Why Building Power Is Key to Protecting Academic Public Health and Advancing Health Equity

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Academic public health is at a crossroads. For decades, research in our field has focused on identifying and describing health inequities, differences in health that are unnecessary, avoidable, unfair, and unjust. We have documented recent declines in life expectancy, increases in maternal and infant mortality, and a range of other disease outcomes—all with marked differences by race, ethnicity, geography, education, and class. The field has been called on to reduce these inequities, yet little progress has been made, and in many cases, the gaps have widened.[1,2] Now, federal health agencies, universities, health systems and the communities we serve are in peril. We must ask ourselves: are we willing to address the power structures that jeopardize public health and produce health inequities?

Academic public health must acknowledge that power imbalances are at the root of health inequities.[3] These imbalances persist through laws, policies, institutional practices, and norms leveraged by powerful actors.[4–6] Community organizing is a process of building power across people to address shared interests and priorities through direct and collective action.[7] Community organizing frameworks teach us that power is built and maintained via dominant power (e.g., unilateral power, power over) and relational power (e.g., power that engages, power with, transformative processes, and visioning). Advancing health equity requires addressing these types of power in two ways: (1) building power by cultivating the capacity of people who are disproportionately burdened by health inequities and who therefore have the most at stake and (2) breaking power by weakening and destabilizing the societal, economic, and political forces (or structural determinants) that perpetuate health inequity.[8] Academic public health must enhance its capacity as a strategic partner and join communities in local and national power-building movements.[3]

In this essay, we present the collective analysis of the Health and Power Organizing Project (HPOP), a group of public health academics committed to using community organizing and power-building principles to advance health equity and change the incentive structures within academia. HPOP was initiated in 2023 by faculty and staff at the University of Wisconsin Population Health Institute with funding support from the W. K. Kellogg Foundation. Informed by a community organizing approach, HPOP emerged by tapping into existing networks to identify and invite initial members based on a demonstrated commitment to advancing health equity, an understanding of the

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relationship between power and public health, and a desire to transform systems connected to public health academia.

Consistent with the goal of building relational power, a diverse group in terms of disciplinary fields, levels of seniority, and identities met to take the initial steps toward establishing this base-building formation. This process prioritized relationship building across members and cocreation of a shared analysis, goals, strategies, and governance of HPOP. Recognizing the importance of integrating academic and community knowledge into our analysis, we also interviewed community-based practitioners and community organizers. Our analysis reflects the critical conversations we had in retreats and virtual meetings over the first two years as a first step in achieving our longer-term goals. We define the nature of the problem and offer opportunities to intervene on the factors we view as the root of the challenge; specific strategies must emerge from the relationships created through organizing. We are not the first, and will not be the last, to reveal the layered power asymmetries driving health inequities; our shared analysis builds on the work of past scholars who have created space for a radical reimagination of our field.[9,10]

ANALYSIS OF THE POWER ECOSYSTEM

In this section, we define the nature of the problem by identifying challenges and offering opportunities for intervention. The political environment is rapidly evolving, but to transform the power ecosystem, academic public health faces challenges at three levels: systemic, institutional, and individual. These levels are based on the social ecological model and reflect our interest in showing how factors at each level impact one another. We describe these levels below and provide select examples in Box 1.

Systemic Level

At the systemic level, leaders of powerful institutions (e.g., corporations, universities, government) develop, spread, and apply worldviews and policies that erode equity. We see this in the censorship and termination of federal research grants related to climate change; lesbian, gay, bisexual, transgender, and queer health; racial and ethnic health disparities; and others.[11] It is also visible in the widespread backlash against teaching about historical injustices, including the legacy of slavery and racial exploitation in the United States. These efforts will have profound implications for scientific research and how we teach public health in the future if students arrive in our classes with little knowledge of the historical context of health inequities. As a preference for "colorblind" racial ideology and hostility toward the concept of equity, itself, becomes normalized, so, too, grows the need for advocates of health equity. Unless we work together to challenge this intellectual backsliding, institutions will continue to exploit and marginalize those with less power. We must respond by building power among those most affected and breaking the power of leaders opposed to equity. Accomplishing this means weakening the ways in which institutions benefit from these practices.[12,13]

Within higher education, academic institutions and professional organizations uphold norms about bias and neutrality that are rooted in inequity and limit the potential to imagine transformative research and action.[14,15] Knowledge produced by academic researchers is considered valid while community-based knowledge is disregarded or minimized. These dynamics cement power solely within established, "legitimate" actors and organizations—many of whom have constructed our current, ineffectual practices. It also erodes relationships with communities who might otherwise participate in cocreating solutions to health inequities and hinders the ability of academics to improve population health.

When it comes to changing the incentives required to transform these practices, progress is often slow or nonexistent because accrediting bodies require consensus across diverse academic institutions and political contexts.[16] Accreditation standards serve as benchmarks for conveying our principles and ethics to students. The federal government is seeking to erode those standards and eliminate accreditation bodies.[17] Allowing these changes would jeopardize the field by worsening the education of new leaders in health equity.

In addition, funders, academics, and civil society have shaped the rules so that communities most affected by health inequities are neither informing public health research and practice, nor are they organized to do so. Even when entities like the National Institutes of Health claim an interest in health equity and correcting power imbalances in research, they rarely fund communities to do this work, and more recently, they have eliminated programs that fund community-driven health equity research.[18] When we rely on funders to determine the direction of the field, changes in leadership (and their attendant priorities) can be

BOX 1— Analysis of the Power Ecosystem and Select Examples of How Power Is Wielded to Influence Health Equity

Level	Analysis
Systemic	Leaders of powerful institutions develop, spread, and apply worldviews and policies that erode equity. • The National Institutes of Health and Environmental Protection Agency have censored and terminated health equity grants in the areas of lesbian, gay, bisexual, transgender, and queer individuals' health; HIV; vaccines; race/ethnicity; and environmental justice. • The Office of Health Equity was eliminated and there have been cuts at the Office of Minority Health and the National Institute on Minority Health and Health Disparities. • Programs designed to ameliorate racial injustices, including affirmative action, have been prohibited, which will lead to less racial/ethnic student diversity.
	Academic institutions and professional organizations uphold norms rooted in inequity that limit transformative research and action. Advocacy or community-based participatory research (CBPR) is often viewed as antithetical to impartiality or lacking rigor.
	Accrediting bodies require consensus across diverse contexts, slowing progress to transform academic practices. • Institutions prohibited by state law from teaching topics related to equity have tried to erode public health competencies. • Executive Orders direct authorities to "hold accountable" accrediting bodies that advance "unlawful 'diversity, equity, and inclusion' requirements" by monitoring, suspending, denying, or terminating accreditation recognition.
	Funders, academics, and civil society have shaped rules so that communities are neither informing research, nor organized to do so. • They set the academic research agenda through their strategic priorities, often with little or no input from communities most affected. • Funders rarely address the power dynamics necessary to position communities to advance health equity.
	Policymakers, when they engage with scientific evidence, often do so in limited or symbolic ways to inform (or confirm) their decisions. • Much scientific research is never translated into policy; many policies are enacted despite overwhelming evidence to the contrary. • Many policymakers distrust science and scientists, are hostile toward equity, and hold conspiratorial beliefs.
Institutional	Most funders do not grant awards for structural change and often view action research as "advocacy," which they do not support. Grant review criteria prioritize a narrow notion of rigor over community needs and incremental progress over structural change.
	Accrediting bodies in higher education do not prioritize organizing (power-building) and policy change in public health training. None of public health's foundational competencies address how to affect policy processes, politics, or power structures.
	Academic institutions often lack trusting relationships with communities because of harms that are rarely acknowledged or reconciled. • Trusting relationships often hinge on personal relationships, leaving them vulnerable to departures and funding changes. • Institutions rely on soft-money positions, requiring researchers to fund their salary or benefits through external support. • Instruction is often geared toward accreditation criteria rather than toward broader critical thinking.
	Academic institutions and disciplines hold norms that limit diversity in the types of research conducted by faculty and students. Grant and publication opportunities prioritize analyses of secondary data sources over CBPR, encourage methods that lack critical analyses of praxis norms, and are shaped by White supremacy, like using race in ways that imply genetic differences.
Individual	Academics are often trained, hired, or incentivized to focus on discrete studies rather than activities leading to structural change. Individuals do not always see themselves as part of social change efforts.
	As researchers, we have not organized ourselves to push for health equity or defend public health and are not prepared to do so. • Only about 25% of US faculty members are unionized, leading to vulnerability when trying to change work conditions and incentives. • Without collective power, it can feel precarious to take public positions on "controversial" topics.
	As instructors, we often lack practically relevant, solution-oriented tools to teach students how to build and break power. In staying out of politics, faculty limit their ability to meaningfully guide students seeking to engage in advocacy.

Note. Please see Appendix A (available as a supplement to the online version of this article at https://ajph.org) for a full list of Box 1 references.

profoundly destabilizing and have widespread implications for scientific knowledge now and in the future.

Finally, policy outcomes are often disconnected from scientific evidence in important ways. When policymakers do consult scientific evidence, they often engage with it in limited or symbolic ways to inform (or confirm) their decisions.[19,20] Academics often study the preferred policies of lawmakers, rather than their constituents, leading to "policy-based evidence-making," rather than evidence-based policymaking. Some lawmakers are actively hostile to science and use their power to restrict action by government, academic institutions, and individual researchers rather than to advance progress.[21]

Institutional Level

At the institutional level, most funders within academic public health do not grant awards for structural change, often viewing community-based research as "advocacy," which they do not support. This is due, in part, to fears of maintaining their federal tax-exempt status. Instead, grant review criteria

prioritize "rigor" over community needs. Rather than facilitating opportunities for marginalized communities to equitably collaborate with academic partners, funders elevate their own philanthropic priorities—an approach that is fundamentally antithetical to the principle of "nothing about us without us."[22]

In higher education, accrediting bodies do not prioritize organizing and policy change in public health training. Such knowledge is crucial if we hope to prevent backsliding in public health and prepare future practitioners to enact the types of transformative change necessary for health equity.

Academic institutions often lack trusting relationships with surrounding communities because of ongoing and historic harms that are rarely acknowledged, much less reconciled.[23] Universities increasingly operate as extraction-oriented bureaucracies, where students are customers. Institutions of higher learning sell education as a commercial product and expand their campuses in ways that displace long-standing local businesses and residents. As universities stockpile billions in their endowments and grow ever-larger real estate portfolios, they often fail to incentivize faculty for repairing or building equitable relationships, nor do they adequately recognize the interests of community partners in setting academic research priorities.[24] When universities do build trusting relationships with community partners, rarely are these relationships institutional. Instead, they often hinge on personal relationships between specific faculty and community organizations, leaving these relationships vulnerable to departures and funding changes.

Academic institutions often reward peer-reviewed publications and grant funding over activities that lead to structural change.[25] They also fail to meaningfully invest in faculty appointments and research centers and instead rely on external support, which constrains scholarship to funders' priorities. That funding is now under threat, jeopardizing the workforces of schools of public health, medicine, and others nationwide. Academia is under siege by the federal government, state legislatures, and interest groups with ideological agendas like the elimination of tenure and diversity, equity, and inclusion practices. Despite this, many colleges and universities still do not perceive their role as political actors or use their power to transform systems.[21] This inhibits their ability to protect their students, staff, faculty, and institutional sustainability and prevents them from demonstrating the value of education and research.

In addition, academic institutions and academic disciplines hold norms that limit diversity in the types of research conducted by faculty and students.[24] They prioritize publication volume over community-engaged research and the use of methodologies shaped by White supremacy.[26–28] Changing these practices can be difficult because scholars with privileged social statuses hold power within academic institutions and control admissions, faculty hiring and retention, and curricular decisions.[26] This underscores the importance of initiatives to embrace viewpoint diversity in scholarship and diversify institutional leadership. It also explains why political resistance to change these efforts is often fierce.

Individual Level

At the individual level, academics working in public health are often trained, hired, and incentivized to focus their energy on research rather than activities that lead to structural transformation. Regardless of whether we envision our roles as academics narrowly or expansively, most of us are ill-equipped to address the central role of politics and power in health equity.[29] As researchers, we have not organized ourselves sufficiently to push for health equity or defend public health and have little preparation to do so. Many of us feel isolated and powerless because we are trained in methods suited for slow, incremental change.[26] We lack relationships with like-minded scholars or those who could use our research as a tool for change (e.g., journalists, policymakers). Still further, most researchers do not study the power-related root causes that create health inequities, (e.g., profit or political incentives) nor how to change them.[24,30]

As instructors, we often lack practically relevant, solution-oriented tools to teach students how to build and break power. Many of our syllabi focus on tweaks to what currently exists rather than encouraging consideration of what could be. This can exclude knowledge and ways of knowing that are best at challenging existing power relations.[28,31] If we do not see or treat students as generators of solutions, we will condemn them to studying—and perpetuating—the status quo.

WHAT WE CAN DO TO BUILD AND BREAK POWER

These factors necessitate a radical change if we are to shift academic public health toward advancing the goal of achieving health equity. We are angered and disheartened by the lack of progress our fields have made over the last 20 years and dismayed by the dismantling of health equity efforts

happening in real time. In response, we are determined to reimagine academic public health and drive social change. We believe public health scholars need to share and build power with communities facing inequities now more than ever.

We aim to strengthen our capacity to break and build power so that we can innovate what we research and teach, hold ourselves accountable to the communities we are entrusted to serve, and increase our impact. We encourage colleagues to reflect on how their own actions might inadvertently perpetuate power imbalances—for example, by considering how we teach students about the structural determinants of health and their relationship to power. We must improve our capacity to organize and build power by forging relationships with colleagues and community organizing groups and advocating accreditation competencies focused on understanding power and its effects on systemic change. We can promote institutional change by examining how our own institutions perpetuate power imbalances and harm, while demanding action to repair relationships with surrounding communities. We can share models for transforming academic institutions to incentivize activities that address inequities, such as adopting promotion and tenure criteria that prioritize impact. Finally, we can create long-term strategic partnerships with organizing groups at the local and national level so that we can become trusted allies and engage in the political work necessary for change. This includes meaningfully connecting with local communities to learn about their needs, assisting with power-building efforts already underway, and encouraging them to hold us accountable. We can also build partnerships with scholars at other universities to resist federal, state, and local policy changes that jeopardize health equity.

As an example of applying a community organizing approach, we are working to grow our relational power within HPOP by building trusted relationships (power) and eliciting the experiences and insights of a wide base of people to inform future collective action. Careful to build power before program (e.g., direct action), our power-building process has involved

1. identifying health equity leaders through one-on-one meetings with academics to understand each person's self-interests, unique and shared pressures, and visions for the future;
2. building relationships with people across different organizations (e.g., groups working to build power to protect academic freedom and health equity initiatives);
3. building community organizing skills;
4. organizing house meetings with our base to collect personal stories that inform our shared analysis and motivate base-building; and
5. holding regular assemblies with HPOP stewards to continue to build relationships, identify shared pressures, and ratify decisions as we expand our organizing approach.

We are also building awareness through presentations and gatherings at public health conferences. Each of these efforts sharpens our shared analysis and helps build a strong network founded in authentic relationships to inform future collective action for health equity. Toward this end, we encourage readers with similar interests to reach out to the authors of this article to learn more about being in relationship with HPOP and to begin building power in their own networks and institutions. We hope that sharing our analysis will lead to broader conversations within our field about the need to build and break power to protect public health and achieve health equity. AJPH

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shared analysis of threats to population health and health equity, the result of collective intellectual efforts since 2023. All authors made substantial contributions to this article. M. L. Givens facilitated the project, and I. J. Ornelas led the development of the article, with writing assistance from C. L. McMurtry. All authors contributed to the shared analysis and contributed to the drafting or revisions of the essay.

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to disclose.

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