

Review Article

Advocacy for Health Equity: A Synthesis
Review

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Policy Points:

- Many barriers hamper advocacy for health equity, including the contemporary economic zeitgeist, the biomedical health perspective, and difficulties cooperating across policy sectors on the issue.
- Effective advocacy should include persistent efforts to raise awareness and understanding of the social determinants of health. Education on the social determinants as part of medical training should be encouraged, including professional training within disadvantaged communities.
- Advocacy organizations have a central role in advocating for health equity given the challenges bridging the worlds of civil society, research, and policy.

Context: Health inequalities are systematic differences in health among social groups that are caused by unequal exposure to—and distributions of—the social determinants of health (SDH). They are persistent between and within countries despite action to reduce them. Advocacy is a means of promoting policies that improve health equity, but the literature on how to do so effectively is dispersed. The aim of this review is to synthesize the evidence in the academic and gray literature and to provide a body of knowledge for advocates to draw on to inform their efforts.

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Methods: This article is a systematic review of the academic literature and a fixed-length systematic search of the gray literature. After applying our inclusion criteria, we analyzed our findings according to our predefined dimensions of advocacy for health equity. Last, we synthesized our findings and made a critical appraisal of the literature.

Findings: The policy world is complex, and scientific evidence is unlikely to be conclusive in making decisions. Timely qualitative, interdisciplinary, and mixed-methods research may be valuable in advocacy efforts. The potential impact of evidence can be increased by “packaging” it as part of knowledge transfer and translation. Increased contact between researchers and policymakers could improve the uptake of research in policy processes. Researchers can play a role in advocacy efforts, although health professionals and disadvantaged people, who have direct contact with or experience of hardship, can be particularly persuasive in advocacy efforts. Different types of advocacy messages can accompany evidence, but messages should be tailored to advocacy target. Several barriers hamper advocacy efforts. The most frequently cited in the academic literature are the current political and economic zeitgeist and related public opinion, which tend to blame disadvantaged people for their ill health, even though biomedical approaches to health and political short-termism also act as barriers. These barriers could be tackled through long-term actions to raise public awareness and understanding of the SDH and through training of health professionals in advocacy. Advocates need to take advantage of “windows of opportunity,” which open and close quickly, and demonstrate expertise and credibility.

Conclusions: This article brings together for the first time evidence from the academic and the gray literature and provides a building block for efforts to advocate for health equity. Evidence regarding many of the dimensions is scant, and additional research is merited, particularly concerning the applicability of findings outside the English-speaking world. Advocacy organizations have a central role in advocating for health equity, given the challenges bridging the worlds of civil society, research, and policy.

Keywords: social determinants of health, consumer advocacy, evidence-based policy, vulnerable populations.

HEALTH INEQUALITIES ARE SYSTEMATIC DIFFERENCES IN health between social groups. Although socially excluded and minority groups are particularly vulnerable to ill health, differences in rates of illness affect everyone: health status diminishes continually along what is called the “social gradient in health.”¹ These

differences relate to the social determinants of health (SDH), the conditions of daily life, which in turn are shaped by the unequal distributions of power, money, and resources within and between countries.²

“Health equity” refers to a state characterized by the absence of systematic inequalities in health. While this state is usually referred to in aspirational terms, because inequalities are pervasive and arguably will never be eliminated, the policy goal of moving toward health equity implies attempts to reduce health inequalities to a minimal level. It is therefore “an ethical concept, grounded in the principle of distributive justice”³ and connected to a field of research that is “unavoidably politicized.”⁴ Advocacy is recognized as a means of promoting policies that help improve health equity. These policies take action on the SDH, either through universal provision of services, as part of strategies to improve the health of disadvantaged groups, or by “leveling up” the health of less advantaged groups to that enjoyed by more advantaged groups in society.^{5,6}

The aim of this review is to synthesize evidence in the academic and gray literature regarding advocacy for health equity and to provide a body of knowledge to inform practice. It was written by a team of research and project managers at EuroHealthNet, a nonprofit network of agencies responsible for public health across the European Union. EuroHealthNet’s aim is to improve health equity by coordinating research projects, highlighting good practices, and increasing capacities to tackle the SDH. Accordingly, this article is written from an EU-level, rather than a national or subnational perspective. We do not focus solely on European evidence here, however, because issues concerning advocacy for health equity may be common *across* countries, regardless of their level of economic development,⁷ so limiting evidence to Europe could result in our overlooking useful practices. Indeed, much may be learned through what has been termed “reverse innovation,” in which practices applied in developing contexts are taken up in the “industrialized” world,^{8,9} and advocacy for health equity should be no exception.

The article is structured as follows: First, we introduce health inequalities in the European political and economic context. Second, we introduce our concept of advocacy for health equity. Third, we outline the methods used. The fourth section represents a synthesis of the reviewed literature. The fifth section comprises a critical discussion of the methodology, the literature reviewed, and barriers and enablers of

effective advocacy for health equity. The final section presents our conclusions. We also provide 5 online appendices: Appendix Tables 1 and 2 summarize the “raw data” of the academic and gray literature reviewed; Appendix Table 3 summarizes the empirical evidence used for this review; Appendix 4 provides a selected glossary of terms; and Appendix 5 describes our search strategy.

Historical and Political Context of Health Inequalities in Europe

The study of systematic differences in health is a scientific endeavor, for it is only as a result of science that we can demonstrate the existence of inequalities in health, propose causal mechanisms, and offer solutions to tackling them.

The evidence regarding health inequalities has worked its way into the policy agenda in European countries at different times. Historically, the 19th century witnessed the emergence of knowledge of systematic differences in health, leading to interventions in the fields of public health and sanitation, among others. Notable in the 20th century was Sweden's efforts in the 1930s to prevent disease and improve child and maternal care and the British government's commissioning of the *Black Report* in 1977, which made links between economic inequalities and widespread health inequalities. Whitehead found that political attention to health inequalities is more likely when the political “left” is in power, although the way the issue is framed (eg, social justice or economic costs), the stakeholders involved in advocating for action to be taken (eg, trade unions or researchers), and the strategies employed (eg, consensus or confrontation) play some role in this, too.¹⁰

More recently, international organizations have kept the issue on the political agenda even when national interest has waned.¹¹ An international high point in attention to the issue was reached with the publication of the World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) in 2008, which called for the “closing of the health gap in a generation” by improving the conditions of daily life; tackling the inequitable distribution of power, money, and resources; measuring and evaluating the problem; and increasing the public's awareness of health inequalities.² This influenced the European Commission to publish a (nonbinding) communication in

2009 outlining a broad set of actions that member states could take to reduce health inequalities.¹²

Most EU member states now take some action to reduce health inequalities, and a minority have national action plans to reduce them.¹¹ This has been spurred on not only by ethical concerns but also by the growing realization that health inequalities have a considerable economic price tag attached to them.¹³ Despite policy attention, however, health inequalities within and between countries persist and, in some cases, are increasing.^{11,14,15} The economic crisis that started in 2008 and its eventual fallout have exacerbated the health risks for disadvantaged population groups to the extent that Europe now faces what some commentators call a public health emergency.^{14,16,17}

Both the CSDH report and the recently published WHO European review identified advocacy as a key means of promoting favorable policy change,^{2,14} but the evidence on how to do so effectively (ie, making efforts that are likely to lead to success) is dispersed across the academic and gray literature, and advocates have no single body of knowledge to support them.

Advocacy for Health Equity

We define advocacy for health equity as “a deliberate attempt to influence decision makers and other stakeholders to support or implement policies that contribute to improving health equity using evidence.” By “evidence,” we mean knowledge derived from qualitative and quantitative research intended for use in support of a conclusion. We take scientific evidence as the starting point for advocacy efforts because it is difficult to sustain any advocacy effort without evidence that those health differences actually exist. As a result, we privilege research-driven advocacy over other forms of advocacy (eg, value-driven and religious).

Methods

Our research question was “What evidence exists in the academic and gray literature about effective advocacy for health equity?” A group of experts on advocacy convened to develop a framework that would enable us to tackle this broad question. The result was the 6 dimensions of advocacy for health equity (Figure 1), which were updated iteratively

Figure 1. The 6 Dimensions of Advocacy for Health Equity

1. The kinds of evidence needed to advocate for health equity and the ways to transfer this knowledge to policymaking processes.
2. The advocates for health equity and their targets.
3. Advocacy messages.
4. Arguments tailored to different political standpoints.
5. Barriers (and enablers) of effective, successful advocacy.
6. Practices and activities that increase the effectiveness of advocacy efforts.

as the study progressed to reduce overlap and improve clarity (eg, to clarify that Dimension 1 concerns scientific practice and knowledge transfer and translation [KTT] and that Dimension 6 refers to non-scientific practices). The influential “five key questions for knowledge transfer” elaborated by Lavis and colleagues are collectively covered by the 6 dimensions.¹⁸ These dimensions also cover the main determinants of political priorities outlined by Shiffman and Smith: *actor power* (the strengths of individuals and organizations concerned with the issue), *ideas* (the ways in which those involved with the issue understand and portray it), *political context* (the environments within which actors operate), and *issue characteristics* (features of the problem including indicators, monitoring, data, and interventions).¹⁹

The methods we used drew primarily on critical interpretive synthesis, a qualitative synthesis methodology described by Dixon-Woods and colleagues.²⁰ Qualitative synthesis is “any methodology whereby [qualitative] study findings are systematically interpreted through a series of expert judgements to represent the meaning of the collected work.”²¹ It enables a critical analysis of a complex body of literature and the creation of a synthetic whole that goes beyond the constituent parts.²² We also referred to the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) statement in order to enhance the synthesis process.²³

Although we initially considered limiting the review to empirical research, it quickly became apparent that a lack of comparable research (by which we mean research that uses similar research questions, uses

Figure 2. Inclusion Criteria Used to Assess Academic and Gray Literature

1. Clear focus on policy change (not on patient advocacy or promoting citizens' access to existing services or benefits, etc.).
2. Emphasis on health inequalities in general and/or early child development, employment and working conditions (including mental health), income, and social protection (including poverty, discrimination, and disadvantage).
3. Arguments promoting health equity, advice on how to raise the profile of health inequalities on the political agenda, the evidence required to convince policymakers, and/or the evaluation of previous advocacy efforts.
4. If gray, the literature is a final (non-draft) version and officially published.

similar methodologies, and results in similar types of data) would severely limit the evidence base considered and therefore the potential utility of the review. We consequently decided to search for and synthesize all directly relevant literature in academic peer-reviewed journals and in the gray literature (information produced by government agencies, professional and international organizations, research centers, and special interest groups).²⁴ A systematic review protocol was prepared to identify academic papers published between January 1990 and March 2013, with search terms included in the title or abstract (online Appendix Table 3). The terms we chose captured the evidence relating to advocacy for health equity in general, and we paid special attention to early childhood, employment and working conditions, and income and social protection because they have consistently been highlighted as holding particular promise in reducing health inequalities.^{2,14,25} We selected 4 databases for cross-disciplinary coverage: PubMed, Web of Science, PsycINFO (EBSCO), and SocInfo.

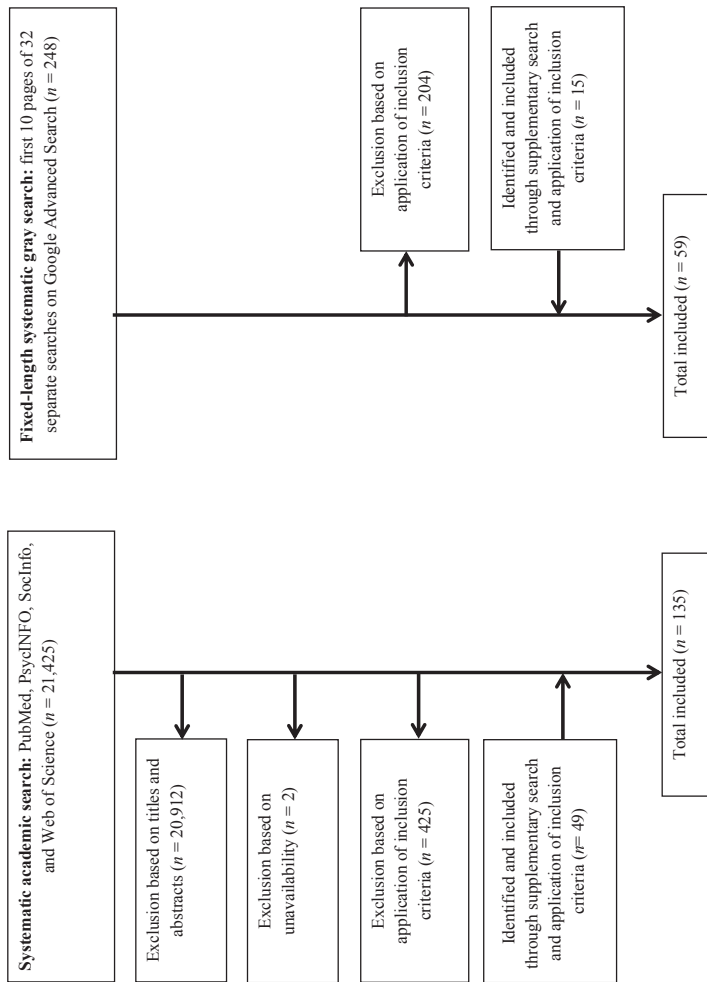
After duplicates were removed, 21,425 individual results were returned. One of us (Linden Farrer) reviewed the titles and abstracts to exclude all articles with no relevance. Another of us (Claudia Marinetti) applied the inclusion criteria (Figure 2), resulting in a total of 86 included articles. We also searched the reference lists of identified articles and subjected potentially relevant articles to our inclusion criteria. In

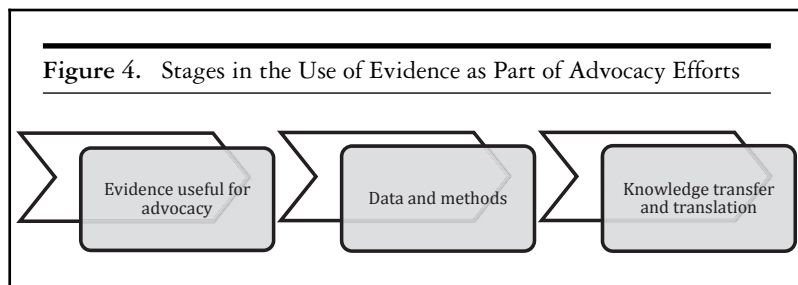
total, 51 additional articles were included that had not been returned by the systematic search (Figure 3). Where appropriate, we used the PRISMA and PRISMA-Equity 2012 extension statements to help guide our search and reporting.^{26,27}

We used the same search terms for the gray literature (online Appendix Table 3). Although we tried to search the Internet-based gray literature repositories (such as OpenGrey), they yielded too few results. We then tried to use Internet-based search engines that do not deliver results based on past search profiles (eg, Startpage and Ixquick), but these also failed to return sufficient search results. Consequently, we entered 32 individual searches into Google Advanced Search and considered the first 10 pages of results for inclusion. Titles, tables of contents, and the body text were scanned to assess relevance, resulting in 248 pieces of gray literature identified as being of possible relevance to the study. These were then subjected to the inclusion criteria and assessed by 2 of us (Linden Farrer and Claudia Marinetti) independently, resulting in the inclusion of 59 pieces of gray literature (Figure 3).

One of us (Linden Farrer) read and analyzed the academic literature, and another (Claudia Marinetti), the gray. The analysis had 5 stages. The first was familiarization with the text, which took place while reviewing titles and abstracts. Because relevant passages could be found in any part of a document, the entirety was read during the second stage, with sections relevant to the 6 dimensions highlighted and notes made of the main themes. The third stage involved extracting the passages marked as relevant and editing them iteratively to reduce length and distill meaning. The fourth stage was refining the themes and developing sub-themes (eg, *Dimension 1: Evaluations: Existing Policies*, *Dimension 4: Human Rights: Right to Health*). During this stage, we frequently discussed confirmatory and disconfirmatory evidence. The fifth stage was drafting the article, which required revisiting the literature and the themes and subthemes to ensure that the synthesized evidence was balanced and represented fairly. We developed keywords to describe the content of the paper “at a glance” and classified each source according to article type and geographical focus. Since the academic search was more thorough, we decided that the academic literature would shape our synthesis of findings, supplemented and enriched by the gray literature.

Figure 3. Sources Contributing to the Review





Results

Online Appendix Table 1 summarizes the 137 pieces of academic literature we reviewed, and online Appendix Table 2 summarizes the 59 gray pieces. Both contain keywords, document type, geographical focus, and evidence categorized by dimension of advocacy. The synthesis of findings that follows describes the main patterns observed in these data.

Synthesis of Findings

Dimension 1: The Kinds of Evidence Needed to Advocate for Health Equity and How to Transfer This Knowledge to Policymaking Processes. Three mutually overlapping and dependent stages emerged in analyzing the literature (Figure 4). The first concerns evidence that is useful to advocacy. This at least partially determined the second stage, which concerns the methods used and the data collected. The third stage concerns knowledge transfer and translation (KTT).

First Stage: Evidence Useful for Advocacy. Corrigan and Watson, Petticrew and colleagues, Hawe and Shiell, Nutbeam and Boxall, and Smith and Keleher suggest that policy and program evaluations, particularly social policies and cross-sectoral initiatives that demonstrate impact on health inequalities, are particularly useful for policymaking processes.²⁸⁻³² The academic and gray literature call for more evidence regarding the costs and benefits of policy action and inaction,^{29,31,33-39} because such evidence can help persuade political leaders that they are not squandering limited resources and are investing in effective services.²⁸ Several authors suggest that the differential outcomes of policies should be central to advocacy efforts,^{3,40,41} and Priest and colleagues put forward PROGRESS (place of residence, race/ethnicity/culture, occupation,

gender/sex, religion, education, socioeconomic status, and social capital) as a useful framework for doing so.³⁶ Causal data and mechanisms are also cited as evidence useful for advocacy.^{4,41-43}

Another type of evidence useful for advocacy efforts focuses on efforts to communicate health inequalities to stakeholders. The International Council of Nurses, Clarke and colleagues, and the Robert Wood Johnson Foundation suggest that research should focus on how narratives and image characteristics are perceived by different audiences,⁴⁴⁻⁴⁶ and Hawe describes a need for sophisticated discourse analysis to ascertain how the public understands “problems and solutions.”⁴⁷ Coffman, the Innovation Network, and Stead and colleagues argue that there is a need for more systematic evaluations of advocacy efforts.⁴⁸⁻⁵⁰ (Sources referenced: 5 academic empirical, 11 academic review, 3 academic editorial/comment, 6 gray.)

Second Stage: Data and Methods. Data used for advocacy need to be recent and timely.^{2,40} Local-level data are said to be particularly persuasive in advocating for health equity, in part because they make social inequities more difficult to ignore.^{30,51-54} Several scholarly articles mention community-based participatory research as a means of bringing the knowledge of local people, who have firsthand experience of the SDH, to bear on research and promoting policy action.^{30,33,52,53,55-57} As Treuhaft noted, methods like community spatial mapping can be “extremely useful for involving community members in the policy process,” indicating that the participatory research role can be intimately linked to an advocacy role.⁴⁰ We did not review any literature critical of these data and methods.

A clear theme in the reviewed literature is a call for greater use of evidence produced by qualitative methodologies in advocacy efforts. Responding to a debate in 1998 between proponents of evidence-based decision making “who cannot and/or will not accept that qualitative research has an important part to play” in informing policy developments and those who claim that “qualitative research may be the only appropriate method to be used in finding a valid and useful answer,” Popay and Williams suggested important roles for both.⁵⁸ The period since then has seen increased support for not only the appropriate use of qualitative data in research on health equity but also greater cross-fertilization of approaches and interdisciplinary collaboration.^{43,53,59-63} There are also calls in the literature for observational studies (eg, natural experiments and cross-country studies), citizens’ jury events, and

analysis of expert and lay knowledge.^{2,64,65} Overall, the literature emphasizes the important roles that qualitative *and* quantitative research can play in advocacy.^{2,3,37,65}

This challenges the prevailing “hierarchy of evidence,” which considers randomized controlled trials (RCTs) as the “gold-standard evidence” and qualitative data as the “lowest standard evidence.” Rychetnik and colleagues argue that although RCTs can provide robust evidence of the effectiveness of interventions, they often cannot provide evidence of process, quality of implementation, and context—data that policymakers value in making decisions.⁶⁶ While calling for more high-quality RCTs, Priest and colleagues assert that the complexity of the SDH means that RCTs may not always be the appropriate research method.³⁶ Therefore, Marmot and colleagues and Petticrew and Roberts argue that methodological appropriateness rather than the hierarchy of evidence should be taken into account.^{1,67} Moreover, policymakers “are probably less interested in the evidence we don’t have, than in which direction the evidence is pointing,”³⁹ and they are prone to use all types of evidence to inform their work, with little regard to scientific hierarchies.⁶⁸ To some extent confirming these views, Whitehead and colleagues note that the evidence types most likely to be useful in policymaking processes are observational studies identifying a problem, modest but politically timely household studies, controlled evaluations of interventions, natural policy experiments, and historical evidence.⁶⁹ No literature that we reviewed dissented significantly from these views. (Sources referenced: 4 academic empirical, 16 academic review, 4 academic editorial/comment, 5 gray.)

Third Stage: Knowledge Transfer and Translation. Priest and colleagues and Maton and Bishop-Josef suggest that while highly focused systematic reviews undoubtedly help drive scientific knowledge forward, summaries of accumulated evidence hold greater promise when advocating for health equity.^{36,60} Based on intensive discussions with senior research leaders, Whitehead and colleagues suggest that one particularly persuasive format of packaging evidence is the “jigsaw of evidence,” which is “not one single piece of evidence, but rather many different bits, of varying quality, creatively pieced together.”⁶⁹ One-page policy briefs are mentioned in the academic and the gray literature as an effective format for presenting evidence.^{33,70-73}

The Robert Wood Johnson Foundation and Jansen-Daugbjerg and colleagues, among others, emphasize that messages used in advocacy

materials or presentations should be simple and brief; avoid jargon; use precise, powerful language and active verbs; use facts and numbers creatively (eg, stating “1 in 3 women” rather than “30% of women”); and balance human interest stories with scientific findings.^{46,71,74} Metaphors may be a particularly effective means of conveying scientific evidence to nonscientists.^{10,75,76} Jansen-Daugbjerg, Maksimovic, and Morris note that it is important to give space to the audience to reach their own understandings.⁷¹ A number of sources suggest that presentations should be accompanied by stories and photos, because such material is more likely to persuade policymakers to act.^{36,45,59,77-80} Roos and colleagues maintain that “good news stories” are particularly useful in helping persuade people that social and health outcomes can be changed.⁵⁴

The literature also makes suggestions about what to avoid. Niederdeppe and colleagues, Goodman and colleagues, and Kim and colleagues assert that advocates should avoid activating negative stereotypes when presenting research, as this leads to blaming individuals for their health conditions and to a resultant lack of policy action.^{79,81,82} Petticrew cautions that the standard scientific practice of calling for more research fails to convince because “there will never be ‘enough’ evidence in absolute terms and the evidence base will probably always be criticized as being ‘weak.’”³⁹ Carlisle argues that emphasizing weaknesses in the evidence base and calling for more research allow policymakers to avoid taking necessary actions at the social structure level to tackle health inequalities.⁴

While scientific evidence is extremely important in demonstrating the existence of systematic differences in health, showing how policies or interventions can affect health, and providing information to back up policy recommendations, research is unlikely to be the “final word” in any decision,⁸³ and scientists should, in the first instance, aim for their evidence to be discussed and understood.⁸⁴ Lomas and Brown caution that even when research *is* understood, scientists should be prepared for setbacks to their efforts, as “complex forces compete with research for the attention of civil servants and politicians: the interests of stakeholders, the values of the public, the ideologies of governing parties, the constraints of prior policy, and so on.”⁸⁵ (Sources referenced: 8 academic empirical, 13 academic review, 1 academic editorial/comment, 5 gray.)

Dimension 2: Who Advocates for Health Equity and to Whom? Much of the academic literature concentrates on the role of scientists

and health professionals (eg, psychologists, mental health specialists, pediatricians, psychiatrists, doctors, nurses, and social workers) in advocating for health equity.^{60,76,86-91} Their experiences can be particularly persuasive in advocacy efforts.⁷⁴ The academic literature also privileges the role played by public health and the health sector more widely,^{3,4,31,38,84} often in close cooperation with other sectors (eg, trade unions and environmental organizations)^{32,56,92,93} or alongside communities as part of wider social movements.^{1,94-97} Civil society groups were frequently cited as important advocates, particularly in the gray literature.^{40,98-102}

Jansen-Daugbjerg and colleagues and the Division of Health Education suggest that communities and disadvantaged people should be involved directly in advocacy efforts, as this can be empowering and personal testimony holds particular persuasive force.^{71,103} Participation is an important tenet of human rights,¹⁰⁴ and many rights-based advocates work alongside communities directly (eg, in the field of children's rights,^{43,105,106} women's rights,⁵⁹ mental health,¹⁰⁷ and ethnic minorities¹⁰⁸). The literature we reviewed did not critique any challenges on working alongside these different groups of advocates.

The reviewed academic literature generally considered undefined "policymakers" as the target of advocacy. Two examples stand out from this tendency in the literature reviewed. Baum and colleagues more carefully delineate this group into civil servants and various government ministers, all with competing agendas and under pressure from different interest groups,⁷⁷ while Petticrew and colleagues describe the process by which policymakers may interact with more senior officials.²⁹

International institutions are frequently cited as having an important role to play in keeping the issue of health inequalities on the political agenda, and they are also identified as a target of advocacy. Labonté and Schrecker propose targeting the G8 and G20 countries to live up to their commitments to protect health and well-being.¹⁰⁹ Harmon (among others) argues that the WHO needs to fulfill its advocacy responsibilities,^{110,41} and several papers mention the United Nations (UN) and the World Trade Organization (WTO) as targets of advocacy *and* potential advocates for health equity.^{103,111,112} Lenders and donors, who wield huge economic influence are infrequently mentioned, although they undoubtedly are important.^{106,113} Similarly, the media can be the target of advocacy and often advocates themselves.¹¹⁴ Finally, the

academic and the gray literature we reviewed mentioned the role of the private sector as a target of advocacy and an advocate.^{2,51,54,71,115}

Overall, one gets the sense that every stakeholder could be a target and become an advocate, although it is not possible to gauge the effectiveness of advocacy by these different groups in different situations. Given this complex and dynamic situation, there is consensus in the literature that it is important to consider who has the power to effect change, who is most vulnerable to pressure, who is an ally, and who will actively oppose efforts.^{2,71,103,112,116,117} (Sources referenced: 11 academic empirical, 21 academic review, 9 academic editorial/comment, 14 gray.)

Dimension 3: Advocacy Messages. In reviewing the literature, we were able to discern distinct categories of advocacy messages, which are detailed next.

Health as a Value and Social Justice. Reiterated throughout the health-focused literature, the argument for health as a value posits that health has a value in itself because everyone needs it to live and function—it is an enabler of social and economic participation in daily life. Kickbusch, Luis and colleagues, and Marmot maintain that health is a public good and global resource and that high levels of health are a measure of a society's health.^{96,118,119} Anand and de Campos state that while valid reasons can be made for the existence of economic inequalities (eg, to encourage labor market participation and enterprise), the same cannot be said of health inequalities, because they do not provide incentives and instead represent systematic constraints on individual agency and a denial of equal opportunity.^{120,121} Leppo and colleagues argue that “the intrinsic value of health or health's contribution to sectoral or societal gains can be useful in discussions with politicians and policymakers across sectors.”¹²²

Evidence concerning the social gradient in health forms the basis of the social justice argument, which emphasizes the unfairness of the unequal distribution of health. A notable example of the social justice argument was contained in the CSDH report, which argued that systematic differences in health among population groups are a gross injustice that is “killing people on a grand scale.”² (Sources referenced: 0 academic empirical, 2 academic review, 3 academic editorial/comment, 2 gray.)

Human Rights. Several academic papers cited human rights as an advocacy message and a means of holding governments to account, with Freedman suggesting that human rights offer an alternative vision to the current economic and social order.¹²³ Hunt asserts that they represent

“equity with ethics and teeth,”¹²⁴ by defining the right to health and the indivisibility of rights, emphasizing the duties of states to progressively realize the health of citizens, and providing a framework for organizing the equitable delivery of services.¹⁰⁴ A number of specific human rights are relevant to improving the SDH, which include the right to health,^{6,95,122,125-129} children’s rights,^{91,105,106,130,131} the right to food,⁵⁹ economic and social rights,⁶³ the right to social protection,¹³²⁻¹³⁴ and the right to health of marginalized individuals and populations.^{135,136}

Pavlish and colleagues and Sheather contend that the world of human rights can seem a “stark black and white world of rights and wrongs” couched in legalistic terms.^{87,128} Consequently, it may fail to mobilize public opinion and does not necessarily provide natural rallying points for campaigns or social movements. However, this view is contradicted by Coke and colleagues, who suggest that human rights are useful in mobilizing people affected by human rights violations, but less so for policy elites.¹³⁶ Several papers caution that the power of human rights in a country is dependent on whether and how individual pieces of human rights are ratified into national law.^{95,135,137} Furthermore, some scholars point out that national governments are hostile to “unelected human rights organisations meddling in national affairs” and remind us that mechanisms rarely exist within domestic law to take legal measures to uphold rights.^{111,126} Ratification into domestic law, as Forman notes, does increase the chances of human rights having positive health impacts,⁹⁵ though Chapman reminds us that even in countries where human rights legislation *has* been ratified, many policymakers are either unaware of their international obligations or treat them as aspirational objectives to be attained at a later point in time.¹³⁷ Finally, as de Campos and Nixon and Forman note, the use of human rights legislation is limited in an increasingly globalized world, as it is applicable only to nation-states and not to international institutions, corporations, and investors, who increasingly wield power and generally adhere only to voluntary codes.^{121,135,138} (Sources referenced: 2 academic empirical, 12 academic review, 3 academic editorial/comment, 11 gray.)

Environmental Sustainability. A third argument, put forward by Masuda and colleagues and Baum, is that unbridled economic growth is incompatible with the aims of health equity and that more radical changes toward sustainability and nongrowth societies may be required to create the conditions necessary for health and well-being.^{53,94,139} (Sources referenced: 0 academic empirical, 3 academic review, 0 academic editorial/comment, 0 gray.)

Economic. A fourth set of arguments may be termed “economic.” Mackenbach and colleagues set out a number of different cost categories in estimating losses to the public purse as a result of health inequalities, which include health care savings, social protection savings, and the increased productivity (and therefore tax revenues) of healthy workforces.¹³ Accordingly, international development organizations maintain that health equity should be pursued as an economic imperative.⁴¹ Different arguments may be employed for different SDH. For example, Eamon and colleagues state that social protection can be hailed as a stabilizer of the economy,³⁴ while Landbergis and Cahill suggest that interventions to reduce workplace stress should emphasize reduced rates of employee absenteeism, lower risks of litigation, reduced staff turnover, and increased profitability.⁹² Interventions in early childhood and youth are framed in economic and social investment terms in several sources.^{64,75,131,140-143} Stiglitz argues more fundamentally that the overall purpose of economic activity is the well-being of individuals,¹⁴⁴ which suggests that powerful arguments can be developed by economists and others concerned about health equity. (Sources referenced: 1 academic empirical, 6 academic review, 0 academic editorial/comment, 5 gray.)

Self-Interest. The reviewed academic literature contained several examples of messages framed in terms of self-interest. Several pieces of literature frame economic inequalities as “socially destabilizing,” leading to higher crime levels and less social cohesion, possibly threatening the legitimacy of the state itself should it fail to protect the rights and well-being of disadvantaged population groups.^{41,71,132,134,145} Viladrich states that the failure to improve the health of immigrants and other disadvantaged groups can be framed as health risks to the rest of the population.¹⁴⁶ (Sources referenced: 0 academic empirical, 2 academic review, 0 academic editorial/comment, 3 gray.)

Dimension 4: Tailoring Arguments to Different Political Standpoints. There was a general consensus in the literature that health equity is an issue that resonates better with the “left” of the political spectrum than the “right.” Whitehead describes how left-leaning governments have tended to initiate policies to improve the SDH, while right-leaning governments have either delayed initiatives or steered them toward lifestyle or behavioral issues.¹⁰ The literature agreed that this is because the “left” maintains that people’s lives are shaped by inequitable social and economic systems—which in turn shape health and health behaviors

in accordance with these inequalities—while the “right” assigns equal (or close to equal) agency to individuals of all backgrounds, thereby expecting them to be responsible for their own behavior and standing in the social hierarchy.^{31,45,47,77}

Several scholars contend that thought needs to be given to how evidence fits political limits and resonates with and caters to politicians’ and policymakers’ assumptions. Reaching such an understanding necessitates using a structured process for comprehending the concerns of different advocacy targets.^{7,19,147} For example, Kim and colleagues argue that health inequalities should be framed as societal problems,⁸² while Eamon and colleagues suggest that poverty should be framed as being a failure of the economic system rather than a failure of the individuals concerned.³⁴

Evidence from the gray literature, such as that carried out by the Robert Wood Johnson Foundation, finds that in the United States, conservatives believe that poor health results from “poor choices” and that messages should concentrate on how policies can help people make “positive choices.” “Equality,” “balance,” “fairness,” and other words and concepts that appeal to “liberal” or Democratic voters should not be mentioned.⁴⁶ While there was agreement in the literature about the need to frame messages to fit the political environment,^{79,148} very few sources explained how to do so outside the United States.^{35,149} (Sources referenced: 7 academic empirical, 5 academic review, 0 academic editorial/comment, 3 gray.)

Dimension 5: Barriers (and Enablers) of Effective Advocacy. In analyzing the literature, we identified a series of barriers to advocacy for health equity, which we examine next.

The Contemporary Zeitgeist. The most frequently cited barrier to effective advocacy for health equity in the peer-reviewed literature (though not mentioned in the gray) is the contemporary economic approach in favor of privatization, deregulation, economic liberalization, the primary role of the private sector in providing services, and the general prioritization of the economic over all other spheres of policymaking. The literature variously terms this approach “market fundamentalism,” “neoclassical economics,” and “neoliberalism” (the last being the term we use in this article).^{34,137,144,150-154}

Exworthy and Whitehead describe how this approach is promoted by national governments, international institutions, and powerful corporate vested interests, which lobby for deregulation under “the

mantra of freedom from regulation.”^{155,156} Chapman and Sanders and Chopra, among others, note that this approach is detrimental to efforts to advocate for health equity because it creates a challenging ideological environment for political intervention and encourages governments to withdraw from policymaking to improve the SDH.^{137,157} As described by Coburn, Schrecker and colleagues, and Yamin, neoliberalism has a hegemonic appeal across the global political spectrum, meaning that governments around the world are ideologically opposed to taking action to improve health equity.^{150,153,154} Braveman and Tarimo argue that neoliberalism at the global level results in countries competing to cut spending, with the result that they are hesitant to invest in improving the SDH lest they lose out to other countries in investment and jobs.⁴¹ Stiglitz describes how neoliberalism has severely limited the ability of individual countries to respond to economic crises and to protect the health and well-being of workers.¹⁴⁴

Going hand in hand with neoliberal economics is a public mood (particularly among influential constituencies)—described by Kim and colleagues, Dorfman and colleagues, Raphael, and others—that values rugged individualism, individual responsibility, minimal collective action, and freedom from collective responsibility.^{46,82,133,136,147,158-160} An early essay on this by Beauchamp (1976), quoted by Dorfman and colleagues, states that ill health is thus regarded as the result of deficiencies on the part of victims themselves.¹⁴⁷ These “individualistic concepts,” Raphael asserts, act as a barrier to government action on health inequalities.¹⁵⁸ Research from Coburn and Lynch back this view, suggesting that citizens of countries with more neoliberal systems are less likely to support measures to improve social protection.^{150,151} According to Muntaner, this public mood is apparent from a young age, with many university students reluctant to accept structural explanations for inequalities because the “predominant economic systems are partially based on the political and cultural legitimization of social inequalities.”¹⁶¹ (Sources referenced: 2 academic empirical, 12 academic review, 2 academic editorial/comment, 0 gray.)

Biomedical Health. Biomedical health is another identified barrier to effective advocacy for health equity. Bambra and colleagues contend that the biomedical perspective is pervasive across the political spectrum and supported by the pharmaceutical and health care industry, the medical establishment, and public opinion.¹⁶² It has powerful professional and commercial links to established political parties,

directs a significant amount of funding to specific diseases, and not only crowds out arguments concerning the SDH with calls to support acute health care services or technological treatments for disease, but also may consider action to improve health equity a competitor for scarce resources.^{77,163,164} Muntaner suggests that this barrier is self-replicating within the biomedical establishment, with teachers of health inequalities facing difficulties when confronted by students who have been trained in causal thinking in biology without a background in social science.¹⁶¹ (Sources referenced: 2 academic empirical, 3 academic review, 0 academic editorial/comment, 0 gray.)

Cross-Sectoral Cooperation. Insufficient cooperation between health and other sectors (eg, environment or social affairs) can hamper efforts to advocate for policies that tackle health inequalities.^{3,32,53,165} This can be a result of inadvertent “policy silos,” a lack of capacity or experience in coordinating across sectors, or even an active defense by the health sector against attempts to redirect resources towards tackling the SDH.^{6,77} (Sources referenced: 1 academic empirical, 2 academic review, 2 academic editorial/comment, 1 gray.)

Political Short-Termism. Improving health equity requires long-term actions to reduce the social gradient in health. Yet as noted by Orton and colleagues, health targets are generally short-term and not amenable to the long-term action required to improve health equity.³⁸ Among other reasons, this is because governments, which face reelection every 3 to 5 years, tend to favor short-term objectives that are easier to achieve and demonstrate.¹⁶⁰ According to the gray literature, this can also negatively affect grant making for advocacy, as philanthropic organizations are reluctant to fund activities that are difficult to evaluate and deliver few easily demonstrable results.^{83,113,166} (Sources referenced: 1 academic empirical, 0 academic review, 0 academic editorial/comment, 4 gray.)

Market-Led Academic Reforms. Some of the academic sources that we reviewed argue that the marketization of higher education has “reduced ideological diversity of social science research in health and medicine,” to the extent that “one of the defining characteristics of academia [in the United States] is its limited academic freedom.”⁹³ Based on interviews with researchers on health inequalities in the United Kingdom, Smith suggests that even when research is undertaken on health inequalities, “When one looks at research bids [from policy sources] there are strong

steers in terms of what they're looking for, what kinds of conclusions one's being steered towards, what kinds of policy messages they want."¹⁶⁷ Researchers are acutely aware of the damage that overly "radical" or "political" research can have on perceptions of their objectivity and ability to attract funding, with the result that there is a deliberate watering-down of ideas and recommendations to please funders, "an unwritten understanding that a researcher won't rock the boat."^{167,168} (Sources referenced: 1 academic empirical, 1 academic review, 1 academic editorial/comment, 0 gray.)

Academic Difficulties or Reluctance to Advocate. As Shonkoff and Bales state, at a fundamental level, scientists fear a blurring of boundaries between science and advocacy and thus are wary of advocating for fear of being labeled "attention seekers" or of being misrepresented in the media.⁷⁵ Murphy and Fafard claim that efforts to promote research findings can rightly or wrongly undermine scientists' claims to scientific credibility.¹⁶⁸ As Kiselica notes, an emphasis on traditional elements of academic work may preclude significant service to communities.¹⁶⁹ This may be because advocacy presents too much of an additional work burden.^{81,170} This emphasis, however, may be so embedded that university administrators frown on efforts by academics to become involved in advocacy-related activities and networks.¹⁵² (Sources referenced: 1 academic empirical, 5 academic review, 0 academic editorial/comment, 0 gray.)

Long-Term Enablers of Effective Advocacy for Health Equity. The literature reviewed suggests that improving public understanding and awareness of health inequalities is a prerequisite to more effective advocacy efforts.^{113,133,171} Understanding and awareness could be improved by incorporating the SDH into health and medical curricula²⁵ and through public awareness campaigns in the media.^{158,172}

Raphael and Bryant, Pavlish and colleagues, and Twill and Fisher deplore the fact that health professions—which historically emerged out of sustained advocacy efforts on behalf of disadvantaged people—have lost touch with their roots in becoming recognized professions.^{56,87,173} Chapman is astonished that despite the "critical role of advocacy in translating research into policy," "few courses in public health place anything but passing attention on how to advocate the policy implications of research, and public health advocacy remains barely a sub-discipline within the field."¹⁷⁰ Several scholars suggest that advocacy, human rights, media

work, and social justice should be included as part of professional training for social workers, pediatricians, nurses, and doctors.^{88,90,91,95,174} Goodman and colleagues and Kiselica propose that students have greater contact with disadvantaged communities during their studies,^{81,169} as this could help reduce students' "middle-class bias," some of which undoubtedly results from a lack of direct experience or contact with hardship.^{81,161,173}

Besides higher education, efforts to create a more favorable policy environment for health equity include supporting recognition of human rights legislation in domestic legislation, invoking national and international legislation on health-related human rights,^{111,122} and advocating for their enforcement.¹³¹ Providing training on human rights to key stakeholders, such as lawyers, policymakers, and advocacy organizations, or even including human rights in general schooling or academic studies could also increase support for such measures.^{130,136} (Sources referenced: 3 academic empirical, 7 academic review, 5 academic editorial/comment, 8 gray.)

Dimension 6: Practices and Activities That Increase the Effectiveness of Advocacy Efforts. As Head and Stanley point out, health inequalities are complex, and attempts to address them are likely to come from organizations working together and sharing ideas, information, and resources.⁴³ In general, there are 2 ways that organizations can advocate to decision makers: antagonistically (which implies opposition) or cooperatively (which implies a degree of agreement); each entails a different balance of practices.^{100,175} The gray literature, in particular, emphasizes the need for organizational capacity and for cooperation among organizations, often as part of coalitions, to help share workloads and combine organizational strengths.^{83,113,136,175,176}

A large number of articles in the gray and academic literature emphasized the importance of social mobilization as part of advocacy for health equity.* Social mobilization can involve empowering disadvantaged groups to have a voice and building a broad base of support for change to exert pressure on decision makers. Social mobilization also includes influencing electoral processes, such as identifying "pro-child candidates,"¹⁰⁸ monitoring politicians' actions to encourage accountability to voters,²⁸ and carrying out letter-writing campaigns, petitions,

*References 2,19,59,65,71,78,103,106-108,112,114,137,154,157,171,177,178

and other activities to pressure policymakers to implement policies favorable to health equity.¹⁰⁷

Lobbying is mentioned in the literature, often as part of a more comprehensive advocacy strategy involving social mobilization and media engagement.^{92,100,169} Lobbying requires knowing key personalities, anticipating electoral changes, and recognizing and then working with sympathetic legislators who are knowledgeable about passing legislation.⁸⁶ Clancy describes his experiences working on health equity with the private sector in the United States, arguing that business leaders have preferential access to legislators, so partnering with them can help improve the SDH.⁵¹

Collaborative networks, consisting of researchers, policymakers, and NGOs, can formulate policy messages based on scientific evidence and the experiences and insights of constituents.¹⁴⁸ Policy-research networks, or even “job shadowing,” can help build understanding and foster communication between the worlds of policy and research and also open opportunities to present research evidence.^{60,69,70,148}

The literature indicates that the media are important for diffusing ideas in the public sphere and that media outreach can increase the visibility of advocacy efforts and, in turn, increase pressure on decision makers to take action.^{100,101,164,178} Several pieces of gray literature provide advice on how to engage effectively with the media.^{44,55,83} A striking example of media outreach is described by Usdin and colleagues, who explain that in advocating for a new domestic violence act, advocates successfully obtained the support of the national media by sending a media resource pack to media representatives.¹¹⁴ Press releases can ensure a constant “drumbeat” of strong and unambiguous messages,¹⁷⁹ although health promoters should also consider the nonmainstream media when raising public awareness of health inequalities.¹⁵⁸ Andrews and Caren and Grantmakers in Health caution that involving the media requires dedicated time and effort to build relationships with journalists and editors and entails a long-term investment of resources.^{101,113}

There was consensus in the literature that effective advocacy must be ready to take advantage of “windows of opportunity,” particularly since health inequalities struggle to stay on the policy agenda for long.^{19,29,122,155} High-profile commissions chaired by prestigious figures and publishing authoritative reports can open windows of opportunity,^{7,10,165} but such windows can similarly open unexpectedly as a result of closely fought elections,¹⁰² stories in the press,⁷⁷

reorganization of government departments,⁸⁵ or government debates.¹⁰ Advocates should take advantage of these moments, not least because they quickly become closed processes involving just a few people.^{152,180} Both the gray and the academic literature mentioned stakeholder analysis as an important exercise for determining the position of influential groups and individuals in and out of government.^{76,136,143} (Sources referenced: 16 academic empirical, 16 academic review, 5 academic editorial/comment, 15 gray.)

Discussion

Methodology

The literature reviewed is difficult to compare directly because it is written for a variety of purposes and about different subjects. It includes evidence arising from different scientific methodologies and opinions formed as a result of direct (and often long-standing) professional experience. But it would have been much more difficult to bring evidence together concerning all 6 dimensions if we had relied solely on empirical research. Online Appendix Table 1 shows that only 27 of the reviewed papers (20% of the academic literature reviewed) documented original research on advocacy for health equity. As shown in online Appendix Table 3, these cover a variety of disciplines and have widely different research questions, from the relationship between research on health inequalities and policy¹⁶⁷ to the analysis of narratives and visual images used to convey the SDH.⁴⁵ Even when the topic of research is the same (eg, the role of news media in shaping public opinion^{101,181}), different methods and research questions make a direct comparison of results impossible. Nevertheless, we feel that the empirical evidence contributed relatively more in weight to this review than the small number of sources would indicate. Ideally, however, advocates would be able to draw on an extensive body of empirical research to inform practice, but that will be possible only with more comparable research on individual aspects of advocacy for health equity.

We had originally anticipated some challenges comparing the peer-reviewed scientific evidence with that contained in the gray. But not all the academic evidence was necessarily peer reviewed (eg, editorials and opinion pieces), and peer review was probably not exclusive to the academic literature—the gray contained many reports that must have gone

through different kinds of review processes. If we were to try to characterize the 2 bodies of evidence, we would say that the academic literature focused much more on data, methodology, the role of science in policy, and the political and ideological context and that the gray presented more practicable advice for nonscientific audiences wishing to advocate.

Limitations

A number of potential limitations of the search strategy should be mentioned, some of which relate to the fact that “many of the words describing disadvantaged populations or settings are not indexed in the major databases [and] . . . [t]here are no validated health equity search filters, and equity terms are not indexed consistently.”¹⁸² First, the resources available allowed us to search 4 academic databases; future research could consult more with a view to increasing cross-disciplinary coverage. Second, the keyword “equity” was not always included in the title or abstract. Third, by focusing on equity, we excluded substantial knowledge accumulated from other fields. Fourth, we did not search for some keywords connected to equity: “health inequity,” “SD(O)H,” “health disparity/ies,” and “non(-)medical determinants of health,” which might have returned additional search results.

The literature reviewed has clear bias toward English-speaking countries. Although we did not deliberately attempt to exclude non-English-language sources, we did not actively seek them out either, as such a task would have been unrealistic. It is not possible to ascertain the extent to which the findings of this study are applicable to other language-speaking communities. English-speaking countries generally share a 2-party political system (United States, Canada, United Kingdom, and, to a lesser extent, Australia and New Zealand), often (but not always, like New Zealand since 1996) a result of first-past-the-post electoral systems. This undoubtedly affects how debates on health equity are framed across political divides and how issues are sustained across electoral cycles. As a result, it seems prudent to consider “appeals to the majority of middle-ground and moderately engaged voters on issues concerning health inequalities,”¹⁰⁸ a highly questionable strategy in countries with more pluralistic and representative political systems.

Evidence Useful for Advocacy

There was consensus in the reviewed literature that the hierarchy of evidence, which favors systematic reviews and RCT-derived evidence

over qualitatively derived evidence, is not always suited to research on the SDH or is not even the most useful evidence for advocacy purposes. Qualitatively derived data were frequently cited as important for providing evidence useful for advocacy efforts. However, the literature reviewed also suggested that advocacy would be aided by the availability of much more evaluation, cost-benefit and causal data, and evidence that uses RCT, longitudinal, survey, or other research designs that are higher up in the hierarchy of evidence. While this review can add little to this long-standing methodological debate, it does suggest that advocates should consider their use of evidence carefully, as “highest standard scientific evidence” does not necessarily equate to “the most effective advocacy evidence.”

Scientists as Advocates

An issue looming throughout the review is whether advocacy and science are compatible. This issue raises fundamental questions about the role of science in society and about the degree to which science can or should be value free. As we have seen, many scientists are wary of advocating, and understandably so. Ultimately, it is for individual researchers to decide how comfortable they are advocating. Much of the academic literature reviewed here was written from the perspective of scientists who *have* decided to become involved in one or more dimension(s) of advocacy, but such political engagement can hardly be considered mainstream.

Our review does suggest practices that could increase understanding and trust between the often disconnected worlds of scientists, health professionals, and policymakers.⁶² Networks and other structures that bring researchers and policymakers into closer working orbits are cited as important for aiding KTT.^{53,70} Job shadowing activities could be another method to increase understanding between researchers and policymakers. Such activities would increase interactions and build working relationships between policymakers and researchers, thereby helping bring research evidence more efficiently to decision-making processes, educate policymakers about the world of science and the validity of evidence, and inform researchers about the “messy and nonlinear” processes and data needs of the policymaking world.⁵⁴ Research by Lavis and colleagues from outside the field of health equity, and therefore not picked up by this review, lends credence to this finding.^{18,183,184} Of course, such activities require substantial commitment and resourcing.

Pervasive Barriers to Advocacy

The academic literature we reviewed described a series of fundamental barriers at the level of economic, political, and public opinion, which challenges the effectiveness of advocacy efforts. The current economic and political zeitgeist shapes how every policy decision on health inequalities is made¹⁴⁴ and assigns equal agency to disadvantaged people. Yet, as noted by the CSDH (referring to earlier work by Farmer and Sen), disadvantaged people have *less* agency to participate in decision-making processes and *less* control over the SDH,^{2,185} resulting in policy decisions that are skewed toward those with greater agency and representation.^{19,53,59,78,160} The CSDH was famously derided by *The Economist* as “baying at the moon” in calling for changes to global imbalances in the distribution of power and money that lie at the heart of health inequalities,¹⁸⁶ and it seems likely that this assessment would have been shared by many who held political and economic clout.

As Shankardass and colleagues point out, “Given that political will is shaped by public awareness and opinion . . . greater awareness may be required to move the health equity agenda forward.”¹⁷¹ Teaching the SDH, health inequalities, and human rights in public and academic schooling could help raise public awareness. Action could similarly be taken to improve support for health equity among important groups of health professionals by incorporating work alongside disadvantaged communities in academic syllabuses; teaching advocacy, human rights, and political science as part of health-related courses; and reorienting health professions back toward advocacy. Promoting greater uptake and enforcement of human rights legislation in international and national legislatures would provide “legislative hooks” for advocacy efforts to latch on to. Such longer-term enablers, however, could take decades to bear fruit and require the active involvement of many different stakeholders.

Rather than the “end of history” and the total triumph of neoliberalism as predicted by Fukuyama in 1989,¹⁸⁷ the market fundamentalist paradigm is under increasing pressure following the shocks and setbacks of the financial crisis starting in 2007 and 2008.¹⁵³ Books by Stiglitz, Piketty, and Krugman have been widely read and discussed, stimulating new thinking about the flaws in the neoliberal doctrine, the nature of inequalities, and possible policy strategies for reducing them.^{188–190} These debates, while not directly about health equity, do open up space

for justifying action to tackle health inequalities and present an important window of opportunity for those wishing to put forward alternative economic visions that may be more amenable to health equity.^{160,191} Moreover, if we really are failing on health equity because we are failing on equity itself, as Braveman asserts, then debate about this macrodriver of health equity and inequity can only be welcomed.¹⁹² Worryingly, the policy response to the crisis in Europe thus far mostly appears to have failed to take these lessons into account.¹⁹³

Gaps in the Evidence Base on Advocacy for Health Equity

It is always tempting to end a scientific paper with a call for more research. In fact, there is already a wealth of evidence for advocates to draw on, though it varies in quality, and crucially we cannot be sure how applicable it is across political, cultural, and national contexts or ascertain the relative effectiveness of different practices. Nevertheless, advocacy for health equity would benefit from further research in a number of areas. First, there is a need for cross-country research concerning the applicability of our findings in the 6 dimensions of advocacy. Examples are the characteristics and data needs of policymakers involved in health inequalities, norms about advocacy in academia, the types of messages that are most likely to appeal to different target groups, and whether specific practices work in different cultural or political settings. Second, our review suggested there is a lack of evaluations of advocacy efforts. Such research would provide a better evidence base for balancing the presentation of different kinds of health inequalities research, developing the format(s) of materials for different audiences, and tailoring accompanying message(s) to different contexts. Evaluations could, for example, test whether economic arguments really do have “greater traction across a range of political classes than a rights-based argument alone,” as asserted by Labonté (not picked up by this review).¹⁴⁵ The substantial literature evaluating and reviewing knowledge translation from health care professionals to decision makers could provide a useful starting point for such an endeavor.^{18,194} Third, the virtually uniform treatment of policymakers as a singular “catch-all” category is unhelpful in understanding the complex world of policy-making. Aside from some distinction between government ministers or recommendations to identify of policy champions,^{7,29,77,152} very little

can be discerned from the literature reviewed for this article. While a basic division between expert policymakers and elected politicians as 2 separate target groups can be made on the basis of the evidence reviewed for this article, the work carried out by Lavis and colleagues appears more advanced in identifying 4 audiences for health and social research (general public/service, service providers, managerial decision makers, and policymakers at different levels of government).¹⁸ Fourth, social media were barely mentioned. This is probably the result of their development being at a nascent stage. But they have been popular for close to a decade now and are frequently mentioned as a means of putting direct and indirect pressure on decision makers, making this lack of evidence surprising and suggesting an area for future research.¹⁹⁵⁻¹⁹⁸

Conclusions

Our review gathered evidence from the academic and gray literature about practices that can increase the effectiveness of advocacy efforts for the first time. It may be of use and interest to researchers, civil society organizations, supportive expert policymakers, and the private sector in helping move toward health equity, and of interest to research funders and philanthropic foundations—organizations that increasingly wish to demonstrate the impact of their funded work. We showed that certain kinds of evidence are valuable when attempting to influence policy and described how policy-research networks and other structures and activities to bring researchers and policymakers together can help promote evidence-based policy while cautioning that evidence is unlikely to be decisive in any policy decision.^{30,94,103} We explained that effective advocacy means choosing messages and tailoring them to the audience, being able to take advantage of windows of opportunity when they arise, using a jigsaw of evidence to build understanding of the SDH and support for improving health equity among target audiences, working with other organizations when appropriate, showing leadership, and having organizational and personal expertise and credibility. Our review showed that the media occupy a privileged position, opening windows of opportunity and applying pressure that is critical to change but requires dedicated and longer-term engagement by advocates and concomitant organizational capacity. This means that although researchers, health professionals, and disadvantaged communities all can advocate for

health equity, advocacy organizations seem to have a clear role to play. Depending on their type (by which we mean membership, issue of interest, aims, operating context, etc.), they could be central to brokering knowledge between the worlds of science, policy, and practice; identifying opportunities for advocacy; building relationships with the private sector; and mobilizing civil society to apply pressure on decision-making processes in favor of health equity.

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Supplementary Material

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Appendix Table 1. Academic Literature Table of Results

Appendix Table 2. Gray Literature Table of Results

Appendix Table 3. Reviewed Empirical Evidence in the Academic Literature

Appendix 4. Selected Glossary of Terms

Appendix 5. Search Strategy