# Advocacy for physical activity–from to influence

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# *Advocacy*


***Trevor Shilton***


# Advocacy for physical activity– from evidence to influence


**Abstract:** Advocacy is an evolving and underdeveloped element of public health practice. Historically, it was used to describe activities undertaken by persons on behalf of the poor, the sick or oppressed. In the seventies, led by tobacco control advocates such as Pertschuk in the United States, Gray in Australia and Daube in the United Kingdom, public health advocacy became more focused on structural and policy change. Since the Ottawa Charter (WHO, 1986), the health promotion movement has embraced a broader view of the role of advocacy. The public health community now see advocacy as social action primarily aimed at effecting changes in legislation, policy and environments that support healthy living. Advocacy is defined by the World Health Organization as *a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme* (WHO, 1995).

This paper describes a model for understanding and mobilising physical activity advocacy. It outlines a three step process:

1. Gathering and translating the most pertinent physical activity evidence.
   *Why advocate for physical activity?*
2. Developing from the evidence, a physical activity advocacy agenda and articulating a plan (or plans) of key actions that will increase population levels of physical activity.
   *What should be advocated?*
3. Implementing a mix of advocacy strategies to influence and mobilise support for the physical activity agenda.
   *How should advocacy be implemented?*



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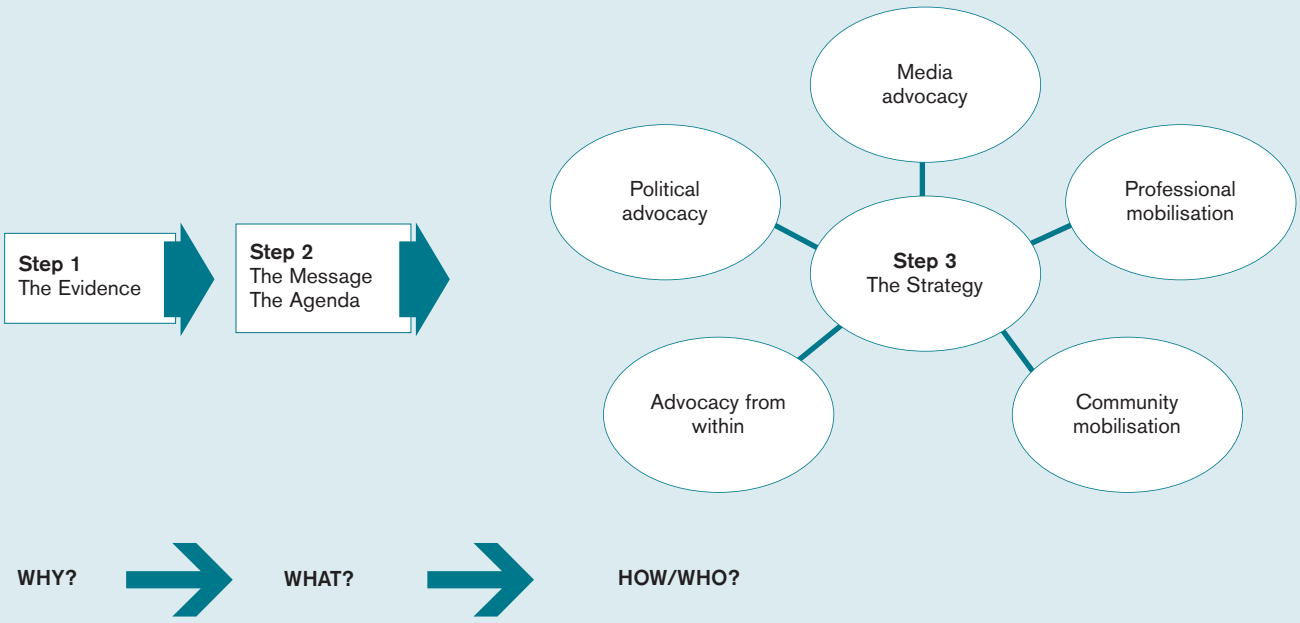
Advocacy is an evolving and underdeveloped element of public health practice. Historically, it was used to describe activities undertaken by persons on behalf of the poor, the sick or oppressed. In the seventies, led by tobacco control advocates such as Pertschuk in the United States, Gray in Australia and Daube in the United Kingdom, public health advocacy became more focused on structural and policy change. Since the Ottawa Charter (WHO, 1986), the health promotion movement has embraced a broader view of the role of advocacy. The public health community now see advocacy as

**Figure 1** A three step (Why, What and How) model of advocacy




social action primarily aimed at effecting changes in legislation, policy and environments that support healthy living. Advocacy is defined by the World Health Organization as *a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme* (WHO, 1995).

There is a contradiction in that, while advocacy is widely accepted as a priority strategy, it remains an underdeveloped element in the fields of health promotion and public health. Chapman (2004) describes advocacy as a 'neophyte' in public health and points out that few master of public health courses include units on advocacy, and there are no textbooks or journals that formally address health promotion advocacy.

Public health advocacy invariably involves health professionals or other campaigners pitting their skills and arguments against an opponent, because their public health objective is at odds with governments, industry or other stakeholders (Chapman, 2004). The lack of an evident industry adversary in some ways adds to the challenge for physical activity advocates. The physical activity advocate instead battles less evident and more pervasive enemies such as apathy, ignorance, political indifference, addiction to labour-saving devices and a 'couch potato' attitude.

**Keywords**
- advocacy
- physical activity

While advocates of physical activity may not have an evident enemy, they do have many assets. Principal among these is the mounting evidence of the public health benefits of physical activity. Other assets are the many opportunities physical activity presents for cross-community benefits and partnerships. Policy and practice in education, sport and recreation, and in those professions that plan our built environment can have a profound influence on physical activity. Physical activity advocates can find allies among those that are concerned about the environment, fuel consumption and traffic congestion. Therefore, there can be major physical activity gains in advocacy that is directed at sectors outside health (WHO, 1997).

This paper describes a model for understanding and mobilising physical activity advocacy. It outlines a three step process:

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In short, this can be referred to as the 'Why, What and How' of physical activity advocacy, as illustrated in Figure 1.

## Step 1: gathering and translating physical activity evidence– Why advocate for physical activity?

Evidence that is systematically collected, published and disseminated is crucial for the sound development of policy and effective physical activity interventions and practice. Evidence serves to justify decisions, and provides a basis for justifying a physical activity advocacy platform and key physical activity messages. Advocacy is principally concerned with the application of evidence, or the weighting and prioritisation of evidence into a set of desired physical activity actions (Dobrow *et al.,* 2003.)

Evidence has different meanings across sectors. Even within health, evidence has important specific meanings that differ across disciplines. Evidence can be used to describe the contribution of physical inactivity to the prevalence, causes and prevention of disease. Evidence can also describe the processes and impacts of physical activity interventions, or it can describe expert knowledge. The health literature describes levels of evidence, where the randomised controlled trial (RCT) is described as a high standard (http://www.cebm.net/levels_of_evidence.asp). However, in health promotion, where the discipline is rooted in the relationships between context, behaviour, environment and the need to influence systems and structures, evidence can be gathered to describe any of these processes (Speller *et al.,* 2005). The IUHPE Journal *Promotion & Education*'s first special issue of 2005 focused on the challenge of getting evidence into practice. The concept of evidence was defined broadly by the authors, acknowledging that in health promotion evidence has scientific, professional and community dimensions (Aro *et al.,* 2005), and should report on results, processes and capacity (Saan, 2005.) Getting evidence into practice is a key advocacy challenge.

Evidence takes on different meanings in sectors other than health. Politicians and key decision makers may want health evidence to be complemented by information demonstrating that proposed physical-activity actions are acceptable with their electorate, popular with the media, or will do no harm to their political standing. Arguments that are constructed around a government's existing policy priorities can be persuasive, and this may include a need for economic analyses, policy analyses and linking physical activity evidence to other community concerns such as economic policy, safety or sustainability. These different understandings of evidence need to be understood by physical activity advocates. Evidence, however defined, is a valuable asset for those who seek to construct advocacy arguments.

Health evidence now provides powerful support for physical activity advocacy. In recent decades there has been a profound shift in the balance of the major causes of death and disease in most countries. Deaths from chronic diseases, which include cardiovascular disease (CVD), stroke, type 2 diabetes, cancers and obesity now represent 60% of all deaths and 47% of the global burden of disease, with 66% of these deaths occurring in developing countries (WHO, 2004a). The *World Health Report 2002* describes in some detail how a few major risk factors now account for much of the morbidity and mortality for non-communicable diseases. More recently, the INTERHEART study of potentially modifiable risk factors associated with heart attack in 52 countries found that nine out of ten heart attacks could be predicted on the basis of nine risk factors, which are the same all over the world (Yusuf *et al.,* 2004). This mounting evidence highlights the central importance of prevention and the promotion of healthy lifestyles, policies and environments as the solutions to the world's leading health concerns.

Physical activity is now recognised as a strong independent predictor of mortality and chronic disease. Physically active individuals will gain a typical risk reduction of around 30% for major chronic diseases when compared to the inactive (USDHHS, 1996; WHO, 2002; Lee & Skerrit, 2001). Among non-smoking women, physical inactivity and overweight and obesity together, may account for as much as 31% of all premature deaths and 59% of deaths from CVD (Hu *et al.,* 2004). In addition to its role in preventing disease, physical activity also has a key role in the management of these diseases (Brown, 2004; Bauman, 2004.)

The health impacts of physical inactivity are further exacerbated by its high and increasing prevalence. Levels of physical activity are decreasing in most populations, however, the patterns of inactivity in communities vary, both between countries and across socio-economic strata and across the life-span within countries. This information should influence where intervention investments are made. For example, investment may be prudent in programmes that target lower socio-economic status neighbourhoods where inactivity prevalence is highest. Another sound investment may be in programmes that target age groups where physical activity declines most rapidly, for example, older adults, adolescent females or young adults with families. Data on low and declining levels of activity, rising obesity and rising sedentariness (television watching and recreational electronic media) can also be newsworthy and can complement media advocacy related to the health consequences of inactivity (WHO, 2002.)

The imperatives for promoting physical activity extend well beyond health. Indeed to present the rationale for increased focus on physical activity purely in health terms is to inadequately represent the broad benefits. Physical activity can deliver benefits, such as, contributions to decongested roads, cleaner air, improved social capital, community safety, participation and civic engagement. Physical activity has relevance across government, and has direct relevance to the portfolios of transport, planning, education, sport and recreation, and local government. Indirect links can also be drawn with crime prevention and tourism. A community-wide approach to physical activity opens many doors for the advocate.

The publishing of evidence in relation to health and community issues typically precedes increases in governmental policy and programme commitment to those issues. Unfortunately, and perhaps specifically because of the lack of or inadequate advocacy, the time lapse between evidence and outcomes can be unnecessarily long. For example, in the case of tobacco control there was considerable delay between the first US Surgeon General's Reports on the Health Consequences of Tobacco and the implementation of progressive policy and programmes. Moreover in many countries there have been much longer delays between the evidence and concerted government action on tobacco. When progressive actions do occur, such as the introduction of Quit campaigns, use of price policy, progressive legislation and regulation to curtail the sale, supply and promotion of tobacco, health warnings and action to reduce exposure to second hand smoke and, more recently, the Framework Convention on Tobacco Control (FCTC), these have been implemented variably across the world, if at all (WHO, 2004b.)

Advocacy for an issue should be a priority whenever the volume of

evidence regarding the health and community benefits exceeds the level of funding and policy commitments to that issue. In the case of tobacco, this imbalance persisted for many decades, and still exists across the world. Improved evidence for the health benefits of regular physical activity gathered momentum in the eighties (Paffenbarger *et al.,* 1986; Blair, 1989) and continued in the nineties (Berlin & Colditz, 1990; Bouchard, 1993). The publication of the US Surgeon General's Report on Physical Activity and Health in 1996 (USSG, 1996), and strengthening research evidence since that time, in concert with the emergence of the overweight and obesity epidemic, created the imperative for advocacy to increase focus on physical activity interventions and research. The case to avoid the delays that occurred with tobacco is both compelling and urgent. There have been successes in countries, such as, Finland and Canada from which others can learn. In addition, there has been increased recognition of the importance of physical activity in chronic disease control by national governments and the World Health Organization. Physical activity advocates need to mobilise their efforts to learn from these successes.

## Step 2: developing and articulating a physical activity advocacy agenda– What should be advocated?

To successfully advocate for physical activity we need to move from the evidence to formulate:

a. Consensus about agreed messages that detail the amount and type of physical activity, and the benefits it will deliver.
b. An agreed, well-justified and prioritised set of actions– an agenda for success.

Physical activity evidence assists the advocate to formulate the right messages and achieve consensus regarding health messages that describe the amount, type and intensity of physical activity that will deliver health benefits. Governments may be encouraged to invest in the process by funding the generation of physical activity guidelines or recommendations for adults, youth and children, or adopting guidelines that already exist. A recent example of this is recent endorsement by Australian Health Ministers of physical activity recommendations for children and youth. These recommendations state that:

- Children and youth should participate in at least 60 minutes (and up to several hours) of moderate to vigorous-intensity physical activity every day.
- Children and youth should not spend more than 2 hours per day using electronic media for entertainment (e. g. TV, computer games, Internet), particularly during daylight hours (Australian Government, 2005).

In addition to consensus regarding scientifically accurate messages (getting the message right), advocates also need to consider language that is most persuasive in communicating the message (getting the right message). Physical activity messages can be framed positively through incentive appeals that promise benefits, or negatively in ways that threaten consequences. Different appeals will be appropriate for different target markets.

Evidence can also inform consensus about advocacy targets including the policy, legislative and educational actions that will have the most significant impact on physical activity, and will find media and political currency. Perhaps the best example of a health issue where such consensus has been achieved is in global tobacco control, where a well-articulated consensus agenda exists around smoke-free policy, price, sale and supply, public education, treatment, packaging, industry advertising and promotion, and point of sale (Jamrozik, 2004; WHO, 2004b) Similarly, the physical activity advocacy agenda should articulate a mix of initiatives, policy, environmental and educational interventions to be implemented across community settings such as transport, local government, health, education, sport and recreation and the media. Such strategies need to be targeted in order to reach those at greatest need, and should give due consideration of differences across gender, culture and the age-span.

While individual strategies may prove effective, the ten point plan in Table 1, summarises a comprehensive population approach to increasing physical activity. It provides an agenda for physical activity advocates. Due to the complex nature of multi-component health promotion interventions it should be acknowledged that there is a lack of insight into the complexity of the cause and effects of the various elements of a multi-component intervention, and the complex nature of both proximal and distal determinants of physical activity. In fact, dissecting comprehensive programmes to determine the effectiveness of sub-components may be a meaningless task. It remains true that a comprehensive approach, incorporating strategies, such as those listed in Table 1, those recommended by the World Health Organization in relation to physical activity and nutrition (WHO, 2004a) and by others in relation to tobacco (Jamrozik, 2004, WHO 2004b, Yach *et al.,* 2005) have the greatest chance of being effective.

## Step 3: implementing a comprehensive mix of advocacy strategies to mobilise support for physical activity– How should advocacy be implemented?

Once the evidence in favour of increased attention to physical activity has been distilled and a clear agenda (or ten point plan) articulated, a combination of strategies is required to shift public and professional opinion and mobilise support and resources for a greater focus on the physical activity actions in the plan. While political and media advocacy tend to dominate the advocacy discourse, a more comprehensive approach is recommended. Such a comprehensive approach includes political and media advocacy, but also professional and community discourse, and organisational change dimensions. These approaches are illustrated in Figure 1.

### 1. Political advocacy

Political advocacy should be a central element of physical activity advocacy. Political advocacy is designed to win the political commitment required for physical activity policy actions (the platform in Step 2). The mounting evidence for the importance of physical activity in chronic disease prevention and its relationship to overweight and obesity is not well understood in political circles. Advocacy has a key role in raising the awareness of decision makers, including health ministers, regarding their key responsibility to fund comprehensive physical activity campaigns and physical activity monitoring. Advocacy for such approaches is understandably directed

at Ministers of Health. However, the cross community nature of physical activity means that physical activity advocacy will often be appropriately targeted at ministers across portfolios and at heads of government. Cross-government engagement in the physical activity agenda is an important objective as policy makers in education, transport, planning, sport and recreation and local government have important roles to play. A wide range of policy decisions can impact on opportunities for people to be active. If physical activity impact assessments were required on policy decisions, possible consequences for physical activity could be identified. Some examples follow.

**Table 1** **A ten point agenda for physical activity**

| Action | Rationale |
|---|---|
| 1. Establish a cross-government structure (a taskforce or council) for physical activity to ensure whole-of-community approaches and highest level leadership. | The establishment of a mechanism for cross-portfolio and cross-community engagement in the physical activity agenda can help ensure participation of policy makers in health, education, transport, planning, sport and recreation and local government. Such a taskforce can provide a mechanism for partnership and intersectoral collaborations. |
| 2. Develop and implement a comprehensive physical activity strategy. | A comprehensive approach that incorporates media, community programmes, policy and environment approaches, and engagement across sectors is required to achieve optimal increases in population levels of physical activity. While each of the points in the 10 point plan have merit, the delivery of a comprehensive strategy is recommended. |
| 3. Ensure appropriate investment of new resources and appropriate re-orientation of existing resources. | Achieving improvements in population levels of physical activity will require significant investment. This can be achieved through new funding or by reorienting existing priorities and the focus of existing policy, programmes and expenditure. For example, greater focus on community recreation in sport portfolios, and greater focus on cycling and walking in transport budgets. |
| 4. Support regular population monitoring of physical activity for adults and children. | Population monitoring on a three-yearly basis will enable insights into trends, successes and failures across time and enable better targeting of initiatives to bring about change where it is most needed. Population monitoring will also provide benchmark data against which progress can be assessed. The goal of supporting regular population monitoring is supported by the World Health Organization in its Global Strategy on diet, physical activity and health (WHO, 2004a). |
| 5. Fund and implement communication and mass media campaigns to promote health benefits of physical activity and its cross-community relevance and importance. | Well researched and implemented mass media campaigns can change community consciousness, awareness, knowledge and behaviour. Such campaigns are most effective when implemented as part of a comprehensive strategy, with adequate and sustained funding. Media campaigns require a bringing together of health promotion and social marketing expertise. |
| 6. Support mass participation through programmes with proven effectiveness. | Programmes, tailored to the needs of specific groups, and to appeal to different ages through the life cycle, increase physical activity. Such programmes need to be located in areas of greatest need and should be accessible and affordable to all. |
| 7. Fund 'active transport'initiatives to increase walking and cycling as transport choices. | Walking and cycling are the most prevalent, popular and accessible physical activities. Walking, cycling and public transport are also environmentally friendly and sustainable choices and can be readily incorporated into the core business of departments of transport. |
| 8. Engage in productive partnerships with those who plan the built environment. | Neighbourhood design, school and building design impact on walking and other physical activities. Health professionals need to engage in partnerships with planning, engineering and architecture professionals. |
| 9. Take a life-stage approach with programmes that target children, young women and mid-age adults. | Within a population approach programmes should be tailored to meet the needs of those in the community most at risk of declining physical activity. Periods in the life cycle where sub-populations are at risk of declining participation include childhood and adolescence, young adulthood (especially in women) and mid-age adulthood.<br>*Children:*<br>Evidence suggests children and schools are amenable to change. Children are greatly influenced by the environment and opportunities that are provided for them by adults<br>*Young women:*<br>Specific attention is required to prevent the sharp decline in physical activity typical in adolescence and early adulthood, and to accommodate the needs of women with dependent children.<br>*Mid-age adults:*<br>With the ageing population the major burden of future chronic disease attributable to inactivity will come from those who are currently mid-age and older adults. |
| 10. Require compulsory physical education, with appropriate standards, quality and teacher training in all schools. | Appropriately designed physical education programmes, and well-trained teachers can increase physical activity and enhance skill learning among children. |

| Policy action | Physical activity consequence |
|---|---|
| • Investment in public transport ➤ | • A plus for walking and cycling |
| • Introduction of daylight saving ➤ | • A plus for afternoon physical activity |
| • Extended trading hours ➤ | • A negative for family, weekend and evening sport and recreation participation and physical activity |
| • Longer working hours and shifts ➤ | • A negative for physical activity, and commitment to regular physical activity. |

Examples of political advocacy:
- Produce and release pre-election platforms outlining key government action needed to support increased levels of physical activity;
- Seek meetings and representations from experts (usually non-government organisations and academics) to promote a physical activity platform;
- Write submissions to relevant government enquiries highlighting physical activity perspectives across the fields of health, planning, transport, education, sport and recreation, environment and local government;
- Advocate for a cross-government approach through the establishment of a physical activity taskforce or council;
- Arrange meetings where politicians can meet visiting physical activity experts (e.g. conference keynote speakers);
- Invite politicians to open or speak at conferences;
- Invite politicians to launch and participate in programmes, and to open new facilities;
- Engage politicians in physical activity initiatives within their own electorates;
- Involve the media. Media opinion is a critical driver of political action;
- Conduct and publish public opinion surveys.

*Example 1: Advocacy for a cross-government strategy (a Physical Activity Taskforce in Western Australia)*

*The challenge of increasing population levels of physical activity will be easier where governments adopt a cross-sector approach. In Western Australia from 1997 to 2001, an advocacy strategy was implemented by the National Heart Foundation of Australia with the goal of seeing the establishment of a cross-Government Physical Activity Taskforce. The Heart Foundation coordinated the preparation of a proposal to Government and sought meetings with Ministers to advocate for the Taskforce. Through this process the Minister for Sport and Recreation was identified as a supporter, and subsequent meetings were held with him to discuss an operational model for the Taskforce. Australian National Physical Activity Conferences and National Health Promotion Conferences were held in Western Australia in 1997 and 1999 and the Heart Foundation arranged meetings between conference keynote speakers and relevant ministers and bureaucrats. Press conferences and media advocacy strategies were implemented in parallel with these activities. The Premier's Physical Activity Taskforce was created by the Government of Western Australia, in June 2001, to oversee the development and implementation of a ten-year whole-of-community physical activity strategy for Western Australia (Physical Activity Taskforce, 2005).*

**2. Media advocacy**

Mass media is an important driver of public opinion and sentiment and an important potential ally for advocates. Strategic use of news media to advance the physical activity agenda can achieve increases in awareness and mobilise support for policy changes that will support physical activity. Physical activity advocates have the opportunity to use the heightened media interest in rising overweight and obesity to promote physical activity as a key part of the solution. For example, in Australia, following the establishment of a government Obesity Taskforce, and the presentation of a national action agenda for children, young people and their families to Australian Health Ministers in November 2003, there was widespread coverage in the Australian media of the importance of physical activity, and school physical education (Commonwealth of Australia, 2003). Similarly, a diversity of issues can be used to provide a frame for physical activity media messages. Community concerns such as neighbourhood planning, environmental issues, obesity and community safety can be used as opportunities to advance physical activity arguments in the media.

Examples of media advocacy:
- Media releases linked with new evidence and science regarding physical activity;
- Media releases attaching a physical activity angle to news in areas such as the environment, planning and transport, overweight and obesity, diabetes, heart disease and cancer prevention stories;
- Media events in connection with physical activity conferences;
- Publicity surrounding physical activity events (fun runs, stair climbs, community walks);
- Media launches of programmes and facilities;
- Letters to the editor;

**Figure 2** **Five dimensions for comprehensive physical activity advocacy**

- Human interest stories highlighting physical activity achievements;
- Releases that attach a local angle and spokesperson to national or global stories;
- Award schemes to publicise and reward best practice.

**3. Professional mobilisation**

While physical activity may not have an overt enemy such as the tobacco industry, it has many potential friends. The physical activity workforce is broad, with representatives from health, education, sport and recreation, planning, transport and other disciplines. These professional 'supporters' may not recognise themselves as part of a physical activity workforce, and much work needs to be done to engage and mobilise them to lend their voice to calls for greater focus on physical activity. Of course such mobilisation is easier when the workforce is well informed and communication is fluid. Rapid and efficient means for communicating information are required to ensure the physical activity workforce is equipped with the evidence and the arguments about physical activity and in relation to current issues, new evidence and breaking news. This also assists in ensuring supporters are speaking with one voice about common advocacy goals. A good example of 'information mobilisation' is the tobacco control e-network *Globalink*. It provides daily news updates and bulletins and a forum for exchange of ideas and information, often about advocacy issues.

The cross-community nature of physical activity underscores the potential for formation of coalitions. Such coalitions have been important drivers for change and can mobilise broad support, as well as third party endorsement.

Examples of professional mobilisation:
- Target professional media and provide up to date and timely information to the workforce through newsletters, e-news, journals and websites;
- Encourage a diversity of professionals through regular information and engagement to consider themselves part of a physical activity movement;
- Mobilise letter writing in support of an issue by providing key arguments and evidence;
- Mobilise submission writing to inquiries that impact on physical activity;
- Provide professional education regarding physical activity and its increasing relevance.

*Example 2: Mobilising support for the WHO Global Strategy on Diet, Physical Activity and Health*

*The World Health Organization's Global Strategy on Diet, Physical Activity and Health represents an important opportunity for increased focus on physical activity globally. Through the late 2003 and early 2004 there was considerable food industry pressure to see the strategy weakened, and to see its focus oriented towards individual responsibility and away from regulation of advertising and industry. Health professionals throughout the world mobilised their efforts in support of the strategy by writing submissions to the WHO and making representations to member-state governments. In the lead up to the WHO's 57th World Health Assembly in May 2004 one professional organisation at the forefront of this advocacy was the International Union for Health Promotion and Education (IUHPE). The IUHPE's World Conference on Health Promotion and Education, held in Melbourne in April 2004, provided a forum to bring together the leading authorities to present and discuss the Global Strategy. The IUHPE at its General Assembly on 29th April 2004 passed a resolution to support the Global Strategy. The resolution recognised the growing burden of non-communicable disease and the special role of nutrition and physical activity initiatives. The IUHPE fully supported the Global Strategy and noted that it was important and timely for global public health. The IUHPE urged its full adoption by the 57th World Health Assembly. The Global Strategy on Diet, Physical Activity and Health was adopted on 21st May 2004 (WHO, 2004).*

**4. Community mobilisation**

Many thousands of community members participate in physical activities ranging from traditional sport and recreation to walking and cycling for transport and recreation. The wide participation in physical activity offers a unique opportunity for community mobilisation, to engage the large numbers of supporters across the community for physical activity causes. Through community mobilisation advocates may build a groundswell of support and sentiment.

Examples of community mobilisation:
- Mobilise letter writing to politicians, councillors, the media, or school principals in local communities to argue for improved facilities, programmes and environmental supports;
- Establish a process for path audits providing walkers with a mechanism for providing feedback to Councils on facilities and hazards;
- Arrange public meetings to advocate for improvements in programmes or infrastructure, e.g. Improved walking and cycling access around schools.
- Mobilise allies such as sporting club members and parents from junior sport clubs to engage in local advocacy.

**5. Advocacy from within (reorienting) organisations**

A frequently overlooked element of advocacy for change is advocacy from within organisations. In order for change to occur in the orientation of organisations, or the priority it affords to physical activity, advocacy may be used to target organisational structures, committee membership, funding priorities, and strategic and operational planning processes. Government employees often feel unable to participate in advocacy processes; however, they are uniquely placed to promote and disseminate new information and lead dialogue within their departments and advocate from within.

Examples of advocacy from within:
- Know your board and committee members and ensure they are well informed on physical activity issues;
- Identify external champions and encourage their invitation to Boards Committees and decision-making structures;
- Identify internal champions and cultivate them;
- Get a spot on the agenda and use it;
- Don't just present issues and reports, win commitment to follow-up actions;
- Mobilise internal supporters;
- Appreciate the power of organisational change;
- Be persistent, change seldom happens at the first attempt.

Reorientation of an organisation's priorities or changing its structures to better address physical activity is an important and sustainable goal of physical activity advocacy. Reorienting

services is a key principle of health promotion articulated in the Ottawa Charter (WHO, 1986). In the health sector such reorientation refers to providing greater focus on primary prevention and health promotion relative to curative services. Reorientation of priorities and services to better support physical activity can also be achieved in other sectors. Examples of this are illustrated in Table 2.

## Who should advocate?

Each of the advocacy strategies above can employ a range of participants. Just as the strategy mix is broad, so too advocacy can involve many players in different roles. Some of these are listed in Table 3.

In addition to the above there is a special role for talented, passionate and articulate individuals who make themselves available to lead the charge for physical activity advocacy. Many successes in public health advocacy have been characterised by identifiable key individuals or 'spark plugs' that have played a key role in igniting the passion in others, and sparking change (Pertschuck M., 2001). Physical activity needs such individuals to take international leadership in physical activity advocacy.

This paper has described a model for understanding and mobilising physical activity advocacy. It outlines a three-step process to gather and translate new and compelling evidence, develop from the evidence a physical activity advocacy agenda or plan, and then implement a coherent mix of advocacy strategies to influence and mobilise support for the physical activity agenda. This is a major undertaking.

Advocacy should be a priority strategy for those seeking to advance physical activity globally. Such advocacy will strongly communicate the arguments and convincingly propose solutions. This will require a long-term and sustained effort.

**Table 2** **Reorientation of priorities and services to promote community physical activity**

| Sector | Reorientation that would promote community physical activity |
|---|---|
| Sport and recreation | Reorient focus from elite sport to participation in walking and moderate recreational physical activity in neighbourhoods |
| Health | Reorient focus to prevention and health promotion services and policies |
| Transport | Prioritise walking, cycling and public transport in transport policy |
| Planning | Give priority to design codes that promote walkability, community recreation, and enhanced active choices in neighbourhoods, schools and the built environment |
| Education | Prioritise physical education, sport education, fitness and active-school environments |
| Local Government | Prioritise physical activity principles in planning and programming in recreation and community development |

**Table 3** **Who should advocate?**

| Stakeholders | Suggested advocacy roles |
|---|---|
| (a) Non-government organisations | Lead political and media advocacy from outside government. This can be delivered by individual non-government organisations (NGOs) through coalitions of agencies or dedicated small groups established for advocacy purposes. NGOs often engage academics in advocacy. |
| (b) Academics | Lead the gathering and provision of evidence, and assist with political and media advocacy. |
| (c) Government employees/public servants | Lead 'advocacy from within' and assist as appropriate with political and media advocacy. |
| (d) Champions | Community leaders and prominent individuals can be identified and recruited to act as spokespersonsand role models. |
| (e) Professionals | Physical activity has a broad workforce from across sectors which can be mobilised to engage in physical activity advocacy. |
| (f) Public | Physical activity can draw on a very broad community supporter base. This includes sporting club members, parents of juniors, rate payers, walking group members. Each of these can be mobilised at the local level to represent physical activity positions through letter writing, attendance at forums, events, etc. |

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