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Advocacy strategies for health communication☆

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ABSTRACT

This article presents a new way of using advocacy communication strategies for health communication. The traditional perspective on advocacy, promoted in mainstream public relations and marketing circles, is being replaced by a more interactive and integrated view on the role of advocacy communication. Newer theoretical and applied contributions to the health communication field support the need to explore (a) a broader understanding of the role of *communication to promote and sustain health behavior*; (b) a broader *social scientific approach to public health* as a social construct and the social determinants of health with stronger emphasis on health policies and management such as governance, accountability and leadership; and (c) *policy perspectives* that deal with resource allocation, human resources and capacity building, enabling environments for health communication, and recognition of the value and contribution of health communication to public health.

Advocacy combines social networking and mobilization, interpersonal communication and negotiation, as well as the use of media for generating public pressure. The authors suggest that the power of supportive evidence as generated by professionals and academics must be effectively utilized through all these means in presenting a powerful case for sustainable social change.

While health communication interventions have been around since the 1960s, especially through family planning programs, health communication found itself at the center of the international agenda in the 1980s. The Declaration of Alma Alta (1978) and the Ottawa Charter (1986) represented a fundamental point of departure from approaches centered on technology and hospital-based care to increased *participatory and empowerment-based approaches in health*. The assumption is that individuals and communities can play an important role in determining their health (see WHO, 1990). In the 1990s, during the post-Cairo and Beijing conference years, the field moved to a *rights-based approach*, while in the last decade a new momentum has been established with a range of new initiatives such as the Millennium Development Goals (MDG) (UN, 2000), the World Health Organization's 3 by 5 initiative (WHO, 2003), and specific issues that emphasize leadership, participation, and empowerment (Yamin, 2009).

In the 1980s and into the 1990s, most of the health communication literature focused on behavior change communication (BCC) approaches. Communication for health promotion was used primarily as a tool to convey information with disregard to the context in which its recipients live. However, new approaches have been developed and gradually incorporated into praxis. A contemporary definition of health communication is:

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"the study of the impact of communication on health and health care delivery, with attention to the role that communication plays in the definition of health and wellness, illness and disease, as well as in developing strategies for addressing ways to deal with those health issues" (Lederman, 2010: 236). It is clear from this definition that the social determinants of health, the basic underpinning of health promotion, should be appropriately addressed through health communication strategies to create change and improve the health of individuals and communities (UNDP, 2006; UNESCO, 2003; WHO, 2003). To achieve long-term goals of health for all, five levels of communication strategies for health behavior, as adapted from the work of Servaes (2007b, 2008) and Servaes and Liu (2007), can be integrated for health communication planning and implementation. They are:

(a) *Behavior change communication* (BCC) (mainly interpersonal communication),
(b) *Mass communication* (MC) (community media, mass media and ICTs),
(c) *Advocacy communication* (AC) (interpersonal and/or mass communication),
(d) *Participatory communication* (PC) (interpersonal communication and community media), and
(e) *Communication for structural and sustainable social change* (CSSC) (interpersonal communication, participatory communication and mass communication).

The resolution of a health issue or the initiation of a health promotion program can be an end in itself, if no public support is taken into account. A new definition of advocacy to empower the grassroots to let their voice be heard should become "participatory-based advocacy", which focuses on 'listening' and 'cooperation' rather than on 'telling what to do', presumes *a dynamic two-way approach towards communication.* Mass media can play two kinds of advocacy roles: (a) supporting development initiatives by the dissemination of messages that encourage the public to support development-oriented projects; and (b) providing the decision-makers with the necessary information and feedback needed to reach a decision. Policy-makers usually respond to popular appeal, to lobby groups, and to their own social network of policy- and decision-makers. *Health advocacy should therefore be viewed in conjunction with social support and empowerment strategies* (for more details, see Servaes, 1992, 2000): (1) advocacy generates political commitment for supportive policies and heightening public interest and demand for health issues; (2) social support develops alliances and social support systems that legitimize and encourage development-related actions as a social norm; and (3) empowerment equips individuals and groups with the knowledge, values and skills that encourage effective action for change.

1. Choices of advocacy strategies

The *choice of advocacy strategies* will vary with the nature of the issue and the expectation of the people or the stakeholders. In order to identify the *appropriate advocacy strategy*, one or more of the following important characteristics of policy problems have to be considered:

1. *Interdependence of policy problems:* This implies that one should not only use an analytic but also a holistic approach.
2. *Subjectivity of policy problems*: Besides 'objective' realities, subjective judgments and values come into play in the decision-making process. Advocacy strategies must address both.
3. *Artificiality of policy problems:* Problems have no existence apart from the individuals who define them, which means that there are no 'natural' states of society that in and of themselves constitute policy problems.
4. *Dynamics of policy problems:* There are as many different solutions for a given problem as there are definitions of that problem.

2. Identifying the right health type and advocacy strategy

There is no single strategic communication response to health-related challenges. One problem remaining is *the risk of reproducing best practices from one health area to another.* For example, the social marketing of individual behaviors (condom use) in family planning strategies in the 1970s and 1980s was very rapidly transferred into a mainstream strategy in HIV/AIDS in the late 1980s and 1990s. This happened in part due to HIV/AIDS being conceived as primarily a problem evolving around practices of sexual behavior. In those days, most theories underlying the models and frameworks used in HIV/ADS prevention strategies and research methodology were based on health behavior change (see Catania et al., 1993; Glanz, Rimer & Viswanath, 2008; Jemmott & Jemmott, 1994; McKee, Manoncourt, Saik Yoon, & Carnegie, 2000; Sandfort, 1998; and UNAIDS, 1999: 18).

UNAIDS (1999: 22–24) gradually criticized these models and theories for, firstly, seeking to influence only behavior in a linear fashion without taking the social context into account. This is not sustainable. Secondly, the emphasis on quantitative measures, rather than qualitative or a combination of both, results in a distorted interpretation of the meanings and realities in observed behaviors. Thirdly, the assumption that decisions about HIV/AIDS prevention are based on rational and volitional thinking is not realistic since the decisions involve more emotional responses to engaging in sexual practices. Hence, one started realizing that there is no sequential linear relationship between knowledge, attitude, belief, and sexual activities. Fourthly, the assumption that creating awareness through media campaigns will necessarily lead to behavior change does not hold true for HIV/AIDS prevention since it implies the consistent use of condoms which is related to the importance and