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# TABLE OF CONTENTS

## ACKNOWLEDGMENTS

## LIST OF CONTENTS

- List of Case Studies
- List of Figures

## INTRODUCTION

## PART ONE: NONCOMMUNICABLE DISEASES – THE FACTS

- Why Should NCDs be a Priority?
- Is Prevention Possible for NCDs?
- What are the Costs?
- What are the Benefits of Acting?
- What are the Priorities for NCD Prevention?
- The Health Conditions of Concern
- Common Underlying Factors
- What Can Be Done?
- Areas for Investment and Action
- Issues and Challenges
- Some examples of population interventions for CVD and smoking

## PART TWO: PRINCIPLES OF ADVOCACY

- What is Advocacy?
- Why advocacy?
- What is the Basis for Advocacy?
- What are the Principles of Advocacy?
- Where Should the Effort Go?
- How to Get Started?

## PART THREE: TOOLBOX FOR NCD ADVOCACY

- Getting NCDs onto the Agenda
- Key Targets for NCD Advocacy
- Researching the Problem
- Defining Desired Outcomes
- Defining Approaches to Advocacy
- Targeting Messages for Key Audiences
- Making Contacts and Assessing Climate for Change
- Building Alliances
- Effective Government Relations
- Elements of Policy Activity
- Influencing Laws and Budgets
- Techniques for Influencing Decision Makers
- Face to face meetings
- Writing Campaigns
- Using the Internet
- How to Work with (or against) Industry
Acting on Non-Communicable Diseases: An Advocacy Guide for the Western Pacific

Industry Friends ........................................................................................................................................................................... 37
Industry Foes .................................................................................................................................................................................. 38
Media Advocacy ............................................................................................................................................................................. 40
Understanding Your Goals, and Understanding Media Goals ........................................................................................................ 40
Understanding the channels of communication and how the media works ..................................................................................... 41
Making Friends with the Media ......................................................................................................................................................... 42
Working with the Media ...................................................................................................................................................................... 43

PART FOUR: HARD WORK WITH HIGH REWARDS.................................................................................................................. 45
Advocacy: Part of a Broader Strategy .................................................................................................................................................. 45
The ‘Tipping Point’ of NCD Control and Prevention .......................................................................................................................... 47
The Law of the Few ................................................................................................................................................................................. 47
The Stickiness Factor ........................................................................................................................................................................... 48
The Power of Context .......................................................................................................................................................................... 48
Reaching the ‘Tipping Point’ ................................................................................................................................................................. 48
The Diffusion of Innovation .................................................................................................................................................................. 48
Some Frequently Asked Questions (and their answers) ...................................................................................................................... 49

PART FIVE: APPENDICES ............................................................................................................................................................... 50

REFERENCES ..................................................................................................................................................................................... 53

LIST OF CASE STUDIES
Case Study 1: .................................................................................................................................................................................... 9
Case Study 2: ....................................................................................................................................................................................... 11
Case Study 4: Tobacco Control in Australia ......................................................................................................................................... 22
Case Study 6: Tobacco Control in Australia ......................................................................................................................................... 23
Case Study 7: Working with other sectors: ......................................................................................................................................... 29
Case Study 8: Advocacy for the Victorian Tobacco Act (1987) ........................................................................................................ 34
Case Study 9: Creative use of the Internet: an example. ...................................................................................................................... 37
Case Study 10: Take Away Food in New Zealand ............................................................................................................................ 37
Case Study 11: Campaign against the Camel Trophy event in Fiji.................................................................................................. 38
Case Study 12: A Challenge to the Tobacco Industry in Australia .................................................................................................... 39
Case Study 13: Singapore .................................................................................................................................................................... 46
Case Study 14: Tianjin Integrated Prevention and Control of NCD .................................................................................................. 46

LIST OF FIGURES
Figure 1: Percentage of DALYs* by Cause in the Western Pacific Region .......................................................................................... 5
Figure 2: Components of NCD Programs ............................................................................................................................................ 6
Figure 3: DALYs in Developing Countries, 1990-2020. .......................................................................................................................... 7
Figure 4: Tobacco Related Mortality by Region. ............................................................................................................................... 8
Figure 5: Factors Affecting CVD (Cardiovascular Disease). .................................................................................................................. 14
Figure 6: Factors Affecting Advocacy .................................................................................................................................................. 20
Figure 7: The Advocacy Process ............................................................................................................................................................ 21
Figure 8: Framework for NCD Control and Prevention. ...................................................................................................................... 45
Figure 9: Burden of Disease in Disability-Adjusted Life Years (DALYs) by WHO Region ............................................................. 50
Figure 10: Prevalence of Current Smoking (%) in Selected Populations .......................................................................................... 50
Figure 11: Preventing Chronic Disease: A Strategic Framework ..................................................................................................... 52
INTRODUCTION

Countries in the Western Pacific Region are undergoing a significant health transition. While infectious diseases are still a problem, noncommunicable diseases (NCDs) - those diseases not vector-borne or transmitted from person to person through contact, air or water - are becoming the major cause of death. This changing pattern of disease poses significant challenges for health sector personnel: not only must they focus on new types of disease and causes of ill-health, but must also find new ways to achieve better health in their communities.

*Disability Adjusted Life Years (DALYs) combine years of life lost due to premature death and years lived with a disability incurred through new disease, adjusted for the disease’s severity.

NCDs can be effectively managed and prevented. A national NCD program will address integrated health services (bringing together preventive and clinical services), lifestyle and behaviour change, and changes to living conditions. Many of the factors affecting NCDs – particularly those factors related to economic and social environment – fall outside the direct area of influence of those in the health sector. Yet it is health sector personnel who will carry the responsibility for defining the issues, initiating action, and building partnerships for change with other sectors. Consequently, health sector personnel will need to take a broad-based approach to NCD management and prevention. They must think hard about the best ways to go about reducing the incidence of NCDs, because often health sector personnel work with limited resources, and so must focus on those issues that are likely to have the greatest effect for a reasonable amount of effort.

In this manual we consider ways that health sector personnel can use advocacy to achieve improved outcomes in the prevention and management of NCDs. While advocacy is an important component of any NCD program, it must be developed together with other components of a comprehensive NCD prevention and control strategy. Advocacy typically focuses on environmental change, but as the diagram below indicates, NCD programs must also include strategies for lifestyle change and health services reorientation. Advocacy is an important part of NCD control and prevention, but it should never be the only strategy used in NCD programs. Moreover, all of these strategies must be controlled and integrated by a coordinating body, so that an entire program takes a unified approach to its battle against NCDs.
This is an advocacy manual for health sector personnel, as advocacy to non-health sectors is a central task for people in the health sector. Advocacy is one of the principal means by which environment change is achieved. It is designed to assist people to act on the prevention and control of non-communicable diseases in the Region – what factors are critical, what can be changed, and how change can be best achieved. Successful health promotion requires multiple strategies at societal, community and individual levels. However, the role of this manual is to deal specifically with advocacy for NCDs.

**This manual will:**
- Demonstrate the importance of NCDs for the Region;
- Suggest priority actions for the prevention of NCDs;
- Outline the fundamentals of advocacy;
- Offer some practical tools for putting a campaign together.

The Western Pacific Region is very diverse and contains countries with very different population profiles, governments, cultures and social systems, levels of development, health practices and concerns. Despite this diversity, many of the challenges faced while trying to slow the growth in the burden of NCDs are the same. Advocacy depends on presenting compelling arguments that convey a sense of urgency for action and that make taking the proposed actions irresistible to decision-makers. Advocacy is also an expression of commitment and passion, because often it involves looking beyond obvious ways of thinking about the conditions that cause NCDs and convincing people outside the health sector to think about NCDs in the same way. Commitment and passion is also required because people outside the health sector often do not regard NCDs as their responsibility, despite the fact that they are often in a position to help the effort to prevent and control NCDs. For this reason, NCD advocates must strive to make those people realise that they can help, and that the prevention and control of NCDs is everyone’s responsibility.
Part One:

NONCOMMUNICABLE DISEASES – THE FACTS

Why Should NCDs be a Priority?

Most countries and areas in the Western Pacific Region have experienced profound change in recent years. There have been dramatic increases in life expectancy across the region (for example, the life expectancy in low and middle-income countries has increased by ten years during the two decades to 1998). At the same time greater numbers of people are moving from rural areas into cities. About 40 percent of people in the Western Pacific Region now live in urban areas. This rapid pace of urbanisation is expected to continue, and by 2015 half of all people in the Region will live in urban areas. The process of globalisation also impacts on the Western Pacific Region in a variety of ways. There has been increased industrialisation, growing mobility of capital and labour and increased trade in many products (including foodstuffs). All these factors impact on the lives of people in the Region – many people now work in different environments and locations, diets have changed, levels of physical activity have reduced, and access to alcohol and tobacco have increased. These and other factors impact on the health and wellbeing of people in the Region, and are common to developing countries throughout the world – developing countries are experiencing shifts in causes of death and disability from infectious diseases to noncommunicable diseases, as the chart below illustrates.

Figure 3: DALYs in Developing Countries, 1990-2020.

| DALYs, by broad cause group 1990 - 2020 in developing countries (baseline scenario) |
|----------------------------------------|----------------------------------------|
| Communicable diseases, maternal and perinatal conditions and nutritional deficiencies | 22 |
| Injuries | 21 |
| Neuropsychiatric ds. | 14 |
| Noncommunicable conditions | 43 |
| 1990 (%) | 49 |
| 2020 (%) | 27 |

DALY = Disability-Adjusted Life Year
Source: WHO, Evidence, Information and Policy, 2000

The World Health Report 2002 discusses how non-communicable disease can be reduced by ‘individual-based’ and ‘population’ approaches to risk reduction. Individual-based interventions focus on people who possess a particular combination of risk factors that make them at high probability of suffering ill-health from a certain health condition, or certain health conditions. This approach deals with a targeted section of the entire population, rather than applying health-improvement strategies to all people. Population approaches to risk reduction, on the other hand, affect everyone in a given population, and ideally result in a small reduction in risk factors across everyone in that population. The WHO suggests that a combination of these approaches is the most cost-effective means of improving people’s
Acting on Non-Communicable Diseases: An Advocacy Guide for the Western Pacific

health. Most advocacy approaches are concerned with the ‘population’ approach to risk reduction, although these should also be combined with ‘individual-based’ interventions to produce the most benefit to society.

Noncommunicable diseases (NCDs) are becoming the major cause of death in the Region. In the past, NCDs have been seen as an issue for developed countries, but they now pose a significant and growing threat to less developed countries as well. World Health Organization data tell us that in the Western Pacific Region:

- Cardiovascular disease (CVD) is one of the leading causes of death in 32 of the 37 countries and areas. It accounts for three million deaths in the Region each year;
- Cancer is one of the three leading causes of death in 26 countries and areas and it is estimated that about 3.5 million cancer cases occur each year; and
- It is estimated that 30 million people in the Region have diabetes and it is projected that there will be at least 55 million adults with diabetes in the Region by 2025.²

These NCDs share common risk factors. For example, tobacco use is one of the major reasons for the increase in NCDs.³ With smoking rates continuing to increase, tobacco use is one of the largest public health threats to the Western Pacific Region. The human cost of tobacco-related mortality can be seen below.

![Figure 4: Tobacco-related Mortality ('000) by Region (WHO 2002)](image)

When the burden of disease in Western Pacific Region countries is measured (in DALYs), tobacco also emerges as one of the most serious health risk factors. In countries with very low rates of adult and child mortality (one of the ways the WHO groups countries in terms of health), tobacco is responsible for the most DALYs among men (994,000) and ranks second among women (325,000, behind high blood pressure). In countries with low rates of adult and child mortality, tobacco is second only to alcohol among men (8,313,000), but is only the 12th ranked cause of DALYs among women (1,296,000).
**Globally, every year, an estimated four million people die from smoking-related illnesses. This translates to close to 11 000 deaths per day, 2000 of which are in China. One in four of the tobacco-related deaths occurs in the Western Pacific Region.**

**Is Prevention Possible for NCDs?**

Prevention of NCDs is possible. Studies of NCDs suggest a multi-factorial pattern of causation, that is, many things contribute to the incidence of non-communicable diseases, and many of these are difficult to ‘pin down’. Although there is disagreement about the full picture of NCD causation, it is generally accepted that behavioural risk factors (such as tobacco smoking, lack of physical activity, and unbalanced nutrition) contribute to a substantial portion of the disease burden. Traditionally, these risk factors have been regarded as matters for individual to deal with, usually with some encouragement from health personnel and health promotion programs. However, many people working in the health sector now recognise that peoples’ exposures to risk are also affected by environmental and supply side factors, such as price signals, advertising, food supply, and opportunities for regular physical activity. While it remains an important goal of the health sector to encourage people to adopt healthy life-styles directly (through behaviour-change health campaigns, for example), it is also important to alter the environment in which people live in order to make it easier for them to adopt healthy lifestyles. This is the goal of advocacy.

**Case Study 1:**

**Life Style Change and the Prevention of Diabetes Type 2**

Recently, studies conducted in Finland and the United States have shown that encouraging people to change their life-styles is a very effective way to prevent diabetes, and to control complications from this disease. In one of these studies, people with impaired glucose tolerance (and thus at higher risk of developing full diabetes) were recruited by researchers and randomly allocated into three groups: one group received placebo treatment; another was given a drug (metformin, thought to prevent or delay the onset of diabetes); and the last group participated in a lifestyle-modification program, with goals of 7% weight loss and at least 150 minutes of physical activity a week.

Results showed that the incidence of diabetes was reduced by 58% in the lifestyle group, and by 31% in the metformin (drug) group. These results indicate that the incidence of diabetes may be substantially reduced through public health programs – not just by directly encouraging people to adopt healthier lifestyles, but also by making it easier for them to adopt healthy lifestyles. Advocates for diabetes prevention might focus on the latter of these, and attempt to change opinions and policies so that it is easier for people to change their lifestyles.

New research also suggests that a number of social factors contribute to the incidence of non-communicable disease. These are particularly evident when socioeconomic differences in disease distribution are examined, and include social support, sense of control, education, employment status, relative income, and workplace stress. There is also evidence that NCDs arise due to cumulative exposure to risk factors across a person’s life span, starting even in the womb. This means that the health of people is not just affected by decisions and policies enacted by the health sector – the health of people is also affected by decisions and policies from a wide range of organisations and agencies. As such, social and economic policies that support the aims and goals of the health sector are crucial to health improvement.
What are the Costs?

The cost of NCDs is enormous. Most obvious is the human cost in pain, disability and premature death. Less obvious are economic costs, which are both direct (the cost of caring for a sick person) and indirect (the loss of productivity when a person is sick, becomes disabled or dies prematurely).

In simple ‘dollar terms’ NCDs absorb increasing proportions of health budgets, for example:

- In Tonga NCDs contribute to more than 50 percent of all deaths and up to 20 percent of the total health care costs
- In Fiji NCDs account for between 22 – 54 percent of all in-patient costs; 42 – 50 percent of all pharmaceutical costs and 19 – 40 percent of all government expenditure on health
- Conservative estimates of the cost of NCDs in Samoa suggest that they account for at least 25 percent of total government expenditure on health
- In China the estimated direct cost of care for people with diabetes in 1996 was US$3.5 billion
- In Japan, the annual direct cost to the health care sector of diabetes is about US$16.94 billion (six percent of the total health budget)
- In New Zealand, five percent of the health budget is spent on direct care and a further five percent on diabetes related disability allowances
- In Australia, at least US$720 million was spent on diabetes health care in 1995 compared with US$550 million in 1990

What are the Benefits of Acting?

It may seem obvious, especially to those in the health sector, that improving health and reducing the incidence of disease has an inherent value in human terms – people are better off when they are healthy than when they are sick. Policies and programs to prevent NCDs also make good economic sense. For example:

- People who smoke incur an additional 31 percent (men) and 24 percent (women) in medical care costs over those who have never smoked
- A reduction in dietary fat intake of one – three percent would reduce the incidence of coronary heart disease by 25 percent, saving US$4.1-12.7 billion in medical costs and productivity losses over ten years
- Spending $1 on a nutritional program for women in poverty saved $2.91 in medical costs by reducing the number of low birth-weight babies born
- If an additional 10 percent of Australians had physically active lifestyles the risk of CVD would be reduced by five percent – a potential saving of A$103.75 million
- In the East Asia and Pacific region a price increase of 10 percent would reduce the number of smokers by 16 million and the number of deaths by four million
Case Study 2:  
The Economic Benefit of Public Health Programs in Australia.\textsuperscript{12}

In Australia, the Department of Health and Ageing produced a report that attempted to estimate the economic benefit, since 1970, of five public health programs, including: programs to reduce tobacco consumption; programs to reduce coronary disease; programs to reduce HIV/AIDS; measles and Hib immunisation programs; and road safety programs and road trauma. For each program, they estimated:

a) the cost of programs  
b) the estimated reduction in disease cases attributable to the disease  
c) the benefits of disease reduction in terms of increased longevity (life), improved quality of life, and reduced health care expenditures  
d) the total return to society of investment in public health activities  
e) savings to government

The authors found that substantial gains, in terms of disease (or injury) reduction, had been achieved across all of these conditions. In 1998, an estimated 17,400 premature deaths were averted because of reduced tobacco consumption (including 6900 fewer deaths from coronary heart disease, 4000 from lung cancer, 3600 from bronchitis and chronic obstructive pulmonary disease (COPD) and 2900 from strokes and other cancers).

The economic benefit of these public health programs was also substantial. The benefit in 1998 alone, due to reduced tobacco consumption since 1970, is $12.3 billion. This includes longevity gains valued at $9.6 billion, improved health status gains of $2.2 billion, and lower health care costs of $0.5 billion.

What are the Priorities for NCD Prevention?

Priority for action should be considered in a four-step process. They are outlined in general terms below, although the specifics may vary between countries, peoples, and communities.

1. What are the health conditions?  
NCDs include a myriad of health conditions. It is impossible to address them all, so areas of most concern need to be identified – that is those that contribute most heavily to the burden of disease.

2. What are the risk factors associated with the health conditions?  
What are the key risk (and protective) factors clearly associated with identified health conditions?

3. Which of these risk factors can be changed?  
Not all of the factors associated with the health conditions highlighted can be modified. Those which can be need to be identified.

4. What are the best activities to invest in?  
Once the factors that can be changed have been identified, an approach to those factors needs to be decided upon.
There are many NCDs, but a number of them share similar risk factors. These ‘core’ risk factors should be the focus of advocacy campaigns, at least initially, because reducing core risk factors will have a positive effect on many health conditions. The major NCDs and key risk factors are:

<table>
<thead>
<tr>
<th>Major NCD conditions</th>
<th>Risk factors¹³</th>
<th>Socioeconomic status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular disease (CVD) (primarily coronary heart disease, stroke, rheumatic heart disease, hypertension)</td>
<td>Smoking, physical inactivity, obesity, high blood pressure, elevated blood cholesterol, environmental tobacco smoke, alcohol consumption, age, family history, diabetes (for stroke).</td>
<td></td>
</tr>
<tr>
<td>Diabetes (Type 2/non-insulin dependent)</td>
<td>Physical inactivity, obesity, ethnicity, age.</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Smoking, occupational exposure, dietary factors, environmental tobacco smoke.</td>
<td></td>
</tr>
<tr>
<td>Other cancers</td>
<td>Smoking, unhealthy diets, excess alcohol consumption, family history, genetic make-up, environmental and occupational hazards, lack of screening and early detection.</td>
<td></td>
</tr>
<tr>
<td>Chronic Lung disease</td>
<td>Smoking, environmental hazards, occupational exposures.</td>
<td></td>
</tr>
<tr>
<td>Mental health problems</td>
<td>Biological factors, psychosocial issues, genetic factors, illicit drugs, excess alcohol consumption.</td>
<td></td>
</tr>
</tbody>
</table>

**CORE HEALTH CONDITIONS**

TO BE TARGETED INCLUDE:

- **CORONARY HEART DISEASE**
- **STROKE**
- **HYPERTENSION**
- **DIABETES**

**Associated health conditions** are those that share some of the core risk factors, but are also affected by other risk factors. These conditions benefit from generic NCD prevention campaigns, but also require specific actions. Health conditions that are associated with core risk factors, but require a broader approach to deal with, include:

- Cancers
- Chronic Lung Disease
- Mental health problems
**The Common Risk Factors: A Focus for Action**

COMMON RISK FACTORS UNDERLIE THE CORE HEALTH CONDITIONS. THESE RISK FACTORS SHOULD BE THE FOCUS FOR ACTION. THEY ARE:\(^{15}\)

- **SMOKING**
- **PHYSICAL INACTIVITY**
- **UNHEALTHY DIETS**
- **OBESITY**
- **ALCOHOL**
- **LACK OF SCREENING FOR EARLY DETECTION**

**Common Underlying Factors**

Health is more than simply an outcome of biology and individual behaviour patterns. Research shows that biology and individual behaviour patterns are affected by social factors and social characteristics of population sub-groups. Ten interrelated aspects of the social determinants of health include:\(^{16}\)

- people’s social and economic circumstances - people higher up the social ladder have better health than those at the middle, who in turn have better health than those at the bottom;
- stress - caused by social and psychological circumstances;
- a person’s early life – people who have slow growth and lack emotional support in childhood are more likely to suffer ill-health when they are adults;
- whether people feel excluded or isolated from the wider community;
- the nature of a person’s work – stress at work increases the risk of disease;
- unemployment puts health at risk – these ill effects also occur if people feel their job is at risk;
- how much support people get from their family and friends;
- addiction to harmful substances such as alcohol, drugs and tobacco;
- the availability of good food; and
- a good public transport system, and policies that reduce driving and encourage walking and cycling.

The connection between behavioural risk factors and the social and environmental determinants of NCDs are illustrated by the following key inter-relationships:

1. **Poverty, Reduced Knowledge and Awareness, and NCDs**: socioeconomic status, literacy and access to health services are inter-related factors that affect the prevalence of NCDs. For example, people with low incomes may access health services less often (due to cost factors). In addition, low socioeconomic status individuals and communities tend to have low levels of education and literacy, which affects their ability to access health services and health information. In these communities awareness of NCD and of NCD risk factors among the general public, decision-makers, and even health professionals is often low. NCD advocacy is largely concerned with raising awareness about NCD risk factors, and advocates in less developed countries should not assume that decision makers and health professionals are aware of these. It is important to demonstrate the social and economic impact of NCDs to your target audience and to highlight the link between poverty and illness.
2. Life-style related risk factors and environmental determinants: Globalisation, industrialisation and urbanisation have had a significant impact on the lifestyles of many people in the Western Pacific Region. For example, global free trade has secured multinational tobacco companies with access to developing countries, so that while cigarette consumption has been declining in developed countries, it has actually been increasing in developing countries. There is also increased availability of, and demand for, imported foods, which are generally less healthy than traditional foods, and increased access to and consumption of alcohol. In Pacific Island countries rapid urbanisation and the transition to cash (or wage-based) economies have changed traditional occupational patterns and reduced levels of physical activity. These factors make some populations particularly vulnerable to NCDs.

The relationship between life-style and environmental factors is complex. Exposure to risk occurs over time and is cumulative. The life-course approach is needed to understand these relationships and to take into account the complex ways in which biological risk interacts with economic, social and psychological factors in the development of chronic disease. The following diagram illustrates the variety of ways in which these interactions occur, using CVD as an example.

**Figure 5: Factors Affecting CVD (Cardiovascular Disease).**

**What Can Be Done?**

NCDs are not preventable simply through one-off efforts, such as promotional campaigns or screening programs. Lifestyles and life chances are complex, and depend on the interaction of many different factors over time. It is easier to develop positive environments and habits early and to maintain them than it is to change large numbers of people and communities once the problems occur. NCD prevention requires strategies that are directed at different levels, different target groups, and over time, as both the Ottawa Charter for Health Promotion and the Jakarta Declaration indicate.
Health Promotion Action means:
- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

Comprehensive approaches to health development include:
- Promote social responsibility for health
- Increase investments for health development
- Consolidate and expand partnerships for health
- Increase community capacity and empower the individual
- Secure an infrastructure for health promotion

### Areas for Investment and Action

Needs may vary in localities, but there are a group of action areas that are critical to NCD prevention in all places. In Australia’s Northern Territory work was done to identify priority interventions for chronic disease control because of the high burden of disease for disadvantaged populations and the high cost of medical care carried by the government and community. This work suggested some of promising areas for investment and action in a comprehensive approach to the prevention and control of chronic disease.

<table>
<thead>
<tr>
<th>Activity domain</th>
<th>Priority Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternal health</strong></td>
<td>➢ Improving infant birthweight</td>
</tr>
<tr>
<td><strong>Promotion of child growth</strong></td>
<td>➢ Breastfeeding</td>
</tr>
<tr>
<td></td>
<td>➢ Preventing childhood malnutrition</td>
</tr>
<tr>
<td></td>
<td>➢ Decreasing childhood infections through better environmental health conditions</td>
</tr>
<tr>
<td></td>
<td>➢ Childhood Immunisation</td>
</tr>
<tr>
<td><strong>Underlying determinants of health</strong></td>
<td>➢ Maternal and childhood education</td>
</tr>
<tr>
<td></td>
<td>➢ Alleviate poverty</td>
</tr>
<tr>
<td></td>
<td>➢ Promote ‘sense of control’ and mental well-being</td>
</tr>
<tr>
<td><strong>Lifestyle modification</strong></td>
<td>➢ Smoking cessation and prevention programs</td>
</tr>
<tr>
<td></td>
<td>➢ Brief intervention for hazardous alcohol use</td>
</tr>
<tr>
<td></td>
<td>➢ Nutrition, weight loss and physical activity programs in high risk populations</td>
</tr>
<tr>
<td><strong>Early detection and early treatment</strong></td>
<td>➢ Screening</td>
</tr>
<tr>
<td></td>
<td>➢ Adult immunisation</td>
</tr>
<tr>
<td></td>
<td>➢ Aggressive blood pressure lowering to prevent progression of renal disease</td>
</tr>
<tr>
<td><strong>Best practice management</strong></td>
<td>➢ Prevention of complication of diabetes</td>
</tr>
<tr>
<td></td>
<td>➢ Aggressive management of heart attacks and known cardiovascular disease</td>
</tr>
<tr>
<td></td>
<td>➢ Rehabilitation and outreach programs (cardiac, respiratory, renal)</td>
</tr>
<tr>
<td><strong>Secondary Prevention</strong></td>
<td>➢ Regular monitoring of disease</td>
</tr>
<tr>
<td></td>
<td>➢ Support, education and advice regarding risk factors (nutrition, tobacco, physical activity)</td>
</tr>
</tbody>
</table>
Issues and Challenges

There are a number of challenges involved in NCD advocacy, particularly in less developed countries in the Region. It is vital to create an understanding, both among the general population and policy-makers, that NCD prevention is important. A number of countries in the Region still have high rates of communicable disease, so that they suffer a ‘double burden’ of disease (both communicable and non-communicable disease). Often, because health resources are limited, the immediate problems presented by infectious diseases are prioritised over the (comparatively) long-term problems of non-communicable disease. Policy makers in these countries need to be convinced that:

- NCDs are a public health issue – they are not solely a problem for individuals;
- NCDs are a problem for less developed countries as well as for wealthy countries;
- NCDs are not an inescapable result of aging, they have a significant impact on the health, welfare and productivity of people in their middle years; and
- NCDs cost – in terms of productivity, medical care and pharmaceuticals, and lost quality of life.

Despite awareness that many important factors for preventing NCDs lie outside of health services, the ability of health sector personnel to bring about changes in the broader social, economic, cultural, and political environment have been limited. As custodians of community health, and as catalysts for change, health sector personnel need tools and skills for advocacy and partnership with elected leaders, policy-makers (in diverse sectors as treasury, agriculture, recreation, and education), media, industry interests, and civil society.

Some examples of population interventions for CVD and smoking

Cardiovascular disease (CVD) accounts for a substantial burden of disease in all countries, even those that are poor, so that cost-effectiveness is a crucial consideration for anyone attempting to reduce incidence of CVD. Comprehensive approaches to the reduction of CVD take into account a number of risk factors: blood pressure, cholesterol, smoking, body mass index (BMI), low levels of physical activity, diet and diabetes, for example. Advocates that focus on reducing the incidence of CVD might adopt the following population-based issues, and work with people such as politicians, law-makers, and industry representatives to have them implemented in their respective countries.
<table>
<thead>
<tr>
<th>CVD RISK FACTOR</th>
<th>ADVOCACY INTERVENTION EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood pressure</strong></td>
<td>Encourage cooperation between government and food industries to adopt appropriate labelling about salt content on products, and begin to reduce the amount of salt added to commonly consumed products, by establishing voluntary codes of conduct, for example. Advocate for legislative action to ensure that labelling and salt reduction in commonly consumed products are adopted by food industries. Costs are generally higher than voluntary codes of conduct, because mechanisms for quality control and enforcement are required. However, the reduction in salt intake is often larger that under voluntary codes of conduct.</td>
</tr>
<tr>
<td><strong>Cholesterol</strong></td>
<td>Advocacy to media organisations and governments (among others) for population-wide health education through the mass media (such as broadcast and print media). According to the WHO, this approach can lead to a 2% reduction in cholesterol levels across an entire population (WHO 2002:116).</td>
</tr>
<tr>
<td><strong>Low fruit and vegetable intake</strong></td>
<td>Short, intensive mass media advertising and community-based consumer education through health facilities, food retailers and food service providers. Advocacy is required to encourage cooperation from the food industry, the mass media, and other stakeholders.</td>
</tr>
<tr>
<td><strong>Smoking (tobacco)</strong></td>
<td>Advocacy to government tax-collection ministers, ministries and agencies for tobacco product tax increases. Some studies suggest that for every 10% rise in real price of tobacco due to tax increases, tobacco consumption is reduced by at least 2%, and as much as 10% (WHO 2002:124). Advocacy to government to introduce ‘clean air’ laws in public places, so that the risk of passive smoking on non-smokers is reduced. These kind of legislative measures have also been shown to reduce tobacco consumption by smokers. Advocacy to government to introduce comprehensive bans on advertising on tobacco products. This should include media advertising, but also the sponsorship of public events, such as sports, by tobacco companies. Consultation will often be required with other stakeholders who stand to lose revenue if tobacco advertising is banned. Encourage the dissemination of health information through warning labels, counter-advertising, and consumer information packages. Advocacy will focus on encouraging cooperation between government, mass media, and health sector agencies.</td>
</tr>
</tbody>
</table>

Although the focus of this table is on CVD risk factors, many of these are also risk factors for other health conditions – tobacco, for example, is a major cause of lung cancer – so that often the benefits of advocacy will not be restricted to particular issues. Obviously, a large number of these advocacy initiatives rely on the support of government, through policy and/or legislation, in order to be successful. However, advocates should also note that they may have to spend some time encouraging other stakeholders to cooperate with their efforts, so that when laws are made by government, they are also obeyed by the people.
Part Two:

PRINCIPLES OF ADVOCACY

What is Advocacy?

Some people see advocacy as organising marches and demonstrations, others see advocacy as involvement in political campaigns or lobbying in the corridors of power, while some see it as editorial comment in the mass media. Effective advocacy may require all of these tools.

Advocacy is a combination of individual and social actions designed to gain political and community support for a particular health goal or program. Action may be taken by, or on behalf of, individuals and groups to create living conditions which promote health and healthy lifestyles.

Why advocacy?

NCD prevention depends on action beyond the health sector, and requires appropriate policies and investments from government, industry, and community organisations. Yet decision-makers are confronted daily with the many competing interests of individuals, groups and organisations, and often they must trade-off one issue against another. The role of public health practitioners in advocacy is to mobilise interested parties and build partnerships, to get messages through to decision-makers at all levels about the need to take action, what actions are possible, and what benefits can be gained from their actions.

What is the Basis for Advocacy?

Advocacy involves securing political action for health gain. A critical starting point for advocacy is knowledge – that is, having a good understanding of the problem and the appropriate policy responses. So, advocates for health should understand:

- How the problem or issue is experienced (what is the average impact and who is affected);
- Both common and uncommon experiences;
- The extent to which social and economic forces impact on the problem; and
- Appropriate policy solutions which are effective given diverse social and economic conditions.

It is not always sufficient to understand the problem solely from an international perspective – advocates must also understand how people think about the problem in their own country. Some lines of argument from international sources may not be effective in a local context.
What are the Principles of Advocacy?

Advocacy for health is not a ‘one-off’ event. It requires sustained action with multiple players. Advocacy needs to be well planned. Previous advocacy efforts provide well-worn tracks and it is important to take the lessons from earlier endeavours. These include:

- Be clear about what you are advocating for
- Establish common themes and messages
- Don’t stray from your message
- Make it local and keep it relevant

Work in Partnership

- Target individuals and organisations that can get your message across
- Get other peoples’ forums and use them for your own
- Recruit corporate allies
- Develop media contacts (including those outside medicine)

Be Credible and Appealing

- Know the facts and the numbers
- Do your homework and document your findings
- Find ‘attractive’ spokes-people
- Use icons who have credibility
- Use interesting stories

Be Tactical

- Start by assuming the best of others (but know peoples interests and arguments)
- Don’t take ‘no’ for an answer
- Be passionate and persistent
- Set realistic goals
- Plan for small wins
- Take the high ground
- Be opportunistic and creative
- Employ multiple strategies
- Be willing to compromise

Where Should the Effort Go?

Decision-making results from a complex process and reflects the interplay between many forces. Advocacy needs to be directed at both policy makers and those who influence policy, depending on where the advocate sits within the system. Successful campaigns recognise the interplay between forces, as illustrated by the chart below. The exact nature of the relationship between these forces is different in many of the Region’s countries. In some, policy makers may be influenced by direct lobbying from interest groups, or by alliances between interest groups and those working within government. In other countries, where policy makers are not directly elected, they may be less amenable to the will of the people.
How to Get Started?

Advocacy depends on presenting compelling arguments that convey a sense of urgency for action. It requires presenting decision-makers with proposed actions that are irresistible. Advocacy efforts need planning. The key steps include:

1. Researching the problem
2. Knowing the target audience
3. Defining the policy outcomes desired
4. Deciding on the advocacy approach
5. Deciding on key messages and key audiences
6. Making contacts and assessing the climate for change
7. Building constituency and building alliances

These steps will be discussed in Part Three – The Advocacy Toolbox.
Part Three:

TOOLBOX FOR NCD ADVOCACY

The Western Pacific Region is very diverse. Its countries have many different forms of government and structures of civil society. One outcome of this is that advocacy campaigns will vary greatly from country to country. However, most campaigns will follow a similar trajectory - although the action at each stage will vary.

Getting NCDs onto the Agenda

It is often a challenge for those working on NCD prevention to be heard. To those outside the health sector NCDs may seem to be a group of diseases with little in common. They do not have the obvious urgency of infectious diseases (for example, a cholera outbreak), and solutions are less direct and conspicuous than those for infectious diseases (for example, the DOTS for TB). In order to raise the profile of NCD prevention, it may be most practical to focus on one condition (for example, heart disease) or one risk factor (such as smoking). Human stories and economic costs are often two useful angles to bring attention to the problem. Success stories, along with public events and photo opportunities, are a good way to interest others in becoming involved.

Key Targets for NCD Advocacy

Policy-makers are a key audience for NCD prevention advocates. Advocacy campaigns will also need to rely on cooperation with media, industry, and civil society. In that sense, these may be the ‘intermediate’ targets for advocacy - in order to convince the policy-makers, you may have to win the support of other groups first. The form of government will often determine the most effective way to target policy makers.

Researching the Problem

Being armed with the facts is an important starting point for good advocacy. Basic information about NCDs should be gathered:

- Human costs - morbidity and mortality
- Economic cost – health care, lost productivity
- Distribution – does the problem impact on some groups more than others
- Current programs and policies – what exist and are they inadequate
While access to information is vital, in some countries in the Region this may be difficult, either because information does not exist or access to it is restricted. If this is the case, then working to improve information systems or improve access to information may be a preliminary or concurrent function for advocates. Using information from neighbouring countries, or countries at a similar level of socio-economic development, may also be considered. Country, or region, specific information may also be available from international sources (for example the World Health Organization). Testimonials and human interest stories can also be used to supplement statistical data, and have the advantage of making the situation more meaningful to non-professional groups and audiences.

While advocates should be very familiar with available information about NCDs (or the specific NCD they focus on), they also need to be aware of how the local situation contributes to NCDs. In particular, they should be aware of the attitudes and practices of people toward the disease, and/or the risk behaviour.

Defining Desired Outcomes

It is important to focus on key aspects of policy that, if changed, will make a difference to the issue. This will be the focus for developing key messages. For any single issue, there may be a group of things that will need to be worked on over time. The following example, from Australia, illustrates multiple policy strategies for a single issue:

**Case Study 3: Tobacco Control in Australia**

- Mass-reach anti-smoking campaigns
- Work to have the tar and nicotine content of cigarettes tested
- The introduction of advertising bans
- The inclusion of large warnings on cigarette packs
- Increasing rates of tax on tobacco
- The replacement of tobacco sponsorship in sporting and other cultural activities
- Legislation to prohibit smoking in workplaces

There may also be a group of policies that will provide a supportive environment for addressing a range of issues. However, approaching a policy maker with a lengthy wish list is unlikely to be effective, and a careful sequencing of activities will be necessary. The following example, from China, illustrates a multi-pronged policy response to a range of NCD issues:
Case Study 4: NCD prevention in China

The Health VII Project in China was a government project, supported by the World Bank, that focused on health promotion. It adopted the following policy framework for NCD prevention. Project staff in all seven project cities worked to effect the following changes:

- Tobacco Control – banning smoking in public places/workplaces/schools, banning advertising of tobacco products, banning sales to minors
- Health Education – free time for mass media messages, school health education programs
- Nutrition – labelling of salt
- Physical activity – access to exercise facilities
- High Blood Pressure screening – service for all aged 35 and over
- Financing for prevention – secure funding for health promotion activities

These policies provide a supportive environment for community-based health promotion activities.

It is important to think about the desired outcomes in both the short-term and long-term. Consider what is achievable in the current political climate. Major long-term goals are important and will generate significant long-term gains. However, they will be more difficult to achieve. Presenting decision-makers with the smaller gains to be made from short-term goals makes their investment less risky and is an effective strategy in achieving change.

Defining Approaches to Advocacy

There are many approaches to advocacy – public campaigns, private lobbying, meetings, petitions, letter-writing, media events. Consider:

- Is it best to work from within (by getting policy papers approved or by lunching with the power brokers)? or
- Would it be more productive to work from the outside (by creating public outrage or by having media and community events)?
- What is the best mixture of internal and external campaigning?

Most advocacy campaigns will require multiple approaches and the selection of approaches depends, in part, on the targets, the allies, and the spokespeople. The maturity of the issue will help shape the approach. Often, when an issue is new, the primary goal is to raise public awareness. This requires ‘making noise’ in the public arena. With a mature issue the goal may be policy change. This may require lengthy negotiations – achieved within the corridors of power.

Case Study 5: Tobacco Control in Australia

The work of advocates to bring about tobacco control in Australia illustrates a variety of approaches round a single issue. Activists graffitied tobacco billboards. This act and their subsequent prosecution generated media attention and public interest in the issue. Encouraging celebrities to speak out against their activities (usually in the sporting arena) being used to advertise tobacco. Picketing sporting and cultural events that had tobacco company sponsorship. Lobbying politicians to bring about an increase in tobacco tax that generated funds to replace tobacco company sponsorship.
Targeting Messages for Key Audiences

In targeting messages for key audiences there are two key points to bear in mind, that is the points that should be communicated in each message that is developed. These are:

- The human and economic costs of NCDs is enormous; and
- The NCD problem is manageable.

In selecting advocacy messages it is important to focus on simple messages that can be repeated. Criteria for selecting messages can be aligned with key health indicators and key policy proposals. Some of the criteria may be that:

- The general public, opinion leaders, and the health and medical communities can easily interpret and understand the message;
- They reflect topics that affect the peoples health in important ways;
- They address problems that can be changed and will have a substantial impact on the health of the population; and
- They can be used in directing public policies and programs.

Once the indicators have been selected, they need to be translated into key messages.

**EFFECTIVE MESSAGES ARE:**

- SIMPLE
- MEANINGFUL
- SHOCKING
- RELEVANT TO DAILY LIFE
- CULTURALLY SUITABLE
- ABLE TO STIR THE IMAGINATION
The message below is one example of how statistics about tobacco related mortality might be translated into a message that people will understand and remember. An advertisement, similar to the one below, was once used following extensive news coverage of an air disaster. The advocate wanted to point out that although aircraft accidents were tragic and spectacular, far more people were dying from tobacco-related deaths – yet that issue barely rated a mention in the media. This advertisement was particularly successful because readers were aware (through the aircraft disaster reporting) of how many people died when jumbo jets crashed.

TOBACCO RELATED DEATHS IN THE WESTERN PACIFIC REGION ARE THE EQUIVALENT OF NEARLY SIX JUMBOS FULL OF PEOPLE CRASHING EVERY DAY

Another example of a message that shocks is a simple statement of fact:

OF ALL THE CHILDREN ALIVE TODAY IN CHINA, ABOUT 50 MILLION WILL DIE PREMATURELY FROM TOBACCO USE
When developing messages, it is important to keep a focus on communicating (in the simplest way possible) the nature of the problem, the desired actions, and the potential benefits. Here are some suggestions:

<table>
<thead>
<tr>
<th>Action area</th>
<th>Nature of problem</th>
<th>Desired action</th>
<th>Potential benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>➢ Focus on (through taxation)</td>
<td>➢ Price increases (through taxation)</td>
<td>➢ Outline the distribution of the benefits and the costs of action</td>
</tr>
<tr>
<td></td>
<td>➢ The distribution of the problem (including any disparities in distribution)</td>
<td>➢ Restrictions on sales, advertising and use</td>
<td>➢ What are the political gains</td>
</tr>
<tr>
<td></td>
<td>➢ The costs</td>
<td>➢ Social education about the adverse health effects of tobacco</td>
<td>➢ What are the economic gains</td>
</tr>
<tr>
<td>Nutrition</td>
<td>➢ Improved food security &amp; distribution</td>
<td>➢ Improved food security &amp; distribution</td>
<td>➢ Make the argument for a return on the investment</td>
</tr>
<tr>
<td></td>
<td>➢ Improved supply of and access to healthy foods</td>
<td>➢ Improved supply of and access to healthy foods</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Pricing policies that encourage the consumption of healthy food</td>
<td>➢ Pricing policies that encourage the consumption of healthy food</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Social education about food safety and healthy food</td>
<td>➢ Social education about food safety and healthy food</td>
<td></td>
</tr>
<tr>
<td>Physical Activity</td>
<td>➢ Physical environments that encourage activity (ie parks, footpaths, absence of hazards)</td>
<td>➢ Physical environments that encourage activity (ie parks, footpaths, absence of hazards)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Programs that educate about and encourage activity</td>
<td>➢ Programs that educate about and encourage activity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Urban planning to discourage private motor vehicle use and encourage effective public transportation</td>
<td>➢ Urban planning to discourage private motor vehicle use and encourage effective public transportation</td>
<td></td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>➢ Universal prenatal care</td>
<td>➢ Universal prenatal care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Postnatal visiting</td>
<td>➢ Postnatal visiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Breastfeeding support</td>
<td>➢ Breastfeeding support</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Universal primary education</td>
<td>➢ Universal primary education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Immunisation</td>
<td>➢ Immunisation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Early childhood development programs</td>
<td>➢ Early childhood development programs</td>
<td></td>
</tr>
<tr>
<td>Poverty alleviation</td>
<td>➢ Progressive taxation</td>
<td>➢ Progressive taxation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Social safety net</td>
<td>➢ Social safety net</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Local economic development</td>
<td>➢ Local economic development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Targeted employment and training programs</td>
<td>➢ Targeted employment and training programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Improved access to, and completion of, education for women</td>
<td>➢ Improved access to, and completion of, education for women</td>
<td></td>
</tr>
<tr>
<td>Mental health promotion</td>
<td>➢ Economic participation through work and education programs</td>
<td>➢ Economic participation through work and education programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Anti-discrimination legislation</td>
<td>➢ Anti-discrimination legislation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Encourage social connectedness through community development and investment in social capital</td>
<td>➢ Encourage social connectedness through community development and investment in social capital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>➢ Social education/marketing to overcome some of the stigma associated with mental health problems</td>
<td>➢ Social education/marketing to overcome some of the stigma associated with mental health problems</td>
<td></td>
</tr>
</tbody>
</table>
Making Contacts and Assessing Climate for Change

Timing and targeting are crucial features of advocacy efforts. The first step in deciding who, how and when to target is to do thorough homework on the issue. Some of the things you should consider include: 1) who are the people or groups sympathetic to the issue; 2) who are hostile; 3) who are the other players involved; 4) what issues are about to become topical; 5) when will these issues become topical, and finally; 6) who are likely to be influential.

As part of this process, advocates will often:

- Make a list of people – elected representatives, advisers, government officials, political party policy committee members, key professional organisations and leaders, key industry organisations and leaders, health reporters and political journalists.
- Talk to them – make a table of their position, their interests, their priorities.
- Sort the list into ‘friends’, ‘possible to win over’, and ‘hostile’ camps – make a list of what each sees as the issues, what drives their views, and what concerns they may have.
- Make a calendar of when critical events are occurring and an apparent time table for decision-making. Make sure you consider the budget cycle and budget announcements, sitting dates for parliament, and election dates. Make sure you are aware of competing policy priorities and their timing.

Mapping out the policy landscape will help decide whether the issue is ripe, how much effort needs to be spent on constituency development, who needs to be spoken with, and when to strike.

An analysis of the stakeholders should result in adoption of strategies for mobilising their support or in managing their opposition. A stakeholder management strategy might look like:

<table>
<thead>
<tr>
<th>SUPPORTERS</th>
<th>OPPOSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VERY IMPORTANT PEOPLE</strong></td>
<td>Mobilise their interest and enthusiasm; keep them informed and involved</td>
</tr>
<tr>
<td><strong>LESS IMPORTANT PEOPLE</strong></td>
<td>Keep them onside and ensure they remain supportive</td>
</tr>
</tbody>
</table>
Some of the key stakeholders to consider for each of the NCD prevention action areas are listed in the following table.

<table>
<thead>
<tr>
<th>Action area</th>
<th>Key Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>Ministers responsible for Communication/Media, Industry, and Trade</td>
</tr>
<tr>
<td></td>
<td>Medical Association</td>
</tr>
<tr>
<td></td>
<td>Tobacco farmers</td>
</tr>
<tr>
<td></td>
<td>Tobacco wholesalers and retailers</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Ministers responsible for Agriculture and Industry</td>
</tr>
<tr>
<td></td>
<td>The food industry (including manufacturers, wholesalers, retailers, transport)</td>
</tr>
<tr>
<td></td>
<td>Bodies representing primary producers</td>
</tr>
<tr>
<td></td>
<td>Bodies representing consumers</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>Minister responsible for Sport and Recreation</td>
</tr>
<tr>
<td></td>
<td>Local government officials responsible for recreation, parks and planning</td>
</tr>
<tr>
<td></td>
<td>Urban planners</td>
</tr>
<tr>
<td></td>
<td>Education sector</td>
</tr>
<tr>
<td></td>
<td>Sports teams and clubs</td>
</tr>
<tr>
<td>Maternal and Child Health</td>
<td>Ministers responsible for Women, Health, and Welfare/Social Security</td>
</tr>
<tr>
<td></td>
<td>The Commissioner for Children</td>
</tr>
<tr>
<td></td>
<td>Women’s groups</td>
</tr>
<tr>
<td></td>
<td>Medical Association</td>
</tr>
<tr>
<td></td>
<td>Education sector</td>
</tr>
<tr>
<td>Poverty alleviation</td>
<td>Ministers responsible for Welfare/Social Security, Employment, Economic Development and Women</td>
</tr>
<tr>
<td></td>
<td>National and local community welfare councils</td>
</tr>
<tr>
<td>Mental health</td>
<td>Groups representing those with mental health problems</td>
</tr>
<tr>
<td>Promotion</td>
<td>Social Welfare groups</td>
</tr>
<tr>
<td></td>
<td>Education sector</td>
</tr>
<tr>
<td></td>
<td>Human Rights groups</td>
</tr>
</tbody>
</table>

**Building Alliances**

Coalition building with community organisations is important in advocacy for health. Policy makers will respond more readily when there is substantial community support for an issue. Good public health policy can be advanced through such coalitions in two ways. First, community organisations can be encouraged to adopt good practice within their own organisation. For example, local schools and industries can be encouraged to promote nutritious lunches, local authorities could increase access to recreational facilities, and local restaurants can provide smoke-free environments as well as low-fat foods. Second, community organisations can be encouraged to lend support during specific campaigns. Potential groups may include churches, schools, social service and consumer organisations, professional organisations, and women, youth, or older people’s organisations. Not everybody is a potential ally, however, and it is important to think about who your friends and foes might be on particular issues.
There are some general principles that may help when you are trying to build alliances with different organisations. These include:

- Choose unifying issues
- Understand and respect institutional self-interest
- Help organisations to achieve their self-interest
- Recognise that contributions from member organisations will vary
- Structure decision making carefully based on level of contribution
- Clarify decision-making procedures
- Agree to disagree
- Play to the centre with tactics
- Achieve significant victories
- Distribute credit fairly

Be warned, however, that making coalitions work takes time and effort. Before you embark on extensive coalition building efforts, make sure you have identified the right partners, that you have sufficient interests in common, and you have an intuitive sense that the coalition can work or be made to work.

Case Study 6: Working with other sectors:
The Penrith Food Project’s Open Farm Day

The Penrith Food Project is a collaborative project co-funded by local government and the local health service. It adopts a multi-faceted approach to improving the community’s food system. One approach taken by the Project was to hold an ‘open day’ on local farms. The aim was to encourage people to eat more fruit and vegetables, and to promote agriculture in the region. It was hoped that giving the community the opportunity to experience farm life ‘first hand’ would do this. Penrith includes both rural and urban areas which, in the past, have had only minimal contact. Land use in the area is contentious as agricultural land comes under increasing development pressure.

A number of farms agreed to participate in the open day and each held different activities including tasting, cooking and buying fruit and vegetables. The event was widely advertised in the local media. The Open Farm Day has been held for three years and has attracted growing numbers of people. At another level, local politicians and managers of the funding organizations have also responded to invitations to attend open day. The council have recently agreed to undertake a land use study and it is hoped this will help ensure the preservation of land for agricultural purposes.

There are lessons from this project’s success that are valuable for all health advocates:

- Multiple strategies are required: the Open Farm Day is only one part of a broad initiative to improve the community food system;
- Success comes from targeting different levels: this project encouraged the participation of both the general community and the decision makers;
- The health sector can’t work alone: Open Farm Day required working effectively with a number of diverse sectors including agriculture, environmentalists, food industry, politicians, tourism; and
- Projects must be sustainable.
Effective Government Relations

Effective government relations require an understanding of how government works and what drives government decision making. The Western Pacific Region is diverse and contains many different forms of government – each with different legislative processes and structures. This section can act as a general guide only. Effective advocates will research the system in their country and be aware of how the processes work and where the points and people of influence are. Remember, however, that in all countries, governments like to have good news and to take credit for good things happening. Effective government relations will ultimately allow governments to feel successful.

Elements of Policy Activity

Identifying the policymakers can be problematic because there are often many players and it can difficult to work out who does what. A helpful approach may be to think about the following:

<table>
<thead>
<tr>
<th>Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Final authority for a policy decision will rest with an identifiable person (a Government Minister) or group (the Cabinet)</td>
</tr>
<tr>
<td>2. There will be officials involved in the process of channelling policy matters to these people</td>
</tr>
<tr>
<td>3. There will be formal procedures for becoming involved in the process (for example, making submissions to select committees)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The process involves the gathering of expertise</td>
</tr>
<tr>
<td>2. The pool of experts includes government officials, academics, business people, lobbyists and consultants</td>
</tr>
<tr>
<td>3. Other experts (policy analyst) are involved more directly in the process</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Order</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy involves the creation of a shared understanding</td>
</tr>
<tr>
<td>2. Creating this ‘order’ will involve dealing with the values of individuals and groups, and the perspectives of organisations</td>
</tr>
<tr>
<td>3. This interaction may challenge the assumptions and working practices of those concerned</td>
</tr>
</tbody>
</table>

Influencing Laws and Budgets

Law making and budgetary processes are two key political activities in which advocates should take an active interest. The mechanics of each process may vary depending on the government structures of particular countries, and so it is important to understand how the system operates. The way the ‘system’ operates can often be quite complex, and may not always work through formal channels. For example, some politicians may regard the opinions of friends and relatives quite highly when making policy decisions, so that if advocates are able to influence those friends and relatives, the issue may be more likely to enter the political agenda. In some countries, politicians bond on the basis of common places of origin or dialect or ethnic group. In decentralised system, local and regional interests may have greater responsibility for decision making, and advocacy efforts will need to be directed more broadly.

Not all policy comes into effect through the law-making process, but it is the ultimate expression of a government’s intent. The following model is based on the Westminster system of government. Many of the countries in the Region will have a different system of law making. However, this model indicates the different stages in the process. In each country these different stages need to be identified so that the advocacy effort can be effectively targeted.
How Laws are Made in a Westminster system

<table>
<thead>
<tr>
<th><strong>Legislation is proposed</strong></th>
<th>Legislation may came from different sources including ministers, their staff, backbenchers, from recommendations of commissions, and from parliamentary committees.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The proposal is refined</strong></td>
<td>Government agencies and ministers will be involved Public input may be sought through the release of Discussion Papers</td>
</tr>
<tr>
<td><strong>It goes to Cabinet</strong></td>
<td>Usually Cabinet approval is needed for the proposal to proceed</td>
</tr>
<tr>
<td><strong>Party approval is sought</strong></td>
<td>This is a good point of influence for advocates because backbenchers (who support your issue) can request changes to the proposal</td>
</tr>
<tr>
<td><strong>The bill is introduced</strong></td>
<td>The bill is read a first, second and third time During the second reading the bill may be debated in detail and amendments are presented and voted on</td>
</tr>
<tr>
<td><strong>Royal approval</strong></td>
<td>The Governor General (on the Queens behalf) gives royal approval to the bill – it is now an Act of Parliament</td>
</tr>
</tbody>
</table>

Irrespective of the process in specific countries, it is important to identify where you might have influence. Using the above model as an example, the points of influence give an advocate the opportunity to:

- Contribute to relevant commissions and parliamentary committees, when they are the source of new legislation;
- Make comment on discussion papers released by the government, to support appropriate legislation, recommend modifications or challenge inappropriate proposals; and
- Lobby backbenchers to request changes the proposal at the party approval stage.

Being involved in the budgetary process is a key activity for advocates seeking policy and program solutions to their issues. While the process may vary from country to country there are two areas to investigate:

1. What is the timing of the process (that is, when is the most effective time to feed ideas into the process)?
2. What are the costs and pay-offs for your proposed solution (that is, in what economic terms can your solution be sold)?
The following points may be helpful:

- Typically, proposals are being developed six to nine months before the budget. Advocacy in this early period should target ministers and departmental officials.

- Three to six months before the budget, the proposals are with senior members of government (Cabinet or a Cabinet sub-committee). They will be considering the possible trade-offs between different sectors and within sectors. This is an important consideration in the health sector where funds may be withdrawn from one area to support another.

- Advocacy during this budget period should target Finance and Treasury as well as key members of Cabinet or the Cabinet sub-committee.

- Policy ideas that are not expensive (or that generate revenue) are popular.

- For policies and programs that are expensive to be considered, potential budget savings will have to be determined.

- In budget submissions it is important to have a convincingly costed proposal.

Techniques for Influencing Decision Makers

When you have identified opportunities for advocacy within the political process, there are techniques you might employ to develop effective relationships with the key players.

TEN COMMANDMENTS TO INFLUENCE POLICY MAKERS

1. Learn about the history of the issue
2. Find out who will make the decision
3. Timing is critical
4. Learn about everyone's interest and arguments
5. It's OK to think like an economist but don't write like one
6. Keep it simple
7. Policy makers care about who is affected by the issue/policy solution as well as efficiency
8. Take implementation and administration into account
9. Emphasise a few crucial and striking numbers and concrete examples
10. Read the newspapers
Lobbying politicians is an important part of advocacy. This involves attracting the support of those with the influence to promote or resolve your issue.

**Face to face meetings**

Face to face meetings with decision-makers are a necessity at some stage in the advocacy process. These meetings require some prior decisions: who you want to meet with (that is, establishing who is in a position to bring about or influence change), and when is the appropriate time to meet with them (usually when you are clear about what you want and when you expect to have maximum impact). It is probably best if a group (rather than an individual) from your organisation or alliance meets with the decision-maker. The following are suggestions about how to handle such meetings.

**Tips for lobbying**

| Identify the right target: | What level of government (local, state or federal) |
| Ask the politician to: | Raise your concerns with Cabinet, Caucus or in policy committees |
| Ask the politician to: | Ask questions in parliament |
| Ask the politician to: | Provide access to government information that might otherwise be difficult to obtain |
| Target ministers: | They usually have more power to influence policy than other politicians |
| Use ministerial staff: | Staff in the minister's office usually know what she or he thinks about an issue and they may be able to influence how the minister sees the issue |

**Face to face meetings**

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**Tips for successful delegations:**

| Choose your strategy | Decide what are the main points you want to convey |
| Select your delegates | It is best if the delegation contains three – five people, ideally: |
| | At least one person with a broad knowledge of the problems and solutions |
| | One to two people with in-depth knowledge of the points you have decided to raise |
| | People who are representative of the age, gender and ethnic mix of your group |
| Summarise your main points in writing | Give these to the person you are meeting. Include: |
| | Your organisation’s name and contact details |
| | The date and place of the meeting |
| | The name of the person you met with |
| | Don’t give your notes out at the beginning of the meeting - this may distract people from listening to you |
Delegates should meet beforehand
Assign the responsibility to make specific points to particular people
Decide who will speak first and last

Assign one person to take notes so that you can report back to your group
It is polite to check with the person you are meeting with before you begin note taking

Listen during the meeting – this is a good chance to gather, as well as impart, information
Be honest if you don’t know the answer to a question – promise to follow the request for information as soon as possible

Write a report of the meeting
Use this to work out your next steps
Follow up any issues that arose during the meeting
Send a thank-you letter (include your group’s understanding of what was discussed and agreed to at the meeting)

Make an appointment.
Prepare for the meeting.
Provide illustration of policy change impact.
Relate any adverse impact.
Do not be argumentative.
Be flexible.
Get a response – in a nice way


In 1987, the Anti-Cancer Council of Victoria, Australia, met with the Victorian Health Minister, who indicated that he was interested in doing something about tobacco in the state. Following this, the ACCV prepared proposals for legislature. They proposed that tobacco company advertising and sponsorship be restricted, that the sale of tobacco to minors be prohibited, and that the sale of small packets of cigarettes (which appealed to young people) be banned. They also proposed that a health promotion foundation be established, which would use money derived from tobacco taxes to fund health promotion, and sponsor sporting and cultural events.

Despite staunch opposition from the tobacco industry, all of these recommendations were eventually incorporated into the Victorian Tobacco Act (1987). Anti-tobacco advocates did not try to get everything they wanted put into legislation all at once, but selected those aspects of tobacco control that they thought were achievable at that time. In particular, they did not push for tobacco advertising to be prohibited in print media, because most print media was printed in another state (New South Wales), and disputes about the technicalities of tobacco advertising may have undermined the Bill’s chances of success.

The recommendations prepared by the ACCV, and other anti-tobacco advocates, were the result of thorough consultation with sympathetic politicians and public servants. In order to get the legislation approved by Parliament, advocates employed a number of tactics and considerations: they proposed tobacco tax increases in a year when the Government was likely to run into a $100 million budget deficit; they kept their activities secret from the tobacco industry until the last minute, so that it could not undermine their efforts; they approached editors of major newspapers and convinced them to run stories on the ill-effects of tobacco as the Bill was being presented in Parliament; and they approached other politicians in formal and informal situations (sometimes through mutual acquaintances) to try and convince them to support their cause. For example, church leaders were approached and asked to encourage politicians who belonged to their churches to support the legislation.
Anti-tobacco advocates employed these and many other tactics, and coordinated their efforts very effectively to ensure that the legislation was passed through parliament. Their success depended on the cooperation of a many advocacy groups, large numbers of volunteers, and a good understanding of, and support from, key politicians and media representatives.

**Writing Campaigns**

Writing campaigns are frequently used as a tool for advocacy. Before beginning a writing campaign it is important to be clear about who you are writing to, why you are writing to that person/s, and what response(s) you hope to achieve. At different times you will need to write to different people. For example, you might consider if the issue requires that letters be written to all elected members of parliament, or just to those in seats which are vulnerable (that is, where the politician holds a slim majority, or electorates in which a lot of people are affected by your issue); whether you will only write to members of the ruling party, or only to members of a specific parliamentary committee? The bureaucracy often responds, or drafts responses, to letters written to ministers, so it is important to consider how you will ensure that your concerns and proposals receive a sympathetic hearing. It may be useful to identify responsive or sympathetic officers within the government department, ideally with some influence at the senior level, and liaise with them about your proposed action. They may be able to give you useful advice, or provide appropriate briefings for decision-makers and improve your chances of getting the desired response. Approaching people within government is also a useful way to “test the water” – to find out how politicians are likely to respond to your issue, and to determine what approaches may improve your chances for success.

**Tips for effective letter writing:**

- Keep a letter to a single page.
- Do not use a form letter.
- Cover only one topic or issue.
- State the purpose at the outset.
- Enclose applicable editorials or position papers.
- Ask your policy maker for a response.
- Identify yourself and your organisation.
- Provide a courtesy copy to your organisation.
- Thank your policymaker for his/her cooperation.
- Describe legislation by its bill number.
- Be polite/give reasons for support.
- Include recipient's name and address on both envelope and letter.
- Write legibly or type.
- Follow up with a phone call.
- Send a note of appreciation when the issue is supported.

There may be times when an OPEN LETTER is appropriate – in this case the letter you write to a decision maker is published – this adds extra incentive for them to act on the issue.
Using the Internet

Effective use of new communication technology may be particularly valuable in countries in the Region where formal means of communication are tightly controlled. This technology includes:

- Internet
- Email
- Hotlines
- Faxes

These transcend formal communication structures and can be employed to build ‘communities’ around an issue or group of issues.

There are, literally, millions of web pages of information and many millions of web users. This makes the internet a useful tool for advocates to research an issue, to communicate with others in the field and to lobby policy makers.

Use the internet to:

- Gather information;
- Find out how your issue has been dealt with overseas (this may provide leverage);
- Make contact and build relationships with other advocates in other parts of the country and overseas;
- Gather public support for an issue; and
- Obtain the email addresses of elected representatives (letter writing campaigns may be replaced by electronic mail).

Useful Websites

World Health Organization – Western Pacific Region: http://www.wpro.who.int/
World Health Organization – Tobacco Control: http://tobacco.who.int/
US Centres for Disease Control and Prevention: http://www.cdc.gov/
Secretariat of the Pacific Community: http://www.spc.org.nc/

Regional Government sites

China: http://www.moh.gov.cn/
Fiji: http://www.health.gov.fj
Cambodia: http://www.moh-cambodia.com/
Japan: http://www.mhlw.go.jp/
Viet Nam: http://www.moh.gov.vn/
Malaysia: http://dph.gov.my/
Republic of Korea: http://www.mohw.go.kr
New Zealand: http://www.moh.govt.nz/moh.nsf
Singapore: http://www.gov.sg/moh/
Philippines: http://doh.gov.ph
Case Study 8: Creative use of the Internet: an example.

The Citizens' Health Initiative in Malaysia (a grouping of organisations and individuals seeking to promote greater community involvement in health care reforms and health policy) used their web site to host a poll on options for health care reforms. They were then able to forward this information to the government.

Be aware that this may be open to sabotage or manipulation. Interested parties may increase the response rate dishonestly by repeat voting.

How to Work with (or against) Industry

Industry Friends

Partnership with industry can be helpful in persuading policy-makers to act differently. Industry itself can also adopt more appropriate policies and investments. The key considerations in working with industry are:

- Identify what the industry interests are and how they can gain from advocacy effort
- Identify who the champions might be
- Meet with the champions to establish a working relationship
- Follow the guidelines above on face to face meetings
- Identify and promote good practice within the industry
- Let industry interests own the issues

Also think about:
What are the community perceptions of this industry?
Does this industry have any dealings with government?

Case Study 9: Take Away Food in New Zealand

Hot chips (French fries) are a very popular takeaway food in New Zealand. A survey of deep frying practices in fast food outlets found that the quality control was poor in many of the independent outlets and the fat content of hot chips varied widely between 5 and 20 percent. Work was done to encourage those producing hot chips to use a healthier form of fat and to reduce the fat content by improving their cooking techniques. The aim was to reduce the average fat content in hot chips from the current mean of 11.5 percent to 10 percent. Such a change would mean 0.5 kilo of fat NOT eaten per person per year. The work received a great deal of media coverage and agencies such as the National Heart Foundation, the Ministry of Health, technical institutes and the food industry became involved developing strategies to improve the deep frying practices of the independent operators.

While the diversity of diets in the Region means that this exact campaign may not be appropriate in all countries, there are lessons from this campaign’s success that are valuable for all health advocates:

- The research built on existing knowledge: researchers knew the fat content in New Zealand diets was high and that peoples consumption of fish and chips contributed to this problem;
- It had a clear advocacy point: in this case it was to reduce the average fat content in chips;
- It had a clear message: reducing the average fat content would have a direct impact on the amount of fat New Zealanders consumed;
- Advocates worked for an achievable level of change in a high volume food;
- Simple local research was converted into an achievable outcome and the information was communicated; and
- Information was disseminated to the right people.
Industry Foes

Not all industries will be friendly, however. When it becomes necessary to work against industry, be prepared for the long haul, and for potentially high legal costs. There will be need for careful planning and research, and you will need many allies. Some of the ground work could include:

- Using Freedom of Information requests to obtain information;
- Using international networks and monitoring international action; and
- Cultivating relationships with investigative journalists.

The tobacco industry is an example of an industry that is never a friend. It mobilises significant resources in its attempts to counter the work of health advocates:

- It opposes restrictions that will reduce tobacco sales BUT, in an attempt to appear a good corporate citizen, may support legislation that will have little effect on sales;
- It has substantial financial resources to lobby with;
- It funds medical research;
- It donates funds to political parties;
- Directors within the industry personally lobby individual politicians;
- It builds alliances with trade unions (on the basis that a shrinking industry will lead to a loss of jobs);
- It may harass politicians who support anti-tobacco legislation;
- It uses international lobbyists and ‘experts’ to support the industry;
- It creates diversions to diffuse to debate; and
- It introduces irrelevancies or misinformation into the debate.

Case Study 10: Campaign against the Camel Trophy event in Fiji

Tobacco use is a major public health problem in Fiji, costing the government at least five million dollars in healthcare costs and leading to at least 300 deaths annually. The Ministry of Health of Fiji, through the National Health Promotion Council, established a pro-active Tobacco Control Action Group (TCAG) in 1998 with a broad objective of monitoring tobacco use and providing surveillance on tobacco control activities. Strong collaborative effort and lobbying by the TCAG prevented the introduction of the *I've Got the Power* program, developed by the Philip Morris Group, into schools. The many ways in which the tobacco industry undermines tobacco control activities in Fiji requires a strong collaborative approach by anti-tobacco lobbyists.

Brand stretching is one of the marketing techniques used by the tobacco industry to market their tobacco products indirectly. It came to the notice of the TCAG that the Government of Fiji, through the Fiji Visitors Bureau, and Tongan Government were hosting the *Camel Trophy* event in June/July 2000. This event was marketed internationally as “the worlds greatest international adventure challenge”, and would include water sports in the Pacific Basin between Tonga and Fiji, mountain climbing, hiking and cycling in the countryside. Permission had been obtained from the Ministry of Fijian Affairs to uses the village rokos (headmen) to make villages aware of the event. Support from the Ministry of Tourism had also been obtained as this event was to give Fiji international exposure as a favourable tourist destination. *Camel Trophy* fashion wear had already entered the youth market through one of the major department stores in Fiji.

A sub-group of the TCAG, consisting of representatives from the WHO, UNICEF, the Adventist Development and Relief Agency, the National Substance Abuse Advisory Council and the National Centre for Health Promotion, met to organise a series of actions against the event. The group, through the NCHP, undertook a mini-survey in the greater Suva area to determine the pre-event public association of the *Camel
Trophy brand with tobacco. It was recommended that similar surveys be undertaken during and post-event to monitor the impact of the event on the population.

Following the survey, the anti-tobacco lobby group developed a position statement, which was presented to the Fiji Visitors Bureau, the Ministry of Fijian Affairs and the Ministry of Tourism. The position statement called for a withdrawal of the event, on the grounds that hosting the event would:

- Continue to add to the attraction of a smoking lifestyle;
- Provide an overt opportunity to circumvent ethical and legal controls on tobacco advertising;
- Be a severe setback to Pacific efforts to institute tobacco control measures;
- Portray a negative image of Fiji and Tonga who were, in other ways, leaders in the field of prevention and control of heart disease, diabetes, hypertension, stroke and lung cancer in the region; and
- Allow the tobacco industry to exploit vulnerable developing small island countries, with their limited budgets, to achieve the industry’s long term sales targets.

The position statement was supported by 16 organisations in Fiji. It was presented to the Fiji Visitors Bureau (who had also invited the organisers of the event to the meeting) on the 16th May 2000. The organisers of the event categorically denied any association with the tobacco industry. However, they were not willing to state the same publicly. Before the Position Statement could be presented to the Ministries of Fijian Affairs and Tourism, the civilian coup d’etat of 19th May resulted in the event being moved to Samoa under the name of the Salem Event. Salem is another brand of cigarettes.

Case Study 11: A Challenge to the Tobacco Industry in Australia

In 1986 the TIA, a lobby group representing tobacco companies in Australia, published advertisements which said “there is little evidence and nothing which proves scientifically that cigarette smoking causes disease in non-smokers” – they implied that this view was supported by major health organisations including the WHO.

The Australian Council on Smoking and Health formally complained to the Advertising Standards Council (ASC) that the advertisement was misleading – the complaint was upheld but the ASC only had power to stop it being published again by those media that were members of its organisation – this was less than satisfactory.

The Australian Federation of Consumer Organisations (AFCO) took the TIA to court on the grounds that the advertisements breached the Trade Practices Act (which prohibited misleading and deceptive advertising)

Legal costs for the TIA were estimated at A$7 million. AFCOs costs were A$1.3 million – many of their expert witnesses and legal representatives worked at no cost.

Justice Morling found that the TIA advertisement was misleading, saying that “there is compelling evidence that cigarette smoke causes lung cancer in non-smokers”. He ordered that the TIA refrain from publishing that advertisement in particular and from making other misleading statements regarding passive smoking.

The TIA appealed against Justice Morling’s decision. The Full Federal Court found that the advertisement was misleading and ordered the TIA to pay part of AFCOs costs. However, the Court decided that it would be too difficult to draw up a ruling that would prohibit the TIA making misleading statements in the future.

The tobacco industry has claimed (incorrectly) that the Full Federal Court overturned Justice Morling’s finding that passive smoking causes disease. The TIA has been warned by the courts to be accurate in its reporting of the issue.
Media Advocacy

Media advocacy is the strategic use of mass media to promote a social or public policy proposal. It uses a range of strategies to define the problem and attract broad-based coverage. Media advocacy attempts to shape public discussion in a way that increases support for healthy public policies.  

Media advocacy involves having the problem or issue reported by the media in such a way that creates impetus for the public health policy solution. Media advocacy has three broad functions, which are:

- **Setting the Agenda:** getting access to the media and attracting coverage for the issue. Media coverage raises public concern and, in turn, increases political sensitivity to an issue. Issues that fail to attract media attention are unlikely to be advanced.

- **Shaping the Debate:** involves the definitions of the issues being highlighted. How a problem is defined is critical because the cause suggests the solutions. In advocacy for health, shaping the debate may involve broadening the definitions of health issues so that problems (such as smoking and drug taking) are seen as more than individual pathology.

- **Advancing the Policy:** after attracting attention and defining the problem the final step is to advance a solution – usually in the form of a particular approach or policy.

Effective media advocacy requires careful planning. When planning for this kind of advocacy, the **GOTME** (goal, objective, target, message, evaluation) approach may help.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Setting specific goals is particularly important when groups are working in coalition with others.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective</td>
<td>Objectives support the overall goal established in the first planning step. There are different levels of objectives including program, policy and media campaign objectives</td>
</tr>
</tbody>
</table>
| Target | Identify the three target audiences  
- Those with the power to make the desired change  
- Those who can be mobilised to apply pressure to this group  
- The general population |
| Message | This may be seen in three parts  
- Statement of concern (what the situation is at present)  
- Value dimension (why that situation should be changed)  
- Policy objective (how that change might be effected) |
| Evaluation | Assessing the value of the effort  
Identify any lessons that could be learned for future efforts. |

**Understanding Your Goals, and Understanding Media Goals**

The media – radio, TV, newspapers, magazines – can be an important ally for public health advocates. This is because these media have the potential to deliver an advocacy message to a large number of people. Sometimes NCD advocates will use the media with the intention of swaying public opinion around a health issue (such as smoking), intending that this changed public opinion will pressure politicians and organisations to introduce policies that will lead to improved health outcomes. But advocates should also be aware that the media is not merely a passive ‘tool’ to be used for advocacy – indeed, media organisations (and the people who work in them) will often have their own agendas and interests, which may directly oppose the goals of NCD advocates. Even when the media supports the goals of public health advocates, an
advocacy message may be changed substantially by the media to suit its own perspectives of what is interesting and important – and sometimes this can alter the message so much that it makes no contribution to NCD advocacy (or even undermines the goals of advocates)! This may occur not because the media deliberately set out to undermine public health advocacy, but because the ultimate objectives of public health and the media are very different. Some of these general differences between ‘public health’ and ‘media’ objectives in countries with privatised or profit-oriented mass media include:

<table>
<thead>
<tr>
<th>Mass Media Objectives</th>
<th>Public Health Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To entertain, persuade, or inform</td>
<td>To educate</td>
</tr>
<tr>
<td>To make a profit</td>
<td>To improve public health</td>
</tr>
<tr>
<td>To reflect society</td>
<td>To change society</td>
</tr>
<tr>
<td>To address personal concerns</td>
<td>To address societal concerns</td>
</tr>
<tr>
<td>To cover short-term events</td>
<td>To conduct long-term campaigns</td>
</tr>
<tr>
<td>To deliver salient pieces of material</td>
<td>To create understanding of complex information</td>
</tr>
</tbody>
</table>

These differences are obviously very important, and NCD advocates must make sure they take careful account of media objectives in their respective countries before they approach the media. NCD advocates must always remember that, as far as the media is concerned, not all publicity is good publicity – and that although media advocacy is often very effective, effective advocacy need not always involve the media.

Understanding the channels of communication and how the media works

It is important to know who controls the media in your region and country, and what their interests or motivations might be. In some countries most media outlets are owned privately and often by individuals or firms who own more than one type of media. In other countries most of the media is owned and controlled by the government. There may be a combination of public and private ownership. In some countries in the Region the media are not free to print or publish any issue they choose. When this is the case, advocates need to think creatively about how best to use the media to create change. In this instance tips may include:

- Don’t talk about what the government isn’t doing. Criticising them publicly is unlikely to be effective.
- Develop human interest stories that illustrate your issue.

Media may expect to be paid. Government support might be needed to create public service announcements. In some countries legislation requires the media to provide a quantity of this type of advertising without charge. However, where this does not happen advertising can be costly and this can be a problem, particularly for advocates working with meagre resources. Even when advertising is provided free of charge, it may not always be useful to advocates – free radio announcements at 3am are no use when your target audience is usually asleep at that time, for example. However, if you have the financial resources, and if you are sure your target audience will read/hear/see your announcement, and if you are confident the announcement will further your cause, then paid advertising has a number of advantages over free or ‘incidental’ announcements (see below). With paid advertising you can: 1) determine the content of the announcement, without having to negotiate with reporters / interviewers / sponsors etc.; 2) determine the time and/or location of the announcement, and; 3) control, to a certain extent, who your audience is.
Remember: media revenue might be directly affected by the policy you are pursuing. For example, policies that restrict or prohibit tobacco advertising might significantly reduce the income of some newspapers. If this is the case, you may have to find novel ways to convince the people who control media content (such as editors or producers) that the benefit of your message to the community far outweighs their benefit from lost advertising revenue. If you cannot convince the media, it may be time to consider other means of publicising your message.

Making Friends with the Media

Often NCD advocates do not have the financial resources to purchase large quantities of media advertising. Luckily there are a number of other ways that advocates can get their messages into the media. One tactic often employed by public health advocates is to prepare ‘fact sheets’ on their issue, and provide them to reporters. These should be balanced and informative, but should also draw attention to what you see as the important issues with regard to NCDs, and how these might be improved. Advocates should also remember that media workers often work to short deadlines, and appreciate people who can quickly provide them with good quality information. If you are prompt to provide information when a reporter asks for it, he or she will often return to you when they want more information, or when they are in search of a story. In this way advocates can ‘make friends’ with the media, and make sure that NCD maintains a profile in the media.

Journalists need information and ideas for stories that have importance for the local community. Advocates need to think of themselves as resources who can make it easier for journalists to do a good job. Useful accurate data, examples of local activities, a summary of key issues, and names of potential sources can serve this purpose (Wallack, Duffman et al. 1993:91).

Journalists and other people working in the media are often in search of interesting stories, so NCD advocates can often ‘help them out’ by providing journalists with updates on recent developments in NCD research, or drawing their attention to NCD issues with interesting facts or stories that might provide the basis for a media article. ‘Fact sheets’ are one such way advocates can ‘help out’ journalists. Advocates can also draw attention to NCD milestones and anniversaries as a way of getting their issue into the media. Press conferences can also be a useful way to get media attention – provided the press conference is well attended, and that they are not too frequent (dependent on public and media interest of course). Advocates can also stage special events to secure the interest of the media.

It is always important to remember that timeliness is one of the key characteristics of news media. When a new story or issue hits the headlines, journalists are expected to work very quickly to gather as much information about that issue as they can, and quickly prepare that information for presentation through their media – be it in print, on television, on radio, or the internet. For this reason, if you want your views on a particular issue to receive free media coverage (through news items, for example), you must be able to provide journalists with information as soon as they need it – and, if possible, before they need it. If a news story breaks overnight, and you think it is appropriate for you to comment on it, a proficient advocate would prepare a fact sheet and fax it to journalists before they arrive at work the next morning. That way, when the journalist arrives at work and begins work on breaking stories, your view is going to be one of their first sources of information. This means that sometimes, in order to be a successful NCD advocate, you will have to work unusual hours to achieve your goals. Restricting your work to weekday work hours, for example, may hamper your efforts to make friends in the media, and to get your viewpoint across to your target audiences. For this reason, it may often be useful to keep copies of useful information sources at home, and also to have out of hours access to a fax and the internet.
Working with the Media

Remember that “news is a commodity … selected, packaged and presented in a way that sells newspapers or attracts television or radio audiences”. Journalists are looking for stories that are: new; shocking; about conflict; weird; timely; fashionable; of human interest; and that affect a large proportion of the population.

“Acid rain isn’t a story, it’s a subject. Tell me a story about somebody whose life was ruined by acid rain, or about a community trying to do something about acid rain, but don’t tell me about acid rain” Don Hewitt 60 Minutes (influential news program) producer

Think about the different ways that the media might cover the issues involved. Social marketing (where a public good rather than a commercial product is promoted) is good at generating public awareness. A more inventive way could involve getting the issues integrated into television soap operas or radio plays. This is a clever way of building public interest and was used in India to promote family planning and in South Africa to discuss HIV/AIDS.

The following tips for getting your story into the media may help:

Decide your target
- General or specialist media?
- Television, radio or newspaper?

Know your target
- What is their style of program or paper?
- Who are the key contacts?
- What are their deadlines?
- When are they most likely to be looking for a story?

Issue the Press Release
- No more than a page long
- Attention grabbing
  - The most important information should come first
  - The lead should summarise the story (including who is involved, what is happening, why it is important, when and where)
  - The message should be clear in the first two paragraphs
  - Include 24 hour contact numbers for further information

Look for a news hook
- Is the issue timely – for example is the new information being presented at a conference
- Is there opportunity for television footage or a photo
- Is there a local angle to the story or are there interesting people involved
## Staging an Event
Actions are more newsworthy than words alone
- Protest, march or sit-in
- Inspection of polluted site

### Press Conference?
You may wish to organise a press conference to publicise your issue.
- Send out notices in advance;
- Ring key people to remind them;
- Think about how interesting images, people and information could improve your event.

### Other options
- Newspapers run opinion pieces
- Letters to the editor
- Feature programs or stories
- Newspaper columnists may have particular interests in specific issues

### Remember:
Do this only if you have a strong newsworthy hook that will attract attendance as a poorly attended press conference can be damaging.

### Interviews
If the press release or press conference generates a request for an interview:
- Make sure you are available should someone wish to make contact;
- Be clear about your message (practice beforehand);
- Speak clearly and concisely;
- Don’t be drawn into areas outside your message.

### Tomorrow is another day
Using the media can be very successful – but it is also risky and unpredictable;
- Don’t expect immediate success;
- Even if they run your story be prepared for its format or angle to have altered.
Advocacy: Part of a Broader Strategy

This is an advocacy manual for health sector personnel, designed to assist people to act on the prevention and control of non-communicable diseases in the Western Pacific Region. However, advocacy alone is not sufficient. It is one part of a broader strategy and must be complemented by other activities.

**Figure 8: Framework for NCD Control and Prevention.**

Figure 8 provides a framework for approaching issues in NCD control and prevention. As we mentioned in the introduction to this guide (see...
Figure 2, page 6), NCD advocacy is a critical component of "environmental change", and is also an integral part of policy coordination. But the effectiveness of advocacy efforts will be severely compromised if they are not brought together with the other components of NCD programs mentioned on page 6: lifestyle change and health services reorientation. Lifestyle change is represented above as ‘behaviour change’, and health services reorientation encompasses all of the categories to the right: ‘risk factor detection and control’, ‘acute care management’, ‘chronic care and rehabilitation’, and ‘end-of-life care’. Effective advocacy is not achieved by a narrow focus on environmental change alone, but by constantly keeping in mind the importance of behaviour change and health services reorientation to NCD prevention and control, and by ensuring that advocacy efforts compliment or reinforce activities in these areas.

The following case studies are examples of a multifaceted approach to NCD prevention and control. Both examples recognise the difficulty of achieving sustainable change in the health of the population and illustrate that, to be successful, a combination of advocacy, health services and good policy is required. Despite differences in the two settings, these policy and program solutions share some common features:

- High level political support
- Targeting of key risk factors
- A multi sector approach including different levels and sectors of government, the community, families and workplaces
- The use of a number of complementary approaches
- A sustained effort over an extended period of time

**Case Study 12: Singapore**

Since the early 1980s Singapore has had comprehensive national policies and programs for NCD prevention. Five parts of this national strategy include:

1. Healthy Family – Healthy Nation focuses on major lifestyle risk factors.
   - Special attention is paid to young people
   - It involves strong multi-sectoral collaboration
     - top level political commitment and support
     - community intervention
     - public sector workplace healthy lifestyle program
2. Promoting healthy eating, monitoring eating habits, formulating national nutrition policies and dietary guidelines, developing public education and a food/nutrition information system and promoting healthy food supply
3. Anti-smoking program A Nation of Non-Smokers
4. Monitoring disease trends
5. Developing screening programs for the early detection of chronic diseases

Results include a reduction in some chronic disease and risk factors:
- Reduced hypertension prevalence;
- Reduced mortality from CVD; and
- Reduced total cholesterol and HDL.

**Case Study 13: Tianjin Integrated Prevention and Control of NCD**


Acting on Non-Communicable Diseases: An Advocacy Guide for the Western Pacific

In 1984 a community-based program on the prevention and control of four NCDs (cancer, heart disease, stroke and hypertension) was launched by the Tianjin Bureau of Health to counter CVD, stroke and cancer which have been ranked as the first three causes of death since the 1970s.

- Intensive healthy lifestyle promotion has been conducted in the community focusing on healthy eating, reducing salt intake, smoking control and control of hypertension
- The prevention and control of NCDs has been integrated into community health services and become part of the city health plan
- Policy development and a supportive social environment have been set as priority areas in the project
- An information and monitoring system for NCDs has been established
- Human resources for NCD control have been strengthened

Results include:

- Improved awareness of NCDs
- Reductions in: Levels of blood pressure
  Rates of smoking;
  Intake of salt; and
  Mortality from stroke.

The ‘Tipping Point’ of NCD Control and Prevention

The effects of advocacy efforts, or even of coordinated campaigns against NCDs, may not be immediately apparent. Very often during the process of NCD advocacy, small changes to the ‘environment’ will be achieved by advocates, but there will be no perceivable effects produced from those changes – the same number of people will smoke, diabetes admissions to hospital will not decrease, and despite winning over key politicians to your cause, no new legislation will pass into law. This can be disheartening to NCD advocates, who may feel as though they are making no progress, or even wasting their time.

Patience is required in all aspects of NCD prevention and control, and particularly in advocacy. Malcom Gladwell, in his book *The Tipping Point* (2000)\(^{48}\), suggests that in things like NCD control and prevention, the effects of people’s efforts are not immediately apparent, and that change is not gradual – rather, there comes a point at which people’s efforts finally tip the balance, and dramatic change occurs. An analogy might be: NCD prevention is not a stream that gradually fills a lake – NCD prevention is a stream that fills a dam until it bursts, and so fills the lake all at once. The point at which the dam bursts (or the straw that breaks the camel’s back), is Gladwell’s “tipping point”.

The Law of the Few

Gladwell describes three special qualities that can affect the point at which sudden change occurs, and an ‘epidemic’ of a given phenomenon occurs – whether it be a disease, a sudden jump in crime, sales of a popular book, or even a successful health program. These qualities are what Gladwell calls the Law of the Few, the Stickiness Factor, and the Power of Context. The Law of the Few describes the principal that in any given epidemic – either biological (such as in the case disease) or social (in the case of trends and fads, for example) – the activities of just a few people will have a greater effect than the combined efforts of everyone else. These people have a greater effect because they possess characteristics that make them different
from everyone else – they may be celebrities, or have many friends, for example. In NCD prevention and control, advocates are the people described by the Law of the Few, because advocates champion their cause, make contact with people who can help to influence others, and persist in their efforts until the ‘tipping point’ for NCDs occurs. They are joined in their efforts by other health professionals working in NCD prevention, and if they are successful over time, by people with influence in society, such as politicians or celebrities.

The Stickiness Factor.

This refers to the ‘agent’ of a particular ‘epidemic’, and once again, the tipping point is reached when this agent acquires some characteristic that makes it more ‘sticky’ – such as when an infectious disease becomes more virulent, or when a health campaign devises a particularly memorable slogan. In NCD advocacy, the Stickiness Factor applies to the key ideas and proposals advocates use when trying to champion their cause. If these do not appeal to the people advocates approach, such as the media or policy makers, the ‘tipping point’ may never be reached. For this reason it is essential that advocates are able to communicate their ideas effectively, and tailor those ideas and proposals to suit the interests of key persons – while taking great care not to compromise the ultimate aim of NCD prevention and control.

The Power of Context

Finally, the ‘Power of Context’ highlights the importance of the environment on the effectiveness of NCD advocacy. Occasionally, small changes in the environment may be all that is required for the ‘tipping point’ to occur. The ‘environment’ in this sense includes not just the specific conditions in which NCDs occur, but also the social context in which arguments and strategies for advocacy occur, including cultural context and the considerations that affect decision-makers and decision-making. The timing and the targeting of advocacy efforts also depend on sound analysis of political context. While the Power of Context is sometimes beyond the control of NCD prevention and control, advocates should try to tailor strategies and solutions with cultural context and decision-making contexts in mind.

Reaching the ‘Tipping Point’

By themselves, none of these three qualities of the ‘Tipping Point’ are sufficient for effective advocacy. Successful NCD control and prevention will ultimately rely on a cumulative combination of these factors, which will eventually lead to dramatic reductions in the incidence of NCDs. It may also rely on the efforts of people who are not advocates, but who become supporters of what NCD advocates are trying to achieve. Although some aspects of advocacy will always be beyond the control of the NCD advocate – there are always competing interests and agendas in the field of health, as well as external events which can have a disproportionate or unexpected effect – NCD advocates can have an effect on all of the key components of the ‘tipping point’. Most obviously, advocates are the ‘few’ in the Law of the Few, but NCD advocates can also directly influence the ‘Stickiness Factor’ through the way they present their ideas and proposals to key people and groups, and (less directly) they can also change the Power of Context until the combination of all three factors reach the ‘tipping point’. All the while, NCD advocates should remember the key insight offered by Gladwell – that over time, the cumulative effect of small changes can suddenly cause big changes.

The Diffusion of Innovation

These concepts are quite similar to the literature on diffusion of innovation. Oldenburg et al (1997) suggest that the ways in which new information and research is disseminated between stakeholders in the research and practice arenas depend on a myriad of factors. They point to the importance, and inter-relatedness,
organisational factors – infrastructure, administration, culture, communication, policy, funding;

contextual factors – personal, attitudinal, situational, programs, research;

dissemination effort – strategies, methods, levels; and

linkage systems – widespread implementation, cost effectiveness.

Thus, to do advocacy work requires planning – to ensure that all the factors listed above have been considered and are in place. To do advocacy work also requires an investment – to develop skills, to resource efforts, to undertake research and monitor progress. It requires that people in advocacy think seriously about the range of factors and contexts that affect the way NCDs are regarded, and considered, in society. It also requires that NCD advocates be innovative, forthright, and strategic in the way they go about improving the policy, social, cultural, economic and physical factors that determine behaviour. Finally, NCD advocates must also be aware of what their colleagues are doing toward changing lifestyles and reorientating health services, so that all efforts toward NCD prevention and control can be coordinated and organised effectively. With these things achieved, the NCD advocate will be prepared to become a true champion of health for the community.

Some Frequently Asked Questions (and their answers)

Q: Aren't NCDs just a problem of aging, and people have to die from something?
A: Healthy aging would decrease burden on individuals, families and societies and contribute to both improved quality of life and productivity.

Q: Aren't NCDs just a problem of individuals choosing bad lifestyles?
A: Lifestyles are infectious. Policies and market environments can promote healthy lifestyles, thus making healthy choices easier choices.

Q: Won't promotion against unhealthy lifestyles (such as tobacco control, and fast food intake) be a constraint on economic development?
A: Industries that promote healthy lifestyles also contribute to local economic development, such as fruits and vegetables. Fast food can be healthy.

Q: How can we do anything if we don't have local statistics to know what the situation is?
A: The international trends - in disease occurrence and in risk factors - suggest it's possible and important to start acting before all the local evidence is in. Local research may be needed to ensure intervention strategies are appropriate and effective - the research efforts should be integrated with actions.
Part Five:

APPENDICES

**Figure 9: Burden of Disease in Disability-Adjusted Life Years (DALYs) by WHO Region (WHO 2002)**

![Bar chart showing the burden of disease in DALYs by WHO region.](chart1)

**Figure 10: Prevalence of Current Smoking (%) in Selected Populations**

![Bar chart showing the prevalence of current smoking in selected populations.](chart2)
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*Source: Profile of CVD, Diabetes Mellitus and Associated Risk Factors in the Western Pacific Region http://www.blackbox.com.ph/ncd/ncddbnew.htm
Figure 11: Preventing Chronic Disease: A Strategic Framework

E. Non-modifiable factors: age, sex, ethnicity, family history, genetic make-up

B. Modifiable Behavioural Factors
- Smoking
- Diet
- Physical activity
- Alcohol use

C. Psychosocial Factors
- Self efficacy/sense of control
- Social support

D. Biological Risk Factors / Markers
- Obesity
- Hypertension
- Dyslipidemia
- Impaired glucose tolerance
- Stress response

A. Early life factors
- Low birthweight
- Childhood infections
- Foetal malnutrition
- Abuse and neglect
- Gestational diabetes

G. Social and Physical Environment

H. Underlying determinants
Socioeconomic status, transport, housing, community characteristics, public policy

I. Access to preventive services

F. Causes of illness and death
- Heart disease
- Stroke
- Type 2 diabetes
- Renal disease
- Certain cancers (eg lung, colorectal)
- Chronic obstructive pulmonary disease
- Depression

REFERENCES

www.wpro.who.int/public/policy/RCM_51.asp
3 See the table ‘Prevalence of Current Smoking in Selected Population’ in Section Four (Appendices) for further information
14 WHO Working Group on Integrated Prevention and Control of CVD and Diabetes, 17-21 November 1997, Malaysia www.wpro.who.int
32 See Section Four (Appendices) for further information, see http://www.wpro.who.int for the World Health Organization’s Regional site which contains a profile for most countries in the Region, or http://tobacco.who.int for information on tobacco consumption and control.


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