



ADVOCACY FOR HEALTH EQUITY: Case studies synthesis report

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Introduction

Five advocacy case studies were carried out within the DRIVERS project. They number among a total of 19 case studies carried out in DRIVERS¹, and build on and (to some extent) test the findings of work on advocacy for health equity.

The case studies were conducted by the National Institute for Health and Welfare (THL) in Finland, Blackburn with Darwen Council in England, the Institute of Preventive Medicine, Environmental & Occupational Health (PROLEPSIS) in Greece, the Institute for Healthcare Improvement (CBO) in the Netherlands, and Public Health Wales (PHW). They were individually and collectively co-ordinated by EuroHealthNet in Belgium, with individual reports being produced by each one.

This report provides a short overview of DRIVERS's work on advocacy, including the analytic framework, and a summary of the aims and specific tasks and activities. It then explains the role of the case studies within this work. Using the individual summary and full reports produced by the organisations concerned, it presents the findings of the individual case studies and a synthesis of the findings of the advocacy case studies as a whole. A discussion section draws out commonalities and divergences compared to the wider advocacy workstrand.

There are two annexes. The first provides a list of the individual advocacy case study reports, which can be used to obtain a much fuller account of case studies. The second provides a summary of the findings of the literature review.

None of the work would have been possible without the valued co-operation, insights and hard work of the organisations concerned.

¹ The other case studies concentrated on interventions and practice in early childhood development, employment & working conditions, and income & social protection. For more details see <http://health-gradient.eu/case-studies/>.

1. Overview

a. Advocacy for health equity

Reducing health inequalities and moving towards health equity requires concerted action on the social determinants of health (SDH). Despite a wealth of evidence showing associations between the SDH and health inequalities, policy action has so far been limited and has failed to reduce many inequalities in health².

Advocacy has been identified as a key means of promoting favourable policy change³, but evidence on how to do so effectively (i.e. making efforts that are likely to lead to success) is dispersed or even missing, and advocates have no single body of knowledge to support them. Advocacy for health equity is therefore an important area to develop further, to ensure that policies and programmes make better use of evidence and work towards the aim of health equity.

We define advocacy for health equity as “a deliberate attempt to influence decision makers and other stakeholders to support or implement policies that contribute to improving health equity using evidence”. By evidence, we mean knowledge derived from qualitative and quantitative research and intended to be used to support a conclusion.

The DRIVERS' work strand on advocacy aimed to:

- Synthesise existing knowledge and develop an evidence base;
- Build upon existing knowledge;
- Carry out case studies across Europe to enrich the evidence base;
- Develop materials to support advocacy for health equity.

b. The six dimensions of advocacy for health equity

Partners involved in the DRIVERS advocacy work package met in May of 2013 to discuss the main elements of advocacy for health equity. The result, following iterative development through early tasks (see Table 1), was the six main 'dimensions' of advocacy for health equity (Fig. 1).

These dimensions are meant to be heuristic. By this, we mean that they provide a tool for breaking down the complexity of advocacy into understandable and discrete elements, and to help learn from contextually specific advocacy efforts and different kinds of types of evidence. The six dimensions therefore provided the analytic framework for all the work within WP5.

² See: 1) European Commission. *Health inequalities in the EU - Final report of a consortium. Consortium lead: Sir Michael Marmot.* 2013. Available at:

http://ec.europa.eu/health/social_determinants/docs/healthinequalitiesineu_2013_en.pdf. 2) WHO Regional Office for Europe. *Review of social determinants and the health divide in the WHO European Region: final report.* 2013. Available at: <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report>. 3) Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P. WHO European review of social determinants of health and the health divide. *Lancet*. 2012;380(9846):1011-1029.

³ Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health.* 2008. Available at: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf.



Fig. 1 – The six dimensions of Advocacy for Health Equity

c. Activities undertaken

A number of complementary activities were conducted (Table 1), with earlier activities providing the building blocks for later ones (Fig. 2).

Advocacy partner meeting (May 2013)	Meeting to discuss a work plan, and to discuss and develop the six main dimensions of advocacy for health equity.
Discussion paper & expert workshop (Jul 2013) ⁴	A paper was written based on emergent findings of the literature review. This formed the basis for discussion at an expert workshop attended by 20 advocacy experts from across Europe. Data gathered provided direct input into later work and helped shape subsequent tasks.
Advocacy mapping exercise (May 2013 – Aug 2014) ⁵	A ‘map’ of legislation and interlocutors for advocating at the EU level was prepared by partners, supplemented by additional local-level mapping exercises. This information feeds directly into the Advocacy Toolkit and is meant to help potential advocates identify and make use of organisational and legislative opportunities to advocate.
Literature review (Feb 2013 – Aug 2014) ⁶	A systematic review of the academic and grey literature. Literature was analysed using the six dimensions and synthesised using qualitative synthesis methodology.
Case studies (Sep 2013 – Aug 2014)	Five case studies across Europe, building on the earlier findings of the work package, and again using the six dimensions as a guiding and analytical framework.
Interviews (May 2014 – Aug 2014) ⁷	Interviews with experts, feeding directly into the toolkit.

The relationship between these different activities can be illustrated, as below:

⁴ The results of this workshop were compiled into an internal report, available upon request.

⁵ This mapping document is reproduced in full in the Advocacy Deliverable (D5.1); this document is available upon request.

⁶ This review has been submitted for publication in a peer-review journal.

⁷ These interviews are also reproduced in the Advocacy Deliverable (D5.1) produced for the project.

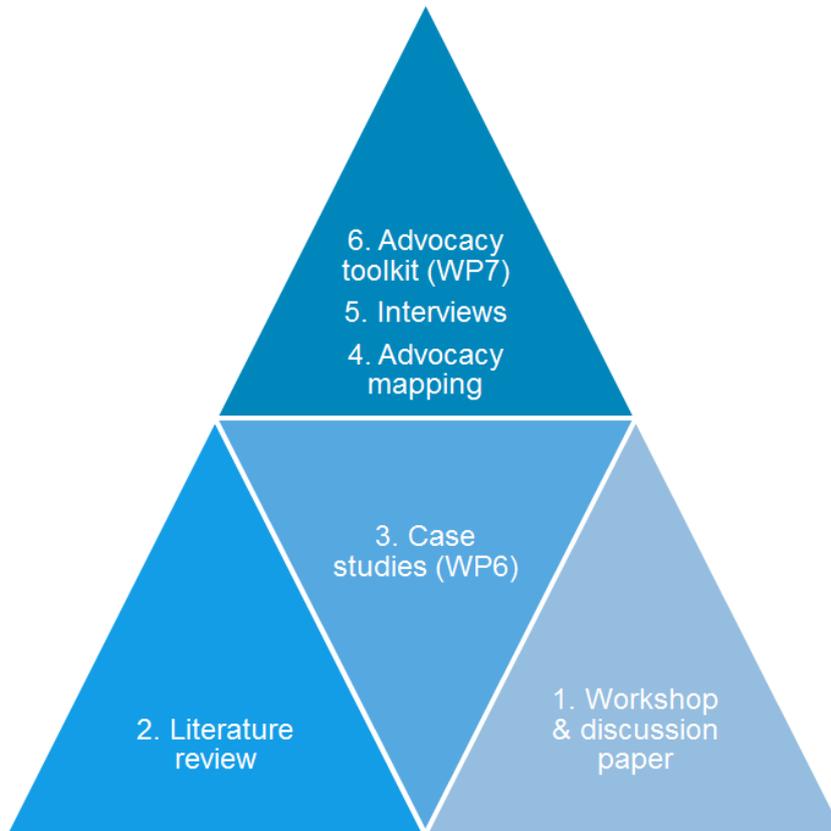


Fig. 2 – Pyramid of advocacy-related activities linking Work Package 5 (Advocacy), 6 (Case studies & final recommendations) & 7 (Dissemination & communication)

2. Case Study Approach

Five case studies were implemented, selected from Third Parties involved in the project that had expressed a written interest in focusing on the issue.

a. Overall process of selection and supervision

EuroHealthNet co-ordinated the advocacy case studies, tried to ensure their compatibility with the research work carried out on advocacy and their coherence with each other.

The process started in the spring of 2013, with an email sent to third parties in the project that were members of EuroHealthNet to request which DRIVERS area they wished to contribute a case study towards, and to provide a brief overview of their idea(s). Third parties were free to choose a case study on early childhood development, employment & working conditions, income & social protection or advocacy for health equity.

Four third parties initially indicated an interest in conducting an advocacy case study: THL in Finland, Blackburn with Darwen Council in England, PROLEPSIS in Greece, and CBO in the Netherlands. PHW, which originally chose to conduct its case study in the employment & working conditions area, moved to advocacy later on because of its clear compatibility with the advocacy work.

EuroHealthNet held a series of teleconferences with the Third Parties to discuss and refine specific ideas and feedback on the results of the advocacy research (particularly the literature review). Each third party prepared a structured plan, covering background of the advocacy activity, the specific aim(s) of the case study, methods, expected outcomes and the dates during which research would take place. The plans went through a series of revisions before agreement was reached. Most case studies refined their plans between autumn 2013 and early spring 2014, and had completed the research work by the late summer of 2014.

Guidance was circulated in March 2014, to try to ensure a common methodological and reporting approach. This requested:

- 1) **Full case study report** (any length including appendices with documentary evidence such as newspaper clippings or policy documents, full data tables, etc.).
- 2) **Case study summary** (six pages of A4, size 12 font, single spaced).

A description of the content requested for each report section in the summary review can be found in Table 2.

Introduction	Background of the case study (e.g. the specific intervention's aim(s), sources of funding, brief history of this intervention in the local context, how the intervention is/was organised, reference to evaluations of the impact of the intervention, the organisation conducting the case study).
Aims	Specific aims of the case study, referring to the Six Dimensions of Advocacy for Health Equity and any specific findings in the review. "What will this case study add to existing knowledge?"
Methods	Succinct description of the methodology/ies employed for answering the aims (please refer to Tong <i>et al.</i> ⁸ to ensure appropriate level of detail).
Results	Raw results/description of the results. May take the form of tables of data if appropriate.
Analysis/Discussion	Analysis of the results and limitations of the study.
Conclusions	Clear set of conclusions of the case study, explaining what the findings of this case study add to existing knowledge. Recommendations for potential advocates (but make sure they are backed up by the results!)

Reference was provided to the *Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups* by Tong *et al.*⁸, though third parties were encouraged to draw on their own methodological and analytical expertise. Third parties were requested to adhere to all rules governing social research in the country (including signed consent, confidentiality, anonymity, etc.). Research would naturally be conducted in the local language of the country, but the two main reports needed to be prepared in English. Interview transcripts could be kept in original language, but extracts used in the reports needed to be translated.

A meeting organised by the case studies Work Package leader, University College London, took place in Brussels in May 2014. This included a plenary session on the role of the case studies within the DRIVERS project, an overview of the main research findings coming out of DRIVERS, and sessions during which each case study area could present and discuss individual case studies in more detail.

Following this, reports were drafted and sent to EuroHealthNet for comment. This synthesis of findings draws on all of the final full and summary reports. It involved careful reading and re-reading of each report, highlighting of the key themes within each, developing standardised descriptions of the interventions, case studies, methods and findings for each case study, and organising the findings according to the six dimensions in tabular format. Moreover, careful comparison was made between the main findings of the case studies, and those of the literature review, so as to draw out areas of convergence and divergence. This report was then shared with third parties for comment and, following feedback from all partners and subsequent revision, finalised in November 2014.

b. Harmonisation of approaches

Each advocacy case study conducted original research on the implementation of a past or present intervention (programme, policy or project) connected to one of the three main drivers of health equity (early childhood, employment & working conditions, income & social protection). Each case study used the six dimensions of advocacy as the analytic framework, and was sent drafts of the literature review to help inform research planning and highlight the

⁸ See <http://intqhc.oxfordjournals.org/content/19/6/349.full>.

areas of interest. Teleconferences helped ensure a sharing of knowledge and harmonisation of approaches. Each case study conducted a review of documents related to intervention, interviews with stakeholders, analysis according to the six dimensions, and (as far as possible) standardised reporting templates.

Each case study was carried out by an organisation that had originally been involved in the intervention's implementation. They thereby overcame a common problem in qualitative research – lack of a gatekeeper and consent. In addition, these organisations had a direct interest in understanding how to improve the effectiveness of advocacy actions (the overall aim of the advocacy work in DRIVERS), because findings could be used to improve on-going or future advocacy efforts and work towards shared goals to improve health equity.

Where possible and appropriate, third parties were encouraged to incorporate advocacy elements into the case study as a form of participatory action research. This arguably brought an ethical dimension to the work (because it helped work towards the political goal of health equity), which is considered important by many researchers when working on issues concerning disadvantage.

3. Summary of the Advocacy Case Studies

This section provides a brief summary of each of the five advocacy case studies. Individual case study reports should be consulted for additional details.

a. Health 2015: Improving inter-sectoral co-operation on Health 2015 to improve health equity (The National Institute for Health and Welfare, Finland)

Finland has a long tradition of inter-sectoral co-operation to improve health, and included health targets in non-health sectors back in 1985. Health 2015, the Finnish public health strategy, was introduced in 2001. It laid great emphasis on reducing health inequalities between population groups through inter-sectoral co-operation, stating that inequalities had become a critical societal, health and economic issue, and were becoming worse.

The Advisory Board for Public Health is an important body within this strategy, bringing together individuals (“contact points”) from different government ministries. These representatives are then meant to act as advocates for health equity within their own ministries. However, their effectiveness has been limited.

This case study examined intersectoral co-operation on Health 2015, aiming to understand the different kinds of information useful for advocacy, the working ideologies of the different sectors, and how to increase uptake of research and statistics by non-health sectors. In addition, it aimed to increase awareness of evidence concerning the social determinants of health, and increase support for reducing health inequalities in non-health sectors. It used a social marketing approach and the “5-I’s” framework for understanding motivations of the different ministries.

Aims:

- To increase inter-sectoral understanding of health inequity.
- To identify factors that can help increase intersectoral co-operation.
- To support the practice of inter-sectoral co-operation between different Finnish ministries.
- To analyse the barriers and enablers of effective advocacy, so as to deepen the findings of the literature review.
- Overall, to help Finnish ministries improve health equity through intersectoral co-operation, thereby contributing to the aims of Health 2015.

Research methods:

- Development of an interview protocol.
- Interviews with contact points in four ministries (Ministry of Finance, Ministry of the Environment, Ministry of Education and Culture, the Ministry of Employment and the Economy).
- Development and preparation of materials for group discussions.
- Group interviews with colleagues of the contact points in non-health ministries.
- Analysis using a social marketing and 5 “Is” approach: information, ideologies, interests, institutions and interventions.

Summary of findings:

- Successful advocacy for health equity requires demonstrating costs and benefits to others.

- It involves finding common goals and suggesting opportunities for co-operation.
- The use of health terminology outside the health sector can be counter-productive.
- Introducing the concept of the social determinants of health (SDH) is a prerequisite to intersectoral co-operation.
- There are multiple advocates, though they may not see themselves as such.
- Advocacy within different ministries requires 1) permanent structures with funding and resources, 2) an appointed responsible body, 3) an internal working group within each ministry.
- Being an advocate within a ministry should be a rewarding experience.

b. Think Family: Analysing advocacy arguments used to promote a programme at the local level (Blackburn with Darwen Borough Council, England)

Blackburn with Darwen Council is situated in north-west England, with a population of 140,000. There are substantial health problems in the area, associated with high levels of social deprivation, and life expectancy for both males and females is the third worst in England. The combined impact of poor housing, low incomes, deprivation and child poverty results in poor health and social outcomes for children; indeed, there are high levels of inequalities in health between different population groups in the borough. The issue of health equity and how to advocate for it is therefore of particular local interest.

Think Family started in 2010. It was a multi-agency initiative which saw family advocates act as a single point of contact to co-ordinate agency responses to issues experienced by families with complex needs. It was a major initiative to provide a new model of support and intervention for families with complex problems living in some of the most deprived local neighbourhoods. It involved significant cross-sectoral and cross-agency co-operation, and was introduced at a time when local authorities were subject to large budgetary cuts. This case study re-examined the processes by which Think Family was advocated for and introduced within the local council.

Aims:

- To learn from the experience of implementing Think Family in relevant dimensions of advocacy for health equity.
- To gain more detailed insights into links between health and well-being, and their links to advocacy and policy making processes.
- To test any new findings through interviews with local partners and policy makers (local authority officers and elected members).

Research methods:

- Document analysis, including (re-analysis of) the interviews conducted as part of the original internal evaluation, and documentary materials (minutes of meetings, working group reports, press coverage, etc.).
- Development of an interview guide.
- Semi-structured interviews with key informants, including children's services managers, early years' practitioners, public health officers, Think Family project managers, internal evaluators and members of the Think Family steering group.
- Full transcription and data analysis using thematic coding techniques.

Summary of findings:

- Local evidence, for example the testimonies of people affected by the intervention were particularly valuable in advocacy efforts; cost-benefit evaluation also extremely important; there is a need to bolster scientific evidence with other kinds of evidence.
- Different advocates can be involved at different points in the advocacy effort; advocates can be dispersed across different departments, but there may be important individuals (“champions”) who help move things forward.
- Having champions is important; these might include expert policy makers who can make the case to elected members.
- Health is not enough to persuade policy makers; economic messages important, but also health as a means of promoting social inclusion and access to work.
- It is important to tailor evidence and frame issues in accordance with the targets of advocacy and stakeholders involved.
- National policy developments can open windows of opportunity to take action at the local level; financial incentives can act as enablers.

c. Food aid & healthy nutrition programme: Developing advocacy arguments to promote a programme which provides nutritious and free school meals to children in deprived areas of Greece (Institute of Preventive Medicine, Environmental & Occupational Health, Greece)

According to UNICEF (2012) 686,000 children in Greece are at risk of poverty and social exclusion; this amounts to 35.4% of all children in Greece. Greece’s persistent economic crisis has led to an increase in unemployment and wage cuts, which in turn appears to have resulted in increased food insecurity and difficulties feeding pupils in socio-economically vulnerable areas.

In an effort to tackle this growing problem, PROLEPSIS designed and implemented the DIATROFI programme, which provides a daily free and nutritious meal to pupils in socio-economically vulnerable areas across Greece. DIATROFI has two main objectives: to combat the malnourishment of children, and to encourage the adoption of healthy eating habits for both the students and their families.

During 2013-2014, the third year of DIATROFI’s operation, 406 schools participated throughout Greece, benefiting a combined total of 61,870 total students. There are pending applications for more than 500 schools that account for more than 70,000 students. DIATROFI has so far mainly been funded by a 100 million euro donation by the (private) Stavros Niarchos Foundation.

This case study explored the reasons why private foundations fund the programme, the arguments and data necessary for advocating to the public and private sector, and barriers and enablers of advocacy. It also organised an information event to increase interest in funding and mainstreaming the programme.

Aims:

- To make the case to policy makers and public services in Greece that the food aid programme in schools has an impact on the SDH and health inequalities.
- To explore the opportunities for large corporations to provide support to actions for health equity.
- To explore the best arguments for promoting the uptake of the intervention through evidence-based recommendations.
- To explore how the government can learn from the case study and similar initiatives.
- To pilot and test the findings at an event for the private and public sector, and to contribute recommendations to the DRIVERS project.

Research methods:

- Development of interview guides.
- Semi-structured interviews with key individuals at the Stavros Niarchos Foundation and other organisations and companies that support the programme or wish to support the programme.
- Semi-structured interviews with key policy makers.
- Full transcription and analysis using thematic analysis techniques.
- Preparation of materials for the public and private sector, including a policy brief and a call to action.
- Organisation of an information event for the private and public sector, which included possibilities to feedback on the effectiveness of the prepared materials.

Summary of findings:

- Advocates should highlight evaluated results and cost-effectiveness.
- While the public sector values a more factual and scientific brief, qualitative evidence including testimonies can also be powerful. Advocacy materials aimed at the general public and media can make greater use of qualitative evidence. Overall, a 'jigsaw of evidence' appears to work well.
- NGOs should demonstrate expertise, have high-level contacts with other organisations (private and public) and have the capacity to deliver.
- The private sector is likely to support an initiative if they understand the scale of an issue, it fits with their corporate social responsibility (CSR) priorities, they know the NGO and have links to it at high levels, the intervention is tested and has a credible methodology, is delivered universally (not means/needs tested) and has cost-benefit evidence associated with it.
- The implementing organisation should provide regular updates to funders, ideally with possibilities of meeting beneficiaries.
- EU level advocacy can exert pressure to act at the national level.

d. Child Poverty and Health: Developing an advocacy strategy to promote a child health intervention for disadvantaged families (Institute for Healthcare Improvement, the Netherlands)

More than one in ten children in the Netherlands live in poverty, and the number is increasing. Research from the Netherlands suggests that 6-19 per cent of elementary school children are at risk of poorer health as a result of poverty, with some not being able, for example, to afford to be a member of a sports club, go on excursions, participate in swimming lessons or have adequate clothing.

Child Poverty and Health (*Armoede en gezondheid van kinderen*) is an intervention developed in 2000 by the Public Health Service in GGD West-Brabant (Netherlands' West-Brabant region). It starts with a routine health examination in elementary schools to identify children deemed to be at risk of poverty-related ill health, and provides them with material and financial support.

Aims:

- To understand what drives policy makers to take action at the local level.
- To obtain further insights relating to the six dimensions of advocacy.

- To interest at least one municipality in the topic of child poverty and health, and to raise awareness of the intervention among key stakeholders in regions of the Netherlands that do not have a child poverty intervention or policy.

Research methods:

- Document analysis of the intervention's handbook, documents of the projects carried out in Groningen and Zwolle, and documents produced by the Netherlands Youth Institute and the National Institute for Public Health and the Environment.
- In-depth interviews with key stakeholders who were involved in implementation of the intervention. These included the intervention owner, policy makers who implemented the intervention in the past, policy makers who are currently involved in implementing the intervention and representatives of municipal health centres. Stakeholders received information about the intervention and the interview questions before the interviews. Where possible, interviews were face to face, but in other cases by telephone.
- Interviews were transcribed.
- Analysis of interviews based on the six dimensions of advocacy, with discussion amongst researchers where discrepancies emerged.
- Preparation of an online questionnaire about advocacy elements of the intervention based on the findings from documents and interviews, in order to validate findings.
- Analysis of questionnaires based on the six dimensions of advocacy.

Summary of findings:

- It is important to make policy makers aware of the scale of a problem and the basic mechanisms involved.
- Information linking the social and the health issue, and local epidemiological data showing the effects in the local area are convincing in advocacy. Such data should therefore be collected or disseminated more widely at the municipal level in the Netherlands.
- Advocates should disseminate materials in more than one format if possible; newsletters and directly with collegial experts appears to be preferred.
- The health argument could be effective, but each policy maker may have a different standpoint and works in a different (political) context; as such, more than one argument should be used in advocacy efforts. The safety net argument was the argument that came up as relevant because it provided an opportunity to reach this vulnerable group.
- It is important to identify key people to convince – in this case the Alderman on Social Affairs and Health was an extremely important target of advocacy, who could go on to be a possible 'ambassador' of the intervention.
- Policy makers may be reluctant to take on board new responsibilities, because of several contextual factors such as decentralisation of laws and tasks, so arguments should be developed with this in mind.
- National networks on poverty and health could help ensure better information flow and increase knowledge and therefore willingness to take action.

e. Mental Health First Aid: Examining advocacy concerning a programme to increase detection and treatment of mental health problems in the workplace (Public Health Wales)

Mental Health First Aid (MHFA) is a training course designed to increase mental health literacy in the Welsh population by providing participants with the knowledge to recognise

mental health problems and to signpost to appropriate services. MHFA was commissioned by the Welsh Assembly Government in 2007 and used by employers across Wales.

Although this advocacy case study was originally assigned to the 'Employment and working conditions' workstrand (Work Package 3), aiming to examine the effectiveness of the intervention, the sheer lack of available data (e.g. sickness absence records, clarity over who was responsible for implementing interventions in employers, low levels of responses to requests for information, etc.) made this unfeasible. The clear compatibility with some of the advocacy elements then became the focus of the work, with the aim of answering several open questions about the intervention.

Aims:

- To understand how and why the decision to commission the MHFA training was made by policy makers.
- To find out what the arguments and evidence were for doing so.
- To find out who the key players were in pushing for it.
- To find out why employers may or may not have invested in it.

Research methods⁹:

- Identify key stakeholders in the Welsh Government, workplace organisations and *Mind Cymru*.
- Develop an interview protocol.
- Interviews with key stakeholders.
- Transcription and analysis.

Summary of findings:

- It is important to make the economic case to policy makers.
- Lower standards of evidence may be acceptable to policy makers if an intervention appears to be ready to implement 'off the shelf'.
- Advocates should highlight the international credentials and pedigree of interventions.
- Advocates need to adapt their messages to the prevailing policy frame (e.g. 'give people control of their lives...').
- Employers see CSR awards and staff well-being as important; dedicated budgets can ensure efforts are made to increase staff well-being.

⁹ The methods detailed here relate solely to the advocacy case study (and not the attempted evaluation of the intervention).

4. Tabular Representation of Findings

Case Study	Dimension 1: Data, methods, knowledge transfer and translation	Dimension 2: Who advocates to whom?	Dimension 3: Advocacy messages	Dimension 4: Tailoring	Dimension 5: Enablers & barriers of effective advocacy	Dimension 6: Practices
Health 2015 (THL, Finland)	<p>Show cost benefits of taking action to reduce health inequalities according to the objectives of the ministry being targeted. Demonstrate the costs of inequalities and the effectiveness of measures to tackle them. Demonstrative opportunities to co-operate.</p> <p>Present data in different formats: presentations, briefings, reports, etc. Provide basic information about the phenomenon, social distribution, qualitative and quantitative data; answer direct questions. Written material needs to be easy to understand, fairly short, preferably graphical and references need to be provided.</p>	<p>There are multiple advocates and multiple targets.</p> <p>Target potential champions, people with responsibility in the ministry, who have a good knowledge of their sector.</p>	<p>Well-being and equal opportunities are messages that work well across Finnish ministries.</p> <p>Health-related messages may be off-putting to non-health sectors.</p> <p>Introducing the SDH can be a good starting point to arriving at an understanding, as it creates a point of mutual understanding linking non-health sectors with the aims of the public health strategy.</p>	<p>It is essential to tailor data, arguments and materials used to advocate to each specific ministry.</p> <p>Talk the language of each individual ministry: use their terminology.</p>	<p>Enablers: 'buy in' from the head of government on the need to reduce health inequalities; education on SDH for different government sectors, long culture of intersectoral co-operation in Finland.</p> <p>Barriers: each ministry has different data sources; data on (health) inequalities is dispersed and people do not always know if it exists or where to find it. Research data can be 'mistrusted' if it contradicts a sectoral assumption. Ministries may compete with each other (e.g. for resources). Short-term policy goals, lack of intersectoral co-operation.</p>	<p>Find and set 'win-win' objectives with allies.</p> <p>Understand the working ideologies and assumptions of different sectors. Social marketing approach can be used to understand different sectoral interests.</p> <p>Find champions within ministries; they can be voluntary or appointed, but will ideally hold a high position within the ministry or sector.</p> <p>Permanent internal inter-departmental working groups appointed by the management of each administrative sector. Make participation in working groups rewarding.</p>
Think Family (Blackburn with Darwen Council, England)	<p>Financial cost-benefit evidence to demonstrate efficacy of the approach. Local testimony (e.g. front-line practitioners or local people) is extremely powerful.</p> <p>Thematically analysed qualitative data less convincing than direct</p>	<p>Public health was the main advocate for addressing the SDH. Local authority officers were targets of advocacy, but went on to advocate for the initiative themselves. Other targets included health and social care professionals and elected members of the council (politicians), and</p>	<p>Due to context of austerity and cuts, economic arguments were strongest, accompanied by health as an enabler of social and economic participation in daily life. Focusing on outcomes to children later on in life can be useful.</p> <p>The social justice 17</p>	<p>Left-leaning councils are a more conducive environment in terms of making argument about SDH and HIs, and the social justice argument that disadvantaged people have worse health.</p>	<p>Enablers: consensus across different stakeholders and sectors to effect change; history of left-leaning local government. Having allies. Financial rules can be built into interventions to improve support.</p> <p>National policy was both</p>	<p>Find a champion within the policy making environment.</p> <p>Have expert policy makers make the case to elected officials.</p> <p>Identify the kinds of stakeholders that need to be convinced.</p>

	<p>interview quotations due to it being further removed from the “personal”.</p> <p>While national scientific evidence can be useful, evidence also had to be grounded in local realities. Overall, a mixture of qualitative and quantitative data should be used in advocacy but it is important to tailor presentation of evidence to different audiences.</p> <p>Keep materials or presentations short; provide summaries with key points, no jargon, demonstrate the costs of inaction. Verbal presentations and face-to-face conversations more persuasive than written reports. Visual presentations (e.g. social or health problems mapped geographically to the local area) can have stronger impacts.</p>	<p>they too went on to advocate in some cases.</p> <p>Advocacy requires diffused leadership at the local level. Advocacy does not “have” to take place, it happens because people decide it is appropriate or useful to their role or organisation.</p>	<p>argument can be used to focus on health outcomes for more disadvantaged people.</p>		<p>an enabler and a barrier. It presented a window of opportunity, but likewise prompted the main agenda to move on from Think Family to Troubled Families.</p> <p>Barriers: it is difficult to demonstrate robust financial outcomes of the programme. Difficulties proving causality. Difficulties working across health and social sectors due to different understandings of what constitutes evidence.</p>	<p>Take advantage of windows of opportunity.</p>
<p>Food aid & healthy nutrition programme (PROLEPSIS, Greece)</p>	<p>Solid data on the phenomenon (malnutrition and linked obesity).</p> <p>Strong (on-going) evaluated evidence of effectiveness, running over several years and to tens of thousands of children. Strong monitoring processes built in to provide timely data.</p>	<p>CSOs to public sector and to private sector. Leaders in CSOs to leaders in other sectors right up to government minister level if possible. This requires insistence and networking.</p> <p>In the public sector this can be ministerial level, government leadership, and expert policy makers</p>	<p>Related to the evaluation of the intervention: food insecurity linked to low level of maternal education; improving nutritional habits can help reduce health inequalities; improved nutrition strengthens social solidarity within schools; nutrition can possibly also help reduce school</p>	<p>Tailor the use of evidence, messages and formats of evidence to public, private and foundation audiences.</p> <p>Tailor presentations to the specific CSR priorities of different private sector organisations.</p> <p>Tailor to the concerns of different public bodies</p>	<p>Enablers: personal co-operation between key stakeholders at the top of organisations; recognition of the problem and how it can be tackled; private sector CSR strategies, and foundation priorities.</p> <p>Long-periods of implementation (e.g. more than three years) can</p>	<p>It is important for advocacy organisations to demonstrate expertise, credibility, and capacity.</p> <p>Important to network and build personal relationships with leaders in public, private or NGO sectors.</p> <p>Policy-research networks</p>

	<p>Cost-effectiveness data, particularly future savings in terms of health savings. Clear presentation of benefits of taking action. Mapping population health and inequalities data geographically.</p> <p>Qualitative data on the intervention's impact on food security and healthy nutrition. Evidence of impact on the wider school environment, children's feelings of security, care and happiness.</p> <p>There should be an overall balance of evidence, including cost-effectiveness, qualitative interviews and testimonials from teachers, children and others. A jigsaw of evidence, with pictures, tables, stories, children's paintings, bullet points, cover pages, is effective. International literature can be persuasive.</p> <p>Direct communication may be more effective than written reports. Testimonials (in person) can be very powerful. Need a variety of different kinds of materials – short articles, scientific reports, materials tailored to different audiences.</p>	<p>in the ministries, local authorities and regional directorates of health.</p> <p>Professional bodies (e.g. paediatric associations) can be targets of advocacy and become useful allies.</p> <p>CSOs and private sector to the general public and media.</p> <p>Teachers, children and others directly involved in/affected by the intervention can be powerful advocates.</p>	<p>dropout (early school leaving) rates.</p> <p>Improvements to social cohesion/fear of lack of social cohesion, particularly in the public sector.</p> <p>Stress the reputational advantages of involvement. Stress innovation in the intervention.</p>	<p>(e.g. social cohesion in local authorities, healthy nutrition in health directorates, etc.).</p> <p>Qualitative and emotionally-oriented materials are more effective when advocating to the general public or private sector, but there are also "idealists" in public sector.</p> <p>Follow strict protocols when writing letters to government ministers.</p>	<p>encourage others to become involved.</p> <p>EU (or WHO) attention to the issue can galvanise public sector attention. A lack of EU action or attention can likewise be a barrier to national-level attention.</p> <p>Barriers: co-operation between public and private sector virtually non-existent in Greece. However, NGOs are able to bridge the public-private divide.</p> <p>No - or severely stretched - budgets, austerity.</p> <p>Lack of understanding among policy makers to understand and prioritise population health needs; 'intense bureaucracy' which hinders the implementation of initiatives.</p> <p>'Sheer avoidance' of some in the public sector – the general notion that public acknowledgement of malnutrition would be detrimental to worldwide image of the country.</p>	<p>to bring population-level data to inform development of interventions and improve the uptake of evidence in policy making.</p> <p>Build support amongst multiple private sector organisations as this helps increase sustainability and credibility ('success breeds success').</p> <p>Find allies – for example in professional bodies.</p> <p>Organise press conferences, send press releases, participate in social media and develop an intervention website.</p>
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<p>Child Poverty and Health (CBO, Netherlands)</p>	<p>A variety of different kinds of evidence can be used in advocacy.</p> <p>Local epidemiological data, data about the scale of the problem and research linking poverty to poorer health outcomes.</p> <p>Success stories and evaluation evidence important. Clear theoretical grounding to interventions can be important.</p> <p>Use a variety of different means of transferring knowledge: these include publications, websites, newsletters, and by discussion with peers.</p>	<p>Aldermen of public health and social affairs were important targets of advocacy in this instance. They can go on to become 'ambassadors' for the intervention at the local level.</p> <p>Other targets include national authorities, policy officers, health professionals and practitioners of the municipal health service, the Children's Ombudsman, elementary school staff and parents and their children. The views of youth healthcare workers are also valued in advocacy efforts.</p>	<p>A variety of different arguments may be used. One of the most persuasive appears to be the safety net argument, which states that intervening at an early age prevents later problems. Other arguments include cost benefits to improving collaboration between health and social services, and the importance of children's well-being.</p> <p>In the Dutch context, a powerful message was highlighting links between the transition of welfare and care tasks from the national to the local level.</p>	<p>N/A</p>	<p>Enablers: a history of left-wing and social politics at the local level; such municipalities already have a special interest in the topic of poverty.</p> <p>Windows of opportunity – in this case decentralisation of care and social responsibilities from national to local levels.</p> <p>Dissemination/availability of local-level epidemiological data.</p> <p>Barriers: fear that intersectoral co-operation could be an additional burden on local government officials. Lack of cross-sectoral co-operation in tackling child poverty.</p> <p>Lack of awareness amongst local policy makers of the links between poverty and health.</p>	<p>Publicising the success of interventions in local media can increase effectiveness of advocacy efforts.</p> <p>The media can be important in influencing local politicians.</p> <p>Identify and convince the specific person within the local authority that needs to be convinced.</p> <p>National-level platforms linking poverty and health would help increase awareness, expertise and effectiveness of advocacy efforts.</p>
<p>Mental Health First Aid (Public Health Wales)</p>	<p>Interventions with evaluation evidence, international credentials, and 'ready to be implemented off the shelf' are likely to appeal to policy makers seeking a specific solution to a problem.</p> <p>Policy makers do not</p>	<p>Business leaders; occupational health specialists; those responsible for corporate social responsibility in private enterprises. Support from wider workforce important.</p>	<p>Key arguments included the focus on socially excluded groups, mental health literacy and empowering 'at-risk groups'.</p> <p>The legal 'duty of care' requirements for employers were important in terms of phrasing</p>	<p>N/A</p>	<p>Enablers: legal duties on employers; corporate health or social responsibility objectives with dedicated budget lines; government prioritising an issue; international credentials and pedigree of the intervention; managers being part of national or</p>	<p>Intervention or policy gap analysis, particularly for certain hard-to-reach groups; training in marketing.</p>

	<p>always require interventions to have strong evaluation evidence. The perceived popularity of a programme can 'trump' evidence (or lack of effectiveness): in particular, the need for quick implementation, the need to take some kind of action.</p>		<p>arguments. The economic case (e.g. reduced sickness leave) can also be made for taking action.</p> <p>Stress the importance of doing something rather than nothing.</p>		<p>other networks. National-level policy can open windows of opportunity.</p> <p>Barriers: lack of key data in private enterprises, difficulties finding 'off-the-shelf' and evaluated interventions that can be implemented when possibility arises.</p>	
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5. Discussion & Conclusions

a. How the findings fit into other evidence gathered by DRIVERS

Dimension 1: The case studies emphasised the need for cost-benefit data and the need to demonstrate the costs of inaction. They emphasised the importance of having strong evaluation evidence to back up arguments for the introduction of interventions. Local-level data were seen as particularly important in advocacy efforts; mapping this data (e.g. by local area or school district) was also seen as persuasive. Given that some of the case studies focused on the local level, this should not come as a surprise, but the increasing decentralisation of health and social care to local levels and the fact that implementation of services is usually local means this may become increasingly important for advocacy efforts. Evidence with an 'international' pedigree was cited as important in Wales & Greece.

Similar to the Literature Review (see Annex 2), the case studies emphasised the utility and persuasive force of using both qualitative and quantitative evidence. While these needed to be balanced according to audience (e.g. quantitative evidence might be differentially more important in certain sectors or certain audiences), the persuasive power of quotations or success stories was mentioned in four out of the five case studies. Interestingly, thematically analysed qualitative data was considered less powerful in advocacy efforts in Blackburn with Darwen than direct interview quotations. Similar to the literature review, the case studies suggested that use of carefully chosen infographics, bulleted lists, carefully selected references and avoidance of jargon were important means of conveying information. Different kinds of materials are useful in different situations.

Going beyond the findings of the literature review, there was mention that direct transfer of evidence (e.g. by face-to-face meetings or conversations) might be a more effective means of transferring evidence than written reports. Regardless, short and succinct presentations and reports are more likely to persuade to take action than more detailed ones.

Dimension 2: In accordance with the rest of our work in Work Package 5, the case studies found there to be many potential advocates and many potential targets. Given the local nature of some of the case studies, specific positions of responsibilities within local authorities were identified as particularly important advocates. These advocates can then go on to be champions within their own spheres of influence. In addition, the importance of reaching policy makers with responsibility was stressed. The case studies highlighted the important roles played by private foundations and the private sector in advocating for health equity. As the Greek and Welsh case studies show, the private sector can take action for a variety of different reasons, and may even act as advocates to government. Teachers, parents and children can likewise be advocates: their voices have particular persuasive force. However, less overall importance was ascribed to this role in the case studies than in the literature review, and involvement was not linked to objectives of human rights or empowerment. Unlike in previous work, particularly the literature review, the role of scientists in advocating was not stressed.

Dimension 3: Health-related messages can be off-putting to non-health sectors. The Finnish case study provides useful evidence about how to align messages with the interests of other sectors. The SDH can provide a useful 'touchstone' for developing understanding of why sectors should work together. The Greek example showed that health could very well be utilised for advocating to the health sector, but that other themes (such as social cohesion) worked better in other sectors. Context was also highlighted: austerity was foremost in Blackburn with Darwen, but the council's left-leaning heritage also meant the social justice argument held some sway. An argument linking the two was 'health as an enabler of social

and employment inclusion'. Unlike the literature review, no mention was made of human rights arguments or those concerning environmental and social sustainability.

Dimension 4: Like the other activities conducted, tailoring to different audiences was seen as a central part of advocacy for health equity. Taken as a whole, one could position 'tailoring' at the very centre of all of the other dimensions. However, unlike the literature review, the case studies deepened our knowledge of what to tailor, and how, in the European context. In Finland it was seen as essential to tailor to individual ministries: each had its own terminology, goals and working assumptions ("ideologies"), meaning that approaches had to be tailored individually to each and every sector. The Greek case study found that evidence, messages and formats had to be carefully tailored to different audiences (e.g. private, public, general public). This includes tailoring messages to the specific CSR objectives of private enterprises, and to the specific concerns of public bodies. Interestingly, the Greek case study also noted that qualitative and emotionally-oriented materials were more persuasive when advocating to the general public and private sector than policy makers, but that they should not be omitted from efforts to advocate to the public sector. Like the literature review, the case studies indicated that the political 'left' is more conducive to taking action on the SDH than the political 'right'. Examples of how messages were tailored can be found in the individual advocacy case study reports (see Annex 1).

Dimension 5: Various enablers were identified. These included the importance of obtaining 'buy in' and commitment from people holding senior positions in government administrations and private organisations. In addition, it was seen as important to arrive at a consensus across different stakeholders, to encourage personal contact and co-operation between leaders of different organisations, and for managers to be part of networks on issues of interest. In addition, CSR strategies, legal duties (e.g. on employers), a history of left-leaning administrations, the international credentials of an intervention or even attention to an issue from international organisations were other important enablers of more effective advocacy.

Barriers had been noted in previous DRIVERS work: difficulties working across sectors and short-term political goals. Other barriers were new: austerity, which puts a strain on budgets and constrains actions that require investment, fear of additional burdens on overstretched staff, or even refusing to recognise a problem for political reasons. Still other barriers, which were found to be significant in the literature review, received less emphasis: neoliberalism, public opinion and academic difficulties advocating.

Overall, these barriers and enablers have more in common with the grey literature reviewed as part of the systematic review than the academic.

Dimension 6: A variety of different practices that improve the effectiveness of advocacy efforts were identified. While relating directly to the individual advocacy case studies, they repeat those identified in the literature review and workshop.

Practices include understanding the working ideologies of other stakeholders and sectors and identifying 'win-win' objectives; the Greek and Finnish case studies both used social marketing techniques to do so. The importance of findings champions for an advocacy effort and specific individuals that need to be convinced was emphasised throughout the case studies. The importance of taking advantage of windows of opportunity was stressed, as was the importance of building relationships with people in authority. Coalitions, permanent structures of co-operation, and national platforms were mentioned as helping improve the effectiveness of advocacy efforts. The Greek study provided additional details of how private sector organisations could work together to advocate, united by shared CSR objectives. Overall, the evidence suggested that advocacy organisations need to demonstrate expertise, credibility and capacity to deliver.

b. Strengths and limitations

The case studies were conducted within set time periods and allocated resources, meaning they were by necessity limited in terms of the efforts that could be expended on them. Although we attempted to promote a consistent approach to methodology and reporting (as outlined above in Section 2), the staff involved naturally drew on their own divergent backgrounds, knowledge and resources to carry out the research. On the other hand, this brought richness to the case studies, making the convergent results all the more interesting. Despite providing some guidance on how to report, there were differences in the formats used.

The six dimensions framework was helpful in providing overall guidance to the conduct of the case studies and analysis. There were some differences of interpretation concerning the specific dimension certain findings applied to, but we have adapted the findings here to help ensure a more consistent approach. The six dimensions should really be treated as a heuristic device, and it is likely that future development could assign greater emphasis to 'tailoring' advocacy to each of the six dimensions.

The methodology employed for the case studies, while not fully harmonised, did show promise for future research on advocacy. Firstly, it directly involved the organisations concerned in the research on advocacy, which was important in terms of gaining the co-operation of a 'gatekeeper' and subsequent access to data, and direct insights into the experiences of advocating. Secondly, these organisations have an interest in being involved: the findings can help improve the effectiveness of on-going or future advocacy efforts. Thirdly, those case studies that incorporated advocacy into the research (Finland, Greece and the Netherlands) had even more reason to try and ensure the validity of their approach and the overall success of the case study, because the case studies tied in to organisational objectives.

Despite the limitations noted above, and the relatively sparse evidence base upon which advocates for health equity have to rely, it is important to return the overall aim of the advocacy work within DRIVERS ('*to gather and build upon existing knowledge*') and the aim of the case studies within this ('*to test and further the knowledge gathered by the literature review in real-life situations*'). The case studies successfully achieved their goal by bringing new insights to the fore and providing evidence that may be used to improve the effectiveness of future advocacy efforts.

c. Conclusions

The case studies conducted as part of DRIVERS provide useful real-world examples of advocacy. They help corroborate the findings of the expert workshop, advocacy mapping exercise and literature review, and provide further evidence of effective practices across the six dimensions of advocacy for health equity. As noted in the literature review, empirical evidence of advocacy for health equity is scant, and these case studies go some way to providing new evidence to inform advocacy practice.

It is useful to note some of the divergences between what was found by the literature review and the case studies, with the latter including: reduced attention to research methodologies, a minor role assigned to scientists and public health, reduced emphasis on human rights and sustainability as arguments, on neoliberalism as a pervasive barrier to advocacy, and the need for policy-research networks to help facilitate the production and use of research evidence in policy processes. This is not wholly surprising given the specific contexts and actors involved in these five case studies.

Of more interest are the convergences. In particular, these relate to the kinds of evidence useful for advocacy purposes, practices that improve the effectiveness of knowledge transfer and translation, complexity and dynamism in terms of 'who advocates and to whom', many of the enablers and barriers of effective advocacy, and the practices that can help improve effectiveness. In some cases, these case studies have nuanced and deepened our knowledge, indicating just how useful empirical evidence is to this nascent field of research and hopefully encouraging future work on this important topic.

Annex 1 – Individual Advocacy Case Study Reports

Authors	Organisation	Report title
Tuulia Rotko & Tapani Kauppinen	The National Institute for Health and Welfare (Terveyden ja hyvinvoinnin laitos, THL)	Advocacy for Health Equity: Improving inter-sectoral co-operation on Health 2015 to improve health equity
Ruth Young & Kenneth Barnsley	Blackburn with Darwen Public Health Department, United Kingdom	Advocacy for Health Equity: Learning from the Think Family approach in Blackburn with Darwen
Nadia Dalma, Afroditi Veloudaki & Pania Karnaki	PROLEPSIS (Greek Institute of Preventive Medicine Environmental and Occupational Health)	Advocacy for Health Equity: The food aid and promotion of healthy nutrition programme (DIATROFI)
Annemiek Dorgelo & Janine Vervoordeldonk	CBO, the Netherlands	Advocacy for Health Equity: The West-Brabant Region intervention on child poverty and health
Malcolm Ward & Rhiannon Hobbs	Public Health Wales	Advocacy for Health Equity: Implementation of Mental Health First Aid in Wales

Annex 2 – Summary of Findings “Advocacy for Health Equity: A Synthesis Review”

Summary

The aim of the literature review, one of the first and most substantial advocacy tasks undertaken within DRIVERS, was synthesis of evidence about advocacy for health equity in the academic and grey literature, to provide a body of knowledge for advocates to draw upon¹⁰. As noted above, the case studies were implemented to help build on this body of knowledge by confirming, disconfirming and deepening findings.

Four databases were chosen for cross-disciplinary coverage: PubMed, Web of Science, PsycINFO (EBSCO) and SocInfo. After removing duplicates, 21,425 academic papers were reviewed by title and abstract. In total, 137 academic and 59 pieces of grey were included in the review and analysed thematically, using the six dimension of advocacy for health equity (see Section 1b) as the analytical framework.

Dimension 1 - The kinds of evidence needed to advocate for health equity and how to transfer this knowledge to policy-making processes

Three mutually overlapping though dependent stages emerged: 1) Evidence useful for advocacy, 2) Data and methods, 3) Knowledge transfer and translation.

Evidence useful for advocacy: Policy and programme evaluations, particularly social policies and cross-sectoral initiatives that demonstrate impact on health inequalities, may be useful evidence in advocacy efforts. This research should provide outcomes broken down by gender, socio-economic group, etc., evidence of costs and benefits of action and inaction, and evidence about why an intervention does or does not work. Other kinds of evidence useful for advocacy include communicating health inequalities to stakeholders, how narratives and images are perceived by different audiences, and evaluations of advocacy efforts.

Data and methods: Data should be up to date. Local-level data can be particularly persuasive to policy makers. Several papers highlighted the use of Community-Based Participatory Research as a means of gathering evidence necessary for advocacy and empowering disadvantaged groups in doing so. Overall, data and methods need to be considered in terms of their aptness, rather than strict adherence to any particular hierarchy of evidence. Some forms of evidence, while low on the hierarchy, have particularly strong persuasive power in advocacy efforts.

Knowledge transfer and translation: There was consensus that data will rarely be the final word in policy-making processes, that advocacy efforts need to make use of a ‘jigsaw of evidence’ derived from a variety of different kinds of research method, and that policy makers have different understandings of what constitutes evidence than researchers. Scientists reduce the effectiveness of their efforts by concentrating on methodological issues, or by calling for further research rather than stressing the considerable body of evidence which points to the need to take action. While policy briefs and carefully tailored presentations to non-expert audiences can help persuade to take action, researchers, policy makers and civil society groups inhabit different cultural spaces. One way to break down differences in

¹⁰ The literature review (Farrer, Marinetti, Kuipers & Costongs – Advocacy for Healthy Equity: A Synthesis Review) will be published shortly. Links to the published paper will be posted on the DRIVERS.

language, and increase understanding and trust, is for researchers and other advocates to work in networks.

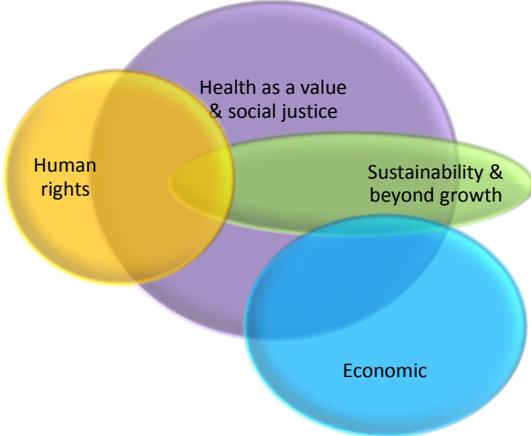
Dimension 2 - Who advocates for health equity and to whom?

The potential role of scientists was unsurprisingly stressed by the academic literature. However, the literature also highlighted the considerable persuasive power held by the medical professions, those working directly with disadvantaged people and disadvantaged people themselves. These groups can provide particularly persuasive personal testimonies. There are clear rights-based (empowerment, participation, etc.) reasons for involving disadvantaged communities in advocacy efforts.

The usual targets of advocacy are undefined policy makers, sometimes more clearly delineated as civil servants, ministers or prime ministers. The media was portrayed as playing a variety of roles in advocacy efforts. For example, they can be the initial targets of advocacy efforts (e.g. to carry a story related to the SDH), but can also go on to become advocates themselves (e.g. by deciding to focus on certain issues or even actively campaign on them). This media pressure can lead to the implementation of certain policies.

Dimension 3 - Advocacy messages

Several types of argument were identified by the review. The largest group was health as a value and social justice, which posits that health has a value in itself because everyone needs it to live and function. This links to social justice, which claims that the systematic differences in health across the social gradient are a gross injustice and ‘kill people on a grand scale’. This, in turn, links to various different kinds of human rights arguments, which suggest that everyone has the intrinsic right to health, or at least to the conditions that are conducive to health. Human rights can also provide a set of principles for the creation of policies or structuring of systems (e.g. healthcare). A separate set of arguments focused on sustainability and ‘ecological’ issues; these claim that health equity and sustainable and non-growth-driven societies go hand-in-hand. A variety of economic arguments made up a fourth group, sometimes highlighting the benefits of taking action, the costs of inaction, or even self-interest (on the part of those who currently experience higher levels of health).



Schematic diagram of different kinds of advocacy argument and potential overlaps

Dimension 4 - Tailoring arguments to different political standpoints

There was general consensus in the literature that health equity is an issue that resonates more with the 'left' of the political spectrum than the 'right'. The literature explains that this is because the 'left' holds that peoples' lives are shaped by inequitable social and economic systems - which in turn shape health and health behaviours in accordance with these inequalities -, while the 'right' assigns equal (or close-to-equal) agency to individuals of all backgrounds, thereby expecting them to be responsible for their own behaviour and standing in the social hierarchy.

While some valuable evidence existed on how to tailor arguments to different political standpoints in the USA, there was a virtual absence of evidence from elsewhere, despite recognition that tailoring was of primary importance in advocacy. Research on this area would yield valuable evidence.

Dimension 5 - Barriers (and enablers) of effective successful advocacy

Barriers: One of the surprise results was the extent to which the academic and grey literature emphasised barriers to effective advocacy for health equity. Foremost, particularly in the academic literature, was the economic and political *zeitgeist* which is hostile to government intervention to improve the SDH. This extends to individualistic public notions, which oppose action to help less advantaged groups.

Biomedical health perspectives can crowd out arguments concerning the SDH, treat health in biomedical rather than social terms, and compete for scant resources. Lack of intersectoral co-operation also hinders effective advocacy, as health inequalities by necessity require concerted action across sectoral boundaries. Political 'short-termism' means that longer-term actions to reduce health inequalities are often seen as too aspirational or lacking too few measurable benefits.

The review highlighted a number of academic difficulties advocating. One was the (sometimes career-threatening) loss of academic credibility, lack of time and pressure from administrators to avoid all non-essential non-core work. Another was the marketisation of higher education, which may lead scientists to 'run the treadmill' of obtaining one research grant after another, influences what subjects and research proposals receive funding and what does not, and can lead scientists to 'water down' the policy recommendations of their work to avoid appearing over 'radical' and upsetting the funders upon whom they rely.

Enablers: Longer-term enablers to overcome some of these barriers could include re-orientating health professions back towards advocacy where many have their historic roots, including teaching on human rights and advocacy in medical training, and promoting work within disadvantaged communities as part of higher education syllabuses. Moreover, raising public awareness of the SDH, introducing the teaching of SDH and human rights in general schooling, and improving the uptake and enforceability of human rights legislation in national law could all promote an environment more conducive to more effective advocacy.

Dimension 6 - Practices and activities that increase the effectiveness of advocacy efforts

A number of different kinds of practices were identified as improving the effectiveness of advocacy efforts. These included working in coalitions, findings champions, identifying key stakeholders that need to be convinced, lobbying, social mobilisation and media activation. Organisational capacity is required for all of these activities, and advocates will need to demonstrate leadership, credibility and expertise.



DRIVERS (2012-2015) is a research project funded by the EU's 7th Framework Programme. It aims to deepen understanding of the relationships between some of the key influences on health over the course of a person's life - early childhood, employment, and income and social protection - and to find solutions to improve health and reduce health inequalities.

The research is undertaken by a consortium including leading research centres and organisations representing the public health sector, civil society and businesses.

