



# Academic advocacy in public health: Disciplinary ‘duty’ or political ‘propaganda’?



K.E. Smith <sup>a, \*</sup>, E.A. Stewart <sup>b</sup>

<sup>a</sup> Global Public Health Unit, School of Social & Political Science, University of Edinburgh, Edinburgh EH8 9LD, Scotland, UK

<sup>b</sup> Centre for Population Health Sciences, Usher Institute, Medical School, University of Edinburgh, Edinburgh EH8 9AG, Scotland, UK

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## ABSTRACT

The role of ‘advocacy’ within public health attracts considerable debate but is rarely the subject of empirical research. This paper reviews the available literature and presents data from qualitative research (interviews and focus groups conducted in the UK in 2011–2013) involving 147 professionals (working in academia, the public sector, the third sector and policy settings) concerned with public health in the UK. It seeks to address the following questions: (i) What is public health advocacy and how does it relate to research?; (ii) What role (if any) do professionals concerned with public health feel researchers ought to play in advocacy?; and (iii) For those researchers who do engage in advocacy, what are the risks and challenges and to what extent can these be managed/mitigated? In answering these questions, we argue that two deeply contrasting conceptualisations of ‘advocacy’ exist within public health, the most dominant of which (‘representational’) centres on strategies for ‘selling’ public health goals to decision-makers and the wider public. This contrasts with an alternative (less widely employed) conceptualisation of advocacy as ‘facilitational’. This approach focuses on working with communities whose voices are often unheard/ignored in policy to enable their views to contribute to debates. We argue that these divergent ways of thinking about advocacy speak to a more fundamental challenge regarding the role of the public in research, policy and practice and the activities that connect these various strands of public health research.

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## 1. Introduction

The idea that public health, by its very nature, entails advocacy, appears to be ascendant. To take one example, a 2014 letter published in the high-profile medical journal, the *Lancet*, written by five public health registrars, argued that ‘it is the duty of UK public health institutions to advocate strongly for evidence-based measures to improve the health of society’ (Tillmann et al., p.213). Whilst difficult to gauge in quantifiable terms, searching the academic databases *Web of Science* for “public health” AND (advocacy OR advocat\*) in 2007–2016 returns over three times as many hits as the previous decade.

The roots of this idea are long-standing. Rudolph Virchow, a nineteenth century Prussian medic, famously argued that, for medicine to accomplish its aims, ‘it must intervene in political and social life’ to highlight ‘the hindrances that impede the normal

social functioning of vital processes, and effect their removal’ (Virchow, 1985, p.33). More recently, public health frustrations regarding deaths and other health harms arising from conflicts (Shenoda et al., 2015), weak responses to pandemic disease outbreaks (Timen et al., 2015), failures to tackle health inequalities (Mackenbach, 2011) and cuts to health system financing (Karanikolos et al., 2013) have all been cited as evidence of the need for advocacy. In some contexts (particularly the UK), the emphasis that research funders have begun placing on ‘research impact’ has provided further impetus for public health researchers to try to achieve political and social influence (Greenhalgh and Fahy, 2015). Yet, there has been little attempt within contemporary public health to examine what advocacy means in practical terms (Horton, 2012), who ought to be undertaking this kind of work or what exactly it involves.

For those who promote the need for public health researchers to engage in advocacy, the relationship between evidence and advocacy is often assumed to be relatively straightforward; once sufficiently robust evidence is available, it can be used to advocate for change (Tabak et al., 2015). Yet, Roberts (2009, p.46) argues that

\* Corresponding author.

E-mail address: [Katherine.Smith@ed.ac.uk](mailto:Katherine.Smith@ed.ac.uk) (K.E. Smith).

doctors' role as advocates for social justice' has been discouraged in medicine due to the 'heavy weight of conservatism' and tradition in the profession (see also Chapman, 2007). Indeed, the role of advocacy in public health has often proved controversial. Even in tobacco control, where the overlap between research and advocacy has been particularly strong in recent years (Smith, 2013), Richard Doll and Austin Bradford-Hill (who together helped demonstrate the link between smoking and lung cancer (Doll and Hill, 1956)), were extremely cautious about engaging in anything resembling advocacy for much of their academic careers:

'At that time (1945–1960) I held the view, indeed I held it very strongly, that the researcher faced with positive results, as we were, had no part to play in telling the public about those results, and still less in how it should behave. Any education aimed at changing habits must to some degree smack of propaganda even in the best sense of that word ... ' (Bradford-Hill, 1971, p.57).

In an era of 'knowledge exchange', 'public engagement' and 'research impact' (Greenhalgh and Fahy, 2015), reservations about simply 'telling' the public about research results seem almost unfathomable. However, other examples continue to court controversy. Editor-in-chief of *The Lancet*, Richard Horton, has explicitly stated that he aims 'to use science as a political instrument to promote social justice' (Shalan, 2013; unpaginated) and has attracted condemnation for his perceived 'longstanding and wholly inappropriate use of *The Lancet* as a vehicle for his own extreme political views,' (Professor Sir Mark Pepys, quoted in Wallis Simons, 2014). In response, Horton has argued that politics and health 'go hand-in-hand' (Wallis Simons, 2014; unpaginated).

Against this backdrop, this article draws on existing literature and qualitative data to ask the following questions: (i) What is public health advocacy and how does it relate to public health research?; (ii) What role (if any) do professionals concerned with public health feel researchers ought to play in advocacy?; and (iii) For those researchers who do engage in advocacy, what are the risks and challenges and to what extent can these be managed/mitigated? In answering these questions, we argue that two deeply contrasting conceptualisations of 'advocacy' exist within public health, the most dominant of which, 'representational', centres on strategies for 'selling' public health goals to decision-makers and the wider public. This way of thinking about advocacy closely resembles 'lobbying'. While valuable, particularly for public health concerns that are currently under-represented in third sector advocacy work (e.g. health inequalities), we argue that this approach to advocacy can be rightly criticised as technocratic and elitist. An alternative, 'facilitational' conceptualisation of advocacy involves taking a more democratic approach to advocacy that centres on listening to, and working with, communities and members of the public whose voices are under-represented in research and policy debates.

## 2. Methods

This article is based on (i) a literature review; and (ii) interviews and focus group discussions with individuals involved in public health research, policy and advocacy. For the literature review, we identified existing academic publications concerning public health advocacy by conducting systematic searches of relevant academic databases. Our search terms included 'public health', 'policy', 'advocacy' and 'research' or 'evidence' (for precise search strings and databases, see Web Appendix 1). In assessing relevance, we focused on publications that either defined public health advocacy or commented on the role of research or researchers within it. We

did not employ any date or methodological restrictions and included essays and opinion pieces as well as empirical research. However, due to resource limitations, we were only able to include publications written in English. ES first conducted this search in May 2013, and then updated it in February 2014 (as we did not include a historical cut off, the searches were intended to capture all available literature in the included databases published up to and including February 2014). Those publications considered to be relevant on the basis of their title and abstract were downloaded to a Zotero library. Once this had been completed for all five databases, all duplicates were removed. The searches produced 129 relevant publications, which were reviewed in full. In this article we draw on the 28 publications that we felt provided the most insights into the questions posed in the Introduction, above.

In addition, 69 individuals involved in public health research, policy and advocacy in the UK were interviewed between 2011 and 2013 and 90 individuals participated in focus groups, 12 of whom were also interviewees (see Table 1). In total, this article is therefore drawing on the perspectives of 147 individuals. Table 1 provides an overview of the professional affiliation of these individuals. All of the interviews were semi-structured and conducted by KS. The majority took place in a private room where, for the duration of the interview, only the interviewee and the researcher were present (one interview was a joint interview involving two interviewees and two interviews were conducted by telephone, at the request of interviewees). A themed interview schedule was employed which focused questions around public health research, policy, advocacy and knowledge exchange. The interviews varied in length, lasting between 45 and 150 min (most were around 60–80 min).

Potential interviewees were selected on the basis of four criteria: (1) their particular public health concern (most had some interest in health inequalities but, beyond this, we tried to identify individuals concerned with a range of issues, including tobacco, alcohol and obesity); (2) their professional role (we tried to identify individuals working on public health in academic, public sector, third/community sector and private sector settings); (3) their role in research and policy (we tried to include individuals who were primarily undertaking research, individuals primarily undertaking policy work and range of intermediaries, including individuals in knowledge exchange and media roles); and (4) their perspective on appropriate policy responses to health inequalities (here we tried to include individuals who were known to favour more upstream, radical policy responses and those favouring more meso- and micro-level responses, though we found it harder to identify the latter since there does now appear to be a fairly strong consensus that upstream responses are required, at least among those with a specific interest in reducing health inequalities).

Fifteen focus groups were also conducted, all of which lasted around an hour (the topic guide for all focus groups was designed by KS; facilitation was undertaken by a combination of the lead author and colleagues (see acknowledgements), all of whom met collectively to discuss the aims and approach in advance). One was undertaken at a People's Health Assembly in Nottingham in 2012 and this focused explicitly on discussing 'public health advocacy'. In this focus group, which involved 15 participants, all of whom identified themselves as public health advocates, participants were asked to consider how to define public health advocacy, who they believed did (and should) act as public health advocates and what the relationship between research and advocacy ought to look like. The other 14 focus groups were undertaken during a two-day symposium held in Scotland in December 2012 at which participants (researchers, policymakers, civil society campaigners, public health practitioners and research funders) were asked to explore potential future directions for health inequalities research. The 14 focus groups were undertaken in two sets (seven focus groups in

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