The Roles and Responsibilities of Public Health in the Promotion of Health Equity: A Scoping Review

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By

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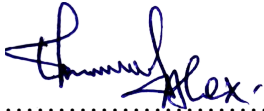
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Abstract

Inequitable health outcomes are by-products of the intersection of myriad factors including race, ethnicity, ability, gender, social class, and place among others. These factors interplay to compromise individual and community capabilities to maximize potential in challenging conditions culminating in poor health and social suffering; with the worst outcomes observed among the socially disadvantaged. Public health strives to realize healthy and productive communities by incorporating principles of health promotion, disease, and injury prevention at the core of its roles and responsibilities. Addressing health inequities, however, requires intentional and systemic interventions directed towards deconstructing the root causes with attention on the social and structural factors. The need to intervene at the root causes makes no single strategy or intervention sufficient in addressing health inequities. Public health thus needs to explicitly address the praxis of health equity within its roles and responsibilities with emphasis on system-level interventions.

The purpose of this thesis was to synthesize existing knowledge regarding the uptake of health equity within public health roles and responsibilities. This paper-based thesis has two independent papers and a general findings chapter. Chapter two sets the stage as a paper that uses personal experience and case study to explore if teaching health professionals on social, structural, political, and cultural causation of illness enhances their capacity to implement health advocacy. Chapter four is the findings from the scoping review that used the Arksey and O'Malley (2005) framework to complete a literature search for the years 1980 to 2018 resulting in 85 articles.

Four broad themes of governance, collaboration, health equity leadership, and health advocacy relating to the roles of public health in the promotion of health equity were generated.

The role of health advocacy emerged as a core link among the different roles of public health. Therefore, chapter five is a paper that explores the role of health advocacy within public health to assess how public health professionals implement health advocacy from within a system. Public health professionals implement health advocacy using six dimensions: health equity issues, barriers, processes, actors, actions, and health equity outcomes.

Healthcare professionals including nurses play significant roles in ameliorating social suffering at the individual, population, and community levels by working to provide supportive services and systems. The health services and support systems are constructed and embedded within systems of politics, law, health, and economics, which manifest as power and authority. Ameliorating social suffering to achieve favorable and equitable health outcomes necessitates building consciousness among healthcare professionals on the complex interplays of social and structural forces and encouraging them to work from and within the system by means of health advocacy.

Key words: *health equity, public health roles, health advocacy*

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Dedication

This thesis is dedicated to my mother, Margret Akello. Despite not having any academic qualification, you always encouraged me to achieve academic heights. Listening to you speak about academics always challenged my attitudes. I am motivated to always achieve more because of your encouragement. All my degrees are in your honor, mother.

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List of Acronyms

BC:	British Columbia
CKD:	Chronic Kidney Disease
CSDH:	Commission on Social Determinants of Health
ELPH:	Equity Lens in Public Health
ICN:	International Council of Nurses
LRA:	Lord Resistance Army
MOH:	Ministry of Health
NCDs:	Non-Communicable Diseases
NGO:	Non-Government Organization
TAC:	Treat Action Campaign
TB:	Tuberculosis
UBOS:	Uganda Bureau of Statistics
UDHS:	Uganda Demographic Health Survey
UMA:	Uganda Medical Association
UNDP:	United Nations Development Program
UNICEF:	Nations International Children's' Emergency Fund
UNMU:	Uganda Nurses Midwives Union
WHO:	World Health Organization

Chapter 1 : Introduction

Persons of poor socioeconomic status face some of the greatest burdens of disease yet, often experience minimal access to affordable quality healthcare, education, and social services (Brady, Burton, Rylko-Bauer, & Farmer, 2017; Farmer, 1997; Marmot, 2010). Limited access to resources for health, including education and healthcare, compromises individuals' abilities to deal with circumstances jeopardizing their resilience and capacity to live to their full potential because of adverse conditions (Breslow, 1997). The differences in capabilities to maximize one's potential in challenging and difficult conditions often culminate in poor health outcomes and resulting social suffering because of adverse social conditions (Breslow, 1997). According to Marmot (2010), differences in health outcomes are associated with differences in wealth, privilege, and power that are perpetuated by inequities in resource distribution and allocation.

The World Health Organization (WHO) Commission on Social Determinants of Health (WHO, 2010) report urges public health professionals to refocus actions from an emphasis on lifestyle options to address the conditions in which people live and work. The Commission further challenges public health with the responsibility to identify and address the root causes of ill health at both structural and social levels even if the factors are at the outer edge or periphery of health systems (WHO, 2010). The emphasis on the conditions in which people live, grow, and work indicate a need to address the root causes to promote health equity and social justice.

The Commission thus attributed public health the important role of deconstructing societal injustices and leading work to build healthy sustainable communities. Public health has continuously assumed a leading role in initiating, implementing, and evaluating vital health promotion principles. Through health promotion principles, public health works to attain healthy communities by means of population health and strives to redress health inequities (The

Bangkok Charter for Health Promotion in a Globalized World, 2006; Catford, 2004; de Leeuw, Tang & Beaglehole, 2006; Hancock, 2011; WHO, 1986).

Despite numerous approaches geared towards realizing health equity within and between countries, inequities in health outcomes persist. For example, a child diagnosed with sepsis in North America and Europe has a 10-fold higher survival chance as compared to that of a child the same age in areas of Africa and South East Asia (Khilanani, Mazwi, & Paquette, 2014). Within the United States, the probability of dying among children born to black parents is 3-times higher as compared to those born to non-back parents, and the life expectancy of black adult males and females is five or more years lower than the non-black of the same age (Bleich, Jarlenski, Bell, & LaVeist, 2012). Among pregnant women, there exists over a 50-fold difference in safe outcomes for expectant mothers in Africa as compared to mothers from high-income countries (Anderson, 2009). The large differences in health outcomes among and within regions signal a mismatch between the required actions and expected outcomes.

The numerous recommendations including collaborations with sectors outside health care systems have been foregrounded as strategies for public health to work to build sustainable health infrastructures that provide health-related services, as a process to achieve health equity (Hancock, 2011; Labonte, 1997). Public health emphasizes population health as well as health equity and social justice as the core principles of practice (Hancock, 2011; Raphael, 2003). However, little evidence exists on the praxis of health equity within public health roles and responsibilities, especially about systems-level interventions.

The purpose of this study was to synthesize existing knowledge regarding the uptake of health equity in public health roles and responsibilities. This scoping review was conducted with

the intent to understand both the functions related to health equity and the ways some of the roles are enacted within a public health context.

1.1 Current State of Knowledge

Health equity means the absence of a structured or organized disparity in the broader social determinants of health, including power, privilege, and wealth among groups of different social status (Braveman & Gruskin, 2003). Structures are social systems relating to aspects of law, economics, politics, culture, religion, health, and education, which are effective means of governing a society (Brady et al., 2017). In a global culture driven by excessive individualism, how societies are organized and managed can perpetuate social exclusion. Social exclusion arising from inequitable distribution and alignment of social structures results in avoidable social suffering (Popay, Escorel, Hernández, Johnston, Mathieson, & Rispel, 2008). Social suffering is a form of pain that results from the experience of living through structural violence (Brady et al., 2017; Farmer, 1997, 2003). The intersections of a myriad of factors including race, ethnicity, ability, gender, social class, and place lead differential exposures to unfavourable conditions. These factors intersect to produce varying levels of bad health with the worst outcomes often observed among more socially disadvantaged persons (Pauly, MacDonald, Hancock, Martin, & Perkin, 2013; Raphael, Brassolotto, & Baldeo, 2015). The United Nations Development Program (UNDP) (2015) postulates that healthy communities are attainable if individuals and professionals serve to protect human rights. The advent to sustainable, healthy communities necessitates moving beyond the individual biological and behavioral health interventions to refocusing on the root causes of unjustified inequities in health outcomes and social/structural conditions (Breslow, 999; Hancock, 2011; Labonte, 1997; Marmot,

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2010; Raphael, Brassolotto, & Baldeo, 2015). Healthy communities are those where there is equity in power, privilege, and resources for health. Constructing sustainable, healthy communities through the protection of human rights is a significant means of achieving health equity. Public health strives to realize healthy communities by incorporating principles of health promotion, and disease and injury prevention at the core of its roles and responsibilities (Raphael, 2003). However, public health professionals need to possess core competencies essential to analyzing and implementing key community program initiatives that aim to build healthy communities (Population Health and Wellness, 2005). Bridging the gap in health inequities requires public health professionals to scan the environment critically to examine socioeconomic, cultural, and political factors rather than just a focus on biological and lifestyle factors (Brady et al., 2017; Raphael et al., 2015; White, 2012). The existing evidence, however, suggests there is limited knowledge of the required action to address the daily realities of the socio-economically disadvantaged persons by healthcare professionals (Bloch et al., 2011). Maximizing human potential remains somewhat elusive as a public health function. Most health professionals and systems pay little attention to the broader social determinants of health; instead, they give preference to the individuals' biological and behavioural determinants (Hancock, 2011; Raphael, 2003). For example, in Uganda, Kiguli and colleagues (2011) have suggested training undergraduate health professionals in the areas of population health, leadership and management, health systems, as well as clinical practice to meet the national health needs. Despite having clearly stated objectives, implementing the suggested reforms remains inconsistent and heavily biased in favour of the biological and behavioural health concepts (Kiguli et al., 2011). Canada, a foundational nation in health promotion

principles, has struggled to live the ambitions of eliminating health disparities (Hancock, 2011; Raphael, 2013). McNeil et al. (2013) report that nurses, physicians, and nurse practitioners in Canada have limited knowledge required to address the social determinants of health that accompany homelessness and poverty. The lack of knowledge and skills that are required to work with socially and structurally disadvantaged persons regarding appropriate actions and practical communication skills (Frenk et al., 2010) indicates a chasm in addressing the health equity agenda. Brasolotto et al. (2014) further explored the differences in knowledge and perceptions of critical concepts among public health professionals relating to the social determinants of health. Brasolotto et al.'s (2014) study was inspired by how public health units across one Canadian province differed in their approach to actions on social determinants of health. The findings from Brasolotto et al. (2014) related to the discourses of social determinants of health articulated by Raphael (2011), which revealed varying perceptions and conceptualizations on social determinants among public health professionals. The social determinants of health perceptions also reflected on the extent to which the public health units approached and addressed issues related to health equity. Brasolotto et al. (2014) generated three main domains representing the differing perceptions: functional, analytical, and structural. The functional domain associated the social determinants of health with recognizable lifestyle-generated risky behaviours and focused on designing, implementing, and evaluating programs that influence behavioural change (Brasolotto et al., 2014). The analytical domain recognizes the influence of the conditions in which people live on health outcomes, and Brasolotto et al. (2014) reported that it is within public health responsibilities to address the inequalities in health outcomes. The actions within the analytical domain involved fostering

collaborations with community organizations to address issues related to food insecurity, housing, poverty, childhood development, and other determinants (Brasolotto et al., 2014). The structural domain combines the actions within the functional and analytical domains but also includes advocacy for public policy restructuring and public education, focusing on the role of class, gender, and racism on health outcomes (Brasolotto et al., 2014). Aligned with Brasolotto et al. (2014), Pauly, Shahram, Dang, Marcellus, and MacDonald (2017) found similar ideas in a study to explore health equity "talk" among public health leaders in British Columbia (BC), Canada. The participants acknowledged the lack of a shared understanding of the definition of health equity by persons involved in health equity work. The discussions and perceptions of health equity among the public health leaders resonated with the functional, analytical, and structural domains as presented by Brasolotto et al. (2014). In addition, Pauly et al. (2017) indicated public health professionals who viewed health equity as a social justice construct demonstrated a deeper understanding of the concepts but were still faced with a challenge on how to translate health equity concepts into action. Noteworthy, some of the participants in this study acknowledged that it was difficult and challenging to talk about health equity due to the layers of complexities spanning across structural and social relations. The study participants also identified "health equity talk" as implicit within practice due to the intricate political structures that intersect aspects of a health equity agenda. As such, most of the "talk" was directed to the functional domain recognizing the at-risk populations, and developing, implementing, and evaluating interventions targeting behavioral changes (Pauly et al., 2017). The complexities that arise from the intersections of both societal and individual determinants necessitate that the challenges be addressed using a multi-facet approach. For example, the BC government

developed a roadmap to bridge unjust inequalities in health outcomes from a public health perspective with two lenses – equity and population (Population Health and Wellness, 2005). The addition of the equity lens provides a means to acknowledge that the apparent disparities in health outcomes has root causes within the socio-economic, environmental, political, and cultural determinants that are not within the dominion of public health practice, but reassures that public health has a duty to reduce inequities within its principles (Population Health and Wellness, 2005). The population lens accounts for a preferential option for the at-risk sections of the population to safeguard from the detrimental impact of the socio-economic, political, environmental, cultural, biological, and other related factors (Population Health and Wellness, 2005). The 2005 BC roadmap delineates and contextualizes the aspirational and persuasive use of the term health equity – a language that public health professionals have used with no clear boundaries regarding its use and the accompanying praxis (Brasolotto et al., 2014; Pauly et al., 2017). The roadmap, however, did not have real specific health equity actions for public health professionals. The lack of guided interventions was further reiterated by the health equity talk study where public health professionals faced a challenge in translating health equity concepts into actions (Pauly et al., 2017). Health equity, as a matter of social justice, is both a process and goal that involves achieving fairness in the allocation of resources that shape the social determinants of health and constructing just social and health systems to promote well-being (Buettner-Schmidt & Lobo, 2012). The need to intervene at the root causes of health inequities makes no single strategy or intervention sufficient in addressing health disparities. The roles and responsibilities of public health need explicitly to address the praxis of health equity to improve the social and structural systems including power and

privilege that determine equity. Pauly et al. (2013, 2017) began addressing this need within a program of research aimed at fostering learning about the use of an equity lens in public health during a period of complex system change to inform systemic responses to reducing health inequities. Beyond the initial four studies in Pauly et al. 's (2013) program of research was a preliminary scoping review study conducted by a research intern. This present master's thesis updated the initial scoping review study by the intern under the supervision of Pauly and colleagues, with the aim to understand public health roles and responsibilities in promoting health equity and includes a specific focus on the role of advocacy. This thesis consists of six chapters. This introductory chapter has identified the research problem and the origin of this study. Chapter Two consists of a paper submitted to the Global Public Health Journal in a special issue: "The African Voices in Global Health: Knowledge, Creativity, and Action." The paper lays the foundation upon which this thesis was built. Chapter Two uses personal experiences and a case example of a medical interns' movement in Uganda, to explore some of the reasons health care professionals appear silent in the face of social suffering and injustices despite bearing daily witnesses. Chapter Three describes the scoping review methodology. Chapter Four consists of the broad findings from the scoping review; Chapter Five is a publishable paper looking specifically at advocacy from the results of the scoping review. Finally, Chapter Six consists of a summary discussion and identifies the implications of this work for nursing education, practice, and research.

Chapter 2：Social Medicine Education and the Development of Medical Intern's Advocacy in Uganda

Unpublished Manuscript under review with Global Public Health.

2.1 Abstract

Healthcare professionals bear witness to the devastating disproportionate health outcomes arising from the inadequate distribution of health resources. Achieving health equity requires healthcare professionals to work to address the mediators of social and economic forces that structure population health outcomes. Healthcare professionals can use health advocacy to address structural barriers including health policy. This paper uses experiences from the social medicine course offered in Uganda and a case of the Uganda 2016/2017 medical interns' movement, to examine whether social medicine education enhances the capacity of healthcare professionals to enact health advocacy. Drawing on critical skills and knowledge from the social medicine course, medical interns in Uganda were able to identify, communicate, and rally against the potential inequities that would arise from a change in internship policy. Social medicine serves to conceptualize and make explicit the intersectionality between social disadvantage and marginalization, and the constructs of politics, economics, power, and privilege that reinforce poor health outcomes. In Uganda, the social medicine course has fostered conscientization on mediators of poor health outcomes and built advocacy competencies among participants.

2.2 Introduction

In Uganda, a recent effort to educate healthcare professionals on the role of social, economic, and political forces in determining health outcomes from a social medicine perspective is taking shape (SocMed, 2011). The Uganda social medicine approach is

delivered through a global health lens, and it is conducted as an elective in Gulu by an international not-for-profit organization, SocMed Global. Learning through a social medicine lens aims to concretize the haphazard concept of social suffering and deconstruct the invisible abstracts of privilege perpetuated by economic, social, and political forces (Finnegan, Morse, Nadas, & Westerhaus, 2017; Westerhaus et al., 2015).

Differential access to economic, social, and human resources cultivate vulnerability and results in suffering and avoidable health inequities. Addressing health inequities require systemic approaches. This article uses the experiences of facilitators and students in the Uganda social medicine course to reflect upon the significance of social medicine in enhancing health professionals' capacity to address structural forces. These structural forces include healthcare policies that affect economic and human resource distribution within the healthcare system.

The paper begins with an overview of the Uganda social medicine course, followed by an analysis of how the course fosters an understanding of the causes of health inequities and concludes with a brief description of a process of building advocacy skills and knowledge. The 2016/2017 Uganda medical interns' movement is used as a case study to examine how social medicine training can facilitate health advocacy, to promote equitable health outcomes. Advocacy is viewed as a set of actions directed towards persons in power with an objective to influence policy processes and systems to enable social and structural changes (de Toma & Gosling, 2005). The Uganda social medicine course equips health professional students with the knowledge and skills required to initiate, implement, and analyze advocacy initiatives.

2.3 Background: Situating the Ugandan Case Study within the History of Social Medicine

Social medicine, a term coined by Jules Guerin in 1800s is viewed as a basis to extend the understandings of medicine to address social problems (Madison, 1993). Contemporary

advocates of social medicine, such as Paul Farmer, have been influenced by Jules Guerin and

Rudolf Virchow, who, in the nineteenth century, argued social and economic forces including

poverty, education, employment, and housing are mediators to deplorable health outcomes

and that healthcare professionals were obliged to reduce social ills to improve health in the

population as a whole (Farmer, 2003).[1] In the 1930s and 1940s South Africa, Kark and Kark

used social medicine principles to educate and inform family physicians about social, cultural,

and economic determinants of health and develop community-empowering health programs

emphasizing prevention (Kark & Kark, 2006).

Economic and social structures are primary mediators for health inequities within the

social determinants of health (WHO, 2010). In Uganda, social and economic inequities

continue to drive poor health outcomes. Achieving health equity necessitates dismantling

structures of power and privilege, which perpetuate inequities and disparities in health

outcomes (Jones, 2009). Social medicine is seen to be a key construct in diminishing health

inequities (Farmer, 1997; Kark & Kark, 2006).

Social medicine operationalizes health as a social product and pays attention to social and

economic forces as a gateway to health and well-being (Porta, 2014). The principles of social

medicine include community involvement, social epidemiology, disease prevention, political

action, and the organization of services (Social Medicine Consortium, 2016). Farmer has

emphasized a need to break social and economic barriers associated with the treatment and

prevention of diseases such as HIV, tuberculosis, and non-communicable diseases (NCDs)

(Farmer, 1997). Addressing economic and social barriers have proven effective in improving the

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[1] For more on Virchow's thinking on social medicine, see: Taylor and Rieger, 1984

quality of life of patients across developing nations including Rwanda, Peru, and Haiti (Farmer, 2003). The work of social medicine practitioners demonstrates that when inserted into healthcare education, social medicine can serve as a basis to construct an understanding of the impact of social relations, culture, and economics on health outcomes.

2.4 Background: The Case of the Ugandan Social Medicine Course

Social medicine courses serve to conceptualize and introduce language that makes explicit the intersectionality between social disadvantage and marginalization and the constructs of politics, economics, power, and privilege that reinforce poor health (Westerhaus et al., 2015; Farmer, 1997). For example, social medicine training highlights how social systems such as laws, economies, cultures, and politics can be a source of repression for disadvantaged sections of societies. The experience of social disadvantage cultivates social suffering in the form of unjust injuries, illnesses, pain, and avoidable deaths (Brady, Burton, Rylko-Bauer, & Farmer, 2017). With a focus on social and structural forces and relating historical constructs to the present, social medicine education serves as a basis for developing critical consciousness on the impact of poverty, power, privilege, and wealth on health outcomes.

Over the past eight years in Uganda, 30 interprofessional healthcare students – medicine, nursing, pharmacy, and public health – from Rwanda, Zimbabwe, Uganda, United States, Canada, Lebanon, and Mexico gather annually to attend a month-long social medicine course. The course is organized and implemented by SocMed, a non-profit organization, and held at Lacor Hospital, Gulu – Northern Uganda. Northern Uganda is a region with over 20 years of historical trauma arising from the Lord Resistance Army (LRA) rebel activities and cattle rustling. The conflict is historical and has been attributed to regional exclusion in

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politics, economics, and social services since the colonial times (United Nations

Development Program (UNDP), 2015).

Northern Uganda has since experienced a breakdown in areas of health, welfare,

childhood development, education, and law and order. To date, the region continues to

register poor health indicators with maternal mortality at 369 per 100,000 live births and

under-five mortality at 80 per 1000 live births (Uganda Bureau of Statistics (UBOS), 2017).

Over 27% of the households do not have a toilet facility, and about 68% of the households in

Northern Uganda are overcrowded (UBOS, 2017). In Northern Uganda, 30% of the

households walk more than 5 kilometers to access a health facility (UBOS, 2017), and 53.4 %

of the population live in poverty (UNDP, 2015). The historical conflicts, poor health

indicators, and high poverty rates among other structural issues that affect Northern Uganda,

provide sufficient local and global context for the global social medicine students to examine

the complex intersections of biological, behavioral, and broader social determinants of health.

The students come from different social, political, geographical, and cultural contexts;

this enhances the depth of discussions on the impact of social and economic forces on health

outcomes. The course contents are delivered through an amalgamation of innovative multi-

media teaching pedagogies such as Augusto Boal's Theatre of the Oppressed, cultural

immersion and reflection, community visits, and the analysis of films and art works among

others. Embedded within the guiding principles of the 3Ps – *Personal*, *Praxis*, and *Partnership*

(Finnegan et al., 2017), the social medicine course in Uganda aims to enhance the following:

- critical analysis of global health interventions and issues related to global health

  in a resource-poor setting with an emphasis on local-global contexts

- the development and implementation of a clinical approach to disease and illness using a biosocial model,

- an understanding and skill set associated with health advocacy,

- an international solidarity and partnership in engineering solutions to global health challenges facing current societies (SocMed, 2011)

Using the 3Ps, the interprofessional global students engage deeply in conversations, including human rights, colonialism and medicine, racism, neoliberal economic policies, health in a globalized world, gender equity and equality, and shortfalls and lessons from global health. The course uses the concept of *Personal* to encourage students to familiarize their lived space through critical self-reflection of their past and present experiences. *Praxis* is a Latin term co implemented by a Brazilian pedagogist, Paulo Freire as a teaching strategy to develop nuanced critical reflection with an action component among learners (Freire Institute, 2018). *Partnership* is a principle for the collaborative framework to address the complex intersections of social, political, cultural, and economic factors with health outcomes through collective strategies. In wrestling with the principles of social medicine, the class, with a multi-racial and ethnic composition, construct an atmosphere reflecting real-world situations. The conversations can deepen self-analysis about the concepts of social class and privilege within social and political systems as a function of society.

2.4.1 Understanding social and structural determinants of health, a social medicine approach.

Social medicine links history to the present by questioning the status quo through critical self-reflection and analysis (Finnegan et al. 2017). It takes an awareness of the intersection between history and present to identify and name the intricate social, economic,

cultural, and political forces characterizing health and social systems. The Uganda social medicine course utilizes intentionally structured emotion-striking-conversations as a learning strategy to create a critical awareness of self and a structured relationship with the surrounding environment. For example, throughout discussions, students constantly reflect upon, and locate, their personal experiences within the constructs of power, privilege, and wealth and how these inform their interaction with others. Sharing personal stories as a learning tool stirs intense emotions and serves to make explicit the causes and realities of marginalization. Some students have themselves been victims of social, economic, and political violence. Throughout the learning process, debriefing sessions are used as a strategy to ensure students are comfortable; students are also encouraged to approach a facilitator should they feel unsafe during or after discussions.

The learning is even more pronounced when students from the northern part of Uganda take time to reflect upon, and share, their ordeals during the LRA war. For a long time, Northern Uganda has faced civil and political unrest, leaving millions of people displaced and dead (Finnström, 2008). The ordeals of Northern Uganda is a social construction of reality driven by the cultural arrogance and colonial legacy that resulted in chronic social suffering (Finnström, 2008; UNDP, 2015). The conflict in Northern Uganda must also be traced back to the early 1960s when Uganda gained independence. Following independence, Apollo Milton Obote from the Lango tribe, one of Northern Uganda's most revered anti-colonial personalities, became president. Obote's action to abolish Kingdoms in Uganda including the then prestigious Buganda Kingdom in 1966 was not received favorably by many Ugandans.

Furthermore, the infamous dictator Idi Amin Dada was from a tribe in Northern Uganda. This important contextual history cannot be overlooked because it led to the uprising resulting in the isolation of Northern Uganda from central Uganda, breeding insurgencies like the LRA (Finnström, 2008). The social medicine course examines how medicine and health outcomes in the Northern region needs to be understood through the broader lens of Uganda's past, including the colonial and immediate post-independence periods.

Since independence, Northern Ugandans have lived in dehumanizing circumstances characterized by poverty and poor sanitation, and high maternal and under-five mortality rates. Uganda's social medicine course utilizes the historical construction of Northern Uganda and extrapolates it to include the concepts of racism and global neoliberal policies, to make explicit the impact of structures of power and privilege on health outcomes. The structures of power and resource distribution, constructed by the colonial legacies, exposed subsequent generations to historical disadvantage and marginalization; these undermine the strengths and values of the current society. (Jones, 2009).

The colonial construct has also bred conduits to "legal disparities." Global health and national health policies have embraced and continue to use a catch phrase *hard to reach places* to justify why certain geographies and populations do not have the social and economic resources sufficient for their health and well-being (UNICEF, 2016). This phrase has a deep-seated colonial legacy that many governments, especially those of current developing nations, do not attempt to deconstruct. For instance, in Uganda, the colonial settlement was highly concentrated around the Lake Victoria basin, establishing infrastructures and social services within and around this region; many of these places are currently known as main towns or cities in Uganda. In the post-colonial era, Ugandan governments have continued to entrench

colonial ideologies by attempting to concentrate social services and infrastructures in pre-established colonial regions, upholding and widening the disparity gap. Many places far from where the colonial masters settled are currently known as *'hard to reach'* including most of the communities of Northern Uganda.

The course content conscientizes students to critically interrogate the legacies of colonialism in relation to health inequalities. This happens in light of the current health and education systems that are structured to act as conduits to implement neoliberal health, social, and economic policies, which marginalize and blind the people they aspire to empower (White, 2012). Current and future custodians of health must be given a chance to examine how the legacies of colonialism operate in the present system to disproportionately disadvantage sections of society. By inspiring action through praxis of health advocacy to enhance health equity, the Uganda social medicine course fosters a critical understanding of the processes and contributors to social marginalization, which lead to differential poor health outcomes (Finnegan et al. 2017; Westerhaus et al., 2015).

2.4.2 Building health advocacy skills and knowledge.

Health advocacy is a tool used to call to attention and build support for actions related to societal injustices (de Toma & Gosling, 2005). Healthcare professionals experience and witness the impact of social suffering, which usually manifests in the form of skewed disease burden, poor health outcomes, and unnecessary deaths. Health advocacy can facilitate holding governments accountable for the health outcomes of populations. To amplify their advocacy processes, healthcare professionals need to be empowered and driven by the principle of health as a human right.

The social medicine course in Uganda utilizes the principle of personal reflection and praxis to raise the consciousness of future healthcare professionals on the facets of injustices within social and healthcare systems and the need to act through health advocacy. With its emphasis on the continuum of the personal, praxis, and partnership, the course fosters health advocacy through a longitudinal integration of advocacy knowledge and skills. In the first and second week of the course, the content of advocacy including root-cause analysis, group work, and social movements and activism are introduced. Constructive dialogue and health advocacy in the local context are introduced in the third week; and, a capstone advocacy group project in the last week. The content is delivered by course facilitators and a mix of guest speakers including course alumni. Health advocacy in the local context is presented by a guest speaker actively engaged in advocacy in Uganda. The course further emphasizes advocacy skills through a close examination of successful and failed advocacy initiatives both locally and globally. This is achieved through an analysis of advocacy documentary films including the South African HIV Treatment Action Campaign (TAC) and the Liberian women's movement for peace examined through the documentary, *Pray the Devil Back to Hell (*Dargis, 2008*)*.

The practical skills of health advocacy are enhanced through group process and activity. During the first week of the course, students are put in random groups of five with an emphasis on a global and interprofessional composition. The group tasks usually involve a clinical case relating to the burden of malaria, HIV, teenage pregnancies, diabetes, among others. *Figure2- I* illustrate a root cause analysis completed by a group of students during the first week of the class.

Figure 2-1: Root cause analysis of TB conducted by a student group during the social medicine course
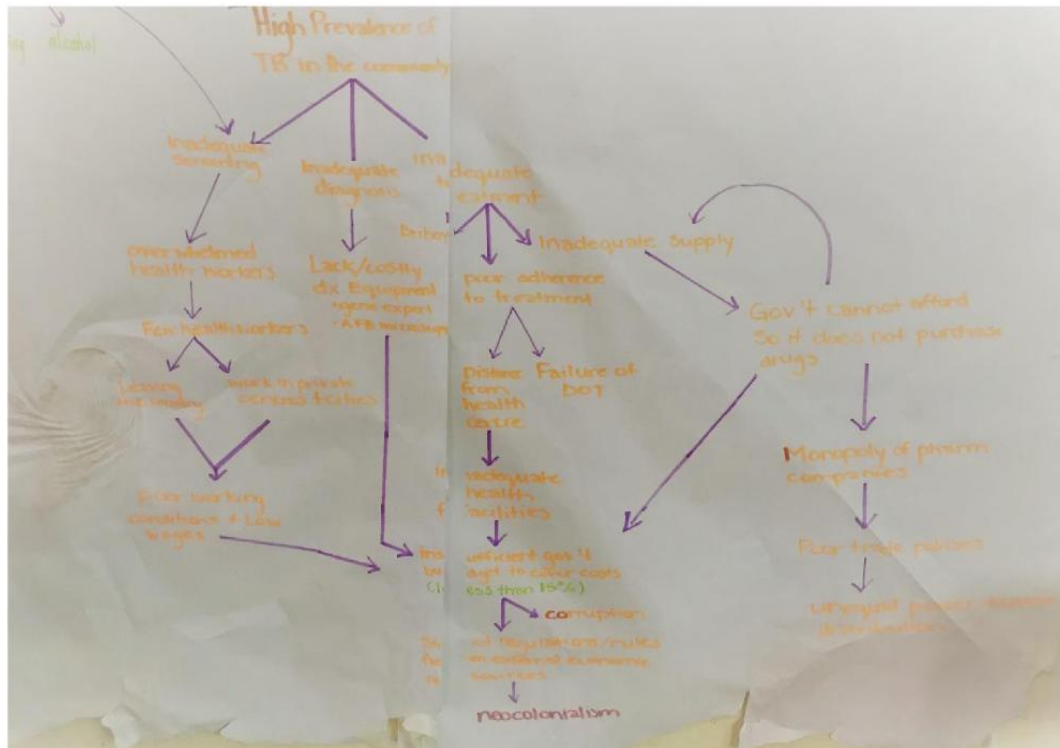
The expectation here is for students to complete a challenge identification and prioritize an action through root-cause analysis. The process involves group dialogue and brainstorming utilizing individual experiences to prioritize a health challenge with the appropriate level of intervention using an evidence-based approach. An evidence-based approach requires students to complete a rapid literature review to solidify their understanding of the issue and intervening response. The groups often develop different levels of intervention spanning across individual, population, and system levels. The class is expected to come up with one, or at most two, advocacy project(s) by the end of the course. The groups arrive at a final project(s) to focus on by consensus, which involves each group pitching their project to the class. Each project is assessed on its creativity, feasibility, urgency, amount of time required for completion, and the evaluative strategies proposed by the group. A score is assigned, including feedback by facilitators. Where three or more projects are identified, the class votes on the project to be pursued. Most class

projects have aimed at creating awareness and stimulating discussions on social and economic challenges.

In 2015, the project selected developed into the *Focus15ForHealth* campaign. The campaign aimed at urging the Ugandan government to allocate 15% of the country's budget to healthcare (Focus15forHealth, 2015). The campaign comprised of a video, a social media campaign – Twitter, Facebook, and WhatsApp– an online petition, and an open letter delivered to government officials.

The learning outcome of the group project is to support students to deconstruct and reconstruct cohesiveness and foster ownership of a project. The group process further emphasizes the need for collaboration with differently resourced actors, especially when the student groups merge projects and proceed to draw on strengths from other groups to advance a single project. The group process fosters skills in open-mindedness, ownership, focusing and refocusing, collaboration, use of evidence, communication, and identifying and prioritizing challenges and actions. In the social medicine course, completing an intense health advocacy intervention often builds self-confidence among students and acts as a source of motivation to pursue advocacy strategies beyond the classroom.

In Uganda, some students in the social medicine course are in their final year or semester at medical, nursing, or pharmacy undergraduate schools. Upon completing undergraduate programs, most undergo one year of medical internship – a period of supervised practice, where medical interns have exercised their health advocacy skills. For example, a student in the 2016 cohort described how the social medicine concepts shaped his clinical practice. "I better understood my patients because I took a broader social history, getting to

know their dreams and beliefs, as well as their challenges in daily living" (Key informant, Henry)[2]. Henry described how this helps his patients:

> In a pediatric ward, a child had chronic kidney failure (CKD) and had been in the ward for about a month. You know these patients are on long term medication, during the ward rounds no clinician seem bothered about his medication. Time came when the baby was to go for dialysis. Looking at their condition, I spoke to the caretaker who was also a teenager, and they told me how they have been trailing in life. They lost their mother on a fight with their father; they had been living alone and couldn't afford food, clothing or medications. I had to connect with other caring staff to help this young patient; we collected money and linked up with an NGO called caring hands. In the end, we collected money and deposited an amount enough to do dialysis for one year. It is what I could do and offer then given my enlightenment of the social determinants of disease. (Key Informant Henry)

After the social medicine course, many students utilize individual level advocacy as described by Henry, as well as engage with the Ministry of Health (MOH) at a system-level to challenge government policies that threaten economic marginalization of medical interns. This level of involvement has mostly happened at the internship level. For many social medicine students from Africa including Uganda and Zimbabwe, the medical internship has provided a platform to exercise and hone advocacy skills.

In Zimbabwe, graduates from the Uganda social medicine course have pursued leadership of medical interns and stewarded advocacy and activism initiatives to urge the government to improve the living and working conditions of medical interns (Daily News

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[2] In this article for ethical reasons relating to human rights issues, I've decided not to divulge the names of key informants, dates and locations of interviews and personal correspondence. Instead pseudonyms are used

Zimbabwe, 2017). Medical interns' advocacy has revolved around working and living conditions of healthcare professionals. This paper will now focus on the 2016/2017 Uganda medical interns' movement and the impact of training in social medicine on these initiatives.

2.5 Medical Internship in Uganda

Medical internship is a period of supervised hands-on experience undertaken by graduates from select healthcare professional programs – medicine, nursing, pharmacy, and dental surgery. In Uganda, medical internships started in the 1950s with the pioneering program being in medicine, followed by the addition of dental surgery and pharmacy, with nursing joining in the 1990s (MOH, 2014). Medical interns are frontline healthcare providers in most urban and major peri-urban public hospitals, where the majority of the patients are poverty-stricken, socially disadvantaged, and unable to afford private healthcare services. Currently, the Government of Uganda, MOH is responsible for the recruitment and payment of every medical intern allowance for one year.

Unfortunately, over the last five years medical internship has been plagued by numerous irregularities such as poor working and living conditions; lack of, or inadequate, pay; and lack of supervision and direction from MOH. (Anderah, 2016; Namagembe, 2017, 2018; Wesaka, 2016). Most interns struggle to save patients' lives and yet fail to pay for rent, transport, food, and clothing (NTV Uganda, 2015). With the recent development of a social movement representing medical interns, their economic and social despair has become public. For medical interns in Uganda, the challenge has been to recognize an injustice within a system, strategize, and act to disrupt the status quo. Medical internship has long been engraved with economic, social, and health injustices and interns who engaged in activism are often advised to reconsider their choice of being a nurse, doctor, or pharmacist (Anderah, 2016;

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Nanyonjo, 2016; NTV Uganda, 2015). As shall be demonstrated, the involvement of the social medicine course graduates in the 2016/2017 medical interns' campaign was pivotal to the movement identifying, initiating and sustaining the advocacy strategies.

2.6 The 2016/2017 Medical Internship Campaign

The 2016/2017 campaign was implemented by graduates from medical, nursing, pharmacy, and dental surgery schools, who were awaiting internship placement in early August 2016. The purpose was to challenge the MOH proposed changes to the medical internship guidelines. Three changes in the proposed internship guidelines were highlighted as a source of concern: 1) introduction of pre-internship exam; 2) only graduates who went to university on government scholarship were to receive internship allowance, leaving privately sponsored graduates to cater for themselves while serving in government or private hospitals; and 3) a mandatory two-year return to government service (MOH, 2016). Medical interns, however, questioned the intentions of the proposed guidelines and strategized through different processes: forming a leadership committee; framing the issues; reaching out to engage MOH officials and other stakeholders including professional associations, academic institutions, and law makers through active dialogue; forging collaborations with the media; and, activism (Key informant, Phil)

2.6.1 Organizing leadership and framing the argument.

Before 2016, the internship cycle has always been mid-August, and induction is usually at the MOH level, two or three days earlier, before the commencement of each internship cycle (MOH, 2014). The 2016/2017 medical interns did not, however, have any formal communication from MOH regarding internship placement by August 10th, 2016, a time when interns should have been informed of their internship placement status. At the time,

there were ongoing discussions at MOH aimed at rolling out a proposed medical internship guideline by late August 2016 (Business Guide Africa, 2016; Parliament Watch, 2016). Due to the delay, several medical interns spear-headed a strategy to reach out to their colleagues for a proposed informal meeting. During the meeting, it was agreed that a committee to steward engagement with the MOH officials be elected. At this point, medical interns who had completed the Uganda social medicine course were elected into key positions including vice chair, spokesperson, general secretary, and profession representatives.

The elected leaders proceeded to frame the argument as per hearsay because the interns at the time had not received any written information from the MOH. "It was still not clear about what we were standing up against. "In fact, 90% of the times, our claims were rubbished as mere rumors. But we kept the movement going..." (Key informant, Max). The leaders drew on concepts from the social medicine course to aid their analysis of the issue. "I... found root cause analysis very very important...with the goal post shifting from MOH...to the foreign aid donors, International Monetary Fund, World Bank and that..." (Key informant, Jones). "We had to know from the very start what the problem is...is it really a problem, who is affected...what is the root cause...I think problem analysis was a critical skill here" (Key informant Max).

The social medicine course concepts emphasize that before taking any course of action, individuals need to perform a self-analysis on how they are situated within the structures of power and privilege. The interns proceeded to frame their argument around economic and social disenfranchisement of interns; and argued the proposed policy would not only impact the living conditions of interns, but also negatively affect the quality of services provided (Bagzy, 2016). This argument reflects an understanding of the impact of social and economic

forces on population health outcomes, the tenets emphasized in the social medicine course. Three aspects were raised as points of concern: the proposed changes contradicted the guiding principles of internship policy; the proposals were unfair and would cause divisions; and, a lack of engagement of key stakeholders including interns in the decision process. Each concern will be considered in turn.

The proposed changes contradicted the policy guiding principles. The proposal was seen to contradict the internship policy principles I, II, and IV. Principle I speaks to equity; II to equality and highlights the need for a rational access to internship placement by all interns; and, IV indicates internship must be conducted in accordance with the Uganda labour laws, which provide for remuneration for all professional services rendered (MOH, 2014).

The proposed changes were unfair and divisive. The concept that only medical interns who completed school under a government sponsorship would receive monthly allowances was unfair, and impacted the legitimacy of other interns, who would not receive any support for their services. Social medicine argues for practitioners to be cognizant of structures including policies that may be a source of repression. The interns argued the proposed changes would result in economic disenfranchisement of a select group and cause divide and demotivation impacting the quality of care; infringing directly on the impoverished clients.

The proposed changes were developed without the engagement of key stakeholders, including interns. The interns argued key stakeholders, including members of the community, internship site supervisors, academic institutions, legislators, and professional bodies were not consulted in the guideline development (Nanyonjo, 2016; Wesaka, 2016; Watera, 2016). The medical interns decried the lack of consultation surrounding the processes to develop the guideline and questioned the reason for a quick turn around on the policy process. The process

of organizing the meeting, formulating leadership, and framing the issue all happened between August 7th and August 15th, 2016; by August 15th, medical interns had initiated a dialogue with MOH.

2.6.2 Dialogue processes and building collaborations.

In the process of creating collaborations, the medical interns found some of the course contents from the social medicine significant, "...key skill that helped in the movement was...constructive dialogue skills, which saw many sections of intern/student leaders engage the stakeholders at the MOH, ...civil society organizations, parliamentarians...to understand the plight of interns" (Key Informant Jones). The interns sought dialogue with MOH officials but were denied access. This led to medical interns' leaders seeking opinion and partnership with professional associations including Uganda medical association (UMA), Uganda nurses and midwife union (UNMU), and the Uganda pharmaceutical associations; legal firms; media houses; and, students' associations. The UMA played a critical role in mediating continued negotiations between the MOH and interns' leaders, including a meeting with the Parliamentary Committee on Health (Business Guide Africa, 2016; Watera, 2016).

Despite numerous attempts to dissuade the MOH from implementing the guidelines, the officials were steadfast to enforce the guideline. Negotiations hit a deadlock and interns were at the verge of terminating their advocacy initiatives. As reflected in the statement below, the interns' leaders who possessed advocacy skills obtained through the social medicine course became the engine to maintain for the campaign "...mainly focused on developing strategies and making sure the movement has strategies in place to become successful. I took up...this role" (Key Informant Max). Many leaders continued to encourage their colleagues and other stakeholders on the need to speak against the MOH policy change, "I ...remember participating

in dialogue with the dean [of the] medical school, participated in the NTV People's parliament among others before we finally hit the road and the court" (Key Informant Jones). The actions culminated in collaborative strategies that aided in drawing a critical mass to the campaign, and the interns established a movement. The social medicine course foregrounds collaboration through the principle of partnership to gain power and momentum for effective actions.

2.6.3 Activism.

The desire to persist and speak against the proposed changes prompted the medical interns to seek alternate avenues to air their grievances. The interns found the social medicine course session on social movements useful in formalizing their strategies.

Social medicine course on social movements played a major role in helping us stay aware of what we were going through and how to deal with it. From knowing what our purpose was, to understand the stage of growth we were in (Key Informant Max).

The leadership strategized to engage legislators and a video crafted by social medicine alumni highlighting the need to halt implementation of the proposed policy was released and circulated through different social media platforms including WhatsApp, Facebook, and Twitter among others (Bagzy, 2016). The purpose was to rally interns, medical students, and others for a march to Parliament. Various student groups participated through moral and financial contributions, and some advised on the different roles they could play in social movements, "when analyzing social change wheel...confrontational strategy. We ...found ourselves playing different roles...I was more of an advocate, organizer and a rebel" (Key Informant Jones). For the first time, this level of organization saw a countrywide interns' protest joined by medical students who marched in solidarity with the interns to Parliament (Nanyonjo, 2016). *Figure 2-2* is a photo of medical interns demonstrating against

the proposed policy on the streets of Kampala, Uganda. Attempts by the police to disrupt the peaceful march generated a public outcry (Mwesigwa, 2017), but it was a deliverable for the interns

> I remember discussing with a colleague that the only way we could draw media attention without fail, during our demonstrations was by having the police arrest some of us. An indeed after laying for them…we had some of our rebels arrested by the police. It was a move well calculated to get us a key deliverable, public sympathy. (Key Informant Max)

Figure 2-2 Medical interns interfacing the Uganda police during a peaceful demonstration

Despite all the strategies and actions, the MOH was committed to implementing the proposed policy. However, a group of medical interns led by social medicine alumni collaborated with a pro-bono legal firm and sought an injunction against the proposed policy (Anderah, 2016). This was the first time Uganda medical interns attempted a legal challenge over unfair and oppressive health system policies. The Courts issued an injunction against the policy and ordered the MOH to deploy all interns using the 2014 medical internship policy (MOH, 2014). Albeit an injunction on the proposed policy, the Courts did not rule on the case, which has since been serially adjourned for lack of interest on the part of the MOH.

2.7 Discussion

Constructing an understanding of complex social, economic, and political forces that impact health outcomes can serve to inspire healthcare professionals to be active witnesses to policy structures that advance health inequities. White (2012) indicates there is a need to engage and challenge the structural-ideological discourses that shape healthcare services. Social medicine emphasizes the need to be critical of socio-economic, political, and cultural forces that constitute healthcare policy and practice. Educating health professionals using a social medicine approach can provide a necessary tool to enact changes in the health system. Healthcare professionals, owing to their experiences with the impact of health inequities are well positioned to analyze and deconstruct the structural injustices engraved within health systems (Sklar, 2016).

Healthcare professionals who value health as a human right are poised to act in the face of health and social injustices. The social medicine course in Uganda aims to not only achieve conscientization of the mediators of poor health outcomes but also strives to foster motivation towards action by integrating advocacy as a tool for praxis. The principles of personal reflection, praxis, and partnership utilized through the class discussions serve to build an action-oriented conscientization. The practical advocacy project provides for a simulation of advocacy interventions mimicking individual, population, and system complexities. This serves to build self-confidence and skills-oriented advocacy competencies, as well as motivate actions beyond the initial advocacy activity.

Advocacy skills when not directed to address issues of population interest through a social justice lens may have potential to exacerbate health inequities. It is important to note that some individuals or institutions may use advocacy skills to achieve personal interests and gains at the expense of health equity. However, the Uganda social medicine class emphasizes

the use of health advocacy to deconstruct systems and social structures, with health equity and social justice principles at its core. Knowledge and skills are critical in cultivating self-confidence and resilience in health advocates.

The Uganda medical interns' movement demonstrated an enhanced sense of personal capacity to engage in strategic advocacy, which was sustained for over two months. Notably, the movement stood its ground amidst discouragement and intimidation from colleagues, senior professionals, MOH officials, and politicians (Mwesigwa, 2017). The intern advocates displayed a mastery of skills, open-mindedness, resilience, and effective collaboration and communication strategies. The intern's movement benefited from those with the knowledge of health advocacy, "other people who didn't have the principles activism didn't support us, in fact even discouraged us. But after the success, they wished they had the same knowledge as we did" (Key Informant Phil). The Uganda social medicine course serves to build conscientization on the facets and drivers for ongoing health inequities, and empowers future healthcare professionals with the necessary knowledge and skills to act.

2.8 Conclusion

Learning through social medicine approach can serve to illuminate an understanding of the complex drivers of inequities. In Uganda, the medical interns' movement leaders were in a position to identify, communicate, and rally against the potential inequities that would arise from the proposed internship policy. The root-cause analysis skills and knowledge on social movements, and constructive dialogue can serve to inform effective, tactical, and meaningful advocacy and activism. The case of the social medicine course conducted in Gulu, Uganda serves to construct a critical consciousness on social, economic, cultural, and political

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causes of illnesses and inspire healthcare professionals to be active witnesses of system

perpetuated inequities, through an emphasis on personal reflection, praxis, and partnership.

Chapter 3 : Methodology

The poor person does not exist as an inescapable fact of destiny. His or her existence is not politically neutral, and it is not ethically innocent. The poor are a by-product of the system in which we live and for which we are responsible (Gustavo Gutiérrez, *The Power of the Poor in History,* as cited in Farmer, 2003, p.139)

The above quote reminds me of my personal experiences in growing up in an impoverished rural community of northern Uganda. I lived and watched relatives, friends, and neighbors die preventable deaths. Within the impoverished community, a feeling of powerlessness, hopelessness, and inability often defined every action. The people could not see anything better than what they already had. Needless to say, hunger, war, poor sanitation, and the lack of healthcare services that characterized the lives in my community were a near normal situation. However, involvement with the social, economic, political, and historical forces as a construct of our societies, through a social medicine course as a student, and later as a facilitator, submerged me into a self-introspection.

Through personal reflections, I realized that the life I had lived in an impoverished community was not normal and neither was it a making by the people who lived these dreadful experiences, but rather, a social construction of reality. The suffering the people faced were as a result of a failure in social, economic, and health systems. These systems define who lives and who does not, with a high preference for those in a higher socioeconomic status. My enlightenment on the impact of health, social, and economic systems was further braced during my professional role as a nurse. In working as a nurse, I witnessed clients with no family caregivers groan in pain; most could not afford medication and others had nothing to eat; the end result was often painful deaths. Patients encountered

undignified deaths because the hospital frequently experienced stockouts, no active social support system, and no provisions for food for the sick. It was evident that the painful deaths that patients succumbed too were a result of a failure in systems, yet, no one seemed ready to act. It occurred to me that there was no better time, and that I was best suited to speak for the patients and communities, as a nurse.

The desire to locate myself within the suffering of many patients and the members of the community I had witnessed, ignited an interest to understand the role healthcare professionals assume to alleviate social suffering. This is what inspired me to pursue a Masters degree with the intent to understand what healthcare professionals do to achieve health equity. My supervisor's experience with researching the use of a health equity lens in public health was handy and played a critical role in shaping my thesis. As a person who believes health professionals are obliged to alleviate human suffering, and through the guidance of my committee, I sought to understand the literature describing the role of public health professionals to promote health equity, with a focus on health advocacy from a system lens.

3.1 A Scoping Review Methodology

This study uses the Arksey and O'Malley (2005) scoping review framework. Scoping review designs enable researchers to establish existing gaps in the literature by examining a broad range of peer-reviewed and grey literature without paying attention to the quality and methodological lenses of the studies. The current study sought to examine the praxis of public health roles and responsibilities in advancing health equity from the early 1980s; a time when health equity began to emerge in practice and the literature.

3.2 Study Questions

1. What are public health roles in promoting health equity?

2. How is advocacy as a means to promote health equity implemented within public health roles and responsibilities?

3. What are the facilitators and barriers to implementing health advocacy within public health?

The study was conducted in two different phases using the same methodological approach based on the first research question. The first phase, conducted within a research project "Equity Lens in Public Health (ELPH)", involved retrieving literature for the years 1980 through 2015 from five databases: Medline, CINAHL, PubMed, Web of Science, and Sage Articles. The first phase of the study was not completed beyond the literature search and preliminary analysis. The second phase of the study involved updating the search strategy using the set criterion by the ELPH research team, to capture data for the years 2016 through 2018 across the original databases. The selected articles from both searches were aggregated for data extraction and analysis, as shown in *Figure 3*. The Arksey and O'Malley (2005) scoping review framework follows five stages including identification of 1) the research question, 2) relevant studies, 3) the search strategy, 4) data charting, and 5) organizing, summarizing, and reporting of results.

The first stage involves identifying the research question and follows an iterative process. In this study, question (1) "What are public health roles in promoting health equity?" was developed in the first phase of the study and maintained through phase two. However, question (2) "How is advocacy, as a means to promote health equity, implemented within public health roles and responsibilities?"; and, question (3) "What are

the facilitators and barriers to implementing health advocacy within public health?" were added in phase two, during database update and formed the basis for data extraction.

The second stage in Arksey and O'Malley's (2005) framework is identifying the database from which to perform the search to answer the set study questions. The searches were conducted using the fields "title," "abstract," "keyword" and "subject heading" and limited to publications between January 2016 and June 2018. A previous search for the years 1980 to 2015 was performed by the ELPH research team, and this study involved updating the database and conducting data extraction with an emphasis on question 2 and 3. Table 3-1 shows the search strategy and the key terms used to retrieve articles from the databases. The database update was conducted across the five databases used in the first phase of the study: Medline, CINAHL, PubMed, Web of Science, and Sage Articles using the same fields and search strategy.

Table 3-1: Search Strategy

EQUITY LENS IN PUBLIC HEALTH							
Research question: What are public health roles and responsibilities for promoting health equity?							
Health Equity Searched using OR	A N D	*Type of article*	A N D	*Public Health* Searched using OR	A A N D	*Context / Population / time span*	
"health equit*" "health inequit*" "health equality" "health inequalit*" "social justice" "health disparit*" Inequities "health status disparit*" "healthcare disparit*"		English or translated to English		"public health" service* "public health" system* "public health" role* "public health" function* "public health" sector* Policy Advocacy "health promotion" "health protection*" "preventative intervention*" "health assessment*" "disease surveillanc*" "develop* polic*"		2016 -2018 Any country	

The third stage involved the selection of retrieved articles following the database search. Figure 1 provides the details of the study selection process. In the second phase of the study, articles were retrieved and uploaded into Endnote 10 for de-duplication (Bramer, Giustini, de Jonge, Holland, & Bekhuis, 2016). After de-duplication, articles were then transferred into Distiller for a quick title scan, followed by reading of the title and abstract, and reading of the full text.

The fourth stage involved data extraction and charting. Data extraction followed key aspects guided by the research question constructed in the first phase of the study and during the database update. *Table 3- 2* shows key fields that guided data extraction and constituted the basis of analysis.

Table 3-2 : Data extraction table template

Source, Author, and Title	Purpose	Country	Public health role	How Advocacy is enacted	Facilitators	Barriers	Comments

The fifth stage involved analyzing and reporting findings. Data extraction and analysis were iterative. Eighty-five articles were included for data extraction using a pre-designed data capture table as indicated in *Table 3- 2*. For articles highlighting the role of public health in the promotion of health equity as advocacy, data extraction was further extended to include how advocacy was enacted, facilitators to advocacy, and barriers to implementing advocacy. Data analysis was thematic and involved reading through the data sources looking for similarities and differences and categorizing them into themes (Morrow, Rodriguez, & King, 2015). The generated themes were assessed further for any form of association.

The research intern from phase one had provided an initial summary of what constituted the literature, with incomplete notes on findings. Therefore, it was necessary to retrieve data from all 85 papers, contributing to the reliability of the outcome. Additionally, approximately 10 percent of the article titles and abstracts were reviewed by a second reviewer to ensure rigor in the data selection process. The overall result is a reproducible search strategy and demonstrates trustworthiness in the scoping review findings

Figure 3-1: Study selection process for 1980-2015 and 2016-2018 search strategy

Databases: Medline, PubMed, CINAHL, Web of Science, and Sage Articles

1980 – 2015 Database Search | 2016 – 2018 Database Search

5703 | Retrieved Articles | 9067

3960 | After de-duplication | 5499

2498 | **Title contains**: "public health roles or responsibilities", health equity, policy (health), advocacy, disparities, social (health) (in)justice, or health systems | 701

371 | **Title and Abstract:** Discusses or suggests public health Roles in advancing health equity or integration process | 183

318 | Reviews, no full articles, discusses equality | Reviews, no full articles, discusses equality | 151

Full text: Discusses health equity at a system level or extrapolates programmatic integration to include system level approach, extends (in)equality discussion to include (in)equity. **Total articles included 85**

Chapter 4 : Findings

There are 85 published peer-reviewed articles in this review. *Figure 4- 1* indicates the percentage distribution of the different articles by type, categorized as discussion papers, non-empirical papers, empirical studies, commentaries, and editorials.

Figure 4-1: Percentage distribution of papers reviewed by article type
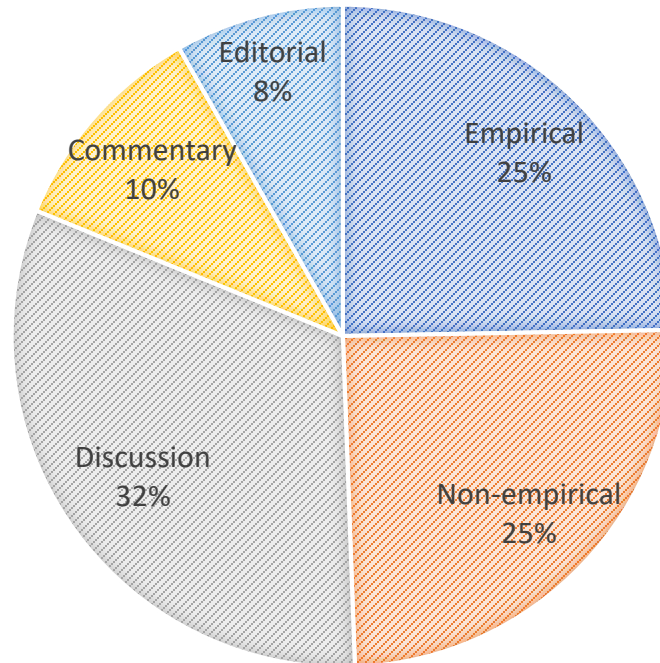
The articles are from 52 different journals with *American Public Health Journal* contributing the highest number of articles at 16.47%, followed by *Journal of Health Services Management Research* 5.88%, *International Journal for Equity in Health* 4.71%, *Journal of Public Health*; *Advanced Nursing*; *Health Promotion and Practice* at 3.53% each and the other 46 journals contributing 1.18% each.

The diverse journals were representative of geographical focus accounting for over 12 different global geographies (regions) including North America, Western Europe, Global, Asia, Scandinavian, New Zealand, Latin America, North and Central Europe, Africa, and the

Caribbean, Arctic and Sub-Arctic regions. *Figure 4- 2* indicates the percentage distribution of the articles across the regions.

Figure 4-2: The percentage distribution of the articles reviewed by geography (regions)
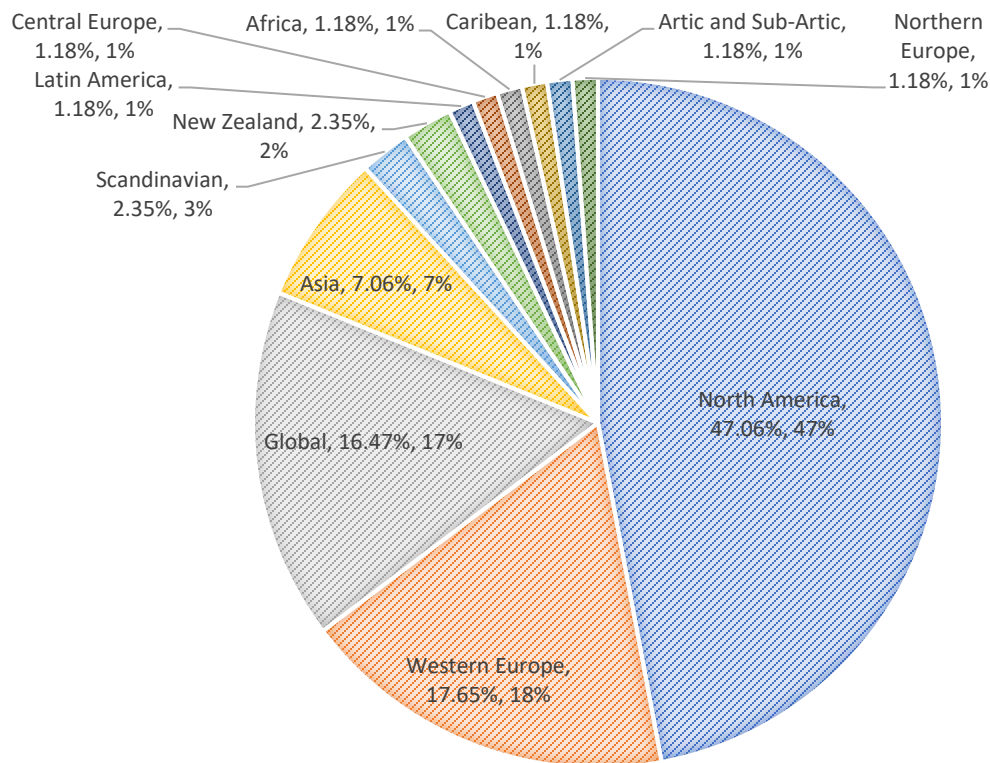
Four primary themes and eight sub-themes relating to the roles and responsibilities of public health in the promotion of health equity were generated. The themes and sub-themes include:

1. Governance: policy and financing

2. Collaboration: multi-sectoral and community empowerment

3. Leadership: education, and surveillance and mapping

4. Health Advocacy: research and communications

The data sources that constituted this review are presented numerically in a table format below, highlighting the number of articles, the region of focus, the type of study (either

empirical, non-empirical, discussions, commentary, or editorial), and the authors. In this chapter, a summary of thematic findings including governance, collaborations, leadership, and health advocacy are presented descriptively. In subsequent chapters, I focus on health advocacy and present recommendations and conclusions.

4.1 Governance

Table 4- 1 indicates the number of articles for geographical regions while Table 4 shows the number, design types, and the authors that constituted the theme of governance.

Table 4-1: Region of Articles for Governance

Regions of Focus	Number
North America	5
Asia	2
New Zealand	1
Global	7
Western Europe	3
Africa	1
Scandinavia	1
Latin America	1
Total	21

Table 4-2: Type of Articles for Governance

Type of Studies	Authors	Number
Empirical studies	Aspinall & Jacobson (2005); Gopalan et al. (2011); Came et al. (2017)	3
Non-empirical studies	Antin et al. (2015); Chuma & Okungu (2011); Fredriksson et al. (2013); Hall et al. (2016); McGowan et al. (2016); Diamond & Freudenberg (2016); Furtado & Banks (2016); Lal et al. (2018)	8
Discussions	Bloom (2001); Forde & Raine (2008); Hurrelmann et al. (2011); Hartmann (2016); Labonté & Stuckler (2016)	5
Commentary	Bayoumi (2009); Beaglehole & Bonita (2000); Balarajan et al. (2011); Bert et al. (2015); Levin (2017)	5
Total		21

Governance is presented as a strategy on how public health structures including a strong political will, policymakers, professional leadership, and finances can be aligned or

orientated to address health inequities (Beaglehole & Bonita, 2000; Bloom, 2001; Fredriksson, Blomqvist, & Winblad, 2013). Addressing health inequities requires a system lens approach implemented at all levels of governance and administrative structures including ministries, local governments, and municipal councils (Gopalan, Mohanty, & Das, 2011). Policy makers at the level of governance often fear to engage in critical discussions concerning significant trade-offs between political orientations and health equity principles during policy reforms. This facilitates over-reliance on ideological orientations rather than discussions based on evidence (Fredriksson et al., 2013). The fear is worsened by the unwillingness of policymakers (stakeholders) to relent political positions. Furthermore, the lack of practical governance tools to facilitate the utilization of the health-in-all-policy framework derails health equity intervention from within a system (Bert et al., 2015). The ideological challenges of governance can be addressed using advocacy process strategies that aim at the inclusion of health in all policies across sectors using a social determinants of health approach with health equity at its core (Bert et al., 2015; Forde & Raine, 2008; Hurrelmann, Rathmann, & Richter, 2011).

4.1.1 Policy

Implementing health equity principles from a system lens requires an operational strategy grounded in policy frameworks to enhance accountability (Beaglehole & Bonita, 2000; Fredriksson et al., 2013). Some of the key health equity governance principles including strengthening health infrastructure, improving disaster preparedness, and a focus on social protection infrastructure require ultimate commitment (Acevedo-Garcia et al., 2008; Furtado & Banks, 2016; Levin, 2017; McGowan, Lee, Meneses, Perkins, & Youdelman, 2016). Antin et al. (2015) and Chuma and Okungu (2011) argue that influencing policy processes to address the social and structural barriers to health can be achieved through active

engagement of the public in the policy process. Additionally, Came, McCreanor, Doole, and Simpson (2017) highlight political and cultural competencies as critical determinants towards addressing structural and social barriers that impede access and participation in the process of health. Health disparities are rooted in the "geography of opportunities," therefore priority should be given to policy options that aim to reduce poor neighborhoods and accelerate access to social and health services (Acevedo-Garcia, Osypuk, McArdle, & Williams, 2008; Diamond & Freudenberg, 2016). Demonstrating health equity system performances requires the use of health equity matrices that target gathering, using, and applying data directed at health outcomes and processes (Antin et al., 2015; Balarajan et al., 2011; Bayoumi, 2009; Hurrelmann et al., 2011; Lal, Moodie, Peeters & Carter, 2018). Health equity metrics need to focus on health outcomes and processes and must utilize an enhanced health system and a health-equity research knowledge base (Antin et al., 2015; Balarajan et al., 2011; Bayoumi, 2009; Hurrelmann et al., 2011; Lal et al., 2018). Furthermore, public health professionals need to aim at mapping economic and social protection reforms for the socially disadvantaged (Acevedo-Garcia et al., 2008). Metrics on social and economic outcomes can be championed at governance platforms to enhance financing support and commitment (Furtado & Banks, 2016; Levin, 2017).

4.1.2 Finance

The impact of structural factors on health outcome performances across macro, meso, and micro stratifications greatly depends on financial commitments at the governance level (Hurrelmann et al., 2011). However, soliciting financial support and commitment from the public and politicians requires an equity sensitive financing framework that accounts for disadvantaged needs with an emphasis on risk-subsidization

as a way to enhance universal healthcare access (Antin, Lipperman-Kreda, & Hunt, 2015; Chuma & Okungu, 2011; Hartmann, 2016; Labonté & Stuckler, 2016).

Balarajan, Selvaraj, and Subramanian (2011), Hall, Graffunder, and Metzler (2016), and Hurrelmann et al. (2011) indicate public health professionals can influence policy and financial commitment at the level of governance by implementing a transparent pro-health equity decision-support process. The decision-making process to achieve health equity needs greater development within all segments of society to enhance accountability and transparency and requires improved leadership within the health care system (Balarajan, Selvaraj, & Subramanian, 2011). A decision framework can further be enhanced by incorporating health impact and technology assessment strategies; this encourages and coordinates the relevant governance sectors to play a part in reducing health disparities (Hall et al., 2016).

The practice of governance directly affects the type of health policies and the flow of finances into health equity strategies. Aspinall and Jacobson (2005), argue that professionals with the required expertise need to be strategically positioned to influence and direct health equity-friendly policies and allocation of finances. According to Bayoumi (2009), public health professionals at the position of governance need to play a role to educate the public and politicians on avenues to achieve equity in health care services. Achieving health equity from a system level requires broad lens interventions targeting policies and sustainable financing strategies.

4.2 Collaborations

Tables 4-3 and 4-4 indicate the data number of articles, type, the area of focus, and the authors that constituted the theme of collaborations.

Table 4-3: Region of Articles for Collaborations

Region of Focus	Number
North America	8
Asia	1
Global	1
Western Europe	1
Northern Europe	1
Scandinavian	1
Caribbean	1
Total	14

Table 4-4: Types of Studies for Collaborations

Type of studies	Authors	Number
Empirical Studies	Lillefjell et al. (2018); Storm et al. (2016)	2
Non-empirical Studies	Fagan et al. (2007); Koo et al. (2016); Wan & Su (2016)	3
Discussions	Acevedo-Garcia et al. (2008); Basch (2014); Anderko (2010); Bard (2005); Fawcett et al. (2010); Hanafin et al. (2002); Vanderbom et al. (2018)	7
Commentary	Cloos (2010); Price et al. (2018)	2
Total		14

Collaboration is a process through which different communities, ministries, sectors, departments, and professionals work together to effect relational and contextual parameters that affect health. To achieve health equity, collaborative strategies need to be based on shared responsibilities for health outcomes (Fawcett, Schultz, Watson-Thompson, Fox, & Bremby, 2010). Multiple sectors including education, transportation, social services, and primary and public health units work to impact health outcomes. The two main themes relating to collaboration include multi-sectoral collaboration and empowerment. Multi-sectoral collaboration recognizes the complex causes of health inequities and emphasizes the need for a consorted effort towards addressing the root causes from a system level. Community empowerment alludes to the importance of a community-generated solution towards addressing inequities.

4.2.1 Multi-sectoral collaboration.

Public health departments, health research institutions, and governments need to establish multi-sectoral collaborative actions that integrate health equity and social justice at their core (Cloos, 2010; Bard, 2005; Hanafin, Houston, & Cowley, 2002; Price, Khubchandani, & Webb, 2018; Wan & Su, 2016). Koo, O'Carroll, Harris, and DeSalvo (2016) recommend existing collaborative strategies including data and metrics, and philanthropic initiatives need to be implemented with health equity as a guiding principle. Basch (2014) further argues that public health needs to address the conflict of loyalties between project funders and the interest of targeted communities.

In the Netherlands, a study to examine how municipal public health units addressed health challenges using multi-sectoral action across three municipalities indicated that collaboration was anchored within a shared common health goal across all sectors within the municipalities (Lillefjell et al., 2018; Storm, den Hertog, van Oers, & Schuit, 2016). Diverse actors implemented collaboration across all three municipalities through a seven-stage process model (Lillefjell et al., 2018). The processes in the model were: setting a society health mission; defining a knowledgebase for inclusion of actors; identifying and developing a locally based strategy that works to address health inequity; planning new initiatives to advance the local initiatives; implementing and evaluating outcomes using local resources and assets; and; turning action into new knowledge. The actors included politicians, corporate bodies, citizens, public administration, voluntary institutions, and researchers (Lillefjell et al., 2018). The process model and actors provided a basis for an organized collaborative platform that was goal oriented and focused on population health outcomes (Lillefjell et al., 2018). The processes in this model are similar to the seven collaborative strategies for public health proposed by Fawcett et al. (2010), described below.

The strategies by Fawcett et al. (2010) begins with (one) establishing a monitoring system to assess progress in population health outcomes with health equity at its core. The second stage involves developing and using action plans that assign responsibilities for changing communities and systems across sectors. The third stage requires facilitating natural reinforcement for people working together across sectors by a principle of the tended system. The fourth stage identifies the need to establish an adequate funding base for collaborative efforts that is sufficient to improve and sustain population health outcomes. The fifth stage involves organizing training and technical support for those working in collaborative partnerships. The sixth stage requires establishing a participatory evaluative system for assessing progress and readjustments, and the last stage (seven) involves arranging group contingencies to enhance accountability and progress improvement.

Common to the processes in both models is centering community and population health outcomes and having health equity form the basis of any collaborative strategy. These processes when implemented form a structured basis for shared responsibility towards the health equity outcomes across sectors and can empower communities (Lillefjell et al., 2018). When communities are involved in driving and implementing health equity actions, there is a sense of ownership. However, vulnerable populations often feel powerless and may not have capacity to change the status quo (Basch, 2014). A critical aspect in the process of addressing health inequities is empowering communities experiencing inequities.

4.2.2 Community empowerment

In an effort to address the root causes of inequities, Basch (2014) proposes three interrelated models of action - locality development, technical action, and social action as a

strategy for public health in redress of social injustices. *Locality development* aims at building capacity within the community members, allowing them to take ownership of the problem. *Technical action* involves urgent responses to public or individual challenges that may have high burdens regarding costs and health outcomes if not addressed in time. *Social action* entails the use of advocacy strategies to influence and sustain a legislative or political response to issues of interest (Basch, 2014). The three interrelated models need to be implemented in close collaboration with the communities as a strategy to empower and build capacity within the vulnerable population.

Anderko (2010) indicates one public health strategy to build the public's capacity is to collaborate with the communities through a participatory community-based approach, including the process of assessment, planning, and implementation. The participatory community-based approach is a process to prioritize and empower the community through equitable, collaborative partnerships to capitalize on the resources and strengths within the community members. Equitable shared partnerships improve control and ownership; provides a unit of identity; builds political, social and economic capital; and acknowledges the relevance of the local health problems (Anderko, 2010). Through building partnerships based on common goals between communities and the different sectors working to enhance health, public health can achieve an empowered community that takes ownership of health issues and demand accountability from people with power.

A common shared goal enhances political and community commitment and fosters cooperation and coherence across government sectors addressing health equity challenges (Fagan, Moolchan, Lawrence, Fernander, & Ponder, 2007; Lillefjell et al., 2018). Public health

professionals have the mandate to advocate for multi-sectoral collaborations across systems

and programs to address health inequities from a broader lens (Furtado & Banks, 2016;

Vanderbom, Eisenberg, Tubbs, Washington, Martinez, & Rauworth, 2018). Initiating and

sustaining effective concerted multi-sectoral collaborations based on health equity principles

requires a

strong health equity leadership within public health. Health equity leadership is a

critical milestone towards addressing social injustices at global, national, and local

levels.

4.3 Leadership

Tables 4-5 and 4-6 indicate the number of articles, area of focus, type, and authors that

constituted the theme leadership.

Table 4-5: Region of Focus for Leadership

Region of Focus	Number
North America	14
Asia	3
New Zealand	1
Global	6
Western Europe	7
Central Europe	1
Artic and Sub-Artic	1
Total	33

Table 4-6: Types of Studies for Leadership

Types of Studies	Authors	Number
Empirical Studies	D'Angelo et al. (2013); Haafkens et al. (2014); Almond & Lathlean (2011); Green et al. (2013); Blanchard et al. (2013); McPherson et al. (2016); Bliss et al. (2016); D'Ambruoso et al. (2008); Eslava-Schmalbach et al. (2017); Sokol et al. (2017)	10
Non-empirical	Hahn & Truman (2015); Hofman et al. (2013); Douglas et al. (2015); Alang et al. (2017); Furtado & Banks (2016); Hennessy & Bressler (2016); Braveman et al. (2011); Carey et al. (2015)	8
Discussions	Abel & Frohlich (2012); Culyer (2001); Binns et al. (2017); Came & Griffith (2018); Griffith et al. (2006); Alvarez (2007); Aranda & Hart (2015); Bryant et al. (1997); Fotaki (2010); Baum et al. (2009); Marcellus & Shahram (2017)	11
Commentary	South et al., (2018)	1
Editorial	Easley et al. (2001); Kreslake et al. (2018) Adams (2012)	3
Total		33

Health equity leadership in public health is presented as a significant component necessary to generate and steer a mass that demands and implements fairer healthcare services. Public health professionals are viewed as stewards who can instigate and sustain the inclusion of a health equity lens at both local, national, and international platforms (Alvarez, 2007; Aranda & Hart, 2015; Marcellus & Shahram, 2017; Baum et al., 2009; D'Ambruoso, Byass, & Qomariyah, 2008). As argued by Easley et al. (2001), the challenge for public health professionals wishing to engage in health equity and social justice is how to move beyond the emotional attachment to social justice and human rights and acquire the knowledge and practical skills necessary to put human rights into health practice while caring for the population. Building capacity of public health leaders across sectors to support and influence health equity leadership at local, national, and global platforms is critical in attaining the initiation and sustainability of health equity interventions (Sokol et al., 2017).

In a study to examine key factors that influence the development of social determinants of health by public health nurses, McPherson et al. (2016) identified three key themes. The themes included: (1) leading change when navigating ideological tensions, competency, and establishing novel collaborations; (2) shifting the organizational practice environments impacted by role placement and acting to achieve structurally embeded health equity priorities; and, (3) bridging policy implementation gaps related to local-provincial implementation and reporting expectations (McPherson et al., 2016). Leadership is a critical factor when implementing the health equity framework within public health roles. Strategic leadership spanned across three levels, individual, organizational, and system, and were seen as a significant hindrance or enhancer towards health equity actions (McPherson et al., 2016).

On how to build health equity leadership and encourage actions on the determinants of health equity, two themes were identified: education, and surveillance and mapping. *Education* involves making available the appropriate knowledge and skills both within and outside public health departments and outside the departments to facilitate informed discussions and decision-making. *Surveillance and mapping* involves identifying the broad determinants of health inequities and successful health equity interventions, with emphasis on their processes and outcomes.

4.3.1 Education

In addressing health equity, educational programs that aim at enhancing personal attributes can be used to produce public health professionals and communities with effective leadership skills towards social justice principles (Hahn & Truman, 2015; Haafkens et al., 2014). Enhancing personal attributes extends beyond an emphasis on subject-matter knowledge, reasoning, and problem-solving, and includes an awareness of one's own emotions

(reflexivity), those of others, control of emotions, and associated abilities to interact effectively. The effects of personal attributes are pervasive, cumulative, and self-amplifying along the life course and improves health by increasing effective agency, enhancing not only a sense of personal control but also encouraging and enabling a healthy lifestyle for self and others (Hahn & Truman 2015; Haaftkins et a., 20l4). Awareness and control of personal emotions and ability to interact with others are critical attributes towards health equity leadership.

Culyer (2001) argues that the ability to promote health equity requires or demands a form of knowledge, and providing the required knowledge is the responsibility of public health practitioners. Understanding the choices in the health-relevant agency should not be reduced to healthy behaviors or lifestyles among individuals. Instead, the focus should be on structurally based choices that can and should include options for individual and collective action on the social conditions of health (Abel & Frohlich, 2012; South et al., 2018). These options would ideally allow for initiation and re-enforcement of processes that yield transformations or modifications of the structural conditions relevant for health and health behaviors. Education programs need to aim at empowering individuals to be active agents of change both at the individual and collective levels to move public health practice and research beyond a reductionist ideology (Abel & Frohlich, 2012).

D'Angelo et al. (2013) proposed health equity training as a way to provide foundational knowledge, attitudes, and skills required for health leaders to enhance health equity praxis. The content matter in training for the praxis of health equity promotion may include but not limited to; social and health equity; and undoing racism and stereotyping Came et al. (2018) presents an anti-racism training framework that consists of reflexive

practice, socio-political education, structural power analysis, systems change, and monitoring

and evaluation to address inequities by public health professionals. The anti-racism

framework is viewed and presented as a tool that deepens the action with intent to deconstruct

systems and structures that work to advance inequities across extra-organization, intra-

organization, and at the individual level (Came et al., 2018). In their education model,

D'Angelo et al. (2013) noted a significant increase in the level of knowledge, skills, and

improved attitudes towards addressing health equity during a pre and post-test assessment.

Public health participants in the education program highlighted opportunities to conduct

reflections that enhanced self-awareness, personal bias, knowledge of health inequities, and

the ability to educate others on health inequities and the importance of the role of advocacy in

public health.

There is a recognized need to shift the narrative of health if public health

professionals and departments are to work towards bridging the health equity gap (Fotaki,

2010). The health equity lens requires a focus on the broader causations of illnesses including

social, economic, political, and social determinants of health (Adams, 2012; Alang,

McAlpine, McCreedy, & Hardeman, 2017; Kreslake, Sarfaty, Roser-Renouf, Leiserowitz, &

Maibach, 2018). If public health leaders are to influence decisions and actions on broad lens

determinants of inequities, there is a need to develop effective surveillance and mapping

system.

4.3.2 Surveillance and mapping

Health equity leaders need to develop and implement wider and improved surveillance

systems that captures social determinants of health and measures inequities accounting for

economic, trade, education, housing, social, and environmental factors that significantly

impact health outcomes (Blanchard et al., 2013; Hofman et al, 2013; McPherson et al., 2016). Evidence indicates health equity leadership extends beyond individual (micro) organization leadership and should include meso and macro-organization leadership. Public health leaders can ensure buy-in, commitment, resource allocation, transparency, and accountability by the different sectors, institutions, organizations, and personalities by capturing the broad lens of data that impact health outcomes.

For planning and implementation to be health equity sensitive, researchers argue that there is a need to center vertical healthcare equity principles as a basis and a means to pay attention to proportionality across policies (Almond & Lathlean, 2011; Bryant, Khan, & Hyder, 1997; Carey, Crammond, & De Leeuw, 2015; Douglas, Dawes, Holden, & Mack, 2015). Public health professionals need to investigate actively and appraise the population of interest about the intended healthcare interventions (Binns, Lee, Low, & Zerfas, 2017; Douglas, Dawes, Holden, & Mack, 2015). Additionally, there is a need to emphasize a broad range of data sources to move beyond measuring outcomes when gauging health equity progress (Douglas et al., 2015; Eslava-Schmalbach et al., 2017; Green et al., 2013; Griffith, Moy, Reischl, & Dayton, 2006; Hennessy & Bressler, 2016). Griffith et al. (2006) argued that capturing data on social determinants that constitute the structures and processes anchoring inequities would ensure a broad consideration of ecological factors in addition to individual variables that currently dominate public health policy discourses.

Health equity leadership faces both structural and process challenges. Bliss, Mishra, Ayers, and Lupi (2016) indicate public health leaders need to be able to harness the diverse needs and ideologies of the private and public institutions. Blanchard et al. (2013) argued for

the need to construct and promote creative partnerships that facilitate win-win or co-benefits

within limited resource investment. Creative partnerships are critical strategic interventions

that health equity leaders can undertake, and enhance asset-based investment (Blanchard et

al., 2013). Public health professionals need to be equipped with health equity principles,

knowledge, and tools if they are to lead a health equity discourse comprehensively.

4.4 Health Advocacy

Tables 4-7 and 4-8 indicates the number of articles, type, the area of focus, and authors that
constituted the theme of health advocacy.

Table 4-7: Region of Articles for Advocacy

Regions of Focus	Number
North America	13
Western Europe	4
Total	17

Table 4-8: Type of Studies for Advocacy

Type of Studies	Author (s)	Number of Articles
Empirical studies	Falk-Rafael & Betker (2012); Fetherman & Burke (2015); Blenner et al., (2017); Kapilashrami et al., (2016); Pauly et al. (2018); Ndumbe-Eyoh et al. (2016)	6
Non-empirical studies	Davidson et al. (2003)	1
Discussions	Garcia et al. (2015); Asthana & Halliday (2006); Braveman et al. (2011); Dicent Taillepierre et al. (2016)	4
Commentary	Thomas (2017); Freimuth & Quinn (2004)	2
Editorial	Cooper et al. (2015); Green (2014); Liburd et al. (2016); Narain& Zimmerman (2018)	4
Total		17

Health advocacy involves engaging with power to influence structural processes, and

the act is legitimized through reflective engagement with praxis alongside communities

experiencing the negative impacts of health inequities (Falk-Rafael & Betker, 2012).

Attaining health equity requires targeted actions on social and structural forces, and public

health needs to champion and advocate for policy options that deconstruct disadvantaged ideologies (Falk-Rafael & Betker, 2012). Kapilashrami et al. (2016) argued that public health has a critical role in advocating for health equity and can implement health advocacy through community mobilizing, action research, continuous dialogue with stakeholders, and movement building.

Public health professionals have utilized two forms of health advocacy, one-on-one and a community level approach (Falk-Rafael & Betker, 2012). One-on-one is often directed to clients impacted by adverse conditions and aims to make explicit clients' values, opinions, and beliefs with emphasis to support the clients without imposing professional values on clients.

The purpose of one-on-one health advocacy is to empower clients to achieve self-agency as well as to conserve and enhance their human dignity (Falk-Rafael & Betker, 2012). A community approach aims to address the upstream causes of ill health and to achieve structural agency. Community health advocacy involves working with political and community advocates to create supportive and sustainable physical, social, political, and economical environments through collaborative strategies (Falk-Rafael & Betker, 2012).

Health professionals engaging in health advocacy have used different strategies including writing opinion letters, meeting with politicians, and advocating for the health professional voice to be part of the policy processes (Garcia, Hernandez, & Mata, 2015; Thomas, 2017), and organizing protests (Falk-Rafael & Betker, 2012). Two sub-themes including research, and communications relating to health advocacy strategies were identified. *Research* is presented as a way to generate evidence pointing to the processes and outcomes of health equity challenges and probable interventions. *Communications* concerns with

framing the language relating to health equity to instigate a public debate about a health concern; and following up on political leaders to propel commitments for the proposed health equity strategies (Davidson, Hunt, & Kitzinger, 2003).

4.4.1 Research

Health equity research needs to move beyond outcomes and focus on processes to delineate the context of interventions and account for the political dimensions of health (Green, 2014). Addressing structural and social changes through research needs to focus on effect and must center on methodological pluralism to explore assemblages of networks that inter-relate to produce and reproduce bad health (Asthana & Halliday, 2006; Green, 2014). There is a need to develop collaborative strategies with academic units to produce appropriate data highlighting cost-effectiveness and return on investment (Dicent Taillepierre et al., 2016; Narain & Zimmerman, 2018) within health equity frameworks to act as advocacy data (Braveman et al., 2011; Liburd et al., 2016; Pauly et al., 2018) when dealing with policymakers within the different political ideological orientations (Cooper et al., 2015; Narain & Zimmerman, 2018).

Public health professionals have utilized different research methods including community-based participatory action research and iterative model of mixed methods as an advocacy tool. Implementing research collaboratively with community agencies builds capacity and empowers community agencies to be advocates for marginalized groups using internal and external resources within their disposal (Fetherman, & Burke, 2015). Community agencies proximal to population groups are best suited to propagate effective, comprehensive policy strategy to address the complexities of health inequities (Fetherman & Berke 2015). Cooper et al. (2015) argue that to reframe the current discourse and discussions about health

inequities, public health practitioners need to design and evaluate rigorous interventions using a social determinants of health framework.

Cooper et al. (2015) further emphasize the need to frame health inequities for positive influence through testing multi-level interventions that target socio-economic disadvantage as a means to improve choices and opportunities to reduce health disparities. Central to achieving health equity within public health is addressing the bi-directional linkages among science, policy, and practice (Braveman, Egerter, Woolf, & Marks, 2011; Liburd et al., 2016). Science can only contribute to health equity if public health research is translated to evidence-based practice and policy that aims "at prevention where possible, and risk reduction as a rule" (Liburd et al., 2016, p. 3). Public health policies even if designed to enhance health equity can only be effective when consistently implemented to their full intent (Liburd et al., 2016). Public health professionals can engage with community and policy makers through effective communication strategies.

4.4.2 Communication

Communication is viewed as a critical attempt towards successful health advocacy (Freimuth & Quinn, 2004; Ndumbe-Eyoh & Mazzucco, 2016). Building relationships is a crucial part of communication and ultimately advocacy, but it is dependent on the level of trust, honesty, transparency, and knowing whom among the parties involved in this relationship aligns with the intended course of actions. Multiple determinants underlie health inequities, and public health needs to expand their use of health communication strategies to cater to individual, community, organizational and multiple determinants of health for effective advocacy processes and outcomes (Freimuth & Quinn, 2004). Organizational policies addressing social determinants of health with health equity at its core need to

structure their communication strategies to facilitate skill set development among public

health professionals to enhance policy analysis, feedback mechanisms, and dissemination of

important research findings to stakeholders (Ndumbe-Eyoh & Mazzucco, 2016).

Blenner, Lang, and Prelip (2017) employed an advocacy curriculum that implemented

experiential learning for graduate public health students to gain advocacy skills and knowledge

in the areas of legislation and regulations, judicial proceedings, institutional policy framing and

practices, community engagement, and media interventions. From a practical lens, students need

to be exposed to holistic advocacy approaches that cover aspects of legislation and regulations,

judicial proceedings, institutional policies and practices, community engagement, and media

interventions (Blenner et al., 2017; Liburd et al., 2016). Experiential learning improves

communication skills and the culture of advocacy competency among health equity leaders.

Reframing the current health inequities discourses will call for dismantling historical

and contemporary drivers of stigmatization and discrimination, and prioritizing community

engagement through equitable shared power between the community and public health

researchers (Cooper et al., 2015). Research and communication have been used to convey real-

time evidence to inform and fuel advocacy processes as well as monitor and evaluate health

equity outcomes (Kapilashrami et al., 2016; Thomas, 2017). Within public health, effective

communications have been structured and used to give breadth and attention to the root causes

of health inequities (Freimuth & Quinn, 2004).

Overall, the public health themes (roles) in promoting health equity that are generated

through this review indicate the complexity of health inequity processes. Data from this

review demonstrates that the themes (roles) including governance, collaboration, health

equity leadership, and health advocacy are not mutually exclusive but coexist in a bi-

directional relationship. This relationship was evident during data extraction, and further

refined during analysis. *Figure 4- 3* shows a thematic bi-directional relationship among the

public health roles in the promotion of health equity from a system level.

4.5 A Bi-directional Thematic Relationship of Public Health Roles

As health equity research advances, the literature indicates public health departments

and professionals need to deliberately and strategically assume the roles of governance,

collaborations, health equity leadership, and health advocacy. Public health performance of

health equity hinges on how well these roles interact and inform each other. Leadership at

local, national, and regional levels need to inform governance and collaborations on the basis

of interest towards health equity outcomes of interest (McPherson, Ndumbe-Eyoh, Betker,

Oickle & Peroff-Johnston, 2016). Health equity leadership informs governance and

collaborations using health advocacy strategies designed and framed within evidence and

effective communication mechanisms.

The role of health advocacy emerged to play a mediatory role to inform the

functionality and praxis of governance, collaborations, and leadership intended to promote

health equity outcomes. Public health roles of governance and collaborations operate at a broad

level and need to interact at equal power to address the complexity of health equity dynamics

(Liburd, Ehlinger, Liao, & Lichtveld, 2016). Appropriate health equity leadership at every

level of operations including local, national, and global shoulders the product of the interaction

between governance and collaborations (Liburd et al., 2016). However, health equity needs to

form the core of interactions between governance and collaborations, and health advocacy

serves as a basis and means through which the roles interact to influence health equity

outcomes. Health advocacy in this interaction serves to outline the what, why, and how of the

interaction.

Figure 4-3: Thematic bi-directional relationship for public health roles in the promotion of health equity

In this review, advocacy emerged as an important role serving a mediatory purpose

linking the different governance, collaboration, and leadership roles, to enhance the health

equity outcome. Chapter 5 examines in more detail how public health practitioners enact the

role of health advocacy as a means to promote health equity, and the facilitators and barriers

to health advocacy within public health

Chapter 5：A Public Health Approach to Advocacy for Health Equity: A Scoping Review Study

Unpublished Manuscript to be submitted after defense

5.1 Abstract

Unjust societal systems and structures perpetuate health inequities. Restructuring health systems to pay attention to the drivers of health inequity require a focus on the role public health professionals play in advancing health equity. Advocacy is one of the core basic foundational skills needed for public health professionals to promote health equity, and yet the praxis of advocacy continues to be a challenging concept for health care professionals. Health advocacy can serve as a basis through which public health professionals work to create supportive community health structures, reorient healthcare services to meet the changing needs of society, and empower communities to take control of their health. The purpose of this paper is to report findings from a scoping review that examined the literature to assess how public health enacts advocacy for health equity within health systems and the facilitators for health advocacy. Four themes relating to facilitators and six dimensions on the praxis of advocacy within health systems emerged. Facilitators include collaborative structures, the locus of control, language and communications, and knowledge and skills. The dimensions of health advocacy include health equity issues, barriers, processes, actions, actors, and health equity outcomes. The six dimensions constitute a thematic public health framework for the praxis of health advocacy. The framework offers the utility to rethink advocacy as a collective process requiring diverse inputs across local, national, and global actors. The advocacy dimensions also constitute a scientific basis for planning and reporting health advocacy initiatives.

5.2 Background

Health as a positive experience requires attention to personal resources including income, social networks, and physical capabilities to enhance the well-being of individuals and communities (Egan, 1965; Lomazzi, 2016). Different conditions and structures including socioeconomic status, living conditions, food security, housing, transportation, and government policies impact the distribution of personal resources and affects individual and community capabilities to achieve health, and are the primary drivers of health inequities (Alvarez, 2007; DeSalvo et al., 2017; Raphael, 2003; WHO, 2010). Health inequities are rooted in societal systems and structures including policies, economics, laws, and politics that influence the allocation of resources and the delivery of health and social services. Unjust systems and structures that perpetuate health inequities require systemic approaches incorporating diverse sectors including public health units, social services, transportation, housing and urbanization, education, and financing (Starfield, 2011).

To effectively address the primary drivers of health inequity, there is a need to strengthen the public health professional roles and capabilities related to addressing societal systems and structures. Public health through protective, preventative, and promotional services aspires to build a conducive environment that minimizes community and population exposure to adverse conditions that would otherwise jeopardize personal and community capabilities to achieve health and well-being (DeSalvo et al., 2017; Egan, 1965). Healthcare professionals can work to achieve health equity by assuming active roles in health advocacy (The Bangkok Charter for Health Promotion in a Globalized World, 2006; WHO, 1986). The praxis of health advocacy, however, continues to be a challenging concept for health care

professionals (Sklar, 2016). Lomazzi (2016) notes that "despite the evidence that the different

public health functions

need to be much better integrated into health systems, a 'know-do gap' is apparent" (p.

210). There is a need to understand how healthcare professionals enact health advocacy for

health equity from a system level.

5.2.1 What is health advocacy?

Health advocacy is defined as a set of processes intended to influence the views and

perspectives of persons in positions of authority with the overall objective to effect policies

and systems, to achieve social and structural change that cultivates a positive experience of

health (de Toma & Gosling, 2005). Health advocacy is an important undertaking in the

process to achieve health equity. Advocating for health equity incorporates a conscious action

that spreads beyond caring for individuals, to paying attention and taking deliberate actions on

social and structural determinants, which impact the health of individuals at personal,

population, and system levels (Hubinette, Regehr, & Cristancho, 2016; Law, Leung, Veinot,

Miller, & Mylopoulos, 2016; Sklar, 2016).

Just like caring for the sick in a clinical setting, health advocacy for social and

structural changes is a moral imperative, and healthcare professionals ought to be actively

involved in the process of health advocacy if they are to improve the health and well-being of

clients and community (Falk-Rafael, 2005). Improving health requires a secure foundation in

the basic skills of advocacy. Advocacy is one of the foundational skills needed for health care

professionals to create supportive community health structures, reorient healthcare services to

meet the changing needs of society, and develop personal skills required to empower

communities to take control of their health (The Bangkok Charter for Health Promotion in a Globalized World, 2006; WHO, 1986).

Through health advocacy, health professionals can use their expertise and experience of caring and working with communities to enable and nurture favorable living conditions in communities by influencing decisions and policy processes that impact health outcomes (Catford, 2004). The voices of health care professionals are among some of the respected voices in communities, and professionals can work to exert pressure for a positive change if their expertise and professional experiences are informed and framed on values driven to achieve social justice for communities (Law et al., 2016). Healthcare professional experiences can further serve to call attention to the recurrent challenges and health threats to the community. Healthcare professionals can achieve this by communicating the issue or challenges to concerned authorities with a matter of interest and praxis and mobilize support for the resources required to effect the social change (Falk-Rafael, 2005; Law et al., 2016). Despite the promising impact of health advocacy in ameliorating health inequities, several barriers, including resources and time constraints, improper mentorship in the role of being a health advocate, and the diminishing empathy for suffering while on training, play a part in preventing health care professionals from assuming the health advocate role (Sklar, 2016).

Sklar (2016) questions the level and extent of engagement of health professionals in health advocacy and the effectiveness of their engagement processes. Engagement in health advocacy particularly at the system level is challenging because it involves navigating different established societal structures that may not be feasible in the realm of individual advocates (Law et al. 2016; Sklar, 2016). Law et al. (2016) indicates numerous approaches can be used to enhance health professionals' capacity for health advocacy from a system level. These

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approaches include mentorship, collaborations, education, being self-reflexive, a sense of satisfaction with advocacy processes, and supportive structures at both organization and system levels (Law et al., 2016). Knowledge of how advocacy for health equity is enacted at a system level by public health professionals is important in accelerating professional engagement with methods of advocacy.

The involvement of public health professionals in advocacy may amplify a system level response to health inequities. Cohen and Marshall (2017) indicate there is limited literature on the practice of advocacy for health equity at the system level by public health professionals. The goal of this paper is to report findings from a scoping review study that examined the literature to assess public health roles and responsibilities relating to promoting health equity. Particularly, the focus is on the public health role of health advocacy, to advance an understanding of how public health professionals enact health advocacy and the facilitators and barriers to action on health advocacy.

5.3 Methodology

This study utilized the Arksey and O'Malley (2005) scoping review framework to examine a wide scope of the public health literature relating to the praxis of public health roles in promoting health equity from within health systems. This included health advocacy as one of those roles. The Arksey and O'Malley review framework follows five key stages. The first stage involves identifying the research question followed by establishing the relevant databases from which to complete the search. The third stage involves completing the search and sorting the relevant studies. The fourth and fifth stages entail data charting and organizing, summarizing, and reporting of results.

The scoping review included literature from 1980 to 2018 and focused on the roles and responsibilities in promoting health equity (as described in Chapter 3). Advocacy was one of the themes that connect the roles. In this paper, we are reporting on two questions from the review:

1. How is advocacy as a means to promote health equity implemented within public health roles and responsibilities?

2. What are the facilitators and barriers to implementing health advocacy within public health?

The search strategy and details from that review are reported elsewhere (Chapter 3). The search was conducted across five databases including Medline, CINAHL, PubMed, Web of Science, and Sage Articles. Data analysis was iterative and followed a thematic discourse that involved reading to familiarize with the key concepts, sorting, and grouping the concepts into themes (Morrow et al., 2015). The themes were further examined looking at how distinct they are from each other. This involved paying attention to the obvious differences and similarities across the themes to delineate their distinctiveness. The process to delineate and make explicit individual themes resulted in a framework that demonstrates the positioning and flow of health advocacy. This is described in more detail in the next section.

5.4 Findings

Of the 85 articles reviewed, 17 (20%) highlighted advocacy as a public health role as noted in Table *5-1*. *Table 5-1 indicates* the distribution of the 17 articles relating to health advocacy as a public health role by type, in the categories of empirical studies, non-empirical

studies, discussions, commentary, and editorial. As indicated below, about 60% of the articles

are neither empirical nor non-empirical studies, being discussions, commentary or editorials.

Table 5-1: Type of Studies for Advocacy

Type of Studies	Author (s)	Number
Empirical studies	Falk-Rafael & Betker (2012); Fetherman & Burke (2015); Blenner et al. (2017); Kapilashrami et al. (2016); Pauly et al. (2018); Ndumbe-Eyoh et al. (2016)	6
Non-empirical studies	Davidson et al. (2003)	1
Discussions	Garcia et al. (2015); Asthana & Halliday (2006); Braveman et al. (2011); Dicent Taillepierre et al. (2016)	4
Commentary	Thomas (2017); Freimuth & Quinn (2004)	2
Editorial	Cooper et al. (2015); Green (2014); Liburd et al. (2016); Narain& Zimmerman (2018)	4
Total		17

Table 5-2 indicates the number of articles relating to the public health role of advocacy

by the region of focus. More than 75% of the articles came from North America, primarily the

United States and Canada, and 23.53% of the articles are from England and Scotland.

Table 5-2: Region of Articles for Advocacy

Regions of Focus	Number of articles
North America	13
Western Europe	4
Total	17

5.4.1 How is advocacy as a means to promote health equity implemented within public health roles and responsibilities?

In answer to our first question, health advocacy strategies fall into six dimensions:

health equity issues, barriers, processes, actions, actors, and health equity outcomes.

Public Health professionals enact health advocacy through a series of organized iterative

steps that involve both anticipating and strategizing to circumnavigate potential barriers.

These steps are what we refer to as dimensions for health advocacy (see Figure 5-1).

Figure 5-1: Dimensions for health advocacy

1. **Health Equity Issues**
2. **Barriers:** Individual and Community level
3. **Processes:** Directed to navigate the barriers to change at individual and community level. Three processes including research, education, and communications.
4. **Actions:** Implemented simultaneously or successively by an actor or group of actors. Three broad actions including mobilizing, lobbying, and seeking political input
5. **Actors:** Members of the community experiencing injustice, Public health professionals, Academic Institutions, Researchers, Politicians, Legislators, Policy Makers
6. **Health Equity Outcome:** Local, national, and international.

5.4.1.1 Health equity issues (Dimension 1).

Health equity issues specifically refer to unfair and unjust differences (Falk-Rafael & Betker, 2012) and are derived from and within the local population or area. In public health, the identification of health equity issues is the first step into advocacy. The proceeding steps involve public health professionals strategizing through processes and specific actions to take in collaboration with several actors (Liburd et al., 2016). Achieving health equity, necessitates the issues be locally derived with a critical engagement of the populace living the experience of injustices (Fetherman & Burke, 2015; Kapilashrami et al., 2016). Public health professionals can identify health equity issues through their experience of working with communities deprived of resources necessary to facilitate healthy living by conducting targeted research to prove the existence of health inequities within and among communities (Falk-Rafael & Betker, 2012; Fetherman & Burke, 2015). Conducting research provides the evidence necessary to mitigate both potential individual and community barriers towards achieving health equity.

5.4.2.2 Barriers (Dimension 2).

Barriers are immaterial or material structures that hinder actions (Barrier, n.d) making it difficult to actualize the intended health equity outcome of interest. Two broad barriers at the individual and community level, have been identified to hinder health advocacy attempts, and public health professionals continuously strategize to navigate the barriers to reach the desired health equity outcomes.

5.4.2.2.1 Individual level barriers.

Individual barriers include attitudes relating to the feelings of powerlessness, hopelessness, and a lack of knowledge on the status quo or existing local services (Kapilashrami et al., 2016; Thomas, 2017). These attitudes are often exhibited by persons living the experience of inequities, who are often vulnerable, socially disadvantaged, and powerless in the face of the circumstances that are a result of unjust systems (Falk-Rafael & Betker, 2012). For public health professionals in practice, the lack of insider support and the prolonged time to realize results may be discouraging and may force advocates to terminate health advocacy initiatives prematurely (Thomas, 2017). The lack of experience or familiarity with the policy processes among professionals further reduces their level of resilience through health advocacy initiatives (Garcia, Hernandez, & Mata, 2015). The lack of experience is further worsened by inadequate knowledge regarding health equity principles; this often results in ideological tensions among policymakers, healthcare professionals, and politicians. The ideological tensions majorly relate to equality versus equity principles where some individuals may prefer equality (Cooper et al., 2015; Falk-Rafael & Betker, 2012).

Furthermore, individual tensions can arise from the concept of scientific remit and preference for data sources from randomized control trials, rather than considering data from

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different methodological approaches (Asthana & Halliday, 2006; Braveman et al., 2011; Dicent Taillepierre et al., 2016; Liburd et al., 2016). Randomized control trials or quasi-experiments that are often preferred may fail to locate the structures and processes of health inequities within a system and instead, serve to perpetuate unjust systems that further marginalize people (Green, 2014). In addition, some research questions may not be necessarily addressed using randomize control trials. The preference for quantitative data also de-privileges lived realities, and insights from quantitative data may make politics and processes implicit or appear incidental to outcomes, especially with the emphasis on downstream interventions (Braveman et al., 2011; Green, 2014; Kapilashrami et al., 2016). Health equity barriers are complex and knitted within the fabrics of societal structures and cannot be uncovered under controlled stringent research methodologies (Cooper et al., 2015; Green, 2014). Public health professionals in addition to anticipating and strategizing to overcome individual barriers, also work to navigate community level barriers.

5.4.2.2.2 Community level barriers.

The complexities and magnitude of health equity barriers to be navigated during health advocacy actions increases with the number of individuals and institutions opposed to the cause. When there are many layers of individuals within or outside institution(s) identified as potential barriers to effective health advocacy, the barrier ceases to be individual and becomes a community barrier (Davidson et al., 2003; Falk-Rafael & Betker, 2012; Liburd et al., 2016; Narain & Zimmerman, 2018). A community barrier is complex and requires resilience and persistence to navigate through to the outcomes of interest, especially in circumstances of uncoordinated structures and systems (Falk-Rafael & Betker, 2012; Liburd et al., 2016).

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The working silos and uncollaborative tendencies among like-minded organizations impede a powerful consolidated action to address health inequities and marginalization, promoting social justice (Dicent Taillepierre et al., 2016; Fetherman & Burke, 2015; Green, 2014; Narain & Zimmerman, 2018). The uncollaborative tendencies often stem from unshared organizational goals or purposes towards promoting humanity, specifically relating to addressing the concepts of social justice (Falk-Rafael & Betker, 2012). The attributes of social justice are not explicit in the core competency statements of some organizations making decisions and practices relating to social justice much more guided by situational and relational ethics rather than stemming from a framework of universal principles or professional codes and obligations (Falk-Rafael& Betker, 2012).

The lack of structural guidance creates a disconnect between the reality of practice and what healthcare professional educators perceive as prudent and substantial roles of practitioners. Professionals face complex challenges that are partially addressed in educational competencies (Blenner, Lang, & Prelip, 2017; Falk-Rafael & Betker, 2012; Garcia, Hernandez, & Mata, 2015). Restructuring and refocusing public health practice and education that isolates individual and family health promotion work from political advocacy work is critical if we are to achieve structural guidance in practice of social justice and health equity (Blenner, Lang, & Prelip, 2017; Falk-Rafael& Betker, 2012). Fostering structural guidance framed on shared goals enhances effective and efficient collaborations across systems and professions. In implementing health advocacy, public health professionals strategize to navigate both individual and community level barriers through organized and targeted processes.

5.4.2.3 Processes (Dimension 3).

A process is a continuous development that manifests in a successive incremental effect towards a goal (Process, n.d), such as a health equity outcome of interest. Liburd, Ehlinger, Liao, and Lichtveld (2016) view processes as a way of consciously organizing to live the actions that lead to a health equity outcome of interest through disrupting the intricate barriers at both individual and community levels. The advocacy processes are directed towards unlocking the individual and community level barriers to health equity. Public health professionals work to avert individual and community level barriers into opportunities for change through *one-on-one* and *community lens* strategies (Falk-Rafael & Betker, 2012; Thomas, 2017).

The one-on-one health advocacy strategy is directed towards clients living the impact of injustice or to leaders within institutions. The purpose of a one-on-one approach is to influence individual behaviors and attitudes by making explicit the implicit personal beliefs, values, and opinions relating to societal injustices (Falk-Rafael & Betker, 2012). For individuals within the authority or holding power, a one-on-one health advocacy strategy serves the purpose to make explicit the moral and ethical obligations towards conserving and protecting human dignity (Thomas, 2017). For persons experiencing an injustice, one-on-one health advocacy serves to empower individuals to be active agents of change in their terms by reminding them of their capacities and capabilities towards a cause; this serves to achieve self-agency (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016; Thomas, 2017). A one-on-one advocacy strategy serves to instill independence and to build a community and network of individuals, who are cognizant of their surroundings and act as conduits to a concerted action through a community lens.

A community lens strategy aims at mitigating the community level barriers and strives to empower communities, populations, and institutions to achieve structural agency (Falk-Rafael & Betker, 2012). Advocacy processes that pay attention to structurally transformative agencies empowers citizen participation and increases autonomy in community health matters (Falk-Rafael & Betker, 2012). Public health professionals achieve one-on-one and community level strategies using three interrelated processes (1) research using a combination of qualitative and quantitative approaches to navigating anticipated barriers; (2) communication using a strategy directed towards challenging ideological orientations and effected through different media platforms; and, (3) education as a means to empower individuals and communities by providing advocacy skills and knowledge (Blenner, Lang & Prelip et al., 2017; Freimuth & Quinn, 2004; Gracia et al., 2015; Green, 2015; Hahn & Truman, 2015; Kapilashrami et al., 2016; Liburd et al., 2016; Ndumbe-Eyoh & Mazzucco, 2016).

5.4.2.3.1 Research process.

The ideological orientation of experts within institutions can be detrimental to advocacy strategies and a barrier to health equity, especially if the expert's opinion deviates from the preferred community solution. Public health advocates for health equity have used research to counter ideological barriers. The research process often extends to include testing of interventions and its effectiveness to reduce case fatalities, community responsiveness, and perspectives to the proposed idea. For example, in a strategy to create a safe neighborhood, Thomas (2017) researched the major causes, timing, and frequency of accidents within the neighborhood.

Garcia et al. (2015) used real-time data obtained from research to fuel the advocacy strategy to influence policies that aim to create a smoke-free environment. The

evidence consisted of data from different sources including qualitative and quantitative research approaches, packaged to appeal to both policymakers and members of the community. In England, Kapilashrami et al. (2016) employed participatory action research engaging community members, health leaders, policy advocates, and researchers to generate action points to demand a commitment from political leaders towards the health issues of interest raised by the community. Working with members of the community facilitates awareness, enables follow up, and demands accountability on issues of common interest (Kapilashrami et al., 2016). To counter and mitigate ideological orientations, researchers can make use of different research approaches, including the use of quantitative methods to facilitate tailoring advocacy messages that appeal to a diverse group (Liburd et al., 2016).

However, researchers must communicate data from research appropriately and strategically to the target audience. Communication is viewed as a key process towards deconstructing the barriers at both the individual and community level (Liburd et al., 2016; Thomas, 2017). Good data from research can contribute to mitigating the ideological barrier if packaged and communicated to intended audiences appropriately.

5.4.2.3.2 Communication strategies.

Communication structures beliefs and attitudes on what constitutes and affects health. Freimuth and Quinn (2004) recognize the need to expand communications about health to incorporate strategic interventions at the individual, community, and organizational level considering the multiple determinants of health that underlie disparities. Changing perspectives and beliefs of public health professionals from a predominantly reductionist ideology needs to be rooted within the communication process. Communication processes

directed towards community-level barriers to influence change should account for ideological perspectives and orientations of the person of interest (Thomas, 2017). For example, being aware of individual orientation enables practitioners to design precise information that speaks directly to the targeted population and person (Liburd et al., 2016). Knowing the composition of your target audience, the kind of data most preferred by individuals in authority and being cognizant of their level of understanding of the issue of interest, is critical when designing effective communications that seek buy-in from politicians and policymakers (Freimuth & Quinn, 2004; Green, 2015; Liburd et al., 2016).

Additionally, communication processes need to account for the different platforms to disseminate information. Ndumbe-Eyoh and Mazzucco (2016) argue policies for organizations working on social determinants of health need to be structured to facilitate public health professionals to use the different social media platforms as professional communication strategies when there is a need for advocacy, policy analysis and feedback, and in the dissemination of important research findings. Public health professionals need to use social media platforms including Facebook, Twitter, Instagram, Youtube, and LinkedIn to disseminate information regarding health equity actions and processes (Ndumbe-Eyoh & Mazzucco, 2016). Social media platforms have the potential to reach a wide audience in a short time; this assists with exerting pressure to the concerned authorities, especially when dealing with a public matter of interest (Ndumbe-Eyoh & Mazzucco, 2016). However, it is important to build a relationship with the intended audience grounded on principles of trust, honesty, and transparency to facilitate use and uptake of information (Liburd et al., 2016; Ndumbe-Eyoh & Mazzucco, 2016). These approaches require a certain level of skill and knowledge if the

process is to be effective. Education on advocacy for health equity serves to cultivate the necessary skills and knowledge through which advocacy can be enacted and sustained.

5.4.2.3.3 Education

Blenner, Lang, and Prelip (2017) implemented an advocacy curriculum designed for graduate public health students in the praxis of health advocacy through honing skills and knowledge in the areas of legislation and regulations, judicial proceedings, institutional policy framing and practices, community engagement, and media interventions. Education as a process, in this case, is viewed as an advocacy initiative and as a basis for advancing the practice of advocacy by equipping public health professionals and students with the necessary skills. Educational initiatives that aim to cultivate personal attributes can enhance self and community agency and encourage public health professionals to be sensitive to social justice (Hahn & Truman, 2015).

Public health professionals work with communities, institutions, and politicians both within and outside public health through education, research, and communications; to help create a supportive and sustainable physical, social, political, and economical environment that enhances equitable health outcomes. The combination of the interrelated processes of research, education, and health communications utilized within specific actions carried by an individual public health actor or in collaboration with several actors help navigate complex barriers at both individual and community levels. Implementing advocacy processes oriented toward reducing barriers allows for initiation and re-enforcement of actions that yield transformations or modifications of the upstream structures that define and shape health outcomes.

5.4.2.4 Actors (Dimension 4).

Actors are individuals, institutions, or communities that play active roles (Actor, n.d) in the experience of health inequities. In enacting health advocacy for health equity, public health professionals work with actors both within and outside public health. In the public health literature, health advocacy actors include both public health professionals and institutions, and non-public health professionals or institutions (Clarke, 2005; Latour, 1996). Non-public health actors include victims of unjust systems and those within the authority with a certain level of influence towards the health equity outcome of interest (Kapilashrami et al., 2016; Thomas, 2017). Actors play significant roles in redressing health inequities and strategizing for health advocacy involves critically mapping actors against potential barriers following identification of the health equity issue.

In this scoping review, health advocacy actors included members of the community; researchers; academic institutions; educators; philanthropic agencies; funding agencies; politicians from the local, national, and global platforms; legislators; policy advocates; media; policy makers; community-based organizations; and, members of the community (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016; Liburd et al., 2016; Thomas, 2017). The actors span across all geographies including the local, national, and global boundaries; with the local actors providing context and guidance in the implementation of the processes including education, research, and communication (Falk-Rafael & Betker, 2012). Implementing a process towards an outcome of interest involves completing a set of actions or tasks.

5.4.2.5 Actions (Dimension 5).

Actions are defined as activities in a field (Action, n.d), and public health professionals undertake directed advocacy actions towards achieving a health equity outcome of interest. Advocacy actions begin from the local context, transcending national and global boundaries to

achieve the change of interest and are implemented either simultaneously or successively by a group of actors both within and outside public health (Kapilashrami et al., 2016; Latour, 1996; Thomas, 2017). Actors outside public health are recruited by public health professionals to complete advocacy actions. Advocacy for health equity is advanced through incessant pushing of the issues of concern including modification and re-modification of ideas to make them compelling to decision-makers (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016; Liburd et al., 2016; Thomas, 2017).

Public health professionals implement the actions directed to individual and community level barriers in collaboration with non-governmental advocacy organizations, elected council leaders, and persons within decision-making bodies (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016; Liburd et al., 2016; Thomas, 2017). Public health professionals utilize three broad advocacy actions including *mobilizing*, *lobbying*, and *seeking political input* to achieve the desired change.

5.4.2.5.1 Mobilizing action.

Mobilization involves rallying communities and building or enhancing their capacity to influence the processes of existing structures including policies and leadership styles that are potential barriers to health (Garcia et al., 2015; Thomas, 2017). In addition, public health professionals conduct community education on health matters aiming at making explicit the structures and processes of injustices existing within their communities (Falk-Rafael & Betker, 2012; Fetherman & Burke, 2015; Garcia et al., 2015). Furthermore, mobilization involves door-to-door campaigns and individual meetings with opinion leaders, administrators, or politicians aimed at building community buy-in to the health equity issues facing the population (Falk-Rafael & Betker, 2012; Thomas, 2017).

5.4.2.5.2 Lobbying.

Lobbying involves seeking attention from politicians within an existing political framework. Lobbying entails inviting and seeking buy-in from different professionals, administrators, and political leaders through constant and persistent dialogues (Thomas, 2017). Public health professionals implement lobbying through well-designed targeted communication strategies using real-time evidence from research processes. Specific tactics that public health professionals employ include framing the language within the issue of concern to generate public interest in the issue and instigating a debate to direct attention to the causes of health inequity and related praxis (Davidson et al., 2003; Falk-Rafael & Betker, 2012). An additional tactic is initiating strategic media releases at a time when there is no trending issue on the media platform (Davidson et al., 2003; Kapilashrami et al., 2016). Targeted media releases are achieved using advocacy briefs, opinion letters, and case summaries drafted for follow-up with political leaders to propel commitments for the proposed health equity strategies (Falk-Rafael & Betker, 2012).

5.4.2.5.3 Seeking political input.

Public health professionals also champion for the inclusion of health equity leaders as part of policy framing committees and organize protests to demand commitments from political leaders (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016). These are realized through forging partnerships and coalitions with various actors across professions within the healthcare sector, outside health sectors, and working with community groups, who have a shared goal for policy change towards health equity (Falk-Rafael & Betker, 2012; Kapilashrami et al., 2016; Liburd et al., 2016; Thomas, 2017). Engaging several actors across sectors is significant in advancing the issue; this breaks down silos and enhances a consorted effort giving traction to advocacy processes.

Falk-Rafael and Betker (2012) indicate that public health professionals employ health literacy and sharing of health and life experiences to advance advocacy initiatives. Advocacy actions involve mobilization, lobbying, and seeking political input and approval for health equity interventions; and, demanding for a commitment from politicians vying for political positions, especially during campaigns (Garcia et al., 2015; Liburd et al., 2016; Thomas, 2017). These actions when implemented diligently following the right processes and utilizing appropriate actors can lead to a health equity outcome of interest.

5.4.2.6 Health equity outcome (Dimension 6).

An outcome is a result or consequence (Outcome, n.d), and a health equity outcome is a result of a just and equitable health experience realized and lived by the community of interest following intentional and targeted processes and actions (Thomas, 2017). The health equity outcome may be cumulative with each milestone leading towards the outcome of interest. In this review, the outcome of interest included influencing policy processes (Garcia et al., 2015; Fetherman & Burke, 2015; Thomas, 2017); fostering commitments and accountability from political leaders for their time in office (Kapilashrami et al., 2016); challenging ideological orientations and achieving allocation of funds for health equity activities (Liburd et al., 2016; Ndumbe-Eyoh & Mazzucco, 2016); empowering individuals and communities by providing knowledge regarding health inequities affecting their communities (Falk-Rafael & Betker, 2012); and acquisition of advocacy skills through education (Blenner et al., 2017).

Education on advocacy aims to equip students and professionals with the skills and knowledge required to be independent advocates as well as health equity leaders (Blenner et al., 2017). Health equity leadership and advocacy are considered outcomes of interest because they constitute essential skills required to propagate health and social justice (Blenner et al., 2017).

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Processes when strategically implemented using targeted actions by the right actors can translate health equity barriers into opportunities for change, ultimately yielding the health equity outcome of interest.

5.4.2.7 Summary and framework of the dimensions.

In summary, the six dimensions of advocacy health equity issues, barriers, processes, actions, actors, and health equity outcomes fit together to formulate a complete health advocacy strategy. As illustrated in *figure 5- 2,* the dimensions of health advocacy presented above are not mutually exclusive. When pursued at a system level, these dimensions overlap across the local, national, and global platforms.

Figure 5-2: A System Level Framework for the Praxis of Advocacy for Health Equity
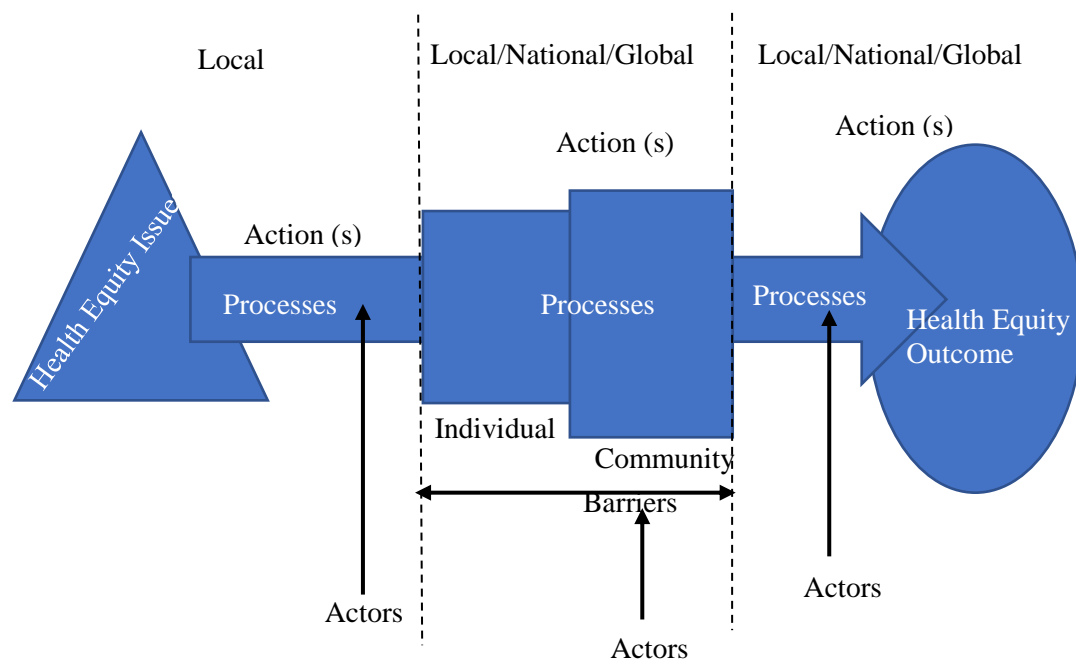
Whereas *the system level framework for the praxis of advocacy for health equity* appears linear, the implementation of the advocacy dimensions does not. Executing the dimensions follows an iterative process spanning across the local, national, and global

platforms. Effective advocacy for health equity necessitates the issues to be derived from the communities with a critical engagement of the populace living the experience of injustices (Fetherman & Burke, 2015; Kapilashrami et al., 2016). Person- and community-oriented health equity interventions require public health units and leaders at the local level to instigate and bring forth the issues to national and global platforms. The identification of a health equity issue from the local context by public health professionals is the first step into advocacy initiatives.

However, the issues need to be matched with the potential or apparent barriers that perpetuate the inequities. Upon identifying the issue(s) and the anticipated barriers, public health professionals, need to develop an explicit health equity outcome, indicating the primary and subsidiary outcomes of interest; different outcomes account for the magnitude of the barriers, and each milestone needs to be cumulative to the primary outcomes. The processes and actions to be undertaken either by public health professionals (actors) or in collaboration with several actors are mapped against potential barriers. The actors operationalize the processes and actions across local, national, and global levels of influence.

5.4.3 What are the facilitators and barriers to implementing health advocacy within public health?

In answer to question 2, this scoping review indicates the barriers to health advocacy were synonymous to the barriers to achieving health equity outcomes. Public health professionals and units identify and address health equity issues from the local level by means of health advocacy, anticipating and strategizing to mitigate potential community and individual level barriers. Furthermore, when health equity issues extend beyond the local remit, professionals consciously advance to national and global platforms (Falk-Rafael &

Betker, 2012; Liburd et al., 2016; Thomas, 2017). The specific barriers to implementing

advocacy for health equity were presented earlier in this paper. This section focuses on

specific factors that favor the initiation of health advocacy strategies by public health

professionals

Four themes emerged as facilitators (enablers) for health equity advocacy within

public health: collaborative structures, language and communications, locus of control, and

advocacy knowledge and skills.

5.4.3.1 Collaborative structures.

A multidisciplinary approach to health advocacy defies professional and individual silos

and gives practitioners working on health equity issues a sense of togetherness towards an

action. Collaboration across sectors involves the identification and establishment of potential

and significant actors (Thomas, 2017). The selection of potential actors to implement the

process of health advocacy needs to be strategic and mapped against the identified barriers

to the outcome of interest. Public health professionals have collaborated with different actors

including researchers, policy advocates, community agencies, politicians, and community

members to implement advocacy (Falk-Rafael & Betker, 2012; Garcia et al., 2015; Liburd et

al., 2016; Thomas, 2017). However, effective health advocacy draws on the level of

preparedness on the chosen course of action (Garcia et al., 2015).

5.4.3.2 Language and media communications.

Public health professionals collaborate with communities and establish community

structures including media outlets; by constructing a health equity language using metaphors to

convey true meaning and gravity of the issue (Falk-Rafael & Betker, 2012; Liburd et al.,

2016). When related to life circumstances within their surroundings, language framing helps

members of the community to understand the purpose of advocacy and generates willingness

and support from the community; all of which are critical in rallying people towards

influencing policy processes (Braveman et al., 2011; Falk-Rafael & Betker, 2012; Freimuth &

Quinn, 2004). Readily accessible media platforms encourage health equity practitioners to

voice their concerns, and media offer critical support regarding visibility and pressure from

concerned parties to reach decision-makers (Davidson, Hunt & Kitzinger, 2003). The

presence of media allows for public involvement during policy discussions and provides for

framing and re-framing of the policy contents paying attention to issues at hand (Davidson et

al., 2003). Consistent media coverage enables reinventing of policy contents to facilitate

pressure on the decision-makers to commit resources required to see the policy live out its

intention (Liburd et al., 2016; Thomas, 2017).

5.4.3.3 Locus of control.

Locus of control is a "concept that refers to how strongly people believe they have

control over the situations and experiences that affect their lives" (The Glossary of Education

Reform, 2013, p. 1). Activating the locus of control is a critical input towards advocacy

(Kapilashrami et al., 2016). Individuals or communities living the impact of injustice may be

unsatisfied with the status quo yet are unable to act. Persons experiencing injustices often

view circumstances as out of their control and may be unable to take any action (Falk-Rafael

& Betker, 2012; Kapilashrami et al., 2016).

To empower communities towards effective collective health advocacy, where every

entity plays a role, public health professionals work with community agencies to enable them

to realize their power and ability to advocate for their clients (Fetherman & Burke, 2015;

Kapilashrami et al., 2016). Public health professionals empower community agencies through

data collection and analysis and encourage agencies to perform introspective and external analysis of allies (Kapilashrami et al., 2016). An analysis of allies builds community agencies' capacities by making explicit internal and external strengths that can be used to influence structural processes that impact the lives of their community members (Fetherman & Burke, 2015; Kapilashrami et al., 2016). The willingness to act against an injustice depends on how empowered an individual is, and the belief bestowed upon their capacity to influence change.

5.4.3.4 Knowledge and advocacy skills.

Knowledge and skills are means to empower individuals and are critical components of an initiative. The skills relating to health advocacy involve mobilizing, lobbying, communicating, collaborating, and research (Braveman et al., 2011; Blenner et al., 2017; Falk-Rafael & Betker, 2012; Garcia et al., 2015; Kapilashrami et al., 2016). The ability to utilize empirical evidence, gain community support, and communicate effectively are instrumental in drawing attention and support from policymakers (Blenner et al., 2017). The skill sets required to advance health advocacy processes can be attained through experience, mentorship, and education.

Experience can be acquired through exposure to social injustices or through conducting advocacy initiatives. Among public health professionals, the continued exposure to the impact of social and structural forces including power differences, politics, social class, and the lattices of involvement serve to construct an understanding and enhances a critical consciousness of the effect of unfair social systems on populations (Falk-Rafael & Betker, 2012). Encounters with injustice can be at a personal level, as a victim of the unfair systems or bearing witness while working with communities impacted by social and structural forces

(Falk-Rafael & Betker, 2012; Thomas, 2017). An encounter with a dehumanizing condition of unfairness, either as a victim or as a witness to victimization motivates public health professionals to be advocates for social justice and equity, through influencing policy processes (Blenner et al., 2017).

Mentorship from advocacy experts helps to develop naïve professionals on the process of health advocacy and aid independent action when the need arises (Garcia et al., 2015). Whereas academic institutions, community, and community-based organizations serve as health advocacy agencies, they can also act as mentorship centers for health advocacy practitioners.

Mainstream educational advocacy curriculum is critical in enacting the essential skills and knowledge required for health advocacy (Blenner et al., 2017; Falk-Rafael & Betker, 2012).

Overall, a combination of different factors including external and internal factors work to foster self-confidence and encourages action in the face of health injustices (Falk-Rafael & Betker, 2012; Garcia et al., 2015; Kapilashrami et al., 2016). Organizational policies that encourage public health professionals to initiate advocacy and the availability of collaborators can act as external motivators to promote health equity (Falk-Rafael & Betker, 2012; Ndumbe-Eyoh & Mazzucco, 2016). Internal motivators include a sense of control and the skills and knowledge required to act when need arises (Blenner et al., 2017). It is important to equip healthcare professionals with the knowledge and skills required to conduct health advocacy, foster appropriate language, and instill the motivation required to speak against societal structures and systems that perpetuate health injustices.

5.5 Discussion

There is a need to streamline health system approaches to tackle health inequities with an emphasis on societal systems and structures. Structuring societal systems that pay attention to the health of its population is the responsibility of governments; this can be achieved by orchestrating health and health-related policies at all levels of governance (Liburd et al., 2016). Achieving a structural grounding is critical if public health professionals are to enhance the allocation of social and health resources, adequate for populations to live an economically and socially productive life (Catford, 2004). However, orchestrating health and health-related policies addressing health inequities through established government structures and systems requires political will (Alvarez, 2007; DeSalvo et al., 2017; Raphael, 2003; WHO, 2010;). Lomazzi (2016) argues political leaders who play key determinant roles in structuring societal systems and policies and often pay lip service to community health initiatives need to be held accountable for their actions. In this study, public health professionals use health advocacy as a basis for holding government systems, structures, and persons in authority accountable for the health of communities (Kapilashrami et al., 2016; Liburd et al., 2016).

Public health professionals utilize a combination of research and personal experiences to initiate and enact advocacy initiatives. This review demonstrates scientific evidence is a critical tool towards successful health advocacy and acts as an enabler, and not necessarily as a basis for initiation of advocacy strategies. Advocacy driven by scientific evidence was presented by Farrer, Marinetti, Cavaco Yoline, and Costongs (2015), as a preferred alternative to any other form of health advocacy including value-driven advocacy. The findings partially

agree with Farrer et al. (2015) but further emphasize the critical role of personal experiences in the work of health equity, especially in establishing a call to action.

Public health professionals sometimes make use of their personal experiences and the stories of their clients in the communities they serve to initiate a call for attention to the health equity issues (Falk-Rafael & Betker, 2012; Liburd et al., 2016). This is because there may be no readily available scientific data to demonstrate the issue, and conducting research may take time, which may not be readily available to public health professionals. Liburd et al. (2016) reminds health equity leaders of the need to be mindful of the chosen communication strategies when using personal stories or lived experiences to initiate health advocacy. As indicated in the systems level framework for praxis in health advocacy (Figure 10), the first step into advocacy for health equity is an identification of a health equity issue, which can be from lived experiences of public health professionals or derived and demonstrated through research processes.

Public health professionals need to implement advocacy for health equity through a systems lens (Hubinette et al., 2016; Liburd et al., 2016). The systems level framework for the praxis of health advocacy illustrated in this paper offers a chance to rethink advocacy as a collective effort; where every actor both within and outside public health play a role to contribute to the overall health outcome of interest. Health inequities are rooted within systems, and advocacy initiatives in redress to health inequities need to consider interventions spanning across individual, population, and system levels. The view of individual and community barriers as a constituent of health advocacy praxis enables advocates to design and map an advocacy process, action, and actor(s) against potential barriers and each outcome by an individual actor contributes to the health equity outcome of interest. Outcomes are viewed

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as successive and built over each milestone. As suggested by Hubinette et al. (2016), this approach offers a chance to leverage individual efforts across levels of interventions without a feeling of burden on the shoulder of any specific actor.

The system lens in the framework in Figure 10 offers utility for the praxis of advocacy that aims at developing practice skills directed towards collective health advocacy as a means to promote health equity at the individual, population, and systems level. This approach speaks to Hubinette et al.'s (2016) suggestion, on the need to develop advocacy competency skills that aim at fostering collective practice rather than grooming advocates who tend to practice alone. Specific dimensions of health advocacy including identifying a health equity issue; projecting individual and community level barriers; designing the processes including education, research, and communication strategies required to mitigate the barriers; implementing and assigning specific actions in collaboration with different actors; and, clearly stating what the desired outcome of interest at local, national, and global levels can constitute competencies for healthcare professionals.

In addition, the framework also offers a logical approach to structuring and reporting advocacy initiatives. For example, a public health professional taking on health advocacy needs to identify the issue, anticipate the barriers towards the outcome, outline and design a process for mitigating the barrier, identify the specific actions to be taken and by whom (actors) providing possible timelines, and indicate the subsidiary goals (successive outcome) and overall goal of the project. The plan can then be updated by reporting explicitly on the processes, actions and actors, and the successive and overall outcome.

Like the findings of Cohen and Marshall (2017), Farrer et al. (2015), and Law et al. (2016), the findings from this study indicate multiple factors intersect to facilitate the

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initiation and sustenance of advocacy strategies. Collaborative structures, knowledge, and sense of control and power are critical elements in enabling the initiation of health advocacy efforts. Prior experience with injustices and knowledge and skills in addition to collaborative structures are considered important factors in building resilience and sustaining advocacy efforts. Advocacy outcomes are long-term and can be frustrating; it is important that advocates build resilience and remain persistent throughout the process (Sklar, 2016). Resilience can be shaped by engaging public health professionals through mentorship and education that aims to provide hands-on health advocacy skills.

Whereas the review offers a substantial level of information on how public health professionals have enacted advocacy for health equity through a system level, there is little empirical literature on public health's use of advocacy to influence systems towards health equity. This finding correlates with Cohen and Marshall's (2017) findings, where they reported a lack of data on public health use of advocacy to promote health equity at a system level. In addition, the concept of health equity outcomes arising from public health advocacy initiatives is under-developed. Further research is needed to assess how public health professionals define a health equity outcome as a basis for health advocacy. The population would include active public health advocates (projects) with an interest in how they define individual, population and system level outcomes. Future research also needs to focus on specific tools aligned to evaluate the health advocacy outcomes. This will offer practical guidance on how to assess advocacy outcomes, a phenomenon that is still undeveloped in the field of advocacy for health equity (Cohen & Marshall, 2017).

5.6 Conclusion

This study examined the public health literature to assess how public health has enacted the role of advocacy as a means to promote health equity. Public health professionals use advocacy to hold systems and persons in authority accountable for the health of the population. Public health professionals witness the impact of health inequities through their day-to-day interaction with individuals and communities. Owing to their experiences and exposures, public health professionals have the mandate and the authority to advocate on behalf of, or with the members of the community they serve, this can be enhanced by available data or by initiating research processes.

Public health professionals enact advocacy for health equity accounting for specific dimensions; health equity issues, barriers, processes, actions, actors, and health equity outcomes. The specific advocacy dimensions constitute a system lens public health framework for the praxis of advocacy. The framework offers a tool to rethink advocacy for health equity as a collective practice that requires participation within and across systems and professions. In addition, the framework can be used to develop health advocacy learning competencies and provides a scientific basis to plan and report public health advocacy initiatives. However, more research is needed to develop some of the dimensions of the system lens public health framework for the praxis of advocacy, especially on the dimension of health equity outcomes.

Chapter 6 : The Significance of the Scoping Review

This research was informed by personal experiences in learning and teaching healthcare students the social determinants of health with an emphasis on the social, structural, cultural, and political determinants of health, and how to inspire healthcare professionals to be active witnesses and leaders for health equity. The research was further shaped and refined within an earlier established scoping review that aimed to examine the roles and responsibilities of public health in the promotion of health equity from a system level. The increasing multi-morbidity and the differential health outcomes across populations require healthcare professionals including nurses to make intentional attempts to reorient health systems and services to meet the needs of diverse groups (Falk-Rafael & Betker, 2012; McPherson et al., 2016; Liburd et al., 2016). Furthermore, there is a recognized need to strengthen public health functions and capacity to improve health and well-being of the general population (WHO, 2018). Public health professionals including nurses, being directly in touch with the population and with communities, witness persons living with the impact of social suffering and can thus use personal experiences to inform and delineate systems and structures that advance health and social inequities. The findings in this thesis contribute to the nursing profession body of knowledge and practice.

6.1 Significance to Nursing

Nursing, as a profession, is positioned to support and enhance health and well-being using the most attainable means possible. The International Council of Nurses (ICN) (2012) stipulates ensuring social justice and health equity as ethical principles within the profession of nursing, and indicates nurses need to advocate for social, economic, and environmental conditions that are well suited to enhance both individual and population health outcomes. In

the subsequent sections, I focus on the significance of this thesis to the profession of nursing in areas of education, practice, and research and policy.

6.1.1 Education.

The ICN (2012) indicates the foremost ethical role of a nurse is to provide responsible care that aims at improving individual and population suffering. Nursing care is intertwined within complex systems of economics, law, and politics. The complex systems interplay to compound the quality of care provided by nurses, impacting the overall care outcomes. Nurses need to assume intentional positions within systems of power if they are to play active roles in actualizing the goal of the profession. The ICN (2012) further indicates that "the nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular, those of vulnerable populations" (p. 2). Initiating social support systems, however, requires influencing systems of power, and working within a power structure requires foundational advocacy skills (Falk-Rafael & Betker, 2012; Liburd et al., 2016; Thomas, 2017).

Educating nurses on how to work towards health equity thus needs to aim at building critical consciousness on the roles and effects of power structures on health outcomes. To assist in the role of a nurse as an advocate, this thesis offers two tools. First, an innovative teaching pedagogy that uses personal awareness within the constructs of power and privilege, praxis, and a pragmatic approach that aims to rally support towards a cause. Chapter two provided a brief description of this innovative teaching pedagogy and its influence on the capacity to implement health advocacy. The second tool is the system level framework for the praxis of advocacy for health equity, with six advocacy dimensions. The dimensions offer a tool to develop learning competencies for health advocacy with emphasis on power structures

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that expand across local, national, and global platforms. The system level framework presents health advocacy initiatives as a collective effort that requires input from diverse actors within and across professions and institutions. Knowledge of health advocacy strategies and conscientization on the effects of power on the care nurses provide can serve to motivate proactiveness when nurses engage with social, economic, and political systems that often shape nursing care (Falk-Rafael, 2005).

6.1.2 Practice.

The Ottawa Charter for Health Promotion offers health advocacy as a means through which healthcare professionals empower individuals and communities to be active participants in their care, and work to reorient healthcare services to meet complex needs (WHO, 1986). Nursing care can empower individuals and communities to be active participants in promoting their health (Falk-Rafael & Betker, 2012). Nurses can use their clinical and community expertise as health advocates to enact political engagement as a strategy to reorient health systems to meet the complex needs of society (Falk-Rafael & Betker, 2012; Zauderer, Ballestas, Cardoza, Hood, & Neville, 2008). Furthermore, nurses use health advocacy to empower populations and communities to be actors and co-creators of their health, through health literacy; this enables communities to hold systems accountable for health outcomes (Falk-Rafael & Betker, 2012).

Working to influence reorienting health systems requires a system level approach, this can be laborious for practicing nurses who are already time constrained. However, the system level framework for the praxis of advocacy for health equity provides an opportunity to rethink health advocacy as a collective effort that requires input from diverse actors within nursing and outside the nursing profession. This view shifts the health advocacy strategy

workload from an individual to multiple players accounting for time constraints, expertise,

social relations, and power structures. The framework allows for nurses to collaborate with

other actors to plan, implement, evaluate, and disseminate health advocacy initiatives with

minimal but incremental inputs towards the outcome of interest. The advocacy dimension of

health equity outcome offers a tool to evaluate the effectiveness of each process and action,

with a critical focus on the population outcome.

6.1.3 Research and policy.

Providing access to basic health resources can address over 80% of societal health

needs (Lancet, 2018). The future of health systems lies in research and societal policies,

including health policy, which needs to be evidence-based in order to address population

needs with an emphasis on the broader social determinants of health. Using health advocacy,

nurses can influence social and economic policies that impact health outcomes (ICN, 2012).

The system level framework provides for traceable systematic health advocacy strategies. To

contribute to the science of health advocacy practice, nurse advocates can use the dimensions

for health advocacy to plan and disseminate initiatives.

6.2 Recommendations

In the analysis of the literature on health advocacy, none of the researchers that

implemented health advocacy action explicitly stated their measures of success, the outcome,

nor how they measured the outcome. Additionally, the 17 reviewed articles relating to health

advocacy do not provide sufficient information on their strategies. Three of the articles in this

review indicated the need to evaluate the process for health equity initiatives including their

outcomes (Braveman, 2011; Liburd et al., 2016; Falk-Raphael & Betker, 2012). To

effectively evaluate health advocacy, future research needs to examine what health advocates

consider to be outcomes of interest, paying attention to population-level outcomes, and the tools used to measure the outcomes. Cohen and Marshall (2017) noted gaps in health advocacy evaluation tools, reporting that outcomes influence the replication of advocacy initiatives, and therefore influence actors to implement what has shown to be effective.

The system level framework for the praxis of advocacy for health equity may serve a purpose towards standardization of strategies and reporting for health advocacy initiatives. However, more research is needed to develop the thematic framework further. Probable research would use a multi-case study design across different settings, with the different advocacy projects constituting the cases. The outcome of interest would include the advocacy dimensions of health equity issue, barriers, processes, actions, actors, and the outcomes of interest across the different cases. Using a framework such as this can help to ensure that research on health advocacy initiatives provides a scientific base on which future health advocacy initiatives can build.

6.3 Limitation

In light of the findings from this study, it is important to note some limitations. Firstly, the study was initiated by a research intern, whom the researcher of this thesis did not have an opportunity to interact with, when conducting the second phase of the study. The extent of conceptualization may have thus been restrained and limited within the concepts set by the earlier researcher. Secondly, this study was conducted as a Masters thesis and thus the scope of analysis was limited by time. Thirdly, the findings may be subject to publication bias since most of the studies reviewed were from the developed regions, primarily North America and Europe. Targeted grey literature search from the developing nations may contribute in advancing the notion of health equity praxis highlighted in this thesis. Finally, it is important to

note that the findings from this study may not be directly applicable to other settings, but it is transferable taking context into account.

6.4 Conclusion

Health as a human right requires healthcare professionals to pay critical attention to social justice and health equity. This research has revealed four broad roles that public health professionals assume in pursuit of health equity. The identified roles include health advocacy, governance, collaboration, and leadership. Health advocacy emerged as a critical role through which public health professionals, through the role of leadership, interact to inform and influence established societal systems and structures to be sensitive to health equities. The review stipulates advocacy as a basis for setting collaborative principles across systems sectors, and structures with an emphasis on the *what, why, and how*, elements of collaboration.

Addressing health equity calls for public health professionals to work in collaboration with diverse sectors to provide supportive health services and structures within political, law, economics, social, and health systems. Furthermore, improving population health outcomes requires critical attention to the imbalances in resource and service distribution across settings and populations. Healthcare professionals play significant roles in ameliorating social suffering at the individual, population, and community levels by working to provide and advocate for supportive services and systems that improve health outcomes. Ameliorating social suffering to achieve a favorable and equitable health outcome necessitates educating public health professionals including nurses to building consciousness on the complex interplays of social and structural forces and encouraging healthcare professionals to work from and within the system by means of health advocacy.

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