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Addressing **Equity in Health**

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MEASURE Evaluation

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Table of Contents

Addressing Equity in Health

PURPOSE

Health and poverty are intertwined. It is often the poor and other vulnerable groups who experience the burden of disease, which can plunge them deeper into poverty. Recognition of these facts has put health and poverty issues high on the international agenda. Despite the best of intentions, however, health resources and program efforts often fail to reach those in greatest need.

As a result, it is imperative that policymakers and program managers better engage the poor and other excluded groups in the design of policies, programs, and financing mechanisms to make certain that they meet the needs of these groups. This course presents the EQUITY Framework for Health, which provides practical guidance on how to ensure that the voices of the poor are actively engaged in policymaking and that pro-poor strategies are incorporated throughout the policy-to-action process.

OBJECTIVES

At the end of this course, you will be able to:

- Define inequality and inequity
- Use survey data to identify inequalities and inequities in health utilization indicators
- Define the steps involved in the EQUITY Framework for Health
- List three ways in which to engage the traditionally excluded
- Identify supply-side and demand-side barriers that may hinder the achievement of more equitable health outcomes
- Name two examples of opportunities for integration
- Define targeting and required
- Provide an example of an indicator for program design, implementation, service uptake, and equity impacts

TIME

This course takes approximately two hours to complete. It follows an interactive version found on the MEASURE Evaluation Web site at: https://www.cpc.unc.edu/measure/training/online-courses

Equity in Health

1

DEFINITION OF INEQUITY

Equity in health stems from the principle that health is a basic human right. This was first articulated in 1946, in the *Constitution of the World Health Organization* (WHO) and repeated in other international documents, such as the 1948 *Universal Declaration of Human Rights* and the 1976 *International Covenant on Economic, Social and Cultural Rights*.

In the years that followed, the international community came to realize that achieving universal good health would require reducing the differences in health status between countries and between groups in the same country.

In a now-classic paper published in 1992, Margaret Whitehead laid out definitions and distinctions between inequality and inequity in health.

- *Inequality* is a statistical measure;
- *Inequity* has a moral and ethical dimension;
- Not all *inequalities* are *inequities*; *inequity* refers to differences that are:
    - Unnecessary and avoidable; ***and***
    - Unfair and unjust

Equity in health means that everyone should have an equal opportunity to attain his or her full health potential. Many of the poorer health outcomes and greater health risks experienced by disadvantaged groups, such as the poor, ethnic minorities, women, or others, relative to more advantaged social groups can be classified as health inequities.

Highlights

It is inevitable that some individuals will have poorer health than others due to genetics, lifestyle choices, accidents and other factors. What is important is that belonging to a particular group should not stand in the way of good health.

WHAT DOES EQUITY IN HEALTH COVER?

Health can be measured in many ways. The WHO considers three broad dimensions:

1) <u>Access</u> to health goods and services

Achieving equity in health means that all members of society have equal access to at least basic health goods and services. This means reducing physical barriers, such as distance and/or lack of transport, economic

barriers, such as high prices, and social-cultural barriers, such as provider attitudes that discriminate against people from certain ethnic groups.

2) Use of health goods and services

Equity in health means that everyone has the opportunity to make equal use of health goods and services for equal needs. Many members of disadvantaged groups do not use services because of fear of being treated badly or because they do not speak the same language as the service providers.

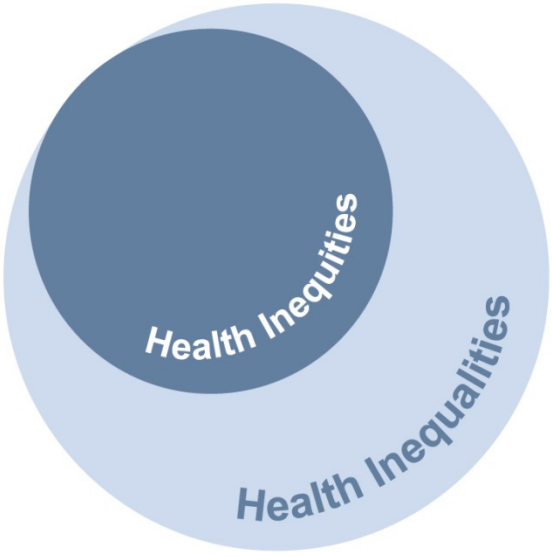
3) Health status (such as life expectancy, mortality rates, nutritional status, etc.)

Equity in health means that any differences in health status are not due to different use of health goods and services that stem from unequal access to them.

Highlights

Around the world, people who are poor and/or live in rural areas tend to have less or limited access to health services, to make less use of services that are accessible, and consequently to show worse overall health status compared to people who are better-off and/or live in urban areas.

INEQUALITY VS. INEQUITY



We can see from Whitehead's definition that all inequities in health involve inequalities, but not all inequalities are necessarily inequities.

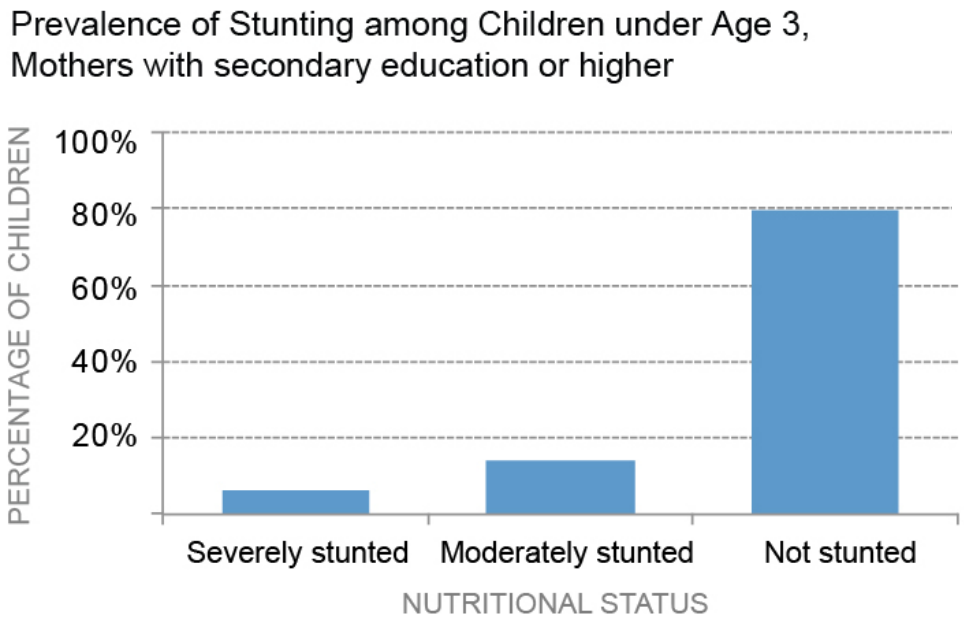
For an inequality to be considered an inequity, two conditions must be met:

1. The inequality is between different population **groups** (e.g., poor vs. not-poor; rural vs. urban; etc.) and not among individuals; and

2. The differences are both unnecessary and avoidable **and** unfair and unjust.

WHEN IS INEQUALITY AN INEQUITY?

EXAMPLE 1



Let us take a look at some common health problems in developing countries and see if they meet the criteria for inequity.

We begin with early childhood malnutrition and findings from the 2008-9 Kenya Demographic and Health Survey (DHS). Nationwide, some 30% of all children under the age of three were chronically malnourished (stunted) as measured by height for age.

The graph on the left presents children of mothers with a secondary education or higher. We can see that 6% were **severely stunted** and another 14% were **moderately stunted**.

Practice Question

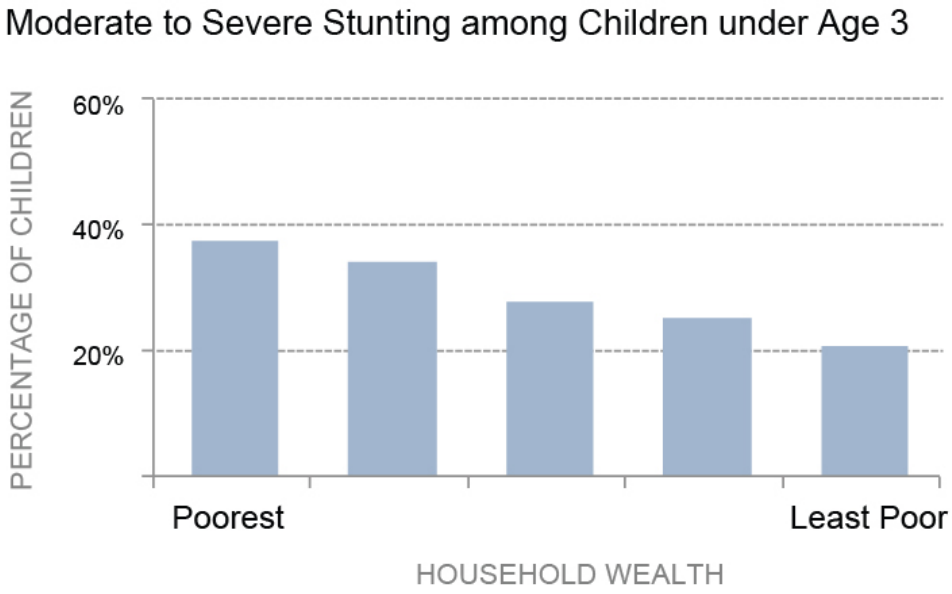
Do these findings demonstrate inequity, and why or why not?

Answer

The findings demonstrate differences (inequalities) among individual children with similar backgrounds. They do not show differences between population groups and therefore are not evidence of inequity

WHEN IS INEQUALITY AN INEQUITY?

EXAMPLE 2



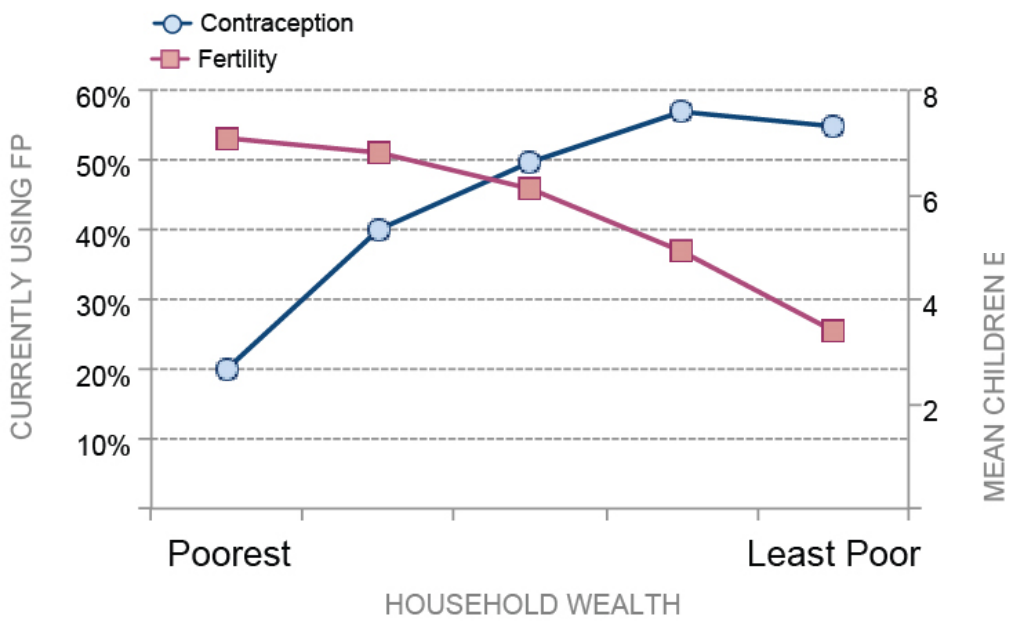
Now, let's look at all children under age three. The graph on the left shows prevalence of moderate-to-severe stunting by household wealth. We can see that more than 1 in 3 children from the poorest households were stunted, compared with approximately 1 in 5 children from the least poor households.

Practice Question

Do these findings demonstrate inequity, and why or why not?

Answer

The findings compare different population groups, so the differences meet the first criterion for inequity. Second, the root causes of stunting lie in poor food intake and poor sanitation, which are avoidable. Finally, it is arguably unjust that the poorest households cannot afford to feed their children or provide clean water and sanitation. Therefore, the differences in stunting by household wealth are likely to be an inequity in health.



WHEN IS INEQUALITY AN INEQUITY?

EXAMPLE 3

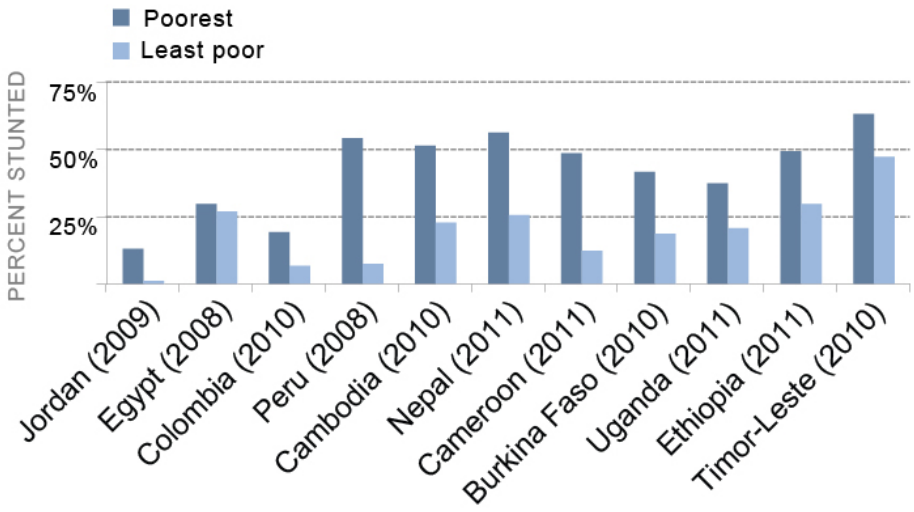
In our last example, we look at fertility and the use of contraception, also from the 2008-9 Kenya DHS. The graph above compares mean children ever-born among women ages 40-49 to current use of contraception among married women 15-49, by household wealth. The poorest women have the largest families and are least likely to be using family planning – in fact, as family planning use goes up, fertility comes down.

The impact of family planning on fertility is well known. Clearly, the higher fertility among the poorest women could be avoided if they used

contraception. ***But are these differences unfair and unjust? In other words, what do women want?***

As it turns out, Kenyan women from the poorest households want on average twice as many children as women in the least poor households. Therefore, one could argue that the higher fertility levels among the poorest women in Kenya, while potentially avoidable, may not be completely unwanted. To the extent that this higher fertility is wanted, it would not be unfair and unjust and therefore not meet the criteria for *inequity*.

At the same time, the reasons behind the desire for more children – lack of educational opportunities for women, higher child mortality rates, etc. – may represent social inequities, and higher fertility levels in and of themselves pose potential health risks for the poorest women and their children.



This graph shows differences in malnutrition rates among children under 5 between the poorest 20 percent of the population (dark blue column) and the least poor 20 percent (light blue column) in eleven countries around the world.

THE POOR HAVE WORSE HEALTH OUTCOMES THAN THOSE BETTER-OFF

Did you know?
Throughout the world, a child born to a poor family is much more likely to die before his/her fifth birthday than a child born to a wealthier family.

Note that the malnutrition rates among the poor are higher than rates among the wealthiest population group in every country. This demonstrates within-country inequities.

Note also the pronounced differences among countries: from Jordan, where only 8% of all children under age 5 are malnourished, to East Timor, where 58% of children under age 5 are malnourished. This demonstrates between-country inequities.

What other within- and between-country differences do you see?
(Hint: compare Colombia and Peru)

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 12 to see the correct answers.

1. Even in the best situations, it is inevitable that some individuals will have poorer health than others.

   [a] True
   [b] False

2. The concept of health as a human right was first articulated

   [a] By the Health Committee of the League of Nations in the 1930's
   [b] In the 1940's
   [c] In World Health Organization Alma-Ata Declaration of 1978
   [d] In the 2000 United Nationals Millennium Declaration
   [e] None of the above

3. The concept of health equity draws particular attention to

   [a] Measurement of health disparities
   [b] Health inequalities that are unnecessary and avoidable and unfair and unjust
   [c] Health finance
   [d] b and c
   [e] all of the above

4. All inequalities in health can eventually be shown to derive from inequity.

   [a] True
   [b] False

5. Equity in health covers

   [a] Access to health goods and services
   [b] Use of health goods and services
   [c] Health status
   [d] a and b
   [e] All of the above

6. High fertility rates endanger women's health and the health of their children. Women in rural and poorer households usually have more children than women in urban and wealthier households. This evidence is sufficient to demonstrate inequity in access to family planning.

   [a] True
   [b] False

KNOWLEDGE RECAP: ANSWERS

1. Even in the best situations, it is inevitable that some individuals will have poorer health than others.

   [a] True

2. The concept of health as a human right was first articulated

   [b] In the 1940's

3. The concept of health equity draws particular attention to

   [b] Health inequalities that are unnecessary and avoidable and unfair and unjust

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   [b] False

5. Equity in health covers

   [e] All of the above

6. High fertility rates endanger women's health and the health of their children. Women in rural and poorer households usually have more children than women in urban and wealthier households. This evidence is sufficient to demonstrate inequity in access to family planning.

   [b] False

Policy Approach to Equity

2

ADDRESSING INEQUITY WITH POLICY

There is growing consensus that overcoming inequalities and inequities in health requires a strong, enabling policy environment.

For more than two decades, the United Nations, the World Bank and other multilateral and bilateral donors have supported strategies, plans, and programs to end poverty and ensure equitable development. Among the most ambitious of these are the Millennium Development Goals (MDGs), launched at a UN summit in 2000. Three of the eight MDGs explicitly deal with health.

Nevertheless, many of these efforts fail to meaningfully involve the poor and other excluded groups. This leads to strategies that may be ill-suited to the reality faced by the very groups they are designed to benefit or do not adequately account for the barriers they face.

The EQUITY Approach, originally developed by the Health Policy Initiative Project, addresses this critical shortcoming. It is a practical, step-by-step process to actively engage the poor and other excluded groups in policymaking and ensure that pro-poor strategies are incorporated in policy design and implementation. It draws on project experiences and international best practices.

The remainder of this course is adapted from the Equity Approach. The approach has been modified to include a wider range of social factors that may give rise to inequity in health and a section on performance monitoring.

Did you know?

There are a growing number of communities of practice dedicated to equity in health. For example, see the Pan American Health Organization

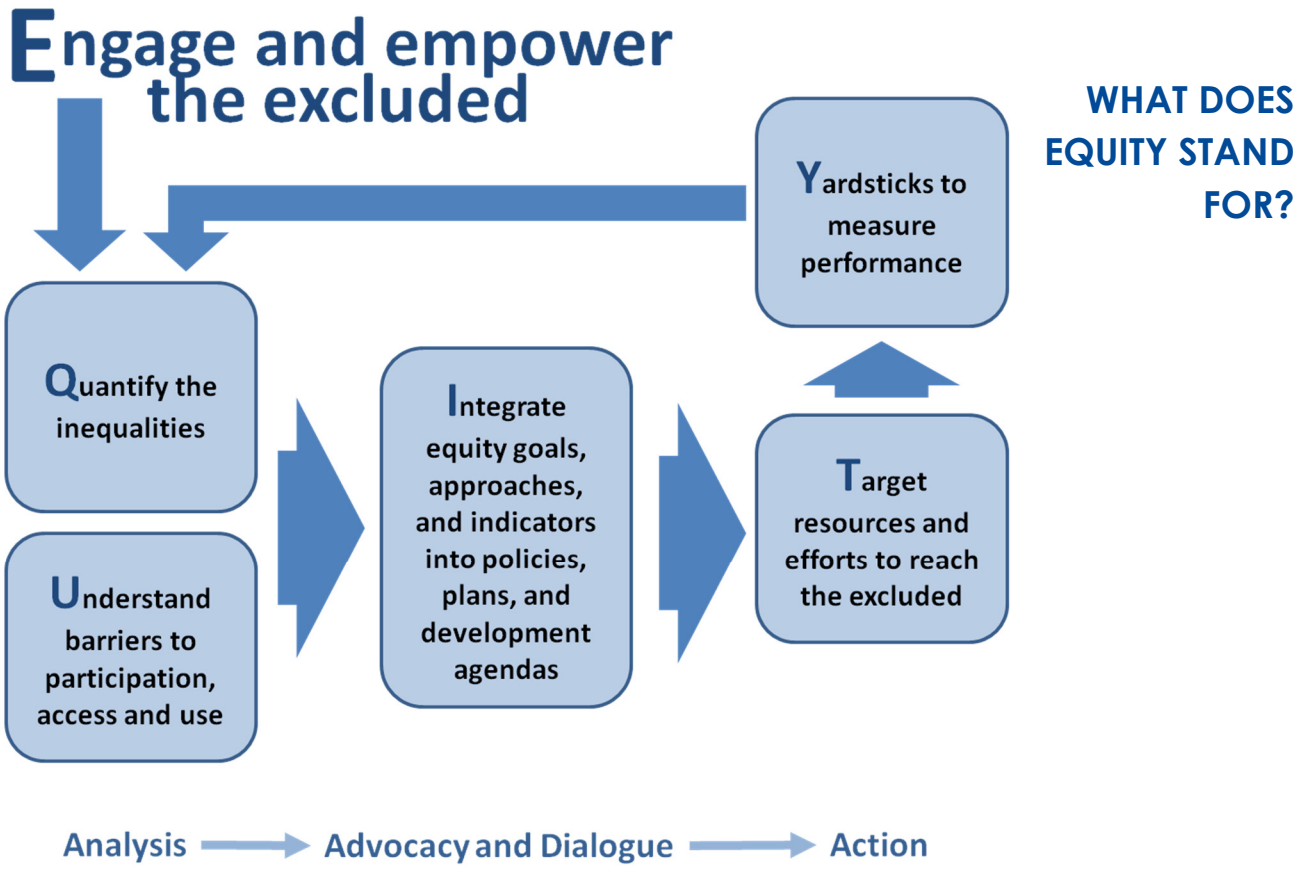
THE EQUITY APPROACH OVERVIEW

The EQUITY Approach is distinguished by three fundamental principles:

1. **Participation** (beginning with identifying and engaging those who have been excluded from mainstream health benefits and empowering them to participate throughout the process)

2. **Synthesis of quantitative and qualitative information** (to quantify inequalities and understand the range of barriers to access and use), and

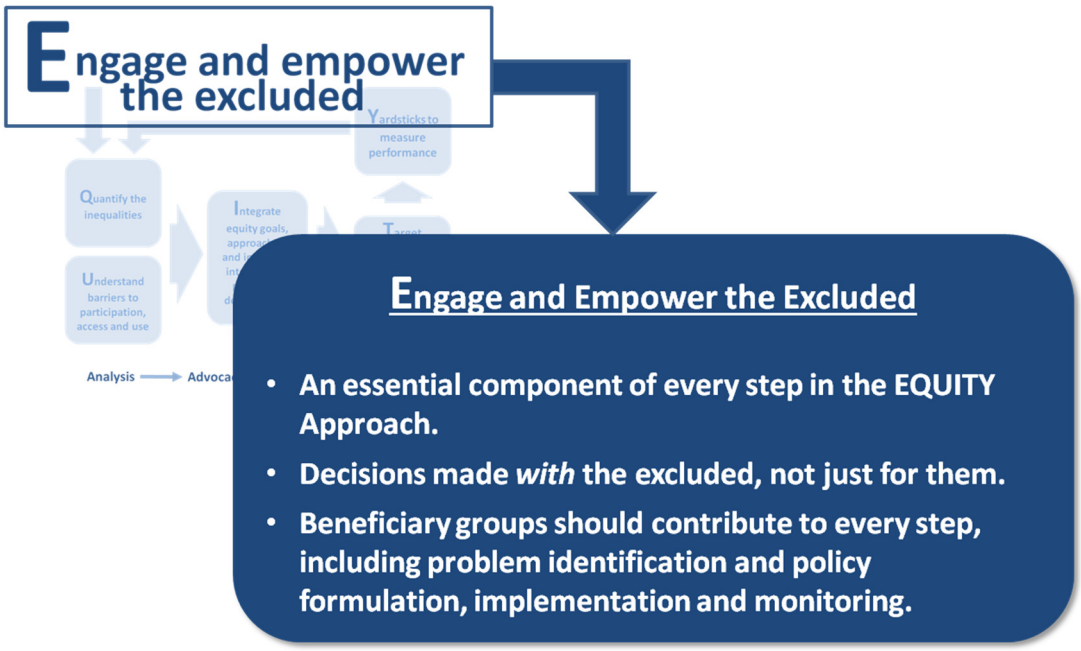
3. **Feedback** (throughout the cycle from analysis to advocacy and dialogue to action).



- ***E***ngage and empower the excluded
- ***Q***uantify the inequalities in health care use and health status
- ***U***nderstand the barriers to participation, access, and use
- ***I***ntegrate equity goals, approaches, and indicators into policies, plans, and development agendas
- ***T***arget resources and efforts to reach the excluded
- Implement ***Y***ardsticks for performance monitoring

The EQUITY Framework Figure above illustrates the approach. The next few pages will take you briefly through each of the six steps of the EQUITY approach.

E: ENGAGE AND EMPOWER THE EXCLUDED



The guiding principle of the EQUITY Approach is that policy, program, and implementation decisions affecting the poor and other excluded groups should be made with them, not just for them.

Empowering excluded groups is to give them a voice in the policy arena. Empowerment means that the intended beneficiaries define their own priorities and identify the barriers they face in accessing health services. It means that policymakers and others in positions of authority listen to what they have to say, and that political leaders and healthcare providers become more accountable for achieving results that benefit the excluded.

To learn more about working with the poor and other traditionally-excluded groups, see the next session on Engaging and Empowering the Excluded.

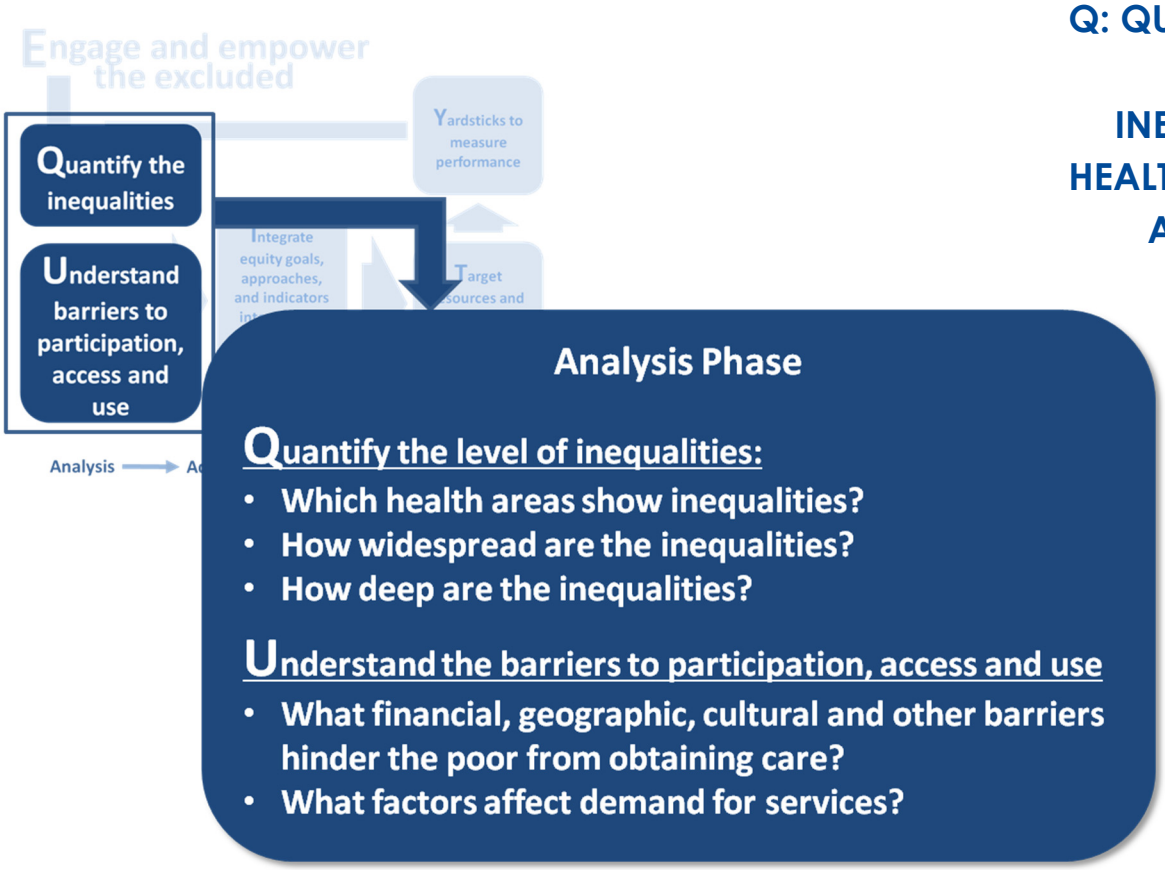
Highlights

When excluded groups are involved in policy and program design, solutions are better suited to their needs.

Ideas in Action

Think and act holistically to engage excluded groups. Where do they live (rural areas or urban slums)? Are they concentrated among ethnic minorities? Their group identity may be shaped more by these characteristics than by being poor.

Q: QUANTIFY THE LEVEL OF INEQUALITY IN HEALTHCARE USE AND HEALTH STATUS



Advocates for health equity need quantitative information to convince policymakers that inequalities in health are serious and deserve attention.

Planners need quantitative information to set targets, propose budgets, and allocate resources.

- *Which* health areas show inequalities? (only family planning? Family planning and maternal health? All areas of maternal and child health, including childhood vaccination, etc.)
- *How widespread* are the inequalities? (only the poorest of the poor? The entire rural population, etc.)
- *How deep* are the inequalities? (are the most disadvantaged 25% less likely to use the needed services than the better-off population? Half as likely? One-tenth as likely?)

Did you know?
A country that shows high inequalities on one health indicator is likely to show high inequality on other health indicators. However, different health outcomes may show markedly different levels of inequality. For example, childhood vaccination coverage generally shows less disparity between the poorest and least poor segments of the population than childbirth in a health facility.

U: UNDERSTAND ALL THE BARRIERS TO PARTICIPATION, ACCESS, AND USE

What are the reasons that socially-excluded groups tend to show low use of healthcare services? We cannot remove barriers to access until these reasons are fully analyzed and understood. Potential barriers to access and use may arise from both supply-side and demand-side issues.

Supply-side:

- Are there sufficient health facilities and service providers near to where people live, work, or shop? Traveling more than a few kilometers can be a barrier, especially if transport is limited or expensive.
- How much do facilities and service providers charge? Can the poor afford to pay these prices? Sometimes public facilities offer free services, but the medicine or commodity must be purchased.
- Do the facilities and service providers that the socially excluded tend to use, offer the services that they need?
- Are operating hours convenient? Are services offered every day or only once a week?
- Are there interpersonal barriers between providers and clients? Do providers speak the same language as the clients; are there differences in social class? Are female providers available for women who may be reluctant to accept physical examinations from male doctors?

Demand-side:

- Do consumers even want the services? Do they see the inequalities as a problem?
- Are there negative attitudes or beliefs that the services are harmful or that they violate cultural or religious values?
- Are there others in the household (spouse, parents, parents-in-law) opposed to the service?
- Do women have a say in how household resources are used for their health and the health of their children?

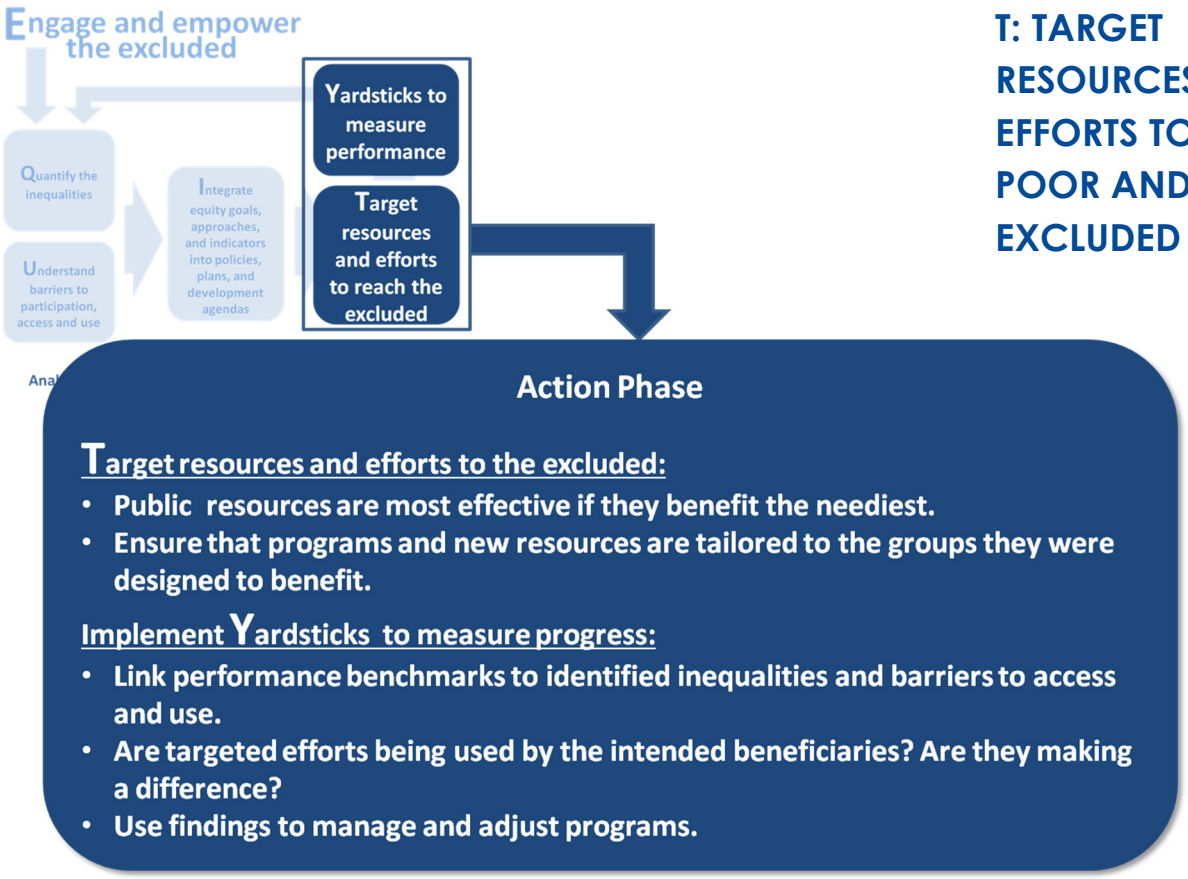
I: INTEGRATE EQUITY GOALS AND APPROACHES IN POLICIES, PLANS, AND AGENDAS

Governments around the world have set ambitious goals to improve the health and welfare of their people. For example, in 2000 the United Nations General Assembly, representing 189 countries, unanimously adopted the Millennium Declaration. This resulted in 8 goals, 18 targets and 48 indicators known as the Millennium Development Goals (MDGs). Among the health targets are:

- Halve the proportion of people who suffer from hunger (malnutrition) between 1990 and 2015
- Reduce by two-thirds the under-five mortality rate between 1990 and 2015
- Achieve universal access to reproductive health

Achieving the Millennium Development Goals means improving the health of the poor. As governments set and revise policies and plans to improve their health programs, poverty-related inequalities and equity goals should be explicitly included in dialogue and documents.
Governments need to:

- Set firm goals for improved coverage and health outcomes among the poor and other excluded groups
- Design strategies to achieve equity goals
- Ensure equity-based monitoring
- Ensure that poor and traditionally-excluded clients know their health rights and choices as citizens



T: TARGET RESOURCES AND EFFORTS TO THE POOR AND OTHER EXCLUDED GROUPS

There are two basic approaches to designing health policies and implementing programs:

- Mainstream or general population approaches seek to benefit all segments of the population. These would include efforts to provide universal access to priority services, such as childhood vaccination and family planning.

- Targeted approaches seek to selectively enhance provision of needed but under-utilized services or access to services by specific groups.

Targeting for equity means directing resources and outreach activities to those most in need, to improve their service utilization and health status and to achieve greater equity. Strategies targeting the poor are also known as "pro-poor".

Ideas in Action
Depending on the country situation, target groups may include urban poor, rural poor, the entire rural population, indigenous populations and refugees, as well as other disadvantaged or excluded groups.

Effective targeting for equity requires policies that:

- Focus on reaching and serving excluded or underserved segments of the population
- Take into account both poverty and other social factors associated with poverty, such as place of residence, ethnicity, gender, etc.
- Mobilize additional resources for excluded and underserved groups either by
    - redistributing existing public resources from those who are better-off and/or
    - adding new resources to specifically reach the excluded and underserved.

Resource mobilization – adding new resources for health – is a major component of effective targeting. It can take many forms, including general tax revenues, selectively charging fees for services, public-private partnerships, etc. Each of these strategies faces challenges, which are discussed in more detail in the session Targeting for Equity.

Y: IMPLEMENT YARDSTICKS TO MEASURE PROGRESS

Once a program has identified inequities in health and designed and implemented strategic interventions to address them, it will want to monitor progress and evaluate results. Monitoring and evaluation answer two distinct but related questions:

(1) Are our interventions reaching the right people (monitoring)?

Regardless of the specific targeting strategy, the basic objective of targeting for equity is to increase service uptake by previously excluded groups. This can be estimated by measuring what proportion of program clients belong to the target group. While this does not translate directly into program coverage (i.e., the proportion of the target population that uses services), increasing the numbers of people served is a necessary first step in reducing overall inequity.

(2) Have they been sufficient to make a difference (evaluation)?

Sooner or later, policy makers and program managers will want to know if their interventions made a difference in improving the health status of the targeted group. This will require population-level data similar to those used to quantify the inequalities earlier.

Highlights

To learn more about Performance Monitoring and Evaluation, including selecting performance indicators, collecting data and interpreting findings, see the session Implementing Yardsticks to Measure Performance.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 23 to see the correct answers.

1. The EQUITY approach rests on which of the following principles:

   [a] Building core competencies of a professional cadre of analysts
   [b] Emphasis on nationally-representative surveys to quantify inequalities
   [c] Feedback throughout the cycle from analysis to advocacy and dialogue to action
   [d] All of the above
   [e] None of the above

2. Empowering traditionally excluded groups means that policy makers and other authorities listen to what the excluded groups say and become more accountable for achieving results that benefit equity.

   [a] True
   [b] False

3. Is lack of consumer knowledge about the importance of childhood vaccination usually an issue of supply or of demand?

   [a] Supply
   [b] Demand
   [c] Both supply and demand
   [d] Neither supply nor demand

4. To further progress towards health equity, national health policies and strategic plans should include

   [a] Targets for poor and excluded groups
   [b] Equity-based monitoring indicators
   [c] Outreach to ensure excluded groups know their health rights
   [d] A and B
   [d] All of the above

5. Singling out socially excluded groups for special attention

   [a] Perpetuates discrimination against those groups
   [b] Tailors new and/or additional resources to the neediest areas
   [c] Is a basic principle of universal health coverage
   [d] B and C
   [d] All of the above

KNOWLEDGE RECAP: ANSWERS

1. The EQUITY approach rests on which of the following principles:

   [c] Feedback throughout the cycle from analysis to advocacy and dialogue to action

2. Empowering traditionally excluded groups means that policy makers and other authorities listen to what the excluded groups say and become more accountable for achieving results that benefit equity.

   [a] True

3. Is lack of consumer knowledge about the importance of childhood vaccination usually an issue of supply or of demand?

   [b] Demand

4. To further progress towards health equity, national health policies and strategic plans should include

   [d] All of the above

5. Singling out socially excluded groups for special attention

   [b] Tailors new and/or additional resources to the neediest areas

The Basis: Engaging and Empowering the Excluded

3

Poverty is a key factor contributing to social exclusion.

Depending on the country context, other factors may include rural residence, gender (women and girls), ethnic group or caste, sexual identity and other characteristics outside the "mainstream".

Social exclusion is a vicious cycle whereby members of excluded groups are prevented from participating in the social and political decisions that affect their lives, leading to low educational achievement, poor health, lack of employment, and continuing poverty, and that perpetuate exclusion in the next generation.

To combat these effects, the first component of the EQUITY Framework is to engage and empower the excluded.

Engaging and empowering groups which have been traditionally excluded both improves the quality and effectiveness of strategies to address poverty and other inequities in health, and builds social capacity and leadership in those communities.

POVERTY, SOCIAL EXCLUSION, AND

Ideas in Action
When excluded groups define their own priorities, identify barriers to accessing health services, and help design solutions, they can become true partners in the resulting programs. The programs will also be more sustainable and better tailored to meet their needs.

WHERE TO FIND THE EXCLUDED

People tend to self-identify and associate with others on the basis of religion, ethnicity, occupation, and/or shared concerns.

The poor are not usually affiliated with organizations led by national and regional policymaking elites. However, they may be found in civil society organizations and associations outside the formal sector.

Urban workers in the informal sector often organize in associations of market vendors, hawkers, peddlers, and other trades. For example, in Ghana, market porters known as kayeye are organized by tribal membership, pay monthly dues, and receive assistance in housing and transport back to their villages. Rural subsistence farmers may belong to cooperatives, community self-help organizations or insurance pools.

Ideas in Action The Nyanza and Coast provinces of Kenya have the highest rates of poverty and poor landless farmers. Female-headed households are especially likely to be poor. Civil society organizations that represent landless farmers and female-headed households may provide effective entry points to engaging the excluded.

Church groups and traditional structures such as councils of village elders or tribal leaders may also represent the interests of the poor and other excluded groups. However, these organizations often do not speak for all of the disenfranchised, especially women.

EMPOWERING THE EXCLUDED

Most excluded groups lack the technical, interpersonal, and organizational skills needed to advocate effectively on their own behalf. Long-term training, mentoring, and other types of assistance are needed to bring them together and impart the knowledge and speaking skills to participate effectively in the policy arena.

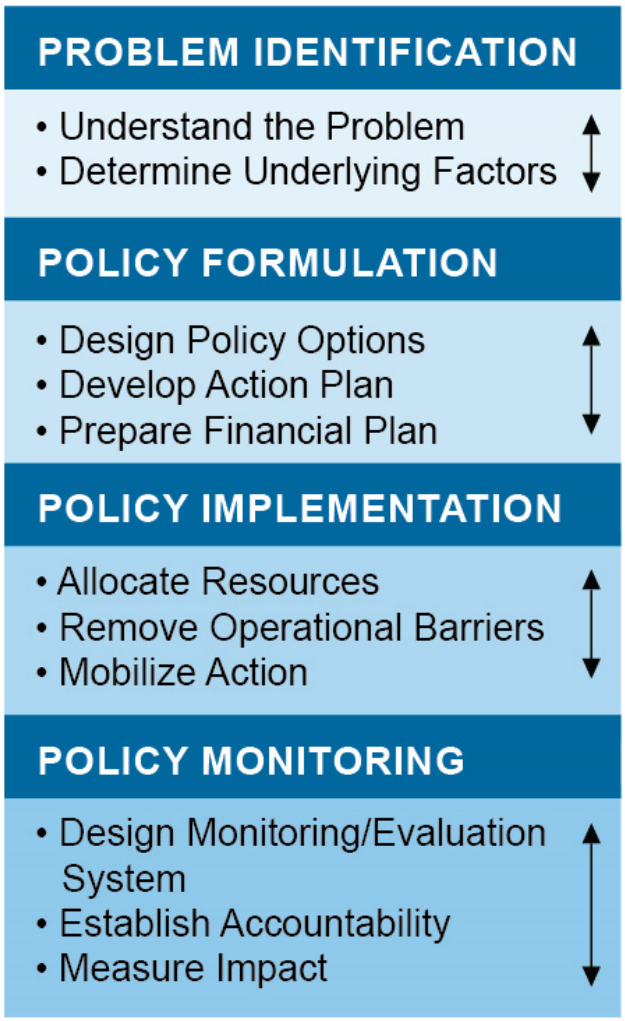
For example, the USAID-funded Health Policy and Education Project in Guatemala has provided technical assistance to build capacity of indigenous women to organize networks, strengthen knowledge of sexual and reproductive health issues, and analyze health inequities. As a result, indigenous women at the national and local levels have engaged in dialogue and advocacy to transform policies, increase financial resources for FP/RH programs, and encourage culturally appropriate services for indigenous women.

Women have come together to form the National Alliance of Organizations for Reproductive Health of Indigenous Women of Guatemala, ALIANMISAR, and departmental (provincial) networks in the predominantly Mayan highlands, including Alta Verapaz, Chimaltenango, Quetzaltenango, Quiché, San Marcos, and Sololá. The national alliance now consists of more than 90 organizations and actively participates in citizen monitoring, advocacy, and policy dialogue to promote better, more culturally-appropriate health services that are accessible to the indigenous populations, especially those living in rural areas and in poverty.

Ideas in Action

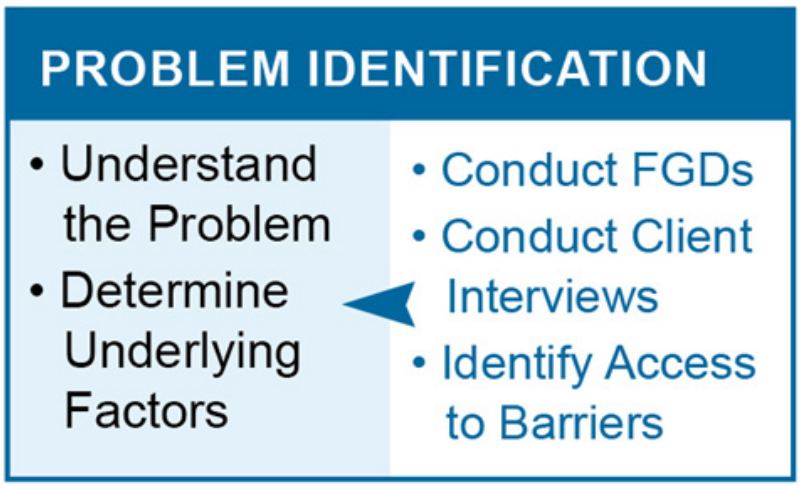
Empowering the excluded goes beyond health services. In Nigeria, the Women's Rights Advancement Protection Alternative (WRAPA) advocates and mobilizes communities to promote women's human rights, eliminate discriminatory practices and violence against women, and enhance women's living standards.

ENGAGING THE EXCLUDED IS A CONTINUING PROCESS



It is important to engage and empower the excluded in every stage of policy formulation, implementation, and evaluation.

This framework displays the steps of developing and implementing strategies to address inequities in health and shows how poor and excluded groups can participate in each step.



*FGD=Focus Group Discussions

While data from surveys, expenditure studies, etc. can quantify types and levels of inequalities, **understanding barriers to equitable access and use of services requires qualitative information**.

This qualitative information must come directly from those who are affected by social exclusion. They alone can give insights into their day-to-day worries, factors that affect their ability to access services, and cultural norms that constrain them.

In Sierra Leone, the Health Policy Initiative explored operational barriers to family planning use among people affected by conflict (Sonneveldt et al. 2008).

Interviews and focus group discussions with refugees and internally displaced persons revealed both demand- and supply-side factors. Interest in family planning varied at different phases of the conflict, depending on whether people were preoccupied with basic survival, fleeing from danger, displaced from their home, settled in refugee camps, or traumatized and feeling insecure.

Women stated that they were unable to use family planning due to their inability to locate services, lack of funds to pay for services, provider biases regarding specific contraceptive methods, disruption of health services, and frequent commodity stockouts.

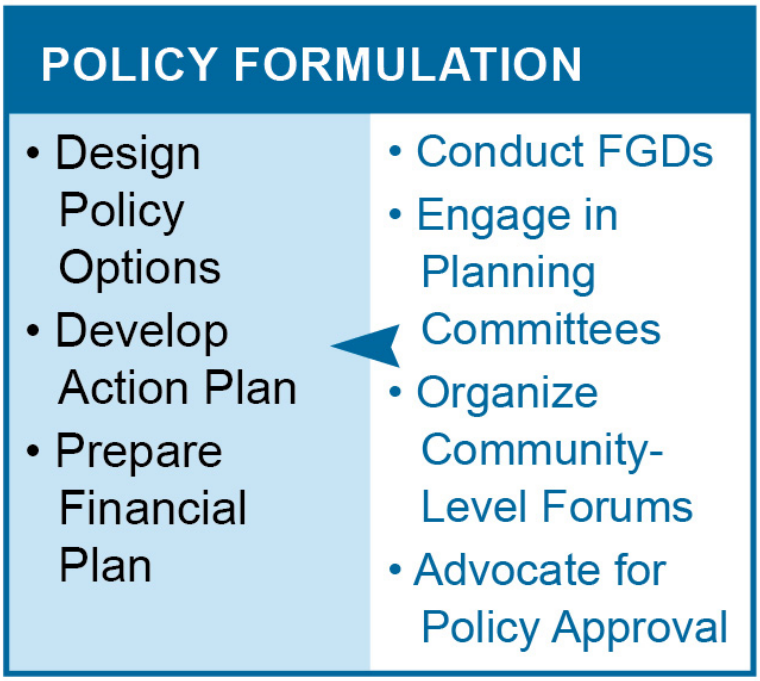
The insights provided by potential users themselves are essential to provide FP/RH services to people affected by conflict.

Highlights

The poor can provide unique insights to understand the dynamics behind poverty rates and trends, social and economic characteristics of underserved groups, inequalities in service access, and other factors that contribute to inequitable health outcomes.

Did you know?

For more information about quantifying the level of inequalities and understanding barriers to access, see the next session.



POLICY FORMATION

Highlights
To learn more about policy implementation, see the Integrating Equity Goals session.

Intended beneficiaries can advise on the appropriateness and feasibility of various policy options and advocate for adoption of needed policy changes and allocation of the necessary resources.

They can also be engaged in the design of policies and action plans—for example, by participating in public policy dialogue, providing testimonies to policy drafting committees, and reviewing draft policies and legislation.

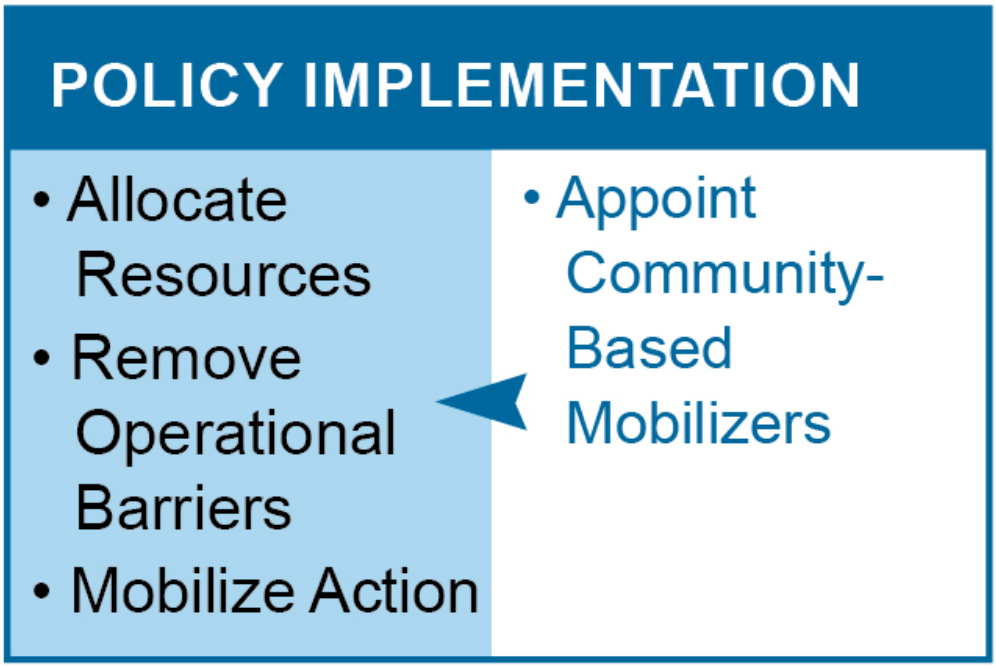
The Health Policy Initiative project assisted national stakeholders to engage the poor in the formulation of Kenya's new National Reproductive Health Strategy. The project conducted focus group discussions with poor women and men in Nyanza Province to assess barriers to FP/RH service use.

Findings were disseminated through provincial- and community-level meetings with local health authorities, program implementers, service providers, and community members themselves.

These sessions provided a forum for the poor to engage service providers and decision-makers directly to discuss the challenges they face in accessing FP/RH services and to propose potential solutions. The government then convened a national policy dialogue session, which

brought feedback from community and provincial deliberations to national decisionmakers.

Informed by this feedback and additional analyses, the National Reproductive Health Strategy includes clear, time-bound equity indicators and specific strategies to target resources and efforts to the poor.



POLICY FORMATION

Highlights

To learn more about the process of policy implementation, see the Target Resources and Implement Yardsticks session.

Service beneficiaries can be actively engaged in implementation as experts on operational barriers and community educators and organizers. They can encourage community participation and serve as trusted sources of information and supplies.

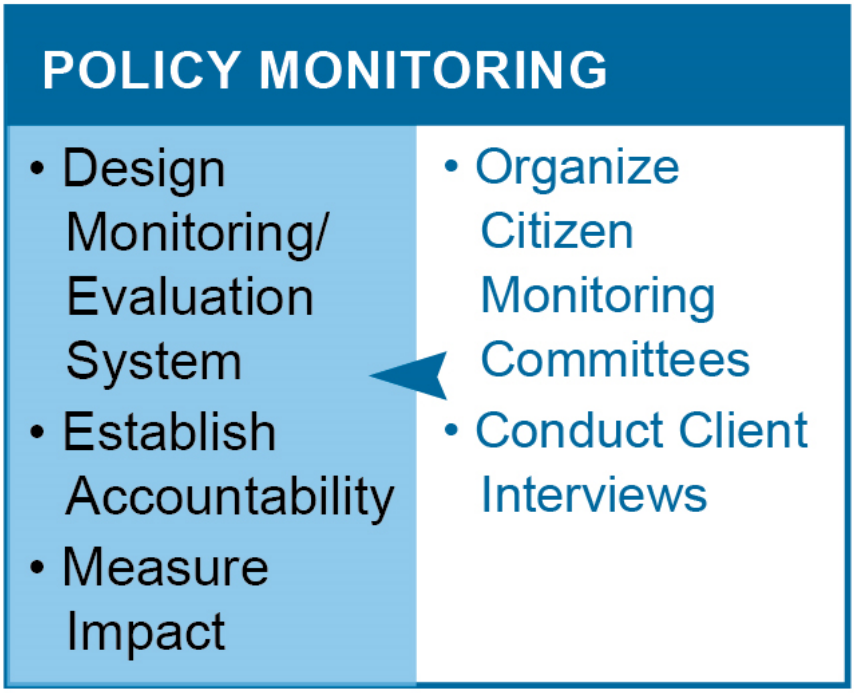
For example, the HIV epidemic in Vietnam is concentrated among already-marginalized key populations at higher risk of HIV - people who inject drugs, men who have sex with men and female sex workers. Stigma and discrimination keep those most in need from accessing prevention services, care, treatment and support (UNAIDS 2012).

USAID-supported projects, including the POLICY Project and the Health Policy Initiative, engaged people living with HIV (PLHIV) and Most-at-Risk Populations (MARPs) to reform Vietnam's HIV policy environment to adopt international standards and best practices and human rights approaches.

To ensure that PLHIV and MARPs are aware of their rights and have the means to redress grievances, the Health Policy Initiative and in-country partners launched five HIV legal clinics and a national HIV hotline.

PLHIV serve on the clinics' advisory boards and as peer counselors in the clinics and hotline. They provide counseling and legal representation to people who visit the clinics and assist in legal outreach and community awareness-raising through PLHIV support groups.

For more information, see:
http://www.globalhealthlearning.org/sites/default/files/page-files/802_1_Vietnam_Making_Policies_Work_for_People_FINAL_acc.pdf



POLICY MONITORING

Users must know their rights and have appropriate channels to communicate with authorities to fully exercise those rights.

Traditionally excluded groups can provide important feedback on policy initiatives. They can be engaged through citizens monitoring, civil society "watchdog" and local health oversight committees, collect information through client interviews, and compile community scorecards.

Involving traditionally excluded groups is essential for providing first-hand accounts of implementation issues on the ground. For example in Peru, the USAID-funded POLICY Project provided technical and financial assistance to establish five *Centers for the Resolution of Conflicts in Health*. The centers are managed by local NGOs and employ multidisciplinary teams. To foster widespread community support, the Boards of Directors include leaders from various sectors.

In three years, the five centers took up some 750 cases dealing with mistreatment, lack of information, difficulties using the social insurance system, lack of informed consent, and violations of privacy. In addition, by compiling and analyzing information from individual cases, the centers successfully promoted policy decisions to improve local public health systems and services.

For more on using alternative dispute resolution (ADR) mechanisms to increase access to healthcare, particularly for poor and vulnerable populations, go to: http://www.globalhealthlearning.org/sites/default/files/page-files/296_1_Guidelines_CEPRECS_Final.pdf.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 34 to see the correct answers.

1. Intended beneficiaries should not be engaged in monitoring and evaluation because they lack technical expertise and including them in evaluation creates conflict of interest.
   [a] True
   [b] False

2. The poor are often not affiliated with national or regional civil society organizations.
   [a] True
   [b] False

3. Most excluded groups lack the technical, interpersonal and organizational skills to advocate effectively on their own behalf.
   [a] True
   [b] False

4. The most useful information on barriers that limit access to and use of health services comes from those who are directly affected by social exclusion.
   [a] True
   [b] False

5. The EQUITY approach encourages engaging traditionally excluded groups in
   [a] Identification of problems in access to and use of health services
   [b] Formulation of policy reform
   [c] Resource allocation
   [d] Program implementation and monitoring
   [e] All of the above

KNOWLEDGE RECAP: ANSWERS

1. Intended beneficiaries should not be engaged in monitoring and evaluation because they lack technical expertise and including them in evaluation creates conflict of interest.
   [b] False

2. The poor are often not affiliated with national or regional civil society organizations.
   [a] True

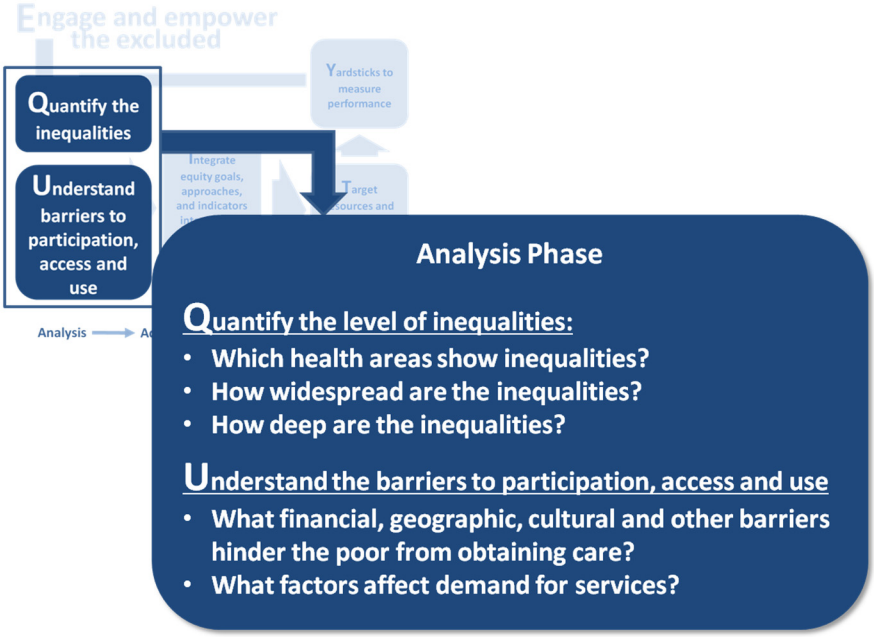
3. Most excluded groups lack the technical, interpersonal and organizational skills to advocate effectively on their own behalf.
   [a] True

4. The most useful information on barriers that limit access to and use of health services comes from those who are directly affected by social exclusion.
   [a] True

5. The EQUITY approach encourages engaging traditionally excluded groups in
   [e] All of the above

Analysis: Quantifying and Understanding Barriers

4



IDENTIFICATION AND ANALYSIS OF EXISTING INEQUALITIES

The second phase of the EQUITY Framework deals with the identification and analysis of inequalities inherent in existing strategies. This session will cover analysis of existing data as well as collection and analysis of new data to better pinpoint problem areas and identify barriers that may hinder the achievement of more equitable health outcomes.

There are many dimensions to inequalities in health:

- Who is disadvantaged?
- How many are affected?
- Where are they located?
- Which health indicators show inequalities?
- How much is the disparity?

QUANTIFYING INEQUALITIES

Let's start with poverty: who is poor? We often see two basic definitions of poverty:

Absolute poverty: A person is considered to be poor if his/her income and/or expenditures are below an established "poverty line." The World Bank considers the international poverty line to be $1.25/day. Most countries define their own poverty lines using local currencies, and some governments establish different poverty lines for different parts of the country based on cost of living.

Relative poverty: Instead of considering a single poverty line, it is possible to "rank" people from the poorest to the wealthiest (or least poor) and divide them into categories. For example, the Demographic and Health Surveys (DHS) include equal-sized wealth quintiles: Quintile 1 consists of the poorest 20% of the population, Quintile 2 consists of the next 20%, on up to Quintile 5, which consists of the wealthiest 20% of the population.

Ideas in Action

Quantifying inequalities will help decide whom to engage and what to discuss. Similarly, discussions with excluded groups will suggest issues that need further quantitative analysis.

Did you know?

How many people are considered to be poor depends on the definition of poverty used.

MEASURING POVERTY

How do we measure poverty – what data can we use?

There is no one "best" way to measure poverty. Many economists, including the World Bank and national statistical institutes, measure poverty directly through expenditures surveys that ask households how much they spend on different things and/or how much money household members earn.

However, national expenditures surveys rely on lengthy questionnaires and do not leave time to ask detailed questions about health. Health surveys, such as the DHS, often rely on indirect measures of poverty, using durable assets (such as household appliances) and housing characteristics (such as electricity, composition of the roof and floor, etc.).

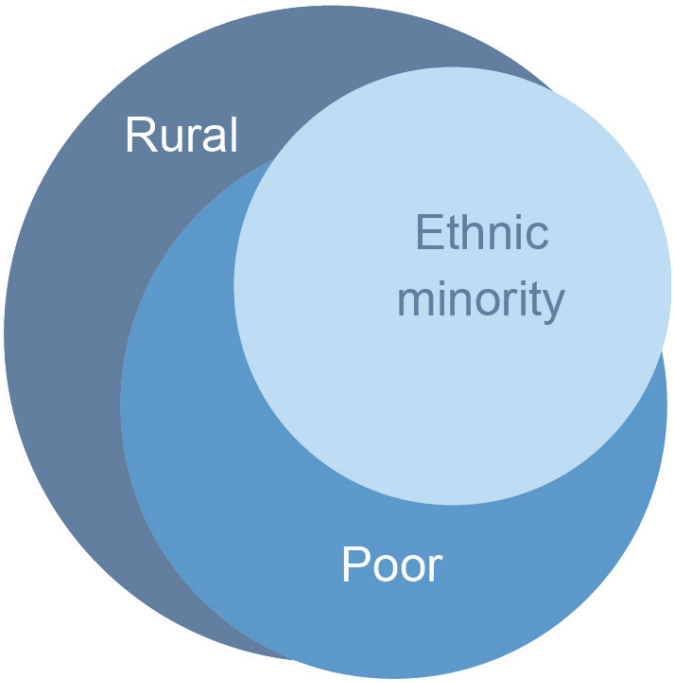
Assets can be used as a proxy for expenditures if they are included in or can be linked to an expenditures survey (absolute poverty). If expenditures data are not available, assets data can be used to estimate relative poverty.

Highlights

The World Bank *Living Standards Measurement Study* has provided national expenditures data since 1980.
For the last 10 years, the *Demographic and Health Surveys* have included relative measures of household wealth based on assets data.

FACTORS TO CONSIDER

While expenditures-based and assets-based measures of poverty generally show the same trends, ***they do not always identify the same individuals as being extremely poor***.



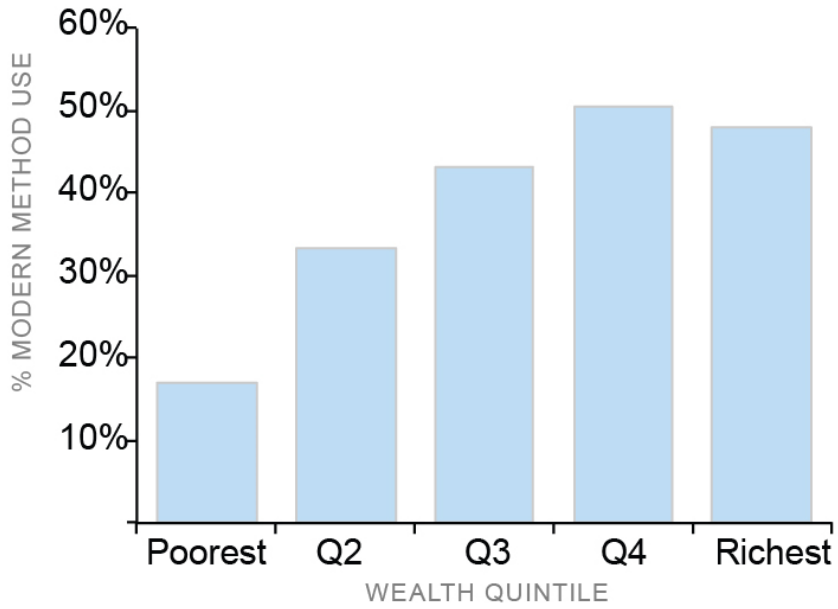
In a previous module, we saw that poverty is only one factor contributing to social exclusion. Quantifying inequalities should also consider other factors associated with health inequalities and the degree to which they go together.

We should ask broadly, ***"Who is likely to show lower health status?"***

Poverty is often associated with other factors that contribute to inequity in health. Separate wealth quintiles should be constructed for urban and rural populations to better understand the contributions of poverty and place of residence.

For more information, see *Addressing Poverty: a guide for considering poverty-related and other inequities in health* (http://www.globalhealthlearning.org/sites/default/files/page-files/ms-08-27.pdf).

FACTORS TO CONSIDER: PLACE OF RESIDENCE

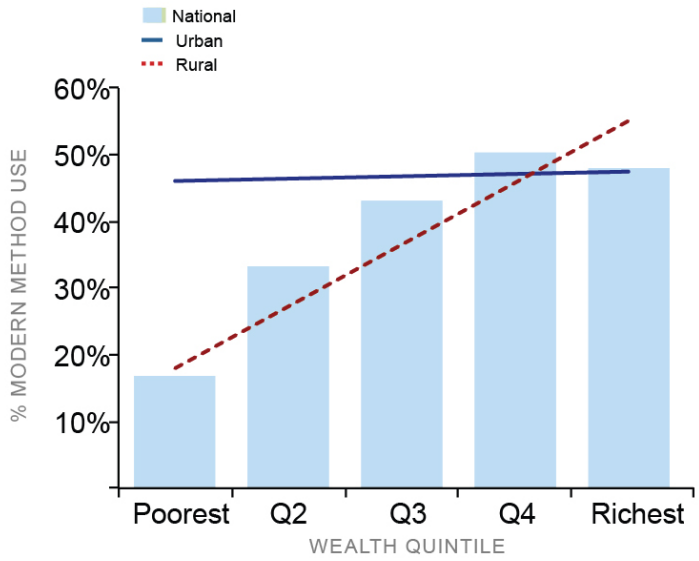


Place of residence is highly correlated with poverty: in sub-Saharan Africa, the wealthiest quintile is often almost exclusively urban while the lowest quintiles are almost exclusively rural population is distributed among the lower quintiles. Therefore, any comparison of the poorest quintile with the least poor quintile is also comparing the poorest of the rural poor with the urban population.

To illustrate the problem, let us look at the 2008 Kenya DHS. That survey found much lower use of modern family planning methods in the poorest quintile than in the least poor quintiles, 4 and 5.

What was responsible? Poverty? Place of residence? Both?

FACTORS TO CONSIDER: URBAN VS. RURAL



A good way to visualize the separate contributions of place of residence and poverty is first to divide the population into urban and rural residents.

Then, divide each residence group into its own wealth quintiles. This allows us to compare the poorest rural residents with the least poor rural residents, and the poorest urban residents with the least poor urban residents.

In the figure on this page, we construct separate wealth quintiles for urban and rural women in Kenya and compare them with the national trend.

Does our understanding of the relationship between wealth and use of family planning change?

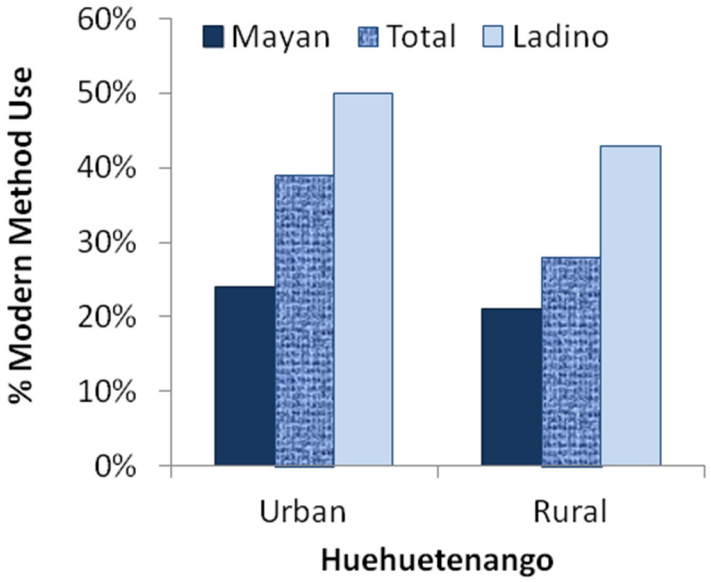
Notice that the use of modern family planning by urban women, shown in the blue line, is essentially the same across all wealth quintiles, while modern method use among rural women increases steadily with increasing wealth.

This suggests that the difference between the lowest and the highest national quintiles is due almost entirely to the very low rates of use among the poorest rural women and that poverty plays almost no role in family planning use in urban areas.

FACTORS TO CONSIDER: ETHNICITY

In some countries, ethnicity plays an important role in social exclusion. In Guatemala, the Mayan population, which is concentrated in the country's highlands, is especially disadvantaged.

The figure on this page presents modern family use in Huehuetenango Department in 2008, broken down by place of residence and ethnicity. What do these data tell us?

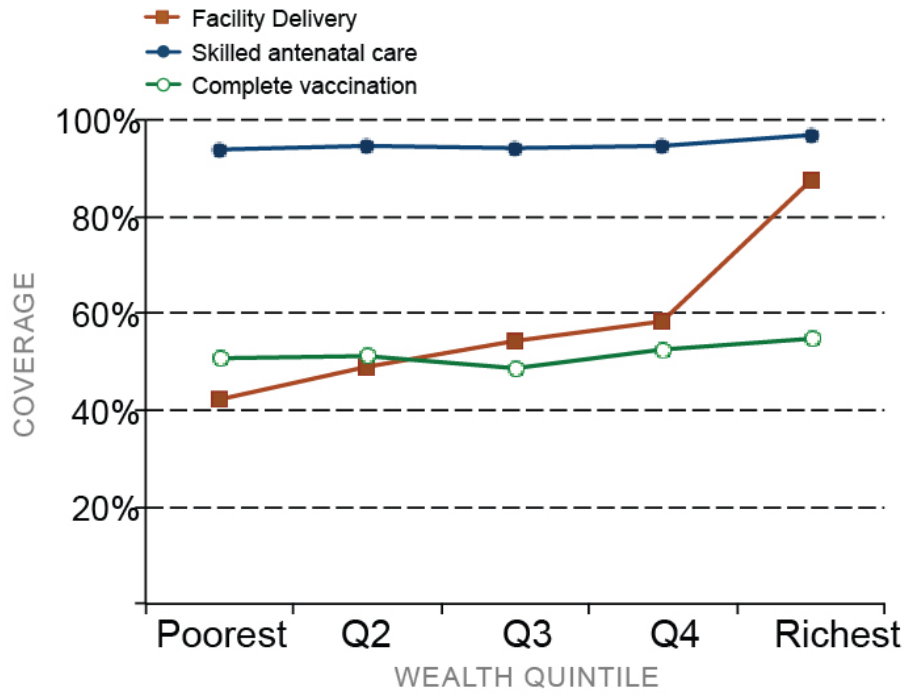


The textured blue bars in the middle of the graph represent all urban women (on the left) and all rural women (on the right).

Notice that the urban bar is higher than the rural bar. This shows a clear urban advantage, similar to what we would see in Africa.

We also see pronounced ethnic differences in both urban and rural areas. Note that the urban advantage almost disappears for Mayan women, suggesting that they face similar barriers to family planning use in both urban and rural areas.

FACTORS TO CONSIDER: DIFFERENT HEALTH INDICATORS



A final consideration is that different health indicators may show different patterns of inequality.

The figure on this page presents results from the 2011 Uganda DHS for three critical child survival indicators: antenatal care by a skilled provider, delivery in a health facility and timely completion of childhood vaccinations.

Levels of *skilled antenatal care* are high and uniform across wealth quintiles, indicating no inequities; in contrast, women in the top wealth quintile are more than twice as likely to *deliver in a health facility* than women in the poorest quintile. Does this suggest inequity?

The international community recommends that at least 80% of children be *vaccinated* against childhood diseases.

Practice Question

Has Uganda reached that target? Are there inequities in the levels of childhood vaccination?

Answer

Vaccination levels do not vary appreciably across income groups. Therefore, there are no inequities in this indicator even though national coverage falls short of the 80% target.

UNDERSTANDING BARRIERS

What is access to health care?

Analysts have identified the following five critical dimensions to access (Pechansky & Thomas 1981):

- Availability. Do providers have trained staff, equipment and supplies to meet clients' needs?
- Accessibility. How easily can clients physically reach the provider's location?
- Accommodation. Is the service organized to meet clients' preferences – for example, hours of operation?
- Affordability. Are clients able and willing to pay the provider's charges?
- Acceptability. Are clients and providers comfortable with one another – for example, in terms of ethnicity, gender, social class, etc.?

Highlights

Financial concerns may not be the greatest barriers to access to health care faced by the poor.

Supply-side barriers

Inability to pay providers' prices is not always the greatest barrier to service use by the poor and other excluded groups. Remote rural areas often lack appropriate facilities, making it necessary for residents to travel to other locations to obtain services. Operating hours may not match clients' schedules; health providers may be unresponsive to or discriminate against women and/or certain ethnic groups. Even when services are supposed to be provided free of charge, "under the table" fees and other costs such as supplies and medicines not provided by the facility, may prevent poor families from obtaining the health services and goods they need.

Demand-side barriers

Members of socially excluded groups may not be aware of service locations or face social, cultural and/or family opposition to using services and goods that would benefit their health. For example, in 2003, political and religious leaders in northern Nigeria urged parents not to vaccinate their children against polio, charging that the vaccine might contain contraceptives, HIV, and cancerous substances.

IDENTIFYING BARRIERS

While national surveys such as the DHS are usually excellent data sources to quantify inequalities in use of health services and health outcomes, they seldom are sufficient to identify barriers to use.

Once the priority groups and health indicators have been quantified, group members should be engaged in dialogue and qualitative research. Qualitative research methods, such focus group discussions and in-depth interviews, are excellent ways to identify the problems that prevent excluded groups from obtaining services.

To obtain the most useful information and to ensure that appropriate ethics procedures are in place to protect participants' privacy and confidentiality, we recommend that programs work closely with professional researchers. A number of training courses in research ethics online; for example, the free CITI Program for researchers involved in international research.

Geographic information systems (GIS) are another source of information on physical access. Many countries have computerized files of the locations of health facilities, which can be combined with maps of transportation corridors and physical obstacles, such as rivers and mountain ranges, to determine whether service availability is a significant barrier to use.

This information can form the basis of discussion and subsequent identification of strategies to eliminate or reduce barriers. Suggestions for possible strategies may emerge from open discussion of the analysis findings with communities, policymakers, and other stakeholders.

Did you know?

In Kenya, the Health Policy Initiative held focus groups with poor urban and rural residents to identify barriers to accessing and using family planning.
Many women feared pain, infertility, or birth defects.

Other barriers included costs, family opposition, preference for large families, and limitations of health providers.

This qualitative information helped the government devise solutions to improve equitable access and FP use.

EXAMPLES OF SUPPLY- AND DEMAND-SIDE BARRIERS

In each scenario, can you identify whether the apparent barriers to equity are related to issues with supply or demand?

A health clinic serves over 15,000 people in a rural district. The clinic is located in a secluded area that is a half-day's walk for the majority of the district's population. It receives regular deliveries from the central hospital, but does not have adequate staff to maintain normal hours. Most days, the clinic is only open for 3-4 hours in the morning, which usually coincides with school days and morning farm schedules.

Practice Question

What is the primary barrier preventing access to health services and is it related to supply or demand?

Answer

The primary barrier to access is related to the supply of man-hours (in this case, qualified staff) that are needed to keep the health post open so that customers are able to receive services. A secondary barrier to access could be the limited number of health facilities in the region, creating a demand for services that is too great for the health providers to satisfy.

A school has an unofficial policy of not allowing pregnant students to be enrolled in class. This rule is enforced by the director and despite complaints to the district education office, no alternative arrangements are made to educate pregnant students.

Practice Question

What is the primary barrier preventing access to educational services and is it related to supply or demand?

Answer

The primary barrier to access of educational services for pregnant women is the sociocultural views of pregnant women.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 46 to see the correct answers.

1. Place of residence is highly correlated with poverty

   [a] True
   [b] False

2. Measures of wealth based on possession of durable assets and housing characteristics are sufficient to identify which individuals and households live below the national poverty line

   [a] True
   [b] False

3. The impact of poverty on use of health services often differs substantially between urban and rural areas.

   [a] True
   [b] False

4. If a country shows uniformly high performance on one key indicator for child survival, other child survival indicators usually also show uniformly high results.

   [a] True
   [b] False

5. All of the following are good potential sources of data to understand barriers to health service use **except**:

   [a] Geographic information systems (GIS)
   [b] Focus group discussions
   [c] Nationally-representative health surveys
   [d] In-depth interviews
   [e] All of the above are good data sources to understand barriers to use of health services

6. Which of the following may pose substantial barriers to using health goods and services

   [a] Operating hours of health facilities
   [b] Unofficial practices of local authorities
   [c] Transportation corridors
   [d] Language
   [e] All of the above

KNOWLEDGE RECAP: ANSWERS

1. Place of residence is highly correlated with poverty

   [a] True

2. Measures of wealth based on possession of durable assets and housing characteristics are sufficient to identify which individuals and households live below the national poverty line

   [b] False

3. The impact of poverty on use of health services often differs substantially between urban and rural areas.

   [a] True

4. If a country shows uniformly high performance on one key indicator for child survival, other child survival indicators usually also show uniformly high results.

   [b] False

5. All of the following are good potential sources of data to understand barriers to health service use **except**:

   [c] Nationally-representative health surveys

6. Which of the following may pose substantial barriers to using health goods and services

   [e] All of the above

Advocacy and Dialogue: Integrating Equity Goals

5

INTEGRATING EQUITY GOALS AND APPROACHES

More than 40 years ago, policy planners coined the term “wicked” to describe social problems such as inequity. By their nature, wicked problems must be considered in their context, have multiple causes and must be addressed by multiple interventions.

What does this mean for equity in health? It means that the health sector alone is incapable of eliminating health inequities. In the words of the 1973 seminal paper, “Every wicked problem can be considered to be a symptom of another problem" (Rittel and Weber 1973).

The failure to achieve the lofty goals of the 1970’s, such as “health for all by the year 2000” of the 1978 Alma Ata Declaration, and the growing focus on the social determinants of health has given rise to a new approach, *Health in all Policies* (HiAP). The central tenet of HiAP is that **all sectors must share in the goal of improving health.**

WHAT DOES INTEGRATION REQUIRE?

Integrating equity goals into health planning and beyond requires that we recognize that different sectors and stakeholders are usually competing for the same – and often limited – resources. What is “in it for them” for the non-health sector to advocate for more attention to health, or for better-off groups to advocate for increased resources for the poor and socially excluded?

There is ample evidence that better health contributes to economic growth. Efforts to integrate health equity into the national agenda should look for opportunities to bring together groups that often have little formal contact with one another:

- Whole of government (e.g. health, finance, education, industry and agriculture, etc.)
- Private sector, both for-profit and not-for-profit
- Civil society, especially traditionally excluded groups

Did you know?
The greatest impetus for integration to date has come from regions with arguably the lowest levels of health inequities, such as Europe and Australia.

While the greatest impetus to integrating health and health equity has come from the industrialized world, the importance of the work supersedes national boundaries. In the words of the Adelaide Statement of 2010:

…we are clearly reaching an untenable, unsustainable situation within health systems worldwide. The problems facing health are wicked. Solutions must be innovative and revolutionary. That is Health in All Policies.

WHERE ARE THE OPPORTUNITIES FOR INTEGRATION?

Equity in health cannot be achieved without financial resources (see next module on Targeting). Therefore, some of the best opportunities for integration may lie in policies and planning being led by the ***finance sector***, especially around poverty reduction. Below are two examples.

Poverty Reduction Strategy Paper

In 1999, the International Monetary Fund (IMF) and World Bank initiated the Poverty Reduction Strategy Paper (PRSP) process to focus greater attention on poverty reduction and to explicitly link loans and debt forgiveness to achieving the UN Millennium Goals (MDGs).

Incorporating equity into PRSPs does face challenges.

- Most developing countries already have or have submitted final plans for approval. Once approved, the PRSP is good for 3 years. Changes can be made on the basis of an Annual Progress report.
- While *health* figures prominently in all PRSPs, health *equity* is seldom mentioned. For example, the Burundi PRSP for2012-2015 mentions "equity in health" once in passing, and none of the health indicators include inequalities.

Highlights

Countries prepare Poverty Reduction Strategies to qualify for multilateral loans and debt relief. They must describe the policies they will strengthen and/or adopt to alleviate poverty and meet the Millennium Development Goals. The HPI guide, *Making Family Planning Part of the PRSP Process*, can be adapted to promote health equity.

Cash transfer programs

They have been gaining in popularity, first in Latin America and more recently in Asia. In many programs, recipients must meet certain conditions to continue receiving their grants, such as keeping their

children in school and obtaining preventive health care for children and pregnant women.

For cash transfer programs to be successful in improving health equity, needed services must be available. This is not always the case, as can be seen in the following example from Peru.

EXAMPLE FROM THE FIELD: PERU

While modern contraception is widely used in Peru, use lags behind in rural areas, in the Sierra region – home to large numbers of indigenous women – and among the poorest quintile.

In 2005, Peru launched the JUNTOS program. It provides a monthly cash transfer of 100 *soles* (US$31) to poor households with pregnant women and/or children under age 14 provided that recipients meet requirements such as enrolling children in school and obtaining prenatal care.

Participation in Family Planning (FP)/Reproductive Health (RH) orientation at a health facility was included in the menu of program conditions, but was slow to be fully implemented. Discussions with clients and providers revealed a lack of culturally appropriate and adequate FP/RH information for poor, indigenous women, and that providers needed training in high-quality, culturally appropriate counseling.

Through policy dialogue and advocacy, Health Policy Initiative worked with health authorities to integrate cultural beliefs of indigenous populations into program FP/RH counseling guidelines and to design guides for healthcare providers. The project trained 19 trainers who trained physicians, nurses, midwives, and paramedical personnel in culturally appropriate counseling, and made field visits to rural health facilities for practical skills development. Health personnel also prepared action plans and monitoring indicators for their facilities.

In less than a year, the number of monthly FP/RH information sessions tripled and attendance nearly doubled. The MOH allocated funds through JUNTOS for new informational materials and approved the guidelines on culturally appropriate counseling for use in health facilities in areas with substantial indigenous populations.

Highlights

Achieving policy change for equity requires data analysis and stakeholder engagement.

Affected groups are best able to speak to the challenges and barriers they face and suggest interventions appropriate for their needs. They can also assist with implementation, for example, as outreach workers for their peers.

To read more about health policy reform in Peru, click here.

KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 52 to see the correct answers.

1. Some of the greatest opportunities for eliminating health inequities may lie outside the health sector

   [a] True
   [b] False

2. Financial concerns are almost always the greatest barrier faced by the poor in accessing and using health goods and services

   [a] True
   [b] False

3. Wicked social problems

   [a] Are evil in nature
   [b] Usually arise from other social problems
   [c] Require multiple interventions to solve
   [d] B and C
   [e] All of the above

KNOWLEDGE RECAP: ANSWERS

1. Some of the greatest opportunities for eliminating health inequities may lie outside the health sector

   [a] True

2. Financial concerns are almost always the greatest barrier faced by the poor in accessing and using health goods and services

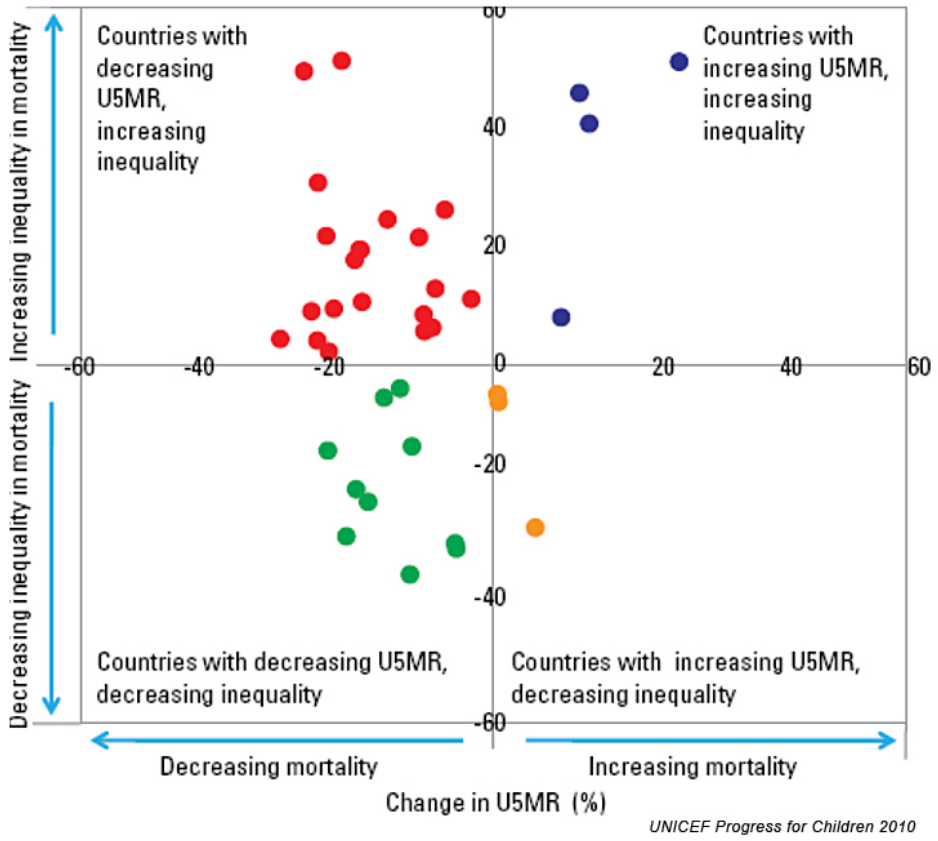
   [b] False

3. Wicked social problems

   [d] B and C

Action: Target Resources & Implement Yardsticks to Measure Progress

6



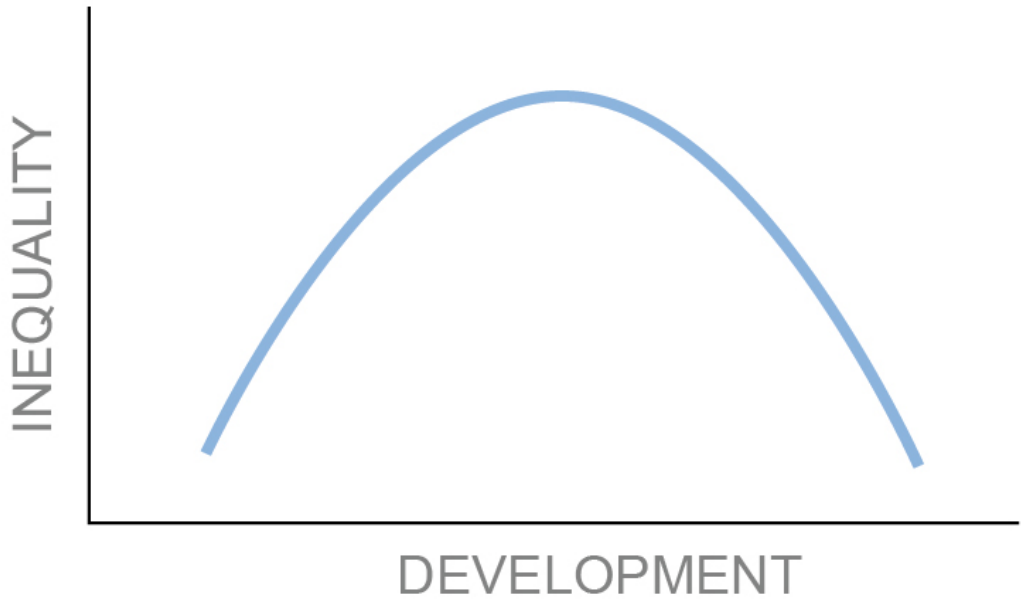
THE DEVELOPMENT PARADOX

Did you know?
"…there is little reason to expect that working to reach universal coverage will lead to improvements in health equity.In fact, the quest for universal coverage could have the opposite effect…"
(*Source:* Gwatkin & Ergo 2011)

In 2010, UNICEF reported a startling statistic: *two-thirds of the countries making progress in reducing child mortality showed increasing inequalities*. In other words, as national under-5 mortality rates were decreasing, the gap between the poorest and the best off groups was growing. In this figure, each red dot is a country where inequities have grown despite progress towards meeting MDG 4.

This was not the first time such a finding had been reported. It was first described in 1955 by the economist, Simon Kuznets. Kuznets hypothesized that inequality will first increase while a country is undergoing development and then begin to decrease.

RELATIONSHIP BETWEEN DEVELOPMENT AND INEQUALITY



The relationship between development (on the x-axis) and inequality (on the y-axis) follows an inverted U-shaped curve.

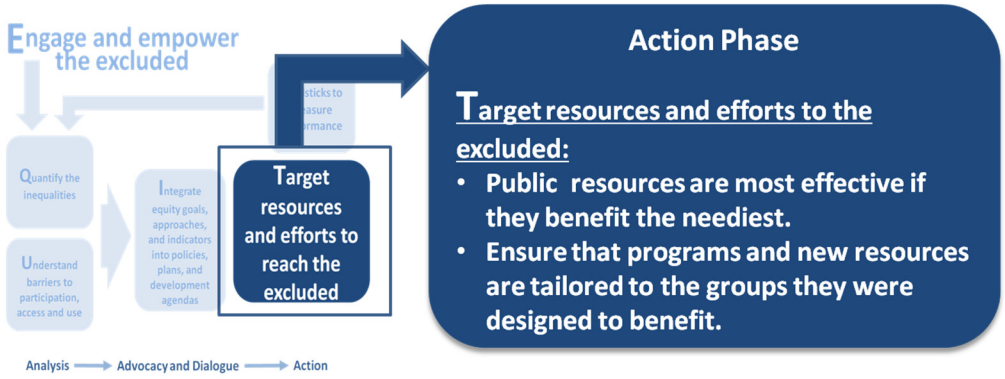
Since its publication, the "Kuznets curve" has been found in a wide range of disciplines from economics to health to environmental sciences.

There are varying interpretations of the Kuznets curve and debate as to whether or not all countries must undergo a period of high inequality before differences between wealth groups decrease.

For example, diffusion-of-innovation theory would suggest that the rise and fall in inequality is inevitable, because the first individuals to adopt an innovation tend to be of higher social class, wealthier, and with higher formal education than those who adopt later.

Others would argue that inequalities could be eliminated or reduced by focusing efforts on the poor rather than by expecting general development to "trickle down." In fact, experience has shown that health interventions will not reach the neediest groups without appropriate planning and oversight. In this module we discuss ***targeting***, a mechanism to direct resources to those most in need in a planned manner to achieve greater equity.

Did you know?
For more details on the Kuznets curve, click here.



WHAT IS TARGETING?

Targeting means focusing efforts directly on the poor and/or other excluded groups so that the benefits reach all the excluded groups and only them.

Arguably, targeting should be considered only when health gaps have opened up between the least and most well-off segments of the population.

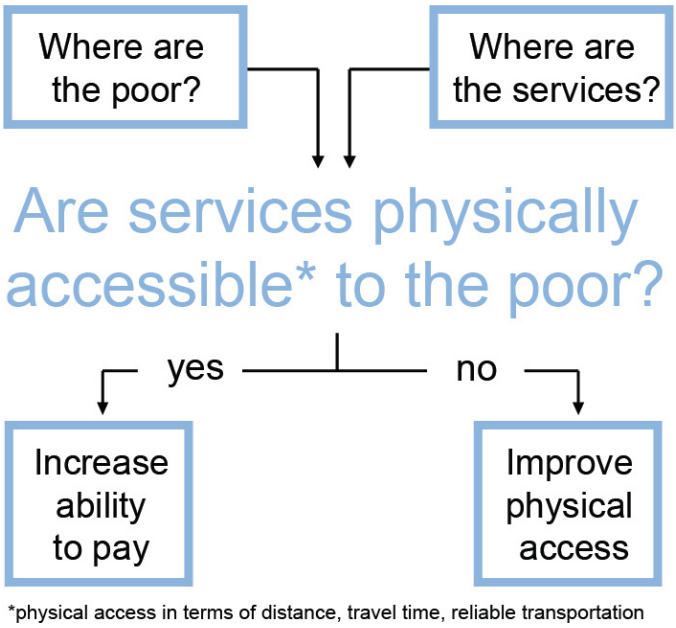
If everyone shows equally bad health indicators, a more universal approach to expanding health coverage may be more appropriate.

Did you know?

Targeting is not new. South Korea began including family planning in national development plans in 1962 and directed government resources to rural and poor urban families. Due to this early history coupled with the introduction of social health insurance in 1977, Korea consistently shows among the least health inequalities in the world. (*Source*: Yang 1979)

Highlights

Without well planned and effective targeting strategies, public resources often go to people who need them least, while the poorest do not benefit.



WHAT DOES TARGETING REQUIRE?

Developing and implementing a targeting strategy is a major policy undertaking.

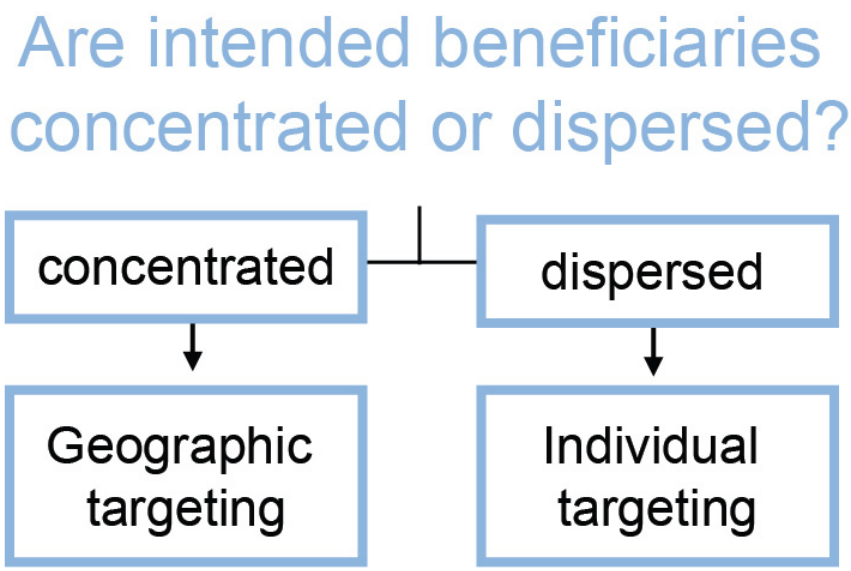
Some important aspects to consider include:

Political will. Policy dialogue and advocacy will be needed to convince policymakers, program planners, and managers that targeting for the poor and/or underserved is essential to meeting the country's health needs. If targeting is perceived as taking services away from some groups, it may generate political opposition. Wealthier and more politically powerful groups may oppose any effort they see as reducing their benefits.

Resources. Underserved groups are usually more expensive to reach than the rest of the population. Extending services to reach the underserved will require dedicated resources, either from raising new funding for the targeted efforts and/or by re-directing resources from better-off areas.

Infrastructure. Often times poor and other excluded groups live in areas that have neither public nor private health care providers. Reaching them will require investments in building, equipping and staffing new health facilities or establishing outreach channels such as mobile services. The figure above illustrates the kind of planning that should be conducted as part of the targeting process.

IDENTIFYING INTENDED BENEFICIARIES



The operational goal of targeting is to provide government benefits to everyone who needs them while ensuring that benefits do not go to those who do not need them.

The first step in any targeting scheme is to identify the people who will be eligible for the targeted services.

No identification system can be 100% accurate in discriminating between those who need targeted assistance and those who do not.

The more difficult or onerous the system classifying individuals needing assistance, the less likely it is to be implemented and the more vulnerable it is to misuse or manipulation.

As can be seen in the flow chart on this page, there are two basic options to identify target beneficiaries:

- ***geographic*** targeting (i.e., everyone resident in areas classified as poor is eligible for targeted assistance)
- ***individualized*** targeting through the application of specially-designed data collection and certification procedures or self-identification

If there are geographic areas with high concentrations of poverty, the entire area can be targeted and all residents eligible for assistance.

Ideas in Action

The example from India, on the following page, illustrates targeting approaches to distribute vouchers to increase ability to pay for private providers. Two methods were adopted to identify beneficiaries:

- individualized targeting for rural households participating in a larger government-funded poverty-alleviation effort
- geographic targeting for urban slums

If the poor are scattered, an individualized approach may be appropriate.

Whatever approach is adopted should consider the costs of administration relative to the costs of the benefits to be conferred.

VOUCHERS FOR REPRODUCTIVE HEALTH SERVICES IN INDIA

The Government of India is committed to reducing fertility and infant and maternal mortality. Improving access to FP and RH is necessary to achieve these goals. India will not meet its goals unless the health of the poor improves.

India enjoys a vibrant private health sector that provides FP and RH services to those who can afford to pay. Using public subsidies to help poor clients use private facilities might be more a more cost-effective way to increase FP/RH use by the poor than investing in expanded public services.

Therefore, USAID/India asked the Family Planning Services Technical Assistance Project (ITAP) to help plan and test the feasibility of providing vouchers to poor families to enable them to receive FP/RH services from private providers.

The project, *Sambhav* ("it is possible"), was implemented between 2006-2012 in four districts in the northern states of Uttar Pradesh, Uttarakhand, and Jharkhand.

QUANTIFYING INEQUALITIES AND UNDERSTANDING BARRIERS

To ensure that the program design was appropriate for local conditions, ITAP carried out baseline surveys and discussions to understand health status, service use, and barriers to seeking and receiving care.

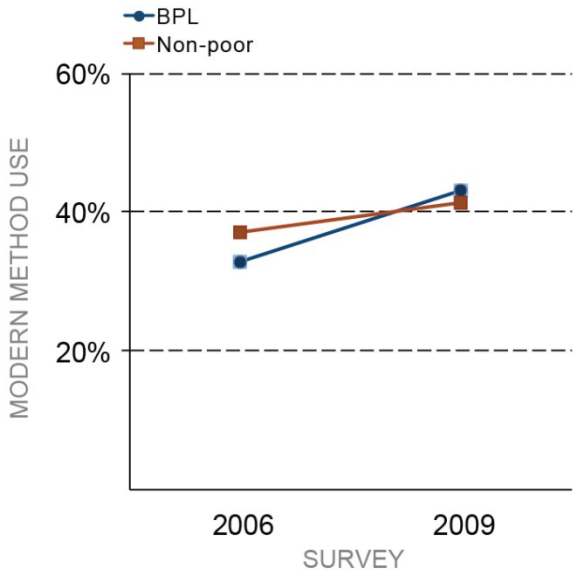
They found higher fertility rates and maternal, neonatal, and child mortality and morbidity among both the urban and rural poor due to lower use of maternal health services and higher unmet need for FP than women from the higher income groups. Further, poor women incurred substantial out- of-pocket expenses for FP/RH services, including medicines and transportation.

The project also identified private nursing homes and hospitals that were willing to offer services at reduced rates in return for increased client volumes.

ITAP continued to actively consult with government, state health societies, NGOs, community leaders, and the private providers to design, implement, and later monitor the voucher system.

Everyone had concerns: would government bureaucracy delay payments to private providers? Would private providers comply with government standards and guidelines?

ITAP helped to bridge the sectors and encourage participation in the pilot.



TARGETING STRATEGY AND MEASURING PROGRESS

The voucher schemes targeted those most in need.

Different procedures were designed to identify beneficiaries in different areas.

- In rural areas, households with *Below Poverty Line* (BPL) certificates were eligible.

Highlights

For more on the Sambhav experience, go here:

http://www.globalhealthlearning.org/sites/default/files/page-files/SAMBHAV%20report.pdf

- Kanpur City adopted *geographic* targeting: all residents of the selected slums were eligible, and individuals could use their ration cards as proof of residence.

Both of these strategies illustrate **I**ntegration with other programs: BPL and food rations are Government of India programs designed to assist poor families. Click here for a detailed figure as to how the system worked.

By the time the pilot was completed, *Sambhav* covered 11 rural blocks in three districts and 368 urban slums in one city, with implementation time periods ranging from about 1–2 years.

Results

The vouchers:

- Enabled nearly 12,500 babies to be born in private health facilities
- Supported approximately 47,600 antenatal and 10,300 post-natal visits
- Provided treatment for 6,750 RTIs/STIs
- Paid for 2,000 sterilizations and more than 1,700 IUDs and 3,000 injectables
- In Hardiwar, the voucher program reversed the inequalities in modern family planning use between BPL recipients and women in non-BPL households, as can be seen in the above figure.

CHALLENGES TO THE HEALTH SECTOR

Highlights

Communication between the public and private sectors is integral to overcoming these challenges.

Targeting may require major changes in the way services are delivered in both the private and the public sectors.

Private sector. If targeting is intended to shift wealthier users out of the public sector and into the private sector, there must be private sector capacity to absorb these new clients. Private providers may face policy constraints that will need to be modified for the sector to expand, such as:

- Import restrictions on commodities needed by the commercial sector;
- Price controls that restrict prices private providers can charge;

- Licensing requirements that restrict the services private providers can offer;

- Lack of training opportunities for private providers.

Public sector. Reaching remote rural areas and/or urban slums through the public sector brings its own challenges:

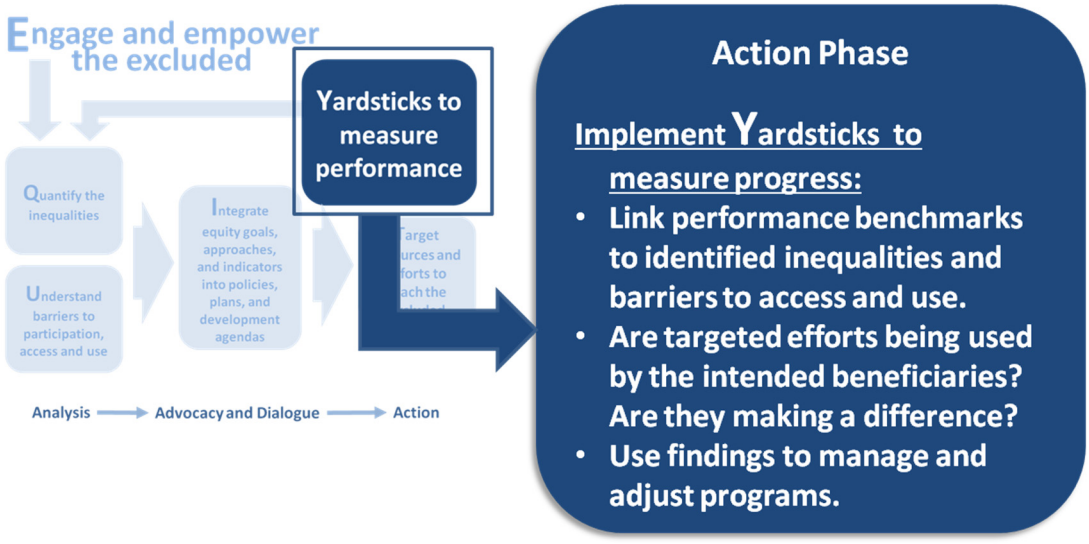
- Public sector staff are usually protected by civil service regulations and may be unwilling to move to rural areas or work in dangerous urban slums

- Recurrent costs (logistics, supervision, etc.) to keep rural facilities functioning may be higher than for comparable facilities located in urban areas.

Highlights
Generating demand for and educating the community about available resources is just as important as providing the resources themselves.

Finally, where the poor face non-financial barriers to using services (language, culture, etc.), effective targeting may involve developing new educational materials, retraining providers to address the specific needs of target groups, or even hiring new cadres of health workers.

PERFORMANCE MONITORING



All equity-based programs share two inter-related goals:

(1) to improve the health status of previously excluded groups, and in so doing,

(2) to reduce the inequalities between the worst-off and better-off segments of the population.

Performance yardsticks allow us to see how close the program comes to reaching these goals and provide information needed for programmatic decision-making.

Two cardinal principles should be kept in mind when designing and implementing performance yardsticks:

1. Collecting data uses program resources; and

2. Collecting data for reporting that are not used for management wastes program resources.

There are no hard-and-fast rules for designing monitoring and evaluation (M&E) systems that would apply to all programs, or even to the same program at all stages of its life span.

A few key questions to consider:

- What short- and medium-term decisions will need information?
- What kind of evidence will policymakers, managers, and community members find most convincing?
- What human and financial resources can be mobilized to carry out monitoring and evaluation?
- Can the program make use of data collected for other purposes and/or by other organizations, for example population censuses, national living standards surveys, etc.?

Highlights

This table describes the stages of program development, the kinds of decisions that are involved at each stage, the information needed to make the decisions and the primary stakeholders involved. Going back to the EQUITY framework, we see **E**ngagement of the excluded in every stakeholder group, **Q**uantification of inequalities and **U**nderstanding barriers in the first stage, and **I**ntegration and **T**argeting in the second stage. **Y**ardsticks to measure progress come to the forefront in stages 3 and 4.

CHOOSING INDICATORS

Ideally, four sets of indicator yardsticks would be selected, covering program design, implementation, service uptake, and equity impacts:

Design: These yardsticks are principally qualitative and can be answered yes/no to the following questions:

- Are equity goals explicitly stated in the policy and program documents?
- Are priority beneficiaries clearly designated and do they match the groups identified in step **Q**?
- Are desired health outcomes (e.g. maternity care, child vaccinations, family planning, etc.) clearly specified and do they match the outcomes showing the greatest inequalities identified in step **Q**?
- Do the program strategies (demand creation, supply strengthening) match the barriers identified in step **I**?

Implementation: Have resources been spent on or directed to priority areas/beneficiaries? Equity-based disaggregation can be introduced into a variety of monitoring indicators, for example:

- Number of policies or guidelines that focus resources or other attention on poor and/or other underserved areas or groups
- Increase in resources allocated to underserved areas
- Number of health facilities rehabilitated in designated priority areas
- Number of people trained from priority areas and who remain in their assigned areas
- Number of service delivery points in priority areas experiencing stock-outs of essential drugs and supplies

Service uptake: These indicators monitor client characteristics to assess whether users belong to the intended target group. If geographic targeting is used, service statistics can be disaggregated geographically:

- Number of antenatal care (ANC) visits by skilled providers from facilities in priority regions
- Number of deliveries with a skilled birth attendant in priority regions
- Number of children reached by nutrition programs in priority regions
- Couple years of protection (CYP) in priority regions

Highlights

Policies can demonstrate a government's priorities and commitment to improving the lives of its people. When health inequalities are recognized as a priority that requires action, policies and strategies should outline clear, time-bound equity goals.

Highlights

For more details on equity-focused monitoring, click here.

If individualized targeting is used, routine service statistics may need to be augmented with periodic client interviews to measure poverty status, ethnicity or other characteristics associated with low health status.

- Number and percentage of vouchers redeemed by users under the poverty line

Impact: Population-level surveys are needed to measure impact yardsticks. They should be assessed against baseline measures taken during the **Q** stage.

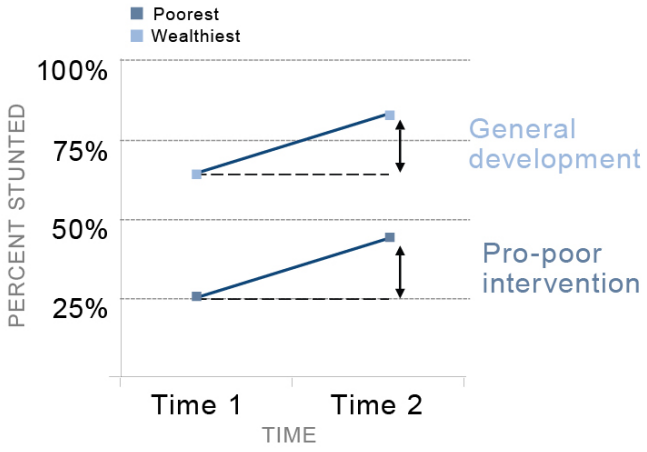
- Change in health outcome(s) among previously excluded groups.
- Reduction in inequality/inequalities between worst- and best-off segments of the population.

MORE ON IMPACT INDICATORS

Reduction and elimination of poverty-related and other inequalities in health is a long-term goal. In the short- and medium-term, programs should focus on improving the status of the excluded groups.

For example, the 2011 Ethiopia DHS showed enormous poverty-related disparities in safe motherhood practices, but only half (49%) of the births to the wealthiest women took place in a health facility.

Economic development may mask the equity impacts of targeted interventions. If health outcomes for the best-off groups improve due to general development, while the poor benefit from targeted interventions, both groups may show improvements over time while the gap between them remains constant. The graph on this page illustrates the two influences on stunting in children.



KNOWLEDGE RECAP

Answer the following questions to see how much you know about this topic. Go to page 65 to see the correct answers.

1. By and large, the countries that have made the most progress towards reaching the Millennium Development Goals for child mortality have done so by reducing disparities between the poorest and best-off segments of their population
   [a] True
   [b] False

2. As their health indicators improve, most countries will go through a period of increasing inequality before differences between wealth groups disappear
   [a] True
   [b] False

3. Directing special efforts towards the poor and/or other excluded groups
   [a] Is a core element of universal health coverage
   [b] Tends to increase stigma and discrimination towards the targeted groups
   [c] Is especially important where health status is uniformly low
   [d] a and c
   [e] None of the above

4. Extending coverage to traditionally under-served groups will
   [a] Increase health system costs
   [b] Usually require dedicated resources
   [c] Often be opposed by politically powerful groups
   [d] All of the above
   [e] None of the above

5. Means testing – that is, identifying individuals who cannot afford to pay for health goods and services – is usually the simplest way to ensure that government benefits do not go to those who do not need them.
   [a] True
   [b] False

6. Performance monitoring becomes a priority activity only after programs are implemented.
   [a] True
   [b] False

7. Failure to reduce inequalities between the worst-off and best-off segments of the population means that efforts to improve health equity have had little or no impact.
   [a] True
   [b] False

KNOWLEDGE RECAP: ANSWERS

1. By and large, the countries that have made the most progress towards reaching the Millennium Development Goals for child mortality have done so by reducing disparities between the poorest and best-off segments of their population
   [b] False

2. As their health indicators improve, most countries will go through a period of increasing inequality before differences between wealth groups disappear
   [a] True

3. Directing special efforts towards the poor and/or other excluded groups
   [e] None of the above

4. Extending coverage to traditionally under-served groups will
   [d] All of the above

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   [b] False

7. Failure to reduce inequalities between the worst-off and best-off segments of the population means that efforts to improve health equity have had little or no impact.
   [b] False

Recap

7

SUMMARY

By harnessing the arguments of human rights and justice, the equity approach expands the case for public health beyond the traditional health sector and brings in new advocates and champions for increasing resources for the poor and other excluded groups.

Designing and implementing effective health solutions begins with the active participation of those who have been excluded from the policy debate and are most affected by deep-rooted health disparities – the poor, isolated rural populations, ethnic minorities, women, and/or other disadvantaged groups.

Health inequalities and inequities are fluid and may vary markedly from country to country, within countries and across health outcomes. Solutions must rest on a solid foundation of understanding the depth and breadth of existing inequalities and the barriers faced by excluded groups to access and use of healthcare.

The health sector alone cannot achieve equity in health. Mobilizing political will and resources to reach the most disadvantaged will require new advocates and champions and integration with larger development initiatives.

Continuous performance monitoring completes the equity approach, ensuring transparency and accountability as well guiding changing strategies for changing situations.

ADDITIONAL RESOURCES

New publications on equity in health appear daily and make any bibliography instantly obsolete. The websites below add new resources as they become available.

- World Health Organization, Action on the Social Determinants of Health
- World Health Organization, Gender, Women and Health
- Pan American Health Organization

- Unnatural Causes, sponsored by the National Association of County and City Health Officials (United States)
- National Collaborating Centre for Determinants of Health (Canada)
- Health Equity Initiative

Did you know?
Use your favorite internet search engine to find more free courses. Type in *"health equity" + course + online*.

Other free on-line training courses also proliferate. Two of the many possibilities are listed below.

- Michigan Public Health Training Center, Measuring health disparities (on-line course)
- Empire State Public Health Training Institute (New York)

Final Exam

Congratulations — you have nearly completed this course!

The final exam will test your understanding of the material presented. Answer the following questions to see how much you know about M&E fundamentals. Go to page 71 to see the answers.

1. The concept of health equity draws particular attention to

   [a] Measurement of health disparities
   [b] Health inequalities that are unnecessary and avoidable and unfair and unjust
   [c] Health finance
   [d] b and c
   [e] all of the above

2. All inequalities in health can eventually be shown to derive from inequity.

   [a] True
   [b] False

3. High fertility rates endanger women's health and the health of their children. Women in rural and poorer households usually have more children than women in urban and wealthier households. This evidence is sufficient to demonstrate inequity in access to family planning.

   [a] True
   [b] False

4. The EQUITY approach rests on which of the following principles:

   [a] Building core competencies of a professional cadre of analysts
   [b] Emphasis on nationally-representative surveys to quantify inequalities
   [c] Feedback throughout the cycle from analysis to advocacy and dialogue to action
   [d] All of the above
   [e] None of the above

5. Empowering traditionally excluded groups means that policy makers and other authorities listen to what the excluded groups say and become more accountable for achieving results that benefit equity.

   [a] True
   [b] False

6. Intended beneficiaries should not be engaged in monitoring and evaluation because they lack technical expertise and including them in evaluation creates conflict of interest.

   [a] True
   [b] False

7. If a country shows uniformly high performance on one key indicator for child survival, other child survival indicators usually also show uniformly high results.

   [a] True
   [b] False

8. All of the following are good potential sources of data to understand barriers to health service use **except**:

   [a] Geographic information systems (GIS)
   [b] Focus group discussions
   [c] Nationally-representative health surveys
   [d] In-depth interviews
   [e] All of the above are good data sources to understand barriers to use of health services

9. Some of the greatest opportunities for eliminating health inequities may lie outside the health sector

   [a] True
   [b] False

10. Financial concerns are almost always the greatest barrier faced by the poor in accessing and using health goods and services

    [a] True
    [b] False

11. Directing special efforts towards the poor and/or other excluded groups

    [a] Is a core element of universal health coverage
    [b] Tends to increase stigma and discrimination towards the targeted groups
    [c] Is especially important where health status is uniformly low
    [d] a and c
    [e] None of the above

12. Extending coverage to traditionally under-served groups will

    [a] Increase health system costs
    [b] Usually require dedicated resources
    [c] Often be opposed by politically powerful groups
    [d] All of the above
    [e] None of the above

13. Means testing – that is, identifying individuals who cannot afford to pay for health goods and services – is usually the simplest way to ensure that government benefits do not go to those who do not need them.

    [a] True
    [b] False

14. Even in the best situations, it is inevitable that some individuals will have poorer health than others.

    [a] True
    [b] False

Final Exam Answers

1. The concept of health equity draws particular attention to

   [b] Health inequalities that are unnecessary and avoidable and unfair and unjust

2. All inequalities in health can eventually be shown to derive from inequity.

   [b] False

3. High fertility rates endanger women's health and the health of their children. Women in rural and poorer households usually have more children than women in urban and wealthier households. This evidence is sufficient to demonstrate inequity in access to family planning.

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14. Even in the best situations, it is inevitable that some individuals will have poorer health than others.

    [a] True

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eCourse available for download:
http://www.measureevaluation.org/resources/publications/ms-15-105

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