The Equity Gauge

Concepts, Principles, and Guidelines

A guide for social and policy change in health

The Equity Gauge: Concepts, Principles, and Guidelines

The Global Equity Gauge Alliance (GEGA)

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In the mid 1990's a global network of researchers, policy makers and NGO activists collaborated on a process entitled the Global Health Equity Initiative, which culminated with an edited volume entitled: "Challenging Inequities in Health: from ethics to action." One of the themes of the volume is the importance of "measuring and monitoring" health inequities, as a critical platform upon which to inform and evaluate policy and action. This specific recommendation was further addressed at a meeting held in Chile in November 1999, during which a declaration emerged that identified the vision to develop measurement capacities at the country level by the year 2015. The 15-year time horizon was thought to be a reasonable frame for the development of these capacities, and subsequently corresponds to the development outcome targets of the Millennium Development Goals.

Moving forward with action toward achieving this ambitious aim for 2015, a subsequent meeting took place in South Africa with the objective of developing an "active" approach to monitoring inequities in health – what has become known as an *Equity Gauge*. This manual provides concepts, principles and guidelines for implementing the three pillars of an *Equity Gauge*: Assessment and Monitoring, Advocacy and Community Empowerment. It represents an effort to cull experience from a diverse set of demonstrations at the local and national levels in 11 countries and 3 continents. That a manual embracing such diversity comes together in a cogent whole is testimony to the high level of cooperation of its contributors and the exemplary stewardship of the Health Systems Trust.

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The Equity Gauge: Concepts, Principles and Guidelines

The purpose of this document is to describe the concept and key principles of an *Equity Gauge*, and to provide guidelines for putting the concept and principles into action. GEGA's ultimate goal in disseminating the document is to contribute to the creation of an effective global alliance of *Equity Gauges* bound by shared principles and common approaches.

THE CONCEPTS AND PRINCIPLES OF AN EQUITY GAUGE

Concern about equity in health[1] is not new. International health and development agencies, researchers, and activists have been pointing to inequities in health between different countries, between rich and poor people, between racial/ethnic groups, and between men and women, for many years. Equity was one of the key principles of the 1978 Alma Ata Declaration on Health for All. However, despite evidence of wide and sometimes widening disparities between and within countries on every continent, few countries routinely monitor equity in health, health care, the underlying determinants of health, or the social consequences of illness. Equity is an urgent public health issue today.

An *Equity Gauge* places health equity squarely within a larger framework of *social justice.* While some health inequalities are inevitable and acceptable (for example, elderly people generally have poorer health than young adults), many health inequalities are avoidable and unjust (for example, lower rates of immunization coverage among girls than among boys, or higher mortality rates among some racial/ethnic groups compared to others). *Equity Gauges* are concerned with health-related inequalities that are *unfair.*

[1] In this document, 'equity in health' refers to equity in health outcomes, distributions of health care resources and other determinants of health, and the social consequences of illness.

Such an orientation strives towards a world in which disadvantaged population groups can achieve their full health potential, as indicated by the health enjoyed by those groups in society who are most advantaged socially, i.e., with respect to wealth, power, and prestige. This approach calls for affirmative and preferential action to improve the health of those who face the greatest underlying obstacles to achieving their full health potential.

The adoption of a social justice framework is reinforced by massive evidence from rich and poor countries showing that health is closely associated with social position and its underlying political, economic, and cultural determinants. The correlation between poverty, disease, and mortality, for example, is well documented. The effects of poverty on health may be accentuated or aggravated by other factors that influence social position, such as gender, geography, race/ethnicity, language, and disability. For example, in countries where women occupy a lower social position than men, women have poorer health-related indicators. In other countries, racial discrimination aggravates and accentuates the impact of poverty and marginalisation on access to health care and other health determinants.

Although many determinants of health lie outside the health care sector, health systems can do much to reduce health inequalities. They can pro-actively target the health problems of the disadvantaged and marginalized, not only through health care but also through a range of public health actions. They can help to reduce poverty by removing financial barriers to health care for the poor; health care expenses are a cause of impoverishment worldwide. The health sector can also work with other sectors — such as education, finance, labour, transportation, and housing — to help address the major determinants of health outside the direct reach of the health sector.

Part of the solution to the problem of health inequities lies in eliminating poverty, racism, and discrimination, and making opportunities in society more accessible to the excluded. An *Equity Gauge* therefore seeks to address both the socio-political determinants of health inequities, as well as inequities associated with the health care system. Another key objective of an *Equity Gauge* is to contribute to building a society that routinely considers equity in all its policy and decision-making processes.

What does an Equity Gauge do?

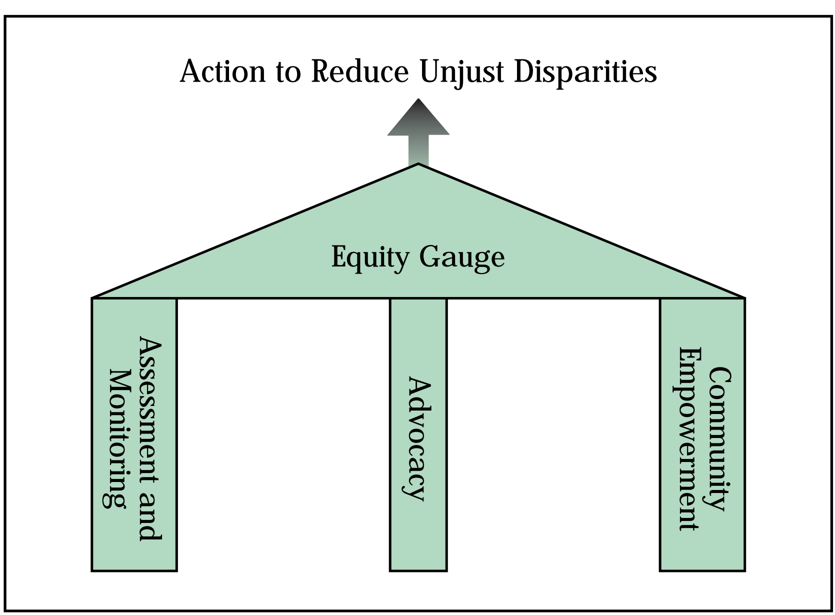
An *Equity Gauge* is an active approach to addressing inequity in health that not only monitors equity, but also incorporates concrete actions to bring about sustained reductions in unfair disparities in health and health care. In this sense, an *Equity Gauge* should function more like a thermostat than a thermometer, not just measuring or 'gauging' equity and inequity but also triggering actions to reduce inequities. This active approach requires the involvement of a range of actors in society including researchers, health workers, policy makers, the media, the general public, and NGOs concerned with development and justice.

An *Equity Gauge* is more than a conventional research project, and reaches beyond actions in the health sector. Inherent within the *Equity Gauge* concept is an understanding that the determinants of health inequities are largely socio-political in nature, and often relate to unfair distributions of power, influence and wealth. Therefore, achieving a more just distribution of resources needed for health requires some degree of social and political mobilization.

Based on these concepts, an *Equity Gauge* seeks to reduce unfair disparities in health through three broad spheres of action, referred to as the 'pillars' of an *Equity Gauge* (see Figure 1). The three pillars, each essential to an effective *Equity Gauge*, are:

- Assessment and Monitoring, to analyse, understand, measure, and document inequities
- Advocacy, to promote changes in policy, programs, and planning
- Community Empowerment to support the role of the poor and marginalized as active participants in change rather than passive recipients of aid or help.

Figure 1: The three pillars of an *Equity Gauge*



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Although one might get the impression from Figure 1 that the pillars work independently, they actually define a set of interconnected and overlapping actions. For example, the selection of indicators to assess and monitor equity should be informed by the views of community groups and by consideration of which issues would support a successful advocacy campaign. In turn, the strength of advocacy arguments relies on scientifically sound information produced by the Assessment and Monitoring pillar.

Another important feature of the *Equity Gauge* pillars is that the three sets of actions do not take place in any particular sequence. The traditional linear approach of collecting data first, analysing it and then engaging in information dissemination and advocacy activities, is not often effective. In an *Equity Gauge*, the actions of all three pillars should be happening simultaneously and influencing each other.

Current Equity Gauge teams include diverse groups, such as representatives from Ministries of Health and other social sectors, local governments, legislators and policy makers, community organizations, public and private research and policy institutions, universities, international NGOs and donor agencies, and other social groups.

In institutional terms, an *Equity Gauge* is not defined as the activities of a single organisation, nor according to a particular set of funded activities, but rather by the dynamic interplay of pillar activities. Although one organisation may play a lead role, diverse skills and actions are needed; thus, *Equity Gauges* generally should be assembled from several groups or institutions.

PILLAR 1: ASSESSMENT AND MONITORING

Assessment and Monitoring includes identifying contexts and processes that contribute to health inequities, and tracking selected inequities over time in relation to those contexts. Both assessment of and monitoring health inequities require the use of qualitative as well as quantitative information, and both are performed expressly to guide action. 'Assessment' connotes attention to the circumstances contributing to inequities, while 'Monitoring' implies ongoing documentation of inequities over time.

Assessment

If an *Equity Gauge* is well designed, it will fit the needs and conditions of a given country, region, or city. Thus, a systematic assessment of the social, political and economic circumstances relevant to equity (see Figure 2) is essential for effective and appropriate priority setting, analysis, development of policy recommendations, and strategic planning for advocacy and community empowerment.

Figure 2. Assessment of the social, political, and economic circumstances leading to inequities.

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Questions to Assess the Context for an Equity Gauge

The following questions are designed to help *Equity Gauges* think through the issues of a context assessment.

The general state of inequity

Answering these questions should help to sketch out the broad picture of inequity in your situation.

• How much socio-economic inequality is there in society? Has it been growing, diminishing, or stagnating over the past 10 to 50 years? What are the most likely underlying causes of this trend?

• Are there identifiable populations who are socially and politically discriminated against? Are any groups marginalised or disadvantaged on the basis of economic status, gender, religion, race/ethnicity/tribe, language, sexual orientation, or other socio-demographic characteristics? If so, who are they, what is the size of these groups, what is the nature of the discrimination/persecution/ marginalisation, how severe is it, what evidence is there of this, and what are the historical roots? Is the situation worsening?

The Equity Gauge in Ouagadougou, Burkina Faso, has demonstrated that inequalities between better-and worse-off urban groups are comparable to rural-urban divides, in a context where development groups focus on rural populations.

The Nairobi Gauge has similarly demonstrated the exclusion of poor urban groups from development initiatives.

• Is there a rural-urban divide in terms of wealth and poverty? Are the needs of each population adequately represented in public policy? Is this reflected by disparities in health, access to and utilization of health care services, or other health-affecting resources between the populations?

Government

These questions are intended to help elicit thinking about how best to engage with government institutions to promote pro-equity action. Many of the questions also suggest processes that support or undermine health equity.

• What is the system of government and electoral representation? Is there democratic representation through fair elections? Is there "good and just" governance? Is there a culture of transparent and accountable government?

• At what level of government (e.g. national, provincial, local, etc.) are important decisions affecting health equity made?

- To what extent would the government support the objectives of an *Equity Gauge* and be responsive to its findings and recommendations? Is it likely that the *Equity Gauge* will be able to promote equity through open and constructive dialogue with government? Are there laws to support freedom of information and public access to information?

- Is there an independent legislature (or other body) with the responsibility, authority, and procedures for monitoring the role and performance of the executive arm of government? Could that body or its members potentially act as advocates on behalf of the poor and marginalised? If so, how can they be identified and lobbied?

- Within government, to what extent are health and health care (and social services that strongly affect health, such as education, housing, nutrition programs, and social security) considered a priority and/or a government responsibility? What proportion of GDP and the government budget is spent on health care and other social sector services? What proportion of health care and other social services benefit the poor and other marginalized groups, as opposed to more privileged groups, e.g., civil servants?

- Which health equity issues are on the 'radar screen' of policy-makers? What important health equity issues are not on the agenda but could be?

- Are there examples of positive actions for supporting health equity that can be built upon or expanded? Is there information on the effects of these actions that can be used to support further actions?

Other decision-making and power-brokering institutions

In some countries, the formal structures of government may be weak in relation to the influence of external institutions; the following questions are intended to prompt Equity Gauges to consider other important stakeholders.

- To what extent are economic, social, and public policy decisions influenced by external agencies such as non-governmental donor agencies or bilateral/multi-lateral agencies, e.g. United Nations, the World Bank, or the International Monetary Fund?

- How much of social sector spending comes in the form of external aid/assistance? Do conditional loans or grants, such as Structural Adjustment Programmes or Poverty Reduction Strategies, reflect equity concerns in a meaningful way?

- Do donor activities explicitly take equity issues into account in planning? To what extent donors or bilateral/multi-lateral agencies be a target or partner for *Equity Gauge* advocacy initiatives?

- Does private industry play a significant role in shaping public policy?

- Are there other potentially influential non-governmental institutions that need to be considered as targets for advocacy in favour of greater equity in health, such as professional associations, business groups, trade unions, religious organisations, or other civil society groups? Which of these institutions are likely allies and which are likely opponents?

The civil society environment

These questions are intended to help to sketch out and identify potential collaborators, synergies, and 'levers' — that is, promising pressure points or areas where action should be focused — for an effective advocacy strategy.

- Is there much awareness about human rights, or an official commitment to human rights? Which international conventions or declarations on human rights (that could be used as an advocacy lever) have been signed and ratified?

- Do individuals and/or communities have any constitutional or legal rights to basic social and economic needs? To what extent is recourse to the courts a viable method of advocacy to support the poor and marginalised groups in the attainment of their rights?

The Ecuador Gauge, focused in the Andean town of El Tambo, has included in its focal issues the low level of provision of maternity care to indigenous populations, a legal right guaranteed to every citizen by law.

- Is there an independent and functional judiciary? How sympathetic is it to the plight of the poor and those suffering discrimination? Could it potentially act as an advocate on behalf of the poor and marginalised in society? If so, how can sympathetic members be reached and lobbied?

- Is there an active non-government sector? Are there other groups or initiatives working on human rights, poverty alleviation, and social justice who might be potential collaborators of an *Equity Gauge*? If there are groups suffering from discrimination, persecution, or a denial of basic human rights, are there existing initiatives or movements designed to overcome this?

- Could any of the following social groups be potential partners or advocates for improved equity in health: religious organisations, trade unions, women's groups, or academic institutions?

- Is there a free press or independent media? How informed and sympathetic is it to the plight of the poor and marginalised? Does it play a role in advocating for fair and accountable government, and if so, can it be involved in some *Equity Gauge* activities?

Macro-economic and public policy environment

These questions can help to identify relationships between economic and public policy and health inequities as well as help inform recommendations for reducing inequities.

• Is the *Equity Gauge* operating in a high, middle, or low-income environment? What is the stability and growth of the country's economy? What proportion of total government spending is used for debt re-payments? Is this hampering the capacity of government to strengthen social sector services, particularly those targeting the poor and marginalised?

• What is the ideological/theoretical basis of the country's economic and public policy? To what extent is equity a key objective of public policy, and to what extent should economic and public policy be challenged explicitly and publicly from an equity perspective? For example, to what extent do public sector or macro-economic policies favour greater reliance on markets and privatisation without demonstrable benefits to the poor and marginalised? To what extent is there support for an active welfare state or public provision of basic social services?

• Do international trade policies, sanctions, or protectionist subsidies of other countries undermine economic and human development, or play a more direct role in exacerbating health inequity? Do drug cartels or monopolies inhibit the ability of the government to ensure access to vital medicines for all? Does the private market in health care services or equipment discourage equity-enhancing spending in the health sector? To what extent do intellectual property laws inhibit provision of vital health needs?

The health care system

• How equitable is the health care system? What information currently exists to demonstrate the state of inequity in health? Often a wealth of information is not being used.

The Cape Town and Zimbabwe Gauges demonstrated that, because the governments' health resource allocations were largely historically based rather than needs-driven, allocations were sometimes inequitable. In response, the Gauges developed formulas for the equitable allocation of human resources and district budgets, respectively.

class? For example, is there a two-tier or three-tier health care system based on income/wealth?

• What is the size of the private health care sector? Is it growing or shrinking? What effect does it have on the level of inequity or equity in health and health care?

• Have there been any significant health sector reforms in the country over the past 10 years? Has this led to worsening or improving health inequities? What are the key reforms? Are any future policies or reform efforts being considered or planned that may have equity implications?

- Is decentralisation of the health care system occurring or being planned? What effect has this had, or is it likely to have, on health inequities?

The Uganda Gauge is examining the effects of decentralisation on health equity in several districts, in terms of both health outcomes and process.

- How is health care financed and how progressive is it—that is, to what extent do those with fewer resources pay less and those with more resources pay more, not only in absolute terms but also as a percentage of their resources? Have there been changes in the way health care is financed, and if so, have they been progressive or regressive? Where and how are decisions about health care financing made?

- To what extent are marginalised groups provided an opportunity and encouraged to influence decision-making within the health care system? For instance, do clinic committees and hospital boards offer a formal platform and mechanism within the health system for promoting the needs of the most disadvantaged and marginalized, or are committees and boards generally controlled by those who represent the interests of more privileged groups?

Although these questions are not likely to lead to simple answers regarding health inequities, conducting such an assessment enriches an *Equity Gauge* by:

- Helping to define and shape a concept of 'inequity' that is relevant and persuasive for the local/national context and contextualises findings of health outcomes and distributions of health determinants

- Guiding thinking about priorities for monitoring, e.g. identifying disadvantaged population groups

- Suggesting strategic activities and goals for advocacy and community empowerment, as well as effective points of entry in society for the work

- Improving understanding of the background forces that support and undermine health equity, and suggesting responses and/or recommendations for policy or change.

Monitoring

The second aspect of this pillar is 'Monitoring,' which refers to ongoing activities for describing, measuring, understanding, analysing and tracking inequities in health. Monitoring entails identifying information sources and the socio-demographic groups for whom equity comparisons will be made, and selecting key indicators and methods for analysing data.

Information Sources

Equity Gauges can approach both qualitative and quantitative information collection in three ways: by generating primary data and information, by expanding existing information sources, or by extracting relevant information from established information sources. The three approaches have very different resource requirements. In many situations, an *Equity Gauge* many not need to collect new data if enough data of an acceptable quality already exists.

The Thai Gauge and Chile Gauge have been successful in convincing decision-makers to integrate equity-sensitive questions into ongoing data collection instruments.

The China Gauge is working to establish the nation's first national household survey relating health to socio-economic factors.

Existing information sources that may be relevant could include any of those below. The quality of the information, which may vary in different countries, should be taken into account:

- Surveys (Demographic and Health Surveys (DHS), Living Standards Measurement Studies (LSMS), and other large household surveys)
- Census data
- Budgets
- Research reports and publications by government, universities, and civil society.

Socio-demographic Groups

Equity analysis requires a comparison between better- and worse-off social groups. These groups can be defined in terms of:

- Socio-economic status (reflected by income, expenditures, accumulated economic assets, occupation, or education level)
- Race/ethnicity, religion, and/or language
- Gender
- Geography (e.g. urban–rural, or different provinces, districts, villages, or urban neighbourhoods)

- National origin (e.g. comparing immigrants/refugees with local nationals)
- Age (e.g. the elderly and children experience social disadvantage in many societies)
- Sexual orientation
- Disability (including direct effects of physical or mental disabilities as well as societal attitudes that lead to further social and/or economic exclusion)
- Other characteristics that define marginalised or disempowered populations.

Table 1 represents a framework to assist in identification of relevant social groups that can be compared to each other (e.g., rich and poor, dominant racial/ethnic group(s) and minority/excluded groups, or boys/men and girls/women).

Indicators

In order to make meaningful comparisons between more and less advantaged social groups, indicators need to be selected to reflect any of the following dimensions of health:

- Health outcomes e.g., illness/disease/injury rates, mortality rates, quality of life, and major risks to health
- Health care financing and health care resource allocation
- Access to and utilization of health care services (actual use of recommended services is the most valid way to measure access)
- Quality of health care services
- Access/exposure to underlying determinants of health, e.g., poverty, nutrition and food security, behavioural risk factors such as smoking and unprotected intercourse, and exposure to occupational or environmental hazards
- Social and economic consequences of ill health, e.g. impoverishment due to ill health, or economic exclusion or stigmatisation due to HIV infection.

Table 2 can be used as a framework to help organize thinking about indicators and comparative social groups for an *Equity Gauge.*

Analysis

Given the potential number of variables, many different analyses could be performed with different data sources. However, *Equity Gauges* need to produce enough reliable, valid information to influence change, which often does not require a complete and detailed picture of all health inequities. In fact, presenting too much data to policy-makers and advocacy groups can get in the way of having a clear message come through and making an impact. Priorities therefore need to be set regarding which issues are most important and the data that are most likely to be successfully used as a platform for taking action to reduce health inequities.

While health equity is often monitored using quantitative indicators, a qualitative assessment process is used to interpret patterns of inequities, and can be use to describe inequities. In fact, the problems that the poor and marginalised may experience in accessing health care, and the devastating consequences of ill health on poor families, are often more powerful when described in the form of stories than with numbers alone. A case study approach can be used to describe the situation of health and health care in a particularly impoverished area and can act as a lens through which health policies and health systems reforms can be evaluated in terms of their impact on the health care of the poorest and most marginalised. Stories and case studies, then, can greatly enrich quantitative information by demonstrating the human impact and real-life meaning of the numbers.

There are many potential approaches to obtaining qualitative information that can be relevant to the interests of an *Equity Gauge*, including review and analysis of historical documents and policies; interviews with key informants or focus groups; tracking compliance with policies and laws; and health, social, or environmental impact assessments, to name a few. Table 3 shows some of the ways in which qualitative methodologies can be useful for *Equity Gauges*.

While Monitoring may require both qualitative and quantitative approaches, in either case, *Equity Gauges* should use scientifically rigorous methodologies and base their conclusions and recommendations on the best evidence available.

Table 1: A framework for identifying social groups to compare when measuring health disparities and inequity

Type of social group	Size of disparities in health outcomes Magnitude of difference between advantaged and disadvantaged groups			Size of disadvantaged groups Size in proportion to the overall population			Level of public awareness Public attention paid to the health of the disadvantaged group(s)		
	Large	Moderate	Small	Large	Moderate	Small	High	Moderate	Low
Socio-economic (rich / poor; education; occupation)									
Race and / or ethnicity									
Religion									
Language									
Gender									
Geography (e.g., rural / urban; regions; slums/ other urban areas)									
National origin									
Sexual orientation									
Age									
Disability									
Other social groups that are excluded / marginalised									

Table 2: Dimensions of health to consider when comparing more and less advantaged social groups

Dimensions of health Social groups to compare	Health status, including disease, mortality, quality of life	Access to and utilisation of health care services	Health care financing and resource allocation	Quality of health care delivery in various categories, (e.g., MCH, communicable diseases, trauma, mental health)	Access/exposure to underlying health determinants - Water/sanitation - Nutrition/food security - Formal education - Environmental or occupational hazards - Behavioural risk factors	The consequences of poor health on social and economic status
Socio-economic (rich / poor; level of education; occupation)						
Race and / or ethnicity						
Religion						
Language						
Gender						
Geography (rural / urban; regions; slums/ other urban areas)						
National origin						
Sexual orientation						
Age						
Disability						
Other social groups that are excluded or marginalized						

Table 3. Issues that can be highlighted using qualitative methodologies

- Capturing humanistic and experiential aspects of equity issues
  - Examining the effect of human relationships and attitudes on equity-related decision-making, practices, or processes, e.g. how racism among providers creates health inequities
  - Capturing aspects of complex behaviours, attitudes, and interactions, such as implicit routines and rules used by decision-makers, managers, and health care professionals
  - Documenting and describing the common psychological and emotional response to illness or disadvantages, e.g. Voices of the Poor, published by the World Bank, increased sensitivity to the human face of poverty

- Performing policy analysis
  - Uncovering dysfunctional processes that are obstacles to policy implementation
  - Tracking governmental or private-sector compliance with regulations that affect health, determinants of health, or consequences of ill health
  - Examining the equity-related consequences of changes in resource allocation and management practices

- Documenting quality
  - Examining the quality of health care service provision, e.g. tracking changes in quality can be especially useful in times of reform or policy change
  - Examining aspects of the quality of health determinants such as housing, sanitation, education, and the environment

PILLAR 2: ADVOCACY

Advocacy is the process of promoting and supporting a particular position, argument, policy or belief. It entails an intention to facilitate change towards a particular goal or objective. For anyone concerned with social justice, *advocacy is the process of using information strategically and acting to change policies to improve the lives of disadvantaged people*. In the context of an *Equity Gauge*, advocacy involves a set of organised actions to support pro-equity policy and its implementation. This should be done in a way that will not only ensure greater health equity but also help less privileged social groups to express and achieve their rights to better health.

An advocacy process may develop in the following way, usually with several components being carried out simultaneously and with considerable overlap:

Advocacy actions can take the following forms:

„ Informing stakeholders: Effective and strategic accessing, compiling, and/or dissemination of information, education and communication (IEC) materials, including packaging and delivering them differently for different target groups and stakeholders.

Despite widespread evidence that health inequalities and other inequities exist, policy makers, and the public in general are often surprised when presented with the data, and may not fully understand the issues. Consequently, there is an ongoing need for Equity Gauges to engage in sensitization and capacity building in order to maximize the effect of advocacy and community empowerment activities. Several Gauges have incorporated sensitization and training into their activities.

„ Shaping public discourse: Bringing health equity issues onto the public agenda, especially by interacting with the media, constructing convincing and effective arguments, and developing recommendations for policy and interventions.

„ Sensitising social organisations and fostering coalitions: Convincing and enabling various organisations, especially those working for disadvantaged populations, to support systematic action for health equity; providing them with appropriate knowledge, skills and other resources to help them contribute to advocacy efforts; and helping in the formation of coalitions and networks working for health equity. These actions in particular will also foster Community Empowerment, the third pillar.

„ Influencing decision-makers directly through an expert role: Direct engagement and active lobbying of policy makers, decision-makers and other potential change agents; where appropriate, participation in governmental advisory bodies, involvement in preparation of major official documents, and other service in the capacity of expert roles that influence policy.

„ Influencing decision-makers through a campaign or by facilitating social action: Civil society mobilisation and campaigns, including challenges to policies or actions that seem likely to lead to greater inequities; promoting parliamentary and legal action to further health equity.

An *Equity Gauge* may not necessarily engage in all forms of advocacy, as they may not all be appropriate in a given setting. For example, direct challenges of government by civil society may not be strategic in some settings where a co-operative approach could be more effective. What is important from an *Equity Gauge* perspective is that advocacy efforts must extend beyond the passive and unimaginative dissemination of information on inequity that often typifies the efforts of well-meaning researchers concerned with health equity.

At the local, provincial, national, regional, and global levels, advocacy efforts should generally seek to address three types of audiences: decision-makers, civil society, and specific disadvantaged groups.

Decision-makers: In most instances, health policy-makers (including ministers, senior health managers, or parliamentarians) will be central advocacy targets. Policy-makers in other government departments such as finance, housing, welfare, and

agriculture may also be relevant advocacy targets, though they may also serve as stakeholders or partners when interests overlap. The civil service and health sector bureaucracy may also be important targets, since even in countries with a pro-equity policy environment, inequities may continue to persist because of poor policy implementation.

The South Africa Gauge supports the National Parliamentary Portfolio Committee on Health by conducting equity analyses of proposed policies, laws, and budgets related to health, providing ongoing sensitisation and capacity building, and responding to queries.

In countries where governance levels are low, donor agencies and multi-lateral organisations such as the World Bank may be important advocacy targets, as they often are *de facto* decision-makers. It may also be useful to target advantaged segments of a society who strongly influence decisions and whose support and understanding may be important. Other decision-making groups in the health sector include the medical profession and hospital associations, who may, for example, oppose a shift of resources away from expensive tertiary care services that benefit a minority of the population, to pubic health or primary health care services.

Civil society: An *Equity Gauge* should also engage with the public and with various social institutions and organisations. Religious organisations, trade union organisations, traditional leaders, women's organisations, civic groups, human rights agencies, NGOs, and academic institutions are all components of civil society with a stake in health equity. Journalists and the media in particular are an important constituency because of their ability to disseminate and amplify the message of an *Equity Gauge.*

Specific disadvantaged groups: An *Equity Gauge* should be especially concerned with those social groups that are disadvantaged, and whose health needs must be addressed to best improve equity. These may be, for example, indigenous people, poor rural communities, women, slum dwellers or squatters, migrant workers, disabled people, or HIV-positive persons. These and other groups would be key stakeholders in the process of promoting health equity, and advocacy efforts would entail contacting, informing, and involving Community Based Organisations and NGOs working with such groups in *Equity Gauge* campaigns or other pro-equity activities. In addition to involving such organisations in broad advocacy efforts, an *Equity Gauge* may work more intensively with a few select communities to support a process of Community Empowerment (see next section).

Tables 4 and 5 provide frameworks to assist *Equity Gauges* in developing their advocacy strategies.

Table 4: Developing a stakeholder map

Potential Stakeholders	What are the potential reasons for these groups to resist or support health equity efforts?	How can these groups support or impede the attainment of your Equity Gauge goals?
Mass Media / Journalists		
Civic organisations		
Consumer groups		
Women's groups		
Religious organisations		
Human rights organisations		
Trade unions		
Traditional leaders		
Health workers and representative organisations, including medical and nursing associations		
Traditional health practitioners		
Health science (e.g., nursing, medical, etc.) students		
Clinic committees, hospital boards, etc.		
Celebrities / Politicians		
Community based organisations		
Donor organizations, multi-laterals, bi-laterals		
Academic groups, researchers, and think tanks		
Local government bodies		
Ministries of Health, parliamentary health committees		
Other Ministries with ties to health, or to the proposals advocated by the *Equity Gauge*		
Other		

Table 5: Planning for effective advocacy
Based in part on the assessment of the context (see Pillar 1), the following table may be used to assist *Equity Gauges* in planning an advocacy strategy.

Advocacy actions	Actors Who are your allies and potential partners in pursuing these activities? Who might be your opponents?	Strategy What are the key action points, how will they be implemented and which groups will be targeted? How will the media be used?	Resources required What resources are available and what additional financial and human expertise are needed?	Timeframe
Informing stakeholders: Effective, strategic dissemination of IEC materials				
Shaping public discourse: Constructing convincing arguments and effective policies, proposals and recommendations for improving equity				
Sensitising social organisations and fostering coalitions				
Influencing decision-makers directly through an expert role: Direct engagement with and active lobbying of policy makers and decision-makers				
Influencing decision-makers by facilitating social action: Civil society campaigns for equity, including challenges to policies / actions that could lead to greater inequities				
Other				

Finally, it is worth keeping in mind that social advocates should show a commitment to equity and ethics through the manner in which they work, and not only in their stated goals. Social advocates can come to wield power, and they must adopt and sustain democratic and transparent mechanisms in order to be accountable. Even when under pressure, *Equity Gauges* should remain in regular communication with key constituencies to keep them informed and to stay responsive to their concerns, shouldering responsibility yet sharing credit, and consciously following the principle of 'just means for just ends.'

PILLAR 3: COMMUNITY EMPOWERMENT

While there is considerable overlap and intermeshing with the Advocacy pillar, the Community Empowerment pillar has some unique features that need to be kept explicitly on the agenda of an *Equity Gauge*. While advocacy, to some extent, involves speaking on behalf of disadvantaged communities, actions to support community empowerment help such communities to more effectively speak for themselves.

Community empowerment involves moving away from conceiving of the poor or disadvantaged groups as passive beneficiaries. It involves a bottom-up developmental approach and encourages a greater accountability of all institutions to the poor. An empowered community is able to make its own decisions and initiate action on their priority issues. Where outside decisions affect it, an empowered community is able to exert influence on the other decision-makers. To quote one definition,

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

Supporting the empowerment of poor and disadvantaged communities would logically lead to demands for a fairer distribution of health-affecting resources and greater accountability of the health system. This requires opening pathways for initiative and action by the poor/disadvantaged on their own behalf.

The Bangladesh Gauge team includes BRAC, a non-governmental organisation that not only provides clinical care services across the country, but also sponsors a nation-wide micro-loan program as well as 34,000 primary schools aimed at improving access to education, especially for poor girls.

For the purposes of an *Equity Gauge*, community empowerment might be supported by working either directly with particular communities and their leaders, with Community Based Organisations (CBOs), or through NGOs that are in direct contact with communities. Activities may range from skills training, to supporting advocacy efforts on particular issues, to engaging in specific interventions or projects designed to improve health and socio-economic development.

There are several reasons why it is important for *Equity Gauges* to support community empowerment.

First, while equitable health policies may exist on paper, good policies may not always fully translate into better or more equitable services or conditions in reality, unless communities ensure that changes are really made and sustained at the ground level. For instance, communities that are empowered with awareness of a legal, moral, or human rights to improved services or other mechanisms to improve health can persistently demand that these rights be achieved, and ensure that *change on paper* gets translated into *change for people*. When communities are sensitised to equity issues and become empowered to demand change, mechanisms for monitoring are created, social pressure for equity improvements becomes more sustainable, and equity-oriented decision-making is more likely to become institutionalised.

Second, suggestions for policy change from an *Equity Gauge* may at times be viewed by decision-makers as academic or unrealistic, and recommendations may not have sufficient 'social momentum' to convince decision-makers. However, when empowered communities decide to raise similar demands and issues in parallel, as part of a formal or informal alliance, such ideas often gain much more force and legitimacy, leading to a better chance for positive change. The *Equity Gauge* and empowered communities, then, can be mutually complementary allies in the process of promoting health equity. This is particularly effective when communities are included in the identification of inequities and advocacy strategies.

Third, *Equity Gauges* may not always have a full grasp of the real barriers to good health that exist at the village or neighbourhood level. By interacting with communities, *Equity Gauge* representatives can gain a realistic view of the problems and obstacles faced by people, enabling the *Equity Gauge* to develop much more workable and effective recommendations. In other words, when experts and communities interact in the process of community empowerment, it is not only the communities that are empowered — *the experts get enabled, too*.

Finally, people's own perceived needs, beliefs, and wishes are important factors in appropriate priority setting and successfully bringing about change for better health, yet those perceptions are often ignored by policy-makers and even those with an explicit desire to help them. Therefore it is important for an *Equity Gauge* to involve poor and disadvantaged communities in order to ensure that it is connected to the real needs and wishes of those who deserve to benefit.

Effective support for community empowerment is generally not an easy, rapid, or straightforward process. It would be impossible for an *Equity Gauge* to engage with all poor and marginalised communities in a meaningful way. Wherever disadvantaged communities are *already organised* in some way, on a common issue or platform, an *Equity Gauge* is likely to be much more able to interact effectively with such a community, and help its members to take initiative for their health rights. Therefore, in most instances, an *Equity Gauge* would want to work with one or a limited number of communities as part of its overall activities, preferably in conjunction with CBOs or with NGOs working with those communities.

The Zambia *Equity Gauge* oversees four district-level *Gauges* that are largely run by community members, health care personnel, and political or community leaders. This structure supports community empowerment by directly involving communities in priority setting and skills transfer. It creates a replicable model for community empowerment that will hopefully spur action in other districts as national sensitivity to equity issues develops.

An *Equity Gauge* could carry out, in collaboration with communites or organisations, a number of activities to support community empowerment, including:

- Raising awareness and giving information about key health issues, health rights, and equity findings
- Facilitating local organising for health initiatives by contributing to community meetings, helping in efforts to form a local health group or committee, etc.
- Incorporating communities into *Gauge* activities, such as identification of local priorities and concerns as well as advocacy efforts
- Helping communities to conduct their own health needs assessment or survey to identify key perceived and real health problems, priorities, health services issues, and possible interventions
- Facilitating dialogue with health care providers or other local officials for better services and improvements in other health determinants.
- Promoting a system of community monitoring of health services, and whether they meet perceived needs in an acceptable manner; enabling people to give critical feedback to providers about their services
- Establishing mechanisms and enabling community representatives to present their viewpoints to local decision-making bodies
- Giving technical inputs for local health campaigns
- Assisting development of community-based model projects to improve health services or health-related living conditions in an area; training and skill development for the same.

A particular *Equity Gauge* may decide to carry out only a few of these activities or may take up other activities, depending on local needs and circumstances.

There are a number of approaches and tools by which community empowerment has been strengthened, but no recipes. Community empowerment requires commitment, knowledge, and a sensitive awareness of the socio-cultural-political context in which poor, disadvantaged, and oppressed communities live. Under the best conditions, it is a two-way process, in which the people of the community and the 'resource persons' from outside may not always agree, but both emerge wiser and more effective in bringing about positive, pro-equity change.

The following resources provide further information relevant to work in each of the three pillars; additional resources are available on the GEGA webpage at *http://www.gega.org.za.* GEGA is currently in the process of developing additional materials for establishing and strengthening an *Equity Gauge*, especially in relation to Advocacy and Community Empowerment. Please check the GEGA webpage for future documents or contact the GEGA Secretariat by email at *secretariat@gega.org.za.*

Documents related to the Equity Gauge Approach

Equity Gauge: A tool for monitoring equity in health and health care in South Africa; Equity Gauge: Monitoring Health Reform Progress in South Africa, both by the South Africa Equity Gauge, Health Systems Trust. Available online at *http://hst.org.za/hlink/equity.asp* or at *http://www.gega.org.za.* Both documents provide an overview of Gauge activities and design within the three pillars to address major health inequities in South Africa.

Assessment and Monitoring

Monitoring Equity in Health: a Policy-Oriented Approach in Low- and Middle-Income Countries, by Paula Braveman. WHO, 1998. Available online at: *http://whqlibdoc.who.int/hq/1998/WHO_CHS_HSS_98.1.pdf*. Also available on the GEGA webpage at *http://gega.org.za/download/braveman.pdf.* This document provides a practical approach to monitoring social disparities in health within countries for the purpose of guiding policies—focusing on low- and middle-income countries' needs and resources—and suggests data sources, methods, and indicators. The material is intended to raise issues for further exploration concerning the best options for obtaining information on a routine and ongoing basis to guide action toward health equity in countries.

Social Inequalities in health within countries: not only an issue for affluent nations, by Paula Braveman and Eleuther Tarimo. *Social Science and Medicine*, vol 54, no 11 (June 2002), pp 1621-1635. Available online at the *Social Science and Medicine* website. This paper aims to articulate a rationale for focusing on within- as well as between-country health disparities in nations of all per capita income levels, and to suggest relevant reference material.

Measuring and Monitoring Socioeconomic Inequalities in Health, by Anton Kunst and Johan Mackenbach. Published by the WHO Regional Office for Europe, 1994, available on the web: *http://www.euro.who.int/document/PAE/Measrpd416.pdf.* This document provides more technical detail on a number of topics, including summary measures of inequalities, and will be of interest to more technically advanced teams. While most of it is widely relevant, it is written with Europe (and the data sources available there) in mind. The authors also provide ideas on what to do when data is limited. A subsequent article goes into more depth on summary measures: Measuring the magnitude of Socio-economic inequalities in health: an overview of available measures illustrated with two examples from Europe. By Johan Mackenbach and Anton Kunst. Available at the *Social Science and Medicine* website (1997;44(6): 757-771).

La medicion de las desigualdades en salud (Measurement of inequalities in health), de C Borrell, M Rue, MI Pasarin, J Benach, y AE Kunst. Gaceta Sanitaria 1 Diciembre 2000; 14(3). *http://www.doyma.es/cgi-bin/wdbcgi.exe/doyma/mrevista.resumen?pident=10019051*. Los objetivos de este trabajo son presentar las medidas actualmente disponibles para valorar las desigualdades en salud y mostrar un ejemplo práctico de su cálculo. Las características más importantes de las distintas medidas de desigualdad son: la incorporación o no del nivel socioeconómico en el análisis, la disponibilidad de datos agregados o individuales, si son medidas de efecto o de impacto total, la escala de la variable socioeconómica, si se incorporan o no todos los grupos en el análisis y si son medidas relativas o absolutas. Las medidas que se describen en esta revisión son: cocientes y diferencias de indicadores de salud, las medidas de dispersión, indicadores derivados de la curva de Lorenz, indicadores derivados de la correlación y la regresión y el índice de disimilitud. Se presentan las características, las ventajas y las limitaciones de cada una de ellas, así como un ejemplo de su cálculo con datos reales. En un estudio de desigualdades en salud para obtener una visión de conjunto, es aconsejable utilizar varias medidas que se complementen entre sí. Además, deben seleccionarse las medidas más relevantes acorde a los objetivos del estudio y a las limitaciones de la información existente.

Inequidades en salud: cómo estudiarlas, de J Norberto Dachs. Chapter 6, pages 84-104. En H. Restrepo and H. Málaga. Promoción de la Salud: cómo construir vida saludable. Bogota: Editorial Médica Panamericana. Available online at *http://www.medicapanamericana.com*, click on Resto del Mundo and go to the "catalogo". This chapter is mainly concerned with showing how to measure inequalities in health and with demonstrating that inequalities can be meaningfully measured even in contexts where apparently one has little information, especially at the local level.

Qualitative Research: Rigour and qualitative research, by Nicholas Mays and Catherine Pope. BMJ 1995; 311: 109-112. Qualitative Research: Reaching the parts other methods cannot reach: an introduction to qualitative methods in health and health services research, by Catherine Pope and Nick Mays. BMJ 1995; 311: 42-45. Qualitative Research: Observational methods in health care settings, by Nicholas Mays and Catherine Pope. BMJ 1995; 311: 182-184. All papers available free online at *http://bmj.com/.* The aim of this series is to introduce some of the main qualitative research methods currently used in health care research and to indicate how they can be appropriately and fruitfully employed. The papers review observation, in depth interviews, focus groups, consensus methods, and case studies.

Who gets vaccinated in Bangladesh? The Immunization Divide. Equity Watch Paper No. 1, by A.M.R. Chowdhury, A. Bhuiya, S. Mahmud, A.K.M. Salam, and F. Karim. 2002. Dhaka: Bangladesh Health Equity Watch. Available on the GEGA website at *www.gega.org.za.* Hard copies available from the BHEW secretariat, SBSU, ICDDR,B, GPO Box 128, Dhaka 1000, Bangladesh. This document, written by the Bangladesh Equity Gauge, provides an example of presenting accessible information from the Assessment and Monitoring pillar.

Advocacy

Advocacy for Social Justice - a global action and reflection guide, by David Cohen, Rosa de la Vega and Gabrielle Watson, Kumarian Press 2001. This document was jointly written by the Advocacy Institute and Oxfam, and provides an excellent conceptual introduction to advocacy, including several case studies. To see an overview of the guide's chapters and to get ordering information, go to *http://www.oxfamamerica.org/advocacy_guide/index.php*.

A New Weave of Power, People and Politics - the action guide for advocacy and citizen participation, by Lisa VeneKlasen and Valerie Miller, Oklahoma City, World Neighbors 2002. This is a more hands-on and detailed practical manual and includes ideas for advocacy training. Table of contents and introduction available free online at *http://www.wn.org/wnstore/PDFs/WeaveofPower*. Ordering information at *http://www.wn.org/wnstore*.

Community Empowerment

Questioning the Solution, by David Werner and David Sanders. 1997 by Healthwrights, TWN, IPHC and Partners in Health. This book argues that, too often, health and development planners try to use technological fixes rather than confront the social and economic inequities that perpetuate poverty, poor health, and high child mortality. The book explores the history of medicine and public health since colonial times,

and shows that health is determined more by the equity or inequity of social structures than by conventional health services. Examples from African and Latin American countries illustrate instructive approaches to health and development that put human needs before top-heavy economic growth. Overview and ordering information avaiable at *http://www.healthwrights.org/books/questioning.htm.*

Helping Health Workers Learn, By David Werner and Bill Bower. A 'people-centered' guide to teaching community heath workers. Intended for those who feel that their first allegiance lies with working and poor people. Discusses (and simplifies) the awareness-raising methodologies developed by Paulo Freire. Overview and ordering information at *http://www.healthwrights.org/books/helpinghwlearn.htm*.

Community-led primary health care initiatives: lessons from a project in rural Bangladesh, by Abbas Bhuiya et al. In: John Rohde and John Wyon (eds): "Community-Based Health Care: Lessons from Bangladesh to Boston", Boston, Management Sciences for Health, 2002. Overview and ordering information available at *http://www.globalhealth.org/sources/view.php3?id=258*.

Primary Health Care: On Measuring Participation, by Susan Rifkin et al. *Social Science and Medicine* vol 26, no 9, pp 931-940. Available online at the *Social Science and Medicine* website. This article outlines a tool for assessing community participation called a spidergram, which can be useful either in assessing public participation or evaluating the ability of *Gauges* to encourage participation.

The Global Equity Gauge Alliance currently includes member-teams, called Equity Gauges, in the Americas, Africa and Asia. Each Gauge works to promote health equity through an integrated strategy of: Assessment & Monitoring of health inequities, Advocacy for pro-equity policy, and support for Community Empowerment.

This document is available online at
www.gega.org.za
www.hst.org.za