

PERSPECTIVES FROM THE FIELD

ADVOCACY IN HIA: INCREASING OUR EFFECTIVENESS AND RELEVANCE AS PRACTITIONERS TO ADDRESS HEALTH, EQUITY, AND DEMOCRACY

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Abstract:

The role of advocacy in Health Impact Assessment (HIA) is debated among practitioners. Concerns revolve around whether engaging in advocacy undermines objectivity and credibility. While there is agreement that dissemination of findings and recommendations is necessary, there is a spectrum of activities that can be undertaken in an HIA, one end of which might be considered advocacy.

In this *Perspective from the Field*, We posit that in conducting an HIA, practitioners are choosing to advocate for a set of causes that may include improved health, decreased inequity, and increased democracy. We come to the table with these values and the intent to advocate for them. For any HIA to be relevant and effective at advancing these causes in decision-making contexts, practitioners must use the best available evidence *and* a range of strategies to communicate evidence to policy audiences, including deliberate tactics with community organizations, decision makers, and others that can aid in addressing power imbalances. Though we believe that HIA practice cannot reach its full potential without embracing advocacy, practitioners must make decisions given their context, including local power dynamics as to how far into the advocacy spectrum they venture in any given HIA.

This paper is geared towards HIA practitioners and others who want to understand the opportunity advocacy provides. We begin by describing the underlying values of HIA that inspire this perspective, including those in the 1999 Gothenburg Consensus Paper on HIA (Quigley et al., 2006). After briefly describing concerns HIA practitioners may have with advocacy, particularly that it undermines the objectivity and credibility of the HIA process, we then discuss common advocacy activities practitioners might undertake, and ways to address risks these activities may pose. These opportunities to undertake advocacy include partnering with diverse stakeholders, developing advisory committees, gauging the power and policy context, and thinking broadly about the best tactics to effectively communicate findings. We conclude with a case study describing how advocacy was used in the Treatment Instead of Prison HIA in Wisconsin to advance health, equity, and democracy.



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Introduction

The 2014 *Minimum Elements and Practice Standards for Health Impact Assessment* open by describing the goal of HIA:

“Health Impact Assessment (HIA) is a practice that aims to protect and promote health and to reduce inequities in health during a decision-making process” (Bhatia et al., 2014, p. 1). As practitioners seeking to accomplish this goal, we recognize that use of sound science is necessary. We also recognize that it is not sufficient; in our perspective, advocacy is also necessary.

Advocacy is defined by Merriam-Webster as “the act or process of supporting a cause or proposal” (Retrieved 2015, from <http://www.merriam-webster.com/dictionary/advocacy>) and a variety of activities within HIA can be judged as advocacy [see Box 1]. Advocacy may be seen as the involvement of stakeholders with a pre-determined position in the HIA and giving them control over aspects of the HIA. Communications and dissemination activities are also often characterized as advocacy, most often when the HIA is used to influence the outcomes of a decision, for example through direct or grassroots lobbying [see Box 2].

The appropriateness of these activities is debated among practitioners (Advocacy in HIA Working Group, 2013). Layered on the debate are questions about the relationship between advocacy and research objectivity, bias, and neutrality. We posit that in order for most HIAs to be relevant and effective at protecting and promoting health and reducing inequities – as well as advancing democracy, another core value of HIA – in the context of a decision-making process, it is necessary for HIA practitioners to engage in advocacy to influence how decisions are made. Many HIAs that we and others have conducted have failed to affect decision making as a result of our limited engagement with the decision-making process.

We believe this is because those who benefit from current inequities and limitations on democracy are powerful forces

and, in the face of these forces, data by itself does not lead to change. This is evident in a wide range of policy debates, from gun control to climate change, and from healthy food access to access to paid sick days. As Congressman Henry Waxman says, “When you look back on key legislative fights over public health issues, you will see that the expertise

and advocacy of public health professionals provide a critically important counter pressure to the lobbying clout of special interests. The grassroots efforts by the public health community help educate legislators and play a pivotal role in our legislative efforts to improve the health of the people of the United States” (American Public Health Association, 2005, p. 5).

Practitioners, therefore, must often use the best available evidence *and* a range of strategies to communicate the evidence to various policy audiences, including deliberate tactics with community organizations, decision makers, and other stakeholders that can aid in addressing power imbalances. There are barriers and risks to conducting advocacy, but there are also opportunities throughout the HIA process to overcome and allay those.

This paper is geared towards HIA practitioners and public health professionals who want to understand the opportunity advocacy provides to advance a more effective and relevant HIA practice. We begin by describing the larger context of HIA practice that drives this perspective, barriers to engaging in advocacy, and opportunities and best practices to conduct advocacy in the context of HIA. We end with a case study describing how advocacy was used in an HIA in Wisconsin to advance health, equity, and democracy.

Box 1. Examples of Advocacy Activities within HIA

What is perceived as advocacy varies based on the institutional context of practitioners. Most commonly, however, advocacy is perceived as how stakeholders are engaged in the process and in HIA communications and dissemination. Below we describe activities that may be considered to be advocacy within HIA.

Stakeholder Participation

Including stakeholders, such as those who have a pre-existing position on a proposal, in the HIA process

Prioritizing the HIA goals and research questions based on the interests of stakeholders

Using assessment methods (e.g., Community-based Participatory Research) that are directed by only some stakeholders

Prioritizing recommendations based on the interests of stakeholders

Giving stakeholders decision-making authority over the process

Inclusion of impacted populations and communities facing inequities – who are perceived as having a predetermined position – in the HIA process

Fostering coalition and consensus building within HIA

Communications and Dissemination

Public release of findings and recommendations

Proactive outreach to highlight and translate findings and recommendations to decision makers, media, and/or stakeholders

Responsiveness to informational and educational requests from decision makers, media, and/or stakeholders

Publicly highlighting and translating evidence via interviews, letter writing, public testimony, and other activities

Working with stakeholders to build their capacity to use HIA findings and recommendations in decision making venues

Direct lobbying of decision makers to encourage support or opposition of a specific action

Grassroots lobbying of the public to encourage support or opposition of a specific action

Foundations of our Perspective

Health Impact Assessment is shaped by a set of foundational values and concepts, and that inspire our perspective that advocacy is essential to the field’s success. The 1999 Gothenburg Consensus Paper on HIA and the 2006 International Association for Impact Assessment Special

Publication on HIA (Quigley et al., 2006) define values that guide the practice: democracy, equity, sustainable development, ethical use of evidence, and comprehensive approach to health. The Gothenburg paper contextualizes these values by stating that: “All policy processes are carried out in the framework of values, goals, and objectives that may be more or less explicit in a given society and at a given time. It is essential that such values are taken into account, otherwise HIA runs the danger of being an artificial process, divorced from the reality of the policy environment in which it is being implemented” (p. 4) As practitioners, these explicit and motivational values – and the worldview they represent – inspire us to be part of the field.

The World Health Organization’s Commission on Social Determinants of Health Final Report (World Health Organization, 2008) provides guidance as to what equity and democracy mean in wider public health practice: “Any serious effort to reduce health inequities will involve political empowerment – changing the distribution of power within society and global regions, especially in favour of disenfranchised groups and nations.....Health equity depends vitally on the empowerment of individuals and groups to represent their needs and interests strongly and effectively and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources (the conditions for health) to which all men and women, as citizens,

have equal claims and rights” (p. 18). In other words, both the process of empowerment within the democratic process and the power accumulated by groups currently without power are considered central to the pursuit of health equity.

In accepting a set of values to motivate our practice, practitioners acknowledge that we inherently reflect a set of cultural norms and worldviews in our work; foremost among these worldviews is that research should inform policy making. As stated by Michael Nelson, professor of environmental ethics and philosophy at Michigan State University, “advocating for the use of science and for revealing the discoveries of science, as well as for specific policy positions are forms of advocacy. Simply because the former is uncontroversial does not mean it is not a form of advocacy, it most certainly is. So in some ways the question is not, is advocacy acceptable, but which kinds of advocacy are

acceptable and, most importantly, how ought we to go about advocacy....” (Nelson, n.d.). Indeed, a recent Pew study that found, “a large majority of the public (76%) and nearly all scientists (97%) say that it is appropriate for scientists to become actively involved in political debates on controversial issues such as stem cell research and nuclear power.” (Pew Research Center for the People & the Press, 2009, p. 34).

In choosing to conduct an HIA, practitioners are either consciously or unconsciously choosing to advocate for a set of causes including improved health, decreased inequity, increased democracy, and empowerment. These values – or causes – are not neutral. They reflect a world with a set of policy outcomes and decision-making processes that are different from our current policy climate. The transition to this better world will not occur naturally, even if the evidence points towards it. Powerful social forces, including dominant

interests, entrenched ideas, and disenfranchisement – that converge to maintain the status quo – need to be overcome. Advocacy is a necessary, though not sufficient, tool that can motivate policy makers to overcome these forces and advance health, equity, and democracy.

Concerns with and barriers to engaging in advocacy

Some within the HIA field have expressed unease with a wider perspective of advocacy, particularly that a practitioner engaging in advocacy undermines the objectivity and credibility of the HIA process,

findings, and recommendations and may also reflect the biases of researchers (Advocacy in HIA Working Group, 2013). Concerns can be summarized as follows: engaging in advocacy makes the practitioner seem biased and engaging with others who advocate makes the practitioner biased by extension; scoping and assessing topics based on the priorities and concerns of historically impacted communities may lead to particular findings and recommendations that deviate from the dominant worldview; taking a position is not appropriate when practitioners may not know or understand the universe of competing priorities or unintended consequences related to a decision; and having our role as neutral public health practitioners evolve from informing to advocating to lobbying is potentially problematic.

Our perspective is that these concerns are based on perceived risks that can be addressed in the HIA process. While

Box 2. Advocacy and lobbying.

Direct lobbying: attempts to influence a legislative body through communication with a member or employee of a legislative body, or with a government official who participates in formulating legislation. The communications must refer to and reflect a view on the legislation (Internal Revenue Service, 2015).

Grassroots lobbying: attempts to influence legislation by attempting to affect the opinion of the public with respect to the legislation and encouraging the audience to take action with respect to the legislation. The communications must refer to and reflect a view on the legislation (Internal Revenue Service, 2015).

According to the American Public Health Association:

“How is lobbying different from advocacy?” Advocacy is participating in the democratic process by taking action in support of a particular issue or cause. Advocacy activities like participating in a town meeting or demonstration, conducting a public forum or press activity, or developing an issue brief for your local policy-makers on a particular public health issue do not constitute lobbying as long as you are not urging a policymaker to take a position or action on specific legislation (American Public Health Association, 20015)

we recognize that these concerns are authentic and real (e.g., both laws and funding sources may limit one's ability to engage in lobbying), one can carry out a sound HIA and advocate for an HIA's findings and recommendations with actions intended to maintain the integrity of the practice.

Advocacy reflects a spectrum of activity (see Box 1), the range of which reflects the institution in which a practitioner is situated. Public health professionals, in particular, face numerous barriers to conducting advocacy, including risk-averse agency leadership, political resistance from elected officials, lack of relationships and understanding of other policy domains, and a lack of capacity and resources. Public health is also disconnected from movements to advance equity and democracy, and unclear about how to contribute to these movements. Addressing these constraints is beyond the scope of this paper or the responsibility of any individual HIA practitioner; however, efforts exist to overcome them (National Association of County and City Health Officials, 2014; Farhang, Heller, Levey, & Satinsky, 2015).

Opportunities to conduct advocacy in the context of HIA

There are a number of best practices we can undertake as practitioners to minimize potential sources of bias and to legitimize our advocacy activities. Primary among these is to be transparent about every aspect of the HIA process, including funding sources, partners and their roles, research approach, and decision-making processes. Information about these should be included in the HIA report and all other communications about the findings and recommendations.

Below, we delve more deeply into opportunities to conduct advocacy in the context of HIA, the potential causes of concern, and best practices to conduct an effective and relevant HIA that leads to improved health, equity, and democracy.

Partner with a diverse set of stakeholders, including those most likely to be impacted by the decision, to conduct the HIA

Some stakeholders, including community organizations, are often perceived to be advocates – and therefore biased – because they might be seen as having a position, use various tactics to get the attention of decision makers, and engage with populations that will be impacted by the decision. Other stakeholders' motivations, in contrast, are not scrutinized in the same way, either because their perspective aligns with the dominant worldview or because we do not even recognize that they are exerting control over the public agenda (Gaventa & Cornwall, 2001).

Often, there are different degrees of power among these various stakeholders. For some HIA practitioners, redressing this imbalance of power – i.e., empowerment as discussed by the WHO's Commission on Social Determinants of Health – in a particular decision-making context may be a goal for the HIA, a goal that should be transparently

stated. Partnership with disenfranchised groups, for example through a community organization, in the HIA process may be considered a way to advance empowerment, democracy, and equity.

Establishing a stakeholder oversight/advisory committee composed of people with variety of experience, including vulnerable populations most likely to be impacted by the decision at hand, to guide the HIA is good practice. By including people with varied experience, the HIA can represent different perspectives and be used to build consensus and relationships, which helps address past disenfranchisement. Establishing such a diverse committee can also address advocacy concerns around partnership with a community organization, as other members may be seen as contributing balance and scientific rigor. The HIA should be transparent about the membership of the committee and the committee's role in the HIA process.

Work jointly with an Advisory Committee to select and assess research topics

As with any research, HIAs require topic prioritization given budget and time constraints. One might believe that public health professionals, who have training and familiarity with the peer-reviewed literature, are in the best position to prioritize research topics. Focusing on topics with which stakeholders – especially members of impacted communities – are most concerned may be considered a form of advocacy, as it prioritizes some topics for research over others and de-prioritizes public health expertise.

However, focusing on topics of importance to stakeholders ensures that an HIA is adding value by responding to unanswered questions. Furthermore, while public health professionals bring their expertise to the HIA process, other stakeholders also have legitimate and valuable expertise; community members, for example, can inform the process with their lived experiences. Last, topics not well studied in the peer-review literature are still valid if they are of concern to stakeholders. The research priorities of many stakeholders make an HIA more robust. Again, transparency is important; the HIA should clearly state which topics were prioritized and deprioritized and why.

In the assessment phase, it is crucial that practitioners do not let their own or stakeholder's pre-conceived notions influence their findings on any of the selected research topics. Guided by the value of ethical use of evidence and the *Practice Standards*, (Bhatia et al., 2014), practitioners must consider evidence that both support and refutes particular impacts, acknowledge insufficient evidence when that is the case, and communicate that predictions are not definitive but based on best available evidence. Review by stakeholders and by professionals not affiliated with the HIA can be useful for identifying potential sources of bias and conclusions that are not supported by the evidence. These potential pitfalls and best practices are important in any HIA, not just those in which stakeholders such as community members

are heavily involved.

Gauge the power and policy context in determining the best strategy for taking a position

Coming to a decision at the conclusion of the assessment phase, after examining and weighing the evidence, about the benefits and harms of a proposal, and generating a set of recommendations, means we are not neutral. HIA recommendations are meant to maximize the benefits and minimize the harms. During the reporting phase, some might consider taking a position on the proposal to be a form of advocacy, believing that an “objective researcher” would let the evidence speak for itself.

However, if the research was carefully conducted and leads to clear conclusions about positive or negative impacts on health and equity, and if the HIA practitioner’s goal is to improve health and reduce inequities, it is important that the practitioner communicate clearly about the evidence and its conclusions. Evidence cannot speak for itself.

This can lead to practitioners taking a position on all or part of a proposal, or being perceived as doing so. While some practitioners may be able to take a position and conduct advocacy based on that position and find that this helps achieve health- and equity-promoting change, others (e.g., those working in government agencies) may be constrained from doing so by their institutions or by lobbying regulations (e.g., they may not be able to communicate their views directly to decision makers). In some cases, other stakeholders who were part of the HIA process may take positions and lead advocacy efforts. These are all acceptable practices.

Importantly, practitioners should consider that they may not understand the full context of the competing priorities and choices faced by decision makers. For example, recommending in an HIA that a project not move forward in a particular community might just mean the project moves forward in another community not studied in the HIA. Given this, practitioners must be attuned to uncertainty in our research, be aware that advocating for HIA recommendations or taking a position could have unintended consequences, and consider how best to account for this in developing recommendations (e.g., by discussing potential recommendations with decision makers when appropriate).

Furthermore, if there is insufficient evidence to reach clear conclusions, the HIA should state so and communications about the findings should not overreach in those areas. Communicating the lack of clear findings can also be informative for decision makers and may, for example through recommendations, point to policy options with more certain impacts.

Finally, after doing several HIAs on similar proposals over time, whether the topic is food accessibility or criminal justice, an HIA practitioner is likely to develop a knowledge base around a set of topics, and may be able to come to a conclusion and/or take a position on a proposal before

completing the HIA. Researching the local context with respect to a proposal and understanding the differences with previous contexts and proposals is important for minimizing bias and before taking a position.

Think broadly about the best tactics to effectively communicate findings

Translation and communication of findings and recommendations in the decision-making process – and to audiences to whom decision makers listen – may be considered advocacy by some. Most practitioners make active efforts to inform decisions, which include, for example, sharing the HIA report and summary materials extensively, letter writing, hosting public meetings, and disseminating products to the media. Some might define these information-sharing activities as advocacy.

At a minimum, practitioners have a duty to produce a publicly accessible report and distribute it to decision makers and other stakeholders. Practitioners should also be willing to interpret and assist stakeholders to accurately use findings and recommendations. Speaking to decision makers, the media, and other stakeholders fulfills this objective. Beyond that, the range of activities in which a practitioner can engage will be construed by their institution and may be considered advocacy. There is no reason classifying such activities as advocacy should delegitimize them.

Some practitioners are concerned that testifying publicly or speaking with decision makers is lobbying and are concerned with overstepping legal limits. Lobbying has specific legal definitions (see Box 1) which vary by jurisdiction and which practitioners must understand. Lobbying restrictions must be followed. Conflating all advocacy with lobbying is counter-productive.

There is validity in asking whether it is in the best interest of improving health, and advancing equity and democracy, if an HIA practitioner takes a position on the proposal and plays a lead role communicating that position. In some contexts, the HIA practitioner may be seen as a “professional expert” and their voice can carry a significant weight. In other contexts, they may be seen as an interfering outsider and their leadership may be counter-productive. Ultimately, understanding context is integral to making the most of advocacy efforts and advancing opportunities – ones that have minimal negative consequences – to achieve HIA goals and align with practice values.

Case Study: Treatment Instead of Prison HIA

To elucidate what advocacy to promote health and reduce inequities looks like in the context of a specific HIA, we describe here the *Treatment Instead of Prison HIA* (Gilhuly, Farhang, Tsui, Puccetti, & Liners, 2012). In 2012, Human Impact Partners partnered with WISDOM (a statewide congregation-based organizing network based in Wisconsin), state agencies, academics, and other experts to conduct an HIA to assess the health effects of increasing funding in the

state budget for Wisconsin's treatment and diversion programs from \$1 million a year to \$75 million a year. Wisconsin, like other states, was incarcerating growing numbers of non-violent drug and alcohol offenders and had stark racial disparities in sentencing. WISDOM was campaigning to cut Wisconsin's prison population by expanding access to treatment programs and the HIA was conducted to understand the impacts these alternatives would have on incarceration. The HIA and other efforts led to a quadrupling of state funding in Wisconsin for treatment alternatives to prison.

In each phase of the HIA, HIP worked to ensure the process was responsive to our values of equity, democracy, and empowerment. From the start of the project, we carried out the process to maximize the advocacy for policy change based on our findings and recommendations:

Project management: HIP and WISDOM convened an Advisory Committee comprised of academics, researchers, and public agency staff to guide the HIA, evaluate the science to make sure the interpretation of information was accurate, and help develop recommendations grounded in the legislative and administrative reality of the state. Members of the Advisory Committee became natural spokespeople and advocates for the HIA's recommendations.

Screening: With WISDOM, we chose to conduct an HIA on a topic for which there were already constituencies engaged; it was a topic that was relevant and meaningful to people. This interest in the topic created a demand for the research and an audience interested in receiving and using the results. These audiences hoped the research would support their campaign, but were taking a risk that it might not. They were also open to changing their policy requests based on the HIA findings.

Scoping: The topics on which the HIA focused were based on questions about determinants of health that the Advisory Committee, WISDOM, and its community constituents – including those formerly incarcerated and their families – thought would have the largest impact on health and on the debate. Answering research questions prioritized by these partners increased the likelihood that stakeholders would use the research in the decision-making process and decision makers would therefore pay attention to the findings.

Assessment: The research process drew on multiple sources of information, including the experience and expertise of formerly incarcerated people, their families, service providers, law enforcement, and judges. For HIP and the Advisory Committee, including the voices of these stakeholders was important from an empowerment perspective and because published studies may not have examined some of the prioritized research questions thoroughly.

The evidence from the literature used reflected the consensus of researchers across multiple disciplines who participated in the HIA process about the potential impacts of the proposal. These researchers participated in meetings to review the evidence and reviewed the draft report.

Recommendations: The recommendations identified were responsive to the impact predictions and – because of the Advisory Committee's local knowledge – reflected the administrative and legislative reality of the state. Because stakeholders involved sought the best outcomes for their communities, they were committed to identifying feasible and actionable recommendations for which they could advocate.

Reporting: Findings and recommendations were summarized into easily digestible materials for decision makers to consider and stakeholders, including community members, to use in the decision-making process. While HIP participated in press briefings and media interviews to explain the HIA process and findings, our perspective was that community members would be the most effective spokespeople to communicate to decision makers and advocacy on their own behalf advanced the goal of empowerment. Through this model, where local voices spoke to the findings and recommendations, there was significant press coverage of the HIA. HIP was transparent with all stakeholders throughout the HIA process and in the final products about who funded the HIA, who was involved, and how the topics and research categories were selected.

Through the research, we found overwhelming evidence that expanding alternatives to incarceration would reduce the prison population, reduce crime, lower recidivism, and strengthen families by keeping up to 1,600 parents a year out of prison each year. Because studies showed that the cost of treatment was about one-fourth of the cost of incarcerating people, we found that the state would also save up to two dollars for every dollar spent on alternative treatment programs.

Based on an internal evaluation that included interviews with key partners, the HIA was a success on multiple levels. It had a tremendous impact on the conversation around treatment over incarceration in Wisconsin. Every major media outlet in the state covered its release, with over 30 news stories about it. In addition to the quadrupling of funding, legislators from both parties have pledged continued support for future funding increases. WISDOM continues to use the research in meetings with legislators, strengthen relationships with the public health community, organize their communities, and keep the issue in the media spotlight. Decision makers and the state budget were directly affected by the HIA findings and recommendations; there was a shift in the narrative around what affects health; new collaborations were formed; community members felt empowered by the experience of participating in the process; and the HIA continues to contribute to the dialogue around incarceration in the state.

Success resulted from the HIA process and the advocacy it supported. Because the project sought to answer a set of socially meaningful and relevant questions, WISDOM's organized constituencies – including citizens, clergy, prosecutors, judges, and service providers – were motivated

to integrate the findings and recommendations into their campaign. The approach also helped legitimize the research for decision makers, who, while caring about the underlying evidence, also cared to see a broad network of community, academic, and other stakeholders bought into the research. Had we not conducted the HIA to advocate for our causes of health, equity and democracy, the HIA may not have had as significant an impact.

The model of the *Treatment Instead of Prison HIA* is reflected in many of our other projects and has resulted in similar successes. In our *Farmers Field HIA* (Lucky, Satinsky, & Nasser, 2012) and our *University of Southern California HIA*, (Lucky & Heller, 2012) community organizations participating in the HIA used research findings to leverage housing, job, and health mitigations via legally binding community benefit agreements. Our *Jack London Gateway HIA* (Heller, 2007) led to changes in the design of a local development to address identified health impacts. Based on these successes, others, including government agencies (Pew Charitable Trusts Health Impact Project, 2014), are also beginning to conduct more advocacy in their HIAs as well. In all of these examples, various forms of advocacy – relevance of the topics of focus to local community stakeholders, empowerment of those groups through the HIA, and the direct and organized use of findings and recommendations in the decision-making process – led to successful HIA outcomes

that may not otherwise have been realized.

Conclusion

Working within a policy context, and driven by a set of foundational values, we must be thoughtful about how we, as practitioners, can be most effective at accomplishing the wider goal of HIA – to protect and promote health and to reduce inequities in health. While we cannot expect that the answers will be the same in all situations and that all practitioners will engage in the same activities, the success of the Wisconsin *Treatment Instead of Prison HIA* and other HIAs provide an example of how advocacy can be woven throughout the HIA process in such a way as to increase its relevance, use, and ultimately its efficacy in the policy-making domain.

The model of HIA described here, that combines sound science with advocacy for health, equity, and democracy, can lead to public health becoming a model of accountable and effective government. While HIA practitioners rely on empirical data, we know that data alone is not enough to influence the policy process. Context, ideas, and power matter.

The process and product of HIA can empower vulnerable populations most likely to be impacted by decision making and start to reform the structures and institutions that currently result in inequity. But data alone will not do this. Data need advocates.

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