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A Qualitative Study of Barriers and Facilitators of Health Advocacy in Iran

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Abstract

Background and Objective:

Health advocacy is a cornerstone of health promotion, social justice realization, and intersectoral collaboration in international documents. In low- and middle-income countries, the challenges and opportunities of public health advocacy are critically important for injury prevention and community health promotion. This study aimed to identify and analyze the barriers and facilitators of health advocacy at individual, organizational, and structural levels.

Methods:

This qualitative study employed the Braun and Clarke thematic analysis approach. Participants included 36 senior managers and experts from the health sector (61.1%), other governmental institutions (33.3%), and non-governmental organizations and media (5.6%), who were selected through purposive maximum-variation sampling followed by snowball sampling until theoretical saturation was achieved. Data were collected via in-depth semi-structured interviews and analyzed using MAXQDA 2024 software.

Results:

Data analysis and extraction of 151 final codes revealed six themes related to barriers and five themes related to facilitators of health advocacy. The barriers comprised: (1) structural and legal barriers; (2) economic barriers and competing priorities; (3) organizational behavior and managerial culture; (4) erosion of social capital and weakened demand-making; (5) political barriers and intersectoral interaction; and (6) cultural and social barriers. The facilitators were categorized into five themes: (1) individual agency and persuasive capabilities; (2) social participation and the role of civil institutions and media; (3) influence tools and strategic incentives; (4) scientific and cultural strategies; and (5) institutionalization and policy-making.

Conclusion:

Enhancing the effectiveness of health advocacy requires a transition from individual and unstable actions toward structural institutionalization, establishing designated organizational positions, strengthening legal and judicial supports, and empowering managers in negotiation skills and evidence translation. Integrating these components within active health advocacy secretariats can provide a contextualized and sustainable foundation for strengthening public health and structural justice.

Introduction

Public health advocacy is recognized as a fundamental pillar in health promotion and the realization of health equity in societies..(1) The World Health Organization's Health Promotion Glossary defines advocacy as "a combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems backing for a particular health goal or program.". (2) The concept of advocacy has been introduced as one of the foundations of health promotion in authoritative international documents such as the Ottawa Charter and the CompHP (Competencies for Health Promotion) European framework..(3, 4)

Health advocacy encompasses a wide spectrum of actions, ranging from supporting individual patients in navigating the health system to influencing macro-level policies and structural changes.. (5, 6) This necessitates the application of effective strategies to engage key stakeholders, influence decision-makers, raise public awareness, and shape social discourse .(7) All PHC providers, given their professional commitment to being responsive to the health needs of the population, are expected to advocate not only for individual patients but also for improving the health status of communities through public policy-making.(8) Although many health professionals possess high levels of motivation and a sense of professional commitment to translate their knowledge and experiences into effective actions for reducing existing harms, only a few consider themselves adequately qualified and prepared to actively engage in advocacy processes.(9)

Although numerous studies have addressed health advocacy, the majority of this research has been conducted in developed countries(10–26), and in developing countries (27, 28) particularly in Iran(29, 30) there is limited evidence regarding the influence of contextual and structural factors on the enactment of this role. Moreover, most advocacy research has primarily focused on specific areas such as tobacco control (31–36), mental health(28, 37–39), gambling(40, 41), or nutrition(11, 13, 14, 42, 43), with less attention given to common patterns of barriers and facilitators(20, 27, 44) across diverse health domains.

Given the growing complexities in public health and the necessity of applying interdisciplinary and intersectoral approaches in health governance, the systematic identification and analysis of facilitators and barriers to advocacy are of particular importance(1, 45, 46). Considering the chronic challenges of Iran's health system—such as budget constraints, organizational duplication, and the pressure of sanctions—the implementation of effective health policies requires interdisciplinary approaches and intersectoral collaboration. Nevertheless, there exists a considerable gap in understanding the barriers to and facilitators of an advocacy culture within the local context. This study was designed to identify, categorize, and analyze the barriers and facilitators of health advocacy in the context of developing countries, based on scientific evidence, and seeks to address the key factors at individual, organizational, and structural levels. The findings can serve as a foundation for developing practical frameworks and enhancing the effectiveness of advocacy actions.

Methods

1. Study Design

This study employed a qualitative approach using the thematic analysis method proposed by Braun and Clarke(47) This method was selected due to its capacity to identify patterns of meaning within participants' experiences and perspectives, and to elucidate the complex dimensions of social phenomena, including health advocacy. Thematic analysis allowed for the examination of data without reliance on pre-determined theoretical frameworks, enabling the researchers to extract and organize context-relevant concepts from the collected data.

2. Study Population and Participants

The study population comprised key managers and experts at both intra-sectoral and extra-sectoral levels. The intra-sectoral participants included managers and experts from the University of Medical Sciences, the Deputy of Health, and the Health Network. The extra-sectoral group included representatives from the Governor's Office, the Municipality, the Department of Environment, the City Council, the District Administration, and the Department of Natural Resources. Additionally, environmental activists and local media journalists—as influential groups in awareness-raising and social demand-making—participated in the study.

3. Sampling Method and Sample Size

Purposive sampling with a maximum variation approach was employed to ensure coverage of diverse perspectives and experiences from various groups involved in the subject, ranging from senior executive managers to representatives of the local community. Subsequently, snowball sampling was used to identify key individuals within the intersectoral interaction network.

Data collection continued until theoretical saturation was achieved—meaning that in the final three interviews, no new data leading to the emergence of new codes or concepts were obtained. A total of 36 individuals participated in the study, and none of those invited withdrew from cooperation. The demographic characteristics of the participants are presented in Table 1.

4. Data Collection Tool and Procedure

Data were collected through semi-structured interviews with 36 participants. The interview guide was developed by the research team based on a review of relevant scientific literature and included open-ended questions to explore participants' understanding, experiences, and perspectives regarding health advocacy and intersectoral collaboration. Key questions included:

1. How do you define health advocacy, and what experience do you have with it?
2. In your view, what are the most significant barriers to intersectoral collaboration in addressing health issues, such as problems related to landfill sites?
3. What local capacities or resources have been underutilized that could play a role in health advocacy?
4. How do you assess the role and degree of influence of each local stakeholder in this process?

Prior to the main interviews, the interview guide was piloted in two test interviews with individuals outside the final sample. Following the necessary revisions, the final version was used.

Interviews were conducted at participants' workplaces or at locations of their choice, under appropriate conditions to ensure privacy. Each interview lasted between 45 and 60 minutes. All interviews were recorded using two audio recording devices and were fully transcribed within a maximum of 48 hours post-interview. Field notes—including the researcher's observations of non-verbal interactions and the interview environment—were recorded and considered during data analysis. No changes were made to the data collection process or tools during the study.

5. Data Analysis

Data analysis was performed using Braun and Clarke's (47) thematic analysis method with the assistance of MAXQDA 2024 software. The analysis process comprised the following stages:

1. Repeated reading of interview transcripts to achieve deep familiarity with the data;
2. Generating initial codes from relevant data segments;
3. Organizing codes and forming initial themes;
4. Reviewing and refining the extracted themes;
5. Defining, naming, and explicating the content of final themes;
6. Producing the final report, including themes, sub-themes, and selected participant quotations.

Throughout the analysis process, the developed codes and themes were continuously reviewed and compared to maintain logical coherence among analytical components. Ultimately, the findings were organized into a set of main and sub-themes reflecting the various dimensions of challenges and facilitating factors in health advocacy.

6. Trustworthiness and Rigor

To ensure the quality and credibility of the findings, the trustworthiness criteria for qualitative research were addressed through the following measures:

Member Checking:

A summary of the initial findings and extracted themes was provided to eight participants with diverse backgrounds. Their feedback on the extent to which the findings aligned with their experiences was obtained, and suggested revisions were incorporated as needed.

Peer Review and Inter-coder Reliability:

Three members of the research team independently coded portions of the data. The coding results were then reviewed in joint sessions, and any disagreements were resolved through discussion and consensus among the researchers.

Auditability:

All stages of the research—including audio files, transcribed interviews, field notes, extracted codes, and analytical process documentation—were systematically maintained. Additionally, the researchers' analytical decisions were recorded throughout the study to enable scrutiny of the analytical pathway.

Researcher Reflexivity:

The interviewing researcher maintained reflexive notes throughout the various stages of the study. These notes included initial assumptions, personal interpretations, and the potential influence of the researcher's positionality on the data collection and analysis processes. This measure was undertaken to enhance awareness of the researcher's role and mitigate potential biases.

7. Ethical Considerations

This study was approved by the Research Ethics Committee of Tabriz University of Medical Sciences. Prior to each interview, participants were informed of the study objectives, the use of information, data confidentiality, the voluntary nature of participation, and the possibility of withdrawal at any stage. Following the obtainment of written informed consent, interviews were conducted.

To maintain confidentiality, participants' identifying information was removed, and each individual was assigned a unique code. Research data were stored in a secure environment, accessible only to members of the research team.

Results

1. Participant Characteristics

The participants included 36 managers and senior experts from the University of Medical Sciences (61.1%), other governmental institutions (33.3%), and NGOs/media (5.6%). The majority were male (77.8%), and 66.7% were aged 35–50 years. Over half (58.3%) had more than 20 years of work experience, and 97.2% had managerial experience. The highest educational degree among the medical group was a PhD (63.6%), while among other institutions it was a Master's degree (58.3%).

2. Extracted Themes from Thematic Analysis

Following the analysis, 1,315 initial codes were identified for the entire study, of which 298 initial codes pertained specifically to the barriers and facilitators of health advocacy. After merging overlapping codes, 151 final codes were identified. Through categorization, six main themes were identified for barriers and five main themes for facilitators. Each theme is further documented with direct quotations below.

Barriers to Health Advocacy (Table)

Theme 1: Structural and Legal Barriers

1–1. Bureaucracy and Weak, Non-Enforceable Laws

The first subtheme within structural and legal barriers was "cumbersome bureaucracy and regulations." Participant No. 7 stated: *"Cumbersome laws and bureaucracy (tenders, exchange rate disputes)."* Participant No. 10 also remarked: *"Law enforcement in our country is also weak."*

1–2. Centralized System and Top-Down Planning

The second subtheme was "centralized top-down system." Participant No. 33 noted: *"The most important is our bureaucratic administrative system... because it is a centralized top-down system."* Participant No. 23 similarly expressed: *"In the current system—at least in the health sector that I am aware of—the perspective is top-down."*

1–3. Weak Structure and Position of Health in the Health System

The third subtheme was "weakness of the health structure post-integration." Participant No. 4 stated: *"Unfortunately, after the integration of health sectors with the university, this power significantly declined."* Participant No. 5 added: *"The health system has no position... for advocacy, no designated trustee or expert for this task."*

1–4. Managerial Instability

The fourth subtheme was "managerial instability." Participant No. 17 remarked: *"I mean the turnover of managers."* Participant No. 24 added: *"Discontinuity between administrations and lack of follow-up on the previous manager's work."*

1–5. Weak Administrative Structure

The fifth subtheme was "weak administrative structure." Participant No. 10 stated: *"The flabbiness of the administrative and governmental structure (unwillingness to work)."* Participant No. 19 added: *"Resolutions left unimplemented and lack of follow-up."*

Theme 2: Economic Barriers and Competing Priorities

2 – 1. Lack of Financial Resources and Budgetary Constraints

The first subtheme was "budgetary constraints." Participant No. 8 stated: *"The first thing that is a barrier is really the budget—I would rank it first."* Participant No. 23 added: *"If those credits were secured or allocations were issued on time, many problems could be well resolved."*

2–2. Competing Economic Priorities

The second subtheme was "livelihood prioritized over health." Participant No. 27 remarked: *"People currently consider their livelihood more important than health."* Participant No. 5 added: *"When he wants to prioritize his expenses, buying a toothbrush is not his first priority—meaning he is not willing to go hungry just to buy a toothbrush."*

Theme 3: Organizational Behavior and Managerial Culture

3 – 1. Weak Managerial Knowledge, Attitude, and Skills

The first subtheme was "managers' unfamiliarity with advocacy." Participant No. 9 stated: *"The first time I hear about health advocacy is from you."* Participant No. 29 added: *"Not knowing, being unaware of the real techniques of the program, can itself be a barrier to its implementation."*

3 – 2. Superficial and Short-Term Solutions

The second subtheme was "provision of superficial and short-term solutions." Participant No. 24 remarked: *"They oversimplify many tasks."* Participant No. 24 also noted: *"When severe pollution occurs, they hold a meeting to ask what to do about the pollution, and some palliative measures—like traffic restrictions—are taken."*

3–3. Lack of Commitment and Accountability

The third subtheme was "lack of commitment and accountability." Participant No. 3 stated: *"Non-acceptance of responsibility by an individual or institution (delegating to the bureaucracy)."* Participant No.

17 added: *"Work conscientiousness—whether the person has the dedication and passion to resolve that issue and problem."*

3–4. Managerial Inefficiency

The fourth subtheme was "managerial inefficiency." Participant No. 14 remarked: *"Job mismatch of officials with their responsibilities."* Participant No. 10 added: *"Non-specialist and emotional involvement in issues (leading to no results)."*

Theme 4: Erosion of Social Capital and Demand-Making

4 – 1. Distrust and Frustration

The first subtheme was "distrust." Participant No. 9 stated: *"Now a year has passed—this creates distrust; I can no longer follow up with that advocate again."* Participant No. 21 added: *"Distrust between people and officials, and sometimes between managers of several executive agencies."*

4 – 2. Weak Demand-Making

The second subtheme was "weak demand-making." Participant No. 24 noted: *"When that demanding front becomes weak, naturally managers' sensitivity also decreases."* Participant No. 10 added: *"They become discouraged by the issues and problems in this field and, as they say, give up—meaning they stop following up, get tired, and withdraw."*

Theme 5: Political Barriers and Intersectoral Interaction

5 – 1. Primacy of Political Issues over Health

The first subtheme was "political issues prioritized over health." Participant No. 31 stated: *"The political-security deputies (the Governor) say you only consider the health aspect of the issue—for us, the security aspect takes precedence over health issues."* Participant No. 14 added: *"The Governor's political expediency is that, for instance, a polluting unit like a cement factory should not be shut down, because he says it would disrupt the political situation."*

5 – 2. Weak Intersectoral Interaction

The second subtheme was "weak intersectoral interaction." Participant No. 6 noted: *"Lack of cooperation and empathy among senior city officials (the most important factor)."* Participant No. 12 added: *"How*

much does that first person in the county make time for you? How much do they allow you to meet with them? How much can you talk to them? What percentage of their time is yours? Or, for example, the Friday Prayer Leader of the county is influential, but how accessible is he to you?"

Theme 6: Cultural and Social Barriers

6 – 1. Culture and Social Norms

The first subtheme was "lack of rule-orientation." Participant No. 6 stated: *"We are community-oriented rather than rule-oriented."* Participant No. 9 added: *"Absence of a clear structure, absence of clear laws."*

6 – 2. Normalization of Problems

The second subtheme was "normalization of problems." Participant No. 24 remarked: *"People do not see the problem as a priority, or they develop coexistence with it."* Participant No. 24 also stated: *"Air pollution, high tobacco consumption—these become almost normal phenomena. When they become normal, they lose their sensitivity."*

6 – 3. Conflict of Interest

The third subtheme was "conflict of interest." Participant No. 30 noted: *"There are a series of conflicts between departments."* Participant No. 33 added: *"Given various issues, we have some opponents. In the field of addiction, there is the drug mafia—cartels behind it. In the field of some diseases, pharmaceutical company cartels are involved."*

Facilitators of Health Advocacy (Table)

Theme 1: Individual Agency and Persuasive Capabilities

1–1. Motivation and Individual Characteristics

The first subtheme was "altruistic intrinsic motivation." Participant No. 33 stated: *"The most important, in my view, is the initial motivation of the individual who wants to take action—that motivation should be high, altruism-oriented."* Participant No. 3 added: *"They should have self-sacrifice—both in terms of the time they devote and the expenses they pay from their own pocket, and fundamentally their self-sacrifice should be honorable."* Participant No. 6 noted: *"The first is persistence—being persistent in any matter will lead to results."* Participant No. 21 added: *"Twenty-one times it was rejected by the Deputy of Research and Technology, and I revised it again and submitted it for the twenty-second time."*

1–2. Communication and Persuasive Skills

The second subtheme was "explaining the issue in the audience's language." Participant No. 31 stated: *"You should explain the importance of the issue both technically and simply—in a way understandable to the Governor."* Participant No. 3 added: *"The method and manner of presenting the issue and its importance to the people and officials should be expressed in a way that is completely impactful and persuades them to solve the problem."*

Theme 2: Social Participation and Civil Institutions

2 – 1. Interaction and Social Participation

The first subtheme was "dialogue and interaction as the best strategy." Participant No. 31 noted: *"Today's world is a world of dialogue—in my opinion, the best way is interaction and dialogue."* Participant No. 26 added: *"We should have continuous communication with them and value the support they provide us."*

2–2. Role of Civil Institutions and Media

The second subtheme was "the role of civil institutions and media." Participant No. 8 stated: *"How to influence managers? For example, through the media, through the people, through social media, NGOs."* Participant No. 24 added: *"This is more the responsibility of those social activists and NGOs as the driving engine of this work."*

Theme 3: Influence Tools and Strategic Incentives

3 – 1. Judicial and Legal Support

The first subtheme was "judicial support and legal leverage." Participant No. 14 stated: *"I said write a letter to the Minister threatening him—legal threat. He wrote, and the Minister was subject to judicial follow-up. Within a month, the Minister allocated a reasonable budget."* Participant No. 27 added: *"Currently in the county, the Prosecutor has said: wherever you see a health violation, shut it down immediately."*

3 – 2. Material and Spiritual Incentives

The second subtheme was "material and spiritual incentives." Participant No. 23 noted: *"A project succeeds—meaning it secures support—when all these aspects, especially the matter of incentives—both material and spiritual—are considered."* Participant No. 20 added: *"For many managers, it is about being seen and through that action they are doing, to gain either material benefits or spiritual and positional advantages."*

3–3. Levers of Influence and Power

The third subtheme was "levers of influence and power." Participant No. 20 stated: *"All issues must be coordinated with the security-intelligence institutions—they should be consulted."* Participant No. 19 added: *"The management of the Governor's Office and the presence of the Prosecutor in meetings for better management."*

Theme 4: Scientific and Cultural Strategies

4 – 1. Education and Awareness-Raising

The first subtheme was "advocacy education." Participant No. 4 stated: *"Advocacy is the missing link in our policy-making, and it must be taught."* Participant No. 21 added: *"Proper justification and training of those who are advocates—meaning the executive managers themselves, at both senior and middle levels, at operational levels—all of them really need proper training on advocacy strategies."*

4 – 2. Utilization of Science and Research

The second subtheme was "utilization of science and research." Participant No. 24 stated: *"Research institutes, think tanks, and universities... should serve as effective entities in providing theoretical support for the program."* Participant No. 21 added: *"Documented and up-to-date statistics enhance our reasoning power in bargaining and in gaining support from others."*

Theme 5: Institutionalization and Policy-Making

5 – 1. Structural Institutionalization

The first subtheme was "structural institutionalization." Participant No. 5 stated: *"We should have advocacy as an institutionalized process within our own organization."* Participant No. 7 added: *"We should have a specialized team and also strengthen our specialized team."*

5 – 2. Laws and Policy-Making

The second subtheme was "clear laws with enforceability." Participant No. 27 stated: *"The most important is the existence of strict laws and enforceability—both the law must be seen and it must have enforcement guarantees."* Participant No. 2 added: *"Transparent laws will be very helpful—for example, the duties of village councils regarding rural environmental health problems should be clearly stated."*

Table 1
– Demographic and Professional Characteristics of Participants by Field of Activity

Characteristic		Total Participants	Health Sector	Other Government Institutions (Municipality, City Council, Departments)	Communities & Media
Gender	Female	8 (22.2%)	6 (27.3%)	2 (16.7%)	0 (0%)
	Male	28 (77.8%)	16 (72.7%)	10 (83.3%)	2 (100%)
Age (years)	35–50	24 (66.7%)	13 (59.1%)	9 (75%)	2 (100%)
	Over 50	12 (33.3%)	9 (40.9%)	3 (25%)	0 (0%)
Relevant Work Experience (years)	Less than 10 years	1 (2.8%)	0 (0%)	1 (8.3%)	0 (0%)
	10–20 years	14 (38.9%)	9 (40.9%)	5 (41.7%)	0 (0%)
	More than 20 years	21 (58.3%)	13 (59.1%)	6 (50%)	2 (100%)
Educational Degree	Doctorate (General, Specialized)	18 (50%)	14 (63.6%)	3 (25%)	1 (50%)
	Master's Degree	10 (27.8%)	2 (9.1%)	7 (58.3%)	1 (50%)
	Bachelor's Degree	8 (22.2%)	6 (27.3%)	2 (16.7%)	0 (0%)
Management Experience	Has Management Experience	35 (97.2%)	22 (100%)	11 (91.7%)	2 (100%)
	No Management Experience	1 (2.8%)	0 (0%)	1 (8.3%)	0 (0%)
Number of Participants		**36 people**	**22 people**	**12 people**	2 people

Table 2
Barriers and Challenges to Health Advocacy

Theme	Sub-themes	final Codes
Structural and Managerial Barriers	Bureaucracy and Ineffective Laws with Insufficient Enforcement Mechanisms	Bureaucracy and Cumbersome, Ineffective Laws
		Lack of a Clear Structure and Transparent Legislation
		Lack of Enforcement Guarantees for Laws
	Centralized System and Top-Down Planning Approach	Centralized (Top-Down) System as the Primary Barrier
		Program Design Without Consideration of Implementers' Needs
		Insufficient Awareness Among Decision-Makers Regarding Problems at Lower Levels
		Lack of Sufficient Authority for Universities of Medical Sciences in Design and Implementation
	Weakness in the Position and Structure of the Deputy of Health Within the Health System	Decline in the Power of Public Health Within the Structure of the Health System
		Lack of a Designated Custodian for Advocacy Within the Health System
		Restructuring of the Health and Food Security Working Group
	Managerial Instability	Person-Dependent Nature of Programs
		Lack of a Clear Model and Structure for Addressing Program Failure
		Program Overlap and Interference
		Managers with a Compartmentalized and Siloed Governance Mindset
		Inconsistency of Certain Programs with Macro Policies
		Frequent Managerial Rotation
		Discontinuity Between Management Successions and Lack of Follow-Up on the Previous Manager's Work
		Failure to Benefit from Others' Experiences and Neglect of Prior Efforts

Theme	Sub-themes	final Codes
		Departure of Experienced Physicians and Replacement with Temporary Contractuals
		Decline in Sense of Belonging and Organizational Commitment Among Health Sector Employees
		Shift in the Nature of the Community Health Worker's Role from Field-Based Activism to Administrative and System-Oriented Function
	Weakness in the Administrative System and Structure	Inefficiency of the Administrative and Governmental System
		Lack of Oversight Over the Implementation of Approvals
		Lack of Judicial Action Against Cases of Omission by the Prosecutor's Office
		Vagueness in Documents and Lack of Role and Task Specification for Each Agency
		Non-Implementation of the Best Plans in the Absence of Law Enforcement
	Managerial Inefficiency	Personal and Discretionary Approach of Managers to Issues
		Retaliatory Administrative Actions Following Legal Complaints
		Mismatch Between Officials' Competencies and Assigned Duties
		Lack of Effective Planning
		Lack of Active and Productive Meetings
		Non-Expert and Emotion-Based Intervention in Issues
		Failure to Train Expert Specialists in Advocacy
Economic Barriers	Insufficient Financial Resources and Budget Allocations	Insufficient Budgetary Resources
		Weakness in Pursuing Credits and Budgets for Certain Programs
		Economic Issues and Constraints
		Delayed Budget Disbursement

Theme	Sub-themes	final Codes
	Conflicts in Economic Priorities	Prioritizing Livelihood Over Health
		Prioritization of Treatment Over Prevention in Public Demands
		Decline in Health Advocates' Activities Due to Economic Constraints
		Donors' Engagement in Equipment Procurement Without Identifying Real Needs
Organizational Behavior and Culture	Weakness in managers' knowledge, attitude, and skills	Lack of managers' familiarity with the concept of advocacy
		Unawareness of advocacy techniques
		Lack of managerial training and accountability for physicians prior to appointment
		Lack of familiarity of managers with the health system
		Weakness in persuading senior managers
	Lack of commitment and accountability	Senior manager commitment to advocacy
		Non-acceptance of responsibility by any individual or institution
		Lack of internal commitment and work conscience
		Lack of individual accountability
		Insufficient time allocation by some officials to the problem-solving cycle
		Lack of courage and boldness among managers to address chronic problems
	Superficial and temporary solutions	Oversimplification of complex problems by managers
		Temporary rather than root-cause solutions
		Managers' fear of stepping outside the framework (inspection concerns)
	Culture and social norms	Executive structure, community culture, and ethical constraints
		Elder/chief-centeredness rather than rule-based governance

Theme	Sub-themes	final Codes
		Lack of proper understanding of the environment and health among the public and legislators
		Public belief in the clinical nature of health centers rather than their comprehensive role
		Lack of awareness of legal provisions and capacities
		Normalization of problems and public coexistence with them
		Close correlation between managers' sensitivity and public sensitivity
Erosion of Social Capital	Mistrust and frustration	Mistrust between the public and officials, and among managers of different organizations
		Societal frustration due to the deviation of service-providing organizations from their mission
		Discouragement of NGOs after years of futile follow-ups
		Ineffective pressure and follow-ups
	Weak public demand-making	Decline in public capacity for demand-making
		Lack of awareness of rights
		Lack of public education on advocacy and problem-solving methods
		Lack of public familiarity with non-governmental organizations
Political Barriers and Inter-Sectoral Interaction	Priority of political issues over health	Prioritization of political-security issues over health problem-solving
		Inefficiency of administrative and governmental structure
		Transformation of professional needs into political ones (political fallacy)
		Lack of political backing for laws
		Fear of political repercussions
	Weak inter-sectoral interaction	Lack of cooperation and empathy among senior city officials

Theme	Sub-themes	final Codes
		Poor communication (incomplete communication and lack of respect for differing views)
		Weak organizational support for the health sector
		Lack of access to key decision-makers
		Incomplete authority of the governor
		Deviation of the city council and municipality from their legal duties
	Conflict of interest	Inter-agency conflict of interest
		Existence of influential opponents (drug mafia, pharmaceutical cartels)
		Existence of individuals opposing health-related ideas
		Lack of perceived benefit among stakeholders
		Lack of audience identification

Table 3
Facilitators and Success Factors of Health Advocacy

Theme	Sub-themes	final Codes
Individual Agency and Persuasive Capabilities	Individual motivation and characteristics	Possession of altruistic intrinsic motivation as the most important facilitator
		Persistence and perseverance (the most important factor)
		Extra effort to complete unfinished projects
		Being tenacious
		Success through connection with powerful individuals
		Dependence of advocacy on individual abilities
	Communication and persuasive skills	Explaining the issue in the audience's language
		Presenting information to officials in simple language
		Using impactful data to garner support
		Specialized advocacy (with figures and expert backing)
		Necessity of prioritizing and magnifying the issue for managers
		Audience identification and the importance of stakeholder analysis prior to action
		Comprehensive understanding of barriers and their solutions
		Articulating the economic and social costs of untimely intervention
		Presenting the importance of the issue to the public and officials in a persuasive manner
		Consultation with experts, village council members, and local leaders (not trial and error)
		Community health assessment as a prerequisite for effective advocacy

Theme	Sub-themes	final Codes
		Prioritization and categorization of problems
		Garnering public support through self-contribution funds
		Enhancing bargaining power
Social Participation and Civil Institutions	Social interaction and participation	Dialogue and interaction as the most important strategy
		Civil coalitions and social participation
		Active participation
		Engaging public opinion (the most important factor)
	Role of civil institutions and media	Leveraging pressure from NGOs, media, and social media
		Role of social activists (NGOs) as the driving engine
		Non-governmental organizations (with greater flexibility than governmental bodies)
		The more effective role of environmental and health activists compared to some officials and laws
		Role of the media in raising awareness and reminding
		Public demand-making (the most fundamental method)
Instruments of Influence and Strategic Incentives	Judicial and legal support	Strong support from the judiciary and threatening officials with legal action
		Authorization from judicial authorities for officials to take action
		Use of legal leverage, persuading the governor and prosecutor
		Issuance of directives by the highest-ranking official
	Levers of influence and power	Role of the Friday prayer leader in securing resources (success factor)
		Engagement with law enforcement to facilitate implementation

Theme	Sub-themes	final Codes
		Coordination with security and intelligence agencies
		Governance by the governor's office and presence of the prosecutor in meetings for better management
	Material and spiritual incentives	Assisting in the visibility and appreciation of managers
		Appreciation and recognition as two motivational strategies (material and spiritual incentives)
		Personal interest as a driver of follow-up
		Inclusion of individuals in program success and helping them gain visibility
Scientific and Cultural Strategies	Training and awareness-raising	Training (a long-term process with lasting impact)
		Proper justification and advocacy training for executive managers
		Necessity of raising awareness among governors and policymakers about health issues
		Ability of experts to persuade officials
	Utilization of science and research	Role of universities, think tanks, and research institutes in theoretical support
		Access to documented and up-to-date health system data
		Transparency of information law and continuous public access to data
		Utilizing the capacity of the private sector to create a successful model
		Use of existing cultural symbols rather than creating new ones
		Influence of regional culture on advocacy
		Creating supportive environments (not merely training)
Institutionalization and Policy-Making	Structural institutionalization	Necessity of structural institutionalization of health advocacy within the organization
		Embedding the science of advocacy within the health system

Theme	Sub-themes	final Codes
		Having a specialized advocacy team
		Need for experienced advocacy trainers
		Existence of a direct and central responsible individual
		Necessity of establishing a secretariat for monitoring advocacy effectiveness
	Laws and policy-making	Existence of clear laws with legal backing and enforcement guarantees
		Legal and administrative definitions of guidelines
		Necessity of planning and memoranda of understanding between agencies
		Joint planning
		Categorization of health-related agencies (grading)
		Removal of non-specialist issues from the agenda
		Use of periodic health committees with problem-solving participants

DISCUSSION

This qualitative study was conducted with the aim of deeply identifying the challenges, barriers, success factors, and facilitators of health advocacy in intra-organizational and inter-organizational interactions. The findings derived from this study—based on Braun and Clarke's thematic analysis of 36 in-depth interviews with a wide range of key stakeholders—provide a comprehensive and contextually grounded picture of the numerous components and non-linear relationships within the health advocacy process in the context of managing health system and environmental issues.

Data analysis revealed that the barriers and challenges to health advocacy were categorized into six main themes: structural and legal barriers; economic barriers and competing priorities; organizational behavior and managerial culture; erosion of social capital and demand-making; political barriers and intersectoral interaction; and cultural and social barriers. In contrast, the success factors and facilitators were organized into five main themes: individual agency and persuasive capabilities; social participation and civil institutions; influence tools and strategic incentives; scientific and cultural strategies; and institutionalization and policy-making.

Elaboration on Barriers to Health Advocacy

One of the most frequently identified barriers was centralization and complex bureaucracy coupled with top-down planning within the health system structure and the realm of law enforcement. This challenge has been extensively reflected in the research literature, with obstacles such as excessive and rigid adherence to redundant formal rules and processes, unfavorable policies, and delays in processing(19, 24, 48, 49) being cited as concrete manifestations of this structural problem. What elevates this finding beyond a mere administrative obstacle is the emphasis on the deep-rooted nature of this issue within the governing philosophy of the country's administrative structure; as long as a centralized, top-down perspective dominates the health system, any effort toward local and participatory advocacy will encounter thick bureaucratic walls, leaving no option but fundamental structural reform. Participants emphasized the weakness in the enforceability of laws in the country—an issue also reported in research (30) as "weakness in the implementation of laws and upstream policies" as one of the key barriers to public participation and health promotion. The noteworthy point in this finding is the distinction between two levels of the problem: law formulation and law enforcement. What participants explicitly highlight is not the absence of upstream laws, but rather the gap in monitoring mechanisms and enforcement binding; such that many approved laws, due to the lack of effective enforcement guarantees, remain at the level of slogans and are stripped of their deterrent and regulatory functions. Furthermore, the decline in the bargaining position of health prevents health trustees from playing an active role in garnering support from other organizations—an issue also identified in the research literature as "weak state institutions" (32) as one of the structural barriers to the effectiveness of health activism. The integration of health with universities, although perhaps aimed at scientific synergy, has in practice reduced the bargaining position of health from a macro-policy institution to a subordinate academic unit. Reviving this position requires a strategic redefinition of health's role within the country's power structure. Moreover, managerial instability and the discontinuity between the programs of previous and new managers render long-term advocacy processes futile. This challenge has been identified in previous research through concepts such as political instability and government changes(50), changes in governments and priorities and attempts to alter or repeal laws over time(51), and continuous turnover of government officials and fluctuations in political support(24) Although managerial change is a natural phenomenon in administrative systems, the absence of knowledge transfer mechanisms and program continuity imposes heavy costs, particularly in the realm of long-term health policies. Instead of reliance on individuals, institutionalization of processes should be emphasized.

delayed allocation of credits were identified as major challenges. As the data indicate, under economic constraints, decision-makers and even the general public tend to prefer treatment-oriented approaches or addressing immediate livelihood needs over preventive and health-oriented measures. This livelihood-oriented and treatment-centric prioritization has been explained in previous research through concepts such as consumer indifference to health issues and screening (52) Additionally, the insufficient allocation of resources and incomplete support for responsible agencies (29) not only aligns with participants' findings regarding delayed credit allocation but also indicates that the problem, more than stemming from the absence of law, is rooted in the lack of timely executive will. On the other hand, what

participants described as treatment-oriented demands from the public has been conceptualized in the literature as the biomedical perspective with its focus on disease and treatment and neglect of the social determinants of health(53), and the predominance of a downstream approach in nursing practice (focusing on individual care and treatment rather than root-cause prevention) (54).

At the organizational behavior level, participants cited managers' insufficient awareness of advocacy techniques and their unfamiliarity with the concept of advocacy—an issue addressed in studies(55, 56) as "inadequate training in advocacy skills." However, the present finding suggests a deeper gap: managers have not only been untrained in how to advocate, but are also unfamiliar with the very concept and its necessity. In other words, before the need for technical training arises, there is a need for fundamental awareness-building regarding what advocacy is and why it is essential in the health system. The adoption of temporary, superficial, and short-term solutions instead of root-cause engagement with health problems was identified—an approach conceptualized as "oversimplifying advocacy"(57) However, what elevates the present finding beyond a mere warning is the emphasis on the counterproductive outcome of this superficiality: short-term and cosmetic solutions not only fail to resolve the problem but also, by creating a mirage of problem-solving, waste advocates' energy and time and prevent root-cause engagement with the underlying causes of health problems. The lack of specialized knowledge among the management body for persuading superior officials leads to non-specialist and emotional decision-making. This communicative inability has been explained in previous research through concepts such as the lack of required communication skills among advocates(52), issues and tensions in interprofessional relationships(58), difficulty in selling prevention ideas to others(21), and most importantly, the inability to translate complex scientific evidence into simple language and tangible stories for policymakers (59). However, what elevates the present finding beyond a mere technical weakness is the emphasis on its pathological chain: the inability to translate scientific evidence into simple language, the consequent inability to persuade superior managers, leading to non-specialist and emotional decision-making, resulting in a lack of effective outcomes, and ultimately weakening the position of advocacy within the organization.

This issue intensifies when political barriers and inter-agency conflicts of interest enter the equation, such that sometimes the political or security expediencies of senior local officials override the health and environmental priorities of the community. This reversed prioritization (politics over health) has been explained in previous research through concepts such as lack of political will or mindset change at the governance level(60), political barriers(40), neoliberal political ideologies emphasizing individual responsibility(60–62), and fear of being politically labeled(63). However, what elevates the present finding beyond a mere external barrier is the emphasis on the dual structure of conflict: on the one hand, inherent conflicts of interest between agencies (e.g., industry versus health), and on the other hand, security prioritization that defines any health-oriented action within the framework of maintaining the stability of the existing order rather than public health. In other words, what participants described as "political expediency is that the factory should not be shut down" is a concrete symbol of the dominance of stability-oriented political logic over preventive health logic.

On the other hand, the present study revealed that instability in fulfilling promises has led to the erosion of social capital, public distrust, and frustration among non-governmental organizations (NGOs). This erosion weakens the community's demand-making front and results in a kind of normalization and coexistence with problems. This gradual process of trust destruction has been explained in previous research through concepts such as cynicism and distrust in decision-making institutions(64), mutual distrust between the government and civil society organizations(48), and negative perceptions of advocates as pursuers of personal rather than public interests (57) However, what elevates the present finding beyond a mere pathological report is the emphasis on two strategic consequences of this erosion: first, with the weakening of the demand-making front and the loss of trust, civil activists gradually withdraw from the advocacy arena, and the vacuum of trust-building intermediary institutions becomes increasingly palpable; and second, with the normalization of problems, citizens, in the face of chronic inefficiency, opt for coexistence with the issue rather than demand-making—which itself constitutes one of the primary barriers to transformation in the health system.

Elaboration on the Barriers to Health Advocacy

In contrast, the research findings elucidate the unparalleled role of individual agency and altruistic intrinsic motivation as the most significant factor driving individuals' actions. This component has also been extensively reflected in prior studies, such that factors including altruism (65), along with the presence of strong personal passion and motivation(25), in conjunction with sustained perseverance and follow-up, are introduced as the most critical facilitators in the realm of health advocacy—a centrality that has also been echoed in other investigations. These studies further affirm that a persistent focus on outcomes is emphasized as a prerequisite for achieving desirable results (16, 66, 67). Perseverance in follow-up is akin to a droplet that gradually pierces the hard stone of organizational indifference; though each individual drop may seem negligible in isolation, its continuity engenders substantial and sometimes unforeseen transformations. Nevertheless, as the data indicate, sole reliance on individual characteristics in the absence of formal structures threatens the sustainability of health advocacy. This caveat has also been reflected in the research literature, underscoring that institutional and systemic structures—such as cohesive social networks and public support (7), a robust legal and policy framework comprising binding regulations and explicit commitments in upstream documents(29), as well as formal legitimation (68) constitute the fundamental pillars for translating individual motivations into sustainable and impactful actions within the health domain. It might be argued that altruistic individual agency serves as the primary engine of any advocacy action; however, for this engine to navigate the intricate and winding road of complex structures, it requires an additional fuel—namely structural support—to safeguard it from premature burnout. If individual motivation represents the initial spark of action, the institutional structure is the vessel that transforms this spark into a sustained flame. Institutionalization entails the process of disentangling health advocacy from dependence on particular individuals and entrusting it to the system—a system that continues to function even in the absence of its original proponents.

Hence, communicative and persuasive competencies function as a powerful instrument for convincing authorities—a necessity that has also been reflected in other studies, which have emphasized its various dimensions. These range from direct and active engagement of the campaign's core team with stakeholders, particularly in rural and remote areas(69), and the cultivation of relationships with key stakeholders through investment in diverse and strategic networks (9, 16), to establishing rapport with policymakers by initiating and maintaining personal and professional connections with decision-makers. (70) Effective communication serves as the gatekeeper for the entry of health concepts into the minds of policymakers; without this skill, even the best evidence remains confined to stacks of technical documents. It is essential to understand how to bridge the language of the public with the language of officials, and to frame messages in a manner that renders them both comprehensible and persuasive across both sides of the negotiation table.

One of the salient findings of this study is the highlighting of the role of legal instruments and judicial levers, which serve as an expedient and penetrating facilitator in advancing advocacy objectives. In executive contexts where routine administrative interactions encounter the rigid and inflexible gateways of bureaucracy, the involvement of judicial and security authorities, coupled with the application of stringent legal guarantees, has proven capable of breaking through administrative barriers. This strategy has also been reflected in prior research, with an emphasis on components such as supporting citizens in legal litigation against industry and utilizing media coverage of such lawsuits to draw public attention to corporate responsibilities(71), as well as the possibility of bringing health-harming companies to the courtroom through judicial proceedings(72). Judicial levers are, in effect, the express highways of advocacy; when the main roads of administrative engagement reach a dead end, these levers can, through a single legal action, untie intractable knots and replace appeasement with accountability.

Furthermore, the establishment of material incentives and the according of a sense of significance to the role of managers were identified as an intelligent strategy for securing the participation of other sectors. Such an approach has also been reflected in another study, wherein the media, through extensive coverage, provided a platform for mobilizing all governmental capacities.(73) It appears that the key to the success of this strategy lies in the integration of two levels of motivation: material encouragement, which addresses tangible needs, and spiritual encouragement derived from visibility, which bestows upon managers an identity of influence and transforms them into active players in the health arena.

Ultimately, participants emphasized the necessity of structural institutionalization of advocacy through the formation of specialized teams and the systematic training of health advocates. This dual emphasis on structure and training has been accompanied in the research literature by the examination of numerous components, each addressing a distinct aspect of this imperative: (1) team structure: team diversity and role clarity(74) ; (2) having a cohesive group structure, a single representative for communication with the council, and effective utilization of formal processes for submitting opinions(75) ; (3) training, skills development, and support for leaders of health advocacy organizations(52) ; and (4) leadership or advocacy training (particularly by employers) was found to increase the likelihood of advocacy by 2 to 4 times (76)

What emerges from this synergy is an undeniable truth: a coherent structure without training is a factory devoid of raw materials, and training without a structure is knowledge adrift in the chaos of organizational disorder. Accordingly, policymakers must simultaneously strengthen both wings of this bird to establish sustainable advocacy.

The utilization of theoretical support from think tanks and universities for the production of scientific content and theorization for advocacy constituted another finding of this study. Interestingly, other studies have also emphasized the enrichment of the advocacy process by academic institutions, particularly through the development of practical resources. Guides and resources developed by non-governmental organizations, donors, and academics for use in low- and middle-income countries can be invaluable, such as tools for empowering effective stakeholder engagement .(48) Reliance on documented data and research-based evidence, which enhances bargaining power in garnering support from others, can confer credibility and legitimacy upon the advocacy process. This premise has been repeatedly tested in policy research, demonstrating that data—not merely as information but as the key to legitimizing demands—play a pivotal role. Examples include the strategic use of data and scientific evidence, reliance on credible national and international data for framing vaping as a public health crisis and legitimizing calls for a ban(33), and the use of valid data and official statistics to persuade legislators.(77) Documented evidence, in the arena of health bargaining, constitutes a powerful lever—one that can transform a simple request into an undeniable evidence-based imperative and render any unfounded opposition invalid in its face.

Implications for Policy and Practice

Considering the political, social, and cultural context of Iran, the findings of this study carry specific practical implications for the health system and social policymakers. For the institutionalization of health advocacy, it is imperative to enhance the competencies of health system managers and experts through the design and implementation of specialized training courses, utilizing instructors with practical experience in the field of advocacy. Such training should focus on skills including stakeholder analysis, effective communication, negotiation, and policy bargaining. Furthermore, the establishment of formal structures and the designation of a specific custodian for advocacy—through the definition of clear organizational positions, the activation of secretariats, and the continuous monitoring of intersectoral interactions within universities of medical sciences—can contribute to extricating advocacy from dependence on individuals and transforming it into a sustainable organizational capacity.

Strengthening legal and judicial underpinnings constitutes another prerequisite for the development of health advocacy. In this regard, the formulation of interagency memoranda of understanding with institutions such as the Judiciary and Governorates can enhance the enforceability of approvals made by health and food security working groups and facilitate intersectoral collaboration. Moreover, supporting non-governmental organizations, media activists, and social advocates through the development of communicative capacities and increasing their access to reliable information and evidence can contribute to strengthening public demand-making and the informed orientation of public opinion toward

the resolution of health issues. Overall, the implementation of these measures necessitates a coordinated approach in which training, structuration, legal support, and social participation are regarded as complementary components of a sustainable health advocacy system.

Strengths and Limitations of the Study

Among the primary strengths of this study are the utilization of the Braun and Clarke analytical approach, the experiential diversity of the participants, and the adherence to trustworthiness criteria throughout the data analysis process. The participants in this study were recruited from various managerial and executive levels, including experienced managers at national, provincial, and county levels, experts from different organizational sectors, representatives of non-governmental organizations, and media activists, thereby encompassing a broad spectrum of professional experiences and educational backgrounds. Furthermore, measures such as member checking, independent coding of data by three researchers, and the meticulous documentation of the analytical process contributed to enhancing the credibility and dependability of the findings.

Notwithstanding these strengths, the present study was not without limitations. The non-participation of certain key groups, including representatives of the private sector and large industries, may have resulted in the incomplete reflection of perspectives pertinent to these stakeholders. Additionally, given the sensitivity of certain issues related to environmental, managerial, and inter-organizational matters, there existed the possibility that some participants exercised caution in freely expressing their experiences and viewpoints. To mitigate this effect, the confidentiality of information was ensured, this bias was reduced to the greatest extent possible, and anonymous codes were employed to protect the identity of the participants.

Conclusion

The findings of this study revealed that structural, organizational, economic, political, and social barriers in Iran are intricately intertwined in constraining the capacity for health advocacy. Centralization, complex bureaucracy, weak enforceability of laws, managerial instability, inadequate resource allocation, and the predominance of a treatment-oriented approach, along with limited managerial familiarity with advocacy, deficiencies in evidence translation and transfer, and the inability to persuade decision-makers, were identified as the most significant barriers. Furthermore, conflicts of interest, political and security considerations, and weak political will, coupled with the non-fulfillment of supportive promises, have led to a decline in public trust, the erosion of social capital, and the weakening of community participation and non-governmental organizations.

Conversely, the success of health advocacy arises from the interaction of individual, organizational, legal, and knowledge-based factors. Individual motivation and commitment, communication and persuasive skills, the ability to translate evidence for decision-makers, and the establishment of effective relationships with stakeholders enhance the capacity to advance health goals. Leveraging legal

capacities, forming specialized teams, systematically training health advocates, strengthening leadership, and utilizing the support of universities and think tanks can also reinforce the legitimacy and bargaining power of advocates. Accordingly, effective advocacy necessitates structural reforms, the strengthening of managerial capacities, sustainable resource provision, and the integration of individual motivation, organizational capacity, legal backing, and scientific evidence within a coherent and systematic approach.

Declarations

Author Contribution

Sajad Lak and Rahim Khodayari-Zarnegh and Javad Babaei came up with the idea for this study and collaborated to write the study plan. The interviews were conducted by Sajad Lak, and the analysis was done by Sajad Lak, Rahim Khodayari-Zarnagh, Javad Babaei, and Maryam Kooshki, who also prepared the first draft of the article.

Ethics and Guidelines:

1-This study was approved by the Ethics Committee of Tabriz University of Medical Sciences (**IR.TBZMED.REC.1405.323**).

2-All participants were adults aged 18 years or older. Prior to data collection, the purpose, methods, potential risks, benefits, and confidentiality measures of the study were fully explained to each participant. All individuals voluntarily provided written informed consent before participating. Participants were also informed that they could withdraw from the study at any time without any penalty or loss of benefits. This study was conducted in accordance with the ethical principles of the **Declaration of Helsinki** and the **national research regulations of Iran**.

Consent to Participate: Written informed consent was obtained from all individual participants included in the study.

Clinical Trial Number: Not applicable.

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References

1. Košir M. A growing need for advocacy skills and knowledge in promoting population health and well-being: Recommended strategies for alcohol prevention advocacy. Int J Alcohol Drug Res. 2024;12(S1):S71–5.
2. Nutbeam D, Muscat DM. Health promotion glossary 2021. Health Promot Int. 2021;36(6):1578–98.
3. Bhatti AJ, Lin S, Post D, Baldock K, Dawes N. Prevalence and characteristics of advocacy curricula in Australian public health degrees. Health Promotion J Australia. 2022;33:50–6.
4. Barry MM, Battel-Kirk B, Dempsey C. The CompHP core competencies framework for health promotion in Europe. Health Educ Behav. 2012;39(6):648–62.
5. Hubinette M, Dobson S, Scott I, Sherbino J. Health advocacy. Med Teach. 2017;39(2):128–35.
6. Hubinette MM, LaDonna KA, Scott I, van der Goes T, Kahlke R. When I say… health advocacy. Med Educ. 2022;56(4):362–4.
7. Goes AR. Advocacy for health and health equity: a call to public health professionals. Portuguese J Public Health. 2025;43(1):1.
8. Kuehne F, Kalkman L, Joshi S, Tun W, Azeem N, Buowari DY, et al. Healthcare provider advocacy for primary health care strengthening: a call for action. J Prim care community health. 2022;13:21501319221078379.
9. Earnest M, Wong SL, Federico S, Cervantes L. A model of advocacy to inform action. J Gen Intern Med. 2023;38(1):208–12.
10. Aghazadeh SA. Advocacy and marginality: Considering legitimacy, authenticity, and culture to extend fully functioning society theory. J Public Relations Res. 2022;34(6):257–73.
11. Brinsden H. Advocacy on front of pack nutrition labelling in the UK—what can We learn? T6: S41: 07. Obes Rev. 2016;17:188.
12. Barclay L, Gregory G. Alliances and evidence: Building the capacity and effectiveness of rural health advocacy in Australia. Aust J Rural Health. 2018;26(5):308–11.

13. Elliott-Green A, Hyseni L, Lloyd-Williams F, Bromley H, Capewell S. Coverage of sugar-sweetened beverages in the British media: an analysis of public health advocacy versus pro-industry messaging. Lancet. 2016;388:S48.
14. Moore M, Jones A, Pollard CM, Yeatman H. Development of Australia's front-of-pack interpretative nutrition labelling Health Star Rating system: lessons for public health advocates. Aust N Z J Public Health. 2019;43(4):352–4.
15. Schober GS, Wenger JB, Lee CC, Oberlander J, Flythe JE. Dialysis patient perspectives on CKD advocacy: a semistructured interview study. Am J Kidney Dis. 2017;69(1):29–40.
16. Cullerton K, Donnet T, Lee A, Gallegos D. Effective advocacy strategies for influencing government nutrition policy: a conceptual model. Int J Behav Nutr Phys Activity. 2018;15(1):83.
17. Mathur MR, Bhosale AS, Abel SN, Fisher J, Listl S, Carrasco-Labra A, et al. Envisioning sustainable oral health through effective advocacy. BMC Global Public Health. 2025;3(1):15.
18. Stoneham M, Coller L, Napolitano J, Scolyer MM, Pollard C. Filling gaps–a case study in building advocacy capacity in the health promotion workforce. Global Health Promotion. 2024;31(4):37–43.
19. Dannefer R, Seidl L, Drackett E, Wohlman A, Campbell S, Herrera D, et al. Harlem Health Advocacy Partners: A local health department's place-based community health worker program. J Ambul Care Manag. 2024;47(3):168–86.
20. Kahlke R, Scott I, van Der Goes T, Hubinette MM. Health advocacy among medical learners: Unpacking contextual barriers and affordances. Med Educ. 2023;57(7):658–67.
21. Hancher-Rauch HL, Gebru Y, Carson Ae. Health advocacy for busy professionals: effective advocacy with little time. Health Promot Pract. 2019;20(4):489–93.
22. King S, Williamsn KM, Hughes BD, Newman EA, editors. Health advocacy through translational science: an experimental model to quantify the impact of human social stressors on health outcomes. Seminars in pediatric surgery. Elsevier; 2025.
23. Hubinette MM, Scott I, van der Goes T, Kahlke R. Learner conceptions of health advocacy:'Going above & beyond'or 'kind of an expectation'. Med Educ. 2021;55(8):933–41.
24. Benjamin KA, Wodnik BK, Cordeaux E, Rashidian L, Riachi MI, Smith LE, et al. Leveraging public engagement to improve healthcare quality: The role of community and stakeholder engagement in Colombia's National Quality of Care Strategy. PLOS Global Public Health. 2025;5(11):e0005333.
25. Jones HE, Manze M, Brakman A, Kwan A, Davies M, Romero D. Physician engagement in reproductive health advocacy: findings from a mixed methods evaluation of a leadership and advocacy program. BMC Med Educ. 2024;24(1):476.
26. Mindell JS, Parag Y, Bartington SE, Stoll L, Barlow J, Janda KB. The Middle-Out Perspective: an approach to formalise 'normal practice'in public health advocacy. Perspect Public Health. 2024;144(4):232–41.
27. Laari L, Duma SE. Facilitators of the health advocacy role practice of the nurse in Ghana: A qualitative study. Health Sci Rep. 2021;4(1):e220.

28. Ionescu A, Mannell J, Vaughan M, Burgess R. Misunderstood and underappreciated: a critical review of mental health advocacy and activism in low-and middle-income countries. Health Policy Plann. 2024;39(5):528–39.
29. Mesdeghinia A, Bagheri Lankarani K, Naddafi K, Hasanvand MS, Paeezi M, Saeedi R. Developing an advocacy document for the management of pesticide residues in agricultural products in Iran. Iranian Journal of HealthEnvironment., Bagheri Lankarani A, Naddafi K, Hasanvand K, Paeezi MS, Saeedi M. R. Developing an advocacy document for the management of pesticide residues in agricultural products in Iran. Iranian Journal of Health & Environment. 2025;17(4).[in persian].
30. Ramezankhani A. Public Participation and Promotion of Community Health. J Med Behav Razm. 2023; [in Persian].
31. Kumar A, Thappa M, Goel S, Singh RJ, Sharma R, Tomar AS. Advancing tobacco control laws through multi-stakeholder engagement at world's largest congregation of religious pilgrims: Tobacco-free Kumbh Mela, Haridwar, India. Tob Induc Dis. 2025;23(1).
32. Crosbie E, Wilson S, Tran B, Albuquerque de Figueiredo B, Severini L, Severini G, et al. Health advocacy strategies to influence policy-making on and regulation of new and emerging tobacco and nicotine products in Latin America and the Caribbean. Revista Panam de Salud Pública. 2025;49:e31.
33. Sadykova J, Ayaganova A, Yergaliyev KA. Mobilizing for Health: A Case Study of Kazakhstan's Vaping Ban Advocacy Campaign. Int J Environ Res Public Health. 2025;22(7):1102.
34. Evans MW Jr. Modification of a local smoking ordinance: a case-report of chiropractic health advocacy. J Chiropr Med. 2006;5(1):32–7.
35. Weishaar H, Collin J, Amos A. Tobacco control and health advocacy in the European Union: understanding effective coalition-building. Nicotine Tob Res. 2015;18(2):122–9.
36. Patterson AS, Gill E. Up in smoke? Global tobacco control advocacy and local mobilization in Africa. Int Affairs. 2019;95(5):1111–30.
37. Hendler R, Kidia K, Machando D, Crooks M, Mangezi W, Abas M, et al. We are not really marketing mental health: mental health advocacy in Zimbabwe. PLoS ONE. 2016;11(9):e0161860.
38. Dimitrova I. Change without change: Remaking mental health advocacy in Bulgaria. Probl Post-Communism. 2025;72(3):240–9.
39. Hann K, Pearson H, Campbell D, Sesay D, Eaton J. Factors for success in mental health advocacy. Global health action. 2015;8(1):28791.
40. David JL, Thomas SL, Randle M, Daube M. A public health advocacy approach for preventing and reducing gambling related harm. Aust N Z J Public Health. 2020;44(1):14–9.
41. Howat P, Maycock B, Slevin T. Community health advocacy to prevent social and health problems associated with gambling-a case study. Aust J Prim Health. 2005;11(1):32–9.
42. Rosewarne E, Moore M, Chislett W-K, Jones A, Trieu K, Webster J. An evaluation of the Victorian Salt Reduction Partnership's advocacy strategy for policy change. Health Res Policy Syst. 2021;19(1):100.

43. Yeatman H. Australia's food regulations—challenges for public health advocacy. Aust N Z J Public Health. 2002;26(6):515–7.
44. Figueira AB, Barlem ELD, Amestoy SC, Silveira RSd, Tomaschewski-Barlem JG, Ramos AM. Health advocacy by nurses in the Family Health Strategy: barriers and facilitators. Revista brasileira de enfermagem. 2018;71:57–64.
45. Kapilashrami A, Smith KE, Fustukian S, Eltanani MK, Laughlin S, Robertson T, et al. Social movements and public health advocacy in action: the UK people's health movement. J Public Health. 2016;38(3):413–6.
46. Schreurs F, Bekker M, Helderman J, Jansen M, Ruwaard D. Transformative governance for public health: a scoping review. Eur J Pub Health. 2019;29(Supplement4):ckz186.
47. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Res Psychol. 2006;3(2):77–101.
48. Masefield SC, Msosa A, Chinguwo FK, Grugel J. Stakeholder engagement in the health policy process in a low income country: a qualitative study of stakeholder perceptions of the challenges to effective inclusion in Malawi. BMC Health Serv Res. 2021;21(1):984.
49. Laari L, Duma SE. Barriers to nurses health advocacy role. Nurs Ethics. 2023;30(6):844–56.
50. Najafi M, Mosadeghrad AM, Arab M. Mechanisms of intersectoral collaboration in the health system: a scoping review. Iran J Public Health. 2023;52(11):2299.
51. Companion A. Four Steps to Public Health Advocacy Success. 2024.
52. Kreps GL, Kim P, Sparks L, Neuhauser L, Daugherty CG, Canzona MR, et al. Promoting effective health advocacy to promote global health: The case of the Global Advocacy Leadership Academy (GALA). Int J Adv Life Sci. 2013;5(1):66–78.
53. Farrer L, Marinetti C, Cavaco YK, Costongs C. Advocacy for health equity: a synthesis review. Milbank Q. 2015;93(2):392–437.
54. Kirk Koyama M. Nurse advocacy: Adopting a health in all policies approach. Online J Issues Nurs. 2018;23(3):1–12.
55. Maloney DP, Moodie R, Daube M, Wilson AN. Are Australian junior doctors failing to act as health advocates? A qualitative analysis. Aust N Z J Public Health. 2022;46(4):527–32.
56. Chrisman M, Hampton N. Evidence-based training to improve communication between health advocates and state policymakers. Social Work Public Health. 2022;37(3):297–301.
57. Alireza Delavari BD. Abbas Vosough Moghaddam. Principles and Techniques of Advocacy in the Health System. ed. n, editor2013.
58. Farias OO, Fontenele MGM, Lima FET, Galvão MTG, Silva, VMd, Lopes MVdO. Analysis of the health advocacy concept from the perspective of the evolutionary method. Revista da Escola de Enfermagem da USP. 2023;57:e20230170.
59. Sessums L, Dennis L, Liebow M, Moran W, Rich E. Health care advocacy: a guide for busy clinicians. Springer Science & Business Media; 2011.

60. Flavel J, Freeman T, Musolino C, Baum F. Health promotion and the need to accelerate advocacy for health equity. Oxford University Press US; 2024. p. daae040.
61. Cohen BE, Marshall SG. Does public health advocacy seek to redress health inequities? A scoping review. Health Soc Care Commun. 2017;25(2):309–28.
62. Townsend B, Tenni BF, Goldman S, Gleeson D. Public health advocacy strategies to influence policy agendas: lessons from a narrative review of success in trade policy. Globalization Health. 2023;19(1):60.
63. Sykes S, Watkins M, Wills J. Public health practitioners as policy advocates: skills, attributes and development needs. Health Promot Int. 2023;38(5):daad102.
64. Litva A, Coast J, Donovan J, Eyles J, Shepherd M, Tacchi J, et al. The public is too subjective': public involvement at different levels of health-care decision making. Soc Sci Med. 2002;54(12):1825–37.
65. Laari L, Duma SE. Health advocacy role performance of nurses in underserved populations: A grounded theory study. Nurs open. 2023;10(9):6527–37.
66. Neves FB, Vargas MAO, Brehmer LCF, KRd L. Grespi LdO, Bitencourt JVdOV. Actions of a cancer surveillance technical group based on the perspective of advocacy. Revista da Escola de Enfermagem da USP. 2023;57:e20220421.
67. Farmer M. Advocacy in Action for Improved Health Outcomes. Promoting Health Equity Among Racially and Ethnically Diverse Adolescents: A Practical Guide. 2018:99–111.
68. Neves FBd V, Brehmer MAO, Rabelo LCF, Rosa M, FSd, Bitencourt JVdOV. The implementation of a cancer surveillance technical group based on health advocacy. Texto Contexto-Enfermagem. 2024;33:e20230148.
69. Keane L, Kite J, Grunseit A, Vineburg J, Tawil V, Thomas M. Perceived fit,understanding, and communication: Key factors underpinning stakeholder and partnership engagement with the Make Healthy Normal campaign. Health Promotion J Australia. 2021;32(1):117–25.
70. Scott SM, Scott PA. Nursing, advocacy and public policy. Nurs Ethics. 2021;28(5):723–33.
71. Chapman S, Wakefield M. Tobacco control advocacy in Australia: reflections on 30 years of progress. Health Educ Behav. 2001;28(3):274–89.
72. Freudenberg N. Public health advocacy to change corporate practices: implications for health education practice and research. Health Educ Behav. 2005;32(3):298–319.
73. Ravindra K, Tripathy JP, Tripathy NK. Dynamics of multi-stakeholder engagement and its role in achieving high compliance of a tobacco control programme. World Dev Perspect. 2016;3:7–11.
74. Hubinette MM, Regehr G, Cristancho S. Lessons from rocket science: reframing the concept of the physician health advocate. Acad Med. 2016;91(10):1344–7.
75. Richards R, Murdoch L, Reeder AI, Rosenby M. Advocacy for active transport: advocate and city council perspectives. Int J Behav Nutr Phys Activity. 2010;7(1):5.
76. Sabo S, Ingram M, Reinschmidt KM, Schachter K, Jacobs L, Guernsey de Zapien J, et al. Predictors and a framework for fostering community advocacy as a community health worker core function to

eliminate health disparities. Am J Public Health. 2013;103(7):e67–73.

77. Myers CR. Promoting Population. Building Innovative Nurse Leaders at the Point of Care. Issue Nurs Clin. 2020;55(1):11.