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Review

Does public health advocacy seek to redress health inequities? A scoping review

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What is known about this topic

- Advocacy is considered a key public health strategy for redressing health inequities.
- There is evidence that public health's advocacy role has not been fully realised; the reasons for this are unclear.

What this paper adds

- A systematic collation and critical analysis of the conceptual and empirical literature on public health advocacy focused on health equity is provided.
- Public health is constrained in its health equity advocacy efforts by neoliberal conceptualisations of health problems, and by multiple barriers at the level of individual public health practitioners, institutions and the social environment.

Abstract

The public health (PH) sector is ideally situated to take a lead advocacy role in catalysing and guiding multi-sectoral action to address social determinants of health inequities, but evidence suggests that PH's advocacy role has not been fully realised. The purpose of this review was to determine the extent to which the PH advocacy literature addresses the goal of reducing health and social inequities, and to increase understanding of contextual factors shaping the discourse and practice of PH advocacy. We employed scoping review methods to systematically examine and chart peer-reviewed and grey literature on PH advocacy published from January 1, 2000 to June 30, 2015. Databases and search engines used included: PubMed, CINAHL, PsycINFO, Social Sciences Citation Index, Google Scholar, Google, Google Books, ProQuest Dissertations and Theses, Grey Literature Report. A total of 183 documents were charted, and included in the final analysis. Thematic analysis was both inductive and deductive according to the objectives. Although PH advocacy to address root causes of health inequities is supported theoretically and through professional practice standards, the empirical literature does not reflect that this is occurring widely in PH practice. Tensions within the discourse were noted and multiple barriers to engaging in PH advocacy for health equity were identified, including a preoccupation with individual responsibilities for healthy lifestyles and behaviours, consistent with the emergence of neoliberal governance. If the PH sector is to fulfil its advocacy role in catalysing action to reduce health inequities, it will be necessary to address advocacy barriers at multiple levels, promote multi-sectoral efforts that implicate the state and corporations in the production of health inequities, and rally state involvement to redress these injustices.

Keywords: advocacy, health inequalities, public health, public health policy, scoping review

Introduction

Health inequities are systematically produced inequalities that reflect disparities between populations in the underlying social and economic conditions necessary to be healthy (Braveman & Gruskin 2003). Although many of the interventions and policies expected to redress health inequities will be found outside the healthcare sector, its essential role in tackling health inequities is widely recognised (Braveman &

Gruskin 2003, WHO 2005, 2008, Baum and Harris 2006, Irwin *et al*. 2006, Newman *et al*. 2006, Marmot *et al*. 2008, Knight 2014). In 2005, the World Health Organization (WHO) called on the health sector to play a much broader advocacy role in catalysing and guiding multi-sectoral action to address the social determinants of health. The public health sector – defined as the publically funded sector within health systems that is responsible for services, programs and strategies for health promotion and protection, disease and injury prevention, and population health assessment and surveillance (PHAC 2007) – with its foundational values of social justice and equity (Drevdahl *et al*. 2001, Anand *et al*. 2004, Powers & Faden 2006), is ideally situated to take the lead in this endeavour (Hofrichter & Bhatia 2010). However, there is evidence that public health's advocacy role has not been fully realised (Raphael 2009, Cohen & McKay 2010, Reutter & Eastlick Kushner 2010, Kapilashrami *et al*. 2016) and growing concern that some public health approaches, particularly those focused on behaviour change of middle-income populations, are contributing to health inequities (Blaxter 2007, Frohlich & Potvin 2008, NCCDH 2010).

The problematic conceptualisation and construction of social determinants of health is also thought to contribute to public health's inability to mitigate health inequities (Raphael 2006, 2011, Hankivsky & Christoffersen 2008, Navarro 2009, Brassolotto *et al*. 2014). These works highlight the importance of interrogating both the underlying conceptualisation and practice of dominant public health approaches related to health disparities. While the analysis, research and practice related to social determinants of health are increasingly under scrutiny, public health advocacy remains relatively unexamined.

The purpose of this scoping review was to obtain an overview of the literature related to public health advocacy, with a particular interest in the extent to which this literature addresses the goal of reducing the social, environmental and structural causes of health and social inequities. We were interested in collating and analysing not only the theoretical and conceptual literature on public health advocacy but also the broader body of literature including empirical literature, professional or educational resources and standards, and secondary literature such as editorials and commentaries. This enabled us to increase our understanding of the contextual factors that may be shaping the discourse and practice of public health advocacy.

Methods

We employed scoping review methods (Arksey & O'Malley 2005, Levac *et al*. 2010, Daudt *et al*. 2013) to systematically examine and chart the peer-reviewed and grey literature on public health advocacy with attention to both concept and practice. Scoping involves five key stages including: identifying the research question; identifying relevant studies; selecting studies; charting the data; and collating, summarising and reporting the results. The sixth stage, consultation with relevant stakeholders, is considered optional and was not formally undertaken as a part of this review. The search terms 'public health' AND advocacy, 'public health advocacy', and 'population health' and advocacy, were used to search for English-language journal articles and books published from January 2000 to 30 June 2015 in PubMed, CINAHL, PsycINFO and Social Sciences Citation Index. Selected articles were used for citation snowballing to locate other relevant materials and sources. Grey literature databases were searched including Google Scholar, Google, Google Books, ProQuest Dissertations and Theses, Grey Literature Report and relevant organisational websites mentioned in peer-reviewed articles. Library catalogues of several Canadian universities were searched for books using the same search terms.

We excluded literature where the term, 'public health' was being used to refer to acute or long-term care advocacy initiatives, general health of the public or publicly funded healthcare systems. Sources were included if public health referred to collective action to enhance the health of the public, or action by the public health sector. Only those items where the focus was on population or community-level advocacy initiatives related to health promotion, prevention of illness, healthy public policy or harm reduction, were included. Materials that focused on individual patient/client advocacy were excluded. Although a number of websites with relevant text were located, only downloadable documents were included. The preliminary screening of documents was undertaken by the authors and supported by a research librarian and research assistant generating 244 documents. The two authors reviewed all full articles at this stage and excluded 61 for a total of 183 documents (published articles, documents and books) included in the final analysis (see Figure 1).

The document charting taxonomy included theoretical documents; documents focusing on public health media advocacy; empirical studies of public health advocacy; professional standards and educa-

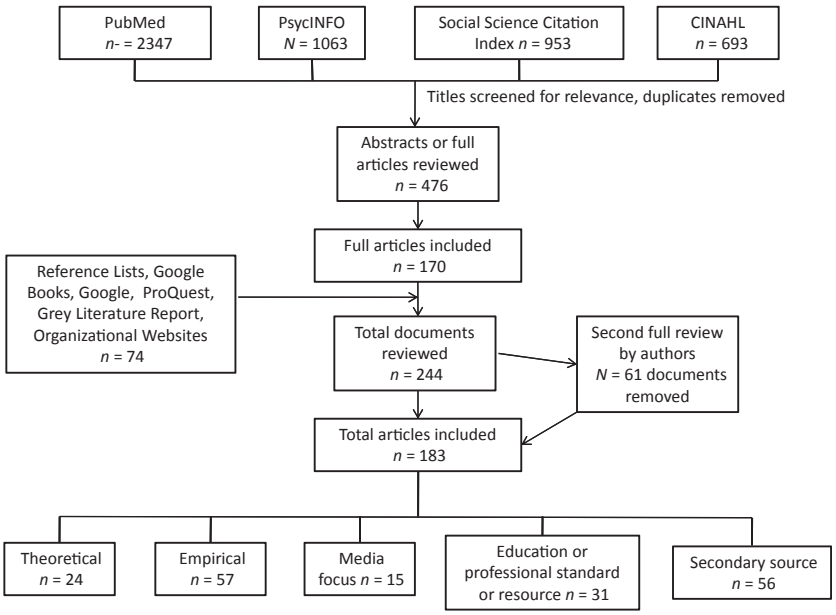

Figure 1 Document Flow Diagram.

tional resources; and secondary sources such as letters, editorials or articles that contributed significantly to the discourse on public health advocacy. The location of the first author was included in the charting table with the recognition that different national governmental forms may influence the discourse and practice of public health advocacy. Thematic analysis was both inductive and deductive in accordance with the stated objectives. Although this review was extensive, we do not claim that the literature search was exhaustive. Other relevant sources may have been missed, particularly non-English language in origin. The search strategy favoured the primary objective in that all search terms included the word 'advocacy', enabling the ability to explore how public health advocacy is broadly conceptualised. However, empirical studies on public health action addressing policy or other structural issues related to the social determinants of health may have been missed if the authors did not define the work as advocacy. Table 1 provides an overview of the included documents and charting taxonomy.

Findings

Several key themes emerged from this scoping review including: (i) a broad conceptualisation of public health advocacy; (ii) theoretical and professional support for public health advocacy for health equity; (iii) limited empirical evidence regarding the role of public health advocacy for health equity in practice; (iv) barriers to, and facilitators of, public health advocacy for health equity; and (v) challenges related to the evaluation of advocacy.

Broad conceptualisation of public health advocacy

Many definitions were used in the literature to describe the concept of 'advocacy' related to public health. The definitions can be categorised according to their focus on (i) actions/processes in favour of a particular cause, issue, idea or policy to protect or promote health, or on behalf of a particular population group (Christoffel 2000, Avery & Bashir 2003, Loue 2006); (ii) actions/processes that aim to strengthen capacity of citizens to act on their own behalf to improve their health (Carlisle 2000, American Nurses Association 2007, Cawley & Mannix McNamara 2011); (iii) actions/processes intended to decrease structural barriers to health (Chapman & Wakefield 2001, New South Wales Centre for Public Health Nutrition 2003, Shilton 2006, CPHA 2009, NCCDH 2015); and (iv) specific use of the media to advance public policy initiatives that will promote population health (Stead *et al*. 2002, Chapman 2004, 2015; Kegler & Miner 2004, Gomm *et al*. 2006, Dorfman & Krasnow 2014). Significantly, there were relatively few examples of definitions that specifically identified equity and/or social justice for disadvantaged populations as a primary goal of advocacy initiatives (Hofrichter 2006, PHAC 2007). However, the NCCDH (2015) states that public health advocacy

Table 1 Overview of included documents

Charting category/country Summary	First Author, Date, Country	
Theoretical [N = 24]		
USA = 8	Carlisle 2000 (UK)	Klugman 2011 (RSA)
CAN = 5	Chapman 2001 (AU)	Lathrop (USA)
AU = 5	Chapman 2004 (AU)	Loue 2004 (USA)
UK = 3	Chapman 2015 (AU)	Loue 2006 (USA)
NZ = 1	Christoffel 2000 (USA)	McCoy *et al*. 2006 (CAN)
RSA = 1	Falk-Rafael 2005 (CAN)	McCubbin *et al*. 2001 (CAN)
INT = 1	Foldspang *et al*. 2014 (INT)	NCCDH 2015 (CAN)
	Gielen and Green 2015 (USA)	Reutter and Eastlick Kushner 2010 (CAN)
	Hann *et al*. 2004 (USA)	Shilton 2006 (AU)
	Health Promotion Forum of New	Smith 2013 (UK)
	Zealand/Runanaga Whakapiki Ake	Smith and Stewart 2014 (UK)
	I Te Haoura O Aotearoa 2004 (NZ)	Wise 2001 (AU)
	Huang *et al*. 2015 (USA)	
	Kegler and Miner 2004 (USA)	
Empirical [N = 57]		
USA = 30	Asbridge 2003 (CAN)	Ingram *et al*. 2008 (USA)
AU = 8	Ashe *et al*. 2003 (USA)	Ingram *et al*. 2014 (USA)
CAN = 8	Avery and Bashir 2003 (USA)	Ingram *et al*. 2015 (USA)
UK = 5	Brassolotto (CAN)	Isaacs and Schroeder 2001 (USA)
MX = 1	Breton *et al*. 2008 (CAN)	Israel *et al*. 2010 (USA)
NGA = 1	Breen 2004 (UK)	Johnson 2001 (AU)
CR = 1	Buchar 2011 (USA)	Katikireddi *et al*. 2014 (UK)
SWE = 1	Cawley and Mannix McNamara 2011 (UK)	Kapilashrami (UK)
BEL = 1	Chapman 2007 (AU)	Kreger *et al*. 2011 (USA)
INT = 1	Chew and Palmer 2005 (CR)	Krieger and Higgins 2002 (USA)
	Cohen and McKay 2010 (CAN)	Laraia *et al*. 2003 (USA)
	Daiski 2005 (CAN)	McAndrews and Marcus, 2014 (USA)
	ECDPC 2014 (SWE)	McIntyre *et al*. 2013 (CAN)
	Falk-Rafael and Betker 2012 (CAN)	Moseley *et al*. 2008 (USA)
	Farrer *et al*. 2015 (BEL)	Mwatsama *et al*. 2006 (UK)
	Freeman *et al*. 2008 (AU)	Okonofua *et al*. 2011 (NGA)
	Freudenberg 2005 (USA)	Owen *et al*. 2006 (AU)
	Freudenberg *et al*. 2007 (USA)	Pelletier *et al*. 2013 (INT)
	Garcia *et al*. 2015 (USA)	Plough 2013 (USA)
	Garcia and Fenwick, 2009 (USA)	Raine *et al*. 2014 (USA)
	Garcia *et al*. 2009 (USA)	Raphael *et al*. 2015 (CAN)
	Giang *et al*. 2008 (USA)	Romero *et al*. 2013 (USA)
	Gomm *et al*. 2006 (AU)	Sabo *et al*. 2013 (USA)
	Gruszin *et al*. 2012 (AU)	Sistrom 2010 (USA)
	Grogan and Gusmano 2007 (USA)	Tabak *et al*. 2015 (USA)
	Guzys and Kendall 2006 (AU)	Thrasher *et al*. 2011 (MX)
	Haring *et al*. 2015 (USA)	Tsoukalas and Glantz 2003 (USA)
	Healton and Nelson 2004 (USA)	Webster *et al*. 2012 (AU)
		Zust and Moline 2003 (USA)
Media advocacy [N = 15]		
USA = 7	APHA n.d. (USA)	Hayes *et al*. 2007 (CAN)
CAN = 3	Chapman 2001 (AU)	The Health Communication Unit 2000 (CAN)
AU = 3	Dorfman 2003a (USA)	King 2006 (AU)
PKN = 1	Dorfman 2003b (USA)	Niederdeppe *et al*. 2007 (USA)
UK = 1	Dorfman *et al*. 2005 (USA)	Rock *et al*. 2011 (CAN)
	Dorfman and Krasnow 2014 (USA)	Stead *et al*. 2002 (UK)
	Galer-Unti 2010 (USA)	Wakefield *et al*. 2005 (AU)
	Haq *et al*. 2010 (PKN)	

(co1

Table 1 (continued)

Charting category/country Summary	First Author, Date, Country	
Professional standards/educational resources [N = 31]		
USA = 17	Allegrante *et al*. 2009 (INT)	Hines and Jernigan 2012 (USA)
CAN = 6	Allegrante *et al*. 2001 (USA)	Hofrichter 2006 (USA)
AU = 4	American Nurses Association 2007 (USA)	Hofrichter and Bhatia 2010 (USA)
UK = 1	APHA 2005 (USA)	Maycock *et al*. 2001 (AU)
IRE = 1	ASTND 2008 (USA)	Minnesota Department of Health 2001 (USA)
ROM = 1	Caira *et al*. 2003 (USA)	NCCDH 2010 (CAN)
INT = 1	CHNC 2011 (CAN)	New South Wales Centre for Public
	CPHA 2009 (CAN)	Health Nutrition 2003 (AU)
	Department of health/Health	PHAII 2007 (IRE)
	Improvement Directorate 2005 (UK)	Radius *et al*. 2009 (USA)
	Drevdahl 2013 (USA)	Reutter and Williamson 2000 (CAN)
	Fagen *et al*. 2009 (USA)	Reutter and Williamson 2000 (CAN)
	Galer-Unti *et al*. 2004 (USA)	Stafford *et al*. 2009 (AU)
	Galer-Unti and Tappe 2006 (USA)	Tappe *et al*. 2009 (USA)
	Genat *et al*. 2009 (AU)	Ungurean and Csiki 2005 (ROM)
	Goodhart 2002 (USA)	Vancouver Coastal Health n.d. (CAN)
	Hearne 2008 (USA)	
Secondary sources [N = 56]		
USA = 30	Adshead and Thorpe 2009 (UK)	Livingston 2011 (AU)
CAN = 11	Auld *et al*. 2003 (USA)	Lobstein *et al*. 2013 (INT)
AU = 6	Awofeso 2004 (AU)	Lopez 2009 (USA)
UK = 5	Bassett 2003 (USA)	Loue *et al*. 2003 (USA)
NZ = 1	Brown 2013 (USA)	Masuda *et al*. 2010 (CAN)
SPN = 1	Bullen and Neuwelt 2009 (NZ)	McIntyre 2011 Moore *et al*. 2015 (CAN)
BRZ = 1	Cartwright and Allotey 2006 (USA)	Nutbeam and Boxall 2008 (UK)
INT = 1	Cohen and Reutter 2007 (CAN)	Ochoa and Nash 2009 (USA)
	DeSantis 2008 (CAN)	Parker *et al*. 2010 (SPN)
	Devlin-Foltz *et al*. 2012 (USA)	Pérez and Martinez 2008 (USA)
	Fineberg 2013 (USA)	Raphael 2009 (CAN)
	Freudenberg and Tsui 2014 (USA)	Sapsin *et al*. 2003 (USA)
	Galer-Unti 2009 (USA)	Satcher and Higginbotham 2008 (USA)
	Gallagher *et al*. 2013 (USA)	Servaes and Malikhao 2010 (USA)
	Gardner *et al*. 2005 (CAN)	Sharp 2009 (UK)
	Goldstein 2009 (USA)	Sinclair *et al*. 2014 (AU)
	Gould *et al*. 2010 (USA)	Snider and Bellamy 2002 (USA)
	Hancock 2015 (CAN)	Spenceley *et al*. 2006 (CAN)
	Health Determinants, Planning and Evaluation	Stanhope and Viverais-Dresler 2008 (CAN)
	Division, Waterloo Region Community Health	Stanley and Daube 2009 (AU)
	Department 2001 (CAN)	Stenvig 2000 (USA)
	Heines 2005 (USA)	Tappe and Galer-Unti 2013 (USA)
	Hsu *et al*. 2003 (USA)	Tillmann *et al*. 2014 (UK)
	Jacobson and Wasserman 2001 (USA)	Wang and Brownell 2005 (USA)
	Jahiel and Babor 2007 (USA)	Weiss and Smith 2004 (USA)
	Katikireddi *et al*. 2013 (UK)	Westphal *et al*. 2000 (BRZ)
	Krahn and Campbell 2011 (USA)	White 2012 (USA)
	Kreuter 2005 (USA)	Yeatman 2002 (AU)
	Lefebvre *et al*. 2006 (CAN)	

AU = Australia; BEL = Belgium; BRZ = Brazil; CAN = Canada; CR = Czech Republic; IRE = Ireland; MX = Mexico; NZ = New Zealand; NGA = Nigeria; PKN = Pakistan; ROM = Romania; RSA = Republic of South Africa; SPN = Spain; SWE = Sweden; UK = United Kingdom; USA = United States of America; INT = Consensus statement/report issued by international group of authors.

'focuses on changing upstream factors related to the social determinants of health' and has 'significant potential' to improve health equity (p. 1).

Consistent with the broad conceptualisation of public health advocacy in the literature, a wide range of advocacy strategies or activities are discussed. Direct lobbying for policy change is only one of many advocacy strategies identified. Activities that may be more commonly identified as forms of health communication, such as celebrating days to bring about public awareness (e.g. International Day to Eradicate Poverty), activities such as coalition building and

Table 2 Range of Advocacy Strategies Related to Public Health Advocacy Roles (NCCDH 2015)

Strategy	Reference
Strategic Communication and Framing the Issue: • Use of mass media and multimedia to raise awareness, (re)frame issues, generate debate • Contesting the way that a problem is constructed or defined by an opposing group • Petitions, public meetings, presentations, seminars, conferences and celebrating days to bring about public awareness • Use of 'social math' and 'killer facts' • Use of authentic voices	Chapman & Wakefield (2001); Dorfman (2003a,b); Dorfman & Krasnow (2014); Freeman *et al*. (2008); Tsoukalas and Glantz (2003)
Gathering and/or Disseminating Information: • Use of research, data, community and impact assessment to build a case or draw attention to an issue ('evidence-based advocacy') • Policy analysis	CPHA (2009); Gomm *et al*. (2006); Isaacs & Schroeder (2001); Lobstein *et al*. (2013); Pelletier *et al*. (2013); Plough (2013); Rock *et al*. (2011); Romero *et al*. (2013)
Working in Collaboration: Developing Alliances or Partnerships: • Community or professional mobilisation and capacity building through, for example, coalitions of interest around defined issues • Personal and professional networks	Buchar (2011); CPHA (2009); Freudenberg & Tsui (2014); Hann *et al*. (2004); Huang *et al*. (2015); Kapilashrami *et al*. (2016); Knight (2014); Masuda *et al*. (2010); McAndrews & Marcus (2014); Raine *et al*. (2014); (Shilton 2006)
Using the Legal and Regulatory System: • Letter writing to legislators, government employees or corporate actors who participate in policy • Direct political lobbying • Grassroots lobbying (supporting the public to take action on specific legislation – public protest) • Litigation: corporate or *Charter* challenges – challenging policies considered damaging to the health of the public	Christoffel (2000); Freudenberg (2005); Kreger *et al*. (2011); Moseley *et al*. (2008); Wakefield *et al*. (2005)

community mobilisation, and even community-based participatory action research, are all described in this literature as forms of advocacy. See Table 2 for a list of advocacy strategies, categorised according to four main advocacy roles for public health (NCCDH 2015): framing the issue; gathering and disseminating data; working in collaboration and developing alliances; and using the legal and regulatory system.

The empirical literature had fewer examples of participatory or community-engaged advocacy strategies (Zust & Moline 2003, DeSantis 2008, Moseley *et al*. 2008, García & Fenwick 2009, García *et al*. 2009, Israel *et al*. 2010), with a tilt towards representational advocacy (Asbridge 2003, Grogan & Gusmano 2007, Breton *et al*. 2008, Freeman *et al*. 2008, Giang *et al*. 2008, Sistrom 2010, Okonofua *et al*. 2011, Thrasher *et al*. 2011, Webster *et al*. 2012).

Advocacy for health equity/social justice – in theory

Advocacy is internationally recognised as a core and legitimate strategy of health promotion to improve the health of individuals, families, communities and populations (McCubbin *et al*. 2001, Health Promotion Forum of New Zealand/Runanaga Whakapiki Ake I Te Haoura O Aotearoa 2004, Allegrante *et al*. 2009). As a result, there is strong theoretical support for the role of advocacy in public health practice in general (Carlisle 2000, Christoffel 2000, Stenvig 2000, Westphal *et al*. 2000, Chapman 2001, 2015, Wise 2001, Bassett 2003, Loue *et al*. 2003, Awofeso 2004, Galer-Unti *et al*. 2004, Hann *et al*. 2004, Health Promotion Forum of New Zealand/Runanaga Whakapiki Ake I Te Haoura O Aotearoa 2004, Loue 2004, Falk-Rafael 2005, Lefebvre *et al*. 2006, McCoy *et al*. 2006, Shilton 2006, Stanhope & Viverais-Dresler 2008, Israel *et al*. 2010, Dorfman & Krasnow 2014, Tillmann *et al*. 2014, NCCDH 2015). Advocacy has been identified as a core competency for public health practitioners in several jurisdictions (Department of Health/Health Improvement Directorate 2005, PHAC 2007, PHAII 2007, Genat *et al*. 2009); advocacy is one of the 10 'Public Health Operations' that are identified as essential for the public health workforce in Europe (Foldspang *et al*. 2014); over 70 public health advocacy skills have been identified (PHAII 2007); and

there has been some effort towards developing public health advocacy 'best practices'. (Minnesota Department of Health 2001, Galer-Unti *et al*. 2004).

Discussion on equity-focused advocacy is most apparent in the public/community health direct service professions literature. There is strong theoretical support for the role of nurses who work in public health or other community health settings to advocate for healthy public policies – including those that address root causes of ill-health, such as social and economic exclusion (Reutter & Williamson 2000, Reutter & Duncan 2002, Daiski 2005, Falk-Rafael 2005, Spenceley *et al*. 2006, Cohen & Reutter 2007, Reutter & Eastlick Kushner 2010, Falk-Rafael & Betker 2012, Drevdahl 2013, Lathrop 2013). Falk-Rafael (2005) argues that advocacy for social justice and equity is a moral imperative for community health nurses.

> Speaking truth to power, that is, influencing public policies that impact health, advocating for those whose voices have been silenced, and challenging ideologies that contribute to the exclusion of some groups for the benefit of others, is to practice empowered caring (p. 220).

Advocacy for social justice and health equity is explicitly identified as a professional standard of practice for community/public health nurses in Canada: '[The community health nurse] understands and uses social marketing, media and advocacy strategies, in collaboration with others, to raise awareness of health issues and place issues of social justice and health equity on the public agenda' (CHNC 2011, p. 11). In the USA, advocacy has been identified by the ASTND (2008) as a core function for public health nurses in achieving health equity: '. . .the PHN [public health nurse] promotes social justice and sound social policy in areas of housing, education, employment and recreation and articulates the connection between public health and social justice' (9).

There are also a few notable examples across the public health literature. Healton and Nelson (2004) note that the poor, the less educated and the disenfranchised smoke more than their better-off counterparts and suffer a disproportionate burden of tobacco-related illness and death. Therefore, they argue, framing tobacco as a social justice issue (as opposed to the dominant view of it as solely an individual behaviour choice) is crucial to success for public health advocates. A strong history of advocacy for social justice and policy change has been documented among allied community health workers (CHWs) and educators, noting that they have a unique opportunity of engaging and including marginalised groups in advocacy efforts and policy action (Galer-Unti & Tappe 2006, Ingram *et al*. 2008, Pérez and Martinez 2008, Tappe *et al*. 2009, Sabo *et al*. 2013, Ingram *et al*. 2014). There is also discussion in the literature about the need for physicians (Bullen & Neuwelt 2009, Ochoa & Nash 2009, Tillmann *et al*. 2014), and academics (Cartwright & Allotey 2006, Livingston 2011, Brown 2013, Katikireddi *et al*. 2013) to be involved in public health advocacy for social equity and distributive justice.

Conceptual frameworks and models have been developed that outline the key elements of public health advocacy (Christoffel 2000, Chapman 2004, Shilton 2006, PHAII 2007), but only a few that specifically address advocacy to reduce inequities in health. Masuda *et al*. (2010) introduce the concept of environmental health justice as a research, policy and advocacy agenda, informed by a confluence of health promotion and environmental justice perspectives, aimed at redressing social injustices that are environmentally mediated. Carlisle (2000) outlines a conceptual framework that maps such complexities as the diversity of advocacy goals and ideologies or philosophies of practice, the range of levels at which practitioners work and how these disparate elements relate to the issues surrounding health inequalities. Advocacy practice is seen to occur along two different axes, facilitational to representational, and cases to causes. Facilitational advocacy is grounded in values of community participation and empowerment, where representational advocacy involves acting on behalf of populations without their involvement. The cases to causes axis encompasses a span of foci from individual lifestyle and behaviour (cases) to social policy and structure (causes), representing the range of conservative to radical politics and their positions on the nature of health inequities. Carlisle (2000) demonstrates how community development, community activism, medical health promotion and social policy reform are positioned along these axes as distinct forms of public health advocacy.

The NCCDH (2015) has recently created a framework that combines Carlisle's (2000) framework with Whitehead's (2007-not included in the review) typology of actions to tackle social inequalities in health. Arguing that, just as there is no single action to decrease health inequities, there is no single approach to advocacy to address these inequities; the NCCDH framework supports public health practitioners to consider how each type of advocacy effort aligns with specific actions to reduce health inequities, depending on the goal and focus. Lastly, although not specific to public health, Farrer *et al*. (2015) identify six dimensions of advocacy for health equity: (i)

Types of evidence needed to advocate for health equity and how to transfer this knowledge to policy processes; (ii) Who advocates for health equity and to whom?; (iii) Advocacy messages; (iv) Tailoring arguments to different political standpoints; (v) Barriers and enablers of effective advocacy; and (vi) Practices and activities that increase the effectiveness of advocacy efforts.

Media advocacy

It is noteworthy that media advocacy has a distinct discourse in the public health advocacy literature. Most commentators agree that the label 'media advocacy' refers to an approach to using the media in public health, which involves generating news or digital media coverage of public health issues in order to advocate particular policy solutions (APHA n.d.). Media activity is often undertaken as part of a broader advocacy approach, which might also involve networking, community mobilisation and lobbying (Dorfman 2003a).

There is a critique regarding the tendency for public health media advocacy initiatives in the USA to focus on individual behaviour change (McCubbin *et al*. 2001). However, the main proponents of media advocacy suggest that it represents a fundamental shift from traditional public health education, communication and social marketing approaches that focus on changing individual risk behaviours. Instead, media advocacy focuses attention on changing the way that a problem is understood as a public health issue, and seeks to mobilise community action and support the development of healthy public policies through the effective use of the media (The Health Communication Unit 2000, Chapman & Wakefield 2001, Dorfman 2003b, King 2006, Galer-Unti 2009). Dorfman and Krasnow (2014) argue that media advocacy is a tool for raising voices in the democratic process that should be used to frame 'wicked problems' (e.g. inadequate housing, unemployment) as social justice issues. The ability to frame a public health issue successfully – i.e. to package and position an issue so that it conveys a certain meaning or problem representation, in order to attract public and political support – is consistently identified as a key factor in effective public health advocacy (Chapman & Wakefield 2001, Dorfman 2003a, Dorfman *et al*. 2005, Dorfman & Krasnow 2014).

With the rapid proliferation of social and digital media, media advocacy has become even more potentially powerful and accessible (Galer-Unti 2010). With the help of online and cellular application and platforms, individuals and organisations are able to disseminate messages more quickly and to wider audiences than ever before. But while the Internet and other digital media provide potentially powerful tools for well-equipped and technically savvy specialists, new barriers are posed for those with fewer resources or know-how to adapt their messages to the faster pace and uncertainty of these new environments (Hayes *et al*. 2007).

Media advocacy is viewed as only one tool to support public health policy initiatives. A broader advocacy approach – consisting of coalition building, leadership development and extensive public participation – must form the foundation from which successful advocacy and media initiatives can make a difference (Shilton 2006). However, although some commentators define media advocacy (and public health advocacy in general) largely as a bottom-up grassroots approach, involving community organising and capacity building (Loue *et al*. 2003, Haq *et al*. 2010), others suggest that media advocacy can be either a top-down or a bottom-up approach, depending on the issue and the context (Chapman & Wakefield 2001, Stead *et al*. 2002). Significant challenges to the use of mainstream media were noted by some authors with respect to the media's disinterest or repeated failure to report on the social drivers of health inequities, and reverting to problematising individual behaviours (Hayes *et al*. 2007, Raphael 2011).

Limited evidence of public health advocacy for equity/social justice in practice

There is a large body of literature describing public health advocacy initiatives, including lessons learnt, challenges and key factors for success. A salient feature is that descriptions of advocacy efforts to influence social norms/ behaviours (e.g. tobacco and alcohol control, safer drug use, healthy lifestyles) are predominant in the literature from 2000 through 2015 (Chapman & Wakefield 2001, Asbridge 2003, Ashe *et al*. 2003, Avery & Bashir 2003, Hsu *et al*. 2003, Breen 2004, Chew & Palmer 2005, Heines 2005, Wakefield *et al*. 2005, Guzys & Kendall 2006, Mwatsama *et al*. 2006, Owen *et al*. 2006, Chapman 2007, Niederdeppe *et al*. 2007, Freeman *et al*. 2008, García & Fenwick 2009, Thrasher *et al*. 2011, Gruszin *et al*. 2012, Hines & Jernigan 2012, Webster *et al*. 2012, Gallagher *et al*. 2013, Tappe and Galer-Unti 2013, Katikireddi *et al*. 2014, Raine *et al*. 2014, Sinclair *et al*. 2014, Gielen & Green 2015, Haring *et al*. 2015, Huang *et al*. 2015).

A smaller proportion of this literature describes policy advocacy initiatives that are directly related to

addressing social determinants of health and reducing inequities in health, such as advocating for policies that ensure access to affordable healthy housing (Krieger & Higgins 2002, Plough 2013), addressing food security and built environment (Laraia *et al*. 2003, Giang *et al*. 2008, McIntyre 2011), addressing gendered and racial inequities in healthcare access (Dorfman 2003a, Zust & Moline 2003, Haq *et al*. 2010, Okonofua *et al*. 2011, Rock *et al*. 2011), improving transportation infrastructure and addressing structural violence resulting from border security policy for underserved border (migrant) populations in the southern USA (Ingram *et al*. 2014); developing physical activity resources in low-income neighbourhoods (García *et al*. 2009), reduce tobacco-related disparities (Garcia *et al*. 2015) and promoting environmental justice (Kreger *et al*. 2011, McAndrews & Marcus 2014). We could find no examples of advocacy by the public health sector for broad income security or poverty reduction initiatives such as a campaign for a living wage or guaranteed minimum income.

As an example of public health advocacy seeking to address the root causes of social determinants of health, Giang *et al*. describe the Food Trust initiative. This community-based organisation took a lead role in creating a broad public health advocacy campaign to bring awareness and change policy regarding the grocery gap in Philadelphia. To help educate the public and government decision-makers about the grocery gap, a detailed report was created, making evident the impact of poor access to affordable nutritious foods on health conditions for low-income urban residents. As a result of advocacy efforts, the Fresh Food Financing Initiative was created and 32 supermarkets were built in low-income neighbourhoods.

Barriers to and facilitators of public health advocacy for health equity

In spite of theoretical and professional support for the central role of advocacy in the field of public health, the empirical evidence suggests that public health practitioners' involvement in advocacy related to social and economic policy development is limited (Cohen & McKay 2010, Cawley & Mannix McNamara 2011, Falk-Rafael & Betker 2012, McIntyre *et al*. 2013, Raphael *et al*. 2015). As Wise (2001) has noted, public health practitioners, researchers and administrators are expected to engage in efforts to influence social norms and behaviours (e.g. policies related to tobacco and alcohol control), but the legitimacy of their role in advocacy related to broader social and economic policy development and implementation to reduce inequities in health is poorly established.

Barriers to engaging in public health advocacy that originate within the health system include: a narrow interpretation of advocacy limited to lobbying; dominance of the biomedical perspective that crowds out arguments concerning the societal determinants of health inequities; internalisation of ideas of health grounded in individual behaviours; a 'service-delivery' (as opposed to structural) approach to addressing social determinants of health; reluctance of public health practitioners to engage in advocacy because of its perceived political nature or because of a lack of advocacy training; failure to strategically frame issues; lack of organisational support for public health employees to pursue this activity; unwillingness on the part of public health organisations to engage in public controversy; insufficient data; lack of interdisciplinary collaboration; and lack of policy analysis capacity in the public health sector (Allegrante *et al*. 2001, Jacobson & Wasserman 2001, Johnson 2001, Hann *et al*. 2004, Chew & Palmer 2005, Freudenberg 2005, Gomm *et al*. 2006, Cohen & Reutter 2007, Breton *et al*. 2008, Goldstein 2009, Lopez 2009, Sharp 2009, Cohen & McKay 2010, Israel *et al*. 2010, Buchar 2011, Cawley & Mannix McNamara 2011, Brown 2013, Fineberg 2013, Plough 2013, Brassolotto *et al*. 2014, Raphael *et al*. 2014, Farrer *et al*. 2015). Nutbeam & Boxall (2008) note the dominance of public health research that focuses on behaviours associated with health disparities, framing the problem as one of personal choices, leading to policy solutions that focus on re-shaping lifestyles of unhealthy populations. These problem representations are often supported by extant government and institutional ideologies (Chapman 2001, Nutbeam & Boxall 2008).

The lack of independence of public health institutions from government bodies has also been identified as a major barrier to public health advocacy. Tillmann *et al*. (2014) argue that public health officials in the UK must be free to draw attention to the actual or potential health impact of any government policies, going so far as to say that 'shying away from advocacy is comparable to medical negligence' (213). Hancock (2015) states that more freedom of speech is required for Medical Officers of Health in Canada, noting that advocacy is not a dirty word but a duty. Fineberg (2013) calls on public health leaders to not be reluctant to speak out, organise and mobilise in relation to public need. He identifies timidity as one of the 'seven deadly sins' of public health, which he describes as 'the fear of being opposed, the fear of being wrong, the fear of standing out, the fear of making change' (48).

Despite the strong professional support for nurses' involvement in public health advocacy, there were very few empirical or case studies found describing nurse-led advocacy initiatives. Falk-Rafael and Betker (2012) have found that short-sighted planning accompanied by continual restructuring and changing priorities of the public health system alienates individuals and breaks down advocacy efforts. These authors also report that increased workloads, lack of resources and funding, and administrative constraints leave many public health nurses feeling powerless. They suggest that, at a personal level, some nurses may feel that this disjointed inequitable approach to healthcare provision (as result of public policy) reflects general Canadian attitudes. For some nurses, this belief creates a sense of apathy that undermines their attempt to achieve change as well as their sense of purpose regarding their profession.

Barriers originating outside of public health organisations may include: proponents of political philosophies that undermine health at the expense of economic considerations or that promote the idea of 'equal agency' and equal opportunities for all citizens (Farrer *et al*. 2015); concern by the public and influential minorities about 'nanny' state interference with civil liberties (Chapman 2001, Breen 2004, Moore *et al*. 2015); a public mood that values individual responsibility and minimum collective action (Farrer *et al*. 2015); influential vested commercial interests (Krieger & Higgins 2002, Breen 2004, Kreuter 2005, Stanley & Daube 2009); limited opportunities based on the current political radar (Chapman 2004); 'political short-termism', where health targets are generally short-term and not amenable to the long-term action required to improve health equity (Farrer *et al*. 2015); insufficient co-operation between health and other sectors that hamper efforts to advocate for policies that tackle health inequities (McAndrews & Marcus 2014, Farrer *et al*. 2015); stigmatisation or inequities based on race, social class and gender (Satcher & Higginbotham 2008); academia's focus on publication and grants rather than social change (Chapman 2001, Klugman 2011, Livingston 2011); lack of minority and low-income representation on community advisory boards (Grogan, & Gusmano 2007); remote geography (Snider & Bellamy 2002); constraints imposed by government policy and procedures (Galer-Unti *et al*. 2004); the growing complexity of policy arenas (Yeatman 2002); and the ever-changing social structure that produces the conditions for inequities (Adshead & Thorpe 2009). Gould *et al*. (2010) highlight the predominance of a societal belief that health inequities are the result of poor individual choices and behaviours, which confounds efforts to mobilise action towards redressing the underlying causes of health inequities.

One of the main barriers noted by several authors is the lack of more than passing attention in the education of health professionals and public health practitioners on how to advance or advocate for policy and social change to redress health inequities, with public health advocacy remaining barely a sub-discipline in the field (Christoffel 2000, Goodhart 2002, Auld *et al*. 2003, Caira *et al*. 2003, Chapman 2004, Radius *et al*. 2009, Hines & Jernigan 2012, White 2012, Brown 2013, Plough 2013, ECDPC 2014). As Freudenberg and Tsui (2014) note:

> The work of public health is inherently political; thus, we argue that all public health professionals and students, especially those who may encounter participatory policy change efforts in their professional practice, should be offered rigorous training in navigating the tensions between politics and science and in the tools of advocacy and participation (13).

The Association of Schools of Public Health in the European Region (2014) have a working group – Public Health Advocacy and Communication – dedicated to motivating schools of public health to 'promote academic and advanced training programmes based on evidence and research related to advocacy' (cited in ECDPC 2014, p. 2). The extent to which rigorous advocacy training is occurring in professional public health education programs in the European Region (or elsewhere), and the extent to which this training focuses on health inequities, remains unknown. However, outside of professional public health education programs, there is evidence of training and support for some public health workers in the field. Ingram *et al*. (2014) describe an 18-month advocacy course for CHWs who are engaged with marginalised migrant populations near the USA–Mexican border. Findings demonstrate that, following this training, the workers worked to initiate discussions about underlying social determinants and environment-related factors that impact health, and identified solutions to improve neighbourhood conditions, create community opportunities and increase access to services.

Several authors have provided insights to assist with developing successful advocacy campaigns. Coalitions or multiple stakeholder initiatives are commonly cited as being a key starting point for advocates representing diverse backgrounds to work together towards common goals (Wise 2001, Bassett 2003, APHA 2005, Gardner *et al*. 2005, Gomm *et al*. 2006, Loue 2006, Freudenberg *et al*. 2007, García *et al*. 2009, Farrer *et al*. 2015). Within coalitions, strong

communication is crucial when collaborating with multiple stakeholders to ensure all participants coordinate expertise and efforts to strategically frame issues to the public and policy makers (Tsoukalas & Glantz 2003, García *et al*. 2009). For example, engaging with media is an important element to advocacy that requires attention to the five Ps: 'precision, passion, promptness, perseverance and personality' to ensure messages are effective (Awofeso 2004, p. 107). Raine *et al*. (2014) studied capacity building for policy work within a coalition comprised of a broad range of stakeholders from diverse sectors (community, profit, non-profit, academic, government) working together in data creation, collection and advocacy for policy change to enable chronic disease prevention. Capacity building helped to foster sustainability, increase competency of the group to plan efforts relevant to political momentum and effectively leverage existing economic and professional resources. The intersectoral nature of the coalition provided important advantages such as enhanced reach and credibility of efforts. Several authors emphasise the importance of using multiple strategies at multiple levels. Gielen and Green (2015) state: 'Comparing an educational approach with a policy or environmental approach, for example, builds a false dichotomy; rather, it is essential to *combine* strategies at all levels to produce synergy' (28S). Huang *et al*. (2015) argue that both 'top-down' and 'bottom-up' advocacy strategies are required for obesity prevention.

A wide range of contextual conditions and resources have been identified to help make advocacy possible, no matter what the goal of the advocacy initiative might be. These include: education, decision-making models, professional development or leadership training for the public health workforce (Maycock *et al*. 2001, Hearne 2008, Ingram *et al*. 2008, Cawley & Mannix McNamara 2011; Freudenberg & Tsui 2014, Vancouver Coastal Health n.d.); creating the capacity to extend public health practice beyond the agency walls to dynamic partnerships with other disciplines, such as economic development, land use planning, housing, transportation and education (Plough 2013); connection and collaboration with community members and experienced advocators (Ingram *et al*. 2008, García *et al*. 2009, Sabo *et al*. 2013); strong organisational capacity, co-operation and flexibility in the work environment (Health Determinants, Planning and Evaluation Division, Waterloo Region Community Health Department 2001, Ingram *et al*. 2008, Israel *et al*. 2010, Klugman 2011); research, including community-based participatory and/or action research and that which disentangles social determinants of health from health conditions (Romero *et al*. 2013, Freudenberg & Tsui 2014, Ingram *et al*. 2015, Kapilashrami *et al*. 2016); a sharp focus towards common goals (Giang *et al*. 2008, García *et al*. 2009, Stafford *et al*. 2009, Parker *et al*. 2010, Parker *et al*. 2010, Krahn & Campbell 2011) and engaging the law (Isaacs and Schroeder 2001, Weiss & Smith 2004). Servaes and Malikhao (2010) have found the crucial elements for the success of advocacy messages are: 'relevance, timing, validity, cultural sensitivity, orientation of the relevant stakeholder groups, planning, communication, action orientation and dissemination of information' (48). Growing a 'rhinocerous hide', respecting the evidence, especially if it changes, recognising that people with lived experience are much more compelling advocates than experts, and understanding that facts and evidence should be anchored firmly to the values that will make them resonate, are among the pieces of advice offered by Chapman (2015) to early-career public health advocates.

Sabo *et al*. (2013) identified predictors of CHW involvement in advocacy initiatives related to their work with socially disadvantaged border populations in the southern USA. CHWs with at least 5 years of experience and previous leadership and advocacy training, who reported community advocacy as part of their job description, who collaborated with community leaders and with other CHWs and who had the autonomy to start new projects with the community, were all more likely to engage in advocacy than were CHWs who lacked these characteristics.

Others have focused on specific facilitators of advocacy for health equity. Raphael *et al*. (2014) found that a strong ideological commitment of Medical Officers of Health and public health staff to a structural view of the social determinants of health, plus centralised organisational structures supporting health equity strategies, led to greater involvement in advocacy related to broader structural determinants of health inequities. Farrer *et al*. (2015) identify long-term enablers of effective advocacy for health equity, including: improving public understanding and awareness of health inequities; the inclusion of advocacy, human rights, media work and social justice as part of professional training for social workers, paediatricians, nurses and doctors; greater student contact with disadvantaged communities during their studies to reduce students' 'middle-class bias'; being ready to take advantage of 'windows of opportunity' (e.g. reports from high-profile commissions, stories in the media, closely fought elections, reorganisation of government departments or government debates); and developing collaborative networks consisting of researchers, policy makers and non-government orga-

nizations, which can build understanding and foster communication between the worlds of policy and research and also open opportunities to present research evidence related to health inequities.

Regarding the use of research to support advocacy efforts, there has been a noted shift in the discourse around public health advocacy and health equity towards a critical discussion of evidence and evidence-based medicine. One of the themes arising in this discourse relates to the role of evidence in policy processes. There is a tension between a belief in the importance of public health advocacy that is 'evidence-based' (Romero *et al*. 2013, Chapman 2015, Garcia *et al*. 2015, Tabak *et al*. 2015) and acknowledgement that the role of evidence in policy processes is limited; power, politics, values and ideology being the more influential factors (Lobstein *et al*. 2013, Smith 2013, Freudenberg & Tsui 2014, Smith & Stewart 2014). A related theme concerns the types of evidence and research methods that inform advocacy efforts. Farrer *et al*. (2015) suggest that advocates should consider their use of evidence carefully as 'highest standard scientific evidence' (i.e. systematic reviews and RCTs) is not necessarily as useful as qualitative evidence for documenting advocacy efforts. Public health advocates are encouraged to draw from a diversity of evidence forms, and the importance of capturing the lived experience of those who are disempowered is highlighted (Smith 2013). Increasingly, community-based participatory and/or action research is promoted as a way to address the problematic role of power in knowledge/evidence production and dissemination (Romero *et al*. 2013, Freudenberg & Tsui 2014, Ingram *et al*. 2015). Lastly, the role of scientists/researchers in advocacy is a notable theme in the discourse around public health advocacy. The consensus in this literature is that advocacy is an appropriate role for researchers, with some (Hancock 2015) arguing that it is a duty of academics who are in privileged positions of power, while others (Farrer *et al*. 2015) suggest it should be up to individual researchers to decide how comfortable they are advocating. However, it is noted that there remains a lack of clarity between professional boundaries and perceived scientific bias (Farrer *et al*. 2015, Kapilashrami *et al*. 2016), and that the idea of researchers engaging in advocacy still needs acceptance by the scientific community (Romero *et al*. 2013). In addition to the possibility that researchers may not have the right skill set, some of the concerns about health equity researchers engaging in advocacy, identified by Smith and Stewart (2014), include: a tendency to work on the feasible/winnable challenges, which results in public health evidence on inequalities being more focused on individual behaviours than structural conditions; once declaring a 'side', it may be difficult to see another, leading to bias; and, by acting on an issue, researchers can become perceived as less credible.

Challenges to public health advocacy evaluation

The complex nature of the mechanism by which advocacy can effect social change has constrained public health advocacy evaluation efforts (Devlin-Foltz *et al*. 2012, Dorfman & Krasnow 2014, ECDPC 2014). The necessity of incorporating theoretical models of social change into evaluations of advocacy initiatives has been noted (Klugman, 2011). Klugman (2011) warns of evaluation methods that focus narrowly on policy change, and provides a number of broad advocacy outcomes including increased organisational capacity, strengthened support base and alliances, and increased data and analysis from a social justice perspective. Fagen *et al*. (2009) call for prospective advocacy evaluation designs that allow for the real-time monitoring of the social, economic and political conditions that shape the advocacy environment, and adjusting of advocacy strategies accordingly. In accordance with such methods, flexibility and non-traditional techniques are recommended. Ingram *et al*. (2015) take a community-based participatory research approach to evaluate a CHW advocacy intervention.

Reflections about country as context

Although not a major theme in itself, it was interesting to note characteristics related to the country of origin of the literature included in this scoping review. Given the criterion of English language sources only, it is not surprising that sources from the USA and other former Commonwealth nations make up the vast majority of included documents (91%). Most of the literature that fit our inclusion criteria originated in the USA (51%). Canada was the second largest source of literature (18%); and Australia was third (14%). The paucity of literature from the UK (only 8%) was surprising, although it is worth noting that one of the conceptual frameworks of public health advocacy with a strong health equity focus was based in the UK (Carlisle 2000).

The role of politics and political ideology as a determinant of equitable distribution of the prerequisites for health has been well documented (Bambra *et al*. 2005, Raphael 2014). For example, the social democratic welfare states of Finland, Norway and Sweden are noted as leaders in proactive approaches towards public

policy that provide more equitable distribution of the prerequisites for health (Raphael 2014). The UK and other European Union nations have (at least on paper) shown a commitment to reducing social inequalities in health. It would have been interesting to compare public health advocacy efforts in those nations with those in liberal welfare states – i.e. Australia, Canada, Ireland, the UK and the USA (Bambra 2007) – where state commitment to reducing these inequities has been minimal (Raphael 2012, 2014). However, with such a small proportion of the empirical examples from European sources, a meaningful comparison was not possible.

Most of the literature included in this review originated in neoliberal states (USA, Canada, Australia) which, in spite of some differences in the degree to which the welfare state remains intact, share some common characteristics, including relatively high levels of health and social inequities (Conference Board of Canada 2013, OECD 2013, 2014, UNICEF Office of Research 2013) and societal norms that highly value individual responsibility for health (Ayo 2011). The empirical evidence from these countries predominantly emphasised advocacy efforts related to behaviour change, rather than advocacy related to root causes of health inequities.

Discussion

The final report of the WHO (2008) Commission on Social Determinants of Health concluded that eliminating inequities in health within a generation is an ethical imperative – a matter of social justice. Public health advocacy will be a key factor in achieving this goal. A key finding of this review is that, although public health advocacy to address the root causes of health inequities is supported theoretically and through professional practice standards, the empirical literature does not reflect that this is occurring in public health practice. This discordance between the discourse and practice may be due to the wide range of barriers to engaging in advocacy for health equity that were identified – some originating at the level of individual public health practitioners, some at the organisational level and others beyond public health organisations. This fits with the observation that organisational capacity for public health equity action in general may be limited by a number of internal and external factors (Cohen *et al*. 2013).

Another explanation for the gap between theory and practice that must be considered is that these types of advocacy activities are taking place but are not being published, as advocates focused on social action may be less inclined towards publication, or advocacy is taking place largely outside of the public health sector. If that is the case, the growing stratification of health, income and accumulated wealth both globally and within affluent countries (WHO 2008, Citizens for Public Justice 2012, Gornick & Jäntti 2013) implies that public health advocacy for social justice is not making significant headway.

If the public health sector is to fulfil its advocacy role in catalysing action to reduce health inequities, it will be necessary to address public health advocacy barriers at multiple levels. There is a clear need for increased education of public health practitioners about public health advocacy in general, and advocacy for health equity in particular. The wide range of advocacy strategies and related skills identified indicates that advocacy is broader than lobbying politicians/policy makers. Little attention has been given to organisational capacity for engaging in public health advocacy, specifically to redress health inequities. Applied research focused on strengthening this capacity is required. Plenty of models, frameworks and guides for evaluating public health advocacy efforts have been developed, and public health practitioners need to engage in equity-focused advocacy and related evaluation research, even when advocacy efforts are unsuccessful at affecting change.

Beyond the instrumental application of knowledge related to advocacy, public health systems can benefit from conceptual knowledge related to the nature of social determinants of health and health inequities. Pelletier *et al*. (2013) describe advocacy as an art, requiring intervention into complex, dynamic and highly contextual socio-political situations. The inherent complexity in the nature of health and social problems leads to a multiplicity of ways in which problems can be understood, with each understanding pointing towards unique advocacy responses. Problem understandings may be considered to fall on a continuum from individual responsibility, to responsibility that lies with the state, the state's institutions or corporate activity. Advocacy initiatives that seek to implement or alter social policy and law may still be derived from an understanding of health issues as problems of wayward individual practices, with solutions aimed at increased citizen regulation or prohibitions. Although the public health advocacy literature demonstrates an ardent critique of advocacy efforts that focus on the health behaviours of populations rather than socio-structural, environmental and corporate drivers of inequities (Sapsin *et al*. 2003, Kreuter 2005, Ungurean & Csiki 2005, Wang & Brownell 2005, Livingston 2011, Raphael *et al*. 2014), this critique does not appear to have significantly influenced public health practice.

In addition to interrogating understandings of complex health issues, public health systems may need to

reconceptualise their role in advocacy. Consistent with the emergence of neoliberal governance, characterised by market fundamentalism, decreased regulation of corporate activities, the dismantling of the social safety-net and a shifting of the responsibility for welfare onto individuals and families (Larner 2000, Clark 2002), the public health sector is poised to either reproduce or resist these politics. A salient feature of this review is that the public health advocacy literature reflects a neoliberal preoccupation with individual responsibilities for healthy lifestyles and decisions, which mirrors that found in the health promotion literature (Ayo 2011). In order to address the structural underpinnings of health inequities, public health advocacy must catalyse multi-sectoral efforts that implicate the state and corporations in the production of health inequities, and rally state involvement to redress these injustices. According to the WHO (2008), 'unequal living conditions are the consequence of poor social policies and programs, unfair economic arrangements and bad politics', rendering public health advocacy for health equity as an inherently political practice.

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