., 2018).

5. Develop legislation: The necessary changes to the draft law were communicated via a press conference early on in the campaign. Also, a position statement with the policy objectives was shared with all 128 parliamentarians and sent out to all media outlets.

6. Determine what is negotiable: Members of the coalition had different opinions on what was negotiable. A critical dialogue ensured all coalition members understood the consequences of a less than evidence-based law.

7. Identify policy champions: Parliamentarians were the focus of our advocacy efforts and we worked to form a group of policy champions using results of our power analysis. Information gleaned informed our face to face lobbying meetings. Personal relationships with parliamentarians were cultivated and a champions' group meeting was launched officially at AUB during a social event attended by 35 (out of the total 128) parliament members (Figure 17-1).

Image 17-1: Members of the Lebanese Parliament and the AUB TCRG coordinator at the AUB champions' reception in November 2010

8. Develop key strategies: The tobacco control coalition managed to persuade some policy makers to change their positions using a multitude of approaches and strategies. Refer to table 17-1,17-2,17-3 (Nakkash et al., 2018).

Table 17-1: Key advocacy strategies from 2009 to 2011 - Published and disseminated policy briefs and positions statements

Approach	Partners involved	Date	Details
Policy Brief: Time to ban smoking in indoor public places	AUB-TCRG	Nov. 2009	Based on a research study evaluating bans on smoking in closed public places in Lebanon Disseminated to parliamentarians and the media
Position statement: Lebanon cannot afford tobacco industry supported loopholes in a new tobacco control law	AUB-TCRG, Tobacco Free Initiative and IndyACT	Feb. 2010	Released during a press conference at AUB Sent to all parliamentarians
Position statement: Ineffectiveness of smoking and non-smoking areas in reducing harm from tobacco smoke	AUB-TCRG	April 2010	Issued to support a strong provision in the law requiring complete bans of smoking indoors Sent to all parliamentarians Covered by media
Policy brief: The transnational tobacco industry effectively hampers tobacco control policymaking in Lebanon.	AUB-TCRG	April 2010	Based on research from Tobacco Industry Documents Sent to all parliamentarians and the media
Policy brief: Economic cost of tobacco in Lebanon	Issam Fares Institute of Public Policy at AUB and AUB-TCRG	May 2010	Disseminated in a press conference to counter parliamentarians' economic arguments against the law Event highly covered by the media Sent to all parliamentarians
Position Statement: No exceptions, no equivocations for a complete smoking ban in public places	AUB-TCRG and Tobacco Free Initiative	Feb. 2011	Issued in response to tobacco industry pressure on parliamentary committee to water down the smoking bans and introduce smoking and nonsmoking sections in closed indoor public places
Position Statement: Conflict of interest in the Parliamentary deliberations	AUB-TCRG, Tobacco Free Initiative and IndyACT	March 2011	Sent to all parliamentarians and media Issued to expose the relationship between the head of the parliamentary committee of Administration and Justice and his son the head of Marketing Levant and Yemen at British American Tobacco
Policy Brief: Testing Pictorial Health Warnings in Lebanon	AUB-TCRG	March 2011	Based on a study evaluating effectiveness of pictorial health warnings among in Lebanon Disseminated to all parliamentarians prior to the general assembly meeting, to media and supporting NGOs
Position Statement: Evidence based pictorial Health Warnings	AUB-TCRG, Tobacco Free Initiative and IndyACT	March 2011	Issued to support inclusion of pictorial health warnings in the law

(Nakkash et al., 2018)

Table 17-2: Key advocacy strategies from 2009 to 2011 - Lobbying Activities (media and other)

Approach	Partners involved	Date	Details
Press Conference	AUB-TCRG, Tobacco Free Initiative and IndyACT	Feb. 2010	Disseminated the February 2010 position statement and conducted an experiment to illustrate to media how smoking and non-smoking sections are ineffective in protecting people from secondhand smoke
Face to face meetings with Parliamentarians	AUB-TCRG, Tobacco Free Initiative and IndyACT	Feb. 2010–Aug. 2011	Met with over 35 Parliamentarians from different political parties
World No Tobacco Day 2010	AUB-TCRG and TFI	May 2010	Emphasized banning of tobacco product marketing to women and girls, more than 80 NGO's pledged their support of the WNTD theme
Press Conference and meeting	AUB-TCRG and Issam Fares Institute of Public Policy at AUB	May 2010	Conducted a conference on the economic impact of tobacco in Lebanon
Sit-in	Indyact	July 2010	In front of Phillip Morris offices 'Tobacco Companies: We are watching you'
Advocacy Action	IndyACT	July 2010	Members of IndyAct gathered as World cup Referees in Front of the Parliament: 'Don't Play With Our Health'
Parliamentarian Champions Reception	AUB-TCRG and TFI	Nov. 2010	Brought together at AUB Parliamentarian members as supportive pressure group to vote for an effective law
Petition: Support endorsement of an evidence-based tobacco control law	AUB-TCRG, Tobacco Free Initiative and IndyACT	Nov. 2010	Circulated to organizations, syndicates, public institutions, private companies, heads of parliamentary parties and all parliamentarians. Published in the media
Seminar open to the public	AUB-TCRG	Jan. 2011	On Corporate Social Responsibility & Controversial Companies: Where to draw the line? Led by Dr. Norbert Hirschhorn.
Seminar open to the public	AUB-TCRG	Feb. 2011	On Alternatives to Tobacco Farming: Addressing Barriers to Tobacco Control Led by Mr. Wardie Leppan from IDRC
Sit-in	TFI and IndyAct	March 2011	Activists protested in front of the Lebanese parliament as pregnant women, and wore t-shirts that say 'Your smoke Kills my baby' They were kicked out by the security
World No Tobacco Day 2011	AUB-TCRG and TFI	May 2011	Event organized for school students across Lebanon to build support for the Tobacco Control law
Training lawyers on Tobacco Control law and strategies for litigation	AUB-TCRG and 'Human Rights Institute' at the Syndicate for Lawyers	May 2011	Building capacity of lawyers in tobacco control policy and litigation strategies led by Dr. Richard Daynard
Seminar open to the public	AUB-TCRG and IFI	June 2011	Translating Science into Effective Tobacco Control Policies: Three Perspectives led by Dr. Greg Connolly

(Nakkash et al., 2018)

Table 17-3: Examples of editorial issued by AUB-TCRG

Approach	Date	Details
Editorial: 'Drafting a Tobacco Control Law: an Unequal Battle with the Tobacco Industry'	Feb. 2010	Lobbies for a stronger draft proposal
Editorial: 'Fighting Smoking'	April 2010	Sent to media to lobby for a stronger draft proposal
Editorial: 'Lebanese woman. . .Resist'	May 2010	Letter sent to media
Editorial: 'An open letter to all legislators'	June 2010	Letter sent to the media

(Nakkash et al., 2018)

Image 17-2: WNTD 2010 marathon event on Beirut's Corniche.

9. Prepare to communicate effectively: Communication was led by an expert journalist and media specialist who was also a tobacco control advocate and member of the coalition. Regular media alerts were sent to the national news agency in response to developments in policymaking. The coalition had an active Facebook page which was used to advertise and post pictures of campaign activities and to expose complicity of policymakers or changes in their positions.

10. Formulate your campaign action plan: Our action plan was to persistently counter any efforts to pass the law in its draft form and to work via media advocacy and lobbying to ensure that an evidence-based version was approved.

11. Run your campaign: The advocacy campaign was sustained over approximately 3 years. Most coalition partners contributed their expertise pro bono. Funding, secured by the NTCP and civil society partners, was used to support activities rather than salaries.

12. Monitor and evaluate: The monitoring of progress was ongoing throughout the campaign via meetings and regular intensive communication. Success was measured by the outcome of the passage of an evidence-based law.

13. Celebrate: In August 2011, law 174 passed the Lebanese parliament with the changes advocated for by the coalition. The ban on advertisements, promotion and sponsorship went into effect immediately after the passage of the law, however, larger textual warnings and bans on smoking in indoor public places became effective one year later.

DISCUSSION

The passage of Law 174 in Lebanon, as a result of sustained advocacy, provides lessons to advance public health policies at national, regional, and international level. In low and middle income countries, NGOs involved in lobbying and advocating for health and social causes are scarce. In such settings, a coalition of stakeholders may be needed to do the job. Our coalition proactively implemented a set of strategies and contributed to the passage of an evidence-based law. The advocacy campaign by this coalition helped to define the tobacco problem and its severity, provided evidence-based policy solutions, advocated for those policies, shaped decision makers and public receptivity for change, and pushed the draft law to the parliamentary policy agenda. Facilitating factors to this success included the FCTC ratification, the health and economic burden of tobacco, the blocked tobacco industry interference, and the overall conducive political environment (Nakkash et al., 2018). Lessons learned revolve around five key considerations of value in any campaign: local evidence, partnerships, perseverance, understanding context, and cultivating personal relationships. Although all coalition partners were knowledgeable of the context, the TCRG contributed to the local evidence which was important for decision makers. As such, the partnerships complemented the advocacy campaign at various stages of its development. Perseverance is key to tolerating setbacks, especially in advocacy campaigns around contentious issues such as tobacco control policy. Finally, cultivating personal relationships was essential for building the trust of various stakeholders (Nakkash et al., 2014).

The story of the passage of tobacco control Law 174 in Lebanon indicates that “a small group of thoughtful, committed citizens can (indeed) change the world”, but that the work of changing the world is continuous with changing targets within one health issue, and between issues. Parts of Law 174 remain implemented and enforced (such as larger text warnings and bans on advertising), while others have gone awry. Enforcement of the ban on smoking in public places in the hospitality sector lasted only three months (Aug.–Dec. 2012). Strong opposition by the hospitality industry, led by restaurants offering waterpipe, subsequently resulted in lax enforcement. The Ministry of Tourism also stopped enforcing the law claiming that it had a negative effect on tourism, despite evidence by the tobacco control coalition to counter this claim. Enforcement of this aspect of Law 174 remains weak till now. Our key take-home message is that public health advocates must remain resilient, resourceful, steadfast, visionary, and ever hopeful.

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DECLARATIONS

Competing interests: The authors declare that they have no competing interests

Funding: The write up of this case study was not funded. The authors and the AUB TCRG were partially funded by the International Development Research Canada (IDRC) during the course of the campaign.

Authors' contribution: All authors contributed to drafting and finalizing the case.

Acknowledgements: The authors thank members of the AUB Tobacco Control Research Group who championed and supported the policy as well as all the members of the coalition.

CASE 18

YOUTH MONITORING OF TOBACCO SALES IN SLOVENIA

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Key words: tobacco, youth, advocacy, mystery shopping

ABSTRACT

In Slovenia 40% of 15-year olds have already tried smoking. Bringing down the sales of tobacco to minors can be done the most effectively by increasing their price, making them less attractive by using plain packaging and banning all kinds of marketing and also by reducing their availability by not selling tobacco products to minors.

The aim of the project was to reduce sales of tobacco products to minors by advocating for better implementation of the Slovenian Tobacco Law. Important aspect was to measure the effects of licencing of tobacco retailers which was introduced with the Tobacco law in 2017 and implemented in 2019.

Results in the first months after implementation of licences indicate that this is one of the crucial policies that can successfully bring down the percentages of tobacco sales to minors. In less than one year time, the reduction of successful tobacco purchases by minors went from 75% to 51%. The important step in between both purchases were mystery shopping interventions with inspectors which led to loss of licences for selling tobacco products in several locations around the country. Mystery shopping or test purchasing means organised purchasing of tobacco products by minors to test compliance of the sellers with the law.

Having a legislation that prohibits sales of tobacco to minors is not sufficient on its own. First factor needs to be that the punishment must lead to loss of sales permit for a certain period of time. And a secondly test purchases should be done regularly in the presence of inspectors to show tobacco sellers that the law must be implemented.

INTRODUCTION

Tobacco harms the health and the treasury of Slovenia since the costs related to smoking are higher than tobacco related income (DG SANCO, 2012). According to recent statistics, in Slovenia 3.600 people die per year (10 people each day) as a consequence of illnesses related to smoking tobacco and 40% of 15-year olds have already tried smoking (World Health Organization [WHO], 2017). The Act on the Restriction of the Use of Tobacco and Related Products was adopted in February 2017 and ranked Slovenia among countries with the strictest tobacco regulation. The Act stipulates the implementation of licensing for retailers of tobacco and related products and a ban on selling tobacco and related products to minors (WHO, 2017).

Slovenia became a Party to the WHO Framework Convention on Tobacco Control (FCTC) on June 13, 2005 (Tobacco Control Laws, 2020). According to the Tobacco Control Scale 2019 in Europe, Slovenia holds now 8th place among 36 countries and has made a big step after being on 28th place in 2016 (Tobacco Control Scale, 2019). However, about one quarter of people in Slovenia smoke, while at least 70% of them started smoking while underage. More than 2.000 children (10-14 years old) and 272.000 adults (15+ years old) continue to use tobacco each day (Slovenia – Tobacco Atlas, 2020). This means that it is extremely important to prevent easy access of tobacco for minors.

No Excuse Slovenia has worked towards FCTC implementation since its establishment in 2006. No Excuse Slovenia focuses on social-mobilization of youth and their education in the field of public health and sustainable development. This engagement leads to meaningful voluntary work of young people and with a help of mentors their activities bring about policy change with correct communication strategies while keeping the experience safe and engaging for young activist (No Excuse Slovenia, 2020). Their research activities in the past uncovered the noncompliance of tobacco distributors with the law, mostly focusing on sales of tobacco products to minors and advertising of tobacco products. In one of the previous studies over 300 points of sale were researched for tobacco advertising, which was exposed in media and presented to decision makers as part of advocacy action for stronger tobacco-control legislation in 2017 (Grant, 2017). Advocacy actions by No Excuse helped Ministry of Health introduce obligatory licences for shops that want to sell tobacco to the new Tobacco Law from 2017, (Article 41, paragraph 15) (Zakon o Omejevanju Uporabe Tobacnih in Povezanih Izdelkov, 2017). As defined in the Global Charter, Advocacy represents leadership and ethics, health equity, social-mobilization and solidarity, education of the public, people-centred approach, voluntary community sector engagement, communications and sustainable development (Lomazzi, 2016).

Mystery shopping or test purchasing means organised purchasing of tobacco products by minors to test compliance of the sellers with the law. The test purchase is done by a young person, usually between the age of 15 and 17 years, who tries to buy a tobacco product. Somewhere in the shop is also present an adult who accompanies the minor at the safe distance and collects the product if the purchase is successful.

CASE

Objective

The aim of the project was to reduce sales of tobacco products to minors by advocating for better implementation of the Slovenian Tobacco Law to reduce underage sales of tobacco products and raise awareness among the relevant stakeholders. Important aspect was to measure the effects of licencing of tobacco retailers which was introduced with the Tobacco law in 2017 and implemented in 2019.

Design

The initiative of Mystery Shopping was introduced in the organisation by International Youth Health Organisation (Youth Health Organisation). Their initial purchasing protocol was described in a Handbook for youth research for compliance with alcohol age limits and alcohol marketing regulations (Franken, 2016). No Excuse Slovenia has adapted protocols for different versions of mystery shopping and improved safeguarding of involved minors. The protocols were written in Slovene and they all consist of:

1. introduction to mystery shopping;
2. explanation of why we are doing this;
3. step by step explanation of how we are going to carry out the purchase (including preparation, execution and what happens after the purchase);
4. closure – giving mental support and information on who to contact inside the organisation.

The money to cover costs of buying tobacco products was raised by volunteer contributions to the organisation. Minors did not receive any financial awards for purchases. During the process underaged activists were trained on how to carry out the protocol of test purchases and were accompanied by an adult. None of the purchased goods were smoked and were used as media material at the press conference to convey a stronger message and were destroyed and disposed afterwards. The study was guided and supervised also by Faculty of Social Sciences, University of Ljubljana and Institute for Youth Participation, Health and Sustainable Development.

Participants

During the project, a selected group of minors (under 18 years of age) were trained to become mystery shoppers to test the compliance with the Slovenian Tobacco Law in six biggest cities in Slovenia. Minors were activists - members of Youth Network No Excuse Slovenia, who were between 15 and 17 years old.

A very important part of intervention research was that the underaged activists were well informed on the harmfulness of tobacco products and the issue of selling these products to minors. Most of No Excuse members joined the organisation at the age of 15. In the first year of their participation in organisational activities they attend a minimum of one working weekend on the topic of tobacco with informal teaching methods and methods of youth work with a youth trainer. Content covers negative aspects of tobacco use, modus operandi of tobacco industry, their manipulations, marketing tactics and so on. They also learn about relevant tobacco legislation. After these trainings they can become peer-to-peer educators in schools with a support of mentors. Peer educators present tobacco industry manipulations through which they gain skills like media literacy, advocacy and presentation skills among others, while empowering their social and life skills. Evidenced-based prevention approach in youth work means creating a safe environment for young members (activists), equipping them with competencies (knowledge, skills and attitudes) and providing opportunities for them to become active citizens that strive to change society for the better. This approach also reduces the possibility of them developing addictive behaviours and thus, tobacco use (Bourgoin, 2019).

Special training is provided for all mystery shoppers to understand the context of research and to practice the protocol with roleplay. It is important that underaged activists feel safe in the role of the mystery shopper and that they understand the reasons for the research, their input and the results. They are accompanied with some distance by at least one trained adult in the shop, since the protocol dictates that they have to pretend that they don’t know each other. Adult activist focuses on the other aspects necessary for the research report. After the purchase, they both meet in a safe distance away from the shop to fill out the report and talk about the experience.

After all the research shopping is over, all the mystery shoppers received a recognition award for their actions at a small celebration. This opportunity was used to address the results of the action, as a reminder of why it was important for the research to be conducted and how it will contribute to a reduction of sales of harmful products to minors.

The organisation also keeps signed parent consent for every activist that participates in the research. These forms were signed before the research, when their parents were informed and asked for approval. Another mandatory document in the research was Child Protection Policy document which describes children rights and protection of personal data.

Results

Sales of tobacco products to minors was 75% successful during the first round of mystery shopping, which was done in 89 shops around Slovenia at the end of 2018, before the licences for tobacco sales were implemented on the 1st January 2019.

In spring 2019 mystery shopping was done with an inspector at 26 shops. The inspector pretended to be a random customer at the shop and only revealed him/herself if the purchase was successful. In such a case the seller and the shop got a fine and a lost their licence to sell tobacco products in the next 6 months in that location. The intervention was successful in 18 shops (69% of all purchases).

In summer 2019 mystery shopping was repeated without an inspector in 102 shops, which means it did not lead to loss of licences. In the third-round minors could buy cigarettes in 51% cases of mystery shopping.

Figure 18-1: Photos taken at the cashier's desk when the minor was paying for the product.

CONCLUSIONS

Results in the first months after implementation of licences indicate that this is one of the crucial policies that can successfully bring down the percentages of tobacco sales to minors. In less than one-year time, the reduction of successful tobacco purchases by minors went from 75% to 51%. The important step in between both purchases were mystery shopping interventions with inspectors which led to loss of licences for selling tobacco products in several locations around the country.

It is important to note, that having a good legislation that prohibits sales of tobacco to minors is not sufficient on its own. First factor needs to be that the punishment must lead to loss of sales for a certain period of time (e.g. 6 months) and not only a financial punishment of a seller. And a second factor must be that test purchases are done regularly in the presence of inspectors to show tobacco sellers that the law is not only there on paper.

To perform regular mystery shopping, one needs a sustainable pool of dedicated minors, who understand that their actions are an important part of advocacy which will lead to a society without tobacco on the long run. Another important lesson is involving a scientific partner that provides a structure of research that will lead to reliable results that can be used with confidence in the advocacy communications. Setting research goals for each phase of the study and seeing the impact of work was a crucial motivational factor to perform more test purchases in a shorter time. Measuring results and celebration at reaching a certain number of test purchases are important factors for underaged volunteers to keep the perspective of why test purchases are a very important part of ongoing activist work in the field of tobacco policy.

Bringing down the sales of tobacco to minors can be done the most effectively by addressing the issue with multiple activities and policies, like increasing their price, making them less attractive by using plain packaging and banning all kinds of marketing and also by reducing their availability, when stores start respecting the law and not selling tobacco products to minors.

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DECLARATIONS

Competing interests: We declare no financial or non-financial competing interests.

Funding: Funding provided for this study was part of the grant received by the Ministry of Health, Slovenia.

Authors' contribution: J.P. wrote draft Case study, U.E. wrote Introduction and Discussion and edited the paper. All authors read and approved the final manuscript.

Acknowledgements: To all co-workers and activists who took part in mystery shopping.

FINAL REMARKS: A PROMINENT ROLE FOR ADVOCACY IN THE FUTURE OF PUBLIC HEALTH.

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ABSTRACT

Learning from historical public health milestones we must acknowledge the primordial role of public policies for shaping population health. Although many public health professionals may feel uncomfortable with the idea of getting involved in politics, we make the case here as to how public health advocacy is an essential part of public health practice and that not getting involved is itself a political action. Furthermore, while scientific evidence on health and disease is essential for guiding public health actions, it is often insufficient to create meaningful change in the policy arena, where innovative strategies are needed to frame and communicate knowledge and take advantage of windows of opportunity as they arise.

As such, improving the health of populations and mainstreaming health and health equity in all policies will requires a major effort to improve the practical and scientific underpinning of public health advocacy. The WFPHA Casebook on Advocacy in Public Health brings together 18 cases of public health advocacy from different corners of the world covering a range of public health topics from tackling climate change at a global level to improving the conditions in African prisons with investigative journalism and strategic litigation. We draw on the similarities and differences of the various experiences included in the casebook and analyse some of the key issues that are raised. We hope that these shared experiences will help encourage public health researchers and practitioners to join the playing field of policy formulation and inform future training schemes so that they are equipped with the tools they need to be successful advocates.

INTRODUCTION

The undoubted advances in medicine in the second half of the twentieth century favoured a vision of health centred on the biomedical paradigm. Science, or rather a certain type of science, was expected to provide answers to the major health problems. Reliance on biomedical responses may have contributed to public health professionals overlooking what the underlying causes of health problems are and what the key strategies are for improving the health of human populations. Public health authorities used solid scientific evidence to establish that tobacco caused disease and that its impact was of great magnitude, yet it took many years, even decades, before effective tobacco policies began to be put in place. It is possible that the influence of medicine on public health has contributed to a way of thinking about the relationship between science and practice that overlooks the relevance of policy formulation and its determinants as a key issue for effective public health performance. As Moore pointed out in the first chapter of this Casebook, public health is political, and it is incumbent on public health professionals to influence politics for better health outcomes (Moore, 2021).

It is true that for some public health professionals, the thought of public health advocacy moves them out of[1] their comfort zone. We have often heard it said that political issues are outside our professional remit. In this regard, Wislawa Szymborska's poem "Children of the Age" comes to mind: "We are children of our age, it is a political age. All day long, all through the night, all affairs— yours, ours, theirs— are political affairs. Whether you like it or not, your genes have a political past, your skin, a political cast, your eyes, a political slant. Whatever you say reverberates, whatever you do not say speaks for itself. So, either way you're talking politics…". In our view, Szymborska hits the nail on the head when she points out that keeping quiet it itself a political action. Precisely, we believe that ineffective public health is defined more by inaction, by what it fails to do rather than by what it does. If our goal is to improve the health of the population, the truth is that we too often stray from our endeavour.

At the turn of the last century, when Kenneth Rothman asked whether the mission of epidemiology should include the eradication of poverty (Rothman, 1998), he received several appropriate answers (McMichael, 1998, Kaplan, 1998). Yet, there is one that ties in perfectly with something that all health professionals need to bear in mind: “Rothman and colleagues talk about poverty and ask whether epidemiologists have the means to eradicate poverty? With respect, this is not the right question. To focus on poverty alone and its eradication will arrest the work of any professional in any discipline. The more valuable question is how can a knowledge of human rights values enrich decisions about what research is carried out and how it is done” (Loff & Black, 1998). Indeed, knowledge of human rights would improve the choices of research questions, but more importantly, as Nancy Krieger pointed out, the effective implementation of human rights and social justice are the foundation of public health action (Krieger, 1998). If these are the fundamentals of public health and our goal is to improve the health of human populations, there is no doubt that we need good science and solid evidence, but we also know that evidence is not enough.

Evidence may be indispensable, but it needs to be coupled with effective strategies to frame the knowledge in such a way that the implications from policy action (or inaction) are clear and we need to create opportunity for change by influencing opinions and priorities amongst the population. If we consider policy formulation the playing field where key decisions affecting health are made, public health professionals have no choice but to get into the field and start playing. Public health advocacy is one of the key strategies for influencing health policy as the history of public health milestones teaches us. This is why the Word Federation of Public Health Associations includes advocacy in its Global Charter for the Public’s Health as one of the four enabling determinants that support the achievement of essential public health functions. The future of public health as an engine of change for improving the health of populations and for mainstreaming health and health equity in all policies requires a major effort to improve the practical and scientific underpinning of public health advocacy.

One of the challenges lies in harnessing and channelling the wealth of interest and experience that in many cases are advocacy practices without their promoters identifying them as such. Many public health practitioners and researchers are interested in advocacy and recognise the need to apply it to improve the health of their communities. However, they do not readily identify who the public health advocacy actors should be or how it should be carried out. On occasion researchers and health professionals are good advocates without necessarily realising they are doing advocacy, nor will they identify their actions as part of an advocacy strategy. The lack of a formal structure or framework within training explains in part the low penetration of advocacy among health professionals and researchers, and the lack of formal advocacy strategies that are comprehensive, i.e., strategies that are inclusive and involve different relevant actors, in particular the participation of communities. Along this line, case 1 describes the Guide from the WHO Collaborating Centre on Investment on Health and Well-being, which provides readers with practical tools, and resources on how to review, synthesise, design and communicate public health evidence. Furthermore, the casebook presents numerous experiences of public health advocacy from different corners of the world covering a range of public health topics from advocating for climate change mitigation at a global level (case 3), to improving the conditions in African prisons with investigative journalism and strategic litigation (case 15) or pushing for changes in medical curriculum and new protocols to promote the systematic screening for Chagas disease among pregnant women from endemic countries (case 12). They also cover a wide range of actions such as holding public events, participating in policy meetings, signing petitions, filming documentaries, mainstream media interventions, academic publications, round table debates at conferences or social media campaigns to name but a few.

Many of the experiences of public health advocacy that we can call informal or spontaneous, are focused on convincing decision-makers and the wider public about the goals of public health. This type of advocacy has been referred to as ‘representational’, resembles lobbying and has been criticised for its technocratic or elitist character, despite its acknowledged value (Smith & Stewart, 2017). These authors propose an alternative, ‘facilitational’ conceptualisation of advocacy that involves taking a more democratic approach. This type of advocacy centres on listening to, and working with, communities and members of the public whose voices are under-represented in research and policy debates. Both types of advocacy are necessary to improve the health of populations. Furthermore, we need to choose the actions and strategies that are most effective, a daunting task if we consider the fact than most advocacy actions are not evaluated. We can look at the work and guidance of leading public health advocates (Chapman, 2007), or the updated recommendations that Michael Moore has described in the introductory chapter of this Casebook (Moore, 2019). However, given that advocacy action must be guided by the principles of equity and equity in health in all policies, it seems obvious that community participation and democratic approaches should be a key part of advocacy. This can perhaps be seen as a common theme throughout the casebook where participatory methods for research and action come up time and time again.

For example, case 5 describes the patient voice as a key change agent for influencing health policy and moving towards fair and equal access to quality healthcare on the African continent, and further afield, while case 8 describes a participatory action research culminating in the creation of a documentary about discrimination against LGBTIQ people in medical practice, and its posterior use to move towards a more inclusive medical education in Turkey. The importance of participatory techniques for successful advocacy is also highlighted in Case 13, which describes the action of a multidisciplinary working group to protect health and safety of workers in Italy. Overall, social mobilization, voluntary community sector engagement and strategic communication are all seen as key components to achieving advocacy goals. Regarding successful communication, the authors of case 2 identify the importance of message testing with focus groups involving key audiences and acknowledge that the local experts were able to advocate for adoption of a child restraint law in the Philippines after only public opinion on the matter had been changed by parallel information campaigns. Numerous authors address new ways to influence public opinion in a world of excess information, where social media plays an increasingly prominent role. Here we can acknowledge a growing space for young dynamic communicators. For example, case 11 describes a social media campaign to change public awareness of antimicrobial resistance that was completely ran and managed by students and student associations in Nigeria.

From the perspective of policy decision-making processes, the involvement of people and their active participation should favour one of the aspects that have been considered relevant in public policy decision-making. While evidence is essential as a starting point for the processes that lead, or not, to decisions that are favourable to the health of the population, it has been proposed that what matters for public health policy is less scientific evidence and much more a set of research-based ideas. Katherine Smith in her book Beyond Evidence Based Policy in Public Health: the Interplay of Ideas (Smith, 2013), develop this idea in detail and suggest that: “research is likely to have more impact on policy where there are strong links between research, advocacy and policy communities and where researchers work with others to (i) develop charismatic ideas (within persuasive ‘policy frames’) and (ii) monitor and actively try to counter the efforts of actors seeking to influence policies in alternative ways (e.g. corporations involved in marketing health-damaging products or think tanks promoting free-market policies and minimal state intervention)". Perhaps the area where the need to counter opposing action from commercial actors is most clear is for tobacco control, and it is an area where public health advocacy is most developed. Cases 16 to 18 of this first edition of the WFPHA Casebook for Public Health Advocacy describe advocacy for tobacco control in Switzerland, Lebanon, and Slovenia, highlighting common challenges in subverting the actions from tobacco companies and enforcing legislation once passed, but similar issues arise in case 14, looking at legislation for asbestos use in Colombia. What is clear is that advocating for public health goals requires persistence and even when policy change is achieved, sustained advocacy is needed to ensure enforcement and to adapt to new hurdles that may arise.

The involvement of communities should facilitate advocacy actions to influence the exchange of ideas in the public sphere so that the construction of agenda and policy frames on health problems and their solutions come closer to public health vision and take into account the above-mentioned principles of health equity in all policies. On the other hand, it is important to be strategic in seizing every window of opportunity. Sometimes it is not enough that advocacy work is done well, with the involvement of the majority of actors, it is necessary to have leverage mechanisms to act when a political window of opportunity opens, as this can be decisive in achieving decisive public health policies (Hernández-Aguado, 2013). Increasingly, it will be necessary to apply the insights of political science to public health policy making in the same way that knowledge of communication science has been incorporated in advocacy tasks. This can equip public health advocacy with better tools counter the efforts of corporations and other actors seeking to influence policies in alternative ways. Here again we must be open to any kind of knowledge and strategy that serves the goals of public health, as the due and undue influences that the aforementioned actors exert to move policy decisions (or ensure policy inactions) in their favour are wide-ranging and of high quality (Hernandez-Aguado & Chillet Rosell, 2018).

Those involved in public health advocacy need to be aware of which actors are involved in shaping policy and what strategies they use to exert their influence at all levels. Several actors, particularly corporations, shape policy from the realm of ideas described. They act for example by trying to get health issues framed in the media as a matter of individual choice (common in obesity for example), influencing the political agenda, acting on the type and orientation of research that is done, and in other brilliant ways that permeate the majority of actors. In doing so, the network of actors involved in the exchange and transfer of ideas, which then influence policy decisions, shape their positions in line with actors who are not in favour of public health policies. The actors include mass media, corporations, think tanks, politicians, scientific and professional societies, academic and research centres, knowledge brokers, advocacy organizations, NGOs, etc. (Madureira Lima & Galea, 2018). The strategies used are sometimes so subtle that they are difficult to detect, for example by getting editorials and commentaries in the scientific literature to be favourable to public-private partnerships as an effective way to promote health (Hernández-Aguado & Zaragoza, 2016) despite the lack of evidence to support their effectiveness (Parker et al., 2019).

Another strategy used to influence policy formulation is to declare that there is insufficient evidence to support public health action, thereby using evidence as a means for delaying legislation. Numerous examples can be found, such as limiting the use of endocrine disrupting chemicals in Europe, but the issue is also raised in case 14, which described the passage of Ana Cecilia Niño law for asbestos control in Colombia coming into force in January 2021 after many years of dedicated work from their community-based advocacy initiative. The name of the law leads us to reflect on an issue that may underpin some successful advocacy efforts, and that is to personalise the issue, attaching an individual face to an issue to help ignite the movement (Ana Cecilia Niño was a noted journalist in the country who died from asbestos exposure). Along the same line, case 9 describes one woman's experience of giving birth in Colombia and how it was used by a team of researchers to generate or feed into a national movement for sexual and reproductive health rights in the country. Finally, while in many cases mainstream media was utilised to strengthen advocacy efforts, in case 7 the fact that the media was unsupportive of the goal was deemed a critical barrier to policy change despite the National Health Council collecting more than 2 million signatures in support of the proposed bill.

CONCLUSION

There are, no doubt, many more issues that emerge when considering public health advocacy and considering the different cases presented here. The task ahead is extensive if we are to strengthen the public health enterprise. One of the most necessary undertakings, in our view, is to put advocacy into action. If possible, it should be done with excellent designs and strategies, considering the premises of effectiveness and with support from local public and private actors, including the media. All of this will be enhanced if we are determined and systematically incorporate advocacy training into public health practice, training, and research. For this task it will be important to evaluate the advocacy strategies undertaken used in order to identify the most effective means, an aspect that is limited in the current casebook. Furthermore, we must develop tools and resources to aid public health professionals.

Finally, we must acknowledge that this casebook would not have been possible without the interest, dedication and support from the authors who have shared their experiences in this first edition of the WFPHA Casebook on Advocacy in Public Health. The range of experiences from different corners of the world is remarkable, as is the range of author profiles from students and early career professionals to experienced advocates with long public health careers behind them. By bringing together different experiences from around the world we hope to create a space to share and learn, and to generate exchange that will help attract public health researchers and practitioners to the playing field of policy formulation. We also hope to promote and inform future training schemes so that the researchers and practitioners are equipped with the tools they need to be successful advocates. Public health advocacy is undoubtably part of the future if we want to reach the goal of public health, which in the words of Nancy Krieger is: a just and sustainable world in which we and every being on this planet may truly thrive (Krieger, 2015).

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World Federation of Public Health Associations

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ISBN E VERSION: 978-84-09-27984-5