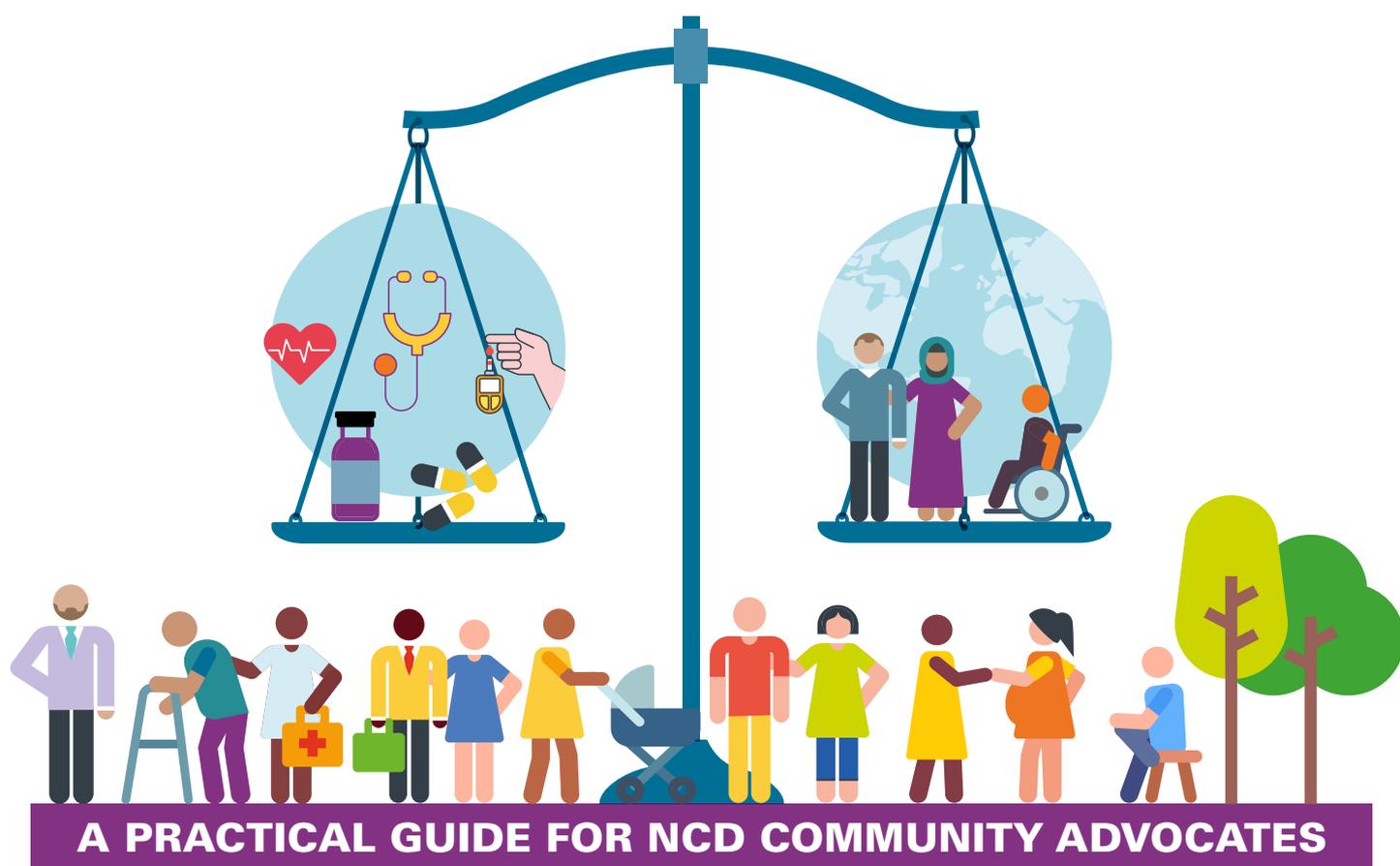


EQUITY IN ACTION

ADDING AN EQUITY LENS TO NCD ADVOCACY



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Introduction to the practical guide

This practical guide aims to support community advocacy on NCDs, translating into practice the concept of **health equity**.

The **OBJECTIVES** of this practical guide are to support NCD advocates to:

Conduct a detailed assessment of the state of health equity on NCDs engaging with communities, people living with NCDs and key stakeholders.

Produce an NCD Equity Report using the assessment findings with clear policy recommendations.

Develop evidence-based advocacy strategies informed by the NCD Equity Report.

It is envisaged that this practical guide and the development of NCD Equity Reports will be put into action using a strong access lens, and building on the work of national NCD alliances who have advocated on UHC, have established networks of people living with NCDs and have experience in community engagement. The access lens facilitates zooming in on how health services are serving communities, and how care can be improved for the most vulnerable and marginalised.

However, the practical guide and NCD Equity Reports apply general principles and a step-by-step approach that can be used more broadly across the NCD response, encompassing both NCD prevention and control. The guide presents tips, tools, and templates to support this work, with scope for advocates to tailor the assessment to their contexts and unique priorities. It is accompanied by the [NCD Health Equity Conceptual Framework for Advocates](#).

How this practical guide was developed

The development of this practical guide by NCD Alliance builds on the consultative and co-creation process employed in the development of the **NCD Health Equity Conceptual Framework for Community Advocates**. The guide's objectives and outline were first presented for guidance by a multistakeholder advisory group set up to provide expertise on health equity in the context of NCDs. Two workshops were held to gain input from the perspectives of people with lived experiences of NCDs (applying the principles of meaningful involvement in the development of this practical guide¹) and NCD alliances and civil society with experience implementing advocacy initiatives at country level. The participants of the workshops included those who had been previously engaged through key informant interviews and focus group discussions for input on an NCD Health Equity Conceptual Framework for Advocates, and first-time contributors involved in NCD advocacy at country level. In addition to a team of consultants with lived experiences of NCDs, contributions to this guide included perspectives of NCD civil society and advocates, academia, and global health stakeholders with expertise and insights on NCDs. Contributors were asked what they would find most useful to operationalise an NCD health equity lens in advocacy, which led to development of the assessment tool along with clear step-by-step guidance.

How to use this practical guide

- The starting point for using this practical guide is to familiarise yourself with the concept of health equity, and how it relates to NCDs. A summary is provided in the Introduction to Health Equity for NCDs below, and further expanded on in the **NCD Health Equity Conceptual Framework for Advocates**. The framework delves deeper into health equity as a concept, gives examples of barriers experienced by different groups of people living with NCDs, and identifies key areas for action.
- With a strong grounding in the conceptual framing of health equity for NCDs, advocates should work through the **assessment tool** to develop an **NCD Equity Report** (step 1 of this practical guide), with a contextual analysis and policy recommendations tailored to the experiences of people living with NCDs through a health equity lens. While the assessment tool includes a broad set of determinants of health equity, including social and structural, commercial, and health system determinants, it is not expected that advocates will assess the state of equity against all of the determinants. For instance, if your advocacy work focuses on access to NCD care, then you might want to spend more time and resources assessing health equity in relation to health system determinants using an access lens. The NCD Equity Report is intended to be developed through a participatory process (guidance on participatory process is provided below).
- After developing the **NCD Equity Report**, advocates can utilise the analysis and evidence collected to work through the **Practical Guide to Strategic Advocacy Planning** (step 2 of this practical guide). A useful guide for both experienced and new NCD advocates, it offers clearly defined steps to develop strategic advocacy plans, for targeted, multistakeholder national advocacy.



¹ This implies undertaking Rights-based approaches where people living with NCDs are fully aware of, and claim, their rights; ensuring that people living with NCDs are treated with Respect & Dignity; placing people living with NCDs and their wellbeing at the center (People-Centeredness) rather than their diseases; prioritizing Equity to ensure that marginalised and under-represented groups are considered central; and facilitating Social Participation by having formal mechanisms for people living with NCDs and communities to have a 'seat at the table' to inform and influence policy and decision making.

Introduction to Health Equity for NCDs

Health equity is the absence of unfair, avoidable, and remediable differences in health status among groups of people. Health equity is achieved when everyone can attain their full potential for health and wellbeing.¹ NCDs are a marker of inequities, placing a disproportionately heavy burden on poor and otherwise vulnerable people, communities, and countries everywhere.

NCDs like cancer, diabetes, cardiovascular diseases, mental health and neurological disorders, and chronic respiratory diseases are the leading cause of death and disability worldwide. Yet NCDs represent far more than a health issue. As a cause and a consequence of poverty, they are a major human rights and sustainable development issue and have been called the 'social justice issue of our time'.² Although the burden is universal, poor countries and communities are disproportionately affected, facing higher exposure to NCD risk factors; more barriers to NCD prevention, diagnosis, and treatment; and health systems that are less equipped to handle a growing NCD burden. Health and illness follow a social gradient – the lower a person's socioeconomic position, the worse their chances for health.³

The conditions in which people are born, grow, live, work, and age, and their access to power, resources, and decision-making, determine to a large degree the ability to access quality health services, good nutrition, healthy environments, and clean air. Along with the poor, other groups are also at a higher risk of being left behind by health systems, due to their gender, religion, ethnicity, education level, political system, culture, and a long list of other factors, many of which are met with discrimination. Discrimination is present between individuals, but is also often embedded within institutions and systems, leading to whole populations being underrepresented, excluded, and having fewer life opportunities. Known collectively as the determinants of health, this complex mix of factors influence and often aggravate one another, widening health and other inequities and deepening poverty.



Equality means the same services are available to all people. Equity means all people have the same ease and opportunity in using them.

Achieving health equity means putting in place policies and allocating resources to reach those who are most marginalised and furthest behind first, to narrow the gap in health and socioeconomic conditions. As a key driver of poverty and inequity, NCDs are inseparable from any conversation on health equity – equity cannot be achieved without addressing NCDs, and NCDs cannot be prevented, and their impact reduced without closing inequities.

“The just and fair distribution of health and social resources to all who need them without unjustified discrimination based on age, class, geography, gender identity, and sexual orientation. Health resources, services and treatments must be timeously accessible and affordable to all who need them. Equity should be undertaken from social justice and intersectional lenses to ensure that there are no health disparities in-country and between countries. Equity should prioritize black health justice and indigenous health justice in countries, regionally and globally because these vulnerable groups bear a disproportionate burden of mortalities and morbidities communicable and non-communicable diseases.” -

Kwanele Asante, Lawyer and Bioethicist, lived experience advocate, South Africa

APPLYING A HEALTH EQUITY LENS to NCDs involves:

Recognising that populations left furthest behind have a fundamental right to more resources to achieve health equity and ensuring that this right is upheld.

Recognising that there can be multiple interacting causes of NCD health inequities because of complex interactions between individual characteristics, social and structural determinants, and health system determinants across the continuum of care.

Ensuring the meaningful involvement of people living with NCDs to voice their needs and develop appropriate solutions.

Identifying where greater investment and intervention in NCDs is needed to achieve more equitable outcomes.



Eight priority areas to improve health equity among people living with NCDs

The table below is a summary of eight priority areas for advancing health equity, along with examples of barriers faced and recommendations to address these. These priority areas are not a complete or exhaustive list of either the barriers to NCD equity or the recommendations to advance NCD equity. The eight areas have been identified following an assessment of the evidence and an extensive consultation with a wide range of subject and lived experience advocates. We recommend that advocates and civil society who use this table adapt it to their context and priorities. After delving into the conceptual framework on health equity, users of this practical guide will have information to shape engagement with their communities, identify barriers to equity, and develop policy solutions relevant to their respective contexts.

1 Ensure the meaningful involvement of people living with NCDs	
BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> • People with lived experience excluded from decision making. • Lived experience undervalued in programme development, implementation, and policymaking etc. • Lack of social participation mechanisms as part of UHC and of NCD governance. 	<ul style="list-style-type: none"> • Call on governments, WHO country and regional offices, and other relevant stakeholders to implement strategies within the NCD Alliance Global Charter on Meaningful Involvement of People Living with NCDs⁴ and the actions set out in the WHO Framework for Meaningful Engagement of People Living with NCDs and Mental Health and Neurological Conditions to operationalise meaningful involvement⁵. • Advocate for the inclusion of people and communities with lived experience who are particularly marginalised.
2 Ensure access to people-centered NCD care	
BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> • NCD services not included in health benefit packages. • Inadequate health system infrastructure. • Unequal geographical access to health services. • Shortage of human resources for health and workforce. • Weak supply chains and procurement practices insufficient. • Lack of health information and training in self-management. • Low availability and affordability of diagnostics and medicines at different levels of the health system. 	<ul style="list-style-type: none"> • Call on governments to include quality NCD services, across the continuum of care, in national UHC health benefit packages, as contained in Appendix 3 of the WHO Global Action Plan⁶. • Call on governments to enable equitable access to health technologies from research and development through to manufacturing and equitable delivery. • Call on governments to increase the share of health and care sector funding dedicated to populations who are left behind. • Encourage the implementation of indicators for different dimensions of access to address the needs of people living NCDs more adequately; NCDA has developed indicators that can be used in NCD access initiatives and programmes⁷.

3 Create health enabling environments

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> • Low-income countries and communities everywhere are disproportionately affected by NCDs and face higher exposure to NCD risk factors. • Commercial determinants of health leave marginalised populations exposed to unhealthy commodities with health policies and regulations non-existent or very weak. 	<ul style="list-style-type: none"> • Call on governments to implement WHO's 'best buys' of evidence-based, cost-effective, and ready-to-use policies to control NCDs and prevent their main modifiable risk factors^{8,9}. • Call on governments to design equitable public policies to ensure policies reach the hardest-to-reach and most vulnerable populations first e.g., public health labels on health-harming products designed to reach the widest audience possible or fiscal policies designed to advance health equity across diverse populations. • Use NCD Alliance's civil society guide to advance NCD prevention policies which further unpack WHO's 'best buys'¹⁰ to explore how to leverage these in advocacy efforts. • Call on governments to implement WHO technical manuals and packages for NCD risk factor control. • Call on governments to implement multisectoral and multistakeholder NCD actions to build health supporting environment and reduce exposure to risk factors.

4 Integrate people-centered prevention and care for NCDs within efforts to realise UHC

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> • People-centered, integrated healthcare services with a life course approach are lacking to respond to the growing number of people living with multiple chronic conditions. • Investment in integrated NCD services across the continuum of care is not proportionate to the risk profile or disease burden, perpetuating inequities in access and person-centered care. • Vertical health programmes receive greater investment in many LMICs, resulting in siloed healthcare delivery undermining a people-centered, integrated approach to care. 	<ul style="list-style-type: none"> • Call on governments to expand delivery of NCD prevention and care at primary healthcare level, including the implementation of WHO PEN-Plus model of care for NCDs. • Call on governments to integrate NCDs into existing disease-specific services. • Call on governments to integrate NCD prevention and care services into UHC and adopt a people-centered approach to UHC. • Call on governments, and support non-government initiatives, to ensure NCD services are embedded within humanitarian responses.

5 Mobilise financial and human resources

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> NCDs are amongst the least funded disease areas in global programmes towards achieving UHC and the SDGs. Lack of investment in NCDs has catastrophic effects on economic and social development of countries. Predicted shortfall of 18 million health workers by 2030. Insufficient NCD-specific knowledge amongst health workers who are often not equipped to work across specialties and along a continuum of care. Shrinking fiscal space for health as a result of macroeconomic downturn and competing national priorities in post-Covid era. 	<ul style="list-style-type: none"> Call for relevant government ministries to conduct analyses of need (risk, mortality, morbidity, financial burden) to inform policies, programmes, and financial coverage for NCD prevention and care. Call on governments, philanthropies, the private sector, and other development actors to explore innovative financing models for NCDs. Advocate for increased domestic resourcing for health with sustainable financing supported by taxation and fiscal measures. Call on policymakers to include NCD prevention and care in national UHC health benefits packages to improve overall efficiency in health spending. Advocate for the inclusion of quality and affordable essential NCD medicines and equipment on essential medicines and diagnostic lists. Call for the expansion of social protection schemes to ensure more people are protected against catastrophic health expenditures for NCDs.

6 Prioritize health literacy

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> Language and literacy barriers, lack of age sensitive information, and the use of medical jargon impact on access to information and health literacy among people living with NCDs. There are barriers to putting health literacy on NCDs into action, including availability or physical access to information, service quality, service responsiveness, cultural safety and stigma, gender inequality, language, cost, or availability of UHC, racism and other discriminatory practices, information, and communications technology (ICT), and complexity and comorbidity. Commercial industry tactics to undermine health literacy, including through heavily resourced marketing campaigns. 	<ul style="list-style-type: none"> Support a health literacy development approach that involves health workers, health systems, organisations, and policy makers and meaningfully engages communities. Call for health literacy approaches that support community and individual health literacy, health literacy responsiveness and development. Ensure that health literacy targets priority groups^{II} that are not easily accessing health information or health care relevant to the prevention and control of NCDs of whose needs are not met by current approaches to health service delivery.

II This is action area 4 of the [WHO's health literacy development approach for NCDs](#). There are five action areas that are based on case studies to promote sustainable improvements in health and equity.

7 Identify and eliminate stigma and discrimination

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> Stigma and discrimination present in various ways, including self-stigmatisation, stigmatisation by association, public stigmatisation, and structural discrimination. Stigma can take many forms and can be due to visibility of symptoms or outward appearance, fear and blame from others, or driven by negative stereotypes in society. Social positioning of people living with NCDs can also influence how they engage with health systems and services. Poor knowledge about NCDs can fuel misinformation and negative perceptions by self and others e.g., personal beliefs and attitudes of healthcare providers. 	<ul style="list-style-type: none"> Call on governments to implement WHO's Comprehensive Mental Health Action Plan 2013-2030 to address stigma and discrimination for mental health conditions¹¹. Call for relevant stakeholders to implement actions listed in the Global Advocacy Agenda of People Living with NCDs to address stigma and discrimination in workplaces, schools, and healthcare settings under the 'human rights and social justice' pillar¹². Call on WHO and governments to implement relevant actions in the WHO Framework on Meaningful Engagement for People Living with NCDs to eliminate stigmatization.

8 Monitor, evaluate and use data for effective decision making

BARRIERS	RECOMMENDATIONS
<ul style="list-style-type: none"> Data collected on NCDs isn't disaggregated by age, gender, disease, geography, or socioeconomic grouping, to inform equitable policy making. Global NCD commitments and targets do not capture inclusive information across populations and disease areas¹³. Data gaps for people living with multiple NCDs and/or NCDs other than the major conditions (beyond the "5x5 agenda"^{III}), out-of-pocket payments, people younger than 30 years and older than 70 years, and morbidity to name a few. UHC service coverage index NCD tracer indicators do not reference NCD care provision. Lack of disaggregated data – by age, socioeconomic status, education level, place of residence, sex and gender, race, ethnicity, indigeneity, and other characteristics 	<ul style="list-style-type: none"> Call for the disaggregation of global and national NCD targets by age, disease, gender, geography, socioeconomic grouping – this also applies to reporting on the UHC Target^{IV}. Call on governments and all relevant stakeholders to recognize a broader set of conditions and diseases beyond the "5x5 agenda", widen the focus from mortality to morbidity and multimorbidity, and strengthen data focus on those under 30 and over 70. Call on governments to disaggregate the existing SDG target for social protection to target poor and vulnerable people living with NCDs. Call on governments to implement WHO's NCD facility-based monitoring guidance for primary care level, which can be leveraged by civil society. Implement community-led monitoring to identify actions to improve health systems, and policy and legal gaps that impact access and uptake of health services¹⁴.

III The "5x5 agenda" as it is informally known, refers to the global NCD response which is currently focused on five diseases – cancer, diabetes, cardiovascular disease, mental and neurological conditions, and chronic respiratory diseases. The five modifiable risk factors are tobacco use, physical inactivity, harmful use of alcohol, unhealthy diets, and air pollution.

IV "To progressively cover 1 billion additional people by 2023 with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to covering all people by 2030."

STEP 1

Developing an NCD Equity Report

A NCD Equity Report is intended to be produced through a participatory process, to co-create evidence and analysis that draws on the perspectives of multiple key stakeholders, including people living with NCDs, community advocates and country experts.

The NCD Equity Report is developed using the NCD Health Equity Assessment Tool, which can be found as an Annex at the end of this guide.

Guidance for completing the assessment and producing the NCD Equity Report through a participatory national process is outlined below:

- Form a working group who will function as the secretariat and help to steer the process. This group can include several people, from one organization or people from multiple organisations – as long as the members work well together, have clear roles and responsibilities in conducting the NCD equity assessment, and have a common understanding of the participatory development process.
- Establish a **National Expert Advisory Group (NEAG)** to provide high-level guidance on developing the NCD Equity Report including guidance on its scope and methodology, inclusive processes, accessing data and information, and identifying and ensuring meaningful involvement of communities including those who are hardest to reach, as well as launching and promoting the report. The NEAG is likely to function best if it is not too large – six to 10 members is ideal. The NEAG should have a Terms of Reference, and members should be selected to form a diverse and representative interdisciplinary group. The Terms of Reference should include meeting dates, which can be timed at key points in the NCD Equity Report development process, such as at the beginning and end of each step.
- Before beginning the assessment, the working group should provide a comprehensive briefing to the NEAG, reviewing the NCD Health Equity Lens conceptual framework, the Assessment Tool, and desired outcomes of improving health equity for NCDs. Following the briefing, facilitate a discussion with the NEAG to unpack the process for producing the NCD Equity Report using the tool, including who to consult, data sources, how best to analyze the information and data you find, organising the multistakeholder meeting and launching the NCD Equity Report. Write up the agreed process into a short methodology document, and where necessary update this document as the process evolves. Include roles and responsibilities for data collection and analysis, as well as target timelines.
- Implement the agreed methodology to apply the Assessment Tool, maintaining the regular NEAG review meetings.
- The Assessment Tool recommends holding a multistakeholder meeting(s) at Stage 3 to review the evidence and analysis, and to co-create policy recommendations. The multi-stakeholder meeting(s) should include the NEAG, secretariat, and broader stakeholders, aiming for diversity and representation of people living with NCDs. NCD Alliance's Practical Guide on Building Advocacy Agendas of People Living with NCDs has a useful resource on planning and holding a multistakeholder dialogue, which can be found at Step 3 of Section 2 [here](#). The secretariat, guided by the NEAG, should manage the facilitation and consolidation of the meeting conclusions to finalise the set of policy recommendations to be included in the NCD Equity Report.
- At this stage you will have completed your assessment and are ready to finalise your report. Summary sections of the assessment tool's Stage 1, Stage 2 and Stage 3 will be the basis for your NCD Equity Report, which presents the findings and policy recommendations in an accessible and compelling format. The report should be brought to life by including short case studies and personal narratives of people living with NCDs (collected in the participatory process including interviews, surveys, and multi-stakeholder meetings). The NCD Equity Report should be launched and disseminated with key stakeholders. It should be publicly available and can be periodically updated.
- The completed assessment and its resulting Equity Report will provide the foundation and evidence for advocacy work on ensuring an equitable NCD response. Strategic advocacy planning is covered in the following section. Derivative advocacy briefs can be developed as needed.

STEP 2

Strategic advocacy planning

The table below provides important clarification of how to use the Assessment Tool and resulting NCD Equity Report as the basis for Strategic Advocacy Planning. The Strategic Advocacy Planning Guide below is based on the detailed steps outlined in the **NCD Alliance Practical Guide to Strategic Advocacy Planning**.

Strategic Advocacy Planning Practical Guide steps	How to align with the Assessment Tool
<p>STEP 1 Advocacy situation analysis</p> <p>Gather data and assess the status of NCD prevention and control, the policy and legal environment, stakeholders, potential partners, and other factors in your setting to plan your overall advocacy strategy.</p>	<p>You have already completed an in-depth assessment to develop your NCD Equity Report.</p>
<p>STEP 2 Select priority issues, goals, objectives</p> <p>Based on what you learn in your advocacy situation analysis, select your advocacy issue, and determine your goal and objective for your advocacy campaign.</p>	<p>Having already completed the Assessment Tool to develop policy recommendations, use this step to prioritise from your policy recommendations and develop a SMART^V advocacy objective. Consider windows of opportunity to select your one priority advocacy objective.</p>
<p>STEP 3 Political mapping</p> <p>Actively map out those who have direct decision-making capacity or influence over your selected NCD advocacy issue.</p>	<p>Identify who has the power to give you your advocacy ask: your priority policy recommendation (refer to Step 3 of the Assessment Tool). Map those who have influence over them. Consolidate your list of advocacy targets.</p>
<p>STEP 4 Advocacy tactics and messages</p> <p>Successful NCD advocacy involves forming partnerships for a common purpose, both within and beyond NCDs and the health sector, to achieve your advocacy goals and objectives.</p>	<p>Complete this section as per the guide.</p>

^V Specific, measurable, achievable, realistic (or relevant) and time-bound (or timely).

Strategic Advocacy Planning Practical Guide steps

STEP 5

Build support among constituencies

Select your advocacy tactics and create your advocacy messages to tell those who have the power to make a change why you want the change and how it will help control NCDs, or improve the lives of people living with NCDs, etc.

STEP 6

Create a workplan and budget

Develop a strong workplan and budget to take concrete steps towards making your NCD advocacy campaign a reality.

STEP 7

Roll out the advocacy plan

Assess when the time is right to launch your NCD advocacy campaign (a window of opportunity).

STEP 8

Monitor and evaluate

Keep track of your NCD advocacy campaign activities and assess your progress through monitoring, make adjustments when needed, and measure your overall achievements and lessons learned through evaluation. Do not forget to celebrate progress and advocacy wins, thanking champions and allies, and ensuring continued motivation of partners.

How to align with the Assessment Tool

Complete this section as per the guide.



ANNEX

NCD Health Equity Assessment Tool

Follow the outlined steps below to conduct your health equity assessment, collating qualitative and quantitative evidence to develop your **NCD Equity Report**.

ASSESSMENT STAGE 1

1. Who is being left behind?

The first step of the **Equity Assessment** is to understand who is being left behind in terms of their needs and the quality of care they are receiving. Step 1 should be completed as a participatory process and the summary of findings should be included in the NCD Equity Report.

When considering the experiences and data for different subpopulations, key **categories to consider** include:

Income and assets	Place of residence (<i>rural, urban, other</i>)		Occupation (<i>workers/employed, unemployed</i>)		
Race or ethnicity	Sex	Religion	Education	Social class	Age
Other characteristics particularly important for the country context (<i>e.g. migrant status, caste, gender identity and sexual orientation</i>)					

1.1. Community knowledge and outreach

Starting with your knowledge of your community, identify who is currently accessing NCD care and who is not:

- Are there subpopulations who experience more or greater access barriers to NCD care?

When these subpopulations have been identified, follow-up questions might be:

- Within these subpopulations, who has greater disease burden (including morbidity and mortality) from NCDs?
- Within these subpopulations, who has greater exposure or vulnerability to NCD risk factors?

In assessing the level of equity that a person experiences in their **access** to healthcare, it is critical to consider the different dimensions of access to develop prompts and questions for consultations and interviews. Here you can refer to the NCDA discussion paper [Rethinking Social Impact](#), which includes an access framework^I. The [Tanahashi model of effective coverage](#)^{II} is another useful resource and links to the elements of the right to health i.e., availability, accessibility, acceptability and quality (AAAQ) framework^{III}.

I See page 55 of the NCDA discussion paper – Rethinking Social Impact.

II Tanahashi T (1978). Health service coverage and its evaluation. Bulletin of the World Health Organization. 1978;56(2):295–303.

III See Step 4 of the [Innov8 approach for reviewing national health programmes to leave no one behind](#).

GUIDANCE

When engaging with your communities it is important to consider the knowledge held by marginalised and underserved populations (those requiring care) as well as the health workforce, health service planners, and decision-makers (those planning and providing care).

You should consult with stakeholders that are relevant to you in your context and use the most appropriate and inclusive consultation format to do so. Some examples include the following:

- Hold **consultative discussions in your community** with people living with NCDs from underserved populations to identify challenges faced, key recommendations and actions. Refer to the Our Views, Our Voices [Community Conversation Guide](#) on how to hold consultative in-person discussions to adapt to your context.
- Engage your **National Expert Advisory Group (NEAG)** for their perspectives, as well as guidance on consulting marginalised communities.
- Hold **key informant/in-depth interviews**, combined with surveys of health administrative bodies, local level health providers and/or community members for insights into reasons why some people face challenges in accessing and benefiting from NCD services, as well as solutions to addressing those challenges.

Summarise your findings from community knowledge and outreach, noting key sources.

1.2. Quantitative data

To compliment community knowledge of inequities, draw on existing data available in your country (official government data, academic and statistical data, grey literature, etc.) to assess which subpopulations experience the greatest NCD risk, disease burden (mortality and morbidity), and lack of access to care.

GUIDANCE

Useful sources of data may include:

- **National data** e.g., National health surveys, NCD specific data and surveys, data collected by the World Bank and WHO at national level.
- **Subnational data** to verify who is and is not accessing services.

In some cases, it could be helpful to draw on **global data**, which can shed light on inequities in countries. Here are two global data sets:

- [World Bank's equity and poverty data](#)
- [WHO's Health Inequality Data Repository](#) – the most comprehensive global collection of publicly available disaggregated data and evidence on population health and its determinants.

If you would like additional guidance on quantitative data sources and methods for measuring health inequities, see page 86 of the [WHO Innov8 framework](#).

1.3. Complementarity of community knowledge and quantitative data

Reflecting on the picture produced from community knowledge and quantitative data, try to answer the following questions:

- Does the community knowledge and quantitative data align or misalign?
- Do you need to verify any findings or find additional qualitative or quantitative data?
- Is there a data gap?

GUIDANCE

- Compare how the two different types of data provide insights into inequities experienced by different populations – in what way are the results of the two types of data similar or different?
- Assess whether you feel that the findings give you a reliable image of who is experiencing inequity. If necessary, highlight gaps in information or data which could be filled, either through further outreach and research by the Assessment Group, or through improved data from institutions. Where there is a lack of data, this may provide the basis for a policy recommendation in Stage 3.

1.4. Those left furthest behind

Who is experiencing the highest unmet need?

GUIDANCE

Consolidate your findings of Stage 1 to describe the groups who are underserved and/or marginalised in their experience of NCDs and those that are hardest to reach and/or left furthest behind. If possible, include detail on each group's demographic status and categories, diseases and conditions, and their population size. Include case studies and quotes from individuals, including on the impact and consequences of being left behind.



ASSESSMENT STAGE 2

2. Why are they being left behind?

Stage 2 focuses on identifying the drivers of inequity. It includes a policy landscape analysis and an exploration of determinants grouped into 1) Social and structural determinants; and 2) Health system determinants.

While not all sections will be assessed in each context, they serve to guide an analysis of the multiple dimensions affecting a person's lived experience and health outcomes. The NEAG will need to agree on which aspects to focus on and include in the NCD Equity Report. The findings and analysis from Stage 2 provide the basis for developing policy recommendations in Stage 3.

2.1. Policy landscape analysis

Any assessment of NCD equity and its drivers will need a policy landscape analysis as a foundation.

Is equity prioritised in national policies and plans relevant to NCDs (e.g., in National NCD Plans, Health Sector Strategic Plans, National Multisectoral NCD Action Plans, disease-specific plans and protocols, UHC guidance etc.)?

GUIDANCE

Draw on desk research, data, and community knowledge to assess how national policies and plans recognise and make provision for equity and reaching specific subpopulations that may be more vulnerable and/or marginalised.

SOCIAL AND STRUCTURAL DETERMINANTS

The **Operational framework for monitoring social determinants of health equity** by WHO aims to provide countries with globally applicable and harmonized guidance for monitoring social determinants of health equity, using data for action to improve health equity. In developing their NCD equity reports, NCD community advocates are encouraged to also refer to the operational framework as a valuable resource including for examples of indicators and data sources. In addition, NCD advocates should refer to the Operational framework with their government contacts, as a helpful resource for work on health equity, given the strong alignment with the NCD equity reports being developed.

2.2. Geographic location

Which geography is this person or subpopulation living in, and what characteristics of this geography affect equity?

GUIDANCE

Draw on community knowledge and data to identify geography and assess how this geography affects unmet needs and experiences of inequity (e.g., access to NCD care for populations in rural and/or remote areas, or disadvantaged urban areas, etc.).

2.3. Demographics

What are the demographic characteristics of this person or subpopulation, and how do those characteristics affect NCD equity?

Demographic characteristics to consider:

Gender	Sexual orientation	Age (e.g., children, youth, older people)
Marital or relationship status	Disability status	Religion
Ethnicity (e.g., racial, or cultural minorities, indigenous groups)		

GUIDANCE

- Demographic characteristics can affect the experience of health equity at the individual level and can also influence broader household, neighbourhood, or community-level characteristics, which can then affect equity.
- Draw on community knowledge and data to identify demographic characteristics and assess how each characteristic affects unmet need.
- For disability, consider physical disabilities – hearing and visual impairments, multiple sclerosis, brain injuries, respiratory disorders – as well as intellectual/developmental disabilities – ADHD, cerebral palsy, intellectual disability, learning disabilities, and invisible/visible disabilities.

2.4. Socioeconomic factors

Are there socioeconomic factors which affect this person or subpopulation’s experience of NCD equity?

Consider the following:

Education level	Employment status and conditions	Income and financial situation
Food insecurity	Housing insecurity	Social status or class

GUIDANCE

- Draw on community knowledge and data to further unpack the socioeconomic factors that affect this person/subpopulation and assess how the characteristics affect unmet need.
- For education consider the amount and level of education (early childhood education, primary, secondary, or higher etc.).
- For employment consider employment status, type of employment (informal/formal with benefits), conditions etc.
- For financial situation consider whether the person/subpopulation has access to health insurance and/or social protection mechanisms.

2.5. Political factors

Are there political factors which affect this person or subpopulation’s experience of NCD equity?

Displacement and refugee status	Conflict	Violence
Racism	Political instability	Civic space

GUIDANCE

- Draw on community knowledge and data to unpack further the political factors that affect this person or subpopulation and assess how the characteristics affect unmet needs. The political determinants of health create the structural conditions and the social determinants that can positively or negatively impact NCD inequities.
- For displacement and migratory status, consider specific policies that affect refugees (e.g., do they have access to social protection benefit packages and access to basic services?).

2.6. Stigma and discrimination

Does this person or subpopulation experience stigma and discrimination, and how does this affect their experience of NCD equity?

Forms of stigma and discrimination to consider:

- Self-stigmatisation (individuals view themselves as lesser)
- Stigmatisation by association (stigmatisation of close associates of an individual with lived experience)
- Public stigmatisation (societal view of individuals with lived experience)
- Structural discrimination (systemic factors such as legal frameworks, policies, and organisational practices)

GUIDANCE

Draw on community knowledge and data to understand if this person/subpopulation experiences stigma and discrimination and assess how this affects unmet need.

Here are some examples of stigma and discrimination to consider in your context:

- Putting blame on person/subpopulation for their health condition
- Exclusion of person/subpopulation based on health status or another characteristic.
- Use of unacceptable language
- Bias of healthcare professionals and healthcare accessibility
- Language or cultural appropriateness of care
- Overmedicalizing and dehumanising individual
- Physical violence
- Emotional and psychological abuse

2.7. Commercial determinants

Are there strategies and approaches by the commercial sector that are damaging to health, increase health inequities and increase NCDs (e.g., harmful marketing and advertising of tobacco, alcohol, and ultra-processed foods)?

GUIDANCE

- Draw on community knowledge and data to understand the commercial factors this person is exposed to and how these affect their unmet need.
- Describe the type of economic activity, its potential effect on the person/subpopulation, and the policy environment that enables or prevents these commercial activities.
- Consider the commercial activities of these industries (i.e., tobacco, alcohol, food and drink, environmental pollutants etc.) that they are exposed to in their community, including schools and workplace, such as exposure to pollutants, promotion of unhealthy substances, exposure to dangerous work practices, and unhealthy workplace lifestyles such as sedentary work.

2.8. Intersectionality (overlapping characteristics)

Do multiple social and structural factors interact to worsen this person's unmet need? Which factors and how?

GUIDANCE

Reflecting on community knowledge and data, is this person/subpopulation exposed to multiple/overlapping characteristics which increase their vulnerability and unmet need? Describe these characteristics, and how they appear to interact. An illustrative case study of a specific individual may be helpful in offering an example.

2.9. Meaningful involvement

Are people with lived experience or a specific subpopulation meaningfully involved in decision making around the different social and structural determinants that affect their health outcomes?

GUIDANCE

- Draw on community knowledge and data to assess whether and how these people or subpopulations are involved in decision making around any of the social and structural drivers that affect their health outcomes.
- Consider whether opportunities exist for the participation of people with lived experience in power and decision making structures at different levels (local, sub-national, national) and in different settings (e.g., schools, community fora/platforms).
- Are there formal mechanisms to promote diversity, inclusion, and intersectionality of individuals with lived experience in various governance processes, activities, and engagements?

2.10. Main social and structural drivers of inequity

Taking stock of the social and structural determinants that affect this person or subpopulation, which of these appear to have the most significant impact on NCD inequities?

GUIDANCE

Reflecting on your analysis in the previous sections, summarise the main social and structural determinants of this person or subpopulation's inequity. This summary analysis should help consolidate your assessment of social and structural drivers, which will provide the basis for focusing on policy solutions in Stage 3.

HEALTH SYSTEM DETERMINANTS

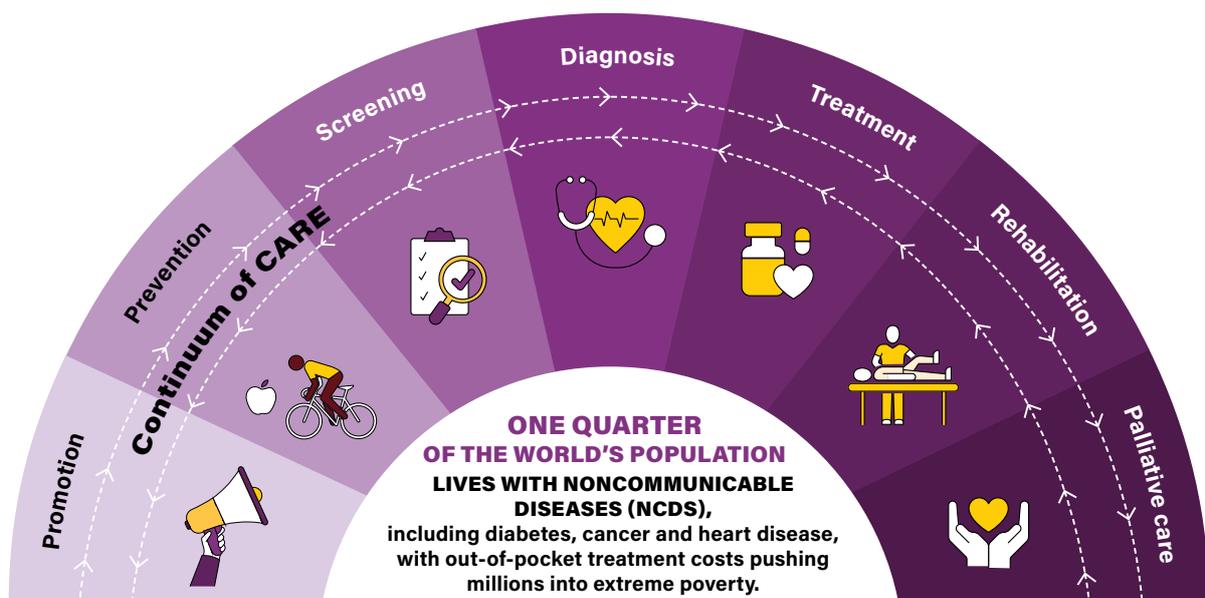
2.11. Access across the continuum of care

Are health systems and services approachable, acceptable, available, affordable, and appropriate, and do communities (civil society and people) play a role in governance, planning and accountability across the full continuum of care?

GUIDANCE

- Draw on community knowledge as part of your participatory process in building the equity report (e.g. community conversations with underserved subpopulation, surveys/interviews of people living with NCDs etc.) and data to assess the level of access available to this subpopulation at each stage of the **continuum of care** and how this affects their level of unmet need.
- Where possible include analyses of policies that affect access across its different dimensions.

Protect people throughout their lifetime and across the continuum of CARE



THE DIMENSIONS OF ACCESS

The following dimensions of access (6As) were developed by NCDAC and build upon other definitions of access, notably the AAAQ of the right to health^{IV} and Tanahashi model of effective coverage^V. These can guide your assessment of access across the continuum of care.

ACCEPTABILITY (ability to seek)

Relates to cultural and social factors determining people's ability to accept different aspects of the health service (e.g. the sex or social group of providers, the beliefs associated to systems of medicine) and the perceived appropriateness of people seeking care.

ACTORS (ability to mobilise)

This recognises the central role that civil society and people living with NCDs play within health system governance, planning, accountability and multisectoral partnerships, which is needed to best address the other dimensions of access above.

APPROPRIATENESS (ability to engage)

The extent to which the provider's operation can meet people's preferences (hours of operation, scheduling practices, communication options). It relates to the fit between services and need, timeliness, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided.

AFFORDABILITY (ability to pay)

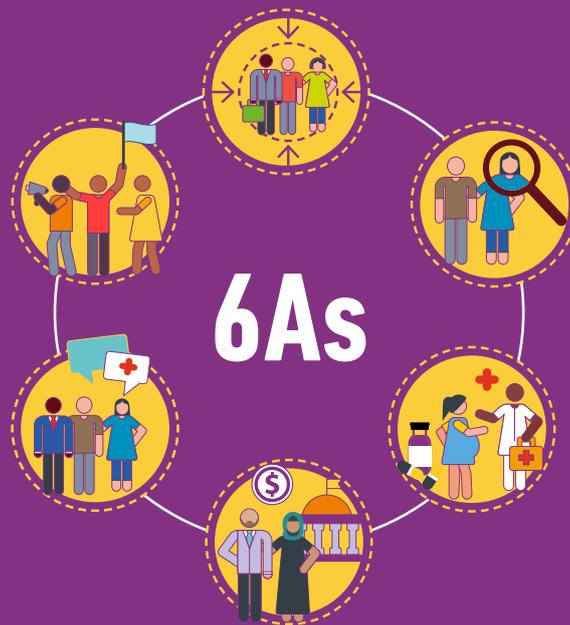
The measure of people's ability to pay for services without financial hardship. It considers the cost of services and indirect costs (e.g., transport and time off work), and is influenced by the wider health financing system and household income.

APPROACHABILITY (ability to perceive)

The ability of people with health needs to identify that some form of service exists, can be reached, and can have a positive impact on their health. Relates to health literacy, knowledge, transparency, and expectations.

AVAILABILITY (ability to reach)

Constitutes the physical existence of health resources with sufficient capacity to provide services. Results from characteristics of facilities, equipment and diagnostics, human resources, routine and specialist service provision, medicines etc.



Useful resources for assessing access and effective coverage include:

NCDAC discussion paper: [Rethinking Social Impact](#)

WHO: [Innov8 approach for reviewing national health programmes to leave no one behind^{VI}](#)

IV See Step 4 of the [Innov8 approach for reviewing national health programmes to leave no one behind](#)

V Tanahashi T (1978). Health service coverage and its evaluation. Bulletin of the World Health Organization. 1978;56(2):295–303.

VI See Tanahashi Framework for effective coverage on page 104 of Innov8 and examples of how equality and discrimination can be considered across the dimensions of access provided on page 106 Innov8.

2.12. Meaningful involvement

Are people with lived experience meaningfully involved in decision-making around the health system determinants that affect their health outcomes? Consider their participation in governance as well as consultations.

GUIDANCE

- Draw on community knowledge and data to assess whether and how these people or subpopulations are involved in decision making around any of the health system drivers that affect their health outcomes.
- Consider whether opportunities exist for the participation of people with lived experience in health governance processes and decision making structures at the local, sub-national, national levels.
- Are individuals with lived experience engaged and actively participating in the co-creation of public health interventions, research, and formulation of national health plans?

2.13. Main health system drivers of inequity

Taking stock of the health system determinants that affect this person or subpopulation, what appear to be the main health system drivers of their inequity?

GUIDANCE

- Reflecting on your analysis of health system determinants, summarise what you feel are the main determinants of this person or subpopulation's unmet need.
- This summary analysis will help consolidate your assessment of health system determinants, which will provide the basis for focusing on policy solutions in Stage 3.

2.14. Integrated summary of causes of inequity

Taking stock of both social/structural determinants and health system determinants, how do they interact and what appear to be the most important drivers of unmet need?

The purpose of this integrated assessment is to understand how the different drivers interact to produce the lived experiences of this person or subpopulation and identify priority areas for policy interventions.

GUIDANCE

- Reflecting on your analysis of the social/structural determinants and health system determinants, what is the interaction between, or balance of social/structural determinants versus health system determinants, in driving the unmet needs of this person or subpopulation?
- Which factors have the biggest impact and should be priority areas for interventions to improve health outcomes for people living with or at risk of NCDs?

ASSESSMENT STAGE 3

3. What policy recommendations can help achieve equity for NCDs?

3.1. Social and structural changes needed to achieve equity

What key social and structural changes will have the biggest impact on unmet health needs of people or specific subpopulations?

3.2. Health system changes needed to achieve equity

- What are key health system changes needed to achieve equity for marginalised groups living with NCDs?
- Which of the elements of care and which dimensions of access need improving to achieve greater equity of access?
- What policy recommendations would enable or support this change?

GUIDANCE

- Draw on community knowledge and data to begin identifying solutions to the equity drivers that are leaving people behind. Building on that knowledge and data, and the prior analysis of social, structural, and health system drivers, convene a multistakeholder dialogue to identify and refine key policy recommendations.
- NCDAs [Practical Guide on Building Advocacy Agendas of People Living with NCDs](#) has a useful resource on planning and holding a multistakeholder dialogue, which can be found in Step 3 of Section 2.

3.3. Resources

For your different policy recommendations, consider what resources and inputs are required to implement these policies.

Resources could include finances, taxation and fiscal measures, information and data, digital technology, human resources and more. These are not resources for advocacy.

GUIDANCE

Through the multistakeholder dialogue as well as additional consultations, assess what resources and inputs are needed to implement the policy change. This will help you refine policy recommendations that are feasible and can help you make the case with policy makers.

3.4. Power and whole-of-government action

Who has power to make these changes? What is the hierarchy of influence among these key actors?

Particularly for social and structural determinants, consider the overall governance in a country, macroeconomic policies, social policies (labour market, housing, land etc.), public policies (education, health, social protection), culture and societal values (see page 26 of the WHO [Innov8 framework](#)).

GUIDANCE

- Through the multistakeholder dialogue as well as additional consultations, identify the targets of specific policy recommendations. This assessment will help make your policy recommendations specific and target key agents of change.
- A whole-of-government approach is needed in NCDs, and it refers to multisectoral action to ensure health-in-all-policies. Often, policy solutions to address all dimensions of a problem go beyond the health sector alone.
- If your country has an existing national NCD coordination mechanism, explore how this might be utilised as part of this assessment.

3.5. Whole-of-society approach

What multistakeholder action is needed to address social, structural, and health system drivers of NCD inequity?

Multistakeholder action refers to the whole-of-society approach, which includes government as well as other stakeholders such as civil society, private sector, the media, and international agencies.

GUIDANCE

- Through the multistakeholder dialogue as well as additional consultations, assess multistakeholder actions and roles played in contributing to NCD equity and supporting the implementation of policy solutions.
- If your country has an existing national NCD coordination mechanism, explore how this might be utilised as part of this assessment.

3.6. Social participation changes needed to achieve equity

How can social participation be strengthened to ensure people living with NCDs, communities and civil society are meaningfully involved in decisions about social, structural and health system drivers?

GUIDANCE

- Through the multistakeholder dialogue as well as additional consultations, assess ways in which social participation can be strengthened, such as through increased representation of people living with NCDs in decision making spaces.
- Try to identify specific decision-making spaces, and the way in which people living with NCDs could be engaged in these spaces.

For further information on social participation and meaningful involvement of people living with NCDs, the following are key technical resources that provide principles of engagement, practical actions, and guidance:

[NCDA's Global Charter on Meaningful Involvement of People Living with NCDs](#)

[WHO Framework on Meaningful Engagement](#)

[WHO UHC Social Participation Handbook](#)

Additional resources

DATA RESOURCES

World Bank equity and poverty data

<https://www.worldbank.org/en/topic/poverty/publication/poverty-and-equity-briefs>

WHO's Health Inequality Data Repository

https://www.who.int/health-topics/health-equity#tab=tab_1

NCD Alliance advocacy networks and initiatives

Our Views, Our Voices initiative

<https://www.ourviewsourvoices.org>

Advocacy Agenda of People Living with NCDs

<https://ncdalliance.org/resources/advocacy-agenda-of-people-living-with-ncds-0>

NCD Alliance Community Conversation Guide

https://ncdalliance.org/sites/default/files/OVOV_2.pdf

Policy guides

Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook

<https://www.who.int/publications/i/item/9789241511391>

NCD Atlas – Bridging the gap on NCDs through civil society action

https://ncdalliance.org/sites/default/files/resource_files/NCDatlas_NCDalliance_Feb2020_FINAL.pdf

Bridging the gap on NCDs: From global promises to local progress – Discussion paper

<https://ncdalliance.org/resources/bridging-the-gap-on-ncds-from-global-promises-to-local-progress-policy-brief>

Protecting Everyone: Integration of Noncommunicable Diseases into Universal Health Coverage in the era of COVID-19

<https://ncdalliance.org/resources/protecting-everyone-integration-of-noncommunicable-diseases-into-universal-health-coverage-in-the-era-of-covid-19>

Shaping the health systems of the future: case studies and recommendations for integrated NCD care

<https://ncdalliance.org/resources/shaping-the-health-systems-of-the-future-case-studies-and-recommendations-for-integrated-ncd-care>

Other relevant reports

World Report on Social Determinants of Health Equity

<https://www.who.int/initiatives/action-on-the-social-determinants-of-health-for-advancing-equity/world-report-on-social-determinants-of-health-equity>

Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage

<https://www.who.int/publications/i/item/9789241507158>

Advancing a world together equitably

https://oneill.law.georgetown.edu/wp-content/uploads/2023/02/P7_ONL_Pandemic_Equity_Models_-1.pdf

Advocacy and communications guides:

Stop the global epidemic of chronic disease: a practical guide to successful advocacy

<https://apps.who.int/iris/handle/10665/43513>

ACT NCDs Communications Guide

<https://actonncds.org/resources/2021/communications-guide>

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- 3 Ibid.
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