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| **Equity**  A Core Commitment for MCSP |
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Legacy

MCSP will promote equitable access to quality health care services for all women, newborns, and children by 1) monitoring and improving the design of identified pro-equity interventions targeting the poor and marginalized to document equity impact in at least three of the countries in which they are being implemented, 2) supporting scale-up of high-impact interventions to less-served populations while removing barriers to access, and 3) contributing to learning about pro-equity strategies through an in-depth case study of its program in Mozambique.

Definition

The World Health Organization (WHO) defines equity as “the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.”[[1]](#footnote-1) MCSP uses the working definition developed under MCHIP:

*Health equity is both the improvement of a health outcome of a disadvantaged group as well as a narrowing of the difference of this health outcome between advantaged and disadvantaged groups—without losing the gains already achieved for the groups with the highest coverage.*

There is a common assumption that programs aiming to increase coverage of health services among the poor are, by virtue, equitable. However, without careful attention to equity in design, implementation, monitoring, these programs may result in narrow impacts that only improve the situation of those who are comparatively advantaged, while failing to meet the needs of the poorest and most marginalized communities. The only way to ensure equity improvements is to choose promising pro-equity approaches, incorporate pro-equity designs, monitor outcomes using feasible and valid measurements, and adjust programs based on these findings.

MCSP also addresses gender-based inequities that affect health. Details of that work can be found in MCSP’s Gender brief.

Why is equity important?

Within the newly adopted Sustainable Development Goals (SDGs), as well as the earlier Child Survival Call to Action (2012) and USAID’s Ending Preventable Child and Maternal Deaths initiative (2014), there is recognition that reaching the most underserved populations is critical to achieving RMNCH goals. Commitment to universal health coverage (UHC) also requires a special focus on the underserved. The final report of the *Countdown to 2015* found that systematic pro-rich inequalities exist for virtually all coverage indicators.[[2]](#footnote-2) USAID’s *Acting on the Call 2016* report brings an explicit focus on equity, with analysis of the impact on lives saved if the population in the bottom two wealth quintiles had equal access to health interventions as the rest of the population. MCSP’s own analysis of coverage disparities of selected high-impact interventions across all MCSP countries shows that there are significant disparities in coverage by income, education, and urban/rural residence. MCSP data support the *Countdown to 2015* report that found that inequities are widest for those interventions requiring 24-hour access to health facilities.

A meta review of strategies to close equity gaps published in the *Lancet* in 2012 highlighted three key strategies for reaching the underserved: shifting delivery channels, using private providers to expand access, and reducing financial barriers to access (see the table for examples of these strategies.)

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| **Strategies to Reach the Underserved[[3]](#footnote-3)** | |
| **Primary Strategy** | **Examples** |
| Shifting delivery channels | Moving toward community-based services, from health workers to lay-workers, from doctors to cadres more available at remote facilities (e.g., nurses), from facility-based to outreach services |
| Drawing on private providers | Contracting with providers to expand access, concurrent with regulation and accreditation efforts |
| Reducing financial barriers to access | Implementing cash transfers or vouchers, reducing or eliminating user fees |

MCSP is well positioned to apply these strategies for improving health equity given its expertise in community health across the full range of RMNCH technical interventions, its emphasis on health worker and lay worker capacity building, and its approach to including the private sector to strengthen the health system. Further, MCSP had identified promising pro-equity interventions since program inception, which are interventions likely to reach the underserved by shifting services to the community level and/or relying on delivery by workers with less formal training.

What do we hope to achieve?

MCSP incorporates equity awareness into program design and monitoring in order to:

* Deliver RMNCH interventions in ways that improve equity and reach the most underserved.
* Provide evidence of equity outcomes to validate previously identified promising pro-equity interventions to inform future scale-up.
* Document implementation results, including implementation and design factors that enhanced or limited equity outcomes.
* Provide data on the economic status of beneficiaries across a range of activities whose primary objective might not include coverage equity, to inform and improve future targeting of the underserved.

What progress have we made so far?

MCSP has made progress to incorporate health equity strategies into country programs and to develop project-level tools to inform and support equity programming in its first two years:

* Constructed equity dashboards for MCSP countries that analyze disparities in coverage by wealth, education, and urban/rural residence for selected high-impact interventions across MCSP technical areas to inform country-level discussions of equity-focused programming.
* Incorporated equity and gender as priority themes in the Rapid Health System Assessment (RHSA) in Mozambique, and included information on equity considerations in the RHSAs in Guinea and Rwanda. A common finding in Guinea, Mozambique, and Rwanda was that while there was intent to prioritize the most vulnerable populations, there were no systematic data to monitor utilization by various groups, and there were no data to monitor whether equity was improving.
* In DRC, Kenya, Mozambique, Nigeria, and Tanzania, incorporated asset questions into Knowledge, Practice, and Coverage (KPC) surveys to construct a socioeconomic profile of beneficiaries and assess differences of knowledge, practice, and coverage among socioeconomic groups.
* In Myanmar, assisted the government to construct an asset index based on census data from over 10 million households that can be used to inform targeting of a variety of social programs.
* Updated and consolidated tools developed under MCHIP to produce a health equity toolkit: *A Practical Guide to Addressing Equity in RMNCH Programs.*
* Refined training materials for using the socioeconomic status profile tool to analyze the socioeconomic status of program beneficiaries.
* Published research to confirm the validity and applicability of using a simplified set of asset variables to evaluate the equity impact of health interventions.
* Developed tools and a resource package to support managers to conduct analysis of disaggregated routine data to identify underserved populations or geographical areas within a district, sub-district, or facility and to identify actions for improvements.
* Introduced and/or scaled-up promising pro-equity interventions, as summarized in the table below:

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| **Implementation of Pro-Equity Interventions by Country** | |
| **Approach** | **Countries** |
| 1. Reaching Every District/Reaching Every Community (RED/REC) | Uganda, Kenya, Malawi, Nigeria, Tanzania, Zimbabwe, Madagascar, Liberia, India, Pakistan, Haiti |
| 1. Advanced Distribution of Misoprostol for Self-Administration (ADMSA) | Mozambique, Haiti |
| 1. Community use of chlorhexidine | Ethiopia, Mozambique, Liberia |
| 1. Integrated Community Case Management (iCCM) | DRC, Nigeria |

What more could be done?

MCSP country programs could devote more attention to equity by:

* Incorporating pro-equity targetingduring program design and workplanning including:
  + Identification of equity gaps by socioeconomic status, geographic location, membership in religious or ethnic minorities, gender, age, or other characteristics.
  + Design and implementation of a pro-equity strategy.
  + Inclusion of equity measures within a broader monitoring and evaluation (M&E) strategy.
* Incorporating pro-equity interventions into RMNCH programming.
* Developing appropriate monitoring strategies to document equity impact in countries implementing promising pro-equity interventions.
* Capturing data on the economic status of program beneficiaries(using the SES profile tool or equitytool.org), even where equity is not one of the program goals; for example, where interventions focus on quality improvement at the facility level, capturing data on the wealth status of the facility users can inform future program design to improve the reach to the underserved.
* Supporting managers to use disaggregated routine datato identify underserved geographical areas and develop strategies for reaching those populations.

MCSP will also build on its work in Respectful Maternity Care (in Nigeria and/or Guatemala) to examine barriers to institutional delivery for under-served populations that are not defined only by wealth but other characteristics such as ethnicity, religion, age, and so on, to see whether alternative strategies for reaching these groups are needed.

1. WHO, [http://www.who.int/healthsystems/topics/equity/en/.](http://www.who.int/healthsystems/topics/equity/en/) [↑](#footnote-ref-1)
2. UNICEF and WHO. A Decade of Tracking Progress for Maternal, Newborn and Child Health: the 2015 report. <http://countdown2030.org/documents/2015Report/Countdown_to_2015_final_report.pdf>. [↑](#footnote-ref-2)
3. Chopra et al., *Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition*. Lancet 2012. [↑](#footnote-ref-3)