

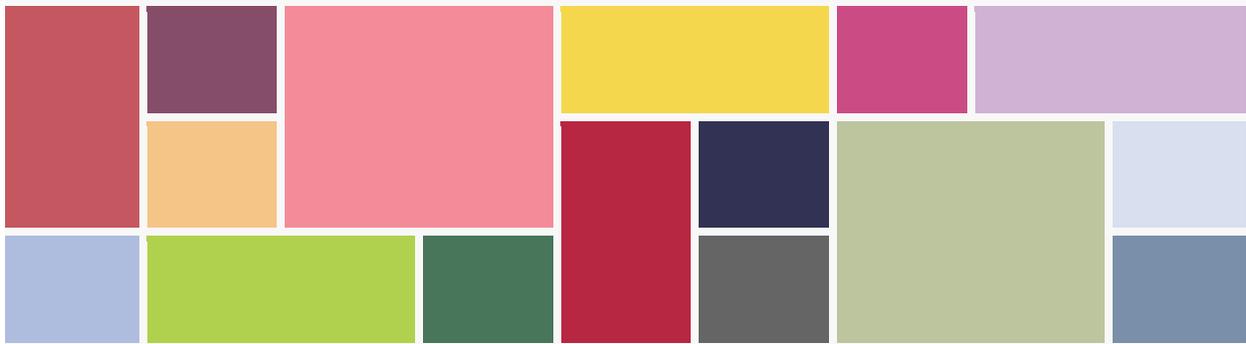


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Maternal and Child  
Survival Program

# Maternal and Child Survival Program Equity Toolkit

A Practical Guide to Addressing Equity in  
Reproductive, Maternal, Newborn, and  
Child Health Programs



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[www.mcsprogram.org](http://www.mcsprogram.org)

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# Introduction

There is a common assumption that programs aiming to increase coverage of health services and reduce morbidity and mortality among the poor are, by virtue, equitable. However, without careful attention to equity in the design, implementation, monitoring, evaluation, and adjustment of the strategy, 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 improves is to choose approaches likely to reach the underserved, incorporate pro-equity design, monitor equity outcomes using feasible and valid measurements, and adjust programs based on these findings. To do so, it is important to communicate how equity is defined within the context of individual programs, what specific actions are aimed at improving equity, how these improvements will be demonstrated, and how these actions, if successful, might be sustained, institutionalized and scaled up in programs and policies.

This guide was developed to give those who design and implement community-oriented health programs a systematic approach to programming that incorporates identifying and addressing health inequities and measuring equity improvements. This guide is aimed at professionals working in reproductive, maternal, newborn, and child health (RMNCH) programs, especially those that are part of country programs of the Maternal and Child Survival Program (MCSP), funded by the U.S. Agency for International Development (USAID).

While this is not a prescriptive document promoting one approach to equity programming, this guide presents a series of concepts and approaches to take into consideration and decisions to be made that lead to the development of a coherent equity strategy as part of program design. These questions can serve as a basis for dialog among teams involved in designing programs and can help to ensure a shared understanding of the equity approach used.

## What Is Equity?

Although they are related concepts, equity is not the same as equality. There are many reasons why health status may differ among individuals or even groups of individuals. Not all of these health inequalities are inequitable. For example, some individuals may be predisposed to certain health conditions because of their genetics, and these may be unavoidable. Concerns of *equity* arise when there are *unfair* and *avoidable* differences related to health. When women and children suffer because they are unable to access necessary, high-quality health care because of socially or economically related reasons, such as their income level or geographic location, these inequities must be addressed through careful programming and intervention as a matter of social justice. MCSP uses the following definition for health equity that was adopted under the Maternal and Child Health Integrated Program (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 group with the highest coverage.”<sup>1</sup>**

According to the Centers for Disease Control and Prevention, health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”<sup>2</sup> Health inequities arise from a lack of opportunity to achieve good health outcomes.

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<sup>1</sup> This definition was developed by a consultative process with MCHIP technical staff to guide approaches to improving health equity. Two key points from this definition are that for MCHIP: (1) It is important to improve health outcomes in vulnerable groups without allowing coverage rates to drop for better off groups; and (2) It is important to measure improvements in health, not just improvements in underlying conditions.

<sup>2</sup> Centers for Disease Control and Prevention. Health Communities Program. 2013. Attaining Health Equity [webpage]. <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm>.

In addition to addressing disparities in health outcomes, health equity also requires attention to how well the care provided meets the needs of the intended patients and program beneficiaries. For example, the needs and appropriate forms of care for adolescent, unmarried, first-time mothers will greatly differ from those of married women in their third pregnancy. Therefore, addressing equity in RMNCH requires a focus on the appropriateness, quality, and respectfulness of care.

## Why Equity Matters for Reproductive, Maternal, Newborn, and Child Health?

Within the newly adopted Sustainable Development Goals, 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 also requires a special focus on the underserved. Nonetheless, across the priority Ending Preventable Child and Maternal Deaths countries, there are significant disparities in coverage of high impact interventions, such as skilled birth attendance and antenatal care, by income, education, gender, religion, and geography.

## Purpose of the Equity Toolkit

This toolkit seeks to provide guidance and resources to address equity considerations at relevant stages in program planning and implementation. It builds upon previous guidance and tools developed under MCHIP to make it easier for program managers to operationalize equity in their activities, from start to finish. For additional details on the concepts described above, please refer to the [MCHIP Health Equity Guidance](#). The toolkit is a set of considerations, worksheets, and available resources that can help program implementers apply the MCSP six-step process for incorporating equity into project design and implementation.

## A Brief Review of the Six-Step Process for Incorporating Equity into Project Design

The following checklist helps program designers and implementers take a proactive approach to include equity in their work. It aims to help identify relevant sources of information to assess health inequities at different stages in the project lifecycle, determine informational gaps on health equity, and take a targeted approach to address, or at least monitor changes in, health inequities. This checklist draws from 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.

The checklist is comprised of the following six steps:

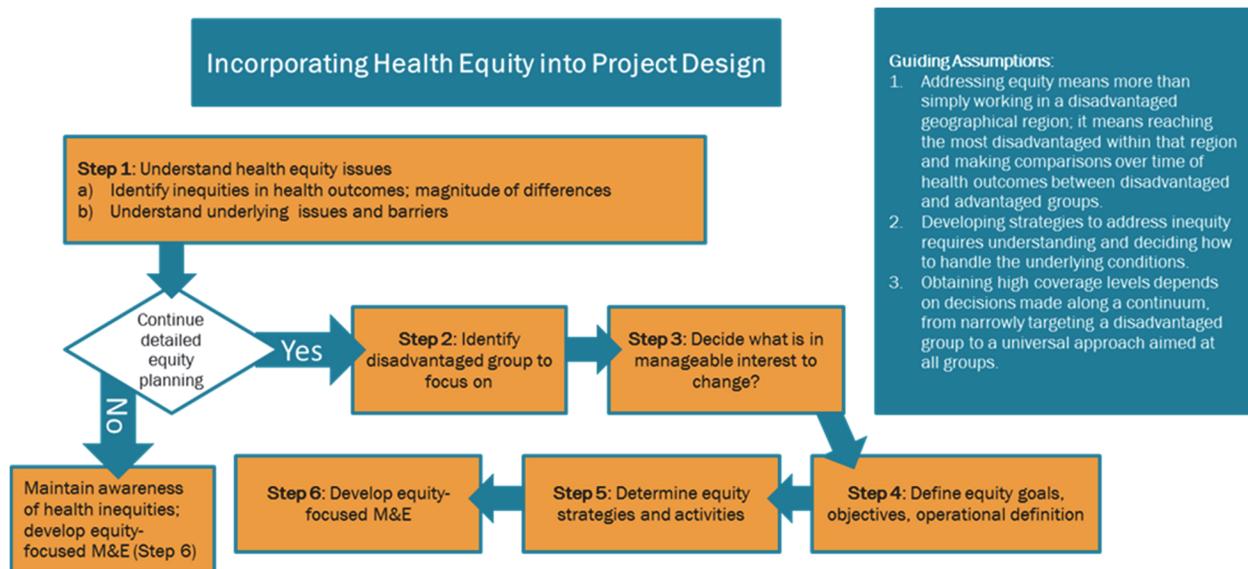
1. Understand the equity issues in the project area:
  - a. Identify inequities in health outcomes and the magnitude of the differences, and
  - b. Understand underlying issues and barriers.
2. Identify the disadvantaged group or priority inequities on which to focus.
3. Decide what is in the project’s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

Note that although these steps are listed sequentially, they can be applied to programs at different stages of implementation, and certain steps can and should be revisited over time to address new inequities and update strategies. For example, some programs may have already identified their “pro-equity” strategies. One example is integrated community case management, which aims to reduce inequities in coverage for child health services arising from geographic barriers to health facilities and instead focus on delivering

interventions and managing childhood illness locally through community-based approaches. Similarly, the “Reaching Every Community” strategy aims to reduce geographic disparities in immunization coverage. For these approaches, the inequities have already been identified. Program designers may want to revisit previous steps when employing these approaches in new regions. Step 1b can provide critical information for the underlying barriers to access that will inform locally-relevant implementation of the approach. Furthermore, project managers may target different disadvantaged groups based on the context (Step 2). Additionally, the goals and specific objectives will vary from place to place, even when employing the same pro-equity strategy. If starting with Step 5, with an identified strategy in place, it is important to have good information and a clearly established vision in place as they relate to the preceding steps.

Lastly, for any program, it is important to determine the impact on health equity in implementation. This requires a baseline understanding of the magnitude of inequities among affected groups, specific goals, and targets for reducing the inequities when that is the primary aim of the approach (e.g., increase diphtheria, pertussis, and tetanus vaccination coverage by X% in the targeted communities within Y time period), and requires appropriate, disaggregated indicators in the M&E plan to assess the impact on health inequities.

**Figure 1: Incorporating Health Equity into Project Design**



# Employing the Six-Step Process for Health Equity: Guidance and Resources

## I. Understand Equity Issues in the Project Area

To be able to address inequities in RMNCH programming, it is necessary to first understand what inequities exist that are relevant to the program and the interventions that are key to the health improvement strategy. These will vary by setting and will depend on the kinds of impacts that will be promoted as well as the activities that will be introduced to achieve these impacts. Begin by considering the following:

What kinds of inequities will be addressed through programmatic activities?

- Inequities in *access* to RMNCH services
- Inequities in *quality* of available services
- Inequities in how *responsive* services are in meeting the needs of different populations
- Inequities in *health outcomes* (morbidity and mortality)

How may inequities present among different groups?

- Inequities among socioeconomic groups
- Gender inequities (for additional resources on gender analysis, see the Jhpiego [Gender Analysis Toolkit](#))
- Inequities in age and stage of life
- Geographic inequities: this includes unfair differences between urban and rural populations, inequities across different districts and communities, as well as inequities within communities based on distance or difficulty in accessing services
- Inequities among different cultural, ethnic, or religious groups

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### “PROGRESS” for considering equity across groups

P	Place of residence
R	Race
O	Occupation
G	Gender
R	Religion
E	Education
SS	Socioeconomic Status

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## A. Identify Inequities in Health Outcomes and the Magnitude of the Differences

Keeping in mind that different kinds of inequities exist across different subgroups of the population, examine the data to determine what inequities exist, who is affected, and to what degree. In some cases, it may be possible to draw upon existing data sources, such as demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS). In other cases, collecting primary data may be needed to explore health inequities. This could include modifying the Knowledge, Practice and Coverage (KPC) survey to generate disaggregated data. See Annex 1 of the MCHIP Equity Guidance to learn more about “Adapting the KPC Tool for Baseline and Monitoring to Capture Inequities in the Project Area.” It may be helpful to use the [Socioeconomic Status \(SES\) Profile Tool](#) (an internal MCSP resource) or resources like [EquityTool.org](#) to examine inequities by wealth quintile. At the end of this section, a list of resources is provided that may be helpful at this stage to examine the presence, nature, and magnitude of health inequities.

The following table lists examples of the type of information that a project might obtain during this stage.

Type of Inequity to Examine	Indicators of Interest	Affected Groups	Potential Sources of Information	Magnitude of Differences (examples)
<b>Outcomes:</b> Maternal mortality	Mortality rates by: <ul style="list-style-type: none"> <li>• Age</li> <li>• Residence</li> <li>• Education</li> </ul>	<ul style="list-style-type: none"> <li>• Young mothers</li> <li>• Rural populations</li> <li>• Women without secondary school</li> </ul>	DHS MICS KPC	Mothers under age 25 are 30% more likely to die than older mothers
<b>Coverage:</b> Immunization coverage	DPT coverage by: <ul style="list-style-type: none"> <li>• Geographic area</li> <li>• Ethnicity</li> <li>• Gender</li> <li>• SES</li> </ul>	<ul style="list-style-type: none"> <li>• Rural populations</li> <li>• Ethnic minorities</li> <li>• Girls</li> </ul>	DHS MICS SES Profile	90% coverage for households in the upper two quintiles versus 56% for households in the lower three quintiles
<b>Coverage:</b> Antenatal care	4+ ANC visits by: <ul style="list-style-type: none"> <li>• Literacy</li> <li>• Ethnicity</li> </ul>	<ul style="list-style-type: none"> <li>• Uneducated</li> <li>• Indigenous groups</li> </ul>	DHS Focus groups	Only 20% coverage for households speaking indigenous languages compared to 80% of Spanish-speaking households
<b>Quality:</b> Adherence to emergency obstetric care (EmOC) protocols	Quality of Care indicators	<ul style="list-style-type: none"> <li>• Rural populations</li> </ul>	Facility Audits Supervision	Only 30% rural health posts meet quality standards as compared to 70% of urban facilities
<b>Responsiveness of services:</b> Youth-sensitive services	Availability of youth-oriented reproductive and sexual health services (signaled by other indicators like “FP need met” by age)	<ul style="list-style-type: none"> <li>• Women under 25</li> </ul>	DHS MICS KPC	Unmet need for family planning is 35% higher for unmarried women than married women

When examining data sources for the presence of inequities, it can be helpful to generate some hypotheses about potential disparities to guide analysis and interpretation of existing data or determine what indicators and disaggregators should be used in primary data collection activities.



## Tools

### Averting Maternal Death and Disability: EmOC Needs Assessment Toolkit

Needs assessment for emergency obstetric and newborn care (EmONC) to evaluate how well and to what extent the health system is providing EmONC. Provides details for planning to address gaps or problems in EmONC services. This is a first and critical step to improving equitable access to EmONC and to strengthening the overall health system.

<https://www.mailman.columbia.edu/research/averting-maternal-death-and-disability-amdd/toolkit>

## D-I-V-A (Diagnose, Intervene, Verify, and Adjust): Strengthening District Management Capacity for Planning, Implementation, and Monitoring for Results with Equity

UNICEF's equity-focused programming and monitoring approach enhances district performance for better maternal and child health outcomes. It is an outcome-based approach to identify and respond to health system and demand-side bottlenecks that arise at the district level. The four steps—Diagnose, Intervene, Verify, and Adjust (D-I-V-A)—can be used to strengthen the district health system, build managerial capacity, empower communities, and help projects be more responsive to the specific needs of marginalized groups. The D-I-V-A approach responds to the significant gap between national policies and effective and equitable implementation at the district level, and is intended to complement current district planning. The D-I-V-A approach aims to facilitate improvements through systematic and comprehensive analysis and monitoring of bottleneck reductions and timely adjustments of solutions and strategies.

For more information and to obtain the latest D-I-V-A tool, contact Ngashi Ngongo, Senior Health Advisor, Health Section, UNICEF, at [nngongo@unicef.org](mailto:nngongo@unicef.org).

### The EquityTool

The EquityTool is an easy to use and easy to interpret mobile or tablet-based app that can be used to quickly evaluate the relative wealth of program beneficiaries. Based on the USAID DHS, the EquityTool reduces the number and complexity of questions required to determine how wealthy beneficiaries are relative to the rest of the national or urban population. <http://www.equitytool.org/>

### Global Health Data Exchange (GHDx)

Comprehensive catalog of surveys, censuses, vital statistics, and other health-related data. Search by country, survey type, and keyword. <http://ghdx.healthdata.org/>

### Knowledge, Practices, and Coverage Survey

A small, population-based survey originally developed by Johns Hopkins University and used by USAID Child Survival and Health Grants Program grantees since 1991. The tool measures health outcomes in the following technical areas: maternal and newborn care; breastfeeding and infant and young child feeding; vitamin A supplementation; immunization; malaria; control of diarrheal disease; acute respiratory infection; water and sanitation; and anthropometrics. The KPC survey can be used in Steps 1a and 2 of the Health Equity Guidance (1a: Identify inequities in health outcomes and the magnitude of the differences; 2: Identify the disadvantaged group on which to focus) by disaggregating data among different economic, ethnic, gender, age, or other groups. The survey will also help projects in Step 6: Develop an equity-focused M&E system. Projects may find that developing additional indicators and adding questions beyond health outcomes will help measure progress toward equity.

[http://www.mchipngo.net/controllers/link.cfc?method=tools\\_mande](http://www.mchipngo.net/controllers/link.cfc?method=tools_mande)

### STATcompiler

The DHS Program STATcompiler allows users to make custom tables based on hundreds of demographic and health indicators. Users can select indicators of interest by country, as well as disaggregators such as age, residence, education and wealth quintile. Users can view and export data, as well as create custom graphs and visualizations. <http://beta.statcompiler.com/>

### SES Profile Tool

A simple and low-cost method for assessing the socioeconomic profile of the beneficiaries of an intervention and determine whether the intervention is pro-poor. This can be done prospectively to identify gaps as well as at midline and endline assessments to determine progress in reaching the poor.

[http://www.mchip.net/sites/default/files/Assess\\_socio-economicprofile.pdf](http://www.mchip.net/sites/default/files/Assess_socio-economicprofile.pdf)

## B. Understand Underlying Issues and Barriers

Once it is clear what health inequities exist and who is affected, the next step is understand why such inequities exist and persist. This information is critical to inform which inequities are in the project's manageable interest to change (Step 3) and what the most appropriate strategies are to adopt (Step 5).

The following lists some commonly found issues or barriers:

- Harmful cultural norms and practices
- Burden of care
  - Women's duties are too time consuming to practice healthy behavior
  - Women cannot leave livelihood activities or other children for preventive care or to take care of illness
- Low literacy
- Barriers in accessing services
  - Economic
  - Distance/lack of transportation
  - Language
  - Health service not culturally acceptable
  - Poor treatment by health staff
  - Poor understanding of health messages given by health staff
- Health systems factors
  - Unequal quality of facilities across geographic areas
  - Supply-chain issues affecting availability of commodities
  - Health financing issues (e.g., delays in transfers of funds resulting in working absenteeism)
- Stigma or violence against group
- Unequal power relationships between disadvantaged and advantaged groups
  - Unequal decision-making power within a family or community
  - Unequal representation in in community structures, i.e., community health development committees

It may be useful to consider the following system levels when identifying underlying issues and barriers: Individual/Household; Community; Health Facility; District, and National.

Qualitative methods are often most effective for gathering this information. In some instances, existing information from prior studies in the region can provide relevant data on local and systemic drivers of inequities. Often, additional inquiries must be undertaken to understand specific barriers in a given locale. These can include consultations, focus groups, and surveys with communities, members of the disadvantaged groups, local health providers, and any other local stakeholders in providing this information.

The following worksheets can help in assessing various types of barriers to access and drivers of inequities.

Worksheet 1 contains examples of common issues and barriers, and can be used as the basis for identifying and assessing systemic inequities. Additional issues should be added as appropriate to the program setting. Program planers can begin by mapping out known drivers of relevant health inequities based on available data sources. At this stage it would be useful to incorporate the results from a gender analysis, which will help

focus attention on gender issues that directly affect health outcomes. Additionally, if a Rapid Health Systems Assessment (RHSA) has been conducted, there should be insights into the facility and systems level factors contributing to health inequities. Where there are critical gaps in available sources of information, primary data collection should be done.

## Worksheet I: Identifying and Assessing Health System Inequities

**Note:** This worksheet is organized according to the levels of a national health system (individual/household, community, facility, district, and national). Examples provided below are merely intended to be illustrative, not prescriptive or exhaustive.

Individual and Household Level			
Issues and Detailed Sub-Categories		Potential Sources	Outcomes Affected
Burden of care	Women's duties too time consuming to practice health promoting behaviors	<ul style="list-style-type: none"> <li>Focus groups</li> <li>Household surveys</li> </ul>	Infrequent hand washing; children with diarrhea
	Women cannot leave livelihood or other children for preventive care or treatment	<ul style="list-style-type: none"> <li>Focus groups</li> <li>Interviews with health care providers</li> </ul>	Children with illnesses are only seen by health care providers after their symptoms are severe.
Low literacy and/or education levels		<ul style="list-style-type: none"> <li>Household surveys</li> <li>DHS</li> </ul>	Low awareness or utilization of preventive services (e.g., immunization)
Barriers in accessing services	Lack of financial resources to pay out-of-pocket expenses	<ul style="list-style-type: none"> <li>National Health Accounts (NHA) data (for OOP)</li> <li>Focus groups</li> <li>Household surveys</li> </ul>	Low numbers of facility deliveries
	Prohibitive distance to services/lack of transportation		Low rate of SBA
	Language barriers		Low follow through on referrals
	Health service not culturally acceptable		Low facility usage rates
	Women not able to leave home unaccompanied		Low facility usage rates
	Poor treatment by health staff	<ul style="list-style-type: none"> <li>Focus groups</li> <li>Household surveys</li> <li>Exit interviews</li> </ul>	Low facility usage rates and/or low quality and satisfaction ratings
Poor understanding of health messages by health staff			
Stigma or violence against a group		<ul style="list-style-type: none"> <li>Focus groups</li> <li>Household surveys</li> <li>Exit interviews</li> </ul>	Low facility usage rates and/or low quality and satisfaction ratings
Harmful cultural norms and practices (e.g., potentially harmful post-birth nutrition or hygiene behaviors)		<ul style="list-style-type: none"> <li>Focus groups</li> <li>Household surveys</li> </ul>	Low rates of exclusive breastfeeding; negative cord care practices
Unequal power relationships within the family unit		<ul style="list-style-type: none"> <li>Focus groups</li> <li>Household surveys</li> </ul>	Exclusion or marginalization of women, children, or elderly individuals

Community Level			
Issues and Detailed Sub-Categories		Potential Sources	Outcomes Affected
Low literacy and/or education levels		See above	See above
Barriers in accessing services	Economic	See above	See above
	Distance/lack of transportation		
	Language		
	Health service not culturally acceptable		
	Poor treatment by health staff		
	Poor understanding of health messages given by health staff		
Health system factors	Unequal quality of services within community segments	<ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Exit interviews</li> <li>• Observation</li> <li>• Review of intake data</li> </ul>	Low facility usage rates and/or low quality and satisfaction ratings
	Overburdened health care providers	<ul style="list-style-type: none"> <li>• Provider interviews</li> <li>• Observation</li> <li>• Review of intake data</li> </ul>	Low facility usage rates and/or low quality and satisfaction ratings
Stigma or Violence against group		See above	See above
Harmful cultural norms and practices		See above	See above
Unequal power relationships between disadvantaged and advantaged groups	Unequal decision-making power within a community or geographic area	<ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Household surveys</li> <li>• Gender analysis</li> </ul>	Delay in seeking care because of community power dynamics and norms; low utilization rates; unmet needs within the community
	Unequal representation in community structures, i.e., community health development committees	<ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Community-level audit</li> </ul>	
Facility Level			
Issues and Detailed Sub-Categories		Potential Sources	Outcomes Affected
Facilities not near communities		<ul style="list-style-type: none"> <li>• GIS mapping</li> </ul>	Low levels of facility or service utilization
Closest facilities do not have adequate staff and services	Stock-outs and supply chain interruptions	<ul style="list-style-type: none"> <li>• Exit interviews</li> <li>• Observation</li> <li>• Facility audits</li> <li>• Service provision assessments</li> </ul>	Necessary medicines low in quantity and/or supply; low facility usage rates and/or low quality and satisfaction ratings
	Staff absenteeism		
	Low skill level of providers		
	Staff treatment of disadvantaged group is poor		
Service delivery	Unequal quality of facilities across regions	<ul style="list-style-type: none"> <li>• Focus groups</li> <li>• Exit interviews</li> <li>• Observation</li> <li>• Review of supply chain and financials</li> </ul>	Unequal access to quality care
	Supply-chain issues affecting availability of commodities		Stock outs
	Health financing issues constrain planned activities		Service disruptions and compromised quality

District Level			
Issues and Detailed Sub-Categories		Potential Sources	Outcomes Affected
Leadership	Inadequate management oversight and accountability	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Systems inefficiencies, lack of transparency
Health financing	Lack of district-level funds, ineffective or inefficient payment systems	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• PER</li> <li>• Other reviews and assessments</li> </ul>	Lack of funds for supervision
Workforce	Inadequate staffing	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Inadequate numbers of doctors, nurses, midwives
	Low staff training or capacity		Doctors, nurses, midwives do not meet competency standards
Medical products, technologies	Supply-chain issues	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Supply chain assessments</li> </ul>	Unavailability of necessary commodities
Information	Ineffective or inefficient data management systems	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• HMIS assessments</li> </ul>	unable to identify facilities or communities with low coverage
Service delivery	Unequal quality of facilities across regions	<ul style="list-style-type: none"> <li>• RHSA, Service Provision Assessments</li> </ul>	Poor quality of care
National Level (many national issues may be beyond the scope of MCSP)			
Issues		Potential Sources	Outcomes Affected
Leadership	Inadequate management oversight and accountability	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Systems inefficiencies, lack of transparency
Health financing	Insufficient funding for national health care	<ul style="list-style-type: none"> <li>• National Health Accounts</li> <li>• RHSA</li> <li>• PER</li> <li>• Other reviews and assessments</li> </ul>	Insufficient funds for interventions, with remote areas most affected
	Poor financial management		Fund leakages or inefficiencies
Workforce	Lack of skilled health workers	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Inadequate numbers of qualified doctors, nurses, midwives
Medical products, technologies	Supply chain issues	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Supply chain assessments</li> </ul>	Unavailability of necessary commodities
Information	Ineffective or inefficient data management systems	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• HMIS assessments</li> </ul>	Health data not used to inform decision-making

National Level (many national issues may be beyond the scope of MCSP), continued			
Issues	Potential Sources	Outcomes Affected	Issues
Unequal power relationships between disadvantaged and advantaged groups	Unequal decision-making power at the national level	<ul style="list-style-type: none"> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Systems inefficiencies, endemic marginalization of disadvantaged groups
	Unequal representation in national structures, i.e., national health committees or advisory groups		
National policies that reinforce disparities and health inequities	Legality surrounding young marriage	<ul style="list-style-type: none"> <li>• National policies</li> <li>• RHSA</li> <li>• Other reviews and assessments</li> </ul>	Poor health outcomes for disadvantaged populations

Is there additional information that the program should collect to better understand the health equity issues in the program area?

- Consider budget, cost, and time before planning primary data collection activities
- Consider what existing research activities are planned that could incorporate questions addressing drivers of existing inequities



## Tools

### Jhpiego Gender Analysis Toolkit

The purpose of the Gender Analysis Toolkit is to provide research questions to guide data collection when performing a project-level gender analysis. The Toolkit provides illustrative questions related to the five domains described in USAID’s Automated Directive System 205, which are: 1) Laws, regulations, and institutional practices; 2) Cultural norms and beliefs; 3) Gender roles, responsibilities, and time used; 4) Access to and control over assets and resources; and 5) Patterns of power and decision-making. The tool presents illustrative general and health area-specific questions organized in matrices related to different levels of the health system. <http://bethechange.org/dev/>

### Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA)

Participatory Rural Appraisal (PRA) is a label given to a growing family of participatory approaches and methods that emphasize local knowledge and enable local people to make their own appraisal, analysis, and plans. PRA (also called Participatory Learning in Action, or PLA) uses group animation and exercises to facilitate information sharing, analysis, and action among stakeholders. Although originally developed for use in rural areas, PRA has been employed successfully in a variety of settings. The purpose of PRA is to enable development practitioners, government officials, and local people to work together to plan context-appropriate programs. PRA/PLA uses several tools, many of them from ethnographic or qualitative research, such as semi-structured interviews, focus groups, community or social mapping, Venn diagrams, transect walks, calendars, wealth rankings, and historical profiles. PRA is exceptionally useful at the project planning stage and can help with several steps in the Health Equity Guidance, including Steps 1b, 2, 3, 4 and 5. While generally not quantitative in nature, PRA activities can help engage a community in Step 6: Develop an equity-focused M&E system. <http://www.crsprogramquality.org/storage/pubs/me/RRAPRA.pdf>

### Partnership Defined Quality (PDQ)

Partnership Defined Quality (PDQ) is a methodology to improve the quality and accessibility of services with community involvement in defining, implementing, and monitoring the quality improvement process. PDQ links quality assessment and improvement with community mobilization using a four-step process: 1) building support, 2) exploring quality, 3) bridging the gap, and 4) working in partnership. Once local decision-makers

have given their support for the need to resolve the issue, focus groups are conducted to gather information on quality of health services and barriers to access for the specific marginalized group. A one-day workshop is then held in which both sides of the “partnership” share the barriers from their vantage point. Together, they come to an agreed-upon set of barriers and then form a quality improvement team to move forward to develop an action plan for resolving the barriers using local human and financial resources. Soon, the community becomes empowered because they are solving their own problems!

PDQ addresses both Steps 1b and 5 of the Health Equity Guidance. PDQ also links and holds service providers (duty bearers) accountable for the services they should be providing for the community and involves community members, both marginalized and non-marginalized, in increasing equity of health services. It is an empowering process for community members who gain a voice to share their opinions. PDQ can assist in Steps 2–6 of the Health Equity Guidance. The PDQ Manual, PDQ Facilitation Guide, PDQ for Youth Manual, and PDQ Monitoring and Evaluation Toolkit are available on the CORE Group’s website. <http://www.coregroup.org/component/content/article/83>

### **Rapid Health System Assessment**

The RMNCH Rapid Health System Assessment (RHSA) is a qualitative exercise used to quickly diagnose operations and management challenges at the sub-national level that may impact RMNCH services and program activities, to prioritize key areas for strengthening, and to identify assets and opportunities in the health system. The overall aim of the RHSA is to gather information that can be used by country teams to generate solutions to enhance the feasibility and sustainability of planned and ongoing MCSP activities, as well as the longer-term goal of strengthening the overall health system. As such, the RHSA initiates a process of analysis and planning that yields recommendations that can be applied at the community, facility, and sub-national administrative levels, as well as further upstream at the national level (if applicable).

#### **Some general resource on qualitative research methods:**

- Training in Qualitative Research Methods: Training Curriculum for Building the Capacity of PVO, NGO, and MOH Partners. 2005. CORE Group. [http://www.coregroup.org/storage/documents/Workingpapers/qrm\\_complete.pdf](http://www.coregroup.org/storage/documents/Workingpapers/qrm_complete.pdf)
- Mack N, Woodsong C, MacQueen K, Guest G, Namey E. 2005. Qualitative Research Methods: A Data Collector’s Field Guide. Research Triangle Park, NC: Family Health International.

## **2. Identify the Disadvantaged Group or Priority Inequities on Which to Focus**

Although there may be many disadvantaged groups, and many types of inequities among various sub-populations, it is important to prioritize. Sometimes stakeholders, such as donors and the Ministry of Health (MOH) may have already established priorities, but it is important to continue with this step in order to understand what is involved in responding to these requirements.

To determine the highest priority areas to address, consider the magnitude of the inequity and if there is a feasible way to address the disparity or reach the disadvantaged group. This will necessarily involve considerations of cost and budget feasibility. Also, consider how interventions targeting inequities fit within the overall strategy of the program, where complementary activities can easily be built in to promote equity, or where focused attention to inequities may divert resources or overburden program staff in ways that would set back the interests of all the intended program beneficiaries.

Some important considerations for prioritizing which inequities to focus on:

- What inequities identified in Step 1a have the largest disparities between the best off and the worst off?
- Where there are inequities, how badly off are the worst off?

- Have the interests of groups affected been chronically overlooked by past government and/or NGO programs?
- Does addressing the health inequity align well with broader project, program, and public health goals?
  - Are the affected groups a key population for the health intervention being rolled out?
  - Are there important public health considerations that elevate a group as a priority (e.g., herd immunity and disease eradication through vaccine coverage)?
- What have local stakeholders identified as their key priorities and key populations with regard to health equity?
  - Local input should guide decisions about which groups to target and which inequities require the most immediate attention
- Are there simple, cost-effective solutions available to address the health inequity?
  - How might alternative investments in targeted pro-equity strategies compare in terms of the relative benefits they yield?

### 3. Decide what is in the Program’s Manageable Interest to Change

No project has unlimited funds and time for implementation. Usually, many different inequitable health situations, different disadvantaged groups, and important underlying conditions can be identified. However, it is important to prioritize and concentrate on a limited number of issues. It may not be possible to work in all aspects of inequity at the same time. Based on the considerations laid out in step 2, program implementers should make a decision about what to focus limited resources on, and what the most feasible issues are to address.

Key considerations for determining the programs’ manageable interests include:

- **Process definition:** This requires mapping how decision-making happens within the program and setting up systems to fill any gaps for communication and administration.
- **Stakeholder inclusion:** While the main stakeholders may vary from program-to-program (and even activity-to-activity), it is essential to identify internal and external stakeholders and determine how they will fit into the decision-making process. These stakeholders may engage in a top-down (MOH or donor-driven) or bottom-up (clinician or local administrator-driven) approach.
  - For example, under MCSP’s Comprehensive Approach to Health System Strengthening, district health managers select a locally-tailored combination of approaches from a holistic menu of health system assets to enable the local health sector to work more efficiently and effectively, leading to better health. Therefore, district health managers were engaged to help lead discussions about local priorities for health systems strengthening and equity, as well as assets available to help address inequities.
  - In other cases, stakeholders may drive decision-making from top-down.
- **Scope management:** Ambitious but realistic internal leadership is essential for defining and overseeing the program’s equity scope. A dedicated Equity representative or team can help to manage expectations and synthesize inputs from diverse stakeholders.

## 4. Define Equity Goals, Objectives, and a Project-specific Operational Definition of Equity

It is important to establish clear equity goals for the program, each with specific objectives, targets and indicators. Clarity about broad equity goals and specific objectives is critical for informing the prioritization of included services and for tracking how well the program performs on its stated targets.

### Formulating Equity Goals

In articulating equity goals, include the type of health inequity to be addressed, the existing gap between groups, and the defining characteristics related to the health gaps between affected groups.

Types of Inequities	Associated Characteristics of Affected Groups
<ul style="list-style-type: none"> <li>• Inequities in health outcomes</li> <li>• Inequities in access/coverage</li> <li>• Inequities in quality</li> <li>• Inequities in responsiveness to patient needs</li> </ul>	<ul style="list-style-type: none"> <li>• Income level</li> <li>• Place of residence (e.g., urban/rural; distance from facility)</li> <li>• Religion, Culture, Ethnicity</li> <li>• Education and Literacy</li> <li>• Age</li> <li>• Gender</li> </ul>

#### Example Goals:

- Narrow the gaps in immunization coverage between children living in rural, remote village as compared to children living in urban centers.

Specific data points on the existing gaps should be included, as informed by Step 1.

### Setting Objectives and Targets

With the goal in mind, set specific objectives and targets. This will orient the strategy and provide a benchmark against which to measure performance. Be realistic about setting targets and be cognizant of the timeframe.

#### Example:

- Objective: Increase DPT immunization among children under 5 in areas that currently have coverage <50% (or in areas that are located more than X kilometers from a health facility).
- Target: Reduce the disparity in immunization coverage between rural and urban children by 50% in the next 3 years.

### Worksheet 2: Formulating Program-Specific Operational Definition of Health Equity

<p><b>Program specific health equity definition:</b></p> <p>Definition should follow a pattern similar to the following: <i>Equity will be improved when the gap in _____ (target coverage indicator) _____ between the _____ (most disadvantaged, specify) and _____ (less disadvantaged, specify) is reduced by/to _____.</i></p> <p><i>Example: Equity will be improved when the gap in skilled birth attendance between the poorest 20% (lowest wealth quintile) of the population and the richest 20% (highest wealth quintile) of the population is reduced to only 20% points from a baseline of 60% points.</i></p>
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## 5. Determine Equity Strategies and Activities

With clearly articulated project goals, objectives, and targets, begin to assess which strategies are most likely to support their realization. These interventions can happen at the level of the individual, community, facility, or even at the district or national level. Remember that strategies for improving equity must often reach beyond working only with the disadvantaged group. Often the most effective interventions address multiple drivers of inequities simultaneously to create a favorable environment for improving health outcomes of the disadvantaged group.

Strategies can address underlying conditions and barriers directly or may be designed to work around them. For example, inaccessibility to health facilities may not require building additional physical structures. The use of community health workers as well as provision of transportation may be enough to overcome these geographic barriers to access.

It may be useful to develop a theory of change for how the project will address the inequities in light of existing barriers to realize its equity goals, objectives, and targets. A theory of change describes the relationship between the intervention activities, intervention contexts, and expected health equity outcomes. A good theory of change needs to be explicit about the mechanisms needed to impact the outcomes of interest, clarify key assumptions about how the interventions will work to address inequities, and describe the theory in a way that can aid implementation in local settings.

Additionally, for each intervention, it is important to think about any negative effects that might occur if changes are made and develop ways to reduce these effects. For example, encouraging women to go to the health services even if men have not given permission could lead to violence against women.

Furthermore, budget considerations must factor into the determination of strategies employed. Is it possible to better achieve the goals or make greater impacts on gaps in health outcome through a more strategic investment?



### Tools

#### *Costing and Budgeting Tools at the Decentralized Level: State of the Art*

This tool from USAID's Health Policy Project gives a brief overview of various software models available to help health planners and managers to estimate and project costs for various health services. These tools can be adapted for use at the state and local level and used to estimate costs to reach a specific goal or to expand or upgrade services.

<http://www.healthpolicyproject.com/index.cfm?ID=publications&get=pubID&pubID=32>

#### *Designing for Behavior Change/BEHAVE Framework*

The Designing for Behavior Change curriculum, developed by the CORE Group Social and Behavior Change Working Group, responds to community health managers' and planners' need for a practical behavioral framework that aids them in planning their projects strategically for maximum effectiveness. The curriculum is built upon the BEHAVE Framework, developed by the Academy for Education Development (AED) and the Barrier Analysis approach, developed by Food for the Hungry. This field-tested, six-day training curriculum enables nongovernmental organizations (NGOs) and their partners to replicate behavior change workshops in their organization's and country programs. The training will help staff design effective activities to decrease inequities in their projects (Step 5: Determine equity strategies and activities) that are based soundly on the underlying issues and barriers identified in Step 1b (e.g., using Barrier Analysis).

[http://www.coregroup.org/storage/documents/Workingpapers/dbc\\_curriculum\\_final\\_2008.pdf](http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf)

## *Lives Saved Tool (LiST)*

The LiST tool was developed by a consortium led by The Johns Hopkins University with funding from the Bill & Melinda Gates Foundation. LiST allows users to set up and run multiple scenarios to explore the estimated mortality impact of coverage changes for proven high-impact maternal, newborn, and child health (MNCH) interventions in a country, district, or project area. LiST makes this estimation using information about the effectiveness of key MNCH interventions as well as information about cause of death and current coverage of these key interventions. LiST can be used to help prioritize investments during the planning phase and evaluate existing programs. The LiST tool can help projects in Step 5: Determine equity strategies and activities, by identifying which interventions will have the most impact on the health of the disadvantaged population. It can also be used in conjunction with the KPC survey to see if the project is actually saving lives in that population (Step 6: Develop an equity-focused M&E system). One limitation with this tool is that it is well-defined for child health indicators, but not for maternal health indicators.

<http://www.jhsph.edu/departments/international-health/IIP/list/index.html>

## *Marginal Budgeting for Bottlenecks (MBB)*

Marginal Budgeting for Bottlenecks (MBB) is a results-based planning and budgeting tool that uses knowledge about the impact of interventions on child and maternal mortality in a country, facilitates identification of implementation constraints, and estimates the marginal costs of overcoming these constraints. This tool has been used in multiple countries to assist in setting targets for proven high-impact interventions; estimating their expected impact, cost per life saved, and additional funding requirements; and projecting the required fiscal space to finance these extra costs.

MBB consists of five key steps:

1. Assessment of key indicators for, trends in, and causes of maternal, newborn, and child mortality and morbidity and access to essential services, and the selection and packaging of evidence-based, high-impact interventions to address the proximate causes by service delivery mode (i.e., family/community-based care, schedulable population-oriented services and mobile strategies, or individually oriented clinical care at primary- and referral-level facilities).
2. Identification of system-wide supply and demand bottlenecks to adequate and effective coverage of essential primary health care services, and obstacles to the application of high-impact intervention packages in each of the main service delivery modes.
3. Estimation of the expected impact on survival rates for each of the interventions. These estimations are based on recent, in-depth analysis of the evidence on the efficacy of high-impact interventions and packages in determining maternal and child survival and health outcomes.
4. Selection of the types, quantities, and costs of additional inputs, such as salaries, drugs, and training, which are needed to implement the actions to overcome bottlenecks and to lift the effective coverage of intervention packages to their frontiers.
5. Analysis of budgetary implications, the identification of likely sources of funding, and the comparison of the marginal costs and additional funding needs to the fiscal space for health spending.
6. MBB can be used to estimate costs and determine priority interventions for the disadvantaged group during Step 5: Determine equity activities and strategies.

<http://www.devinfolive.info/mbb/mbbsupport/>

See examples on pages 4–5 of:

[http://www.unicef.org/publications/files/Narrowing\\_the\\_Gaps\\_to\\_Meet\\_the\\_Goals\\_090310\\_2a.pdf](http://www.unicef.org/publications/files/Narrowing_the_Gaps_to_Meet_the_Goals_090310_2a.pdf)

## *PlanRep*

PlanRep is a software system used for program planning and reporting as part of a management information system. The software is most useful for managing project start-up, systems analysis, monitoring program rollout, and reporting on progress.

## *UNICEF Theory of Change Methodological Brief*

This brief describes what a theory of change is, why it can be helpful, when it should be used, and how to develop it.

[https://www.unicef-irc.org/publications/pdf/brief\\_2\\_theoryofchange\\_eng.pdf](https://www.unicef-irc.org/publications/pdf/brief_2_theoryofchange_eng.pdf)

## **6. Develop an Equity-focused M&E System**

- The health equity focused M&E system should be set up at the beginning of the program (or from the beginning of the equity intervention).
- It is not necessary to create special equity indicators of health outcomes. Instead, the M&E system should be set up to collect standard health outcome indicators, such as skilled attendance at birth, but be able to disaggregate this information into the groups on which the program focuses.
- Special indicators may need to be created to measure changes in underlying conditions.
- Indicators that measure gender equity should be included.
- Plan for surveys to have adequate sample sizes to allow for disaggregation into subgroups and to have enough statistical power to detect change.
- M&E can include both quantitative and qualitative information.
- Ensure access to appropriate expertise for analysis of information.

### Worksheet 3: Sample Monitoring and Evaluation Plan with Equity Focus

Priority Outcome: Young mothers and newborns from poorest and most vulnerable communities have access to high-quality RMNCH services (vulnerability inclusive of indigenous populations).						
Illustrative Indicators	Definition	Unit of Measure	Data Disaggregated by	Data Collection Method(s)	Frequency	Benchmarks
% of patients receiving 3+ ANC visits <b>(quantitative)</b>	<b>Numerator:</b> # of mothers who received 3+ ANC visits <b>Denominator:</b> Total number of deliveries	Women/new mothers	<ul style="list-style-type: none"> <li>Wealth quintile</li> <li>Age</li> </ul>	DHS	Baseline, midline, and final	<ul style="list-style-type: none"> <li>X% by midline</li> <li>X% by endline</li> </ul>
% of deliveries attended by skilled birth attendants <b>(quantitative)</b>	<b>Numerator:</b> # of deliveries attended by skilled birth attendant <b>Denominator:</b> Total number of deliveries	Live births	<ul style="list-style-type: none"> <li>Wealth quintile</li> <li>Age</li> </ul>	DHS	Baseline, midline, and final	<ul style="list-style-type: none"> <li>X% by midline</li> <li>X% by endline</li> </ul>
% of women under 25 years currently using any modern method of contraception <b>(quantitative)</b>	<b>Numerator:</b> # of women under 25 currently using any MMC <b>Denominator:</b> Total number of women under 25	Women under 25 years	<ul style="list-style-type: none"> <li>Wealth quintile</li> <li>Age</li> <li>Ethnicity</li> </ul>	KPC 30 cluster with parallel sampling to ensure adequate sample sizes of indigenous populations	Baseline, midline, and final	<ul style="list-style-type: none"> <li>X% by midline</li> <li>X% by endline</li> </ul>
Community health worker units reach a poorer population than that reached by MOH health centers <b>(quantitative)</b>	Comparison of SES profiles for beneficiaries of CHW unit compared to SES profiles for beneficiaries of MOH health centers	—	<ul style="list-style-type: none"> <li>Wealth quintile</li> <li>Age</li> <li>Ethnicity</li> </ul>	Exit interviews with users of CHW units and MOH health centers	Ongoing data collection through exit interview monitoring	X% of populations served by CHWs in bottom two wealth quintiles
Priority Outcome: Children under two from poorest and most vulnerable communities receive basic nutrition						
Illustrative Indicators	Definition	Unit of Measure	Data Disaggregated by	Data Collection Method(s)	Frequency	Benchmarks
% of children 6–23 months fed according to a minimum of appropriate feeding practices (IYCF indicator, <b>quantitative)</b>	<b>Numerator:</b> # of mothers of children 6–23 months whose child was fed according to a minimum of appropriate feeding practices <b>Denominator:</b> Total # of mothers of children 6–23 months interviewed	Mothers of children 0–23 months from indigenous populations	<ul style="list-style-type: none"> <li>Wealth quintile</li> <li>Ethnicity</li> </ul>	KPC 30 cluster with parallel sampling to ensure adequate sample sizes of populations	Baseline, midline, and final	<ul style="list-style-type: none"> <li>X% by midline</li> <li>X% by endline</li> </ul>
Indigenous grandmothers supportive of exclusive breastfeeding <b>(qualitative)</b>	Grandmothers are supportive of exclusive breastfeeding based on sentiments expressed during focus group discussions	Mothers of women of reproductive age, from indigenous minority groups	—	Focus group discussions with grandmothers	Baseline and final	Increased support for EBF, esp. among indigenous communities, when comparing baseline and final evaluations

# Appendix I: Summary of Reproductive, Maternal, Newborn, and Child Health Equity Guidance Steps and Corresponding Tools

Equity Guidance Steps	Applicable Tools
<p>1a) Identify inequities in health outcomes and the magnitude of the differences</p>	<p><a href="#">Averting Maternal Death and Disability: EmOC Needs Assessment Toolkit</a>            Diagnose, Intervene, Verify, and Adjust (D-I-V-A) Approach  <a href="#">The EquityTool</a>  <a href="#">Gender Discrimination and Health Workforce Development: An Advocacy Tool</a>  <a href="#">The Global Health Data Exchange (GHDx)</a>  <a href="#">Knowledge, Practices, and Coverage (KPC) Survey</a>  <a href="#">STATcompiler</a>  <a href="#">SES Profile Tool</a>  <a href="#">The Health System Assessment Approach: A How-To Manual</a>            Program Design, Monitoring, and Evaluation (PDME)            Rapid Socio-Economic Profile Assessment (R-SEPA) Tool            Sustainability Framework (SF)</p>
<p>1b) Understand underlying issues and barriers</p>	<p><a href="#">Barrier Analysis</a>  <a href="#">The Health System Assessment Approach: A How-To Manual</a>  <a href="#">Jhpiego Gender Analysis Tool</a>  <a href="#">A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action</a>  <a href="#">Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA)</a>  <a href="#">Partnership Defined Quality (PDQ)</a>            Positive Deviance/Hearth  <a href="#">Qualitative Research Methods</a>            Rapid Health System Assessment (RHSA)  <a href="#">Socio-Economic Profile Assessment Guide</a>            Sustainability Framework (SF)</p>
<p>2) Identify the disadvantaged group on which to focus</p>	<p><i>D-I-V-A Approach</i>  <i>KPC Survey</i>  <i>Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA)</i>  <i>Program Design, Monitoring, and Evaluation (PDME)</i>  <i>Socio-Economic Profile Assessment Guide</i>  <i>Sustainability Framework (SF)</i></p>
<p>3) Decide what is in the project's manageable interest to change</p>	<p>D-I-V-A Approach  <i>A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action</i>  <i>Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA)</i>            Positive Deviance/Hearth  <i>Program Design, Monitoring, and Evaluation (PDME)</i>  <i>Sustainability Framework (SF)</i></p>
<p>4) Define equity goals, objectives, and a project-specific definition of equity</p>	<p>D-I-V-A Approach  <i>Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA)</i>  <i>Program Design, Monitoring, and Evaluation (PDME)</i>  <i>Sustainability Framework (SF)</i></p>

Equity Guidance Steps	Applicable Tools
5) Determine equity strategies and activities	Barrier Analysis <a href="#">Costing and Budgeting Tools at the Decentralized Level: State of the Art</a> <a href="#">Designing for Behavior Change/BEHAVE Framework</a> D-I-V-A Approach Gender Budget Analysis <a href="#">Lives Saved Tool (LiST)</a> <i>A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action</i> <a href="#">Marginal Budgeting for Bottlenecks (MBB)</a> Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA) Partnership Defined Quality (PDQ) Positive Deviance/Hearth Program Design, Monitoring, and Evaluation (PDME) Sustainability Framework (SF) <a href="#">UNICEF Theory of Change Methodological Brief</a>
6) Develop an equity-focused M&E system	<a href="#">ADePT Software Package</a> D-I-V-A Approach <i>The Health System Assessment Approach: A How-To Manual</i> KPC Survey Lives Saved Calculator (LiST) <i>A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action</i> Participatory Rural Appraisal/Participatory Learning in Action (PRA/PLA) Program Design, Monitoring, and Evaluation (PDME) Qualitative Research Methods Socioeconomic Profile Assessment Guide <i>Sustainability Framework (SF)</i>

# Appendix 2: Select Literature

Acting on the Call: Ending Preventable Child and Maternal Deaths: A Focus on Equity. 2016. USAID.  
<https://www.usaid.gov/sites/default/files/Final-AOTC-file-v2.pdf>.

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Wilunda C, Putoto G, Riva DD, et al. 2015. Assessing Coverage, Equity and Quality Gaps in Maternal and Neonatal Care in Sub-Saharan Africa: An Integrated Approach. PLoS ONE 10(5): e0127827. doi: 10.1371/journal.pone.0127827.

