

# Checklist for Health Equity Programming

What is your project doing about health equity?

Are you able to clearly articulate your project's response to health inequities?

How can you be sure that you have adequately thought through the details needed for this response?

The following is a checklist that you can use either when designing a program to guide your thinking about health equity or in the middle of project implementation to refine your response to health inequities.

This checklist will help identify gaps in the details needed for health equity programming and communicating about the equity approach. It complements a larger reference document, “Considerations for Incorporating Health Equity into Project Designs: A Guide for Community-oriented Maternal, Neonatal, and Child Health Projects,” which includes an annex of worksheets to keep track of information needed to make decisions about health equity programming. For this document, we use the following definition of improving health equity:

When you are designing a project, use this checklist as part of the process.

**“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 group with the highest coverage.”**

This checklist is based on a six-step process, described in the guide document, which leads to a shared understanding by project staff and stakeholders about how to address inequities in health; how to track the health equity situation over time; and how to explain any improvements.

Remember: A variety of characteristics can cause a group to be disadvantaged, not just wealth status. One way to think of this is the acronym: **“PROGRESS,”** which stands for “place of residence, race, occupation, gender, religion, education, socio-economic status.”

— Davidson R. Gwatkin<sup>1</sup>

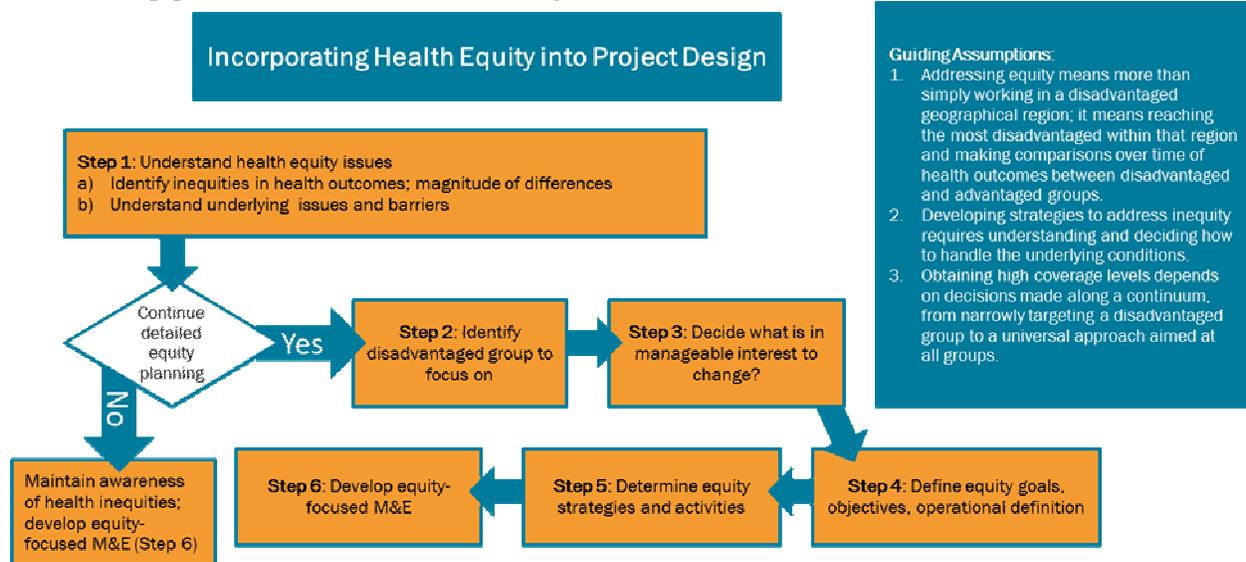
There are three guiding assumptions about health equity that should be discussed and understood by staff and partners before using the checklist:

1. Addressing equity means more than simply working in a disadvantaged geographical region; it means reaching the most disadvantaged within that region and making comparisons over time of health outcomes between disadvantaged and advantaged groups.

<sup>1</sup> From a presentation by Timothy Evans and Hilary Brown. *10 best resources on ... health equity*. Health Policy and Planning 2007: 348–351.

2. Developing strategies to address inequity requires understanding and deciding how to handle the underlying conditions.
3. Obtaining high coverage levels depends on decisions made along a continuum, from narrowly targeting a disadvantaged group to a universal approach aimed at all groups.

The six step process is illustrated in the figure below:



### Six-Step Checklist:

1. Understand the equity issues in the project area:
  - a. Identify inequities in health outcomes and the magnitudes of the differences
  - b. Understand underlying issues and barriers
2. Identify the disadvantaged group on which to focus
3. Decide what is in the projects manageable interest to change
4. Define equity goals, objectives, and a project-specific definition of equity
5. Determine equity strategies and activities
6. Develop equity-focused M&E

## CHECKLIST

**Instructions:** It is up to project implementers to decide how best to use this checklist. This tool provides a series of questions that can be discussed by project staff and/or stakeholders. It can be used:

- At the beginning of a project to inform design
- In the middle of the project:
  - To make adjustments to programming in order to address inequities or
  - To facilitate communication about an on-going equity approach by identifying gaps in details needed for communication
- At the end of the project to explore how health equity was addressed

**Think about engaging local stakeholders in each step of the checklist.**

Examples from the Child Survival and Health Grants Program (CSHGP) are included at the end of each step to provide you with practical ideas of how each step has been implemented by projects. Although these six steps are presented as a linear process, you may return to previous steps to make adjustments or fill in information gaps before completing all the steps. If more details are needed about each step, please refer to the guide document.

## Step 1: Understanding the health equity issues in the project

### A. Identify inequities in health outcomes and the magnitudes of the differences:

- Do you have quantitative information about specific health outcomes that are worse for one group compared to another group?
  - Do you have information that is specific for your project area or for a similar area?
  - Which health outcomes are inequitable?
  - How wide are the gaps?
- Do the gaps in health outcomes justify a special approach to reduce the inequities?

**Complete Step 1 before carrying out baseline surveys so that you can design surveys that appropriately measure the health equity situation.**

#### Step 1A Examples

- In Ecuador, the Center for Human Services (CHS) looked at provincial data on maternal and child health and learned that indigenous populations have much lower rates of maternal health care utilization than *mestizo* (of mixed European descent) populations. For example, the rate of home births among the total population was 46.5%, while for indigenous women it was 71.4%. They then conducted their own Knowledge, Practice, and Coverage (KPC) survey in the project area to confirm the same findings locally.
- Using both national (Demographic and Health Survey) and local (KPC) data, Christian Reformed World Relief Committee (CRWRC) identified gaps in knowledge and coverage between the highest and lowest wealth quintiles in their project in Bangladesh. In the lowest quintile, only 27.3% of women reported consuming iron/folate in their last pregnancy, versus 57.7% of women in the highest quintile.

### B. Understand underlying issues and barriers:

- Do you have information on the underlying conditions and barriers (i.e., cultural, socio-economic, and geographic) that lead to inequities?
  - Was this information systematically obtained (i.e., through qualitative information techniques)?
  - What are the issues?
  - Do gender norms, roles, and relationships lead to different opportunities, experiences, and outcomes?
  - After understanding the health equity issues, are you going to continue with detailed health equity programming?
  - If not, go to Step 6 and design an M&E plan to track the health equity situation; if changes occur later, you can return to detailed health equity planning (Step 2).

### Step 1B Example

To better understand why indigenous women were not accessing services in Ecuador, CHS conducted focus groups and key informant interviews with Trained Traditional Midwives. They found the cultural differences between the indigenous population and the primarily *mestizo* health workers were a major barrier, along with a lack of confidence in the health services and mistreatment by health workers. Additionally, many indigenous communities are located far from the health centers, making geographical access another important factor in the inequity.

CHS also reviewed national data which found that indigenous families preferred home births due to several factors: active presence of a family member during delivery; use of traditional teas or foods; personal choice of delivery position; room temperature and clothing; choice of lighting; emotional support; presence of non-threatening TBA provider or family member assistant as opposed to the authoritarian behavior of doctors and nurses in facility deliveries; and an overall sense of the delivery being not mainly a “medical event” but rather a socially significant family and community event.

### Step 2: Identify the disadvantage group on which to focus

- Have you identified a disadvantaged group?
  - Have you considered different situations that can define a disadvantaged group, such as: place of residence, ethnic group, occupation, gender, religion, education, or socio-economic status?
  - Have you reviewed secondary data that have been disaggregated by different groups, specifically ethnic, geographic, age, gender, religion, or wealth?
  - Have you conducted quantitative or qualitative studies to look at differences between groups?
  - Have you worked with communities and/or religious/social leaders to identify the most disadvantaged groups?
  - Does the national government have a definition that determines which are disadvantaged groups? Would it be useful to follow?
- Have you identified an advantaged group for comparison?
- Is it feasible to reach the disadvantaged group?

### Step 2 Examples

- CHS Ecuador included questions about ethnicity in a KPC survey in order to compare indigenous and *mestizo* populations. CRWRC Bangladesh added questions about household assets to compare socio-economic quintiles in their KPC. In the urban Port-au-Prince, Haiti project, Concern Worldwide used the FANTA Household Dietary Diversity Score to identify the poorest households and compare key healthcare practices between the poorest and wealthiest groups.
- CARE used the definitions from the Government of Nepal to focus on marginalized populations (Dalit, disadvantaged Janjatis, disadvantaged non-Dalit Tarai caste group, and religious minorities). They also worked with communities to conduct social mapping to identify households and villages that were not accessing important household services.
- Using Participatory Rural Appraisal (PRA), CRWRC Bangladesh worked with community members to identify the poorest villages in each “union” of the project area.

### Step 3: Decide what is in the project's manageable interest to change

Which health outcomes did you identify in Step 1 that have gaps which are large enough to justify special actions to reduce inequities?

- Have you identified strategies and activities that could feasibly (including cost) be implemented to reduce the gaps?
- Have you identified underlying conditions that could be feasibly (including cost) changed?
  - What are they?
- Have you considered how differential access and control of resources affects how disadvantaged groups are able to improve their health situation? This is especially important for gender equity.
- Have you identified activities that could be implemented to work around an underlying condition to improve the health outcome or:
  - Have you decided to change the underlying condition?
  - Have you decided not to address the underlying condition?
- Have you considered time and budget for all project activities together before deciding to implement actions to address a specific inequity or underlying cause?
- Are there any donor considerations which must be taken into account when determining what is feasible to change?
- Are there any internal institutional considerations which must be taken into account?

#### Step 3 Examples

- Knowing that social exclusion of marginalized populations (including lower castes) contributes to their poorer healthcare practices, CARE Nepal decided to concentrate on efforts to include the marginalized population in community-level activities, inform them of their rights, and advocate for better treatment by health workers.
- In Ecuador, CHS discovered that cultural differences were a primary cause of the low rate of facility births among the indigenous population. Instead of making efforts to change traditional cultural practices in the community, the project decided to improve cultural responsiveness of institutional health services. Using a method developed by the Quality Assurance Project, which has been incorporated into national Ministry of Health Guidelines, the project plans to bring together community members (women, TBAs, etc.), local government representatives, and health workers to incorporate cultural elements in obstetric and newborn care that meet women's demands.
- While recognizing the existence of underlying causes of inequities including poor transportation, landlessness, and lack of formal education, CRWRC Bangladesh is focusing on using social mobilization to engage poor and disadvantaged populations and empower them to get quality health care services.

### Step 4: Define health equity specific goals, objectives, and a project specific operational definition of equity

- Does the goal include reducing the gap between a disadvantaged group and an advantaged group, while maintaining the gains of the advantaged group?
  - Does it specify which groups?
- Are there objectives that specify gaps that will be reduced between a disadvantaged group and an advantaged group?

- Are there objectives for specific health outcomes?
  - Is it clear which group is disadvantaged and which group is advantaged?
- Are there objectives for improving the underlying conditions?
- Do these objectives specify what change or result is expected?
- Do these objectives specify additional target populations (i.e., health care providers, community authorities who are men, and the most advantaged ethnic group) to work with in order to improve the health situation of the disadvantaged group?
- Do you have a project specific definition of health equity?
  - Does the definition follow a pattern that is similar to: Equity will be improved when the gap in \_\_\_\_\_ between the \_\_\_\_\_ (most disadvantaged, specify) and \_\_\_\_\_ (less disadvantaged, specify) is reduced by/to \_\_\_\_\_ percentage points without the advantaged group losing its gains?

### **Step 5: Determine equity strategies and activities**

- Have you reviewed strategies and activities that you identified in Step 3 and considered the following questions:
  - Have you identified possible negative effects from activities to reduce inequities?
    - Have you identified actions to mitigate these effects?
  - How can project activities be adjusted to fit into and benefit the daily activities of women and men (as opposed to adding work and creating a burden)?
    - Take into consideration location, time of day/week/year, and amount of time spent on activities by women and men.
  - Have you identified where there will be resistance to change?
    - Have you identified actions to reduce this resistance?
  - Are there any other groups (in addition to groups identified in Step 4) that you must work with to carry out these strategies and activities?
  - Are there specific socio-cultural, political, economic, or environmental factors that will influence the ability of women or men from different groups to participate in your (proposed) project activities?
  - Have you considered training staff so that they are sensitive to inequity issues?
  - Do you need to refine any strategies and activities based on the above questions?

### Step 5 Examples

- In Ecuador, CHS identified two primary causes for inequity between the indigenous and *mestizo* populations: geographic and cultural access. To address geographic access, the project focused on bringing better services to women's homes through training TBAs. To increase cultural access, they focused on fostering inclusion of the indigenous members in local community groups for advocacy with the health system, increasing awareness of rights of health service users, and improving cultural responsiveness of institutional health services (through a participatory quality improvement process).
- CARE Nepal used its community mobilization strategy in communities with poorest health indicators to include the marginalized in community activities. They also conducted training for health workers on rights, gender equity, and social inclusion, implemented a behavior change communication program with the marginalized to increase good health practices and access to services, and expanded an existing maternity incentive scheme to increase institutional deliveries (cash transfer). These activities address both direct health issues and the underlying factor of social exclusion and disempowerment.
- Like CARE Nepal, CRWRC Bangladesh's primary equity activity is a community mobilization strategy called People's Institutions that addresses social exclusion (low social capital, which involves degree of social contact and perceived support and trust). Groups formed through this strategy may also decide to work on literacy and income generation, two other underlying factors for inequity. The strategy also includes training community health volunteers and traditional birth attendants and facilitates linkages, and relationships between marginalized communities and health systems/facilities (a part of social capital). Other related activities that directly target poor health outcomes include C-IMCI to reach families that do not have access to (or do not choose to access) health facility services and behavior change communication to reach non-literate families (addressing the poorest lack of health knowledge identified in the PRA survey).

### Step 6: Develop equity-focused M&E

#### A. Health outcomes:

- Have you reviewed the inequitable health outcomes that you identified as being in your project's manageable interest to change (Step 3)? Have you considered the following questions:
  - Have you developed indicators related to these inequitable health outcomes?
  - Have you identified the target group for measurement for each indicator?
  - Have you identified appropriate quantitative data collection and analysis methods?
  - Have you calculated a large enough sample size to be able to compare a reduction in the gap between the disadvantaged and advantaged group?
    - Have you identified the minimal reduction in this gap that you want to be able to measure?
  - Have you developed questions that must be included in order to classify groups as disadvantaged and advantaged?

#### B. Underlying conditions:

- Have you determined what information you need to collect in order to understand changes to the underlying conditions that you identified as being in the project's manageable interest to change? Have you considered the following questions:
  - Have you determined which of this information should be collected using quantitative methods and which information requires qualitative methodologies?
  - Have you identified appropriate quantitative and qualitative data collection and analysis methodologies?

- Have you developed indicators and questions to measure quantitative changes?
- Have you identified target groups for information collection for both quantitative and qualitative methodologies?

### C. Additional considerations for M&E of health equity:

- Have you budgeted adequately for information collection and analysis?
- Do you have the expertise for both quantitative and qualitative methodologies and analysis?
- Have you linked the equity focused M&E to overall project M&E? Equity focused M&E should not be a stand-alone system.
- If you are developing M&E to maintain awareness about health inequities, but have not done detailed program planning, select a minimum number of indicators and qualitative information to track. Use minimally time consuming methodologies to collect this information on a regular basis.

#### Step 6 Examples

- CARE Nepal collected data on caste and ethnicity in its KPC survey in order to disaggregate health indicators by marginalized and non-marginalized populations. The project is also doing annual monitoring using LQAS to track progress in both population groups. Additionally, through the community mobilization strategy, the project is collecting community-level data on pregnancy outcomes that are disaggregated between marginalized and non-marginalized women.
- CHS Ecuador also used their KPC survey to disaggregate data by ethnicity into two groups: indigenous and *mestizo*.
- In Bangladesh, CRWRC not only measured health indicators through their disaggregated KPC using wealth quintiles, but are also planning to add questions to measure the underlying factor of social capital. The project is conducting operations research to test the theory that improving social capital and community mobilization will improve equity of health indicators between the poor and non-poor populations. By incorporating the social capital portion of the questionnaire, CRWRC will be able to measure increases in social capital and evaluate any association with increases in health indicators.

For more information about this checklist and its use, please contact Jennifer Winestock Luna at [jwinestockluna@icfi.com](mailto:jwinestockluna@icfi.com)

To learn more about the Child Survival and Health Grants Program, see <http://www.mchipngo.net>.

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