Appendix 1

Process for choosing project officer informants

Criteria for project inclusion:

- health promotion project (equity or non equity)
- should be well advanced or recently finished
- considered to be good practice
- have some level of documentation such as project plan or report
- be funded from within Health Promotion Unit budget

1. The NSW Health Promotion Annual report 2000 is used as a pool for identifying the potential projects for the interviews
2. Project documentation to be forwarded to SESEAHS HPS.
3. Project team to assess projects against the criteria and make recommendation for inclusion, taking into account types of projects, location and numbers we have the capacity to interview.

4. Phone call to project officer to set up interview (phone or face to face)

Appendix 2

Interview schedule

Interview with project officers

Telephone call

Thank you for agreeing to take part in the consultation process for the Health Promotion Equity Project and for the information you forwarded on your project. The goal of the project is to improve the way health promotion units in NSW address and support actions to improve equity in health at a program and organisational level.

To allow for contribution from all levels of health promotion we are consulting with project officers and Health Promotion Directors. We appreciate your time, expertise and suggestions that will contribute to health promotion knowledge and practice in improving equity in health.

We would like to ask you some questions in relation to (*name of the project*). The interview will take about one hour. We will send you a copy of the interview questions before the interview date.

This call is to make time for the interview and find out your mail or e-mail address to forward the questions. When would it be convenient to meet with you?

Date: Time: Place:

Introduction on arrival

Thanks again for agreeing to take part in the consultation process for the Health Promotion Equity Project and for the information you forwarded on your project. As mentioned in our previous telephone conversation the interview will take about one hour. To help us with our note taking we would like your permission to tape this interview. Everything you say will remain confidential. Results of the interview will be presented in summary form only. From the analysis and presentation of the results it would not be possible to identify individuals. Do you agree with the interview being taped?

YES NO

We are happy to send you a copy of the summary interview. Would you like a copy of your interview summary?

YES NO

The results of the research will be documented in a report. Copies of this report will be sent to all areas Health Promotion Services/ Units.

Project officer:

Project title:

Questionnaire
(Mainstream project)

First, some questions about your project.
Questions 1-4 will be asked in brief to clarify project details. Prompts will be used as required.

1. Please describe your project in brief:
   If a written report/plan is available, prompts are not required.
   - Goal
   - Objectives
   - Target group (proportion of target group reached through the project)
   - Actions
   - Timeframe
   - Resources

2. What theories, models or recognised frameworks did you use to develop your project?

3. Who are your partners on this project?
   - What is your role in the partnership (leader, advocate, partner)?
   - How does the partnership work?

4. What have you done to ensure the sustainability of the project?
   Prompts:
   - *Management support/ commitment*
   - *Resources allocated*
   - *Integration into strategic plan*
   - *Workforce professional development*
   - *Dissemination/ communication strategies*

5. Can you describe aspects of the project that you think are particularly successful or innovative?

6. Which aspects of your project could be improved?

Now, we would like to ask questions directly relating to equity.

7. The broad definition we are using to describe equity approaches in health promotion is “active policy decisions and programatic actions directed at improving equity in health or in reducing or eliminating inequalities in health”.
   - Would you like to make any comments on this?

8. If you were to actively consider equity in your project, what would you do differently?
   Prompt: ‘Good Practice Model’

9. Given the changes you have suggested, how do you think your role would change?
   Prompt: leading role, partner, and advocate

10. What support would you require from your manager/organisation to actively focus on equity within your project?
    Prompts:
    - *Resources*
    - *Professional development*
    - *Management/ organisational support (policy/ protocols)*
    - *Leadership from management*

11. If you were going to actively address equity in your project, what would be relevant process and outcomes measures?

12. Can you see any particular barriers for an increased focus on equity within your work?
    - Within your organisation
    - Outside

13. In your opinion what are the key characteristics of good quality equity focused health promotion projects?

14. Any other comments?

Questionnaire
(Equity-based projects)

Questions 1 - 5 will be asked in brief to clarify project details. Prompts will be used as required.

Please describe your project in brief:
  If a written report/plan is available, prompts are not required.
  - Goal
  - Objectives
  - Actions
  - Target group (proportion of target group reached through the project)
  - Time-frame
  - Resources (funds, staffing)

2. Did you use any theories, models or recognised frameworks to develop your project?

3. Are you working with partners on this project? If 'YES':
   - Who are your partners?
   - What is your/your organisation's role in the partnership (leader, advocate, partner)?
   - How does the partnership work?

4. What role do you or your Unit play in the project? Is it a leading role, as a partner or as an advocate?

5. What have you done to ensure the sustainability of the project?
   Prompts:
   - *Management support/ commitment*
   - *Resources allocated*
   - *Integration into strategic plan*
   - *Workforce professional development*
   - *Communication strategies*
   - *Link with larger or parallel initiatives*

6. Can you describe aspects of the project that you think are particularly successful or innovative?

7. Has the project been implemented as originally planned or was it modified? If so, why? What were the changes made?

8. Which aspects of your project could be improved?

9. What did you do to disseminate results of your project?

10. Can you describe the equity outcomes of the project?
    Prompts:
    - *Infrastructure/ service in place*
    - *Proportion of target group reached*
    - *Development of relationships*
    - *Support/involvement of target group*
    - *Issue raised and lobbied*

11. How do you intend to measure equity-related process and outcomes in your project?

12. What additional support would you require from your manager/ organisation to continue to work on equity issues?
    Prompts:
    - *Resources*
    - *Professional development*
    - *Management/organisational support*
    - *Leadership of management*

13. What barriers have you encountered during the project?
    - Within your organisation
    - Outside

14. What are the most important lessons you have learnt through your experience with equity-based health promotion work?

15. In your opinion what are key characteristics of good quality equity-based health promotion projects?

16. Any other comments?

Appendix 3
Four Steps Towards Equity: a tool for health promotion practice

Four Steps Towards Equity

A Tool for Health Promotion Practice

An initiative of the NSW Health Promotion Director's Forum

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Four Steps was written by the Equity Project team (Health Promotion Service, South East Health).

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Introduction

This tool was developed as a part of the NSW Health Promotion Directors Equity Project. The overall goal of the project was to improve the way health promotion in NSW addresses and supports equity based health promotion action at the local and state level. The tool was specifically written for health promotion practitioners though would be relevant to other population services that have an interest in equity or work with marginalised groups (eg Aboriginal people, prisoners, refugees, homeless people, people with mental illness).

The *Four Steps* tool is based on the project research findings (interviews and consultations with health promotion and population services workers and managers) and existing well-regarded models and frameworks of good health promotion practice such as the Program Management Guidelines and the Capacity Building Framework.[1,2] A range of Australian and overseas publications on planning, equity in health, community development, partnership work, sustainability and organisational capacity have also contributed to the tool development.[3-14]

Aim and overview of the tool

The aim of ***Four Steps*** is to provide a series of questions and prompts to challenge and assist practitioners and managers to consider and integrate equity into their core work practice, rather than as an additional area of work. It is not prescriptive, nor is it intended to be used as a checklist.

The tool has the following components:

- **Equity in health principles** (step 1). This section gives general information about equity in health and why it is an important issue to address. It may be most helpful for those new to equity work.

- **Organisational capacity to support effective equity work** (step 2). This section identifies the elements necessary for an organisation to effectively support equity practice. This needs to be considered when initiating equity related work or may be used to assess areas for further organisational development.

- **Equity strategies in the planning cycle** (step 3). This section will assist practitioners to consider the components essential to equity practice at all stages of the planning cycle. This can be used in the planning stage or may provide ideas when reviewing existing initiatives.

The tool is also supported by the:

- **NSW Health equity and health website** (step 4). This website has been developed by the project team and provides more detailed information on equity including the policy context for equity work in NSW, case studies, reports, references and links to other resources and tools.

How to use this tool

Step 1: Read the information on equity principles
Step 2: Consider the questions related to organisational capacity then check the bullet points for more ideas
Step 3: Consider the questions related to the planning cycle then check the bullet points for more ideas

Step 4: Go to the equity web site for case studies, references, tools and links.

Step 1: Equity in Health Principles

This step is designed to give an overview of the principles of equity in health, why it is important and how prevention services can respond. The following pages aim to draw together a range of evidence and perspectives on equity in health to stimulate your thinking about equity and your work practice.

What is equity in health?

Equity in health is an integral part of health promotion (Ottawa Charter)[15] and a core value of NSW Health.[16]

"Equity in health is not about eliminating all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating equal opportunities for health and with bringing health differentials down to the lowest levels possible."[6]

Equity and equality and their antonyms inequity and inequality are terms often used interchangeably to refer to similarities or differences in measures between groups. However, there are subtle and important differences between them. Inequality (equality) is a descriptive form of the observed differences. It makes no intrinsic judgement about the differences between groups. For example, differences in health status due to biological factors or natural variations such as age, ethnicity, or genetics that are thought to be unavoidable.

Inequity (equity) refers to differences that are considered unfair or unjust, are largely due to factors beyond the individual's control and usually avoidable. Inequity has connotations of injustice related to morals and ethics. Examples include differences in health status between people of different social or economic status.[14]

Why reduce health inequities?

This section has been adapted from the article by Woodward A, Kawachi I, 2000[17] and informed by others as referenced.

1. Inequities are unfair

There is consistent evidence that economic and social factors affect health. People who are most disadvantaged tend to die younger, have more chronic illness, experience more risk factors and use preventive health services less than those who are most advantaged.[18] Differences in health are not just apparent between the most and least advantaged but show a gradient across all social groups.[13,16,19] Inequities become "unfair" when poor health is itself the consequence of an unjust distribution of the underlying social determinants of health (for example, unequal opportunities in education or employment). Health in many instances is more than a matter of personal choice: the decisions that people make about health are shaped by the environment in which they are conceived, raised and live their adult lives. Children from disadvantaged backgrounds are more likely to have poor health in adult life.[20]

2. Inequities affect everyone

It has been proposed that wide differentials in income promote exclusion, lower thresholds for risk and violence, and weaken the social connections that make for

healthy communities.[13] Interventions to reduce inequities by improving the health of the most disadvantaged will benefit all members of society. Some types of health inequities have obvious follow on effects on the rest of society, for example the consequences of alcohol and drug misuse, or the occurrence of violence and crime. Work to reduce the underlying economic and social inequities can limit the follow on effects for the whole of society.

The social and physical environment also influences behaviour by shaping norms, enforcing patterns of social control (for example drink driving), providing or not providing environmental opportunities to engage in certain behaviours, and reducing or producing stress for which certain behaviours may be an effective coping strategy.[21]

3. Inequities are avoidable

Inequities are not a natural outcome of a wealthy and economically expanding society. Those countries that successfully support disadvantaged groups (such as Denmark and Norway) have achieved economic growth, a more harmonious society and better health across the population.[13,17] Economic inequities are not accidental, they result from decisions made by society on issues such as tax policy, home ownership, business regulation, welfare benefits and health care funding.

Inequities in health can be reduced without diminishing the health of the population overall. Universal public health interventions such as sanitation reforms, fluoridation of water, better quality housing, enhanced food security, better roads and seat belt laws improve the health status of the whole population. However, there is a need to continue to invest in targeted interventions for disadvantaged groups. Such programs may also benefit the broader community (for example a Women's Health Service established to cater for the needs of disadvantaged women, can also provide a valuable service for all women).

4. Some health promotion strategies increase inequities

Inequities in life expectancy have remained unchanged, or in some cases increased, in recent decades in many countries. Some public health efforts targeted at individual lifestyle change may have actually worsened health disparities (for example stand-alone media campaigns). If the affluent adopt healthier lifestyles faster than the less well off, the net result of individually targeted interventions is increased disparity in outcomes.[17]

'The reduction of health inequities has a special moral urgency'[22] and as part of its ethical stance health promotion should take steps to play an active role in addressing it. It is necessary for health promotion to take action to improve the health of all people, particularly the disadvantaged, to reduce the increasing gap in health status.

How do values influence work practice?

Our personal and professional values, underlying beliefs and ethics and the organisational culture within which we work make up the foundation of our work practice decisions.

A range of factors including background, education and life experience shape our personal values. Professional values are usually compatible with societal values and assume a consensus within the profession. However, within health promotion in NSW there is no consensus that equity is a core value or an area for action. Although some practitioners and managers feel that equity should be a principle of all health promotion work, concerns have been expressed that health promotion imposes middle class

values, does not take risks and accepts easier middle class targets and results.[23] A recent critique also reinforced that middle class values underpin contemporary health promotion and public health practice in Australia.[24]

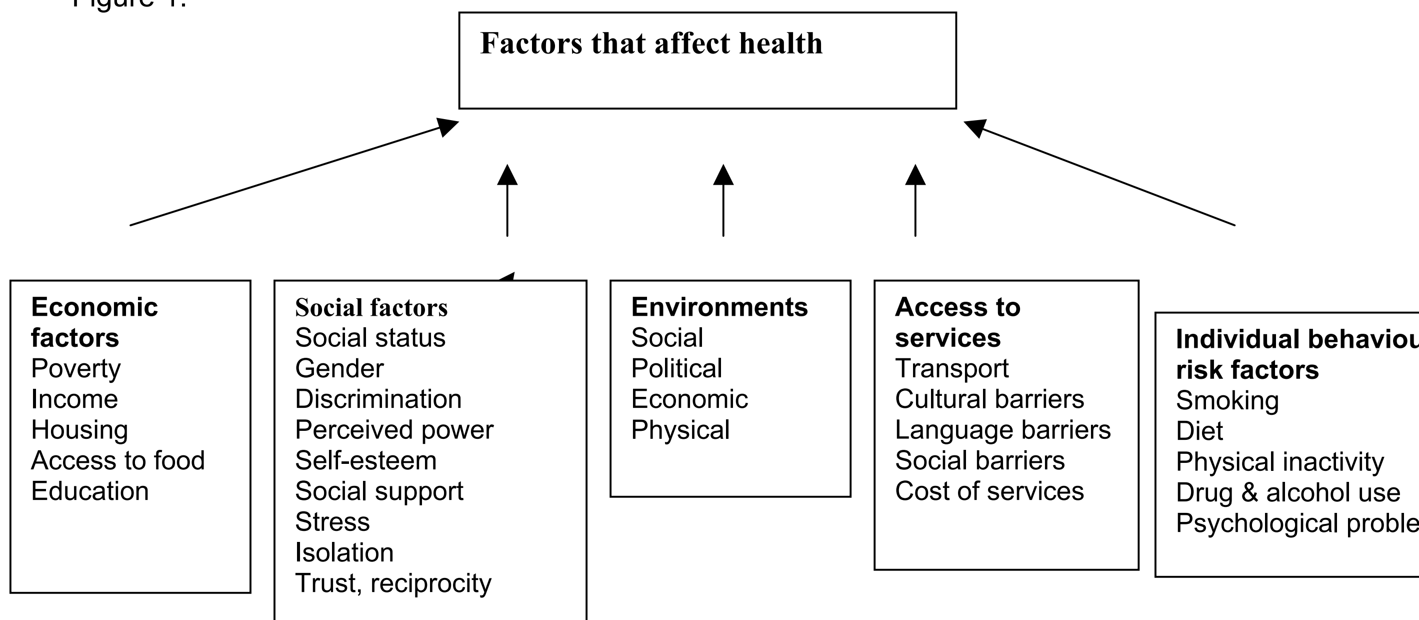
Organisational values very often reflect the broader political agenda and although there is rhetoric around equity in health there is a perception that equity is a low priority with low commitment, which makes it easier for organisations to avoid the issue.[23]

What factors affect health?

Health extends beyond the physical to include the mental, emotional, spiritual and social aspects of health. It is affected by a complex interrelationship of multiple factors that work synergistically on individual, community and societal levels.

Factors that contribute to differences in health between people include: **economic factors** like poverty, income and education; **social factors** including social status, gender, control over life choices, insecurity, discrimination, stress, social cohesion/support, social isolation; **access to** health and other services; social, political, economic and physical **environments**; and individual **health related behaviour** (Figure 1). While poor social and economic circumstances affect health throughout life, there is growing evidence that early childhood experience has a particularly important influence on future health.[16,20]

Figure 1.



(Adapted from CHETRE Newsletter, April 2000)[8]

How can prevention programs address equity in health?

Programs to improve health need to respond to people with different needs in different ways and include a mix of universal strategies (access to a full range of quality services and programs for all people and communities) and targeted programs for those who are vulnerable. Universal strategies are important for improving the health status of the population overall, whilst targeted strategies aim to reduce the gap in health status by

focusing on improving the health and well being of people who are disadvantaged.[25] Within universal programs, there is a place for additional targeted strategies to enhance program effectiveness for disadvantaged groups, for example availability of a language specific quit line for smoking cessation, but this should not replace targeted programs.

Universal prevention strategies often relate to individual risk factor behaviours, the physical environment and health services. Examples include media campaigns to encourage smokers to quit, legislation for smoke free environments and quit smoking advice through general practice.

Interventions that are targeted to address the needs of disadvantaged groups usually give more attention to the social determinants of health (economic, social and environmental factors and access to services). Examples include subsidised nicotine replacement, inclusion of cultural norms in tailored communication messages and promoting access to and appropriateness of available services.

For people who are most vulnerable or those with complex needs, the most immediate need is to focus on those issues that are most relevant to their lives such as economic and social factors. For example, newly arrived refugees need assistance for housing, learning English, income support, establishing social networks and access to appropriate health services, which will require the integration of health and other agencies. Individual risk factor behaviour such as smoking is likely to be a low priority for them at this point in time.

More holistic approaches to improve health equity within communities focus on strengthening the economic, social, educational, physical and cultural aspects of a community. **Community development and community building** initiatives are often resident driven and develop the strengths, assets and capacities of communities rather than primarily focusing on problems and deficiencies.[26] These approaches often occur over a relatively long period of time, in partnership with government and non-government organisations and lead to sustainable outcomes.

What strategies or approaches are particularly relevant to equity work?

Equity work requires the same focused approach to planning, implementation and evaluation as other population health initiatives. All population health programs should respond to the needs of communities in ways that make sense in the local context. However, using developmental approaches such as action research to inform program design and testing feasibility of strategies is particularly important in equity work, as is the need for flexible practice, adequate resources and longer time frames.

Consistent with good practice, equity work should use a range of strategies and approaches, as outlined in the Ottawa Charter for Health Promotion.[15] However in equity work, some strategies may require a greater emphasis and should take into account the broad range of social, economic and environmental factors that affect health and not just focus on behavioural change.

More meaningful **community participation** using a range of methods (such as consultation, consumer reference groups or panels, skill development, project related employment, ‘phone ins’ and committee or board membership) is required. The community’s ownership and involvement at all stages of work can help work towards community empowerment and program sustainability. Community capacity building or **community development** approaches may also feature more strongly in equity work.

Advocacy strategies such as building broader commitment to address community identified needs, arguing for new or different services, or supporting and resourcing a community's need or desire to speak out on issues can also be an important part of programs to address inequity.

Strategies that influence the **physical or social environment** are likely to affect the population more evenly than educational programs aimed at individual behaviour change and have greater potential to reduce health inequities. **Communication** that is tailored to people's literacy and interests can be an effective way to raise interest in and awareness of issues.

Internal **organisational approaches** also feature strongly in equity work. Strategies to develop the capacity of an organisation to address inequity can be a powerful way to positively influence the health of disadvantaged communities. '**Capacity building** outcomes can take the form of changes in commitment, skills, structures and actions. There are examples of where the impact of the project is on the awareness, knowledge and practices of other professionals, such as local government and health services, General Practitioners, or senior managers.'[27]

Another characteristic of equity work is working in partnership with other organisations and working to improve interagency coordination. This can lead to a stronger awareness of the social dynamics affecting disadvantaged people and can encourage a shift from an emphasis on risk factors. Partner organisations can also be an access point to the community, which can assist health workers to build trust, act as facilitators, advocates or educators and gain a broader reach within the community. In the longer term, partnerships can create the opportunity for better understanding of the determinants of disadvantage and appropriately set a health-related agenda within the broader concerns of the focus population. Such partnerships may result not only in direct health-related outcomes such as changes in knowledge and behaviour, but in changes in the capacity of the partner organisations and individuals involved.

Step 1 – summary points

- equity is about fairness and affects the whole of society
- health inequity is avoidable and health promotion has a tangible role to play
- social determinants should be considered when addressing equity
- personal, professional and organisational values influence practice and need to be considered
- health promotion practice needs to change if it is to reduce health inequity
- equity work requires adequate timing and resources
- equity work requires specific strategies mainly: community participation, community development, advocacy, environmental change, capacity building and partnerships.

Step 2: Organisational Support for Equity

This step is designed to help you consider your organisation's ability to effectively support work to reduce health inequities. In this context, 'organisation' relates to both the team and department in which you work as well as the Area Health Service more generally.

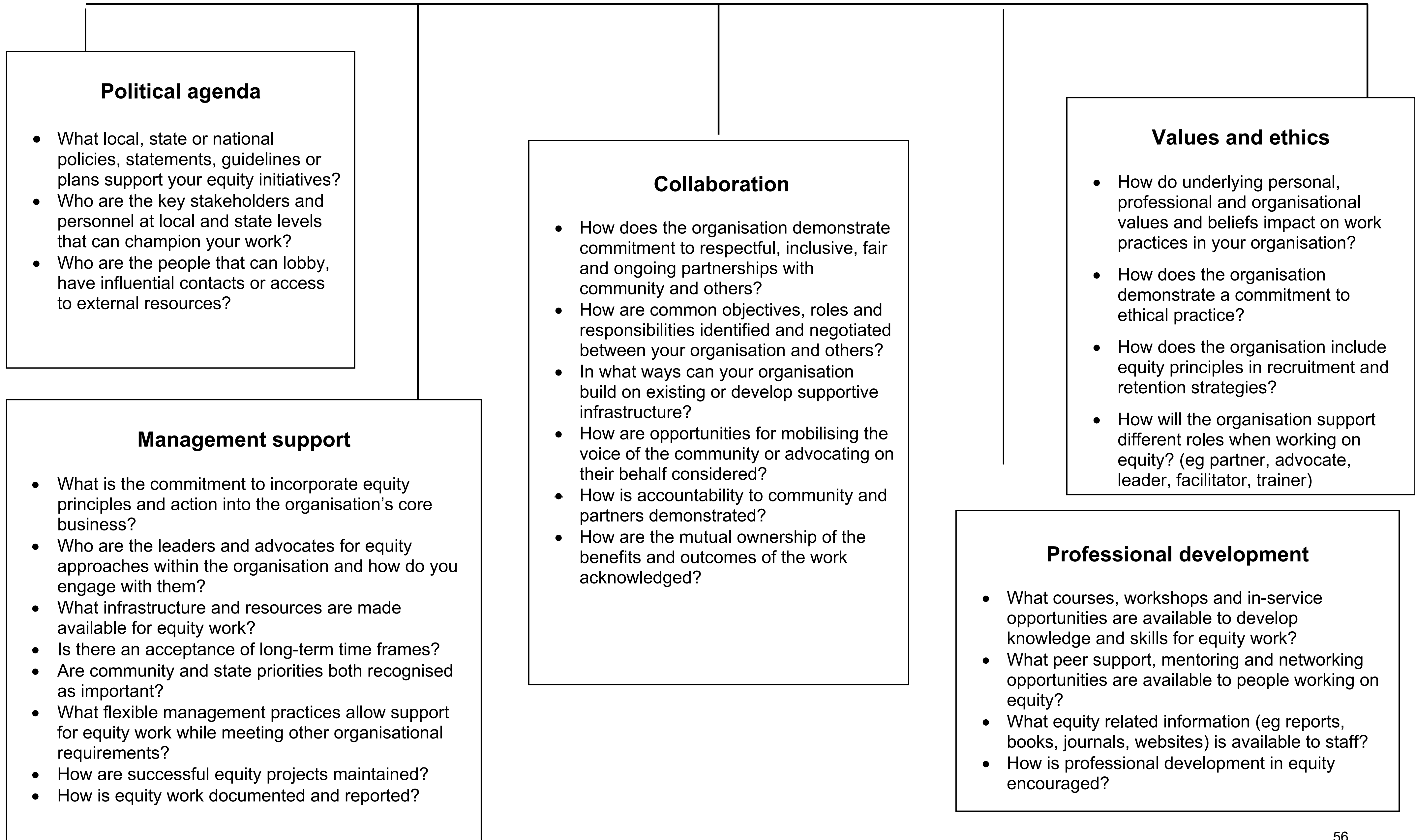
To get you started there is a series of broad questions that relate to organisational support.
Figure 2 then provides more detailed prompts to guide your thinking.

After you have answered the questions and subsequent prompts, you should consider what this means in terms of organisational support for equity work. It may become apparent that additional attention is needed to strengthen support for equity approaches within your team, department or Area. For example, if there is little commitment to equity principles you may consider an advocacy strategy to build support, or if there are few local professional development opportunities you may decide to work with others to fill this gap.

Questions related to organisational support for work on equity

- How do current state and local agendas support work on equity?
- In what ways does your organisation provide management support for local work on equity?
- How does your organisation demonstrate the required skills and commitment to work collaboratively with communities and other organisations?
- How do individual and organisational values and ethics at your workplace influence readiness to work on equity issues?
- What are the professional development opportunities for people to further develop knowledge and skills for equity work and are these opportunities taken up?

Figure 2: Organisational support for equity



Step 3: Issues Related to the Planning Cycle

This step is designed to assist in the planning of equity-based interventions. To get you started there is a series of broad questions that relate to aspects of the planning cycle. Figure 3 then provides more detailed prompts to guide your thinking. Be critical when answering these questions and avoid the temptation to respond positively without due consideration.

After you have answered the questions and subsequent prompts, you should consider whether there are aspects of your intervention where you can incorporate stronger equity dimensions. For example, if the planning stage only addresses demographic and health status data, you should consider including stronger community focused information, or if planned strategies predominantly take an educational approach other approaches such as community development or environmental change should be included.

To be more comprehensive in incorporating equity into your work, consider as many bullet points as possible, and if necessary prioritise those aspects that are particularly relevant to the needs of your intervention.

Questions related to the planning cycle

- In what ways will the focus population be involved in all aspects of the work?
- How will equity principles been incorporated into the planning stage?
- What factors that affect the community (eg social, economic, environmental, service access, behaviour) will be addressed? (See Figure 1)
- Are the strategies, resources and time frame appropriate to the goal?
- How do you plan to assess progress and the range of anticipated outcomes?
- What communication strategies will you use to provide ongoing updates to the focus population and partners and ensure that their feedback is considered and incorporated?
- How will the project show ongoing benefits for participants and maintain community and partner commitment?
- How do you plan to disseminate the successful strategies?

Figure 3: Integrating equity strategies into the planning cycle

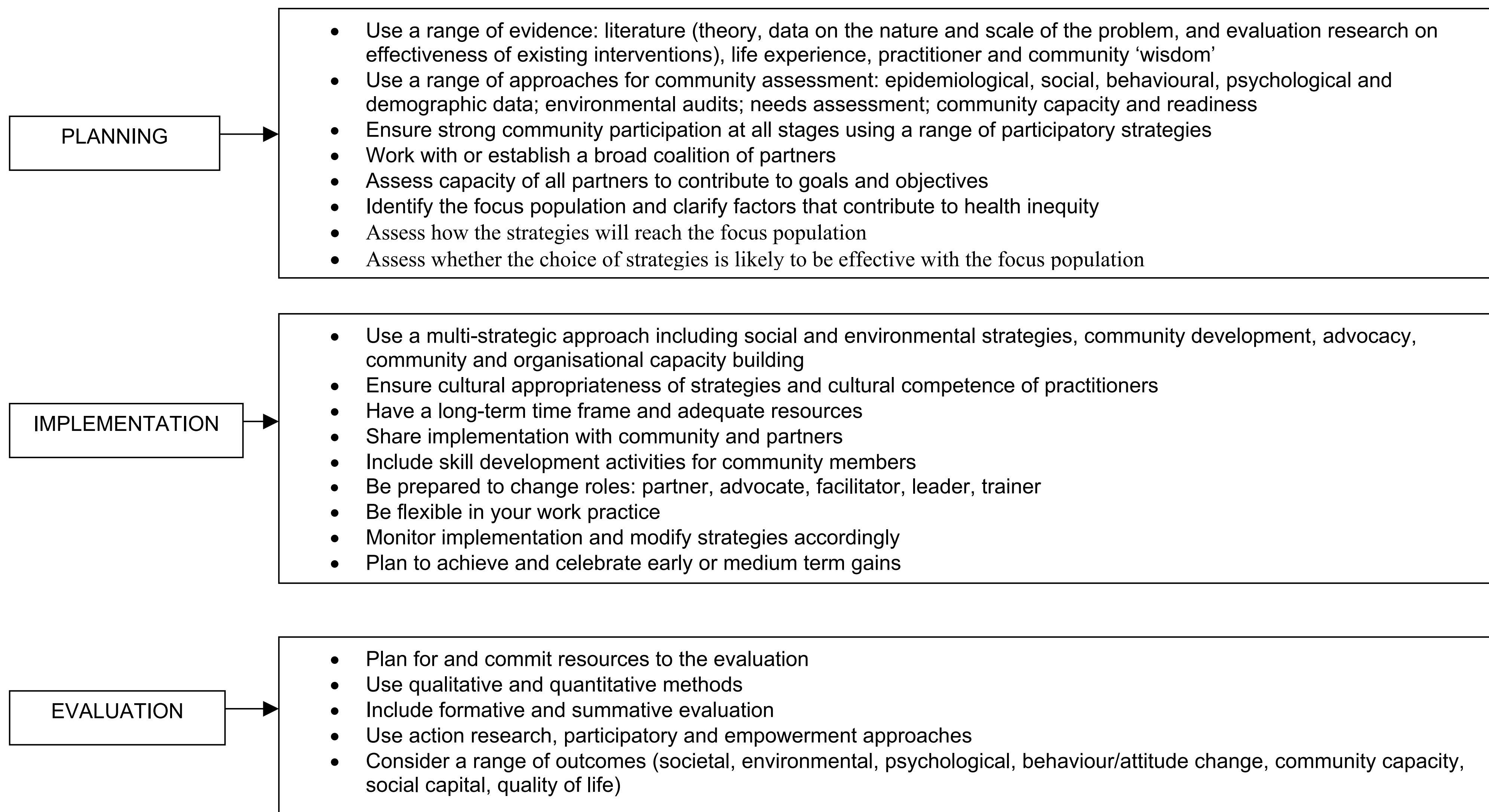
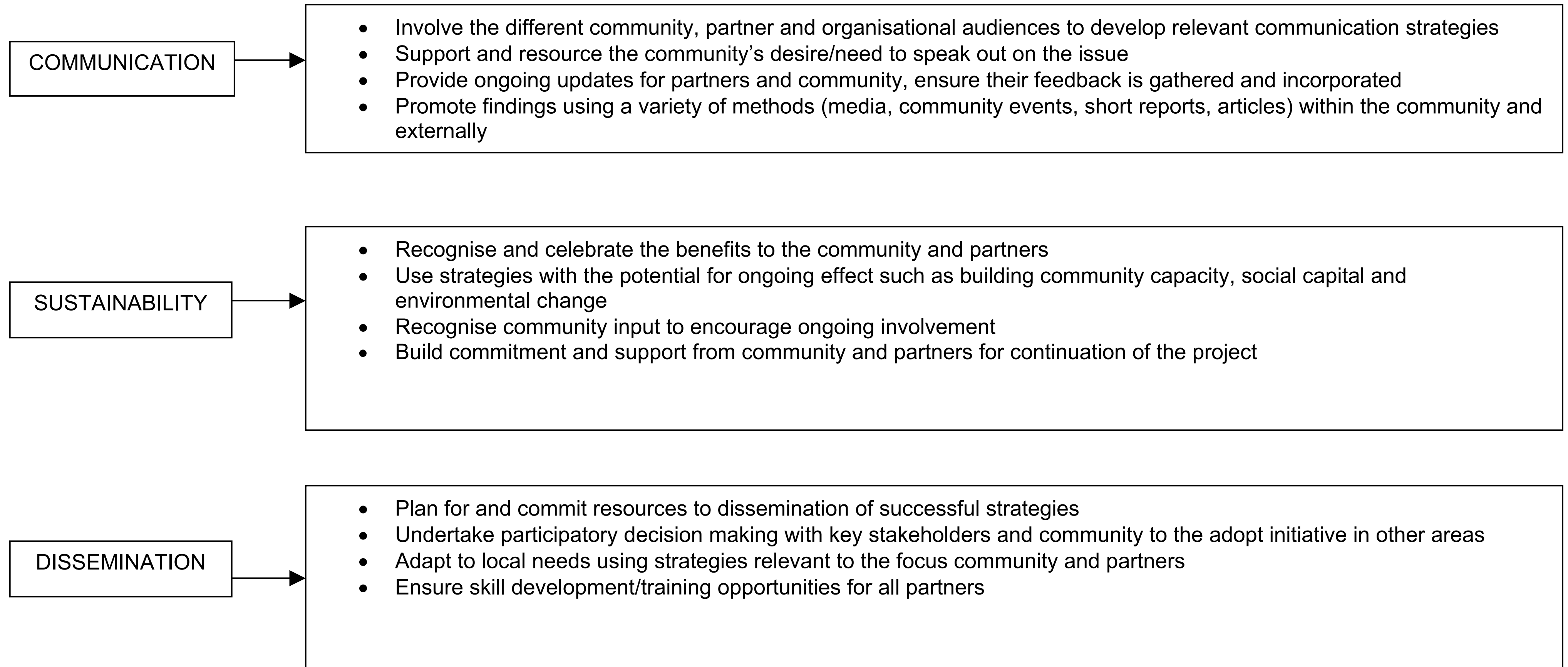


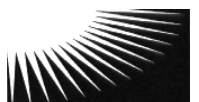
Figure 3 (cont'd)



Step Four: Website

This step is designed to lead you to the NSW Health equity intranet site (which in the short term only available to NSW Health and Area Health Service employees). The address is: http://internal.health.nsw.gov.au and follow the prompts to public health, health promotion, equity and health.

The website provides more detailed information on equity including the policy context for equity work in NSW, case studies, reports, references and links to other resources and tools.



Glossary of terms

Action research is a family of research methodologies, which pursue action (or change) and research (or understanding) at the same time. It does this by using a cyclic process, which alternates between action and critical reflection and in the later cycles, continuously refining methods, data and interpretation in the light of the understanding developed in the earlier cycles.

Community and practitioner wisdom is the life experience and skills inherent within a community or health practitioner.

Community capacity is the characteristics of communities that affect their ability to identify, mobilise, and address social and public health problems; and the cultivation and use of transferable knowledge, skills, systems, and resources that affect positive change for communities and individuals.

Cultural competence refers to the professional characteristics, which allow an individual, organisation or system to respond with respect and professionalism to all individuals.

Determinants of health are the range of personal, social, economic and environmental factors that influence the health of individuals or populations.

Disadvantage is a pattern of limitation of life opportunities in health or in social or economic well-being.

Empowerment evaluation is the use of evaluation concepts and techniques to foster self-improvement and self-determination. The focus is on helping people help themselves.

Equality means equal shares for everyone regardless of need.

Equity in health care is equal access to available care for equal need, equal utilisation for equal need, and equal quality of care for all.

Equity (policy and actions) are active policy decisions and programmatic actions directed at improving equity in health or in reducing or eliminating inequalities in health.

Ethical practice includes the rules, morals and standards that guide the work you do.

Formative evaluation is conducted during the course of program implementation to provide information to improve the program.

Gender refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our biological differences.

Gradient in health status is the continuous, gradual slope across socio-economic groups. The lowest socio-economic group have the poorest health, the second lowest slightly better health and so on with the highest socio-economic group having the best health.

Health does not just mean physical well-being of the individual but refers to the social, emotional, and cultural well-being of individuals and communities.

Inequality is a descriptive form of observed differences that are unavoidable, like differences in health due to age, sex or genetics.

Inequity is a difference that is unnecessary and avoidable and considered unfair and unjust.

Low income is defined in relative terms and is based on the percentage of income that individuals and families spend on the basic needs of food, clothing and shelter in comparison with other Australians. A low-income family spends the greatest percentage on basic needs.

Marginal groups *are social groups excluded from the dominant culture or society due to political reasons (for example refugees, Aboriginal people), low, irregular or uncertain incomes, family environment, health or imprisonment.*

Participatory research is defined as systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action or effecting change.

Poverty refers to those who are exposed to absolute material deprivation involving the failure to meet basic life needs such as shelter, food and clothing.

Social capital is an emerging concept that is still being defined. It relates to sociability, reciprocity and equal relationships in communities and trust on three levels: between friends and family, of strangers and of government. It is a safety, connection and belonging to the community, along with strong emotional support networks among family and community.

Social cohesion occurs when a community has the ability to work together and support each other.

Social exclusion is a dynamic and multidimensional process. It is linked not only to unemployment or low income, but also to housing conditions, level of education and opportunities, discrimination and exclusion in the local community.

Summative evaluation is conducted at the end of a program (or of a phase of the program) to determine the extent to which anticipated outcomes were produced.

Targeted strategies are programs and services that tackle health needs of individuals and communities whose health may be most vulnerable to make sure that the services and programs offered are accessed and appropriate for their needs. Targeted programs are important in reducing the gap in health status between groups.

Universal approaches in service delivery ensure that every one has access to the full range of high quality services and programs. Universal approaches are important for maintaining or improving the health of the population overall.

Vulnerability is the increased susceptibility to adverse health events that may be experienced through chronic health problems (such as mental illness or diabetes), in times of life transitions (such as adolescence or widowhood) or exposure to adverse social, economic or physical environments (such as discrimination).

Wellbeing is a subjective assessment of health, which is less concerned with biological function than with feelings such as self-esteem, and a sense of belonging through social integration. Wellbeing has much to do with achieving human potential physically, emotionally and socially.

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