

COURSE READER

Health Equity - Research To Action



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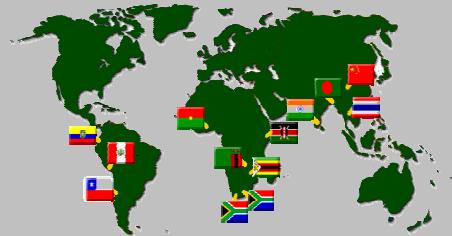
Global Equity Gauge Alliance

2004

COURSE READER

Health Equity - Research To Action

This Reader was developed
for Course Participants



Developed by members of
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The School of Public Health, University of the Western Cape
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Health Equity - Research to Action: Course Reader

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An *Equity Gauge* is a health development project that uses an active approach to monitoring and addressing inequity in health and health care. It moves beyond a mere description or passive monitoring of equity indicators, to a set of concrete actions designed to effect real and sustained change, in reducing unfair disparities in health and health care. This entails an on-going set of strategically planned and coordinated actions, involving a range of different actors, who cut across a number of different disciplines and sectors. An Equity Gauge is therefore innovative, logical, challenging and effective.

1 INTRODUCTION TO THE COURSE

'Of all the forms of inequality, injustice in health care is the most shocking and inhumane.' Martin Luther King Jr.

Welcome to the *Health Equity Research to Action* course. We look forward to your participation in this short course. Here is a little background to the course. In 2003, the Global Equity Gauge Alliance (GEGA) ran a training course in Chile, with the intention of piloting training which would facilitate wider adoption of the GEGA approach. With this foundation, two three-day courses were developed and run in Durban, South Africa in 2004, as part of GEGA's ongoing training programme. Titled *Health Equity - Research to Action*, this training draws on the GEGA principles and approach. Out of this course, a manual has been developed to enable trainers to deliver the same or a similar course. The course that you are attending is a development of those initiatives.

The course content has been drawn from the collective experiences of a number of Equity Gauges. In the same spirit, learning through this course is expected to take place through a participative learning process. Your experience and contribution will help to inform the participants and facilitators of other contexts, issues and approaches that have been used in working for equity.

In the manual you will find summaries of key concepts and content, a selection of readings and additional references on the course topics; and guidelines for the two major activities of the course. Should you want copies of any other sections of the course, please ask the facilitator. You could add your own notes to the end of each section.

We hope that you will enjoy the course and that you will be inspired to continue to work for equity in health wherever you are.

2 COURSE AIM AND OBJECTIVES

The main aim of the course is to sharpen awareness and understanding of equity issues with an emphasis on health systems. However, because the achievement of equity in health is dependant upon a broader framework of social justice, encompassing structural issues that underpin society, the course adopts a broader *social determinants* approach to health.

The course objectives are:

- To encourage participants to reflect on the issue of equity in health and in their work.
- To introduce the concept of equity in relation to other competing objectives in health and development.
- To introduce the participants to the GEGA model of equity.
- To familiarise participants with the Equity Gauge approach.
- To familiarise participants with mechanisms and strategies to reduce inequities.
- To enable participants to consider how the approach may be applied in their own country context.
- To go through the preliminary steps of applying the Equity Gauge approach to a specific health equity problem or issue.

3 PROGRAMME: HEALTH EQUITY - RESEARCH TO ACTION

Insert Training Programme here:

DATE	TIME	PROGRAMME

4 CONCEPTS OF EQUITY

The purpose of this section is to clarify the concepts of equity and health equity. We have provided selected slides from the training course which may be helpful for later reference. At the end of each section, you will find a list of readings and references. You will find the Primary Readings for this section organised alphabetically by author in section 11 of this Reader.

4.1 THE MEANING OF EQUITY AND HEALTH EQUITY

Here is a selection of slides from the session.

EQUITY AND EQUALITY (Slide 4.1.5)

EQUALITY = SAMENESS
EQUITY = FAIRNESS
EQUITY = JUSTICE

ACHIEVING EQUITY = REMOVING UNFAIR, UNJUST
DIFFERENCES BETWEEN GROUPS OF PEOPLE

SOME DEFINITIONS OF EQUITY (Slide 4.1.9)

Whilst these definitions vary, they all share a social justice and human rights perspective, although there are different interpretations and emphases.

“Equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage or disadvantage.”

Braveman and Gruskin, 2003

“Inequities are differences in health that are unnecessary, avoidable, unfair and unjust.”
Whitehead, 1992

“Equity is righting the injustices represented by inequalities or poor health conditions among the disadvantaged.” Gwatkin, 2000

“Equity is a world without “systematic differences in ... health status across socially, demographically, or geographically defined populations or population subgroups”
Starfield, 2001

“Health inequities are differences in health risks or harms between sub-populations, or over time, that are unfair, avoidable, and unchosen, and for which a responsible agent can be identified.”

Bambas, 2002

What are Inequities?

The term *inequities* refers to the avoidable unequal provision of resources, which result from discriminatory or structural differences in social or political status, economic level, gender, ethnicity or cultural status. An example is the lower rates of immunisation coverage among girls than boys, because families give them greater priority or spend more on them; another example is the higher mortality rates amongst some racial/ethnic groups when compared to others, resulting from poverty or lack of other resources.

4.2 EQUITY IN PRACTICE

WHAT IS EQUITY IN PRACTICAL TERMS? (Slide 4.2.2a)

EQUITY = CUTTING THE CAKE FAIRLY
EQUITY = REDISTRIBUTING ACCORDING TO NEED

HORIZONTAL AND VERTICAL EQUITY (Slide 4.2.3)

Horizontal equity = Equal resources for equal need. This term refers to situations where there is equal health need, and therefore an equal need for resources, for example, sharing resources equally between population groups with the same socio-economic and health profiles. In horizontal equity, there is no requirement to examine needs in order to decide on how to cut the cake.

Vertical equity = Unequal resources for unequal need. This refers to situations when there are different needs. This means that the resources need to be adjusted to meet the different needs. Examples include different geographical circumstances, such as urban/rural; urban/peri-urban; and some urban/urban (poor and rich areas within a city). Here the cake needs to be cut differently to be equitable.

EFFECTIVENESS AND EFFICIENCY (Slide 4.2.4)

<p>EFFECTIVENESS "doing things that work" TECHNICAL EFFICIENCY "doing something in the cheapest way possible" ALLOCATIVE EFFICIENCY "the greatest good for the greatest number"</p>
--

Effectiveness and efficiency are important considerations for managers, and therefore important to understand when addressing equity. Effectiveness is about spending money/resources on services/programmes that have a proven impact in improving health. In other words, it is about doing things that work. The argument is that if they do not work, then they should not be done. For example, telling a poor mother with a child

suffering from under-nutrition what is required for a balanced diet, and expecting her to be able to provide it, is not effective.

Efficiency can be **technical** or **allocative**. Technical efficiency is about doing something in the cheapest way possible. This could be:

- Delivering the same amount or the same quality at a lower cost;
- Delivering a greater amount or better quality at lower cost; or
- Delivering a greater amount or better quality at same cost.

This is technical efficiency, because it looks at cost saving, *but it works against equity*.

Allocative efficiency is choosing what is the best for the population, that is, the “greatest good for the greatest number”. For example, allocative efficiency would be about providing immunisation for a whole community as opposed to providing leukemia drugs for one child. Allocative efficiency is usually equitable.

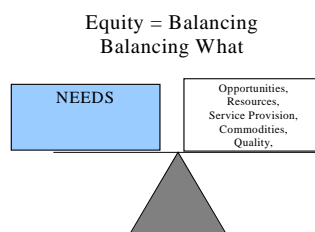
Allocative decisions can be quite difficult. For example, there are occasional circumstances when allocative efficiency works against equity. In a situation with restricted resources, what is better? Building a ramp so that a wheelchair-bound patient can have access to a clinic, or fixing the leaking roof of the clinic to keep everyone dry? Equity would imply building a ramp; allocative efficiency would suggest fixing the roof. A solution: Fix the roof and make arrangements to lift up the wheelchair patient.

There is a strong emotional pull towards individual stories, which can influence the way that resources are spent. Repeatedly, the media tend to highlight individual stories over population need, and natural disasters over ongoing deprivation. For example, a child requiring funding for an organ transplant may get massive media coverage, whilst ongoing poverty is not reported; natural disasters such as floods hit the headlines, but absence of water and sanitation in poor areas does not.

These aspects are important to consider when planning advocacy for equity.

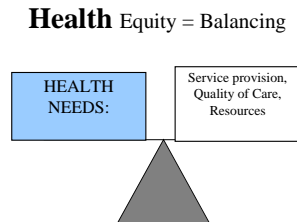
WHAT IS EQUITY? (Slide 4.2.2b)

EQUITY = balancing NEEDS with OPPORTUNITY, RESOURCES, SERVICE PROVISION, COMMODITIES & QUALITY



WHAT IS HEALTH EQUITY? (Slide 4.2.2c)

HEALTH EQUITY = balancing HEALTH NEEDS with SERVICE PROVISION, QUALITY OF CARE & RESOURCES



Equity is about redistribution. In our society, people have different health needs, and so should receive resources according to their needs. For example, it costs more to provide services to infants than it does to adults, because infants have greater needs than adults, such as immunisation, growth monitoring and treatment of illnesses. To be fair or equitable, infants should receive *more* resources than adults, to provide for their relatively *greater needs*.

USING A DETERMINANTS BASED APPROACH TO ANALYSE AN EQUITY ISSUE (Slide 4.2.5)

Where does one start in operationalising an equity project?

- Identify a health inequity, e.g. Infant Mortality Rate.
- Analyse and categorise the determinants into immediate, underlying and root causes.
- In the light of these determinants, decide what health measures or interventions are most likely to have an impact on health inequity.

This approach is a social approach to understanding the causes or determinants of a problem. This is the first step towards analysing whether an issue is a case of inequity. Using diarrhoea (as one of the factors leading to the high IMR), here are its determinants categorised as immediate, underlying and root causes, e.g. IMMEDIATE - bacteria from contaminated water (Biomedical Paradigm).

CATEGORY OF DETERMINANTS	PARADIGM	DETERMINANTS OF DIARRHOEA
IMMEDIATE	Biomedical Paradigm	bacteria from contaminated water
UNDERLYING	Public Health Paradigm	poor sanitation, using a stream, lack of purification, problems with nutrition, no breast-feeding
ROOT CAUSES	Social Paradigm	poverty, education, government priorities, injustice

CATEGORIES OF INEQUITY (Slide 4.2.6)

Inequities can be:

- Differences in health status;
- Disparities in access and utilisation of health care services;
- Differences in health care financing and resource allocation;
- Differences in quality of health care and delivery;
- Differential exposure to underlying health determinants, e.g. water, sanitation, food security, formal education, environmental or occupational hazards, behavioural risk factors.

4.3 USING AN EQUITY LENS

At this stage, equity is a vision which is certainly not easy to achieve. In addition, many of the inequities in our society remain masked rather than obvious to those who administer or manage the health services, and those who use them. It is important therefore to establish ways of looking at existing data and service provision in such a way that inequities become apparent. This is done by adopting what has been called an *Equity Lens* or perspective.

AVAILABILITY OF INFORMATION FOR EQUITY (Slide 4.3.1)

It is a concern that only 39 of 192 WHO member states have a relatively strong information system for equity analysis, i.e. Vital registration and major household surveys; and potential for effective record linkages.
BUT 90 of 192 countries have systems with only a weak ability to complete an equity analysis, i.e. Census or household surveys or no data at all.

The availability of data for assessing equity is limited. This highlights the need for either using existing data and viewing them through an Equity Lens, and/or supplementing them with additional data. If there is no equity data, then the local Equity Gauge may have to create it. If there is, they can use it to monitor and evaluate the effectiveness of equitable implementation measures.

WHAT IS AN EQUITY LENS? (Slide 4.3.2)

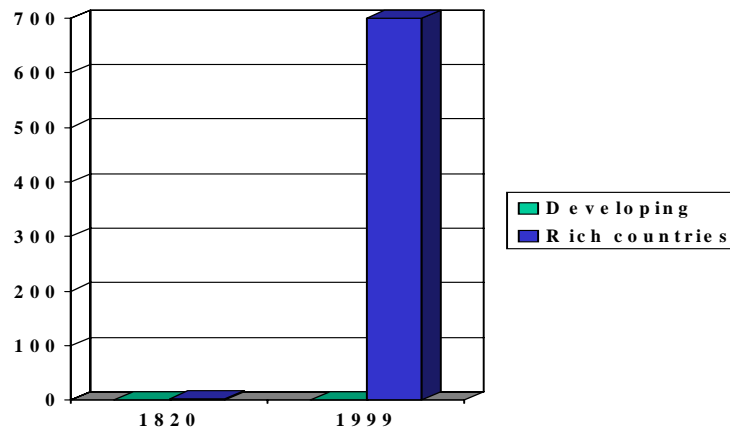
AN EQUITY LENS ...

- Is a way of looking at things;
- Looks beyond average numbers, i.e. of a population's overall status;
- Compares how different social groups are doing (more and less advantaged social groups) in relation to absolute standards or targets and in relation to each other.

EQUITY CAN BE MEASURED AT THESE LEVELS (Slide 4.3.4)

Local level, Provincially, Country wide, Continent wide, Globally.

EQUITY BETWEEN COUNTRIES (Slide 4.3.3b)



Difference of income between the rich and the 'developing' countries
3:1(1820) and 700:1(1999)

(Source: Poverty, Health & Development AIFO)

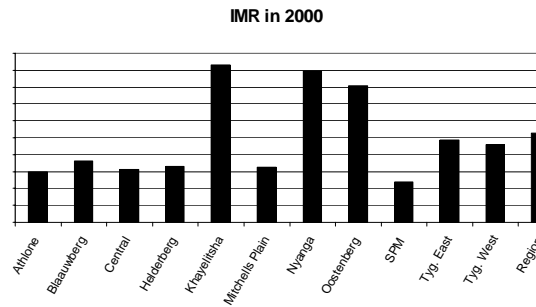
Equity between countries is as important to measure as equity within countries, and in some countries this could be the focus of the Equity Gauge's level of interest. For example, using an Equity Lens in countries that have generalised poverty will not expose inequities: it will rather expose a spread of poverty. This means that there will be no resources to reallocate. In these cases, it may be more important to monitor the impact of globalisation on a country, and to develop measures to tackle these. This points to the need for a strong global network to address equity.

EQUITY MEASUREMENT AT DIFFERENT LEVELS (Slide 4.3.8)

IMR IN SOUTH AFRICA: VARIATION IN INFANT MORTALITY BY REGION COMPARED TO NATIONAL RATES (Slide 4.3.8a)	
REGION	IMR (per 1000 livebirths)
Western Cape	31
KwaZulu Natal	74
Eastern Cape	80
National	56

IMR IN THE WESTERN CAPE (Slide 4.3.8b)	
Area	IMR (per 1000 livebirths)
Urban Area	26
Rural Area	47

IMR IN CAPE TOWN'S HEALTH DISTRICTS (Slide 4.3.8c)



EQUITY STRATIFIERS (Slide 4.3.5)

Socioeconomic groups

occupation, education, income/assets

Gender

Ethnic groups

racial/ethnic, tribal, religious, and national origin groups

Geographic location

urban vs rural, northern vs southern hemisphere

Other stratifiers

age, disability, HIV status, sexual orientation

THE DANGER OF AVERAGES (Slide 4.3.9)



"The poor are getting poorer, but with the rich getting richer it all averages out in the long run."

The key messages are:

- Do not look at averages, as they can distort the picture. Look at the smaller detail and compare groups. In this case, looking at global averages from the standpoint of a wealthy developed country, masks the level of privilege of these countries compared to others. It also masks the level of inequities within these countries.
- The more heterogeneous the population, the more dangerous the use of averages.

PRIMARY READINGS ON EQUITY FOR SECTION 4

These readings have been provided, and are set out in alphabetical order, by author, in Section 11.

Braveman, P. & Tarimo, E. (2000). Social Inequalities in Health Within Countries: Not Only An Issue for Affluent Nations. *Social Science and Medicine*, 54: 1621-1635.

Braveman, P. A. & Gruskin, S. (2003). Defining Equity in Health. *Journal of Epidemiology and Community Health*, 57: 254-258.

Conarchy, M. (1999). Social inequality and poverty increasing worldwide UN Human Development Report. [Online], Available: <http://www.wsws.org/articles/1999/aug1999/un-a06.shtml//>

Daniels, N., Kennedy, B. & Kawachi, I. Justice is Good for our Health. How Greater Economic Equality Would Promote Public Health. [Online], Available: <http://www.bostonreview.net/BR25.1/daniels.html//>

Diderichsen, F., Evans, T. & Whitehead, M. (2001). Ch 2 - The Social Basis of Disparities in Health. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (eds). *Challenging Inequities in Health: From Ethics to Action*. Oxford: Oxford University Press: 13-23.

Global Health Studies Teaching Pack: 49-71 [Online], Available: <http://www.medact.org/tbx/docs/Curriculum%20report%20.pdf>

Gwatkin, D. R. (2000). Health Inequality and the Health of the Poor: What do we Know? What Can We Do? *Bulletin of the WHO*, 78 (1): 3-18.
<http://www.who.int/docstore/bulletin/pdf/2000/issue1/bu0287.pdf//>

McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*. Durban: GEGA & HST. [Online], Available: http://www.gega.org.za/download/gega_gauge.pdf//

Peter, F. & Evans, T. (2001). Ch 3 - Ethical Dimensions of Health Equity. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (eds). *Challenging Inequities in Health: From Ethics to Action*. Oxford: Oxford University Press.

SUGGESTED ADDITIONAL READINGS FOR SECTION 4

Basu, K. *The Retreat of Global Democracy*. [Online]. Available: <http://people.cornell.edu/pages/kb40/Globaldemocracy.pdf//>

Braveman, P. & Krieger, N. Health Inequalities and Social Inequalities in Health. Assessing Equity in Health: Conceptual Criteria. *WHO Bulletin*. [Online], Available: http://www.paho.org/English/DBI/Op08/OP08_02.pdf//

Evans, T. & Whitehead, M. (2001). Developing the Policy Response to Inequities in Health: A Global Perspective. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (eds). In *Challenging Inequities in Health: From Ethics to Action*. [Online], Available: <http://www.rockfound.org/Documents/424/chapter21.pdf//>

Evans, T., Whitehead, M., Diderichsen, F., Bhuiya, A. & Wirth, M. (eds) (2001). *Challenging Inequities in Health: From Ethics to Action*. Oxford: Oxford University Press.

Globalization and Health. [Online], Available:

<http://www.medact.org/tbx/docs/Curriculum%20report%20p49-71.pdf//>

Hofrichter, R. *The Politics of Health Inequities: Contested Terrain: Health and Social Justice: Politics, Ideology, and Inequity in the Distribution of Disease*. [Online]. Available: http://media.wiley.com/product_data/excerpt/35/07879673/0787967335.pdf//

Whitehead, M. *The Concepts and Principles of Equity and Health*. [Online], Available: <http://www.euro.who.int/Document/PAE/conceptsrpd414.pdf//>

5 THE EQUITY GAUGE APPROACH

The Global Equity Gauge Alliance (GEGA) was developed as an approach to addressing inequities in health. This section focuses on the Equity Gauge Approach. You will find the reading by McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*, very helpful in introducing the approach. See Primary Readings below.

THE EQUITY GAUGES (Slide 5.1.2)

GEGA spans national, provincial/regional and local levels in 13 countries



The advantages of being aligned to GEGA include: coordination of the Gauges, and support through information exchange, conferences and training. In addition, the approach can be used by countries and cities which are not part of the GEGA network.

The Equity Gauge approach is represented as three pillars supporting equity. The pillars represent:

Assessment and monitoring: to analyse, understand, measure and document inequities.

Advocacy: to promote changes in policy, programmes and planning.

Community empowerment and participation: to support the role of poor and marginalised people as active participants in change, rather than passive recipients of aid or help.

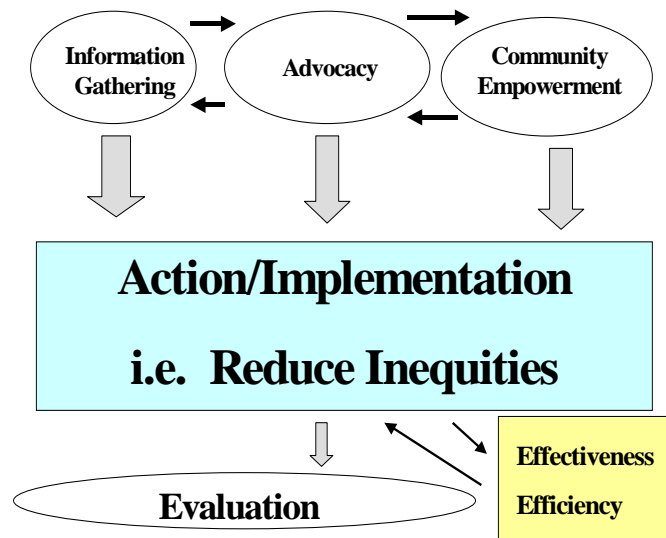
THE EQUITY GAUGE APPROACH (Slides 5.1.4a-b)

The 3 Equity Gauge pillar: in reality – interconnected actions



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THE EQUITY GAUGE MODEL EMPHASISING THE ACTION DIMENSION OF THE MODEL



In the first diagram, the emphasis is on interconnectedness which strengthens the likelihood and effectiveness of action or implementation. In the second diagram, the emphasis is on action.

From our practice, we also know that the three sets of actions or pillars are often inter-connected, for example:

- Influencing decision-makers to change an aspect of their policy or programme requires evidence, the interpretation of which often needs to be “unpacked” for decision-makers, accompanied by some form of planned advocacy or lobbying action, to reach one’s desired objective.
- Citizen-based advocacy, in turn, is based on a principle of collective action and on the understanding that, as an advocate one is speaking on behalf of a particular community or constituency. Thus without collective or community involvement, the force of an advocacy campaign becomes insignificant.
- By working alongside disadvantaged communities and by supporting their empowerment, communities would in turn be able to gather evidence, exert pressure and influence decision-makers by demanding a fairer distribution of resources and greater accountability in the health system.

Do not assume a traditionally linear sequence - where data is collected, analysed, then disseminated, followed by advocacy actions being considered and the community being brought in to advocate for the desired change. In a Gauge, the three sets of actions occur simultaneously, and can thus be seen as three overlapping circles.

AN EQUITY GAUGE AS AN AGENT OF CHANGE (Slide 5.1.5)

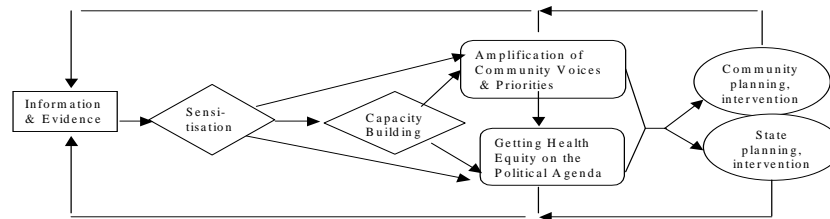
**An Equity Gauge functions as a catalyst for equity,
strengthening the work of existing groups by:**

- Providing evidence of inequities;**
- Strengthening community voices;**

**Strengthening the link between community groups and decision makers;
Directly supporting the role of decision makers through the above.**

An Equity Gauge is about managing change. The means of achieving this will depend significantly on local circumstances, including contexts, political and policy environments. Equity Gauge members need to be sensitive to these contexts, working as a catalyst, but taking account of the realities of the political climate.

GEGA: activities to move research to action



14

This diagram shows the way that research leads to action, which again reinforces and directs research. Note that managing change is a process that requires evidence to substantiate proposed changes, capacity building to facilitate the use of the evidence, community empowerment and advocacy to get the evidence on the agenda, and planning processes to accommodate the change. However, once more, this is not a linear process. It can rather be described as cyclical, with each aspect building on the success of the others.

CASE STUDIES TO ILLUSTRATE THE EQUITY GAUGE APPROACH

Two short case studies of two Equity Gauges are described in order to provide an understanding of the integrated nature of the approach, the range of stakeholders involved and the potential of the approach, and some of the constraints that have been experienced.

CASE STUDY: ZAMBIA EQUITY GAUGE

Case Study Focus

This case study demonstrates a strong bottom-up approach, to build public understanding and a national commitment to health equity. It also illustrates the significant impact which a modest amount of equity information can have, even in resource-poor countries with significant health and health system challenges, if it is effectively presented to the public and linked to policy.

Introduction to the Context

Zambia is a poor country, with a significantly low per capita income as compared to the average figure for Sub-Saharan Africa. More than 85% of the population lives below the US \$2 a day mark. The economy is heavily dependent on copper, cobalt and zinc mining, comprising about 75% of the country's foreign exchange earnings. Owing mainly to the collapse of prices of copper, the economy took a steep downward course during the 1980s, and since then, has never recovered completely. Development, during the heyday of the economy, was strongly skewed, and economic activity is mainly operative along the rail line connecting the mining districts. Even today, this skewed pattern continues, resulting in discrepancies between the levels of development in the mining (mainly urban) districts, and the rural districts.

The main health problems include a high prevalence of HIV/AIDS in the country estimated at 22% for age groups 15-49, a high infant mortality rate of 109 per 1 000 births and a high maternal mortality rate of 649 per 100 000 births. Life expectancy in Zambia is 33 years, undernourishment is high and malaria is the leading cause of death in children.

Activities of the Equity Gauge in Zambia

The Equity Gauge in Zambia has promoted health equity, by developing strong community support for health equity. Initially intended to provide technical support to national-level decision-makers, the Gauge team realised that strong public support for equity would be necessary, to give the issues a high national profile and generate political responsiveness.

The Gauge decided to divide into four teams, one for each district with their varying levels of development. The district teams were comprised of local council representatives and leaders, trained and community health workers, teachers, youth and women's groups, health rights organisations, churches, retired miners, social workers, health administrators, members of parliament, and others.

Work at the local level focused on capacity development, identifying priority equity issues, strengthening involvement in equity decision-making, and supporting interventions to reduce inequities. Key to this work was building a unified voice and reinforcing a culture of equity in communities.

One of the Gauge's earliest activities was to hold a series of workshop for district teams that explored the concepts of equity, and discussed ways of measuring and recognising equity issues, as well as developing strategies for action. These workshops served as a foundation for developing a common understanding and unity of purpose.

In order to build a national platform for advocacy, the four district teams developed and carried out a community survey to identify common local priorities. The survey assessed: knowledge and perceptions of inequities, health levels, access to health care resources and socio-economic inequalities. The cross-cutting issues that emerged were user fees, drug availability and the effectiveness of community based organisations. The locally developed survey was especially useful in empirically demonstrating the socio-economic gradient at work, among and within the districts; it also generated primary information on inequities, to which ordinary people can relate. Armed with a unified voice and

knowledge, the Gauge and district teams began to organise a campaign to advocate for equitable national resource allocation.

The National Parliamentary Portfolio Committee on Health began to take note of the district level activity, and approached the Gauge to develop a common work agenda. With the support of partners within the Global Equity Gauge Alliance, the Zambia Gauge began to provide technical support to the Portfolio Committee, such as equity-focused health budget analysis.

The national campaign culminated in a week-long celebration of cultural activities, including community-developed competitions in song and drama, as well as national media coverage through newspaper articles, radio interviews and television call-in programmes. The high level of media coverage was supported through a project initiated months before, that trained media groups in critical analysis of equity issues, and provided regular information to them.

Involving the Media

The Zambia Gauge developed a very different approach, using an ongoing apprenticeship-type relationship between journalists and the Gauge team. This helped to develop capacity for understanding and reporting the issues, and also incorporated a broader range of media participants, including individuals from radio, print media and television. Participants first attended a series of workshops on health equity, which included input from “experts” from the Gauge, as well as community leaders. This provided opportunities to understand the concepts and learn the vocabulary of health equity, to hear about specific inequities in Zambia and their various influences, and to develop and express their own perspectives on the issues.

Participants then worked with Gauge teams to develop stories, gather evidence and responses and present their work. Although the partnership is ongoing, the work climaxed in a national event to highlight inequities in society; various media events and activities were coordinated around the country. These activities included the release of survey results, competitions of songs and poetry based on equity issues, descriptions of the activities of the Equity Gauge, and radio and television interviews with legislators and leaders in the health community on equity issues.

The campaign not only raised awareness of inequities at the national level, but also spurred other districts to develop district teams; in addition, it generated public discussion, and resulted in ongoing government inquiries into specific issues such as the health budget. In the process, health equity was secured on the national political agenda.

The campaign’s success, and its ability to raise the profile of equity issues was the result of the Gauge’s patient investment in working strategically at the community level, with a constant view to longer-term goals.

CASE STUDY: CAPE TOWN EQUITY GAUGE

Case Study Focus

This case study demonstrates the value of secondary data at the assessment stage, which demonstrated the extent of structural inequities within the City of Cape Town and confirmed key areas of need. In addition, the involvement of local government participants in the assessment process served both as advocacy and capacity development, building government departments' ownership and trust in the process, as well as equipping them with tools to carry out equity-focused interventions. The importance, for equity interventions, of a responsive political environment is also demonstrated. In this Gauge, the three processes of assessment, advocacy and community empowerment and participation have been porous, occurring simultaneously and iteratively.

Introduction to the Context

In the City of Cape Town, like the rest of South Africa, there are vast disparities between the wealthiest communities living in comfortable first world conditions, and the poorest, who live in conditions similar to the worst found in developing countries.

Since health or ill-health is mainly determined by broad socio-economic and environmental factors such as income, housing, water and sanitation, rather than the availability of health services, it is not surprising that there are gross health inequities across Cape Town, resulting from the history of apartheid.

Because the Apartheid system conflated its racial and economic policies, the communities of Cape Town remain almost as clearly separated in "racial" terms as they were a decade ago. Poorer communities live on the peripheries of the Metropole and the state and city continue to struggle to meet the housing, infrastructure and services backlog. In the 1990s, newly established freedom of movement also enabled large numbers of rurally based South Africans to migrate to the city, from even greater conditions of poverty and deprivation. At the same time, the legacy of poverty, and poor education and training for black communities of South Africa, makes it difficult for large parts of these communities to find employment or to afford housing, services or transport to and from low paying jobs. The Metropole therefore includes areas of sprawling low cost housing, interspersed with shack settlements. One of the largest such areas is Khayelitsha.

The GEGA Equity Gauge initiative was developed as a response to this situation - to heighten the awareness and visibility of such inequities, and to advocate for more equity-based policies and budgets across all sectors.

Activities of the Cape Town Equity Gauge since 2002

South Africa's political history has resulted in racially separate and grossly inequitable provision of health services. Those who least require the services, have access to more varied and a greater proportion of them than those who require them most. Not only has this resulted in gross inequity of health service provision, but it has also resulted in fragmentary and uncoordinated provision of services.

The Cape Town Equity Gauge has been in operation since early 2002. The early phase of the initiative focused mainly on the assessment [measurement] pillar of the Equity Gauge approach. Secondary data was used to document the socio-economic, environmental and health status of Cape Town residents, as seen through an Equity Lens. This analysis illustrated the vast inequities across the city, with the poorest districts, that is Khayelitsha and Nyanga, having extremely high rates of all problems, compared to the wealthier districts and the city as a whole. This information has been used in two ways. Firstly, it has provided a baseline data set for the assessment of primary level services, demonstrating a mismatch between need and resources to meet those needs. This led to the development of a Resource Allocation Framework and Tool, now being used by managers in both the City and Provincial Health Departments, as a means of remedying the inequities.

The second use of the baseline data has been to set the context for the development of tracer condition programmes, prioritising conditions identified by the authorities when the Equity Gauge was initiated. The value of these programmes is twofold: firstly they focus on the realities of daily life, thereby providing a powerful indication of the impact of inequities; and secondly, they include strong community participation in their development, and feed into advocacy for policy change.

The first tracer condition, diarrhoea through worm infestation in the informal settlements of Khayelitsha, is being tackled through a community-led action research programme. Identification of high levels of worm infestation in schools led to an integrated schools programme which includes de-worming of the children, inclusion of health and sanitation as part of the school curriculum, and improved provision of sanitation in the schools. The second aspect has been a pilot of dry sanitation toilets as an option for informal settlements. Dry sanitation toilets had not previously been tested in Cape Town, and so the pilot is being used to influence the Strategy for the Upgrading of Informal Settlements. A research report on this action research has been completed. A recommendation from the research is to strengthen the community infrastructure, which is presently under way.

The second tracer condition, HIV/TB/STIs is being developed through an audit of current HIV/TB/STI facilities, as an indicator for future service provision. The audit has now been completed and the audit tools have been successfully piloted in Nyanga, one of the most affected districts. An intersectoral team has developed and tested the tools, and the information arising from this process is now informing implementation. The audit process is currently being rolled out to other districts. Two reports have been developed (Scott V, 2003b, 2003c). A second component of the HIV/TB/STI tracer is a study on the impact of HIV/AIDS on nurses. This work is currently in progress.

The third tracer condition is violence. A study undertaken by the Medical Research Council and the Cape Town Equity Gauge initiative has shown that the highest cause of premature death amongst young men in the city as a whole, and in the two districts noted above in particular, is homicide. See (Scott, 2003a). Funding is now required for a male researcher from the Xhosa community to develop these findings into an action research programme in Khayelitsha.

Finally, it has recently been agreed to include the high, and increasing rates of chronic diseases in Khayelitsha (hypertension and diabetes), as a fourth tracer condition. This builds on existing community based action research by the SOPH, which clearly illustrates the impact of inequities on the growing problem. People in the townships suffer the dual

burden of constraints to prevention, including limited finances for adequate diets, limited healthy diet options in local shops, and limited scope for exercising, as well as inadequate diagnostic and treatment facilities.

REFERENCES

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PRIMARY READINGS FOR SECTION 5

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6 DEVELOPING AN EQUITY PLAN

HANDOUT 6.1.1

INSTRUCTIONS TO PARTICIPANTS FOR GROUP ACTIVITY SELECTING A HEALTH EQUITY ISSUE/PROBLEM AND ANALYSING ITS DETERMINANTS

PART 1: IDENTIFYING A HEALTH ISSUE

For this activity, make use of the notes that you brought along to the training course, as well as the work you have done so far during the training.

- a) Identify a health equity issue* in one of your home contexts that you work with or know fairly well. You could consider any of the following dimensions of health: health status (disease, mortality, quality of life), access and utilisation of health care services, health care financing and resource allocation, quality of care, access to or exposure to underlying health determinants (McCoy et al, 2003: 15).

* Participants could choose a general equity issue too, but this may be too broad and time consuming. Remember the Infant Mortality Rate discussion and the example of diarrhoea discussed in 4.2.5, that showed the importance of identifying and addressing issues at different levels.

- b) Brainstorm and categorise the determinants of the problem by answering these questions:
- What is the immediate, physical cause or determinant of the problem?
 - What are the underlying causes/determinants of the problem?
 - What are the root causes/determinants of the problem? A graphic way to do this analysis would be to draw a tree to represent the problem. Identify the determinants as the roots of the tree, with immediate, underlying and root causes as concentric layers moving deeper into the earth.
 - Discuss what is currently being done about the issue and why current initiatives (if there are any) are not working sufficiently.
 - Identify what has proven to work elsewhere in solving this problem.
- c) Map the consequences of the problem in the city/region/country. You could map the consequences of the problem as the branches in your tree diagram: this might be useful input for advocacy initiatives at a later stage. The outcomes should also be explored at a socio-economic level.

Mapping the consequences of not addressing equity is a useful exercise to highlight how problems escalate and become more serious and costly if not dealt with.

PART 2: LOOKING AT THE ISSUE THROUGH AN EQUITY LENS

- d) Has the issue been defined as an equity issue in your country?
 Use the stratifiers below to subject the issue to an Equity Lens. Do so by using the question: *Equity between whom?* You could use the acronym PROGRESS to remind you of the stratifiers. Decide which stratifiers are relevant, and remember that there will be some overlaps between them.

EQUITY BETWEEN WHOM?		IDENTIFY WHICH STRATIFIERS ARE RELEVANT
	EQUITY STRATIFIERS	
P	Place: urban vs rural; north vs south; rich vs poor areas, etc	
R	Religion	
O	Occupations/household income	
G	Gender	
R	Race/ethnicity, tribal group, national origin etc	
E	Education	
S	Services or resources provision	
S	Social networks/social capital	
	Groups linked in the way in which resources/services are provided	

Adopting an Equity Lens will assist in highlighting the scope of the problem, and focus on areas of need to fill gaps in knowledge and awareness.

PART 3: MAPPING THE CONTEXT

- e) What are the opportunities for your intervention, and what are the constraints?
 Use a sheet of newsprint to map the key factors that impact on your problem. Use pages 6-10 of McCoy et al, 2003, which you will find in your *Course Reader*, to guide your analysis. Make your brainstorm as visual and graphic as possible, e.g. by writing the problem in a circle in the middle of the page, and then dividing the page into segments for the different contexts: the government context, other decision-making and power-brokering institutions, civil society, public policy environment, the health care system, the socio-economic environment and the cultural environment.

You may wish to look back at the contextual descriptions of the two case studies you read in section 5 for the Equity Gauge of Zambia and the Cape Town Equity Gauge.

Reference in the *Course Reader*

McCoy, D. et al. (2003). *The Equity Gauge, Concepts, Principles and Guidelines*. Durban: GEGA & HST: 6-10.

Mapping the context is essential for effective and appropriate priority setting and further planning of your equity work. It provides understanding of the power dynamics, the overall social, cultural and economic environment, and of health service provision.

PART 4: DETERMINING THE VIABILITY OF YOUR INTERVENTION

- f) Assess the likelihood of equity work on this issue being successful in the context for which it is intended, given your assessment of your context.

GIVEN (POSSIBLY) LIMITED RESOURCES, CHECK WHETHER YOUR PROPOSED INTERVENTION IS VIABLE BY ANSWERING THESE QUESTIONS:	
a) Are there severe inequities in the groups?	
b) Is the group a large and heterogeneous enough community to allow equity to be addressed?	
c) Are there sufficient resources within the community for equity to be addressed?	
d) Is it practically possible to make some impact on inequities?	
e) Do the groups comply with government priorities?	
f) Does the issue comply with community priorities?	
g) Are measurement data available?	

Assessing the viability of the initiative covers a range of possibilities. Some are related to political and / or power dynamics identified in mapping the context, some will be practical, about the availability of data showing the inequities, and resources for the inequities to be addressed. Also important is whether the issue complies with government and community priorities.

PART 5: CHOOSING YOUR BATTLE/S

At this point it is important to *choose your battles*, or prioritise the focus of your equity work. Use these questions, but because you are not in your work environment, you may have to make some guesses.

- g) On the basis of all the above, decide on your entry point, that is, which population group or aspect of your issue is most likely to be successfully addressed.
- h) Decide who you would work with, and why. What will they bring to the process?
- i) Decide on the overall aim of your equity work.

Finally, the selection of the intervention will depend on a thorough assessment of the above. The decision made during this exercise will be picked up again in the concluding Session 11, after discussing the pillars in more detail.

Reading in *Course Reader* required for this Activity

See Table 2 page 15, and pages 6-10 of McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*. Durban: GEGA & HST: 5-10. [Online], Available: http://www.gega.org.za/download/gega_gauge.pdf//

7 ASSESSMENT & MONITORING: THE FIRST PILLAR OF THE EQUITY GAUGE

Section 7 aims to develop your understanding of the role of assessment in the Equity Gauge approach. We introduce selected data sources, stratifiers, measures and measurement processes that can be used to identify and assess health inequities, and to track selected inequities over time.

The Concepts of Assessment and Monitoring: Definitions used by GEGA:

Assessment draws attention to the circumstances contributing to inequities. It is sometimes referred to as mapping inequity or measuring inequity.

Monitoring implies ongoing documentation, measurement, understanding and analysis of the inequities over time.

The following slides are included in the Reader as key to the discussion on Assessment and Monitoring.

7.1 INTRODUCTION

LOCATING ASSESSMENT WITHIN THE EQUITY GAUGE APPROACH (Slide 7.1.4)

EIGHT STEPS IN POLICY-ORIENTED MONITORING OF EQUITY IN HEALTH AND ITS DETERMINANTS

- **STEP 1.** Identify the social groups of *a priori* concern.
- **STEP 2.** Identify general concerns and information needs relating to equity in health and its determinants.
- **STEP 3.** Identify sources of information on the groups and issues of concern (qualitative and quantitative information).
- **STEP 4.** Identify indicators of (a) health status, (b) major determinants of health status apart from health care, and (c) healthcare (financing, resource allocation, utilisation, and quality) suitable for assessing gaps between social groups.
- **STEP 5.** Describe current patterns of avoidable social inequalities in health and its determinants.
- **STEP 6.** Describe trends in those patterns over time.
- **STEP 7.** Generate an inclusive and public process for considering the policy implications of the patterns and trends. Include all relevant sectors, civil society, NGOs.
- **Step 8.** Develop a strategic plan for implementation, monitoring, and research, considering political and technical obstacles.

Ref: Braveman P. <http://www.gega.org.za/download/braveman.pdf//>

Steps 1&2 were covered in the practical planning exercise in Section 6. Steps 3 & 4 are covered in this section.

7.2 DATA COLLECTION APPROACHES

Quantitative and Qualitative Measures (Slide 7.2.1)

QUANTITATIVE MEASURES

- Health status measures.
- Health care measures.
- Determinants of health measures.
- Social and economic consequences of ill health.
- Budget allocations and sources of financing.

QUALITATIVE MEASURES

- Mapping the social and cultural context.
- Policy analysis.
- Interpreting the equity implications of qualitative data.
- Bringing in people's voices/testimonies.
- Identifying workable intervention strategies.

SOURCES OF DATA FOR ASSESSING INEQUITIES (Discussion 7.2.2)

Examples of information sources include:

- Existing sources, such as surveys, (e.g. demographic and health surveys), census data, budgets, interviews, government and university research reports and publications. Although this data does not normally provide equity information, equity data can be extracted from it, using an equity lens
- Convincing decision makers to integrate equity sensitive questions into ongoing data collection instruments
- If there are still gaps, primary data and information can be gathered, for example, using surveys, questionnaires and interviews.

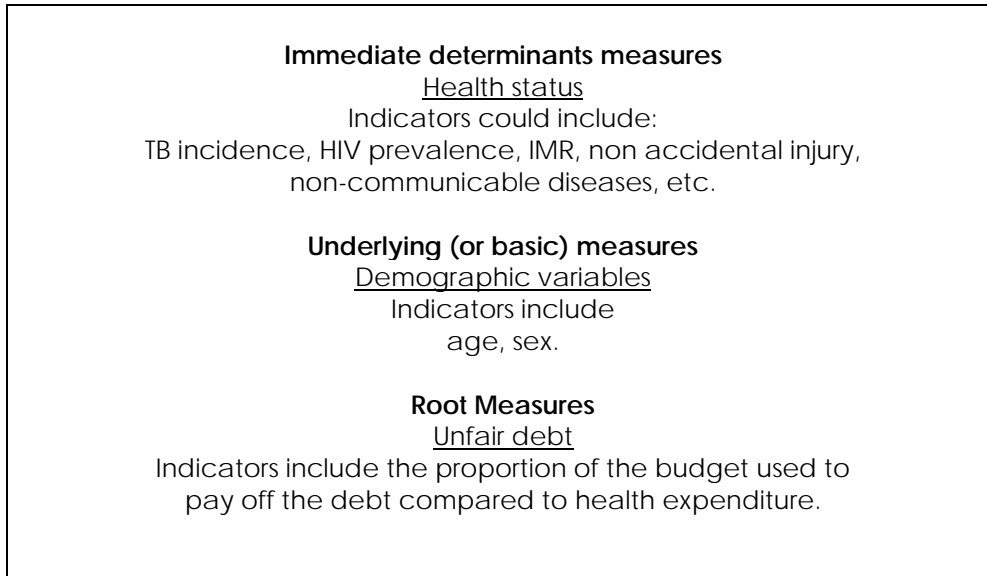
The concept, *action orientated* (or oriented) refers to whether the data provides the basis for advocacy.

7.3 ADOPTING A QUANTITATIVE APPROACH

DIFFERENT MEASURES OF HEALTH (Slide 7.3.1)

Health status
Health care
Determinants of health
Social and economic consequences of ill health
Budget allocations and sources of financing.

TYPES OF HEALTH NEED INDICATORS (Slide 7.3.3)



Note that fewer indicators are needed in cases where the populations being measured are further from equity. When communities are fairly equitable, then more indicators are needed to demonstrate the diversity and clarify disparities.

USING INDICATORS TO ASSESS EQUITY (Discussion 7.3.2)

- Indicators are measures which convert raw data into useful information, to allow comparison between groups, and to measure change over time.
- Indicators can measure what is intended directly, e.g. diarrhoea incidence as a need for health services, or indirectly, e.g. inadequate access to household water causes diarrhoea, so inadequate access to water can be used as an indirect measure of the need for health services. Indirect measures are also called *proxy measures of need*.
- Good indicators often compare two variables, e.g. infant deaths and live births.
- Indicators allow you to make comparisons between different districts and to measure change over time.

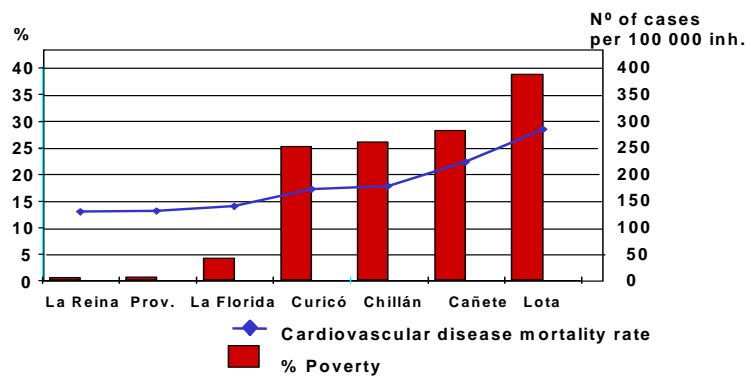
Essential components of an **equity indicator** include:

- Sufficient numbers for stable comparisons.
- The indicator should reflect important policy issues.
- There should be a sustainable process for ongoing work.

Indicators are useful because they allow you to compare two groups in the same terms, or to make valid comparisons. Colloquially this is referred to as comparing apples with apples.

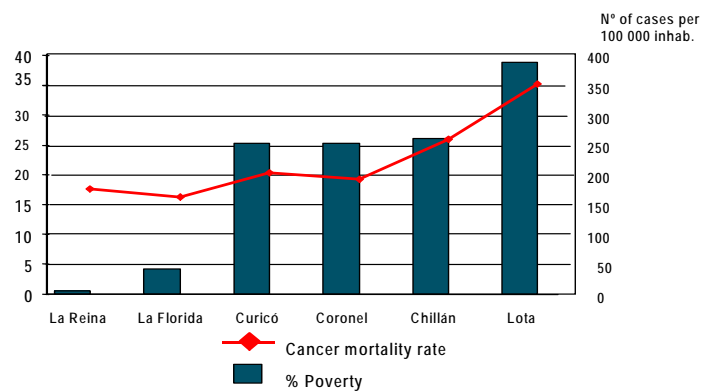
Examples taken from the Chile Equity Gauge include:

Cardiovascular Disease Mortality Rates (45-64 years old) by poverty by counties. Chile 2000

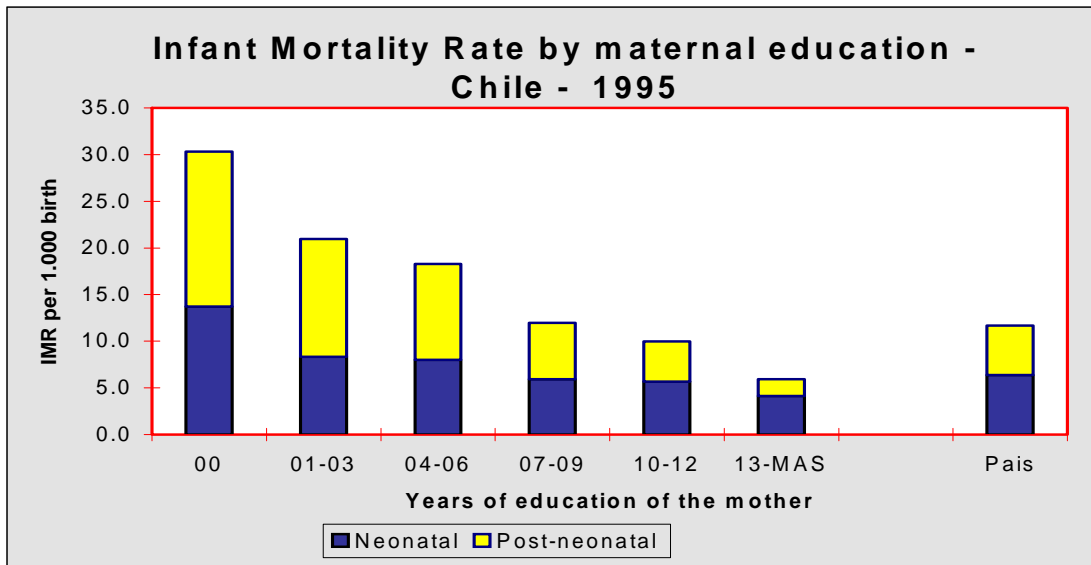


Source: MoH

Cancer Mortality Rates (45-64 years old) by poverty in the counties. Chile 2000



Source: MoH

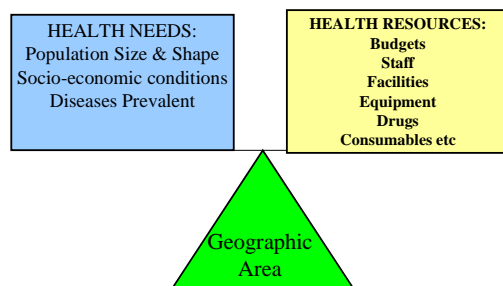


7.4 QUANTITATIVE ASSESSMENT IN THE CAPE TOWN EQUITY GAUGE

This practical example aimed to demonstrate how an Equity Gauge has used secondary quantitative data to assess inequity in health resource allocation, and developed a tool for remedying this inequity

CASE STUDY: STEPS TOWARDS EQUITY OF PRIMARY LEVEL PUBLIC HEALTH SERVICES (Slide 7.4.3)

Measuring Equity of Health Service Provision via **Balancing RESOURCES AND NEEDS**



VERTICAL EQUITY MEASUREMENT TOOL (VEMT) (Slide 7.4.8)

ASSESS HEALTH NEEDS

Population
Dependent population
Increased health need/
Weighted dependent population

ASSESS RESOURCES

Staff and finances

COMPARE RESOURCES TO NEED

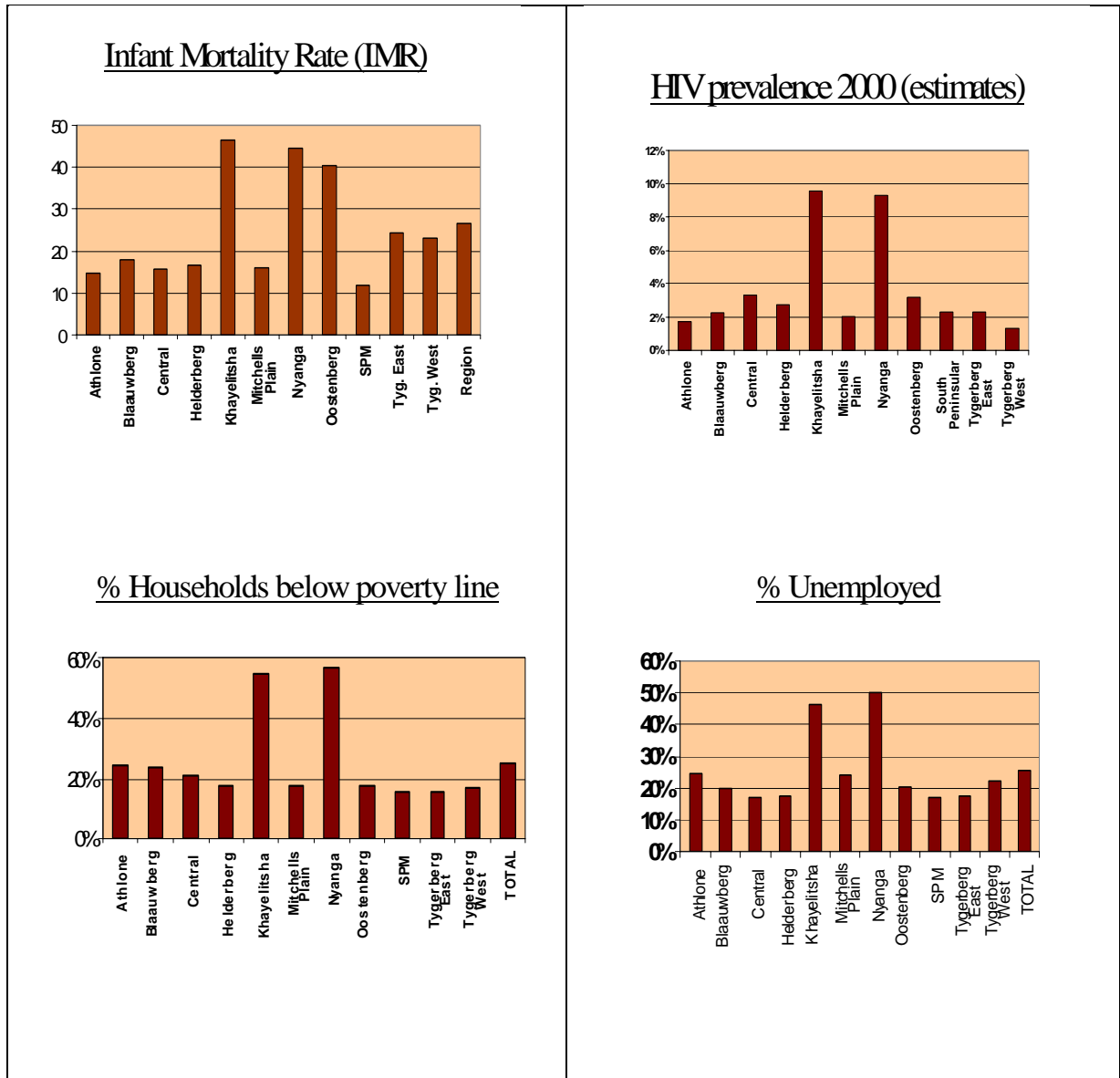
Establish equity amount
Assess level of Inequity

DATA SOURCES USED FOR THE VEMT (Slide 7.4.10)

CENSUS
HOUSEHOLD SURVEY
HEALTH DEPARTMENT INFORMATION SOURCES
(STAFFING, BUDGETS, IMR, HIV PREVALENCE,
TB INCIDENCE, ETC)
LABOUR FORCE SURVEY

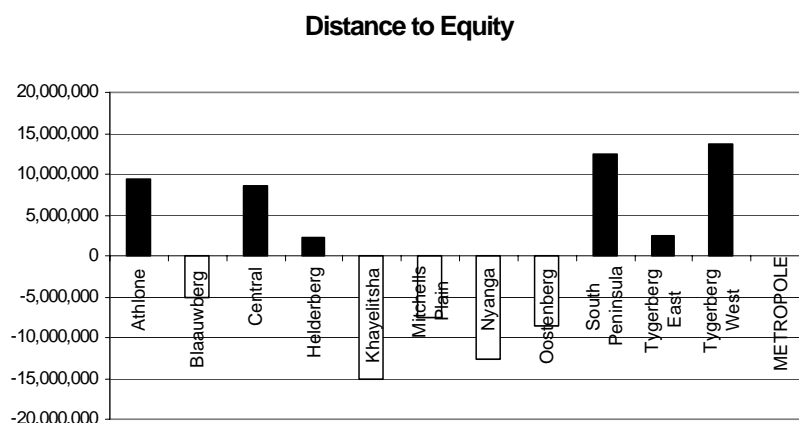
SELECTED GRAPHS SHOWING DISPARITIES OF NEED ACROSS HEALTH DISTRICTS IN CAPE TOWN SOUTH AFRICA (Slide 7.4.11)

Note the similar pattern across all indicators.



INEQUITIES BETWEEN NEED AND RESOURCE ALLOCATION (Slide 7.4.13)

The graph demonstrates the inequities between health districts in Cape Town. The X axis at 0 represents equity, bars above the line are over-resourced, those below, under-resourced.



RECOMMENDED RE-ALLOCATION OF PROFESSIONAL NURSING POSTS IN CAPE TOWN (Slide 7.4.16)

Because staff constitute the major expenditure, reallocation involves shifting staff.

Slide showing the use of the **Resource Allocation Tool (RAT)**, illustrating calculations undertaken to determine realistic shift of nurses (10%) per year, from well resourced districts to poorly resourced districts. The final decision is a management decision based on a range of factors (the right hand column is used for this).

Equity Personnel Shifts - Prof'l Nurses			Nurses				Nurses Practically can be Moved Anomalies and Logistics
District	Equity Prof nurses	Prof Nurses Suggested be moved	Workload Level compared to Avg	Suggested be moved Adjusted for Workload	Prof Nurses Practically can be Moved 10% capping	Prof Nurses Practically can be Moved Zero Sum	
Athlone	60	-6	avg	-6	-6	-6	
Blaauwberg	43	2	low	1	1	1	
Central	65	0	low	0	0	0	
Helderberg	43	-7	avg	-7	-5	-5	
Khayelitsha	157	46	very high	46	16	16	
Mitchells Plain	80	11	avg	11	8	8	
Nyanga	126	15	very high	15	13	13	
Oostenberg	69	0	very low	0	0	0	
South Peninsula	86	-19	very low	-19	-10	-9	
Tygerberg East	58	-21	avg	-21	-8	-8	
Tygerberg West	88	-23	high	-12	-11	-10	
METROPOLE	875	-2		9	-2	0	
Shift	100	78		65	40	38	

Further Reading

For more information about this case study, read:

Scott, V. & Reagon, G. (2004). *Manual 1: Managing an Equity Gauge: A Manual for Subdistrict Health Information Officers*. Cape Town: SOPH, UWC. Available at <http://soph.uwc.ac.za/>

7.5 ADOPTING A QUALITATIVE APPROACH

Qualitative research aims to increase *understanding* of a situation. Part of this understanding is the recognition that different people have different perceptions about information and situations. Qualitative research is useful in conjunction with quantitative measures, or it can be used on its own.

THE POTENTIAL OF THE QUALITATIVE APPROACH IN ASSESSING EQUITY (Discussion 7.5.2)

- Qualitative research is about the less exact side of assessment, explaining the *what*, *why* and *how* of situations. These questions often have to be answered, if we are to develop appropriate strategies and interventions to reduce inequities.
- By improving understanding of a situation, it also becomes easier to advocate for change. Descriptions of human conditions, in particular, are effective tools for advocacy.
- Documenting and amplifying the voices of the people involved, is critical for success. Qualitative research is therefore also about community empowerment and participation, the third pillar of the Equity Gauge.

THE VALUE OF QUALITATIVE STUDIES (Discussion 7.5.5)

Poor people experience a combination of risk factors for poor health: we need to look for these in our equity work and seek explanations. Qualitative research assists us to do this.

Examples include:

- Studies that show the links between the multitudes of risks that are faced by the poor in all aspects of their lives.
- Studies that increase the understanding into why people who are very poor continue to have health-damaging life styles
- Studies that provide an understanding into impacts of globalisation on local poor communities

DEVELOPING QUALITATIVE DATA FOR EQUITY ASSESSMENT (Slide 7.5.6)

EQUITY STRATIFIERS

Socioeconomic groups

occupation, education, income/assets

Gender

Ethnic groups

racial/ethnic, tribal, religious, and national origin groups

Geographic location

urban vs rural, Northern vs Southern Hemisphere

Other stratifiers

age, disability, HIV status, sexual orientation

DIFFERENT SOURCES OF QUALITATIVE DATA (Discussion 7.5.7)

Qualitative assessment tends to favour the following collection methods:

- Focus groups, exit surveys, interviews, testimonies.
- Case studies, direct observation, taking field notes, keeping a journal.
- Participatory methods such as participatory Rural Appraisal (PRA) which includes mapping, Venn diagrams, seasonal charts, etc.
- Document analyses, policy analysis, etc.

Most of this information will have to be generated for specific purposes. The tools are therefore tailor made. This provides the opportunity to build in an Equity Lens from the outset of the research, to ensure that it measures the inequities.

7.6 QUALITATIVE ASSESSMENT IN THE CAPE TOWN EQUITY GAUGE

A Study into the Acceptability of Dry Sanitation Options in Two Informal Settlements in Cape Town, South Africa (Case Study 7.6.1)

For the context of this study, refer to the case study in section 5 of this *Course Reader*. This aspect of the case study is described in detail in a paper which is not included here:

Stern, R. & Mokgatle, M.J. (2004). *The Acceptability of Dry Sanitation: A Preliminary Study in Two Informal Settlements in Khayelitsha, Cape Town, SOPH, UWC*. Available at <http://soph.uwc.ac.za/>

This qualitative study involved interviews with users of toilets, officials responsible for the pilot programme, and policy officers. This was useful for highlighting the impact of inequities and one potential solution to a problem, the lack of sanitation. The study built on work done earlier with community members and parents of schoolchildren who had high levels of worm infestation.

PRIMARY READINGS FOR SECTION 7

- Braveman, P. A.** (Sept 2003). Monitoring Equity in Health and Healthcare: A Conceptual Framework. *Journal of Health Population and Nutrition*. [Online], Available: <http://202.136.7.26/pub/publication.jsp?classificationID=30&pubID=4166//>
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SUGGESTED ADDITIONAL READINGS FOR SECTION 7

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- McIntyre et al.** (2002). Geographic Patterns of Deprivation in South Africa: Informing Health Equity Analyses and Public Resource Allocation Strategies. *Health Policy Planning*, 17: 30-39.
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8 ADVOCACY: THE SECOND PILLAR OF THE EQUITY GAUGE

Advocacy, the second pillar of the Equity Gauge approach, is an essential tool for any cause which strives for social justice and equity. Advocacy actions can influence public attitudes, and contribute towards the enactment of public policies and laws that reduce current inequities, allowing for the vision of a just society to become a reality.

DEFINING ADVOCACY (Slides 8.1.3a,b & c)

“Advocacy is the process of using information strategically to change policies that affect the lives of disadvantaged people”.

McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*. Durban: GEGA & HST: 17.

Advocacy is not

just about getting to the table with a new set of interests, it is about changing the size & configuration of the table to accommodate a whole new set of actors.

Effective advocacy challenges imbalances of power and changes thinking.

VeneKlasen & Miller, 2002, *The Action Guide for Advocacy and Citizen Participation*. World Neighbors

Advocacy is:

targeted **A**ction which is diverse
influencing **D**ecision-makers
a **V**oice
working with **O**thers
Communication
v**A**lues
a positive **C**hange
You as the advocate!

THE ROLE OF ADVOCACY IN AN EQUITY GAUGE (Slides 8.1.4a-b)

Why should a Gauge do advocacy?

Scientific evidence alone is rarely enough to achieve a policy change:
evidence may be necessary but is *not sufficient*.

Pro-equity change cannot and *should not* be a technical fix alone:
it has to be a **public process** with awareness building
and public participation as essential components.

When ought one to advocate?

Advocacy for an equity gauge is **not** a 'once off' activity
at the end of the project cycle.

Different activities - which may not necessarily be recognised as advocacy –
occur at all stages in a project cycle.

Gaining support for & commitment to the desired change
you are advocating for, is however, best considered *upfront*,
strategically & **planned** for.

THE RANGE OF STRATEGIC APPROACHES (Slides 8.1.5 a-b)

The range of advocacy strategic approaches

- informing stakeholders
- shaping public discourse
- sensitising organisations and fostering coalitions
- influencing decision makers through an 'expert role'
- influencing decision makers through a campaign or by social action.

Different advocacy strategies for different moments

- Context - every political environment is different
- Timing - historic moments present both opportunities & challenges

STEPS IN PLANNING AN ADVOCACY CAMPAIGN (Slide 8.2.1)

A step-by-step process of advocacy planning allows one to map out an advocacy campaign in manageable phases. Some have called these steps "moments" - as steps suggest too sequential a process. Although advocacy planning is sequential in theory, it becomes a highly flexible and iterative process in reality.

A STRATEGIC VISION FOR THE GAUGE / ASSESSMENT & POLICY ANALYSIS

For more detail, see Handout 8.2.1 at the end of this section.

- Step 1: Issue identification
- Step 2: Defining your advocacy goal & objectives
- Step 3: Conducting a stakeholder analysis
- Step 4: Conceiving strategies & campaigns
- Step 5: Creating an action plan
- Step 6: Monitoring and Evaluation

INITIAL STEP OF AN ADVOCACY CAMPAIGN: ISSUE IDENTIFICATION (Slides 8.2.2a-d)

What *is* an advocacy issue?

A problem, or a negative condition or a gap (e.g. no policy or inadequate policy/implementation) ... and is something which requires some form of change or ameliorative action.

CRITERIA FOR SELECTING ISSUE	SCORE
The issue is widely felt / affects many people	1, 2, 3
The issue has a significant impact on a person's health (severity)	
The issue is supported by sound data	
The issue is linked to rights - or the abuse of rights & will promote an awareness & respect for rights	
The issue is amenable to an <i>advocacy</i> intervention	
The issue has a clear political and policy solution	
The issue can mobilise a large number of interested partners and other stakeholders (build alliances)	
Addressing the issue is realistic & achievable (chances of success)	
Addressing the issue will empower those affected by the issue	
	<i>Total score</i>

The value of data/information in supporting your issue

- To show that the problem exists
- To understand the extent of the problem
- To challenge myths & assumptions with facts
- To see how it has been dealt with elsewhere and direct one to possible solutions
- To help with presenting your issue to others - media, the public & decision-makers
- Counter oppositional positions & arguments
- To build your confidence as an advocate.

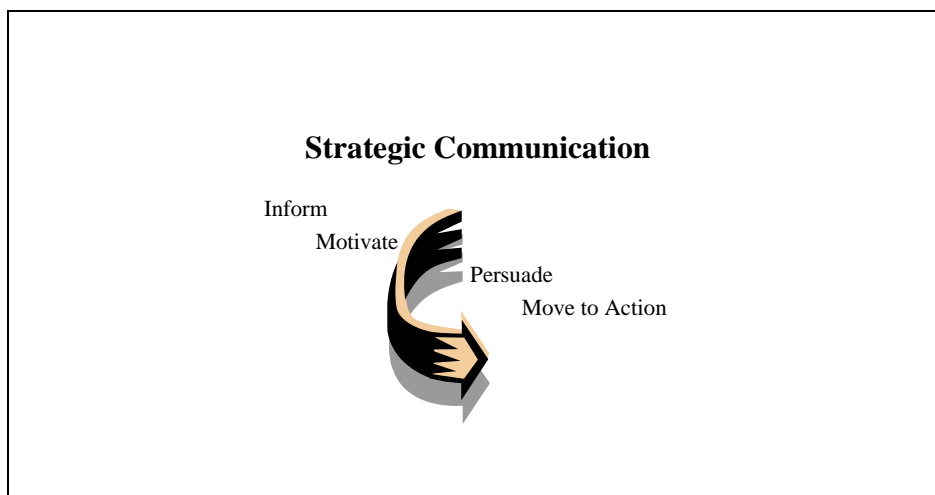
What works well in advocacy in terms of *information*?

- Research conducted by organisations perceived to be credible & reliable
- Research findings emphasize lessons learnt rather than *more* research that is required
- Findings are disseminated to appropriate & multiple audiences using a variety of channels
- Personal stories - and those that make decision-makers sit up and listen!

Types of stakeholders

- Targets: decision-makers or influential bodies who your campaign needs to influence so as to obtain their support.
- Allies: potentially sympathetic elements who need to be sensitised & made supportive of your campaign.
- Partners: members of your advocacy coalition whose interests need to be kept in mind.
- Opponents: those with vested interests or bodies likely to oppose the issue & who need to be neutralised.

ADVOCACY MESSAGES AND THE MEDIA (Slide 8.2.4a)



Five Message Elements (Slide 8.2.4b & c)

Content

- Your information, arguments & solution
- Keep this simple & brief: using life stories & quotes, clear facts & numbers creatively

Language

- Use precise & powerful words, and active verbs

Messenger

- A source who is credible, respected & who your audience will respond to

Format/Source

- The communication channel to be used
- Person-to-Person (discussion, meeting/workshop, rally), Print (fact sheet, letters, press release, poster) Electronic (radio, TV), Drama (poem, street theater)

Time & place

- A suitable moment and context in which to delivery your message.

Mass Media Advocacy (Slide 8.2.4d)

- Assessing the mass media in your context
- Considering what is thought of as “newsworthy”
- Skills provision & training of journalists
- Using alternative forms of media

8.4 ADVOCACY CASE STUDIES

TWO ADVOCACY CASE STUDIES (Slide 8.4.1)

RESOURCE ALLOCATION IN CAPE TOWN

The team assumed a relatively “quiet” advocacy role by providing both technical assistance and capacity development to officials in relation to their resource allocation responsibilities.

Importantly, the team also produced and distributed accessible information to different stakeholders. Informing community representatives about this initiative facilitated community involvement

DRY SANITATION PILOT IN TWO INFORMAL SETTLEMENTS IN CAPE TOWN

The research study aimed to raise the profile of the pilot project, and showed a potential solution, as evidence to inform policy change.

The Equity Gauge measurement data showing inequities in Khayelitsha provided a dramatic backdrop to this research study

The community’s involvement in the dry sanitation pilot project was a significant component of this intervention.

Site visits, photographs and newspaper articles were used as a powerful illustration of the reality of the situation - particularly in relation to the lack of adequate sanitation. They also complemented the qualitative data that was collected as part of the research study.

The presentation of the results to both managers and communities was also an advocacy strategy.

Handout 8.2.1 - Steps in an Advocacy Campaign

A STRATEGIC VISION FOR THE GAUGE / ASSESSMENT & POLICY ANALYSIS

- Step 1: Issue identification
- Step 2: Defining your advocacy goal & objectives
- Step 3: Conducting a stakeholder analysis
- Step 4: Conceiving strategies & campaigns
- Step 5: Creating an action plan
- Step 6: Monitoring and Evaluation

STEP 1: ISSUE IDENTIFICATION

The first step of the advocacy planning approach, issue identification, allows one to prioritise and select an issue that could be taken up as an issue for an advocacy campaign. An issue is a problem, or a negative condition or a gap (for example, a lack of policy, or the existence of an inadequate policy, or the inappropriate implementation of a policy). The group would have explored this in some depth in the previous exercise.

STEP 2: DEFINING AN ADVOCACY GOAL & OBJECTIVES

There are many different definitions of goals and objectives. VeneKlasen & Miller (2002) in their book *A New Weave of Power, People and Politics* have Outlined a simple and effective way of considering these terms in relation to Advocacy: A *long-term advocacy goal* describe the social change that one wants to see. It describes what we ultimately want to achieve from our *collective* advocacy work over a long period of time and is generally more abstract. It is a desirable state for society to move towards.

In practice, in planning an advocacy campaign, an advocate will often develop a *shorter-term advocacy goal* which describes the desired outcome or proposed advocacy solution to the specific issue and serves as the vision for the *particular* advocacy campaign.

An *advocacy objective* is a relatively short term target that contributes towards achieving the advocacy goal or vision. It is an incremental step toward achieving your goal. It outlines the concrete things you want to achieve as a result of the advocacy work, with whom you will achieve them, how you will achieve them and over what period.

To illustrate these terms, here is an example from the Treatment Action Campaign (TAC) in South Africa:

To illustrate these terms, here is an example from the Treatment Action Campaign (TAC) in South Africa:

Long term advocacy goal: To provide accessible and affordable treatment to all people living with HIV/AIDS in South Africa.

Short term advocacy goal: To ensure the implementation of a comprehensive National PMTCT programme by the South African public health service.

Advocacy Goal

A *long-term advocacy goal* describe the social change that one wants to see. It describes what we ultimately want to achieve from our collective advocacy work over a long period of time and is generally more abstract. It is a desirable state for society to move towards.

In practice, in planning an advocacy campaign, an advocate will often develop a *shorter-term advocacy goal* which describes the desired outcome or proposed advocacy solution to the specific issue and serves as the vision for the particular advocacy campaign.

Adapted from: VeneKlasen & Miller (2002). 'A New Weave of Power, People & Politics'

Advocacy Objectives

An **advocacy objective** is a relatively short term target that contributes towards achieving the longer term advocacy goal or vision. It is an incremental step toward achieving your goal.

The **advocacy objective** outlines the specific things you want to achieve as part of the advocacy work, and can be defined by asking:

What specific things would we like to see achieved through this advocacy process?

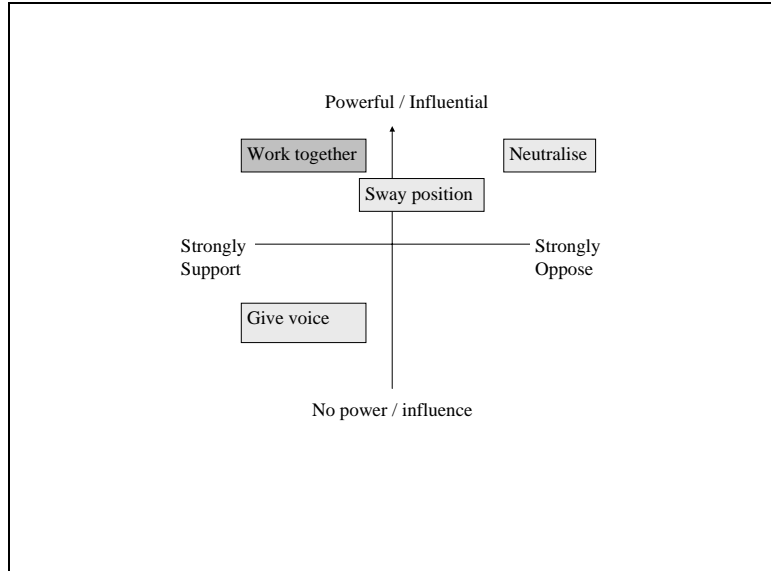
Objectives:

- Within two months, train all TAC volunteers in the three provinces on the issue of treatment literacy so that they will be able to actively participate in the PMTCT campaign;
- In collaboration with TAC's key national partners (i. e. faith-based organisations and unions), develop a media campaign by September 2001 to conscientise the public about the current lack of universal access to PMTCT;
- Develop and implement a litigation process against the Minister of Health to ensure that the Department's current pilot PMTCT programme is expanded appropriately to other public health facilities in South Africa within 12 months.
- It is important to ensure that the longer-term advocacy goal (i.e. the broad social change that a variety of interventions collectively contribute to over a period of time – with the group's advocacy campaign being *one* of many contributors to this change), and the shorter-term advocacy goal (which describes the desired outcome or change that the advocacy campaign itself is aiming to achieve). The latter ought to be what the different groups present in plenary.
- In considering whether goals are realistic or not, consideration ought to be given to such things as:
 - whether the group will be able to raise sufficient resources to support the attainment of this goal;
 - whether the group will be able to build alliances & gain support from key sectors to achieve this goal;
 - whether the data suggests that by reaching this goal, a more equitable situation will be established which will in turn serve to improve the health and well-being of your constituency.

STEP 3: CONDUCTING A STAKEHOLDER ANALYSIS

During the process of an advocacy campaign one is likely to have to engage with a range of stakeholders. To simplify things, you can divide advocacy stakeholders into four categories.

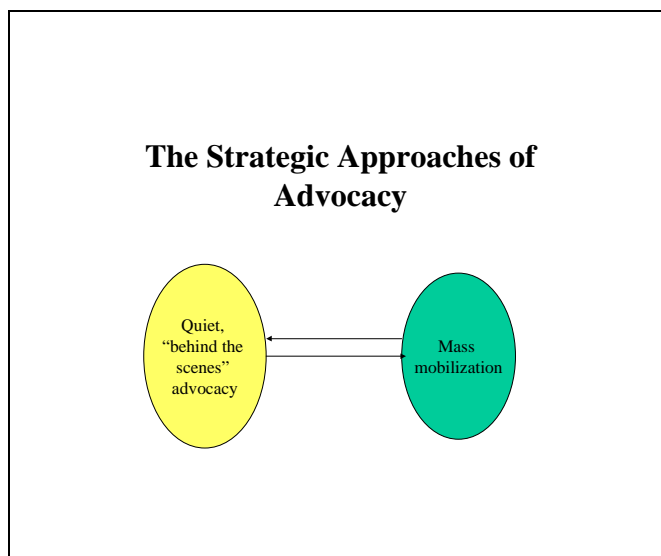
- **Targets:** decision-makers or influential bodies who your campaign needs to influence so as to obtain their support.
- **Allies:** potentially sympathetic elements who need to be sensitised & made supportive of your campaign.
- **Partners:** members of your advocacy coalition whose interests need to be kept in mind.
- **Opponents:** those with vested interests or bodies likely to oppose the issue & who need to be neutralised.



Levels of power and influence can be assessed using this matrix.

STEP 4: CONCEIVING STRATEGIES AND CAMPAIGNS

Based on a previous session, participants ought now to be familiar with the range of strategic approaches that are generally used in advocacy. It would be important at this point to remind participants that there is a *range* of choices in terms of approaches and that the choice of action is dependant on contextual issues, the perceived risks associated with particular actions, and the resources that a group has access to.



STEP 5: DEVELOPING ACTION PLANS

As in any process of planning, it is important to develop an action plan that details:

- the specific issue, problem or need one is addressing;
- what one is aiming to achieve as a result of one’s advocacy efforts (the broad advocacy goal and the specific objectives);
- the various approaches, interventions or activities one will adopt to accomplish the goal and/or each objective;
- the various stakeholders that one has identified and with whom one will need to engage with or work with;
- the time it will take to accomplish specific activities; and
- the resources (human, financial and material) that will be required to achieve the goals and objectives.

This all needs to be documented in an action plan so that the advocacy partners are clear about the direction that the campaign will take, who holds responsibility for what, and what resources are required. This diagram provides an example of one format that could be used for such an action plan.

Objectives: What specifically do you want to achieve?	Who are your target audiences? (direct, indirect)	Activities – What do you plan to do?	Resources required	Persons or organisations responsible	Time frame

STEP 6: MONITORING AND EVALUATING THE CAMPAIGN

In response to the plenary question “How would you know you have been successful in your advocacy efforts?” there are various ways of assessing this. For example,

- You could evaluate the extent to which targets described in your advocacy objectives have been reached, and whether reaching all the various targets

- constitutes accomplishing the identified advocacy goal.
- The advocacy action plan should also include indicators of success for the various activities to be undertaken. These could include, for example, how many press conferences were held, the number of advocacy proposals or solutions related to equity that were adopted by decision-makers, the number of people participating in social action events, the number of grassroots and community-based organisations that have joined your campaign, the number of original "opponents" that have joined your campaign, the way in which partners were able to work together. Indicators like these would be able to provide one with an assessment as to whether one had or not reached the advocacy objectives one had created for the campaign;
 - You could evaluate your campaign by establishing whether local leadership and a local constituency has been built in the process (i.e. by the extent to which the communities affected by the issue have participated in the campaign, and directed and guided the advocacy process);
 - You could also assess the benefits experienced as a result of the campaign, (i.e. by the way in which the communities affected by the issue have experienced tangible benefits as a result of the advocacy campaign).

Participants own experiences will add to this discussion.

PRIMARY READINGS FOR SECTION 8

McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*. Durban: GEGA & HST. [Online], Available: http://www.gega.org.za/download/gega_gauge.pdf//

VeneKlasen, L. & Miller, V. (2002). *A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation*. Oklahoma City: World Neighbors.

[Online], Available: http://www.justassociates.org/Action_Guide.htm//

Chapter 5: The Basics of Planning for Citizen-Centered Advocacy

Chapter 10: Mapping Advocacy Strategies

Chapter 13: Messages and Media: Educating and Persuading (Chapter 13 is not available on the Internet, but is in the *Course Reader*.)

SUGGESTED ADDITIONAL READINGS FOR SECTION 8

American Public Health Association Media Advocacy Manual. [Online]. Available: http://www.apha.org/news/Media_Advocacy_Manual.pdf//

Bambas, L. & Zarowsky, C. (Jan 2004). *Building A Culture of Equity*. The Health Metrics Network.

Christoffel, K. K. *Public Health Advocacy: Process And Product*. [Online], Available: <http://www.ajph.org/cgi/reprint/90/5/722//>

Cohen, D., De la Vega, R. & Watson, G. (2001). *Advocacy for Social Justice – A Global Action and Reflection Guide*. Kumarian Press. Available from:

http://www.oxfamamerica.org/advocacy_guide/index.php (Costs \$ 50)

Walt G. & Gilson. L. (1994). Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis. *Health Policy and Planning*, 9: 353-370.

9 COMMUNITY EMPOWERMENT & PARTICIPATION: THE THIRD PILLAR OF THE EQUITY GAUGE

By combining advocacy with community empowerment, an Equity Gauge will be able to facilitate the communities' role in the advocacy process. Similarly, by providing information, and importantly, building on community information, Gauges will benefit by having enriched information. It will also enable the development of a more equal dialogue between practitioners and communities.

General principles of community empowerment and participation are often assumed, but not shared. They are therefore explored for clarification as part of this section.

9.1 UNDERSTANDING COMMUNITY EMPOWERMENT AND COMMUNITY PARTICIPATION

THE ROLE OF THE COMMUNITY EMPOWERMENT AND PARTICIPATION PILLAR (Slide 9.1.1)

- To involve communities in advocating for equitable change.
- To initiate community empowerment strategies.
- To work collaboratively with those who are affected by inequities.
- To develop different strategies for fostering community empowerment

CONCEPTS OF COMMUNITY EMPOWERMENT AND PARTICIPATION (Slide 9.1.2)

There are many definitions used for both terms. These are the ones used on the course..

“Empowerment is the process by which disadvantaged people work together to take control of the factors that determine their health and their lives. By definition, one cannot empower someone else: empowerment is something that people do for themselves. However, sometimes concerned health workers or facilitators can help open the way for people to empower themselves.”

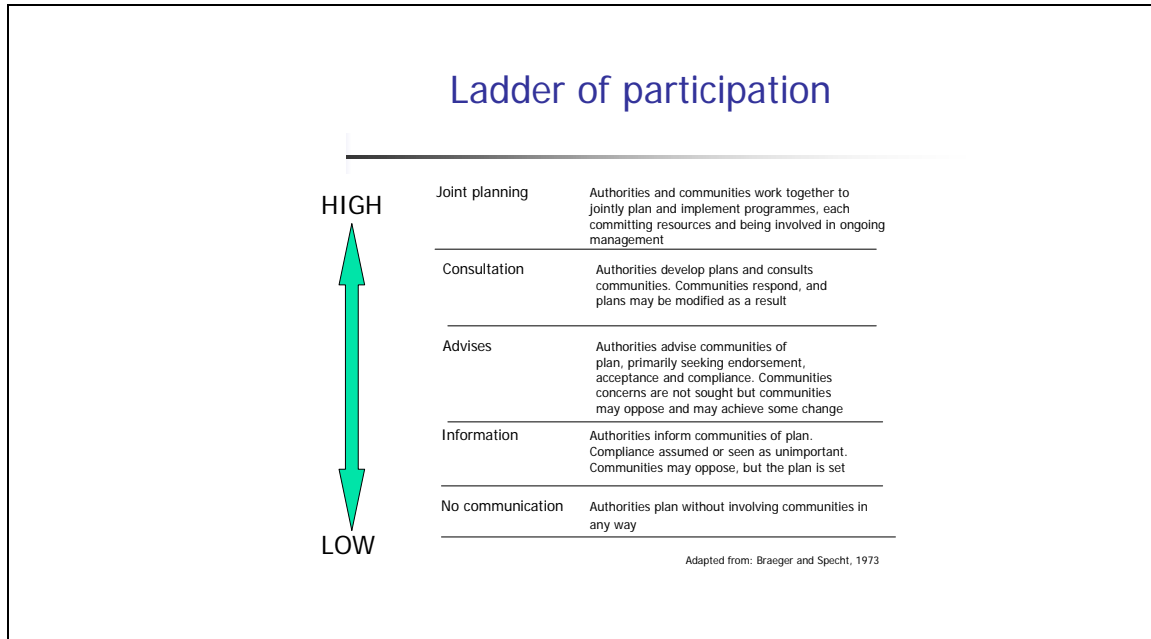
(Werner & Sanders, 1997)

“Community participation ... is the process of initiating and sustaining dialogue with various members of a particular community in a structured manner with the view to genuinely involving them as equals in a programme of activities that aim to build a team between programme managers and community members, to jointly understand health problems in the community and to find common solutions to such problems.”

(Adapted from the Ministry of Health Ghana, 1997, cited in Kahssay & Oakley, 1999: 11)

Community empowerment and participation are generally part of a continuum. Supporting community empowerment would logically lead to the communities' participation

Ladder of Participation (Slide 9.1.3)



There are different variants of the ladder. All show the same general principles

9.2 COMMUNITY EMPOWERMENT AND PARTICIPATION IN PRACTICE

WORKING WITH COMMUNITIES (Discussion 9.2.1)

a) Who is "the community"?

- Communities are not homogeneous. One or two people do not represent the views of "the community".
- Communities are of different types - geographic, communities of interest such as parents of disabled children, users of services, etc.
- Accountability is important. One cannot assume that by having a community representative involved in your programme, they will return to their community and report back, nor that they reflect the common interests of the community. This is particularly the case with community leaders.

b) Why Equity Gauges should work with communities

Reasons include:

- Communities know what they want: this shifts equity work from change on paper to change for people.
- When communities raise issues, they strengthen the Gauge's arguments, e.g. communities lobbying their politicians is an effective form of advocacy.
- Communities provide access to a whole range of valuable networks and alliances.
- Gauges learn from communities, about their needs, their priorities, the barriers they face.

c) Why communities should work with Equity Gauges

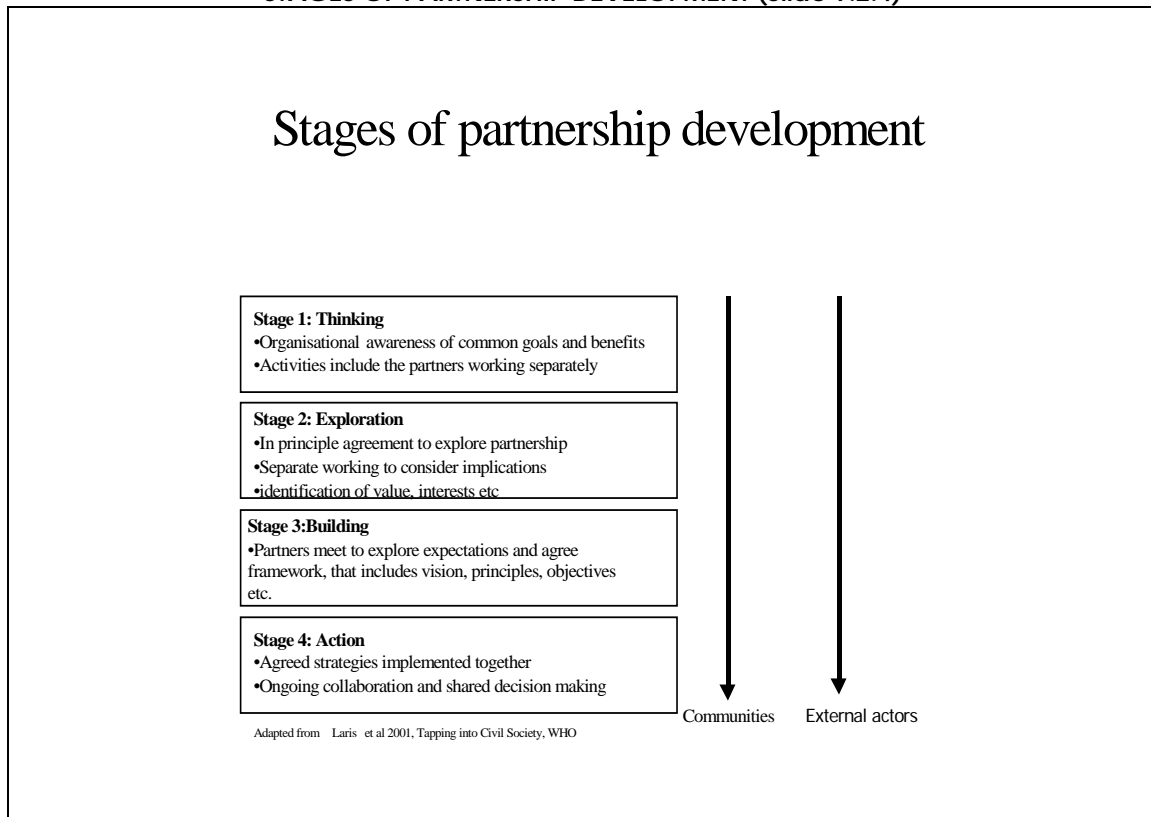
Reasons include:

- It gives them "a foot in the door" to the decision making structures.
- It provides them with valuable information and knowledge.
- It gives them influence.
- It builds their capacity and confidence.

SOME OF THE CHALLENGES OF WORKING WITH COMMUNITIES (Slide 9.2.2)

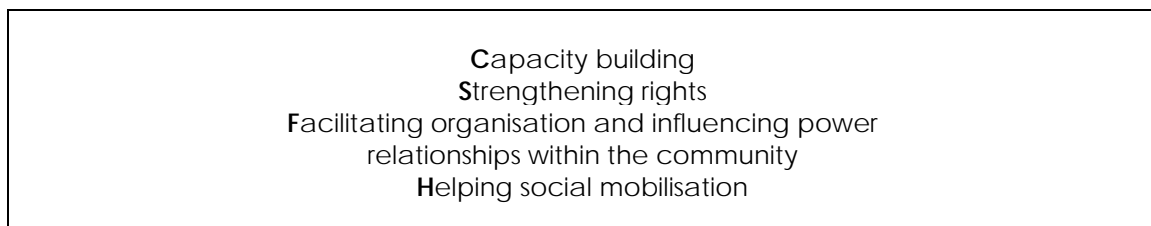
- Perceptions and priorities may differ.
- Imposing priorities on a community.
- Over-emphasis on professional approaches.
- Bureaucracies seldom "rock the boat".
- Groups reinforce the power of the dominant.
- Creating unrealistic expectations.
- Tokenistic involvement.
- Professionals are paid, but not communities.
- Sustaining participation.
- Training for empowerment.

STAGES OF PARTNERSHIP DEVELOPMENT (Slide 9.2.4)



It is often useful for the partner groups (communities and external actors) to meet separately to consider their involvement prior to meeting together. This is particularly important for communities, as the professionals have more power and influence.

STRATEGIES AND ACTIVITIES FOR INVOLVING COMMUNITIES IN AN EQUITY GAUGE (Slide 9.2.5)



9.3 INTEGRATING COMMUNITY EMPOWERMENT AND PARTICIPATION WITH THE OTHER TWO PILLARS

LINKS WITH THE OTHER PILLARS Plenary (Discussion 9.3.1)

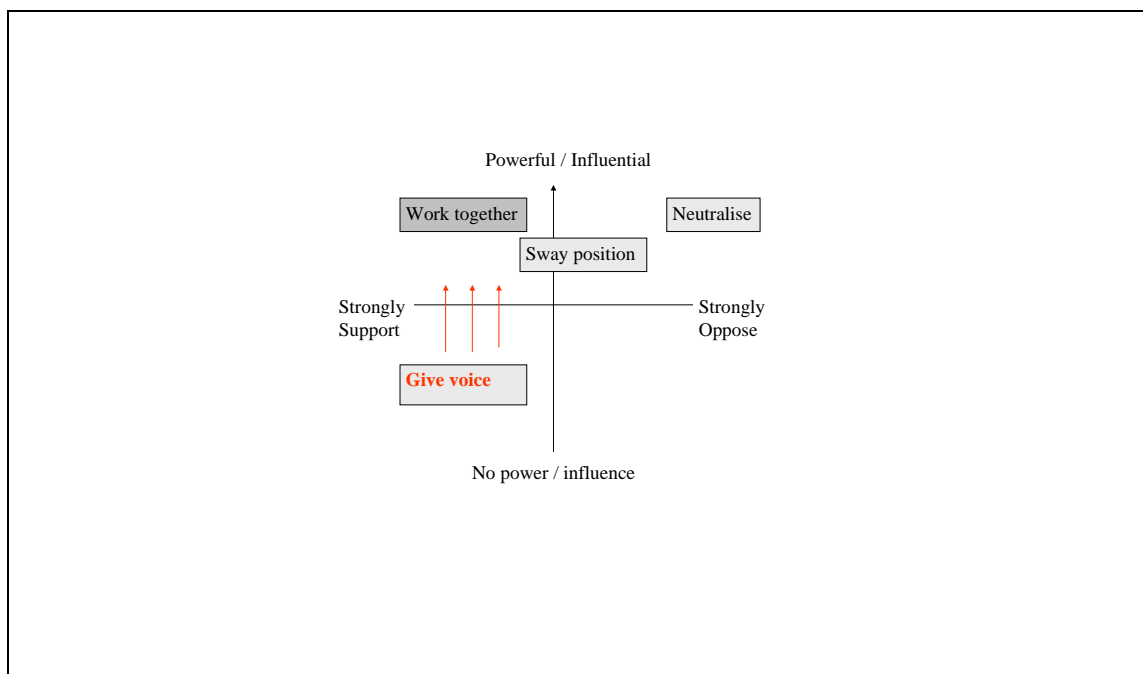
- Communities are valuable in assessment of the context, providing a picture of how they see it both problems and solutions.
- Data collection can be influenced by communities in terms of the nature and extent, the priorities, the way it is collected and the way it is disseminated
- Communities can be extremely effective at monitoring equity changes.
- Communities are powerful advocates. With information they are even more powerful.

It is important to evaluate the success of your community empowerment and participation activities. Indicators could include:

- The level of involvement.
- The nature and level of the interaction between community members and the equity team.
- The extent to which community members have influenced the choice of priorities for the Equity Gauge.
- The extent to which communities have taken independent action.

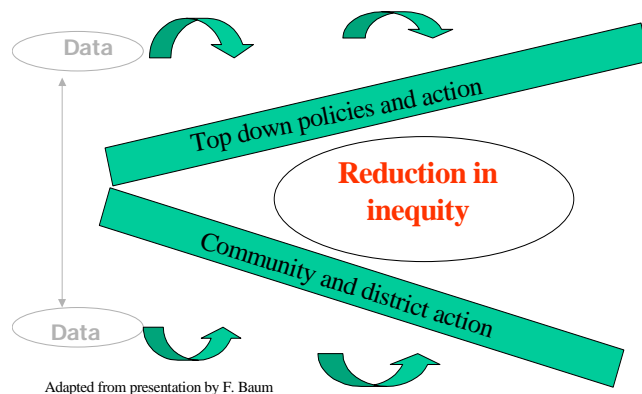
Slide 9.3.2 a-b THE POTENTIAL OF A STRONGER COMMUNITY

This matrix allows you to map partners, or potential stakeholders onto it, and to assess their level of power and influence.



This slide aims to highlight the value of the coming together of the three pillars. On the left are the data, influencing both the “top-down” stakeholders, that is managers and decision makers, and the “bottom up” stakeholders, the communities. This enables both groups to work together on shared evidence. The diagram is reminiscent of a nutcracker: together the stakeholders can crack the nut, or achieve their objectives.

A successful equity gauge campaign



CASE STUDY: CAPE TOWN EQUITY GAUGE - WORKING WITH THE KHAYELITSHA TASK TEAM

COMMUNITY CAPACITY BUILDING WITH KHAYELITSHA WATER AND SANITATION FORUM LED BY CAPE TOWN EQUITY GAUGE (Case Study 9.3.1)

- Building the Water and Sanitation Forum has been an important part of the Sanitation Programme.
- Capacity building has been an essential part of the process. Included is information about water and sanitation
- The Forum have an important strategic influence, as part of a multisectoral team with decision makers, that is, their role as advocates.
- The Forum is an elected body, part of the democratic structures in the community. This gives makes them, recognised, accountable and potentially influential.

PRIMARY READINGS FOR SECTION 9

McCoy, D. et al. (2003). *The Equity Gauge: Concepts, Principles and Guidelines*. Durban: GEGA & HST. [Online], Available: http://www.gega.org.za/download/gega_gauge.pdf//

Oakley, P. & Kahssay, H.M. & (1999). Ch 1 - Community Involvement in Health Development: An Overview. In Kahssay, H.M. & Oakley, P. *Community Involvement in Health Development; A Review of the Concept and Practice. Public Health in Action 5*. Geneva: WHO.

VeneKlasen, L. & Miller, V. (2002). Ch 3 - Power and Empowerment. In *A New Weave of Power, People & Politics: The Action Guide for Advocacy and Citizen Participation*. Oklahoma City: World Neighbors. [Online], Available: <http://www.justassociates.org/chapthreepower.pdf//>

SUGGESTED ADDITIONAL READINGS FOR SECTION 9

Werner, D. & Sanders, D. (1997). Ch 16 - Health Care, Empowerment and Social Change. In *Questioning the Solution: The Politics of Primary Health Care and Child Survival*. Palo Alto, CA: HealthWrights. [Online], Available:

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<http://www.worldbank.org/poverty/empowerment/sourcebook/draft2.pdf>

10 PLANNING ACTION FOR EQUITY

At this stage in the training, it is important to reflect on how you have experienced the training course as a whole. You may be asked to do this orally and as a questionnaire. Your feedback will be useful to adjust the training in future.

Some questions to reflect on:

- 1) Has the course made any impact on you? In what ways?
- 2) Did the sessions address equity sufficiently?
- 3) What do you think is the importance of integrating the pillars?
- 4) Did the course demonstrate sufficiently how this integration might take place?
- 5) Which aspects of the course worked best for you?
- 6) Which session/s worked best? Why?
- 7) Which sessions were the least successful? Why? Which aspects could have been improved and how?
- 8) What improvements do you recommend?

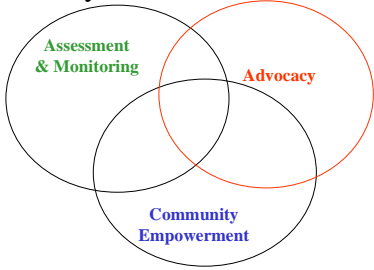
10.2 REFLECTING ON THE EQUITY GAUGE APPROACH

It will also be useful to consider whether you think the GEGA model will be helpful and whether it could enhance your work.

The Purpose of The Pillars

- Assessment and monitoring: to analyse, understand, measure and document inequities.
- Advocacy: to promote changes in policy, programmes and planning.
- Community empowerment: to support the role of poor and marginalised people as active participants in change rather than passive recipients of aid or help.

The location of the Equity Gauge is in fact at the intersection of the three spheres of action - where they come together as three overlapping circles. Collectively they are able to pressurise more forcefully for change, action and implementation.

<p style="text-align: center;">The 3 <i>Equity Gauge</i> pillars: in reality - interconnected action</p>  <p>The diagram consists of three overlapping circles. The top-left circle is green and labeled 'Assessment & Monitoring'. The top-right circle is red and labeled 'Advocacy'. The bottom circle is blue and labeled 'Community Empowerment'. All three circles overlap in a central region.</p>	<p>Questions for Discussion</p> <ol style="list-style-type: none"> Does the GEGA model have any limitations? Suggest ways that the GEGA approach be used in practice? Do you have any suggestions for how to better represent the approach in a diagram? Write on a card in two sentences whether you found the model helpful, and how it could enhance your work. Put these statements up on the wall.
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10.3 FUTURE APPLICATION OF THE APPROACH

You have now come to the final part of the course. You now have an opportunity to finalise your plans for when you return to your own region or country, using what you have gathered from the course. During section 6 (Developing An Equity Plan), you spent time selecting an equity issue or problem, assessing the context within which it is located, and choosing battles. In sections 7, 8 and 9, you explored an advocacy and a community empowerment process that could feed into your equity intervention. This final session gives you time to gather what you have learnt from the course and to develop initial action plans for your return to your Equity Gauges or similar programmes.

Instructions

In your group, develop an action plan based on your work thus far, which consolidates your plans. Be as practical and focused as possible. From this process, prepare a 10 minute presentation on your equity issue, using the Action Plan Template. Use newsprint.

It is not necessary for you to come up with all the answers at this stage. It is more important to address yourself to the sorts of issues that you will need to address when you return to your cities/countries.

Here is a set of questions which you could use in the course of your planning, many of which you have covered in section 6.

Background Information that you could discuss

- What is the equity issue and why has it been selected?
- Why is it an equity issue?

- c) Who would you work with to develop the intervention? How would you involve them?
- d) Which community organisations would be involved? How would you access them? How would you ensure that this is a relevant issue for them?
- e) What information is there already about this issue/area of work?
- f) What data exists to your knowledge, and what needs to be collected? Who would be involved in this process?
- g) If there are gaps in equity interpretation, how would you subject secondary data to an Equity Lens? What additional data analysis/collection would this involve?
- h) How would you disseminate the information? In what form?
- i) How would you ensure that the issue/area of work, and potential solutions and actions receive the attention of key decision makers in the community? This is your advocacy approach.
- j) How would you ensure that the issue, and potential solutions and actions reach the communities that are concerned? Who would you work with to achieve this?
- k) What training/capacity building is needed for:
 - the professionals you are working with?
 - the communities you are working with?
- l) How would you monitor and evaluate the study?

A suggested template for Action Plans is offered below.

Template for Action Plans

Choose the period for which you will be planning, e.g. 6 months, a year. It is probably only possible to plan one or two steps in each pillar of the Gauge at this stage and with limited time.

EQUITY ISSUE				
WHY IT IS AN EQUITY ISSUE				
EQUITY GAUGE PILLAR	WHAT?	WITH WHOM?	BY WHEN?	WITH WHAT RESOURCES?
ASSESSMENT & MONITORING ACTIONS				
ADVOCACY ACTIONS				
COMMUNITY EMPOWERMENT & PARTICIPATION ACTIONS				

11 COURSE READINGS AND ADDITIONAL READINGS OF INTEREST

These readings have been provided, and are set out in alphabetical order, by author or title in the absence of an author.

Braveman, P. & Tarimo, E. (2000). Social Inequalities in Health Within Countries: Not Only An Issue for Affluent Nations. *Social Science and Medicine*, 54: 1621-1635.

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Chapter 5: The Basics of Planning for Citizen-Centered Advocacy

Chapter 10: Mapping Advocacy Strategies

Chapter 13: Messages and Media: Educating and Persuading

Whitehead, M., Dahlgren, G. & Gilson, L. (2001). Developing the Policy Response to Inequities in Health: A Global Perspective. In T. Evans, M. Whitehead, F. Diderichsen, A. Bhuiya & M. Wirth (eds). In *Challenging Inequities in Health: From Ethics to Action*. [Online], Available: <http://www.rockfound.org/Documents/424/chapter21.pdf//>

ADDITIONAL READINGS OF INTEREST

These references are provided for you to follow up should you wish to do so.

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