Social Movements and Public Health Advocacy in Action: The UK People's Health Movement

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Abstract

There are growing calls within public health for researchers and practitioners working to improve and protect the public's health to become more involved in politics and advocacy. Such a move takes practitioners and researchers beyond the traditional, evidence-based public health paradigm, raising potential dilemmas and risks for those who undertake such work. Drawing on the example of the People's Health Movement, this short paper argues that advocacy and social movements are an essential component of public health's efforts to achieve great health equity. It then outlines how the Scottish branch of the People's Health Movement sought to overcome potential tensions between public health *evidence* and *advocacy* by developing a regional manifesto for health via transparent and democratic processes which combine empirical and experiential evidence. We suggest this is an illustrative example of how potential tensions between public health research and advocacy can be overcome.

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The Role of Advocacy in Public Health

Difficult questions face health researchers and practitioners when it comes to the boundaries between their professional, personal and political activities(1-3) This is an increasingly important dilemma, given the growing interest and demand for 'public health advocacy'; a recent publication, for example, argued that *"Shying away from advocacy is comparable to medical negligence".*(4)

Although a wide range of active health campaigning groups, focused on raising the profile of the social determinants of health and creating tools to facilitate change (see for example, Black and Laughlin), have existed for the past 30 years, advocacy tends to be neglected in mainstream public health.(5) Consequently, there remains a lack of clarity about what engaging in advocacy means in practical terms,(6) *who* ought to be undertaking this work(7) and how it relates to the idea of 'evidence-based' policy and practice(8)(9).

Because 'advocacy' stretches beyond 'the reductionist epistemology that underscores most public health enterprise',(5) incorporating economic, political and social rights and experiences, two obvious tensions exist for health researchers who engage in advocacy work. First, efforts that go beyond simply stating research findings to actively promote particular 'solutions' can prompt questions about the boundaries of the scientific remit and the potential for bias (e.g. due to associations with particular interest groups). This also raises questions about the ambiguous position of professionals engaged with advocacy or community—based campaigning groups as they may be caught between professional incorporation and de-legitimisation and between civil society and 'uncivil' society (Choudry and Kapoor 2010). Second, there can be tensions when research findings appear to diverge with practitioner/ community experiences. Such divergence is due, in part, to the nature of 'evidence' prioritised in public health's evidence-based response. For example, the debate on 'what works to address health inequalities' rests on evidence generated by experimental/quasi-experimental studies, for their ability to make causal inference about primary outcomes (10,11). This dis-privileges qualitative insights and lived realities; making politics and process incidental to outcomes of downstream behavioural interventions. This divergence also raises questions about the appropriate focus of public health advocacy: Is

advocacy then a means of promoting research evidence to various audiences (for wider impact) or about ensuring that community voices are better heard by researchers and decision-makers?

In this short piece, we outline how social movements for health seek to change the manner in which evidence can be generated, interpreted and used to achieve healthier policies and practices. Using the People's Health Movement as an example we highlight how joint working between researchers, practitioners, decision-makers and community members can be facilitated to overcome the tensions outlined above, towards shaping a transformative agenda in health policy.

Social Movements and Public health

Social movements have been defined as networks of informal interactions between individuals and groups engaged in political or cultural conflicts on the basis of shared collective identities.(12) They entail sustained interactions between power holders and representatives of constituencies lacking formal representation to achieve changes in the distribution or exercise of power.(13) While campaigns supported by a movement can be issue focused (e.g. resisting the privatisation of health services), the overall objectives of social movements are broader and transformative in intent, aiming at structural and social changes in society and institutions of governance. Social movements 'from below' emerge in dialectical opposition to movements 'from above', as powerful groups and vested interests seek to defend or expand privilege (Cox and Nilsen 2014). With threats to public health from the expansion of private capital in service provision and erosion of regulations on environmental impact, occupational health and citizenship protection, the neoliberal turn in policy development is a movement from above demanding a response and countervailing power from below.

Recent calls for a global movement for health equity(14)(15) illustrate the increasing interest in social movements that aim to achieve substantial health, social and political change(16). The global People's Health Movement (PHM) is one such attempt. Comprising an evolving network of campaigns led by people committed to the values of social justice and fairness, the movement arose from discontent with emerging global orders, growing inequities and

failure to meet promises of Alma Ata, including the goal of achieving health for all by the year 2000.

The emergence of the PHM

Following a year of grassroots mobilisation, people from different countries assembled at the first Health Assembly in Bangladesh in 2000. The 'people's health charter' endorsed at this Assembly called for revitalisation of the principles of Alma-Ata and the revision of international and domestic policies affecting health. Since then, the PHM has expanded in scale (with a current presence in 70 countries) and scope with regard to local and global policy impact.(17)

The UK PHM is part of this growing movement and has so far held two People's Health Assemblies; Nottingham in July 2012 and Edinburgh in April 2014. The first Assembly highlighted a lack of region-specific analysis of health priorities across the UK, the challenges and opportunities presented through devolved health policy, and a potential disconnect between policy debates about health inequalities and lived experiences. A Scottish arm of the PHM, led by Anuj Kapilashrami, sought to address these issues via an approach that combined action research with public health advocacy, summarised in Box 1.

Box 1: Organising for community action and health advocacy in Scotland

- Third sector health organisations were invited to brainstorm key health issues and generate consensus on people's movement for health equity
- Participatory action research was undertaken by Kapilashrami to gain experiential understanding of health effects of austerity and identify local priorities; involving

  - consultations with 14 health and community initiatives

  - public meetings and drop-in story-telling sessions

  - focus groups with black and minority ethnic women

  - participation in multiple community events
- Communities of inquiry and action evolved to address issues significant for those participating; culminating into the 2014 Edinburgh health assembly.

The Edinburgh Assembly attracted 120 participants from across the UK, representing 32 Third Sector Organisations including some longstanding groups advocating for improvements in

health (health activists, environmentalists, carers, trade union health and safety representatives), 10 academic institutions, and the NHS. On the basis of their shared analyses of the current situation, notably the health effects of poverty and austerity-led changes, articulated through powerful personal narratives, the Assembly called for the development of concrete proposals for collective action based on the vision of social justice and health evident in Assembly discussions.

Developing a manifesto for Scotland: combining empirical research with experiential accounts

A democratic process of devising a manifesto (as outlined in Box 2), to seek commitment of political parties to deliver these proposals once elected, was subsequently put in place.

Box 2: Process

- Key action points and demands were identified from discussions at the Health Assembly and the PAR.
- An open call was issued to Assembly participants requesting suggestions for further health proposals/demands.
- These efforts generated a list of 40+ demands, which varied from broad/ generic to extremely specific.
- A first draft of potential demands was developed at a Coordinating group meeting through a process of merging, clarifying, amending and adding.
- These demands were categorised under broad themes for inclusion in a survey, circulated to the PHM mailing lists (200+ members) and their networks, which sought to collectively identify and prioritise demands with greatest support.

This generated the top ten demands (listed in Box 3), which underscore the need for confronting power and vested interests, and initiating upstream changes to improve the environments in which people live. These demands informed the PHM's submission on the 'right to health' to the Smith Commission, established to take forward the post referendum devolution commitments on further powers for the Scottish Parliament, and currently support PHM's lobbying ahead of the 2015 UK general election and the 2016 Scottish elections.

The process ensured that each proposal was underpinned by both empirical research *and* community support, suggesting it is possible to combine public health's traditional, evidence-focused approach to policy with more deliberative and democratic approaches. There were

still, however, some observable differences between the prioritisation generated via the online survey (completed largely by academics and policy advocates) and the action research that engaged socio-economically and politically disadvantaged communities. The former focused primarily on economic, political and commercial determinants of health while the latter generated a mix of policy reforms targeting specific groups (e.g. comprehensive rehabilitation and recovery programs for drug users) and demands to improve the accessibility of public services (e.g. combating abuse and stigma attached to people in difficult circumstances; increasing the availability and quality of mental health services; comprehensive equality training to front-line providers). These differences, which are prompting us to continually revisit the manifesto, emphasise the importance of process in policy advocacy.

The role of advocacy involving public health professionals is legitimised through reflective engagement with praxis alongside communities and workers experiencing the negative impact of health inequalities. Only through ongoing processes of dialogue through community mobilising, action research, movement building and public health advocacy, are we likely to develop clear and appropriately targeted policy proposals for improvements in

population health, now and in the long term. By embracing these processes, social movements offer the countervailing power that embodies the principles of solidarity (Narayan 2013) –at local, national and global level- in realizing health rights, equity and social justice.

Box 2: Top ten demands –Scottish Manifesto

1. Commit to preventing and reducing poverty through specific proposals (e.g. labour market and tax policies to lift all families with young children out of poverty).
2. Commit to ensuring that the NHS in Scotland will remain publicly funded and free at the point of use, and that the Health and Social Care Act does not serve as a gateway to privatisation of health care in Scotland.
3. Do more to act on the multiple causes of social exclusion and ill health (e.g. improve joint working at national, local and service level).
4. Commit to commissioning a Health Rights Commission, which will be responsible for undertaking a Health Inequalities Impact Assessment for all policy decisions liable to impact on health, social/economic determinants.
5. Commit to paying a decent wage (above the living wage) to all individuals employed by the state or working for companies that are contracted by the state, and ban zero hour contracts.
6. Work with others to provide fuller, higher quality evidence on the distribution of income and wealth within Scotland and develop specific proposals to reduce these inequalities.
7. Commit to providing universally accessible, high-quality early childhood education programmes (1 year onwards) located in every neighbourhood, within walking distance of parents' homes.
8. Commit to providing and promoting universally accessible (free), high-quality comprehensive primary, secondary and tertiary health care (including youth education and counselling).
9. Increase support for trade unions, strengthen the legal rights of trade union representatives and ensure enforcement of these rights.
10. Introduce strong, evidence-based marketing controls on established health hazards, including: tobacco, alcohol, unhealthy foods, and gambling.

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