Using EquiFrame and EquIPP to Support and Evaluate the Implementation of the Sustainable Development Goals

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1. HEALTH INEQUALITIES, SOCIAL EXCLUSION AND POLICY

The impact of globalization, economic, and financial crises has led to a deepening and expansion of inequalities across many dimensions of human well-being, within and between societies.[1] Individuals and groups experiencing multiple deprivations (i.e. low-income, poor nutrition, bad housing etc.) are disproportionately more exposed to economic shocks, more affected by cuts in services and benefits, and often vulnerable to ill-health and disease.[2] Identity-based forms of disadvantage pervade most societies and manifest as arbitrary social hierarchies.[3] No society is truly egalitarian; different levels of status and power are assigned to different identity categories.[4] In terms of population health, these dynamics manifest as the social gradient in health.[5] The global burden of disease and injury predominantly

1 Lombe/Sherraden (2008); MacLachlan/O'Connell (2000); OECD (2013b).

2 Mannan et al. (2011); Mathieson et al. (2008).

3 Kabeer (2005); Pratto et al. (2013).

4 MacLachlan (2014); Pratto et al. (2013).

5 Marmot et al. (2008).

befalls the poor, the vulnerable and the most excluded.[6] As a result, these individuals and groups are even further restricted to participate in society. Poor health jeopardizes their ability to generate income, reinforcing or contributing to their financial fragility.[7] The Commission on the Social Determinants of Health (CSDH)[8] attributes the unequal distribution of disease and injury amongst vulnerable groups to the Social Determinants of Health (SDH).[9] Explained through an SDH lens, health is as much a manifestation as it is a determinant of social exclusion.[10] Social exclusion is the product of unequal power relationships in society; between an individual's or a group's relationships and social entities such as institutions, organizations, spaces (social or physical) or individuals.[11] These relational dynamics intersect with deprivation to affect a wide array of social determinants of health.[12]

Complex and multidimensional phenomena such as social exclusion must be addressed through a holistic and joined-up response, and must involve a variety of actors.[13] Such interventions should seek to empower vulnerable groups in the process by improving the terms of their engagement with society at large.[14] Multi-sectoral and multi-agency approaches are being advocated to meet Goal Number 3 of the Sustainable Development Goals (SDGs) which urges governments to ensure »healthy lives and promote well-being for all at all ages« by 2030.[15] The complex relationship between health and socioeconomic development necessitates coherent intersectoral action, capable of addressing multiple health determinants simultaneously.[16]

6 Marmot et al. (2008); Mathieson et al. (2008).

7 Ibid.

8 CSDH (2008).

9 Labonté/Schrecker (2007).

10 Mathieson et al. (2008).

11 Popay et al. (2008); Kronauer (1998) as cited in Mathieson et al. (2008), 12.

12 Mathieson et al. (2008).

13 Guy et al. (2010); World Bank (2013).

14 Fraser (1998); Silver (2015); World Bank (2013), 3.

15 A/Res/70/1, adopted by the UN General Assembly in September 2015.

16 CSDH (2008); Leppo et al. (2013), 43; McQueen et al. (2012).

The »Health in All Policies« (HiAP) philosophy recognizes, for example, that virtually every sector (i.e. finance, education, housing, employment, transport, and health) affects population health.[17] It also recognizes that reducing health inequalities and social exclusion demands a change in agency, particularly in the political realm. Vulnerable groups and their representatives must not just be included, but also empowered in policy formulation and decision-making processes that affect their lives.[18] If inclusive, such processes may challenge prevailing power structures that undermine the political participation of those most vulnerable in society.[19] Political participation is crucial to realizing a comprehensive set of socio-economic rights premised upon a fair distribution of resources.[20] In order to achieve social inclusion and health equity, policy makers and institutional actors must also demonstrate a commitment to human rights and equity.[21]

Public policies are important instruments in the creation of socially inclusive societies.[22] They set out courses of action and determine the wider framework within which inclusion or exclusion occurs.[23] To this end, policies must confer entitlements, protect the human rights of vulnerable groups, whilst aligning actions and objectives with the global vision of sustainable development. Commitments to human rights and social inclusion are unlikely to be enacted unless they are explicitly outlined in policy documents.[24] Similarly, policies are more likely to achieve equitable and inclusive outcomes if an equitable and inclusive policy process supports them.[25] The operationalization of global approaches, ambitious goals and their guiding principles, do however pose difficulties for policy makers. We review two methodologies, *EquiFrame* and *EquIPP*, which have been specifically designed to render public policies and processes more equitable and inclusive, and we discuss these in the context of health inequalities.

17 CSDH (2008).

18 Dani/de Haan (2008); Lavalle et al. (2005); UNDESA (2009).

19 Huss/MacLachlan (2016).

20 CSDH (2008), 18.

21 Braveman/Gruskin (2003); Mannan et al. (2011).

22 Ahmimed et al. (2014).

23 Anderson (2015), 3; Cocozzelli (2014).

24 Ahmimed et al. (2014).

25 Huss/MacLachlan (2016); OECD (2015).

EquiFrame and EquIPP are systematic methodologies to analyse the content of, as well as the wider process of development, implementation and evaluation of public policies. We highlight their potential for policy dialogue and review their application to date. We argue that these tools are useful for policy makers and civil society organizations to guide and monitor progress in achieving social inclusion.

2. GETTING THE CONTENT RIGHT: INCLUSION OF VULNERABLE GROUPS AND CORE HUMAN RIGHTS CONCEPTS IN POLICY DOCUMENTS

The Committee on Economic, Social and Cultural Rights imposes a duty on each state to take the required steps to certify that each person has access to health facilities, goods, and services through the adoption of a national strategy to ensure the enjoyment of the right to health for all citizens.[26] The content of national health strategies or policies sets out what the policy hopes to achieve, whom it is supposed to benefit, as well as any future actions by the government to achieve the objectives outlined. The content of such documents therefore functions as a point of reference. To minimize the gap between intention and the delivery of a policy, the language of documents and the normative values upon which they are premised must be supportive of social inclusion.[27] Mannan et al. developed a policy assessment and formulation tool, EquiFrame, which provides a standardized formulation and measurement instrument to develop and analyse public policies within a human rights framework.[28] EquiFrame outlines 21 core concepts of human rights (Table 1) and twelve vulnerable groups (Table 3), identified in a series of consultation workshops in four African countries – Malawi, Namibia, Sudan and South Africa. The core concepts were derived from United Nations declarations, literature and research evidence relating to human rights and well-being.[29] Core concepts of human rights are concepts that relate »to principles underlying the provision of universal, equi-

26 E/C.12/2000/4, 11 August 2000.

27 Amin et al. (2011).

28 Mannan et al. (2011). See also MacLachlan et al. (2012); O'Dowd et al. (2013).

29 Ahmimed et al. (2014).

table and accessible health services«.[30] These concepts are evidence-based in terms of being empirically linked to inclusion/exclusion and health status in the research literature and they align with fundamental human rights declarations and concepts. They do not, however, claim to be exhaustive and may vary in their relevance across different contexts.

EquiFrame employs »a structured content analysis of policies« to measure the commitment to social inclusion and human rights.[31] As such, it identifies which human rights are accorded to which vulnerable groups.[32] It is premised upon the assumption that the content of a policy must reference the specific vulnerable groups it seeks to protect and the human rights it seeks to safeguard, for the policy to contribute to equity and inclusion in any meaningful way.[33] The inclusion of vulnerable groups and core concepts of human rights in policy documents, or policy on »the books«, allows us to discern the level of commitment to equity in the context of service provision, particularly for those facing the most difficulties in accessing services.[34]

Table 1: EquiFrame core concepts and key language

No.	Core concept	Key language
1.	Non-discrimination	Vulnerable groups are not discriminated against on the basis of their distinguishing characteristics (i.e. living away from services; persons with disabilities; ethnic minority or aged).
2.	Individualized services	Vulnerable groups receive appropriate, effective and understandable services.
3.	Entitlement	People with limited resources are entitled to some services free of charge or persons with disabilities may be entitled to respite grants.

30 Mannan et al. (2011), 13.

31 Ahmimed et al. (2014), 13.

32 Ibid.

33 Huss/MacLachlan (2016).

34 Mannan et al. (2011).

4.	Capability-based services	For instance, peer-to-peer support among women-headed households or shared cultural values among ethnic minorities.
5.	Participation	Vulnerable groups can exercise choices and influence decisions affecting their life. Such consultation may include planning, development, implementation and evaluation.
6.	Coordination of services	Vulnerable groups know how services should interact where inter-agency, intra-agency and intersectoral collaboration is required.
7.	Protection from harm	Vulnerable groups are protected from harm during their interaction with health and related systems.
8.	Liberty	Vulnerable groups are protected from unwarranted physical or other confinement while in the custody of the service system/provider.
9.	Autonomy	Vulnerable groups can express »independence« or »self-determination«. For instance, persons with an intellectual disability will have recourse to an independent third party regarding issues of consent and choice.
10.	Privacy	Information regarding vulnerable groups need not be shared among others.
11.	Integration	Vulnerable groups are not barred from participation in services that are provided for the general population.
12.	Contribution	Vulnerable groups make a meaningful contribution to society.
13.	Family resource	The policy recognizes the value of family members of vulnerable groups as a resource for addressing health needs.
14.	Family support	Persons with chronic illness may have mental health effects on other family

		members, such that these family members themselves require support.
15.	Cultural responsiveness	i) Vulnerable groups are consulted on the acceptability of the service provided; ii) Health facilities, goods and services must be respectful of ethical principles and culturally appropriate, i.e. respectful of the culture of vulnerable groups
16.	Accountability	Vulnerable groups have access to internal and independent professional evaluation or procedural safeguard.
17.	Prevention	
18.	Capacity building	
19.	Access	Vulnerable groups have accessible health facilities (i.e., transportation; physical structure of the facilities; affordability and understandable information in an appropriate format).
20.	Quality	Vulnerable groups are assured of the quality of the clinically appropriate services.
21.	Efficiency	

Source: Mannan et al. (2011)

In order to evaluate public policies within a human rights framework, Mannan et al.[35] developed a scoring system measuring *vulnerable group coverage*, *core concept coverage* and *core concept quality*. Depending on the number of vulnerable groups and core concepts of human rights mentioned in a policy document, percentages are calculated to reflect the level of concept coverage. Core concepts referenced within policy documents are rated on scale from 1 to 4. The score indicates the quality of commitment to individual core concepts. A score of four indicates that the policy specifies an intention to monitor a core concept. An overall summary ranking is then calculated which qualifies a policy as low, moderate or high in terms of its

35 Mannan et al. (2011).

intention to promote human rights and social inclusion. A policy qualifies as high if it achieves ≥50% on all of the three scores outlined above.[36]

A variety of policy documents and revision processes have been undertaken using EquiFrame. A full review of these is beyond the scope of this chapter, and so we simply indicate its range of uses here. Ivanova et al.[37] conducted an EquiFrame analysis on the Sexual and Reproductive Health policies of Ukraine, Scotland, Moldova, and Spain. EquiFrame has also been used to assess regional policies on health priorities in Africa;[38] a variety of international health documents;[39] international donor policies; European Policies on Disability and Development Cooperation;[40] India's Disability Policy[41] and three South African policies on Black economic empowerment, employment and cooperation.[42] It has also been applied to the United Nations Convention on the Rights of Persons with Disabilities (CRPD).[43] EquiFrame has been or is currently being applied to develop new, or revise existing policies in South Africa (disability and rehabilitation policies), Malawi (National Health Policy and National Health Research Policy) and Sudan (to guide the future development of all health policies). In Laos Democratic Republic, Handicap International has used EquiFrame to support the process of developing a Policy/Strategy/Action Plan process on disability. EquiFrame has also been employed outside the strict policy evaluation context; to identify the use of disability inclusive good practice behaviours across 24 countries worldwide.[44]

To promote Health for All, there is a need to focus on equitable, rather than equal healthcare. Policies should strive to promote well-being for all; yet, they must also be sensitive to differential needs. In order to ensure equitable healthcare, special provisions need to be written into public policies to ensure that those most marginalized – politically, socially, culturally or

36 Mannan et al. (2011).

37 Ivanova et al. (2015).

38 Eide et al. (2013).

39 Schneider et al. (2013).

40 Andersen/Mannan (2012).

41 O'Dowd et al. (2013).

42 O'Donnell (2008).

43 Mannan et al. (2012).

44 Emms (2014).

economically – are not left out. This is arguably even more important in low-income contexts, where vulnerability may be more pervasive, and resources even more limited.[45] An inclusive policy content, however, does not guarantee that policies accurately reflect the needs and demands of vulnerable groups or that designated policy benefits accrue to such groups.[46] It is not sufficient to reference vulnerable groups and core concepts of human rights in policy documents; rather considerations of equity and inclusion must shape the entire policy process – from formulation, through to implementation, monitoring and evaluation.[47]

3. EQUALITY AS AN OUTCOME REQUIRES EQUITY IN THE PROCESS

EquIPP (Equity and Inclusion in Policy Processes) seeks to complement EquiFrame by proposing a series of key actions (KAs) to support the development, implementation and evaluation of inclusive policies. Whereas EquiFrame is concerned with the quality of policy content, EquIPP is concerned with the wider processes of policy development and implementation. This relationship is outlined in Figure 1. EquIPP is a framework for an inclusive policy process to support public policies promoting equity and inclusion. An inclusive policy process creates experiences of inclusion for vulnerable groups who often remain marginalized in policy processes; it does this by according them a more central role in policy development, implementation and evaluation.[48] EquIPP is an inventory of 17 KAs and forms a blueprint for an equitable and inclusive policy process (Table 2). The higher the commitment to equity and inclusion is, the greater the degree to which policy makers and stakeholders will afford thorough consideration to these KAs; and be able to point to the evidence of having done so. These actions, if executed in a comprehensive manner have the potential to further the needs and interests of excluded groups and actively involve them in shaping decisions that affect their lives. Like EquiFrame, EquIPP

45 Mannan et al. (2011).

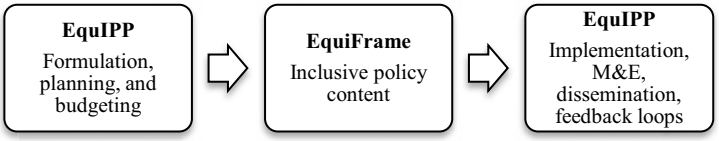
46 MacLachlan et al. (2016).

47 MacLachlan et al. (2015).

48 Huss/MacLachlan (2016).

measures the extent to which social inclusion is enacted equitably, and it provides a score and a mapping of the strengths and weaknesses of the process of inclusion in policy development and implementation. EquIPP was developed in partnership with several United Nations agencies; and in particular the *Knowledge Management Programme of the United Nations Partnerships on the Rights of Persons with Disabilities* (KnowUNPRPD).[49] It was developed through a literature review of stakeholder approaches to equity and social inclusion and several iterations of stakeholder consultations with representatives of more than twenty countries. Draft versions of the framework were also presented at conferences, meetings and workshops across a number of countries representing a range of high-, middle and low-income contexts, as well as cultural and religious differences (for instance, it has been presented in Ireland, Malaysia, Panama, Thailand and Timor-Leste).

Figure 1: The relationship between and functions of EquiFrame and EquIPP



Conceptually, EquIPP draws on Walt and Gilson's[50] policy triangle, which attributes equal importance to the content of policies, the actors involved in such processes, and the wider processes surrounding policies, as well as the context within which these elements are embedded. EquIPP promotes a participatory, equitable and inclusive policy process in which the needs and interests of vulnerable and excluded populations are prioritized and which supports the formulation of an inclusive policy content as well as its translation into practice.[51] Bureaucrats and civil servants are often too far re-

49 UNDP (2016).

50 Walt/Gilson (1994).

51 Huss/MacLachlan (2016); MacLachlan et al. (2015).

moved from actual experiences of marginalization and exclusion and should therefore not be the exclusive designers of policies.[52]

Public policies should be designed and implemented in a collaborative and not in a top-down manner.[53] The value of the EquIPP framework is that it seeks to render the entire policy process equitable, inclusive and *measureable*. While development, implementation, and evaluation are standard components of a policy cycle, budgeting and dissemination intersect with the aforementioned components in important ways but are often not embraced in policy analysis. Budget analyses can draw attention to issues of resource generation and redistribution in matters of health and social policy.[54] Similarly, an emphasis on dissemination shifts the focus to how government communicates information to its citizen, particularly vulnerable groups. Equitable access to information is of course crucial in the creation of equal opportunities within policy processes.[55]

Table 2: EquIPP key actions and definitions

Key action	Definition
Key action 1: Set up inclusive and participatory mechanisms	This key action involves detailing a public engagement strategy for the purpose of policy development/revision.
Key action 2: Ensure the highest level of participation	This key action involves maximizing the quality of participation and ensuring that all relevant stakeholders participate directly or are adequately represented in policy deliberations.
Key action 3: Strengthen cross-sectoral cooperation	This key action involves strengthening communication and the flow of information across government departments and the integration of plans and policies.

52 OECD (2013a).

53 Carey et al. (2015); Rittel/Weber (1973); Roberts (2000).

54 Bonner et al. (2005); Holmes (1998); OECD (1996).

55 OECD (2013a), 7.

Key action 4: Strengthen intergovernmental cooperation	This key action involves the harmonization of national and local level initiatives through the creation of an overarching policy framework.
Key action 5: Plan according to need	This key action involves the adoption of participatory planning techniques to tailor policy provisions to local complexity of needs.
Key action 6: Specify actions by which social needs will be addressed	This key action involves the identification of explicit projects, programmes, and interventions to address social needs and level the playing field and promote social inclusion.
Key action 7: Build equity considerations into budgets	This key action involves the prioritization and funding of programmes, projects and interventions specifically designed to benefit vulnerable groups in government budgets.
Key action 8: Minimise gaps between real and planned budgets	This key action involves creating a favourable and participatory oversight environment to monitor anticipated and actual expenditure.
Key action 9: Devise a responsive and flexible implementation plan	This key action involves developing a detailed and overarching implementation plan in a participatory manner, and which should involve key stakeholders, including relevant government sectors, local governments, service users and service providers.
Key action 10: Adopt the most inclusive selection methodology	This key action involves taking necessary steps to ensure that beneficiaries are identified in the most inclusive manner to yield a maximum of policy coverage.
Key action 11: Select the most appropriate implementation partners	This key action involves mobilizing the non-governmental, civil society and private sector for the operationalization of social inclusion policies.

Key action 12: Encourage cooperation between agencies and service providers	This key action involves strengthening the links between implementers on the ground to deliver a more tailored and holistic response to social inclusion.
Key action 13: Collect qualitative and quantitative data	This key action involves setting up mixed and multi-methods monitoring and evaluation frameworks in a participatory manner.
Key action 14: Integrate, aggregate, disaggregate and share data	This key action involves integrating, aggregating, disaggregating and sharing data to monitor and evaluate policies across multiple domains and over time.
Key action 15: Select appropriate indicator dimensions	This key action involves the participatory design of an indicator framework to measure appropriate social outcomes.
Key action 16: Share information with policy beneficiaries	This key action involves taking steps to ensuring equitable access to all information relating to policy benefits.
Key action 17: Share information with the policy community	This key action involves taking steps to ensuring equitable access to all information relating to the policy more broadly.

Source: Huss/MacLachlan (2016)

A policy process qualifies as inclusive and equitable if evidence can be gathered from documents or stakeholder testimonials to demonstrate engagement with the key actions outlined in EquIPP. An assessment matrix, comprising a 7-point scale was developed to assess the level of prospective or retrospective engagement with the 17 key actions. Higher-level ratings are awarded for *Process* and *Outcome* criteria and can only be achieved if stakeholders indicate satisfaction with the process and outcomes of engagement. Scores for individual key actions are plotted on a spider diagram to visualize the inclusiveness of policy processes.

To date EquIPP has been used in conjunction with EquiFrame across a number of diverse contexts. EquIPP is currently being used in a two-year project to promote social inclusion in South-East Asia as part of UNESCO's Management of Social Transformation (MOST) programme. More specifically, EquIPP has been used in an assessment of the National

Disability Policy in Timor-Leste.[56] The findings from the evaluation were presented at a National Dialogue in Dili, Timor-Leste and will be presented to the Council of Ministers to inform the revision of the document. EquiFrame and EquIPP are also being used to guide assessments and subsequent policy revisions in Cambodia (National Disability Policy) and in Malaysia (Science and Technology Funding Policy). Both instruments have been used to assess the National HIV/AIDS strategy in Malawi.[57] Both instruments have also formed an important part of training and capacity building for policy development, revision and analysis for staff from the United Nations Educational, Scientific and Cultural Organization (UNESCO), World Health Organization (WHO), International Labour Organization (ILO), United Nations Development Programme (UNDP) and United Nations Children's Fund (UNICEF) as part of the United Nations Partnership to Promote the Rights of Persons with Disabilities (UNPRPD).[58]

4. SPECIAL CONSIDERATIONS IN USING EQUIFRAME AND EQUIPP

This overview of various applications of both EquiFrame and EquIPP demonstrates the usefulness of these tools in a range of countries with greatly different cultures, contexts and political systems. This is largely as a result of the flexibility and adaptability of both methodologies; users of these tools are encouraged to adapt the methodologies to suit their contextual needs. Insights and findings from the application of both tools will feed into future revisions of the instruments. Users may find certain core concepts, vulnerable groups or KAs more salient than others. We recognise that EquiFrame's twelve vulnerable groups, or 21 core concepts, are not exhaustive and may also be influenced by the nature of different policy areas. We encourage therefore, the identification of additional vulnerable groups and core concepts as they pertain to specific contexts.

56 Timor-Leste National Commission for UNESCO (2016).

57 Chinyama et al. (2016).

58 UNDP (2016).

In relation to vulnerable groups in particular, we believe that processes of identification must be evidence-based to ensure that the groups in question are in actual fact particularly disadvantaged with regard to the relevant policy area.[59] As noted earlier, while each of the vulnerable groups and core concepts outlined is supported by a significant evidence base and international resolution or conventions,[60] the identification of vulnerable groups was also constrained by the political context of the countries involved. For instance, while we would have liked to recognise the need to promote inclusion of LGBTI persons, in some of the countries involved in the development of EquiFrame, such activities were legally prohibited, and indeed punishable by death. Clearly inclusion works within political contexts that mediate what is legally permissible in society. However, we are painfully aware that promoting inclusion for some marginalized groups, while ignoring it for others, is morally problematic, even given the constraints of what is practically possible in different jurisdictions.

We would encourage others to adopt, add to or subtract from our core concepts or vulnerable group categories; but crucially, to do so on the basis of an explicit and evidence-based rationale. Ivanova et al., in their analysis of Sexual and Reproductive Health policies from the Ukraine, Scotland, Moldova and Spain, argued for the inclusion of four additional vulnerable groups: Lesbian, Gay, Bisexual, Transgender (LGBT), people living with HIV, sex workers and victims of sexual abuse, gender violence and human trafficking.[61] At a workshop on social inclusion in Malaysia participants representing government, academia and civil society identified the additional vulnerable groups of street children, prisoners and indigenous communities.[62]

As already noted, the inclusion of some groups can be contentious in countries, where the legal environment discriminates against or criminalizes their very existence.[63] However, even within such constricting contexts the rights of those marginalized by national laws, may still be considered in national policy. An example can be found in the recently completed analy-

59 MacLachlan et al. (2015).

60 Mannan et al. (2012).

61 Ivanova et al. (2015).

62 National Working Group (2016).

63 MacLachlan et al. (2015).

sis of the National HIV/AIDS Policy of Malawi using EquiFrame and EquIPP. The policy is a notable example of an inclusive policy for men who have sex with men (MSM). In Malawi, the law criminalizes same-sex practices, yet as a vulnerable group, MSM are included as a priority group in the country's public health response in recognition of the significant barriers faced by them in accessing health care.[64] Often disconnected from the pragmatics of need, policy makers can benefit greatly from involving groups or representatives of groups who are marginalized, and therefore best positioned to enrich policies with lived experiences of exclusionary processes. This argument chimes with the Jakarta Declaration on Health Promotion, which states that »people have to be at the centre of health promotion action and decision-making processes«.[65]

While there may be situations where certain core concepts are less relevant in some policy documents, we would expect the empirical evidence for this to be presented by way of justification for their omission. The final 21 core concepts in EquiFrame were deemed to represent a broad range of salient concerns central in achieving equitable, accessible and universal healthcare.[66] We have applied these concepts well beyond health and welfare and found most of them to be salient in others areas too. The core concepts of human rights were not positioned in terms of relative importance but are presented as a generally coherent ›gestalt‹. We note that any omission of a core concept within a policy assessment therefore automatically assigns differential importance to individual concepts.

Table 3: Vulnerable groups outlined in EquiFrame

1	**Limited Resources**	Referring to poor people or people living in poverty
2	**Increased Relative Risk For Morbidity**	Referring to people with one of the top 10 illnesses, identified by WHO, as occurring within the relevant country

64 Chinyama et al. (2016).

65 Keygnaert (2016); WHO (2009).

66 Mannan et al. (2011), 13.

3	**Mother Child Mortality**	Referring to factors affecting maternal and child health (0–5 years)
4	**Women Headed Household**	Referring to households headed by a woman
5	**Children (with special needs)**	Referring to children marginalized by special contexts, such as orphans or street children
6	**Aged**	Referring to older age
7	**Youth**	Referring to younger age without identifying gender
8	**Ethnic Minorities**	Referring to non-majority groups in terms of culture, race or ethnic identity
9	**Displaced Populations**	Referring to people who, because of civil unrest or unsustainable livelihoods, have been displaced from their previous residence
10	**Living Away from Services**	Referring to people living far from health services, either in time or distance
11	**Suffering from Chronic Illness**	Referring to people who have an illness which requires continuing need for care
12	**Disabled**	Referring to persons with disabilities, including physical, sensory, intellectual or mental health conditions, and including synonyms of disability

Source: Mannan et al. (2011)

Grounded in the United Nations declarations and resolutions, we are fully cognizant that the values and philosophy of inclusion, fairness and human rights espoused by these methodologies are a reflection of the dominance of some socio-political thinking and philosophical paradigms over others. Nonetheless, we contend that our approach is justifiable in light of the existence of ill-suited models of social cooperation and unjust societies. Fol-

lowing Braveman and Gruskin,[67] we insist that reductions in health disparities can only be achieved if governments explicitly commit to equity and human rights by according equal opportunities for health for the most vulnerable and excluded groups in society.[68] Government has a legal obligation and society must accept its moral duty to alleviate health disparities. By combining the two, EquiFrame and EquIPP can support States in moving beyond the rhetoric and towards the operationalization of the principles of equity and inclusion.

5. USING EQUIFRAME AND EQUIPP TO GUIDE, MONITOR AND EVALUATE THE IMPLEMENTATION OF THE SUSTAINABLE DEVELOPMENT GOALS (SDGS)

The Post 2015 Sustainable Development Agenda constitutes a unique opportunity for countries and the wider global community to realise the right to health for all. As Hawkes and Buse[69] point out, the Sustainable Development Goals (SDGs) represent an attempt by the global community to move beyond a narrow conceptualisation of health in a biomedical sense and to promote a more holistic approach to health and well-being. SDG No. 3 encourages governments to implement Universal Health Coverage (UHC), including financial risk protection, to ensure access to health services, medicines and vaccines for all (target 3.8). While the provision of UHC has been equated to the practical expression of the right to health,[70] SDG No. 3 also promotes action to curb current and future threats of communicable and non-communicable diseases (targets 3.1–3.6).[71] These health related targets must be situated within the broader development agenda, which promotes action on the underlying social, economic, cultural, political and structural determinants of ill-health and social exclusion.[72]

67 Braveman/Gruskin (2003).

68 Ahmimed et al. (2014).

69 Hawkes/Buse (2016).

70 Ooms et al. (2014); Tangcharoensathien et al. (2015).

71 WHO (2016).

72 Buse/Hawkes (2015); Hawkes/Buse (2016), 337.

Health inequity is often referred to as a »*wicked problem«,* presenting complexities difficult to resolve using siloed policy responses. Kickbush and Gleicher argue that

»successfully solving or at least managing wicked policy problems requires reassessing some traditional ways of working and solving problems, challenging governance structures, skill bases and organizational capacity.«[73]

To this end, working arrangements and relationships amongst different policy actors, across government sectors and levels must be re-oriented towards more collaboration and better coordination.[74] According to Hawkes and Buse, achieving the SDGs require new forms of inter-sectoral coordination as well as new partnership frameworks with an increased emphasis on accountability. Similarly, policy processes must be inclusive, with mechanisms for monitoring and review. [75] Policies promoting health and well-being must be guided by principles of equity and respect for human rights.[76] The methodologies reviewed in this chapter lend themselves particularly well to guide, monitor and evaluate the implementation of the right to health.

In order to promote healthy lives and well-being for all, at all ages, whilst reducing existing health disparities, it is vital to address and rectify fundamental inequalities among different groups in society. The Office of the United Nations High Commissioner for Human Rights and the WHO specified that the application of the right to health for specific groups demands that countries

»disaggregate their health laws and policies and tailor them to those most in need of assistance rather than passively allowing seemingly neutral laws and policies to benefit mainly the majority groups.«[77]

73 Kickbusch/Gleicher (2012), 93.

74 Huss/MacLachlan (2016).

75 Hawkes/Buse (2016).

76 Ibid.; Kickbush/Gleicher (2012); MacLachlan (2014).

77 WHO (2008), 24; see also MacLachlan (2016b); Mji et al. (2009).

Explicitly mentioning vulnerable groups, as they exist in a particular context and in relation to a specific issue area, strengthens their claims to entitlements and nominally commits governments to act on their obligation to secure access to services, goods and facilities for them. Similarly, an emphasis on core concepts of human rights within a policy document commits governments to implement policies in line with such principles. By promoting overt references to core concepts of human rights, EquiFrame can guide policy makers in strengthening the human rights language in their policies.

While the content of such documents constitutes a crucial point of reference, the manner in which they are developed, implemented, evaluated and disseminated presents ubiquitous opportunities to create experiences of inclusion.[78] The Organization for Economic Cooperation and Development (OECD) contends that »the nature of the policymaking process matters [...] for the quality of policies, and thus their outputs«.[79] Ideally, inclusive policies are the outcome of a participatory development process. Key actions 1 and 2 in EquIPP focus on the creation of inclusive engagement strategies, which would allow vulnerable groups and their representatives to partake in the decision-making processes at the highest level possible. EquIPP also encourages the continuous involvement of vulnerable groups and/or their representatives throughout the policy life cycle, from the design phase through to implementation and evaluation, ensuring that policies address priority needs of such groups (key action 5). It does so in recognition of the fact that participation has the potential to improve the design and deliverance of better public services.[80] Moreover, continued inclusion creates new partnerships and collaborations between issue areas and in which, governments, providers and »consumers« of services co-produce the process and content of decision-making.[81]

Inter-sectoral approaches have been deemed most appropriate to address socially determined phenomena such as health inequities and social exclusion. The remit for population health goes beyond responsibility of the health sector; efforts to address particular instances of exclusion thus neces-

78 Huss/MacLachlan (2016).

79 OECD (2013a), 5.

80 UNDESA et al. (2013); Speer (2012).

81 Quick/Feldman (2011).

sitate the coordinated intervention of a variety of stakeholders.[82] Key actions 3 and 4 in EquIPP detail how the strengthening of cross-sectoral and inter-governmental cooperation and coordination promotes equity and social inclusion at an organizational and institutional level. If located within a whole-of-government approach, they can foster critical linkages across previously disconnected silos and levels of operation. Additional avenues for equity and inclusion exist at various junctures of the policy process. Monitoring and evaluation frameworks, for example, should employ a combination of quantitative and qualitative appraisals. Evaluations involving vulnerable groups (as service users or beneficiaries more broadly) display transformative potential, for they seek out the knowledge and experiences of vulnerable groups, which can influence the future course of policies and programmes.[83] Braveman and Gruskin contend that qualitative information collected from vulnerable groups and their representatives is important for it allows the documentation of »unmet need, perceptions of service quality, and obstacles to receiving recommended services in any sector influencing health«.[84] Quantitative data collected should be amenable to disaggregation for different vulnerable groups, to establish differential impact to feed back into the policy cycle and inform the adaptation of policy designs.[85] Moreover, equity and human rights principles require that quantitative data be disaggregated for vulnerable groups and by variables such as age, sex, ethnicity, disability, migratory status, income and geographic location.[86] Key actions 13, 14 and 15 emphasize the importance of routine data collection of quantitative and qualitative information to monitor progress towards social inclusion. EquIPP also addresses information poverty (key actions 16 and 17), which has been recognized as a significant barrier to healthcare access and as a manifestation of social exclusion.[87] The failure to translate policies into local languages, for example, constitutes a prime example of exclusion. Limited access to policy relevant information prevents individu-

82 Hawkes/Buse (2016); Kickbusch/Gleicher (2012).

83 Mertens (2012); Samson et al. (2015).

84 Braveman/Gruskin (2003), 542.

85 Open Society Foundation (2010).

86 Piron/Curran (2005); UNFPA (2016).

87 Britz (2004); Ensor/Cooper (2004); Kennan et al. (2011), 193.

als and groups from fully participating in society.[88] To ensure equitable access to all information relating to benefits a policy has to offer (i.e. entitlements, goods and services, specific provisions), governments must improve how it communicates with citizen.[89] Inclusive dissemination strategies engage in extensive distribution of information in a culturally appropriate manner.[90]

EquiFrame and EquIPP both permit quantitative assessments of the extent to which policy makers are engaging with principles of equity, inclusion and human rights. In EquIPP, for example, evaluators are encouraged to seek out evidence from vulnerable groups or their representatives on their satisfaction with the *process* and the *outcom*e of inclusion. If vulnerable groups or their representatives state ›satisfaction‹ with the *process* and *outcomes* of engagement, this is likely to be indicative of a genuine government commitment towards equity and inclusion.

6. CONCLUSION: WHAT GET'S MEASURED, GET'S DONE!

We argue that in order to address exclusion most effectively, the content of policies as well as the overall policy process must be inclusive. Governments are uniquely positioned to reverse processes of exclusion. Policy makers are interested in quantitative evidence-based evaluations of their work, as it permits them to demonstrate a clear commitment to promoting social inclusion and human rights in their policies. The advent of the SDGs, with their much stronger commitment to social inclusion, means that financial and technical support for the development plans produced by low- and middle-income countries will require governments to clearly demonstrate a strong commitment to promoting social inclusion and equity. The extent of inclusion in such processes has proven difficult to encourage and to evaluate, at least for some marginalized groups.[91] EquiFrame and EquIPP both offer flexible methodologies that allow for quantitative comparison and

88 Kennan et al. (2011).

89 Britz (2004); WHO (2008).

90 Kennan et al. (2011); WHO (2008).

91 MacLachlan et al. (2014).

demonstration of the extent to which policy content and policy processes are inclusive. These instruments seek to *encourage* and to *evaluate;* and we encourage others to build on our own work and that of others by using these ›free to use and free to access‹ instruments in new ways and new places to promote social inclusion and human rights in health, welfare and other polices.

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