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Global Equity Gauge Alliance: Reflections on Early Experiences

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ABSTRACT

The paper traces the evolution and working of the Global Equity Gauge Alliance (GEGA) and its efforts to promote health equity. GEGA places health equity squarely within a larger framework of social justice, linking findings on socioeconomic and health inequalities with differentials in power, wealth, and prestige in society. The Alliance's 11 country-level partners, called Equity Gauges, share a common action-based vision and framework called the Equity Gauge Strategy. An Equity Gauge seeks to reduce health inequities through three broad spheres of action, referred to as the 'pillars' of the Equity Gauge Strategy, which define a set of interconnected and overlapping actions. Measuring and tracking the inequalities and interpreting their ethical import are pursued through the Assessment and Monitoring pillar. This information provides an evidence base that can be used in strategic ways for influencing policy-makers through actions in the Advocacy pillar and for supporting grassroots groups and civil society through actions in the Community Empowerment pillar. The paper provides examples of strategies for promoting pro-equity policy and social change and reviews experiences and lessons, both in terms of technical success of interventions and in relation to the conceptual development and refinement of the Equity Gauge Strategy and overall direction of the Alliance. To become most effective in furthering health equity at both national and global levels, the Alliance must now reach out to and involve a wider range of organizations, groups, and actors at both national and

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international levels. Sustainability of this promising experiment depends, in part, on adequate resources but also on the ability to attract and develop talented leadership.

Key words: Inequalities; Inequity; Socioeconomic conditions; Health equity; Poverty; Monitoring; Advocacy; Health development; Research; Community empowerment; Governance

THE CONCEPT OF AN EQUITY GAUGE

The Equity Gauge initiative traces its beginnings to an October 1999 meeting of the Global Health Equity Initiative in Chile, attended by researchers, advocates, and public-health practitioners from all continents. Participants shared concerns about the current and potential adverse impact of global economic and political trends on health, both overall and particularly on those population groups that are already most disadvantaged. They also discussed options for addressing those concerns strategically and found one approach, recently launched in South Africa, to be particularly promising. The project, called the Equity Gauge, combined policy-oriented research and ongoing monitoring of equity in various aspects of health and healthcare, with a commitment to political action focused on informing and thereby influencing members of parliament to support pro-equity policy.

Following this model of 'gauging,' or measuring health equity along with advocacy for policy action, a network of ten additional Equity Gauges in other countries was launched, resulting in the formation of the Global Equity Gauge Alliance (GEGA). While these eleven Equity Gauges have unique features and vary in scope, with some addressing inequity at the city/district levels and others focusing primarily on provincial or national levels, all share a common strategic vision of the action-based Equity Gauge Strategy.

International health and development agencies, researchers, and activists have for many years pointed to inequalities and inequities in health and healthcare among different countries, among relatively well-off and poor people, among racial/ethnic groups, and among men and women (1-18). Equity was a key principle of the 1978 Alma Ata Declaration on Health for All (19). Despite study findings showing wide and sometimes widening disparities among and within countries on every continent, few countries routinely assess or monitor equity in health, and even fewer can demonstrate effective action to address inequalities when information is available. While assessment and monitoring of health inequalities and inequities are essential for accountability recommendations, experience has how that measurement and monitoring alone do not lead to sufficient pro-equity change. Efforts to obtain and disseminate information must take place within the context of a larger strategy that takes into account forces likely to oppose or support movement towards greater equity and explicitly aims at promoting actions to effectively close demonstrated gaps in health.

What is new about the Equity Gauge Strategy is the explicit link between research/monitoring activities and action. Initially, the Strategy combined information collection (research, assessment, and ongoing monitoring) and advocacy to influence action. That vision has since evolved to incorporate a third element of community empowerment and mobilization, reflecting a recognition that, if advocacy efforts targeting decision-makers are to be effective in a sustained fashion, pressure from below—that is from civil society, including grassroots groups—will often be required to push leaders to make decisions that may not please powerful segments of the population. These three elements—information (referred to as Assessment and Monitoring), Advocacy, and Community Empowerment—form the foundation on which Equity Gauges orient their activities and work, and are referred to as the 'pillars' of the Equity Gauge Strategy.

What do Equity Gauges mean by equity in health?*

An Equity Gauge places health equity squarely within a larger framework of social justice. While some health inequalities are inevitable (for example, elderly people generally have poorer health than young adults), many health inequalities are avoidable and are related to social, political and economic factors that, in a fair society, are inappropriate influences on health. Such inequalities might include, for example, worse health among the poor compared to the rich, higher mortality rates in some racial/ethnic groups compared to others, or lower rates of immunization coverage among girls than among boys

* This section and the following section are based on material from: The Equity Gauge: concepts, principles and guidelines, by David McCoy, Abhay Shukla, Paula Braveman, Antoinette Ntuli, Alexandra Bambas, Meg Wirth, Jeanette Vega, Davidson Gwatkin, Tim Evans, Pat Naidoo, and Mushtaque Chowdhury. (www.gega.org.za).

(8,20-22). This highly-correlated negative impact of poverty, race, and gender (as well as other factors) on health constitutes an injustice and an inequity.

Viewing equity from this perspective encourages striving 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. who have the most wealth, power, and/or prestige (23). 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 endorsement of a social justice framework is fundamentally based on agreement with the values such a framework holds, but is also strongly reinforced by massive evidence from rich and poor countries showing that health is, in fact, closely associated with social position and its underlying political, economic and cultural determinants (1-8,15-17,24-26). The correlations of poverty with disease and mortality, for example, are well-documented (27). Strong evidence also supports a relationship between relative socioeconomic position and health, although there is less consensus about the likely underlying causal factors (28-32).

These various forms of disadvantage often concentrate among the same populations, resulting in cycles and levels of disadvantage that are difficult to address. For instance, the effects of poverty on health may be accentuated or aggravated by other factors, such as gender (7,8,14,33-35), race/ethnicity (12,13,36), language, disability, and geography (16,37), which often interact with poverty to influence social position. Discrimination based on any of these factors can further accentuate their impact on access to healthcare and other health determinants and on opportunities to escape from poverty (7,8,16,36). Other factors that influence health, such as levels of social capital and social cohesion, are less straight-forward to measure but are nonetheless vital to understanding dynamics of social environments and change, as demonstrated by various healthy egalitarian societies that share a high level of social cohesion as an important characteristic (15,29,38-42). Finally, there is mounting evidence that global and international factors, such as agreements on trade/tariffs and international development policies and activities, influence health and health inequalities (43-49).

Although many determinants of health inequities lie outside the healthcare sector (16,50), in developing countries in particular, health systems can do much to reduce health inequalities. They can help reduce poverty by removing financial barriers to healthcare for the poor, given that healthcare expenses are a major cause of impoverishment worldwide (51,52). They can also pro-actively target the health problems of the disadvantaged and marginalized through a range of healthcare and public-health actions (50). Part of the solution to the problem of health inequities also lies in eliminating the root causes, such as poverty and various forms of discrimination, which exclude some groups of people from opportunities to be healthy and to enjoy the benefits of society's progress (50). Therefore, especially in poor countries, health institutions also can and should work with other sectors, such as education, finance, labour, transportation, and housing, to help address the major determinants of health that are outside the direct reach of the healthcare sector (50,53).

An Equity Gauge, therefore, seeks to address the sociopolitical determinants of health inequities as well as inequities associated with the healthcare system, and to contribute to building a society that routinely considers and pursues equity in all its policy and decision-making processes.

Although many empirical trends are common across countries, various factors influence the specific forms and perceptions of health inequities within a particular society. The social, political and economic contexts, and history of a country, along with the role and actions of its prevailing formal and informal institutions, can prominently influence health and health equity. For example, gender-based inequalities strongly affect equity in South Asia, as does racial discrimination in countries with current or previous apartheid-like governments, such as South Africa or the United States.

The pathways between the above-mentioned factors and health and health inequalities are beginning to become more clear, but much work is needed to further elucidate causality, understand interactions between factors, and develop effective interventions at the level of the individual, health systems, social and economic policies, and international relations and agreements. An even greater challenge may be to gather this knowledge and monitor trends in ways that effectively support pro-equity planning and policy development by governments, bilaterals, multilaterals, and other non-governmental organizations.

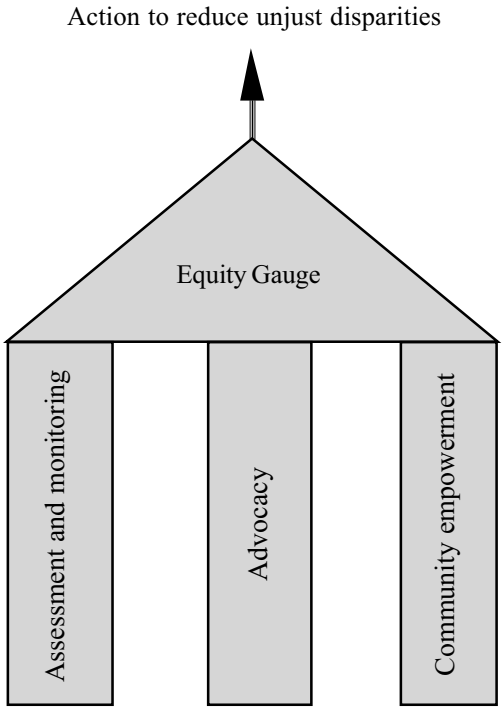
Equity Gauge Strategy

As outlined above, an Equity Gauge is not a conventional

research project; rather, it is an active approach to addressing inequity in health by both monitoring equity and incorporating concrete actions to bring about sustained change. In this sense, an Equity Gauge should function more as a thermostat than as a thermometer, not just measuring or 'gauging' equity and inequity but also triggering actions to reduce inequities. Because the Equity Gauge framework relates the determinants of health inequities largely to sociopolitical factors and to unfair distributions of power, influence, and wealth, achieving a more just distribution of resources needed for health is seen to require some degree of social and political mobilization.

This active approach requires the involvement of an Equity Gauge team, including researchers and academics, health workers, legislators and policy-makers, government workers, ministries, the media, the general public, and NGOs concerned with development and justice. Teams work in a concerted effort to achieve joint

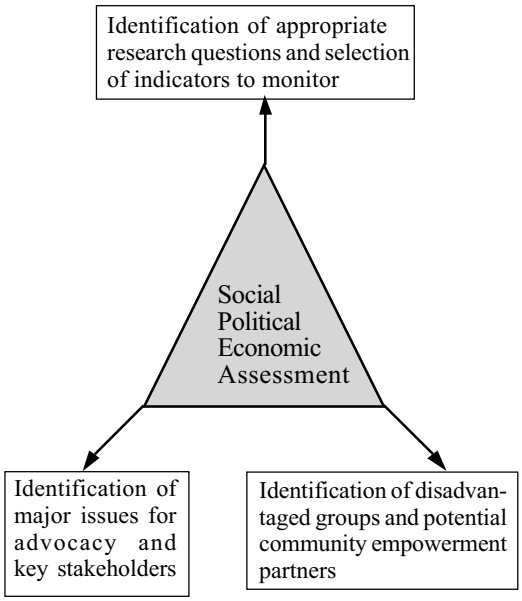
Fig. 1. The three pillars of an Equity Gauge



pro-equity goals, pursued through the three action-based 'pillars' of an Equity Gauge (Fig. 1):

- Assessment and monitoring to measure and track inequalities in health and distributions of determinants of health using quantitative and qualitative research methodologies (Monitoring) and to systematically assess how the findings relate to local, national and global socioeconomic and political conditions and contexts able to better understand the full effect and import of those findings (Assessment) (Fig. 2). Both analytic processes are essential for effective and appropriate priority setting and for development of policy recommendations and intervention strategies. These steps are also integrally related to effective planning for advocacy and community empowerment activities, since well-designed strategies will fit the needs and conditions of a given country, region, or city.

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



- Advocacy to promote changes in policy, programmes, and planning by influencing decision-makers. This pillar includes placing or keeping equity prominently on the policy agenda in all realms that influence health, including through sensitization (raising awareness about equity issues) and training activities; publications; use of media, web-based initiatives, workshops, and study tours; and forming cooperative alliances with, and providing technical support to decision-makers.
- Support for community empowerment of the poor and marginalized as active participants in change rather than as passive recipients of aid or help. Activities in this sphere include working with civil

society groups that advocate on behalf of the disenfranchised, holding community-based workshops, conducting local health surveys that provide an opportunity to educate, and facilitating dialogue and feedback from communities.

The three pillars define a set of interconnected and overlapping actions. For example, the selection of indicators to monitor and assess equity should be informed by the views of community groups about their major concerns and by consideration of those issues that would likely 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 first collecting and then analyzing data, with subsequent information dissemination and advocacy activities, is not often effective. In an Equity Gauge, the actions of all three pillars are intended to happen simultaneously and in mutual influence.

In regard to the functioning of teams, the notion is not that the same individuals or even institutions on an Equity Gauge team necessarily will directly engage activities for all three pillars; rather, various participants in an Equity Gauge network will coordinate their work within a larger strategy that includes all those elements. In the South African Gauge, for example, some team members focus on technical support to parliamentary leaders while others form a coordinated strategy to support local organizations in promoting pro-equity management and activities. The Gauge also works with external partners, both directly—by feeding information to grassroots organizations so that they can better pressure leaders for greater equity—and indirectly—by feeding the press information on dramatic inequities in provision of healthcare, actively disseminating information to groups whose projects may benefit from the findings, and intentionally considering the monitoring and information needs of other development projects when planning new monitoring activities. Positioning the Equity Gauge team within a non-profit organization actively engaged in various activities that monitor equity in health and healthcare in South Africa has further supported links with policy-makers and the press by tying the Gauge work into the organization's broader work.

HIGHLIGHTS OF EQUITY GAUGE EXPERIENCES TO DATE

Equity Gauges currently exist in Burkina Faso (Ouagadougou), Kenya (Nairobi), South Africa (one in Cape Town and another with national scope), Zambia, Zimbabwe, Bangladesh, China, Thailand, Chile, and Ecuador (El Tambo municipality). Although few Equity Gauges other than the national Gauge in South Africa have been operating for more than one or two year(s), there is already a rich body of experience. On the whole, this experience tends to confirm the value of the strategy; at the same time, it suggests the need to reassess some elements and/or approaches. Several highlights illustrate important issues that may be generalized to other contexts.

Assessment and monitoring

While the assessment and monitoring efforts of all the Gauges share the goal of guiding policies and programmes towards greater equity, these efforts are being conducted in diverse ways, using both qualitative and quantitative approaches. Many Gauges make creative use of existing data sources, often population-based household surveys that have rarely been used for assessing equity. Some Gauges have modified the content of existing data sources to adapt them for examining health equity; this strategy is especially useful for long-term monitoring. Where necessary, Gauges are creating new data sources, which allow a more carefully-planned approach to measurement but can require significant resources and pose challenges to sustainable monitoring. Finally, some Gauges have used findings to develop tools for pro-equity planning, including methods to guide equitable health-sector allocation for financial and human resources.

Several Gauges have found success by using previously untapped existing data sources or by incorporating equity-sensitive content into existing data sources. Both the strategies have high potential for sustainability, since funding for data collection is often secured, and they also represent more efficient strategies than reliance on primary data collection, especially if datasets are linked.

Information from existing datasets at times can surprise decision-makers, spurring them to address inequities. For example, using city-level data from the 1999 Demographic and Health Surveys (DHSs), the Ouagadougou Equity Gauge has demonstrated striking disparities within the capital city of Ouagadougou that

have caught the attention of politicians, the health ministry, donor agencies, and community-oriented NGOs. By analyzing data from the annual population-based national Health and Welfare Survey, the Thailand Equity Gauge found strong evidence that government policies on health insurance are moving towards greater equity even during a time of economic downturn. When the population was grouped according to educational level, rates of lack of insurance in some regions declined more rapidly for the groups with less education, indicating that the gap in coverage seen between the least and most educated has diminished considerably. Gaps in insurance rates according to region also became smaller during the same time period. These and other Gauge experiences have been shared both within GEGA and disseminated more broadly to encourage researchers to use previously-untapped data sources.

Gauges also have successfully advocated for integration of equity-sensitive indicators into ongoing data sources. Given the well-documented relationship between wealth and health and the absence of wealth measures in the nationally-conducted Health and Welfare Survey, the Thailand Equity Gauge successfully lobbied with other Thai researchers to include information on income in the Survey, allowing greater ability to disaggregate according to socioeconomic position. The Chilean Gauge developed an entirely new module that was introduced into the annual national survey of living conditions (CASEN) during 2000, markedly strengthening its health content by adding questions on, for example, self-perceived health, physical activity, disability, satisfaction with care, and reasons for not seeking care when ill (Vega J *et al*. Personal communication, 2003).

Gauges have also developed new survey instruments to generate equity-sensitive information, providing an evidence base for a wide range of analyses and recommendations to improve health equity. The South African Gauge has developed assessments of healthcare quality in rural areas through a relatively simple survey of conditions in health centres. The Zambian Gauge has developed qualitative and quantitative methods for capturing community perceptions of unmet health needs and quality of health services by conducting surveys and interviews in four districts in the country. The Bangladesh Gauge has continued to develop approaches to and carry out 'poverty mapping' studies that take into account a broader vision of poverty and its related complex social dimensions. Based on earlier evidence of the utility of this information for understanding equity dynamics and planning effective interventions, several new social and economic variables were introduced into the latest round of Multiple Indicator Cluster Surveys conducted by the Government with UNICEF support. These new variables include: construction materials used in the main living room, sex of the household head, occupation, education, religion, and ethnic background. The Bangladesh Gauge has also made unique contributions to monitor the joint and independent impact of poverty alleviation and health programmes in reducing inequities in health; for instance, their work documented that a woman-focused poverty-alleviation programme significantly improves child survival among the poor and hence reduces disparities (54).

Some Gauges have blazed trails in developing entirely new information sources on health equity. The largest-scale effort has been made by the China Equity Gauge, which has now completed collection of baseline data for longitudinal follow-up of a cohort of 5,400 households in nine provinces across China. The goals are to permit study of important issues regarding health disparities that cannot be answered with cross-sectional data alone, and to create an ongoing surveillance effort with additional cohorts and longer-term follow-up of each cohort. The Nairobi Gauge has implemented and disseminated findings from ongoing surveillance of health and health-related conditions in Nairobi's shanty-towns, which house over 60% of the city's residents. This population's needs have historically been excluded in city planning and development, due in part to their exclusion from routine data collection; like similar urban slums in many lower-income countries, the settlements are not recognized as legal residences and, thus, have not been counted in official statistics.

The Ouagadougou (Burkina Faso) Gauge has also launched a new demographic surveillance system focused on the formerly-uncounted urban poor to ensure that donors and government address their needs in an ongoing fashion. Contrary to earlier assumptions that all city residents were relatively better-off than residents of rural areas, the emerging evidence has revealed clusters of extreme poverty and marginalization within the city's population that are masked by aggregated data.

Finally, Gauges have developed methods to guide equitable resource allocation, based on assessing health equity. The Zimbabwe and Cape Town Gauges have developed formulae to allocate healthcare resources based on equity principles. Most impressively, both have

accomplished this in ways that have resulted in a 'buy-in' by government—at the national level in Zimbabwe and at the local level in Cape Town—and incorporate indicators that reflect some of the most powerful social determinants of health. In cooperation with local community groups, development organizations, and the Ministry of Health, the Zimbabwe Gauge developed an allocation formula that better takes into account the financial needs of under-resourced districts and the additional health burden often faced by populations in those districts. The formula consciously corrected for the effects of historical budgeting, backlogs, and the effect of the Inverse Care Law*, all of which clearly influenced prior allocation patterns. The Cape Town Gauge has developed a resource-allocation tool for primary healthcare facilities that is now being used by local health officials themselves, with plans to develop an accompanying manual and training sessions. The Gauge has also been asked by local officials to produce a similar tool for maternity services and to work with the city to produce a tool for assessing equitable allocation of environmental health officers. A health service manager in one of Cape Town's most under-resourced areas recently requested to use Gauge data as evidence for lifting the current freeze on filling crucial posts in her area.

Advocacy

Several Gauges had early achievements in advocacy, including sensitization and raising awareness about equity issues and/or securing equity concerns on the policy agenda. All of the Equity Gauges have conducted one or more workshop(s) for various audiences, including decision-makers from the health sector and other sectors, the press, and representatives of civil society groups at local, provincial and/or national levels. The China Gauge has also actively involved health ministry officials in designing its surveillance system, viewing the process of incorporating input from local, provincial and national-level policy-makers as a means of increasing their awareness and support of health equity concerns.

The Chilean Gauge has played a highly visible and crucial role in a newly-created National Commission on Health, supplying population-based information for assessment of various aspects of that country's health equity situation. One of the Gauge's earlier studies revealed that women in Chile pay significantly more than men for healthcare, due to higher insurance premiums and greater out-of-pocket expenses for public-sector services (Vega J *et al*. Personal communication, 2003). The Commission has used this information to put gender equity on the political agenda and provoke national dialogue. The Ouagadougou Gauge has educated donors and local government about previously unrecognized deprivation in the urban setting in terms of access to basic social services, including housing, education, and healthcare. These findings have promoted coordination of efforts among governments, donors, and other organizations, and have generated support for ongoing work, including more rigorous monitoring and development of effective interventions. The Bangladesh Gauge started a bi-monthly newsletter, titled 'Equity Dialogue,' that is widely circulated within the country and the region, targeting crucial stakeholders—government agencies, NGOs, grassroots groups, and researchers.

The Thailand Equity Gauge has conducted a series of workshops with managers and practitioners in healthcare facilities at provincial and district levels, designed to sensitize them to the concept of equity, to better understand their views and priorities for the health system, and to encourage them to think about ways to reduce inequities within the scope of their own decision-making. Through its work with legislators, the press, and other development organizations, the South African Gauge has focused attention on the huge health inequalities that still exist in that country nine years after the end of apartheid, made health equity issues more visible and understandable to legislators and the media and provided concrete suggestions for feasible pro-equity actions. As one method for raising awareness, the South African Gauge conducted a study tour of an under-resourced district, showing Department of Health officials, NGO staff, activists, researchers, and lawyers the appalling conditions of people living with HIV; it has produced a video documentary on the experience of the tour for wider dissemination.

Although advocacy work is usually a long process, some Gauges have already seen measurable impact in this arena. For example, the Gauge in El Tambo, Ecuador, detected and then brought public and policy-makers' attention to inadequate implementation—affecting the municipality's poor and largely indigenous population—of the national law mandating free maternity services. In response to those efforts, the municipality now has a designated fund to improve implementation of the law,

* The Inverse Care Law, proposed by Tudor-Hart in 1971, states that the availability of good medical care tends to vary inversely with the need for it in the population served.

and established users' committees, as have several surrounding municipalities, to ensure accountability for implementing the law. Early monitoring of receipt of services indicates that these efforts have greatly improved coverage for indigenous women in the area.

The South African Gauge has seen its work influence parliamentary debates on a range of equity-related issues. Following public dissemination of the Zambia Gauge's assessment of health equity in four districts, health-sector decision-makers withdrew a proposal to raise user-fees, and a fascinating saga has subsequently unfolded. Based on the publicity engendered by the Zambia Gauge's work, the Health Committee of the Zambian Parliament called for ending user-fees altogether. This move, however, met resistance from health workers in urban areas, who saw the user-fees as the only feasible means of maintaining services. The Gauge has responded with renewed efforts, involving drama, dance, songs, and poems, to make officials aware of people's perspectives on health equity. This story continues—a top official in one district was so moved by the people's testimony captured by the Gauge that he has committed to instituting measures to increase health workers' sensitivities to people's concerns. The Portfolio Committee on Health sees the dramas as a mechanism to strengthen advocacy for health equity within the legislature, since it provides a form of public feedback on priorities and creates political pressure for response. The successes of the Cape Town and Zimbabwe Gauges in securing government adoption of more equitable formulae for resource allocation for healthcare are a result of carefully-conceived advocacy efforts, tailored to the particular but very different political contexts in those countries.

GEGA has, until now, focused primarily on equity within countries and specifically within poorer countries, sometimes referred to as countries of the South, where less attention has been paid to intra-country disparities than to disparities between countries of the North and the South. However, it is recognized that many constraints and obstacles to achieving equity within countries, particularly those of the South, are determined largely by forces reflecting between-country disparities in wealth and power—for example, requirements of international financial institutions or trade agreements that directly or indirectly affect major determinants of health. With this in mind, GEGA is beginning to assess how it might make a unique and effective contribution to work towards global equity. A committee has been constituted to provide input to the Millennium Development Project (entrusted by the UNDP with pursuing the Millennium Development Goals), and some GEGA members are beginning joint efforts with other international organizations with similar values.

It is noteworthy that most of the Gauges' advocacy efforts have focused on debate/discussion with decision-makers, i.e. an 'informing policy' model. Direct action through protests or demonstrations has been less common among the Gauges. This may be related to the historical development of the Gauges, especially given the central role of research in the development of the original Gauges. This tendency may also reflect a need for Gauges to be able to access information, such as databases, that are often controlled by governments, which suggests that cooperative approaches may be more strategic than confrontation in many cases. At the same time, the Gauges have been able to generate community action and to help promote communication of public priorities in ways that challenge the government and the status quo.

Community empowerment

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. This pillar involves moving away from conceiving of the poor as passive beneficiaries, and involves a bottom-up development approach encouraging greater accountability of all institutions to the poor. Equity Gauges support community empowerment by working directly with particular communities and their leaders, with community-based organizations, or through NGOs that are in direct contact with communities. Activities with community groups range from skills training, to supporting advocacy efforts on particular issues, to engaging in specific interventions or projects designed to improve health and socioeconomic development. In contrast to community participation, which at times can, in a misdirected effort to involve communities, place heavy burdens on them by requiring the use of their minimal human and financial resources, community empowerment explicitly aims at developing activities in a way that truly support the communities rather than absorbing their limited resources.

The Zambian Equity Gauge has had one of the most creative approaches to community empowerment. Working in the capital city Lusaka and in three more remote, poor and under-resourced districts, they have

attracted local leadership in each district and conducted competitions for poetry, songs, drama, and church sermons to encourage public expression of perceptions of inequities affecting their health. The responses have included poignant, eloquent statements about health and healthcare inequities that have received media coverage in both newspapers and television at national and local levels and have moved political leaders to respond. The success of the project was supported by earlier Gauge efforts to include community members and organizations in the work. For instance, the four district-level Gauges that make up the Zambia Gauge are largely run by community members, healthcare personnel, and local political or community leaders. These participants have been involved in a number of workshops to build understanding of the issues and capacity for the work and have been intimately involved in developing, carrying out, and responding to surveys regarding perceptions equity in health and healthcare. This structure has supported community empowerment by directly involving communities in priority setting and skills transfer. The district-based approach creates a replicable model for community empowerment that will hopefully spur action in other districts as national sensitivity to equity issues develops.

As noted earlier, both Zimbabwean and Cape Town Gauges have worked closely with grassroots groups, including trade unions, church groups, women's organizations, and local community health committees, to obtain their input in developing more equitable resource-allocation formulae and their buy-in to maintain a vigilant watch over implementation. The Zimbabwe Gauge made special efforts to secure input from grassroots groups in developing the formulae (55), reflecting a belief in the importance of this input for developing the best formulae and also for ensuring that active constituencies in the population will recognize their stake in the new allocation formulae and, thus, pressure the Government to follow through with implementation.

The Gauge in Ecuador has conducted a 'Leaderhip School' in the rural municipality where it has focused its efforts. The aims of the school are to empower leaders of the largely-disenfranchised indigenous population and to help them be more effective in advocating for well-being of their community in municipal and provincial political spheres. While not restricted to leadership in health, the school has included curriculum intended to increase awareness and capacity to mobilize around health equity issues. The Ecuador Gauge has also assisted the local community in setting up a user's committee to improve accountability for the implementation of the national law guaranteeing access to maternity care. This activity has not only improved access and quality of services, but has increased capacity for public monitoring and reporting, and has been seen as a welcome input by the local authorities.

The South African Gauge has worked with NGOs in a municipality of the Eastern Cape, to adapt available information on health and healthcare equity to a form that would be accessible to, and capture the interest of, community members. The Bangladesh Gauge is facilitating a process of community mobilization for health in a rural area of Bangladesh and is studying the impact of the programme in reducing inequalities in receipt of health services and even in health status of the villagers (56).

Finally, a number of Gauges have found that activities conceived as Assessment and Monitoring or Advocacy strategies also function as low-level forms of Community Empowerment. For example, the China Gauge is conducting a national household survey on health equity, but in the process of training local interviewers, many of whom are healthcare providers, sensitization is being built and capacity for understanding the issues developed, both informally and through formal structures, such as training workshops. When survey interviews are conducted, that sensitization process is then replicated at a lower level within the community.

ACTIVITIES INVOLVING MORE THAN ONE OF THE PILLARS

To a large extent, the activities mentioned above relate to more than one of the 'three pillars' of the Equity Gauge Strategy. However, this cross-over effect is particularly true of activities in the area of training or capacity-building, as it clearly applies to all three pillars. All the Equity Gauges have engaged in some type of human resource development in their own countries. As noted above, most Gauges have held workshops at national, provincial and/or local levels that focused on increasing both awareness about equity concepts and ability to apply those concepts in routine decision-making and monitoring.

There have also been efforts to support more intensive and specific capacity for equity-oriented work. The Chilean Equity Gauge took the early lead on building capacity for policy-oriented assessment and monitoring.

During 2002, the Gauge conducted a two-week course in Santiago on health equity for over 100 researchers and data-oriented policy-makers in Latin America. Based on the response to this first effort, the GEGA Secretariat will support the Gauge in repeating this course in January 2004. The Secretariat will also coordinate with the Cape Town Gauge, through the University of the Western Cape, to offer courses on health equity focused at building capacity in all 'three pillar areas'. The Bangladesh Gauge, through ICDDR,B: Centre for Health and Population Research, has offered courses on poverty analysis. The above-described courses offer another soon. These courses are increasingly being developed in a way that not only supports building of specific skills, but also supports adoption of the Equity Gauge Strategy.

Finally, in June 2004, when a general meeting of the Global Equity Gauge Alliance is held in Durban, South Africa, in conjunction with the biennial meeting of the International Society for Equity in Health (www.iseqh.org), GEGA will offer a three-day course aimed at potential leaders of new Equity Gauges, which will outline the Equity Gauge Strategy and assist participants in thinking about how they might best use the strategy in their own work.

REFLECTIONS AND NEXT STEPS

We focus here on a few issues that cut across multiple Gauges' experience. These issues span conceptual concerns and questions regarding implementation.

The concept of Equity Gauge and flexibility of the model

At the most conceptual end of the spectrum, issues continue to be raised about what really constitutes an Equity Gauge. Because of the historical development of the original Equity Gauges, the pattern has largely been that a particular organization or small combination of organizations originally involved in the development of a Gauge directly carries out the activities of each of the three pillars. However, the first Gauge teams were not necessarily identified with the capacity needs of the three-pillar strategy in mind. Our experience so far suggests that the composition of a team should be revisited from time to time and reshaped according to the expertise, strategy of the work, effectiveness, and skills needed.

This need to focus on composition team has also shaped the evolving conception of an Equity Gauge and the idea of how a Gauge is defined, resulting in the vision that, although a particular organization or limited combination of groups may take the lead role in conducting an Equity Gauge, in institutional terms, an Equity Gauge is defined neither as those team members or institutions nor according to funding flows. Rather an Equity Guage represents the coordinated and dynamic *interplay* of activities that may be undertaken by various organizations or groups. Although one organization may play a lead role, diverse skills and actions are needed. Thus, Equity Gauges generally should be assembled from several groups or institutions and require a fluid and flexible structure to effectively pursue the goals and needs of the work.

At times, the sense of obligation to develop comprehensive actions for all three pillars and the insularity of teams from outside groups may have drawn some team members away from activities for which they have talent and training into ones for which they are less well-suited. This has been especially common for advocacy and community empowerment work, and the development of future Gauge teams will pay special attention to the need for such skills. The development of the Equity Gauge Strategy has itself been an organic process, and because the Community Empowerment pillar was the last adopted and the least developed, there may have been a degree of confusion about what constitutes a contribution to community empowerment. For example, the involvement of some Gauges in directly providing community services may have seemed necessary for building concrete relationships but arguably may not have represented an optimal use of their unique strengths or limited resources. One approach to community empowerment that may be more realistic and productive in most settings, given the resources and goals of Equity Gauges, and which most Equity Gauges now use, has been to foster links with local community groups, bringing them into the work to greater or lesser extents, rather than trying to directly serve those functions themselves. Gauges are now largely providing grassroots groups and other civil society organizations with information, sometimes strategically packaged, that can be used for mobilizing their constituencies and support advocacy efforts of those groups. Despite the less-intensive role Equity Gauges may play with communities themselves, recognition of Community Empowerment as a necessary part of the Equity Gauge Strategy has been important and useful. In most cases, for instance, these links would not have been sought without the stimulus of Community Empowerment as a distinct pillar.

Capacity-building and training is essential for long-term movement towards equity and a necessary activity for the Gauges and for the organization more generally. Simply establishing Equity Gauges will not be enough to create major shifts in broad understanding of issues, in policy development and planning, and in proper implementation of interventions without attention to skills building. Training is needed to increase capacity for Assessment and Monitoring to support development of equity-sensitive databases and understanding for what such information can tell us about a society, and for arming a new cadre of public-health workers with the skills to address the issues at multiple levels of planning in the society. Training and lower levels of capacity development, such as sensitization, can also be used by Gauges as an advocacy strategy for drawing attention to priority issues and for building advocacy coalitions. Finally, until marginalized communities and their leaders become adept at seeking and interpreting evidence of inequities, developing strategies for participating in political life, and shaping their own role and identifying responsibilities, true empowerment will not emerge.

There has also been growing demand for training opportunities relevant to the Equity Gauge Strategy and its implementation. This demand has been directed both at individual country-based Gauges from within their own countries and at the Alliance as a whole from individuals or groups in other countries. As we are becoming increasingly aware of the unique and large contribution—the multiplier effect, with its implications for sustainability—that can be made by a more explicit focus on capacity-building, there may be a move towards conceptualizing capacity development as a fourth pillar rather than leaving it only as a cross-cutting issue to keep it high on our agenda.

Research to policy issues: breadth vs depth

A central question regarding strategy for successful policy change centres around whether Equity Gauges should focus inquiry on broadly-defined health equity issues or focus on particular issues, especially as a mechanism for cutting their advocacy teeth and creating an initial path for change. The Chile and China Equity Gauges are examining equity using a wide range of indicators, including payment for healthcare and health status, health-related behaviours, and healthcare use. Most other Gauges also cover various indicators of health status and healthcare use. Within the spectre of health status, until recently most Gauges have highlighted general measures of health rather than single issues. However, the Gauges are finding that, although a broad base of equity-oriented indicators provides useful evidence that is often necessary for identifying equity priorities, when it comes to policy recommendations and intervention, it can be useful to narrow the advocacy target by identifying discrete issues for change. Consequently, the Ecuador Gauge has focused on a policy regarding access to maternity care and experienced favourable results, and the South Africa Gauge is now putting a spotlight on issues regarding HIV/AIDS and rural health. Cape Town and Zimbabwe have advocated for specific changes in resource-allocation processes. Nairobi and Bangladesh highlight maternal and child health in their activities. Chile and Ouagadougou coordinate with the activities and goals of specific other sectors and ministries, including education and housing/education respectively.

These more specialized efforts are largely responses to the sense that influencing deeply entrenched inequities requires focusing more concretely on the particular problems and actual details of implementing policies specific to those issues. Although it is, admittedly, the broad political and social values and decisions that societies make regarding their structures and architectures that are the most influential factor in shaping equity, long-term progress may require building on smaller successes, if only to demonstrate that the problems are surmountable.

Turning concepts into action

Most Gauges struggle to varying extents with a range of questions about finding and maintaining a feasible and optimal balance among Assessment/Monitoring, Advocacy, and Community Empowerment. For example, the Equity Gauge model suggests that advocacy and community empowerment efforts be informed by solid findings from assessment and monitoring. However, rigorous population-based monitoring is usually resource-intensive, and in most cases (e.g. when depending on census data or large household surveys), necessary data are available only once every few years or even less frequently. If the model is to continually move policy-makers and grassroots groups to action, Equity Gauges need to develop strategies for maintaining stakeholders' attention between the release of the major reports. The South Africa Equity Gauge provides an example of such a strategy through their ongoing engagement with parliamentarians in a technical assistance capacity.

At the same time, some Gauges have at times felt an uncomfortable tension regarding their relationships with ministries of health and policy-makers in general. Access to decision-makers, especially those who are sympathetic, can be helpful in influencing policy, and all of the Gauges have had successes in building these links. Furthermore, most Gauges work with ministries of health or other governmental groups in a cooperative fashion, sometimes directly incorporating them into Gauge teams. However, the concern has been voiced that linking too closely with official agencies potentially may compromise the Gauge's role as an independent advocate. This concern is a natural one for any group that is simultaneously interested in providing technical support to decision-makers and institutions but also recognizes an obligation to function as a watchdog and as a defender of those in society who have been excluded, either intentionally or not, by those same decision-makers and institutions.

This tension also extends to the image of individual Gauges versus that of the Alliance. One Gauge has expressed concern that its relationship with national government officials, which is now excellent, might be compromised if GEGA began to play a more prominent role in global advocacy, calling for change, for example, in the policies of international financing institutions; the government officials might feel personally sympathetic to the positions taken by GEGA, but be concerned about possible adverse consequences for how financing institutions would treat the country subsequently. However, the Alliance has tried to maintain some space for Equity Gauges to define their own visions of equity and to create their own local image and goals. This concern around identity is common to such networks and is not expected to pose particular problems for GEGA, although we will continue to pay attention to the issue.

Development and future directions

The Equity Gauge initiative has evolved from what was originally conceived as a discrete 'project' in one country to an ongoing coordinated network of research-to-policy activists bound by a common vision. GEGA is now confronted with the need to evolve further, to reach out to and involve a wider range of organizations, groups, and actors at national and international levels, and to adopt a more fluid arrangement. Although expansion inevitably presents potential threats to, and opportunities for the current work, there is a growing recognition that the survival of this promising experiment depends on our ability to build a larger movement linked to other efforts that have shared goals and principles.

Sustainability depends in part on affordability but also on the ability to attract and develop talented leaders with the array of strengths needed to direct an Equity Gauge and make it productive. Equity Gauge leaders must bridge the often sharply-divided realms of research and policy/action. Some members of the team must have the scientific skills to do rigorous measurement and assessment of equity while others take the next steps into the realms of advocacy and community support.

There has been discussion about the advisability and feasibility of more coordination and exchange among different Gauges, such as expansion of particular models of work, based on lessons regarding successful approaches. For instance, several Gauges have expressed interest in working along the lines followed by the South Africa Gauge to provide ongoing technical inputs to parliamentarians. In addition to a pilot expansion with the Zambia Gauge, in August 2003, GEGA joined with Equinet (the Southern African Regional Network on Health Equity) to hold a workshop on Parliamentary Alliances for Health Equity. This workshop brought together groups working on health equity issues from six African countries (including four Equity Gauges) with Parliamentary Portfolio Committees on Health, and parliamentarians from the Southern African Development Community (SADC—the regional governance body for southern Africa) to identify national and regional priorities, to develop plans for targeted technical support to Portfolio Committees, and to identify broad health equity goals for the region. Several Gauges have also expressed the desire to build on the Zimbabwe and Cape Town experiences of developing more equitable resource-allocation formulae, particularly in the context of decentralization. In terms of coordinating activities and building opportunities for cross-national comparison and advocacy, Gauges have expressed interest in exploring the feasibility of developing a limited set of shared indicators across most Gauges. This approach would pose challenges, though, if many Gauges move further towards directing their efforts at single issues and leave behind broad monitoring activities.

We are just beginning to grapple in a focused way with the question of how to integrate country-level and international work for maximum impact on promoting health equity. There is a shared recognition that country-level strategies need to be developed with awareness of the global forces that are constraining efforts towards

greater equity within countries (50). In an effort to support that goal, GEGA is moving towards establishing the Global Health Equity Watch (GHEW) in coordination with MedAct and the People's Health Movement. The GHEW would assess and monitor the global forces shaping the opportunities for achieving health equity within countries.

The question of choosing between international and country-based work—which should not be an either-or proposition—clearly arises only because of resource constraints. Both Rockefeller Foundation and Swedish International Development Cooperation Agency (SIDA) have generously supported GEGA, but additional resources must be mobilized to continue to meet the challenges and opportunities encountered and to expand the organization to include additional countries. From the outset, part of the Equity Gauge vision has been one of working towards the ultimate institutionalization of action-oriented monitoring of health equity within and between countries globally, i.e. its incorporation into the routine work of national and international agencies. Perhaps because of the timeliness of this effort, the current Equity Gauges have made steps towards that goal in their countries that in many ways appear remarkable in light of the brief time they have been operating. Some Gauges now receive partial support from ministries through financial or in-kind donations of time or other resources for some aspects of Gauge work, including health equity monitoring and other research and implementation of programmes, resource-allocation formulae, and interventions. This positive sign of movement towards institutionalization raises the issue of how to ensure sufficient independence to maintain advocacy functions and suggests that the existence of true Equity Gauges may ebb and flow within countries. As goals for institutionalization of pro-equity policy are achieved, new Gauges and teams may have to be developed to tackle other issues. Such a model for the Alliance suggests that the development of new Gauges will be imperative to maintaining the momentum of the organization's work. Policy-oriented researchers and data-oriented decision-makers in a number of additional countries have expressed a desire to initiate Equity Gauges in their own countries, and following this challenge, GEGA is now working towards expansion of the Equity Gauges. While funding for Gauge activities will likely remain primarily the responsibility of the Gauges themselves, resources will continue to be required to run the Secretariat, to provide ongoing support and coordination among the Gauges and with outside groups, to provide technical support for the Gauge activities, to coordinate training and capacity development, and to organize opportunities for exchange.

Many questions regarding the most effective path for GEGA to follow to support health equity are yet to be answered, especially those focused on the sustainability of early successes, how to best use limited human and financial resources within the Gauges and the Secretariat, and which strategies prove most successful in actually improving health equity within different contexts. Much of the next year's efforts will be spent in gathering the lessons of the Gauges and synthesizing and incorporating knowledge from the wealth of other researchers and projects focused on health equity around the world, and using those experiences for further strategic and programmatic planning, for linking with other organizations focused on health equity, and for capacity development with new partners. Although we still have many questions, our experience to date has affirmed our belief that the basic principles of the Equity Gauge Strategy make profound sense—that solid evidence is needed to guide efforts towards greater equity in health; that the evidence must be used in strategic ways to influence policy-makers and to support community empowerment of grassroots groups and civil society; and that capacity must be built to apply this approach in all its aspects. Particularly in light of the current global context and the circumstances we face, we believe that these principles provide the best guidance as we work—albeit against formidable obstacles—to achieve a world with greater equity in health.

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