

**ADVOCACY STRATEGIES FOR GOVERNEMENT
SPONSORED PUBLIC HEALTH AGENCIES: THE BCCDC
A CASE STUDY**

by

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ABSTRACT

The Public Health Agency of Canada includes advocacy as a core competency for public health practice in Canada, yet many public health professionals feel that they are unable to fulfil this requirement due to their proximity to the government. While advocacy in public health is a well-researched area, strategies to overcome the differing barriers dependent on an agency's placement in the public health environment are less well understood. This paper highlights some of the barriers identified by nine (9) program managers, employees, and communication personnel at the British Columbia Centre for Disease Control. Christoffel's conceptual advocacy framework is used to categorize the advocacy efforts that government-sponsored agencies can engage in. Recommendations to overcome these barriers are proposed based on methods employed by other government-sponsored agencies.

Keywords: advocacy, barriers, core competency, government, government-sponsored agency, public health environment

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GLOSSARY

Advocacy	The application of scientific evidence to influence decision making on a particular issue (Christoffel, 2000; Hearne, 2008; UNAIDS, 2005; Vancouver Coastal Health, n.d.; WHO, 2004)
Barriers	A physical or immaterial object or situation that impedes the achievement of a specific action: i.e. resources or funding
Core Competencies	The “essential knowledge, skills and attitudes necessary for the practice of public health” identified by the Public Health Agency of Canada (PHAC, 2007). The thirty-two (32) core competencies are organized into seven (7) categories: public health sciences; assessment and analysis; policy and program planning; implementation and evaluation; partnerships, collaboration and advocacy; diversity and inclusiveness; communication; leadership (PHAC, 2007).
Government	In the context of this paper, government refers to federal, provincial and municipal government levels. As such, government ministries, such as the Ministry of Health, are also referred to as ‘government’
Government Sponsored Agency	A public health agency that reports directly or indirectly to the government: i.e. The BCCDC reports directly to the Provincial Health Service Authority who reports to the Ministry of Health. In addition, a government-sponsored agency is likely to receive the majority of its funding from the government
Public Health Environment	In the context of this paper, the public health environment refers to the network of agencies involved in public health practice including, but not limited to, government-sponsored agencies, not-for-profit agencies, regional and provincial health authorities, and government ministries: i.e. The Ministry of Health

INTRODUCTION

In an effort to strengthen public health capacity, the Public Health Agency of Canada (PHAC) developed a series of core competencies to guide public health practice in Canada. Developed in collaboration with public health practitioners and government representatives these core competencies are recognized as the foundation for public health practice in Canada, encompassing the essential knowledge, skills and attitudes that should be embodied by all public health practitioners (PHAC, 2007). Practicing these core competencies can have a cascading effect on many different levels ranging from the health of the public to the management of public health agencies. These core competencies influence the health of the public through standardized practices, direct people working in public health through providing practice guidelines and can strengthen public health agencies by identifying the skills, resources and relationships that are required for effective public health practice (PHAC, 2007). Advocacy is included among these core competencies, and although many public health practitioners feel that there is an obligation to engage in advocacy activities to be effective, many also perceive barriers with regard to the frequency and methods of advocacy they can employ (Chapman, 2004; Brownson, Royer, Ewing & McBride, 2006; Goodhart, 2002), which impede their fulfilling this core competency.

In spite of its inclusion in PHAC's core competencies, many public health practitioners mistakenly believe that they are "not allowed" (Goodhart, 2002) to advocate as by doing so they may experience a loss of objectivity that may "adversely affect their research" (Brownson et al, 2006). Additionally, a public health agency's proximity to the government can influence the practitioners' perceived ability to act as advocates due to barriers centred around resources and on their autonomy. The purpose of this paper is to explore the barriers to engaging in advocacy experienced by a government -sponsored-agency and to suggest recommendations on how these barriers can be overcome. An exploration of the different forms of advocacy will act as a foundation for this discussion followed by a description of the role of the British Columbia Centre for Disease Control (BCCDC). It is anticipated that identifying means for government-sponsored agencies to overcome these barriers will aid in the fulfilment of the PHACs core competencies. Interviews with program managers, employees and communication personal at the BCCDC along with members of its partnering agencies have been used as a case study for this exploration. The use of a framework to outline several different stages and examples of advocacy will help provide examples of advocacy activities a government-sponsored-agency can employ.

BACKGROUND

The goal of public health is to protect and promote the health and wellbeing of the population. It includes everything from community exercise programs, to nationwide emergency response plans, from mathematical modelling to policy recommendations. Protecting the health and wellbeing of the population is not always a safe and politically popular area. Often practitioners are trying to alter the current environment to protect or improve the health of a population, and where there is change there is often resistance. To achieve change, public health practitioners employ a variety of strategies, one of which is advocacy. Just as there are various forms of promoting and protecting health, there are numerous methods of advocacy. As Bassett explains, “Public health takes place in boardrooms, on street corners, in our homes, and in the legislature. So, too, does public health advocacy” (2003).

Advocacy

Advocacy has been defined in a variety of interrelated ways all centring around the application of scientific evidence to influence decision-making on a particular issue (Christoffel, 2000; Hearne, 2008; UNAIDS, 2005; Vancouver Coastal Health, n.d.; WHO, 2004). This definition does not change when the arena shifts to public health but it is imperative that the issue advocated has its

roots in public health problems with the intent of reducing death or disability rates in a population (Christoffel, 2000).

In both advocacy and public health advocacy, either a social or an environmental change is sought (Bassett, 2003; Dorfman, Wallack & Woodruff, 2005). This change is achieved through research, engaging in meetings with decision makers, participating in press conferences, writing policy statements or employing social marketing techniques (Christoffel, 2000; USAID, n.d.). In addition to a variety of advocacy methods, there are differing levels of risk attached to the methods employed (See Table 1). Advocacy strategies with a high degree of risk can have negative consequences on the individuals or agencies involved. An agency may lose credibility, partnerships or funding without the right mix of support and methods. Engaging in activities that require public support and/or action, such as lobbying or voting, draws more attention to the individual or agency, and subsequently a greater possibility of attracting attention from opposing parties. These activities are often more visible forms of advocacy. Alternatively, if an agency develops a health promotion campaign and distributes pamphlets, there is a low level of risk as there is less opposition. The level of risk involved can also be associated with the specific issue advocated. Issues supported by public opinion are generally less risky as the level of controversy is low. However, issues that are controversial, such as safe injection sites, have a high degree of risk, as there is often less support. In short, the mechanisms through which advances in public health and wellbeing are

achieved are numerous, complicated, and rarely, if ever, are the effects immediate.

Table 1: Levels of Advocacy

Risk				
		Low	Medium	High
Activities	Draft legislation		Issue press releases	Lobby
	Draft regulations		Media interviews	Testify
	Publish papers and editorials		Participating in conferences	Pass laws
	Public education		Join/Build coalitions	Implementation of new regulations
	Research studies		Mobilize residents	Voting
	Translating research findings			

It is evident that advocacy involves a diverse array of individuals and groups, sharing their expertise in areas to advance public health issues. Tobacco control efforts have utilized an integrated approach involving public interest groups, physicians, community groups, tobacco victims, and the media (Wallack et al, 1993 pp. 183-188; Brownson et al., 2006). This collaboration has led to changes in advertisements, sponsorships, product content and availability (Wallack et al, 1993). Advocacy around HIV/AIDS has engaged various groups around the world including people living with AIDS (PLWA), non-government organizations, public health agencies, media, and politicians to advance HIV/AIDS issues. These activities have resulted in “expedited drug approvals, lower prices for medications, and increased funding for AIDS research and care” (Watchter, 1992, as cited in Chapman & Lupton, 1994, pp. 5). It is through

engaging in advocacy that public health practitioners are able to fulfil their goal of protecting the health and wellbeing of the population.

There is a growing sentiment in public health literature that expresses an obligation for public health researchers to engage in advocacy (Brownson et al., 2006). It is no longer sufficient for researchers to discover new knowledge and publish their findings as their role has expanded to also ensure that such discoveries are applied and “actually reach the patients or populations for whom they are intended” (Woolf, 2008). Without this follow through, research findings can be misinterpreted and programs or policies that arise may not have the intended impact. Researchers are now encouraged to take this next step and advocate for the application of their research findings, recognizing it as their responsibility (Armstrong, 2006; Brownson et al., 2006; Ratzan, 2008; Woolf, 2008). Advocacy literature offers many strategies for how researchers can achieve this transition. The strategies referenced commonly focus on changing the attitudes and perceptions of the general public using more visible forms of advocacy such as social marketing techniques, lobbying, and media interactions. Such literature includes recommendations on framing messages, what language is appropriate, who should be invited to the discussion, and lobbying strategies. While these activities are arguably important, if an agency is government-sponsored and/or funded these forms are more risky and may even be off-limits due to funding concerns or the need to appear apolitical (Vernick,

1999). This reveals a gap in the current literature on ways in which agencies can overcome the opposition that comes from within the public health field itself.

Government-sponsored agencies may find themselves engaging in research and uncovering evidence that supports change, yet due to their proximity to the government, they may be unable to promote such changes. These agencies may be concerned with losing funding if they advocate for issues that are 'off the political radar', perceived as unimportant, or off limits due to controversial underpinnings. Government-sponsored agencies may also be dissuaded from engaging in advocacy as they are encouraged to regard themselves as apolitical. In their position as a government-sponsored agency their work must appear objective and uninfluenced by personal interests, as such, there are "incentives to maintain a stance of political neutrality" (Weiss, 1991). Additionally, due to their proximity to the government, it can be presumed that a government-sponsored agency would not need to engage in lobbying activities in order to gain the attention of the government; however, there may be public health issues that are politically controversial, such as safe injection facilities, or which cross ministries, such as housing or income assistance, that complicate how a government-sponsored agency engages with government ministries. For agencies that receive their core funding or are supervised by the government, finding mechanisms through which to advocate for such issues can be highly complex as "lobbying with federal or earmarked foundation funds is generally prohibited" (Vernick, 1999). Unfortunately, it is often government-

sponsored agencies that have the funding to engage in rigorous scientific research and produce the scientific backing necessary for persuasive public health advocacy (Brownson et al., 2006; Chapman, 2004; Gautam, 2008; Hearne, 2008; WHO, 2004). As a result, Chapman explains, “much advocacy suffers from being concentrated in poorly resourced grass roots community groups who can struggle to have their voices heard” (2004).

There are a variety of frameworks that are currently applied in public health agencies that refer the importance of advocacy directly or indirectly. The Canadian Institute of Health Research (CIHR) has a strong emphasis on knowledge translation, with four (4) strategic directions on how it can strengthen health research and practice. The CIHR recognizes that knowledge translation has the potential to “significantly increase and accelerate the benefits flowing to Canadians from their investment in health research”, and as such stresses the importance of investing in knowledge translation research (CIHR, 2008). The Population Health Promotion Approach taken by Vancouver Coastal Health (VCH) highlights advocacy as one of its four (4) action areas, recognizing that “advocacy can be one of the most effective population health/ health promotion strategies, with the end result being the development and implementation of policy that directly impacts health outcomes on a sustained basis” (VCH, 2006, pp. 7). There are also the OCAP principles (ownership, control, access and power), that enable self-determination over all research concerning First Nations, striving towards ‘beneficial research’ for First Nations (First Nations Centre,

2007). Among these principles is stressed the importance of supporting community development and improving the health and well being through research, providing “leaders and decision makers with the knowledge they will need to advocate on behalf of First Nations” (First Nations Centre, 2007, pp. 2). While each of these frameworks has incorporated advocacy in various ways the specific barriers experienced by government-sponsored agencies to engaging in advocacy activities remain unrecognized

The existence of such a barrier to advocacy engagement threatens the achievement of the PHACs core competencies and as such the goal of public health practice.

The British Columbia Centre for Disease Control

The British Columbia Centre for Disease Control (BCCDC) is a provincial agency that focuses on the prevention and control of communicable diseases and the promotion of environmental health for British Columbia (BC). The BCCDC achieves this through the provision of educational, scientific and technical support to BC Health Authorities and in collaboration with the Provincial Health Service Authority (PHSA), it acts as the scientific support arm of the Provincial Health Officer (PHO) (BCCDC, 2002). Established in 1997 and later incorporated as a branch agency of the PHSA in 2002 (BCCDC, 2002), its main responsibilities include:

public health information system management, expert knowledge translation, program consultation, disease surveillance, epidemiological analysis, policy analysis, best practice guidelines, outbreak investigation, disease control and prevention planning and services, research and evaluation, and monitoring and investigations related to the detection and management of emerging diseases (Memorandum of Understanding (MOU), 2007, p. 20).

As a branch agency, BCCDC employees are employed by and are directly accountable to the PHSA (MOU, 2007, p. 6).

The BCCDC is thus involved in a variety of areas including research, education and program development. In collaboration with the University of British Columbia, the BCCDC is engaged in the advancement of public health policy, applied research and clinical teaching. In the area of education, the BCCDC focuses on the training of “health professionals and emergency preparedness personnel, as well as providing reliable and current public health information to the general public” (BCCDC, 2008). Additionally, the BCCDC engages in the development, support and/or implementation of “evidence-based core public health programs related to communicable disease control, environmental health, public health emergency management, health assessment and disease surveillance” (BCCDC, 2007). To fulfil these responsibilities the BCCDC staff is composed of a range of health professionals with specialized skills, including laboratory technicians, researchers, educators, program managers and health promotion specialists.

The BCCDC is a large agency composed of multiple divisions providing a diverse array of services. This project has attempted to narrow its scope to a single division within the BCCDC: STI/HIV Prevention and Control. This Division focuses on the prevention and control of sexually transmitted infections through the development, support and/or implementation of educational programs, training, data reporting and analysis, research and collaborations with partners and clients within BC, nationally, and internationally as well as through its STD/AIDS clinic (BCCDC, 2008b). References made to the BCCDC in the following pages will primarily refer to the perspectives of professionals within this Division.

As an agency engaged in public health research and practice, the BCCDC, and its divisions, are obliged to acquire and maintain the PHACs core competencies to ensure that it remains a leader in public health practice in BC.

METHODS

A purposeful sample of fourteen (14) program managers, employees, and communication personnel from within the BCCDC and with public health professionals external to the BCCDC were invited to participate in an interview (for details see Appendix A-E). One (1) interview was lost due to concerns around confidentiality. Criteria for inclusion included employment or involvement with the STI/HIV Prevention and Control Division and on the participants identified engagement in advocacy activities. Participants from the BCCDC were either situated within the STI/HIV Prevention and Control Division, or had working relationships with the Division. External participants were identified by participants from within the BCCDC and came from current partner agencies including regional and provincial health authorities, non-profit organizations, and a media communications company. The primary goal of these interviews was to explore perceptions of the role of advocacy in BCCDC's public health practice, and to provide specific examples of advocacy activities they have engaged in.

Participants agreed to participate in a 45-minute semi-structured interview composed primarily of open-ended questions and probes. Interviews were conducted either in person or by telephone and all were recorded and later transcribed. Prior to all interviews, participants gave verbal informed consent. Although a list of a-priori codes was developed prior to reviewing the interview

transcripts, additional coding methods were utilized in data analysis. Open coding was performed to enrich the list of preliminary concepts and themes, where a list of emergent codes was developed (for details see Appendix F). Axial coding was then performed, where themes were organized and grouped into key concepts (Neuman, 2006, pp. 462). Once themes were categorized, selective coding was conducted to further develop the identified major themes. The office of research ethics at Simon Fraser University approved this study.

In addition to the above interviews, two (2) government-sponsored agencies were contacted to gain a broader external perspective of how these barriers are experienced. Personal communication methods were utilized with a Chief Executive Officer (CEO) from an International public health agency and a Provincial Health Officer (PHO) from a provincial branch of the Ministry of Health. Participants were asked to describe the forms of advocacy they engage in, if they experience similar barriers to the BCCDC and what, if any, methods are used to overcome the barriers (for details see Appendix G).

BCCDC: THE ROLE OF ADVOCACY

Interviews exploring the role of advocacy within the STI/HIV Division revealed a shared desire to formalize the role of advocacy by including it as part of the Division's mandate. In these discussions, participants highlighted their obligation as public health practitioners to engage in advocacy:

“I think there is an ethical imperative for someone who can make a difference with advocacy to advocate when there are lives at stake” (P01)

“When we have the skills and we have the knowledge and we can respond to it - then I think we certainly are obliged to do so” (P04)

These statements are concurrent with those found in public health literature (Brownson et al., 2006), and with the opinions expressed by external participants. The majority of external participants also regarded it as important that the BCCDC more formally recognize the role of advocacy, focusing on practitioner responsibility and on the BCCDC's position in the public health environment.

“What’s the point of gathering information on pathogens, diseases and risks if you are not going to say anything about it?” (P12)

“...they are able to take a leadership role because they have a little more longevity” (P11)

With this shared understanding that advocacy should be practiced by the BCCDC by both internal and external participants, it is important to now turn to how advocacy has been defined by these agencies and what forms it should take.

BCCDC: Advocacy

When asked to define public health advocacy participants at the BCCDC and external participants expressed sentiments that were consistent with those in the literature. The majority of participants described efforts that centre on the importance of elevating an issue that has public health consequences and basing the discussion on scientific evidence.

“... [it is] identifying underrepresented issues and trying to bring them to the attention of media, and you know, sort of players who have ‘puissance’ (influence)” (P09)

“Public health advocacy is defining your support for an issue because it has public health benefit” (P14)

“I think in public health it has been defined as putting a position forward with the purpose of improving or enhancing the public either broadly or specifically” (P15)

“Advocacy is trying to use information to try and achieve a specific goal” (P10)

When asked to provide examples of how participants engage in advocacy a variety of low risk forms were described, including providing data and data reports to users, translating research findings, creating educational tools and pamphlets, and implementing education and health promotion programs. These forms are less prominent in advocacy literature, and are concentrated among the low risk/less visible forms mentioned above. The majority of BCCDC participants referred to their strengths as lying in their ability to produce, translate and disseminate research findings:

“So for me it's about being fluent in the scientific literature to be an advocate, because otherwise we are just another voice of an institution saying 'this needs to happen' which is great, but that's not unique... what we can do is actually translate that literature very strongly” (P09)

Despite the existence of these less visible forms of advocacy, participants expressed frustrations around their capacity to act as advocates for issues they recognized as particularly important but are not supported by their sponsors.

BCCDC: Barriers

In spite of a shared desire and sense of responsibility to engage in advocacy BCCDC participants described restrictions around the methods or amount of advocacy they felt they could engage in. When discussing barriers, participants primarily focused on a lack of resources and the BCCDC's position as a government-sponsored agency.

It is recognized that a lack of resources is a significant barrier to advancing research to practice through advocacy (Gautam, 2008; Glasglow, Lichtenstein & Marcus, 2003). Without the required number of staff, time and funding it can be difficult to engage in many advocacy activities. Participants at the BCCDC expressed frustrations around what they or partner agencies felt they needed and/or wanted to do and what they actually were able to do due to a lack of resources.

“...some of the challenges you hear from the Health Authorities is that ‘well, we don’t have the resources to do this” (P08)

“There isn’t anywhere near the amount of resources needed” (P12)

“But there is only so many people and so much time. It’s hard to do” (P04)

“It’s sort of, it’s a given, for us anyway, that we can use more resources in almost any area” (P01).

One respondent commented specifically on the difficulty of balancing the responsibility of being up-to-date on the scientific literature and ensuring that findings are translated effectively to external agencies:

“it (advocacy) is extraordinarily time consuming.
EXTRAORDINARILY time consuming and what that takes
time away from is the time spent on the science.” (P09)

The primary barrier identified by the BCCDC participants was associated with their proximity to the government. As the BCCDC receives its core funding from the government, its employees are largely restricted to advocating for issues that are supported by their governing bodies, namely the PHSA and Ministry of Health. As the BCCDC employees are employed by the PHSA they are also directly accountable to them and thus must gain approvals at various levels.

“We are kind of limited in what we can do in the sense that we, whenever we do something, we’re de-facto the Ministry of Health saying this” (P07)

“... it has a lot to do I think with funding. The fact that institutions like ours get our funding from the group that's responsible for the things that most people advocate for or against - so there is a loop there that doesn't work” (P01)

“...the advocacy piece butts up against the independent role. [Sometimes] the hand that feeds you is the hand that you want to alter” (P15)

Specific examples in which BCCDC participants expressed an inability to advocate revolved around a sexual education campaign directed at men who have sex with men (MSM) and social determinants of health issues including housing and income assistance, where influence crossed multiple government ministries. The sexual education campaign consisted of provocative messages that promoted safer sex among young men. Despite being based on reliable scientific evidence, having approached and involved the community during development and having performed focus group testing with the target population, the campaign lost support. When the campaign was brought to the attention of the Public Affairs Office of the Ministry of Health, due to its controversial nature, support for the project was pulled.

“They (Ministry of Health) were worried that the [Health Authority] MLAs would freak out about [how] public funding had gone into this. Who cares! We know that young gay men are acquiring HIV! Deal with it! It's not yours to decide!”
(P09)

BCCDC participants also expressed frustrations around their ability to advocate for social determinants of health issues. As the Division specializes in

STI/HIV prevention and control, participants were cognizant of the many determinants for STI/HIV infection, including housing and poverty. Due to the position of the BCCDC as a government-sponsored agency, it cannot comfortably advocate for housing without making implied criticisms about the Ministry of Housing and Social Development.

“For instance the welfare thing, I mean if (name) did that, I'm sure that we would get a call from the minister the next day and say 'What's this all about? The minister of welfare was in my office a few minutes ago and he's pissed off at you guys', that's what would happen” (P01)

“...I think it is a very tenuous and challenging thing, because to take on something like housing and say that we live in the wealthiest city in Canada, we have so much money, such wealth! Why are there not places? Why do we not have places for people to live? This is crazy! But that reflects badly on the government and they don't like that. So, it's a challenging dance” (P09)

Additionally, participants described objection around having to gain permission from the government in order to advocate for specific issues, which caused many a great deal of frustration. As some participants expressed:

“[my supervisor] is acting under other people so for him to advocate for that he would always have to get [his supervisors'] approval - the more approval you have to get

the less likely it is that you are going to get it - the more watered down the advocacy is going to be in the end” (P01)

“We are too close to the political arm of the government...we should be separate enough that we can comfortably advocate for things and not feel [we] have to get permission. But our relationship is such that if we annoy them in one way it can come back to us in another” (P09)

These scenarios reveal the difficulties a government-sponsored agency experiences when attempting to be advocates for issues that despite having strong scientific evidence there is either a lack of resources or they are off the political radar due to their controversial or complicated underpinnings. In such situations, BCCDC participants found themselves conflicted by the existence of evidence yet an “incentive to maintain a stance of...neutrality” in order to maintain relationships and funding (Weiss, 1991).

ADVOCACY FRAMEWORK

Christoffel's Conceptual Advocacy Framework

It is clear that not all advocacy is about lobbying (Vernick, 1999), that there are numerous approaches to advocacy, and that these methods are dependent on the capacities and on the position of the individuals or agencies involved. Katherine Christoffel (2000) recognizes these different players and capacities by categorizing the different methods of advocacy each often engages in. According to Christoffel's conceptual advocacy framework, advocacy exists on an assembly line with three stages: **information**, **strategy** and **action** (See Figure I: Christoffel's Conceptual Advocacy Framework). All persons involved in public health, from victims to researchers from journalists to legislators engage in one or more of these stages depending on their skill strengths and their position "in society and the health care environment" (for details see Appendix H: Table 3) (Christoffel, 2000). Christoffel regards each stage and form of advocacy in this assembly line as equally important in the process as progress made in one stage facilitates the subsequent stages (Christoffel, 2000).

Many of the advocacy strategies highlighted in Christoffel's framework coincide with the levels of risk associated with advocacy. Advocacy activities concentrated in the information stage are predominantly lower risk, and as one moves along from one stage to the next the level of risk increases with the

transition from gathering information to planning and implementing change. By categorizing these advocacy strategies, a government-sponsored agency can locate itself within the framework, identify at which stages it is strongest, staff its team according to these strengths and become cognizant of how gaps can be filled by collaborating with participants in the public health environment with strengths in those areas. As such, this framework can guide government-sponsored agency's advocacy efforts, facilitating their achievement and maintenance of this PHAC core competency. Although Christoffel's framework is not comprehensive, it provides an effective starting point for locating public health advocacy participants and examples of their roles.

Figure 1: Christoffel's Conceptual Advocacy Framework



Source: Adapted from Christoffel, 2000

Stage One: Information

Stage one involves the identification and extent of the public health problem. Funding for research may be sought from the private sector and government agencies to produce epidemiological statistics, and research reports and articles on the identified public health problem. This scientific evidence acts as a foundation for the subsequent stages, strengthening the position of strategies developed in stage two (Brownson et al., 2006; Chapman, 2004; Gautam, 2008; Hearne, 2008; WHO, 2004).

Stage Two: Strategy

Stage two utilizes the information gained from stage one to “identify what needs to change to improve public health” (Christoffel, 2000). Participants who are skilled and have the capacity to engage in the strategy stage translate research findings to other public health professionals, to non-public health professionals to government bodies and to the general public in attempts to raise awareness and to build collaborative partnerships with interested and affected parties. Recommendations are also drafted in the strategy stage on how change can be achieved.

Stage Three: Action

In stage three the strategies previously identified to address the public health problem are implemented. Such activities may include raising funds, publishing articles, concretizing strategies, developing timelines and lobbying government and/or private agencies. While the final goal of these three stages is

a positive change in the public health problem, Christoffel identifies “changes in attitudes, habits, resource allocation, the physical and social environments, social interaction, and societal rules that can affect the frequency or severity of public health problems” as the interim products of stage three (Christoffel, 2000).

Using Christoffel’s framework it becomes apparent that the BCCDC’s advocacy activities are concentrated in the **information** and **strategy** stages. In the **information** stage, the BCCDC is involved in the detection and surveillance of emerging diseases, research and evaluation of root causes and effective management strategies, and the development and distribution of research reports to Provincial/Regional Health Authorities as well as other partner agencies. The BCCDC engages in **strategy** advocacy activities by creating and implementing educational programs, training, and through the creation of practice guidelines. As a government-sponsored agency, the BCCDC’s **action** stage activities are limited without government support. In situations where they lack government endorsement, action stage activities are restricted to creating, publishing and disseminating research findings. While Christoffel’s framework recognizes all stages of advocacy as important, and it is through these activities that the BCCDC facilitates future advocacy efforts by “creating shoulders for others to stand on” (Avery & Bashir, 2003), BCCDC participants remain dissatisfied with these limitations.

With this understanding of the stages and forms of advocacy that the BCCDC currently employs, government-sponsored agencies can then look to ways they can improve action stage activities. In the following section, government-sponsored agencies from various levels within the public health environment have been consulted on their ability to advocate for issues in light of lack of resources, and for issues that are not endorsed by their governing bodies and how/if they overcome these barriers. The aim of this section is to provide methods for the BCCDC to consider in order to strengthen the gaps their employees have identified in their own advocacy efforts.

OTHER AGENCIES

To gain a broader perspective on how other government-sponsored agencies engage in advocacy and respond to the barriers around advocacy experiences by the BCCDC, two (2) interviews were conducted with employees at a provincial division of the Ministry of Health, and the Public Health Association of Australia. These two participants were able to provide insights into both provincial and international advocacy efforts, the barriers experienced and how/if they are overcome.

Ministry of Health: Provincial Division

The Provincial Health Officer (PHO) is the senior medical health officer of a province and is employed by the Ministry of Health. Under the *Health Act*, the PHO is responsible for advising the Minister and Ministry of Health on health issues in the province, reporting publically on the health of the population, making recommendations on how to improve the health and wellness of the population, and reporting progress on the achievement of the province's health goals (MOU, 2007, p. 15; Province of British Columbia, 2007). Advocating for public health issues is involved in all aspects of the work of the Office of the PHO, as it is always working towards improvements in the health of the population. For the PHO, advocacy activities included all three stages of

advocacy: the dissemination of official reports based on evidence garnered from research agencies (stage one), media interviews (stage three) and informing and translating the knowledge into policy by talking to deputy ministers, policy chiefs, mayors, and elected officials (stage two & three).

Public Health Association of Australia

The main objective of the Public Health Association of Australia (PHAA) is to contribute to strong public health policy in Australia by advocating for the reduction of health inequalities, encouraging research, promoting and providing opportunities for the exchange of views and information and promoting professional development (PHAA, 2001). Advocacy was described as one of the PHAA chief functions, working at both state and national levels. Some of the specific PHAA advocacy activities described were mentoring, organizing conferences with the purpose of strengthening knowledge translation (stage one & two), engaging media, social marketing techniques, and political strategies with the intent of gaining support from the public in order to persuade the government (stage two & three).

A notable difference between the position of the BCCDC and the PHAA is that the PHAA does not currently receive its core funding from the government. While this position could have made it difficult to compare experiences between the two agencies, because the PHAA previously received its funding from the

government they were able to provide insight into the impact of government funding on a before and after basis within this agency. When queried about the impact of government funding, it was expressed that it made a small amount of difference to their advocacy efforts.

“It’s not a critical element of our relationship...I think you can do both (advocate and be government-funded)” (P16)

Strategies

Collaboration

When informed of the barriers identified by the BCCDC, respondents were sympathetic to a lack of independence to act as advocates when faced with a lack of government support. It was recognized that often when advocating against inequities of poverty, education, access to child-care, and access to employment, that things become more complex as these issues cross government ministries.

“[Sometimes] the hand that feeds you is the hand that you want to alter.” (P15)

The primary recommendation expressed by these agencies and those in earlier interviews was the need for, or benefit of, greater communication and collaboration with other agencies and government ministries. It was recognized

by participants that inviting partners from various interest groups, and arms of the government, both supportive and opposing, to participate early in the development process (stage two) was an important aspect of any advocacy work. By engaging these partners in development stages, their concerns can be addressed and a “marriage of interests” (Chapman, 2004) can be achieved (PHAC, 2007; UNAIDS, 2005.; WHO, 2004).

“My experience is that you can do an awful lot if you prepare the ground first” (P15)

Inviting various groups to engage in a dialogue on an issue provides opportunities for concerns to be heard from varying perspectives. With these concerns in mind, options and recommendations for moving forward can be created that satisfy the needs of multiple groups, strengthening support for the issue. For example, a recent campaign called “A Future For Food” (PHAA, 2007), that addresses the approach to food policy in Australia involved a series of academic agencies when writing recommendations. After the recommendations were consolidated, they were later circulated amongst agencies recognized as affected by current food policies, including the Diabetes Association, Cancer Association, and Kidney Association, state public health agencies, government agencies as well as the food industry. Together, these groups engaged in a dialogue on how current policies should be modified. This integrated approach help to create cohesion among the groups involved, highlighting the importance

of knowing who is involved, who supports you and who is against you (Chapman, 2004; Wallack, Dorfman, Jernigan & Themba, 1993, pp. 45).

Collaboration with external agencies can also provide the BCCDC with opportunities to be involved with advocacy efforts that are not supported by their governing agencies as well as fill areas where they are low in resources. By involving external partners who are at more than arms length from the government and networking with other advocates the BCCDC can help facilitate advocacy efforts through the provision of scientific evidence. Facilitating advocacy efforts in this way can help ensure that other interested and affected parties that have more independence adopt BCCDC research findings, programs and campaigns that are not supported by their sponsoring agencies, without engaging in more visible forms of advocacy themselves. Participants described more opportunities for dialogue, more knowledge exchange and greater consultation in program development as methods the Division could employ to improve collaboration. Additionally, by engaging other agencies in the process create opportunities to share resources including evidence and people; distributing tasks so that they do not all become the responsibility of one individual or division.

This collaborative approach is also consistent with Christoffel's framework that includes multiple participants in the advocacy assembly line. As described above, while collaboration does not directly affect the BCCDC's action activities,

by consulting, collaborating and exchanging with external partners, the BCCDC can strengthen the probability of achieving a positive change in the public health problem.

Political Climate

A strong understanding of the political climate was also recognized as an important aspect when engaging in advocacy, falling under stage three advocacy methods. Participants indicated that for a government-sponsored agency to be a successful advocate in unsupportive climates requires it to not only be fluent in the scientific evidence, but also to be strategic, looking and waiting for opportunities (Chapman, 2004; Choi et al., 2005). While the scientific evidence acts as the foundation for change, it was not regarded by external participants as the defining feature for success. As identified by Brownson and colleagues in their exploration of the importance of relationship building between researchers and policymakers, “even in light of sound scientific data, ideas are sometimes not ready for policy action due to lack of public support or competing policy issue” (2006).

“It’s like having a huge kitchen range with dozens of burners. There’s always more issues that need attention than a political or a budget are ready to [deal] with at the time. So, it’s a question, I think, in policy terms, which one (issue)? Being able to spot when there’s a hot spot so that you can

move something that you've been keeping warm in the back up for an opportunity" (P15)

If the political environment and the public environment are not currently aware of the issue, or if there is resistance around the issue, engaging in action advocacy strategies, such as lobbying or media interviews were not perceived to be effective.

Being cognizant of the political climate can also be elevated by building relationships with gatekeepers and opinion shapers within the government (legislative staff members), thereby creating opportunities. Tied to the importance of collaboration with affected parties, Brownson et al describe how through building relationships with legislative staff and expanding their awareness of evidence-based approaches, that public health professionals can elevate issues that were otherwise off the political radar (2006). Building these linkages between public health professionals and policymakers can facilitate the advancement of "issues of societal importance and thereby enhance the health of populations" (Brownson et al., 2006). By being strategic around when and how the BCCDC engages in advocacy, as well as by creating opportunities itself, the BCCDC can strengthen its stage three activities.

DISCUSSION

This case study approach to exploring the experiences of a government-sponsored agency engaging in advocacy has helped to highlight some of the predominant barriers and methods of overcoming these barriers in the future. The BCCDC as a government-sponsored agency is restricted by the methods of advocacy it can engage in due to its position relative to the government. Its connection to the government encourages a stance of political neutrality. And due to concerns around funding it is discouraged to advocate for issues that are not supported by their governing bodies (Vernick, 1999; Weiss, 1991). The utilization of a framework has helped to gain a better understanding of the different forms of advocacy, from information, to strategy and finally, action, all of which are essential stages in the assembly line (Christoffel, 2000). By highlighting these different activities, a government-sponsored agency can locate itself within the framework, identify at which stages it is strongest, staff its team according to these strengths and become cognizant of how gaps can be filled by collaborating with other participants in the public health environment and heightening their awareness of the political climate.

It is clear that the BCCDC's advocacy efforts are predominately in the **information** and **strategy** stages of Christoffel's framework. As a government-sponsored agency, the BCCDC provides **information** through the detection and

surveillance of emerging diseases, research and evaluation of root causes and effective management strategies, and the development of research reports. The BCCDC **strategy** activities include creating and implementing educational programs, training and through the creation of practice guidelines. For each individual or agency in Christoffel's framework, there are divergent and complementary skills. The BCCDC participants identified their greatest strength as being fluent in the scientific literature. With the scientific evidence, a foundation for strong advocacy efforts is created (Brownson et al., 2006; Chapman, 2004; Gautam, 2008; Hearne, 2008; WHO, 2004). Due to its proximity to the government, the BCCDC is able to engage in more less visible **action** activities, but with the provision of scientific evidence the BCCDC is "creating shoulders for others to stand on" (Avery & Bashir, 2003), highlighting the importance for collaboration in public health advocacy.

Greater collaboration was identified as the most predominant method for the BCCDC in overcoming advocating for issues that are not supported by the government. Interviews with BCCDC employees, external partners, and personal communications with other government-sponsored agencies brought attention to the need for more engagement with partners, community agencies and government ministries. Collaboration is important as it implies that every participant has something to bring to the discussion (Chapman & Lupton, 1994). Utilizing the various skills or networks of each participant and building consensus among members can create a stronger and more united message, advancing the

advocacy effort. An additional benefit of participating in greater collaboration is that an in depth understanding of the differing opinions in the public health environment can be garnered. With this greater understanding, a “marriage of interests” is created, unifying the advocates voice (Chapman, 2004). In such situations, compliance to remain engaged in activities that begin with collaborative efforts is high, as all members have helped to tailor the approach to meet their varying needs (Canadian Health Service Research Foundation, 2009). Collaborating with external agencies also provides the opportunity to pool resources – evidence, people with experience/expertise and availability. While collaboration is generally concentrated in Christoffel’s strategy stage, involving external partners to participate facilitates the achievement of advocacy goals for issues that the BCCDC cannot visibly support.

Another important method discussed was the importance of being aware of the political climate when planning advocacy activities. This awareness requires the BCCDC to be strategic, to be aware of the values and beliefs in the current environment and to be ready when opportunities arise to advance a public health issue. By taking into consideration the political climate, including public expectations and fiscal opportunities, a government-sponsored agency can tailor its strategy to ensure the greatest uptake, strengthening its stage three efforts (Chapman, 2004; Dorfman, Wallack & Woodruff, 2005). As recognized by Vancouver Coastal Health, “timing may be critical for taking action on your issue” (n.d.). Additionally, by collaborating with policy makers and legislative staff, the

BCCDC can facilitate the creation of opportunities for advocacy work. As cited by Brownson and colleagues “one of the most important facilitators of moving research into policy is personal contact between researchers and policymakers” (2006).

To highlight how such strategies could be utilized an example illustrating methods with which the BCCDC could address issues that cross government ministries will be explored. There has been a growing sentiment over the last few years among Public Health Professionals, Medical Organizations and Correctional Facilities in Canada for the implementation of needle exchange programs (NEP) in correctional facilities. This harm reduction strategy, not unlike many others, has faced a great deal of resistance from both the general public and from the government, despite consistent and positive results (Lines, Jurgens, Betteridge, Stover & Laticevschi, 2006, pp. 19-43). In a review of 6 current NEPs in correctional facilities around the world (Switzerland, Germany, Spain, Moldova, Kyrgyzstan, and Belarus), it was found that such programs are successful in improving prisoner health as well as reducing needle sharing among prisoners. Although specifics of the programs many vary, a one-for-one exchange of used syringes for sterilized syringes, syringe dispensing machines, or the distribution of sterile syringes without exchange, all variations proved “effective in reducing needle sharing and therefore in preventing the transmission of HIV and HCV” (Lines, Jurgens, Betteridge & Stover, 2005).

If the BCCDC's goal was to advance this issue, it could begin by conducting research, monitoring HIV and HCV trends, and needle sharing behaviour in correctional facilities and developing research reports for dissemination. To aid in its collaboration efforts and its political intelligence, the BCCDC would then conduct an environmental scan of agencies, organizations and government ministries that are affected by this issue and/or could assist in heightening public and political awareness (for details see Table 2 below). By engaging a broad array of partners the BCCDC would become more aware of the current sentiments surrounding this issue and open a dialogue with these partners in order to share their perspectives and concerns, enabling a marriage between partnering agencies. For example, the Correctional Service of Canada & Correctional Facilities in BC as an organization directly involved in the health issue should be invited in order to heighten their awareness of the public health and human rights implications as well as the costs and benefits of program implementation. This would also allow for a determination of potential correctional facilities in need of such a program, and how the program could be tailored to their interests.

Together, partners are able to draft program and practice guidelines collaboratively reducing total cost and time spent. Inviting these partners during the development process can also garner internal support by appealing to their interests (health, human rights or cost benefit) and potentially avoiding opposition in the future. Additionally, although the BCCDC currently has clinical staff with

the expertise required to administer such a program, collaboration with Medical Schools or NGOs with expertise in the field provides an opportunity for pooling resources where students and/or health professionals are employed such that implementation and administration costs do not become the sole responsibility of the BCCDC.

Conversely, if the current political climate does not endorse this program, the BCCDC could choose to seek collaboration with Medical Associations in Canada that have been recognized as supporting this issue (Ontario Medical Association & Canadian Medical Association), and with the Canadian HIV/AIDS Legal Network to strengthen the political voice behind this issue and to highlight both public health and human rights implication (Lines et al., 2006). Identified community groups who have expressed interest in this area could be provided with scientific evidence to promote their own advocacy efforts to facilitate the mobilization of public support. Additionally, the BCCDC should collaborate with various arms of the media to aid in public education and political influence through publishing articles and engaging in media interviews. Effectively engaging in these advocacy efforts with partner agencies would facilitate political support and push the program towards the implementation phase.

Although this is a rudimentary list of potential partners and the activities they could engage in to advocate for NEP in correctional facilities, it provides a

strong indication of those entities that the BCCDC could engage with, and what methods they could employ to strengthen their advocacy efforts in this area.

Table 2: BCCDC Needle Exchange Program Partners & Activities

Partner	Information	Strategy	Action
BCCDC	<ul style="list-style-type: none"> ▪ Conduct research and evaluation ▪ Detection and surveillance of HIV & HCV rates ▪ Develop research reports 	<ul style="list-style-type: none"> ▪ Build/join coalitions ▪ Public education ▪ Draft program/ practice guidelines ▪ Training 	<ul style="list-style-type: none"> ▪ Publish papers ▪ Disseminate findings ▪ Collaborate with media (media interviews) ▪ Administer pilot program
Government Ministries Ministry of Health	<ul style="list-style-type: none"> ▪ Request data ▪ Authorize research ▪ Funding 	<ul style="list-style-type: none"> ▪ Prioritize issue ▪ Draft program/ practice guidelines 	<ul style="list-style-type: none"> ▪ Counsel ▪ Pass regulations/ standards ▪ Fund pilot program
Correctional Service of Canada	<ul style="list-style-type: none"> ▪ Request data ▪ Authorize research ▪ Funding 	<ul style="list-style-type: none"> ▪ Prioritize issue ▪ Draft program/ practice guidelines 	<ul style="list-style-type: none"> ▪ Counsel ▪ Pass regulations/ standards ▪ Fund pilot program
Correctional Facilities	<ul style="list-style-type: none"> ▪ Request data 	<ul style="list-style-type: none"> ▪ Join coalition ▪ Draft program/ practice guidelines 	<ul style="list-style-type: none"> ▪ Apply standards ▪ Lobby
Medical Associations	<ul style="list-style-type: none"> ▪ Conduct research 	<ul style="list-style-type: none"> ▪ Join Coalition 	<ul style="list-style-type: none"> ▪ Lobby ▪ Counsel
Media	<ul style="list-style-type: none"> ▪ Collaborate with researchers & scientists 	<ul style="list-style-type: none"> ▪ Public education ▪ Political influence 	<ul style="list-style-type: none"> ▪ Publish articles
Medical Schools	-	<ul style="list-style-type: none"> ▪ Educational curricula ▪ Training 	<ul style="list-style-type: none"> ▪ Administer pilot program
Lawyers & Canadian HIV/AIDS Legal Network	<ul style="list-style-type: none"> ▪ Describe & interpret human rights violations re: current standards 	<ul style="list-style-type: none"> ▪ Develop options for application of and changes in laws 	-
Community Groups	<ul style="list-style-type: none"> ▪ Request Data ▪ Resource for public sentiment 	<ul style="list-style-type: none"> ▪ Join coalitions ▪ Mobilize public support 	<ul style="list-style-type: none"> ▪ Lobby

Limitations

Selection Bias

This case approach of government-sponsored agencies comprised of a small purposeful sample of interviews. To mitigate the selection bias participants from various backgrounds and positions were selected for interviews (for details see Appendix A). It should also be recognized that this exploration of advocacy and its perceived barriers focused on the perceptions of the BCCDC, and does not reflect wider perspectives of other government-sponsored agencies. Due to this limitation, caution should be taken in generalizing these barriers to other government-sponsored agencies. In an attempt to expand upon this specific perspective, informal discussions with other government-sponsored agencies were conducted.

Due to the purposeful selection of interviews with external agencies, a second selection bias may have occurred. It is possible that BCCDC staff selected agencies that regard the BCCDC positively, and as such would have few recommendations for improving advocacy efforts. Despite this possible selection bias, all partner agencies who participated in an interview provided suggestions for the BCCDC.

Additionally, it should be noted that the position of the respondents from the Ministry of Health and the Public Health Association in Australia were of a

more senior level than that of the earlier interviewees. It is important to recognize this as their level of autonomy to choose which issues to advocate may be different from that of a division within a larger organization, therefore influencing the perception of barriers. In spite of this selection bias, it is the belief of the author that the recommendations provided by these respondents remain applicable as opinions were concurrent with responses from external interviews who held similar positions to the BCCDC participants.

Deference Bias

In the external interviews, the researcher acted as a representative on behalf of the BCCDC. Due to this position, participants may have felt pressure to comment positively on the BCCDC. In recognition of this bias, all participants were assured prior to the interview that their participation would remain confidential and that no names would be attached to any of their responses (for details see Appendix C). It should however, be highlighted that one participant's responses were discarded for concerns of confidentiality.

Research Gaps

As previously discussed, advocacy is a growing area in public health practice. Thus, understanding the barriers experienced by various levels in public health will be necessary to ensure it continues to be an important and successful area. This exploration focused primarily on the barriers experienced by one

division of a government-sponsored agency in BC, as such, further research exploring these and other barriers at additional agencies is required.

Furthermore, research at agencies at other levels in the public health environment may highlight different barriers that may need to be addressed.

Recommendations

As an agency engaged in public health practice, the BCCDC has a responsibility to achieve and maintain competence and proficiency in the PHAC core competencies, including advocacy (PHAC, 2007). Recognized as a responsibility of public health practitioners, advocacy facilitates the research to practice transition, ensuring that findings reach the populations for whom they were intended (Woolf, 2008). It is through engaging in advocacy that public health practitioners are able to fulfil their goal of protecting the health and wellbeing of the population.

Through this exploration, a greater understanding of the various forms of advocacy in public health practice and how barriers experienced by a division within a government-sponsored agency can be overcome has been gained. The use of Christoffel's framework has helped to locate individuals and agencies involved in advocacy and the various skills they possess. Using this framework the BCCDC can staff its teams according to its strengths in stage one and two activities and identify "gaps in knowledge, skills, attention, or staffing that need to

be corrected to enhance the quality and pace of public health advocacy”
(Christoffel, 2000).

By being strategic concerning when and how they advocate the BCCDC can help ensure that the political climates are optimal for uptake of the public health issue. If the BCCDC can detect opportunities that are conducive to such environmental and social change, its advocacy efforts are more likely to be successful, strengthening stage three actions. Additionally, through building “positive working relationships with legislative staff” (Brownson et al., 2006), the BCCDC can facilitate the creation of opportunities, advancing the research to practice transition. In order for the BCCDC to be proficient and effective in these areas, it will need to develop skills that are not traditionally embodied by scientists and researchers. In consideration of this, it is recommended that the BCCDC (through the PHSA) employ an individual who can devote the time and resources necessary to develop political intelligence within the BCCDC.

Collaboration was highlighted as the most important strategy that the BCCDC could improve upon to enhance its advocacy efforts. Although situated primarily in stage two activities, by engaging in greater collaboration with participants in the public health environment, the BCCDC can attempt to fill the gaps in their current advocacy efforts. If collaboration begins at the onset of a campaign or program, concerns from opposing agencies or ministries can be addressed, resulting in support from sponsoring agencies. Alternatively, if

concerns from government ministries cannot be resolved, the BCCDC is able to collaborate with other external agencies who can engage in action stage activities the BCCDC is unable to participate. Additionally, collaborating with other agencies provides an opportunity for resources to be pooled, potentially filling resource gaps identified by BCCDC participants. Although collaboration has been highlighted as a priority area to develop, it may prove to be quite challenging as it will require the BCCDC to accept the views and perspectives of other partners, altering their own in the process. Additionally, the more partners involved, the more difficult it may be to reach consensus. Thus, in order to improve its collaboration, the BCCDC will need to be flexible.

By strengthening these areas, the BCCDC has the potential to overcome the barriers it experiences when engaging in advocacy as a government-sponsored agency. Overcoming these barriers would not only facilitate the BCCDC's attainment and maintenance of the PHAC core competency, but it would also bring the BCCDC closer to advancing public health issues that have previously been hard to address.

APPENDICES

Appendix A: Interview Participants

Agency	Title of Participant(s)
BCCDC	Director
BCCDC	Associate Director
BCCDC	Physician Epidemiologist
BCCDC	Educator/Program Manager
BCCDC	Physician Epidemiologist
BCCDC	Communications Specialist
BCCDC	Promotion Specialist
BCCDC	Program Manager
BCCDC	Education Leader
Good Company Communications	Creative Director
Ministry of Health (Canada)	Provincial Health Officer
Options for Sexual Health	Co-Manager & Executive Director
Public Health Association of Australia	Chief Executive Officer
Vancouver Coastal Health	Medical Health Officer
Vancouver Coastal Health	Program Manager

Appendix B: BCCDC Information & Consent Form

You are invited to participate in an interview/questionnaire to discuss the role of advocacy in the knowledge sharing process between the BCCDC and its partners, with an emphasis on STI/HIV related material. This study will be conducted by a SFU Masters of Public Health Candidate, Meagan Bibby. The duration of each interview and/or the completion of the questionnaire will take approximately 30 minutes. Although it has yet to be decided, the interview/questionnaire may be followed up with a focus group in an attempt to clarify and understand some of the variations in responses.

Project Information and Objectives:

The aim of this interview/questionnaire is to learn more about your perceptions on the role of advocacy in the knowledge sharing process. Information gathered will be used to create a survey and interview guide that will be distributed to partners identified as involved in the knowledge sharing process of STI/HIV prevention and control material the BCCDC produces. The findings will also be included in a poster that will be created at the end of the practicum term and in a report to be completed in the Spring 2009.

Participant Roles and Confidentiality:

As a participant in these interviews your participation is completely voluntary. The structure of the questions will be primarily open-ended and the information gathered in these interviews will be used as a basis for subsequent instrument development; as such you are encouraged to answer as honestly as possible. There are no right or wrong answers to any of the questions. The interviews will be tape recorded to capture a detailed account of your thoughts and experiences. Your participation will be kept confidential and no names will be included in any documents or publications. If you are available for a face-to-face interview, the researcher may also take notes to expand on information discussed. You are free to choose not to answer any questions throughout the interview, as well as end the interview session at any time. There is no direct benefit to the participant in these interviews.

Contact Information:

Should you have any questions or concerns about the study, please contact Meagan Bibby at meagan.bibby@bccdc.ca or 778 837 4595. You are also welcome to contact Dr. Kitty Corbett who is the supervisor of this project. She can be reached at kcorbett@sfu.ca or 778 782 7190. This project falls within the ethic guidelines approved by the Research Ethics Board (REB) for the practicum at Simon Fraser University. Please feel free to contact them at hweinber@sfu.ca or phone at 778 782 6593.

Thank you!

Appendix C: BCCDC Interview Guide

Introduction

1. I would like to explore your understanding of the following **knowledge sharing** activities. Please provide a brief description
 - Knowledge dissemination
 - Knowledge transfer
 - Knowledge translation
 - Knowledge exchange
2. It would seem apparent that BCCDC is *strategic* in how it engages in the above **knowledge sharing** activities. Could you highlight the key considerations that you feel should guide *strategic* engagement in these areas?
3. Which of these do you feel require greater attention at BCCDC? Please elaborate
4. Please provide an example of an **effective** knowledge sharing activity in which you were involved. To what do you attribute the effectiveness of this process?
5. Please provide an example of an **ineffective** knowledge sharing activity in which you were involved. To what do you attribute the ineffectiveness of this process?

The following questions will focus on the issue of public health advocacy

6. How do you define advocacy in general terms?
Do you draw a distinction between advocacy in general and public health advocacy? Please elaborate
7. Do you think that BCCDC should include public health advocacy as part of its mandate?
 - If yes, why? And what approach should this take?
 - If no, why not?
8. Are there any issues that you feel the Division of STI/HIV Prevention and Control should consider tackling using Public Health advocacy? If yes, please define this/these.
Are there any issues other than these (outside STI/HIV) that you feel BCCDC should address in this manner? Please elaborate
9. Under what conditions should BCCDC and/or the Division of STI/HIV take more of a Public Health advocacy stance?
10. When does an issue become elevated for this consideration?

11. What sort of personal experiences do you have with Public Health advocacy?
Please elaborate

The following questions explore the involvement of the Communications department in the knowledge sharing activities

12. Is the Communications department involved in the Division's knowledge sharing activities? Please elaborate
13. What are your expectations of the Communications department in this process?
14. Do you think the Communications department has a role to play in Public Health advocacy? If yes, please elaborate

The following explore the role of monitoring and evaluation in the knowledge sharing process

15. Do you believe that it is important that BCCDC evaluates the effectiveness of knowledge sharing activities?
16. Can you briefly describe any evaluation initiatives that you have been associated with to assess the effectiveness of knowledge sharing activities?

I would like to conduct selected interviews with critical partners identified by the STI/HIV Division to explore their views about Public Health advocacy. Please suggest partners whom I could invite to participate in this research.

Thank you for your time and cooperation

Appendix D: External Information & Consent Form

You are invited to participate in an interview/questionnaire to discuss the role of advocacy in the knowledge sharing process between the BCCDC and its partners, with an emphasis on STI/HIV related material. This study will be conducted by a SFU Masters of Public Health Candidate, Meagan Bibby. The duration of each interview and/or the completion of the questionnaire will take approximately 45 minutes.

Project Information and Objectives:

The aim of this interview/questionnaire is to learn more about your perceptions on the role of advocacy in the knowledge sharing process. Although the researcher is completing this project on behalf of the BCCDC, she is not an employee and seeks only to explore the nature of information sharing between public health agencies and not to critically evaluate the process. Information gathered will be included in a poster that will be created at the end of the practicum term and a report that will be completed in Spring 2009.

Participant Roles and Confidentiality:

As a participant in these interviews your participation is completely voluntary. The structure of the questions will be primarily open-ended and you are encouraged to answer as honestly as possible. There are no right or wrong answers to any of the questions. The interviews will be tape recorded to capture a detailed account of your thoughts and experiences. Your participation will be kept confidential and no names will be included in any documents or publications. If you are available for a face-to-face interview, the researcher may also take notes to expand on information discussed. You are free to choose not to answer any questions throughout the interview, as well as end the interview session at any time. There is no direct benefit to the participant in these interviews.

Contact Information:

Should you have any questions or concerns about the study, please contact Meagan Bibby at mmb7@sfu.ca or 778 837 4595. You are also welcome to contact Dr. Kitty Corbett who is the supervisor of this project. She can be reached at kcorbett@sfu.ca or 778 782 7190. This project falls within the ethic guidelines approved by the Research Ethics Board (REB) for the practicum at Simon Fraser University. Please feel free to contact them at hweinber@sfu.ca or phone at 778 782 6593.

Thank you!

Appendix E: External Interview Guide

Introduction

The BCCDC has a provincial mandate to share knowledge with educational institutions, regional health authorities and other agencies across Canada for the advancement of public health policy and applied research. The following questions explore your perceptions of **advocacy** in this knowledge sharing role, as well as how knowledge is currently shared with your organization and your perceptions on how this process could be improved.

Knowledge Sharing

17. I would like to explore your understanding of the following **Knowledge Sharing** activities. Please provide a brief description of each
- Knowledge dissemination
 - Knowledge transfer
 - Knowledge translation
 - Knowledge exchange
18. Can you describe your personal role in any of the above within your organization? Who assists you with these activities within your organization?
19. Could you describe any examples where the BCCDC has shared knowledge with you/your organization? *Possible examples include: reports, publications, email briefs, notices, meetings, conferences, forums, workshops, data sharing etc*
- If yes, please elaborate
 - If not, should it? Please describe your knowledge requirements that you feel BCCDC could address? **[continue to Question 5]**
20. Could you provide an example of how you **utilize** the information that the BCCDC provides you with? *If helpful, please elaborate on examples from Question 3*
- How would you rate the usefulness of the information provided by the BCCDC?
For each example they may be rated differently
- | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Very Useful | Useful | Somewhat Useful | Not Useful |
- Could you please elaborate on why you rated the usefulness of the information as very useful/useful/somewhat useful/not useful? If you rated it **Not Useful** how could it have been made more valuable?
21. Do you communicate your knowledge needs with the BCCDC? If so, please provide an example including how this has been accomplished? Has this met your needs?

22. Do you engage in **Knowledge Sharing** with your external partners and/or stakeholders? If yes, please describe the ways in which you share knowledge with these partners/stakeholders.

Are there instances that you can point to where knowledge provided by the BCCDC has been utilized in these knowledge sharing activities with your partners/stakeholders?

23. Are your main partners/stakeholders engaged with the BCCDC?

- If yes, in what capacity?
- If not, should they be? Why or why not?

Advocacy and Public Health Advocacy

24. How do you define **Advocacy** in general terms?

Do you draw a distinction between Advocacy in general and Public Health Advocacy? Please elaborate

25. Is Public Health Advocacy included in your mandate?

- If yes, in what capacity – please provide examples of Public Health Advocacy
- If not, should it?

26. Are there conditions under which you believe your agency should take more of a Public Health Advocacy stance?

27. When would an issue become elevated for this consideration?

28. What sort of personal experiences do you have with Public Health Advocacy? Please elaborate

29. Is the BCCDC able to assist you with Public Health Advocacy activities?

- If yes, how? Could this be improved? If yes, please elaborate.
- If no, why not?

30. Do you think that BCCDC should include Public Health Advocacy as part of its mandate?

- If yes, why? And what approach should this take?
- If no, why not?

Thank you for your time and cooperation

Appendix F: Code Guide

<i>A-Priori Codes: Phase I</i>	
Code	Definition
AN	Audience Needs
AUD	Target Audience
AW	Awareness
CAP	Capacity
CO	Collaboration
CH	Change
COMP	Complications
CON	Content
CONX	Context
DIS	Distribution
DU	Duty
EMP	Empowering
KD	Knowledge Dissemination
KEP	Knowledge/Experience
KP	Key Players
LANG	Language
MC	Media Content
MI	Media Involvement
POL	Politics
POS	Position
PRI	Priorities
PRO	Proactive
PROM	Promotion
PROV	Provincial
RES	Resources
RG	Range
SEL	Selective
SH	Sharing Information
SS	Strong Science
T	Time
TRANS	Translation
TRG	Targeted
UP	Useful/Practical
UR	Urgency
UTIL	Utilization
<i>Emergent Codes: Phase I</i>	
AH	Aboriginal Health
DM	Direct Material
ED	Education

EH	Environmental Health
HO	Housing
HR	Harm Reduction
ME	Monitoring & Evaluation
SDH	Social Determinants of Health
ST	Stigma
TECH	Technical Information
UND	Understanding
<i>A-Priori Codes: Phase II</i>	
3PT	3 rd Party
ANN	Announcements
ASO	AIDS Service Organizations
AW	Awareness
CAP	Capacity
CH	Change
COI	Conflict of Interest
COL	Collaboration
CON	Conferences
CRED	Credibility
DS	Data Sharing
DU	Duty
ED	Educator
EDUC	Education
EM	Email
EMB	Email Briefs
FOR	Forums
Gen In	General Information
GP	Good of Population
KP	Key People
LANG	Language
MD	Material Development
MET	Meetings
NOT	Notices
POLI	Policies
POL	Political
POS	Position
PRO	Proactive
PUB	Publications
REP	Reports
RHA	Regional Health Authority
SEL	Selective
SHIN	Sharing Information
SI	Scientific Information
SPI	Specific Information
SS	Strong Science
SUP	Supervisor
TD	Top Down

TEL	Telephone
TRG	Targeted
UP	Useful/Practical
UR	Urgency
WR	Wide Range
WS	Workshops
<i>Emergent Codes: Phase II</i>	
ACC	Accessibility
ACP	Academic Point of View
DEF	Definition
DIR	Director
EVR	Evaluation Reports
EXC	Exchange
FOR	Formal
FUN	Funding
INT	Internal
KE	Knowledge Exchange
LG	Longevity
LR	Leadership Role
MDEV	Media Development
MED	Message Development
NET	Networking
OPT	Opportunity/Timing
PROD	Program Development
RES	Resources
STRAT	Strategic
TO	Tool
TRAN	Transparency

Appendix G: Other Agencies Sample Questions

Good afternoon (name),

My name is Meagan Bibby, and I am a Master of Public Health Candidate at Simon Fraser University in British Columbia, Canada. I am currently engaged in a project that is exploring advocacy strategies for government-sponsored agencies using the British Columbia Centre for Disease Control as a case study. In Canada advocacy is included as a core competency in public health practice yet many practitioners experience barriers around the methods and frequency they can employ. In my initial interviews, several barriers were identified that primarily centred around an agency's resources and proximity to the government: a lack of autonomy to advocate certain issues that may not be particularly supported in the current political environment despite scientific evidence.

Having been identified as a government sponsored agency, if you have the time I would like to ask you about your experience with this issue to gain a broader perspective of how this barrier is experienced. I am happy to speak to you on the phone, but I understand that your busy schedule may not allow for it. If a telephone conversation is not possible it would be greatly appreciated if you would comment on the below questions.

Does the (agency name) engage in advocacy?

If yes: What forms does it take?

Do you find that your position relative to the government influences your advocacy activities?

If yes: How does it influence your advocacy activities?

If yes or no: How do you overcome these barriers?

If you have any questions or comments please feel free to contact me. I look forward to hearing from you.

Sincerely,

Meagan Bibby
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Appendix H: Table 3

Table 3: Public Health Advocacy Participant Roles, In Terms of the Proposed Framework

Participant	Information	Strategy	Action
Coalitions	Request Data	Public education Policy focus identification Bring disparate players together Work with legislators Amplify group efforts Coordinate group efforts	Lobby Testify Get out the vote
Community Groups	Tap resident knowledge Request Data	Public education Join coalitions Work with legislators Mobilize residents	Lobby Testify
Individual health service providers	Case studies, series Research studies Define clinical issues	Clinical perspective Public education Build coalitions	Counsel Lobby Testify
Health provider organization	Identify needed data Some research	Polity statements Model bills Clinical guidelines Join/support coalitions Public education	Vote Lobby Testify
Journal editors	Quality control via peer review	Special issues Choose reviewers	Publish papers and editorials Issue press releases
Journalists	Investigative work	Public education	Publish stories
Lawyers and other legal experts	Describe and interpret laws and their implications	Develop and teach options for application of and changes in laws	Bring suits and injunctions, draft rules and laws
Legislators	Request data Authorize data work Fund data work	Hold hearings Draft legislation Draft regulations	Pass laws Fund enforcement
Private sector (sometimes)	Fund data work Fund research	Funding priorities Fund coalitions	Apply safety standards

including manufacturers and retailers)		Fund education	
Researchers and academicians	Conduct research and evaluation	Develop data-based and theoretical concepts to guide prevention planning; educational curricula for students	Publish Papers Write editorials Testify Media interviews Determine course and qualifying exam questions Vote
Research funding agencies	Fund research Quality control via peer review	Funding priorities Consensus statements	Testify
Victims	Bear witness Participate in research	Victim perspective Public education Join coalitions	Lobby Testify Vote

Source: Christoffel, 2000

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