



Addressing Inequities in the Coverage of Reproductive, Maternal, Newborn, and Child Health Interventions and Services

Strengthening Programmatic Approaches to Reach Underserved Women and Children

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Introduction

Many countries face significant inequities in health care access and outcomes along patient socioeconomic status and other demographic factors. Often, the poorest and most vulnerable populations fall behind. If these gaps are not addressed through proactive interventions, they will only continue to grow. Analysis of population-based coverage data of key reproductive, maternal, newborn, and child health (RMNCH) services and interventions over the Millennium Development Goals era revealed that significant inequities remained despite a steady increase in overall coverage.¹ However, relatively faster increases in coverage among poorer and more rural populations contributed to an overall acceleration in national coverage in many countries.²

Within the Sustainable Development Goals and the earlier Child Survival Call to Action (2012) and the US Agency for International Development (USAID)'s investments to prevent maternal and child deaths, there is recognition that reaching the most underserved populations is critical to achieving RMNCH goals and the broader goals of universal health coverage. The final Countdown to 2015 report found that systematic pro-rich inequalities exist for virtually all coverage indicators.³ USAID's 2016 *Acting on the Call* report brought 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.⁴ A 2017 UNICEF analysis also showed that investments to increase the coverage of key child health and nutrition services among relatively poorer population groups saved almost twice the number of lives compared to commensurate investments in a comparator group, suggesting the relative cost-effectiveness of pro-poor child health interventions.⁵ While progress has been made, opportunities exist to support countries to address these persistent inequities.

The Maternal and Child Survival Program (MCSP) is a global, \$560 million, 5-year cooperative agreement funded by USAID to introduce and support scale-up of high-impact RMNCH health interventions among

¹ Victora CG, Requejo JH, Barros AJ, et al. 2016. Countdown to 2015: a decade of tracking progress for maternal, newborn, and child survival. *Lancet*. 387(10032):2049-2059. doi: 10.1016/S0140-6736(15)00519-X.

² Victora CG, Barros AJ, Franca GV, da Silva IC, Carvajal-Velez L, Amouzou A. 2017. The contribution of poor and rural populations to national trends in reproductive, maternal, newborn, and child health coverage: analyses of cross-sectional surveys from 64 countries. *Lancet Glob Health*. 5(4):e402-e407. doi: 10.1016/S2214-109X(17)30077-3.

³ Requejo J, Victora C, Bryce J. 2015. *A Decade of Tracking Progress for Maternal, Newborn and Child Survival: The 2015 Report*. New York City and Geneva: UNICEF and the World Health Organization.

⁴ USAID. 2016. *Acting on the Call: Ending Preventable Child and Maternal Deaths: A Focus on Equity*. Washington, DC: USAID.

⁵ UNICEF. 2017. *Narrowing the Gaps: The Power of Investing in the Poorest Children*. New York City: UNICEF.

USAID’s 25 maternal and child health priority countries, as well as other countries. Recognizing the persistent challenges in reducing inequities in RMNCH service coverage, MCSP promoted equitable access to high-quality health care services and interventions for women, newborns, and children, and has used data to adapt programmatic approaches to address and learn from persistent equity challenges. This brief summarizes MCSP’s approach to addressing inequities, highlights key programmatic achievements, and identifies opportunities for future programming.

MCSP’s Approach to Addressing Inequities

There is a common assumption that programs aiming to increase coverage of health services and high-impact interventions among the poor are, by virtue, equitable. However, without careful attention to equity in design, implementation, and monitoring, these programs may result in narrow impacts that only improve the situation of those who are comparatively advantaged and fail to meet the needs of the poorest and most marginalized communities. To ensure reductions in inequities, programs must choose promising pro-equity approaches, incorporate pro-equity designs, monitor outcomes using feasible and valid measurements, and adjust programs based on these findings. A meta-review of strategies to close equity gaps highlighted three key strategies for reaching the underserved: shifting delivery channels, using private providers to expand access, and reducing financial barriers to access (Table 1).⁶ MCSP prioritized applying the shifting delivery channels (or task shifting) and engaging private providers strategies for improving health equity because of MCSP’s engagement in community health across the full range of RMNCH technical interventions and its emphasis on health worker and lay worker capacity-building, which in some countries also involved private providers.

MCSP’s Definition of Equity

Health equity is both the improvement of a health outcome of a disadvantaged group and 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.

Table 1. Programmatic strategies to reach underserved populations

Primary Strategy	Examples
Shifting delivery channels	Task-shifting to community-based service delivery, from professional health workers to lay workers, from doctors to health provider cadres who are more available at remote facilities (e.g., nurses), and from facility-based to community outreach services
Drawing on private providers	Contracting with private health care providers to expand access, concurrent with regulation and accreditation efforts
Reducing financial barriers to access	Implementing cash transfers or vouchers, reducing or eliminating health service user fees

Note: Based on strategies identified by Chopra et al. 2012.

Aligned with these overarching strategies to reach underserved populations, MCSP identified and supported governments to implement and scale up promising pro-equity interventions that were likely to reach the underserved by shifting services to the community level and/or relying on delivery by workers with less formal training (Table 2).

⁶ Chopra M, Sharkey A, Dalmiya N, Anthony D, Bikin N, UNICEF Equity in Survival, Health and Nutrition Analysis Team. 2012. Strategies to improve health coverage and narrow the equity gap in child survival, health, and nutrition. *Lancet*. 380(9850):1331-40. doi: 10.1016/S0140-6736(12)61423-8.

Table 2. Country-level implementation of MCSP pro-equity interventions

Intervention	Countries
Reaching Every District/Reaching Every Community ⁷	Haiti, India, Kenya, Liberia, Madagascar, Malawi, Nigeria, Pakistan, Tanzania, Uganda, Zimbabwe
Advanced distribution of misoprostol for self-administration	Mozambique
Facility and community use of chlorhexidine	Liberia, Nigeria
Integrated community case management	DRC, Nigeria

MCSP also incorporated equity awareness into program measurement and monitoring through the following strategies: 1) provide data on the economic status and demographic characteristics of beneficiaries across a range of activities to inform and improve future targeting of the underserved, and 2) conduct analyses on alternative techniques to measure equity and develop actionable tools.

In addition, MCSP provided global thought leadership and country-level support on gender-based inequities that affect health; details of that work can be found on MCSP’s gender legacy site. MCSP also worked to improve the coverage and quality of community-based services while integrating community-based platforms into national strategies, reaching underserved communities in multiple countries. While select pieces of this community-oriented support are highlighted in this brief, additional resources can be found on MCSP’s community legacy site. As this brief highlights some of MCSP’s programmatic innovations, additional resources can be found on the innovation legacy site.

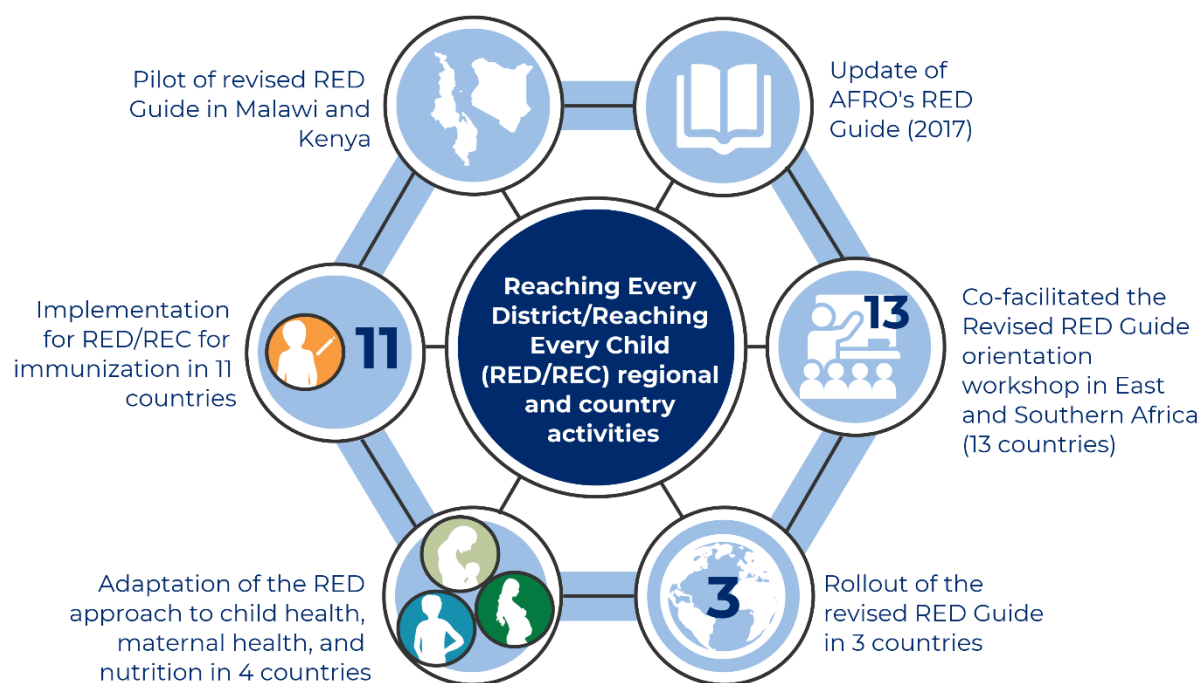
Program Achievements: Scale-Up of Pro-Equity Interventions

Reaching Every District/Reaching Every Community

The Reaching Every District/Reaching Every Community (RED/REC) approach is a management approach with five interrelated components aimed at improving immunization services, maximizing the use of available resources, and guaranteeing sustainable and equitable immunization coverage for every eligible person. The latest 2017 update of the World Health Organization’s Africa Regional Office RED guide—supported by MCSP—put greater emphasis on community engagement, equity, and integration with other sectors and programs to reduce missed opportunities for vaccination. MCSP supported country governments in 11 countries in various capacities to increase equitable immunization coverage while exploring adaptation of the RED/REC to child health, maternal health, and nutrition in four other MCSP-supported countries (Figure 1).

⁷ While the World Health Organization’s Africa Regional Office identifies this approach as RED, the choice to call it RED or REC is left to countries. Some have named it the REC approach to reflect contexts where immunization services reach every district but may not reach every child.

Figure I. MCSP country and regional Reaching Every District/Reaching Every Community activities



Support to implement RED/REC activities at the country level included:

- **Nigeria:** MCSP supported activities in the northern Bauchi and Sokoto states—states with relatively low immunization coverage—to improve community engagement as part of the larger RED/REC approach. The community engagement involved training 2,858 traditional barbers, or *wanzams*, who shave the heads of newborns on their seventh day of life, across both states to [refer newborns for immunization services](#). Barbers engaged in the approach referred 43,380 newborns over 2 years, and 91% of referrals reported receiving vaccination. Overall, an assessment found improvements across all outcomes and study groups in 10 study local government areas (LGAs) in Sokoto. However, the increases in adjusted coverage rates for vaccine birth doses from baseline to endline were higher in the five intervention LGAs compared to five comparison LGAs. For Bacillus Calmette-Guérin vaccine, adjusted coverage rates increased by 12% in the intervention LGAs, compared to 7% in the comparison LGAs. The adjusted coverage rate for oral polio vaccine increased by 8% in the intervention group, compared to 4% in the comparison group, and for hepatitis B, by 8% in intervention LGAs and 6% in the comparison LGAs.
- **Malawi:** MCSP provided technical support to improve community engagement as part of the [My Village My Home approach](#), which involved engaging village leaders in tracking infants and monitoring their vaccination status using hard-copy poster dashboards that were posted at public health facilities and shared with the community. The community empowerment approach in two districts (Dowa and Ntchisi) showed contributions to overall improvements in immunization coverage. Based on a household survey of 130 villages in the two districts, after 1 year, 77% of children were fully immunized by 1 year old, compared to 70% before the program; less than 2% of children both before and after had not commenced immunization services (n = 625). Findings from the endline survey showed that the percentage of children fully immunized increased from 68% to 91%.
- **Uganda:** MCSP supported 11 districts to implement the full suite of [RED/REC approaches](#) to strengthen the provision of immunization services. At the community level, MCSP supported districts to engage district and subdistrict leaders to extend services to an additional 644 villages, thereby expanding critical immunization services to underserved communities.

Recognizing the success that RED/REC has had in increasing coverage of immunization services, MCSP explored the application of RED/REC approaches to other RMNCH technical areas. This support to countries included adaptation of the approach to broader child health in Uganda, maternal health in Haiti, diarrheal case management in Kenya, and family planning (FP), antenatal care, and nutrition in Mozambique. Across these technical areas, a key enabler of the successful adaptation was the [community engagement](#) component of the RED/REC approach. This community engagement helped to bring services to the community level and strengthen the linkage of community-based services with higher levels of care, thereby increasing access to typically undeserved communities.

Advanced Distribution of Misoprostol for Self-Administration

In **Mozambique**, the Ministry of Health (MOH) prioritized the introduction of advanced distribution of misoprostol for self-administration (ADMSA) at community level as part of its National Strategy for the Prevention of Postpartum Hemorrhage. To support this rollout, MCSP partnered with the Mozambican Association of Obstetricians and Gynaecologists to train providers at community and facility levels who were involved in misoprostol distribution in 10 provinces. MCSP also supported the MOH to convene national workshops to discuss key lessons learned across an initial set of 35 pilot districts. MCSP provided targeted technical assistance for [ADMSA rollout in Nampula and Sofala provinces](#), training 646 traditional birth attendants on its appropriate use. While data quality on coverage was a challenge in these provinces, the percentage of women provided misoprostol in advance of delivery increased from 45% of estimated home births in December 2016 to 161% of estimated home births by June 2018. The cumulative coverage total exceeding 100% is attributable to some data quality challenges and differences in the restrictiveness of district distribution strategies. Health facilities involved in the ADMSA program determined eligibility in various ways. Some facilities strictly counted only those who lived 8 or more kilometers from facilities, whereas others did not. Additionally, some facilities instructed community health workers and traditional birth attendants to give misoprostol to those who lived farther than 8 kilometers only if they stated that they planned on giving birth at home. This variability, coupled with the changing proportion of births that take place at home—as evidenced by the changes recorded in the last two Demographic and Health Surveys (DHSs)—made determining the number of eligible women problematic in each catchment area. Therefore, the calculated proportions of eligible pregnant women that received ADMSA are rough approximations. Health personnel were trained and instructed to monitor the potential misuse of misoprostol, but there were no reports of such misuse. Nevertheless, at the national level, provincial-wide ADMSA coverage estimates for Nampula exceeded those of other provinces, possibly as a result of MCSP’s training of traditional birth attendants in Nampula.

Use of Chlorhexidine

In **Liberia**, the MOH adopted a national policy for chlorhexidine (CHX) use at facility and community levels in 2013, but the Ebola virus epidemic of 2014–15 halted substantial progress in its scale-up. To support the scale-up process, MCSP supported the MOH to develop a costed [plan for CHX scale-up](#) and then conducted health provider capacity development, including supportive supervision, to increase distribution and use of CHX. Coupled with these human capacity development approaches, MCSP worked with the MOH to improve routine distribution mechanisms for CHX to primary care facilities and strengthened facility staff capacities in forecasting and requisition to ensure an adequate commodity supply. Although the goal was to move CHX to the community level, in some settings where there was low coverage at facility level, there was pressure to increase coverage in facilities before expanding to community level. During the period of MCSP support, national coverage of facility use of CHX increased from 50% in October 2017 to 76% in February 2018, with coverage exceeding 80% in MCSP-supported counties. The second phase of the CHX scale-up plan focuses on community level, given the high percentage of pregnant women delivering at home in Liberia, and includes more targeted, demand-side interventions. Expansion to the community level will require additional development of supervision systems and distribution of necessary supplies to community health workers.

In **Nigeria**, the National Strategy for Scale-up of CHX in Nigeria of 2016 outlined five principles to achieve a 52% coverage target of CHX use by 2021 both for in-facility and home-based use. To support this scale-up,

MCSP worked with the Federal MOH to convene state-level ministries and stakeholders to develop operational plans for 36 states and the Federal Capital Territory, facilitate a peer learning platform on the [scale-up of CHX](#), and collect and analyze key scale-up indicators. MCSP also supported Kogi and Ebonyi states to implement their scale-up operational and monitoring plans. National coverage has steadily increased but remains low, around 10–15%; however, facility use of CHX coverage in MCSP-supported Kogi State increased from near 60% in January 2017 to close to 100% in December 2017; coverage in Ebonyi reached 74% by late 2018.

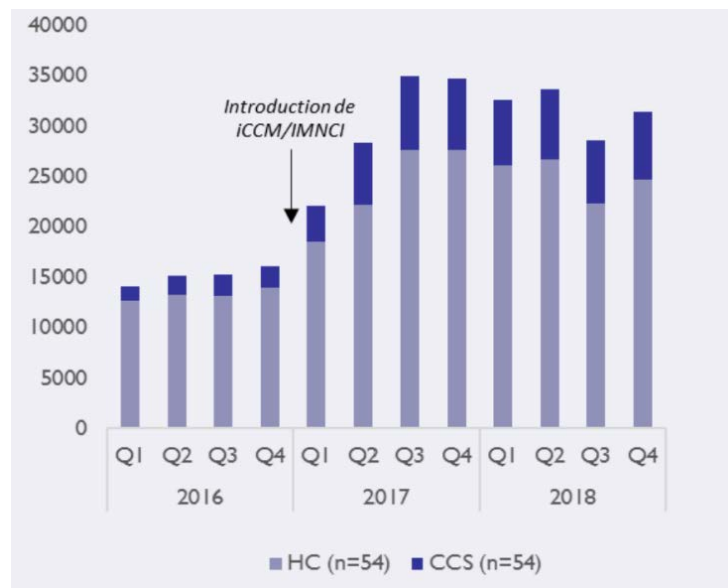
Integrated Community Case Management of Childhood Illness

In **Nigeria**, MCSP worked to engage patent and proprietary medical vendors (PPMVs) in Kogi and Ebonyi states to assess the feasibility and acceptability of [PPMVs providing high-quality integrated community case management \(iCCM\) services within their communities](#). PPMVs are often the first source for child care services and drugs in Nigeria, and they are frequently located in more rural areas of Nigeria, presenting an opportunity to increase services to underserved communities. Baseline assessments of the communities engaged in the interventions showed that PPMVs were the most common source of care for children sick with cough, fever, diarrhea, or pneumonia. The baseline assessment also showed that PPMVs and private pharmacies were often the first source of care across the range of household wealth in Ebonyi State, suggesting an opportunity to reach families in lower wealth quintiles; in Kogi State, however, female caregivers in higher wealth quintiles were more likely to seek care from PPMVs compared to those in the lowest two wealth quintiles. The approach to engage the PPMVs involved PPMV recruitment and registration by the Pharmacists Council of Nigeria, followed by training of PPMVs using national iCCM curriculum with monthly supervision visits from peer and government supervisors. MCSP and the Pharmacists Council of Nigeria also supported engagement with local drug manufacturers and suppliers to ensure a reliable supply of essential child health commodities for iCCM. In a sample of MCSP-supported PPMVs (n = 176),⁸ the percentage of children assessed for all danger signs increased from a baseline of 0–5% in March 2018 to an endline of 85–95% in both states as of November 2018. For treatment and counseling, the percentage of children appropriately receiving amoxicillin dispersible tablets, oral rehydration salts, and zinc increased from a baseline of 7–21% in March 2018 to an endline of 57–64% in November 2018; the percentage of children with fever tested with a malaria rapid diagnostic tests also increased substantially over the same time period. Ultimately, the approach of providing iCCM through PPMVs demonstrated promise in increasing the provision of high-quality child health care services through private providers while reaching underserved communities, given the presence of PPMVs in more rural areas of Nigeria.

⁸ MCSP trained 472 PPMVs at 400 outlets in Ebonyi State and 361 PPMVs at 282 outlets in Kogi State.

In **Democratic Republic of the Congo (DRC)**, as of 2015, the leading causes of childhood deaths were newborn complications, diarrhea, pneumonia, and malaria.⁹ To address this challenge, the Government of DRC began [scaling up the full package of iCCM for childhood illness](#) in 2005. MCSP has supported the MOH to scale up iCCM since 2016 by ensuring that synergetic interventions—such as training and supervision, logistics and supply system, and communication strategies—are carefully designed, systematically costed, and regularly monitored. This support also included developing a fully costed National Integrated Management of Newborn and Childhood Illness Strategic Plan (including iCCM) and the National Community Health Strategic Plan. Nationally, the number of health zones providing iCCM increased from

Figure 2. New cases of sick children under 5 receiving treatment at health centers and community care sites in Base-Uele and Tshopo provinces, DRC, 2016–2018



119 in 2014 to 402 in 2017 (of 461 eligible) in all 26 provinces, resulting in 6,968 community care sites providing iCCM; however, at the end of 2017, only 12 of the 26 provinces were providing the full iCCM package in more than 80% of their health zones. MCSP’s support to iCCM and IMNCI provider training, supervision, and equipment provision in Tshopo and Base-Uele provinces contributed to substantial increases in the number of children treated for common childhood illnesses; four times more cases of child pneumonia and diarrhea were treated at the facility level and nine times more cases were treated at the community level after MCSP support. This collective intervention resulted in approximately 20% of sick children receiving treatment at the community level in these two provinces in 2018 (Figure 2).¹⁰

Program Achievements: Strengthening Measurement of Inequities

Measuring inequities in coverage of key RMNCH services and interventions at global, national, and subnational levels are critical to monitoring and informing program and policy design to better reach underserved women and children. MCSP led work to assess and measure the status of equity challenges at global and country levels, and developed evidence and tools to aid countries to better address RMNCH inequities.

- MCSP developed [country-level equity dashboards](#) (Figure 3) and [cross-country comparison dashboards](#) for MCSP-supported countries that analyzed disparities in coverage by wealth, education, and urban/rural residence—including changes in disparities over time—for selected high-impact interventions across MCSP technical areas to inform country-level planning for equity-focused programming. This analysis across all MCSP countries showed that there were significant disparities in coverage by income, education, and urban/rural residence. These analyses also corroborated the Countdown to 2015 report that found that inequities are widest for those interventions requiring 24-hour access to

MCSP’s Equity Toolkit

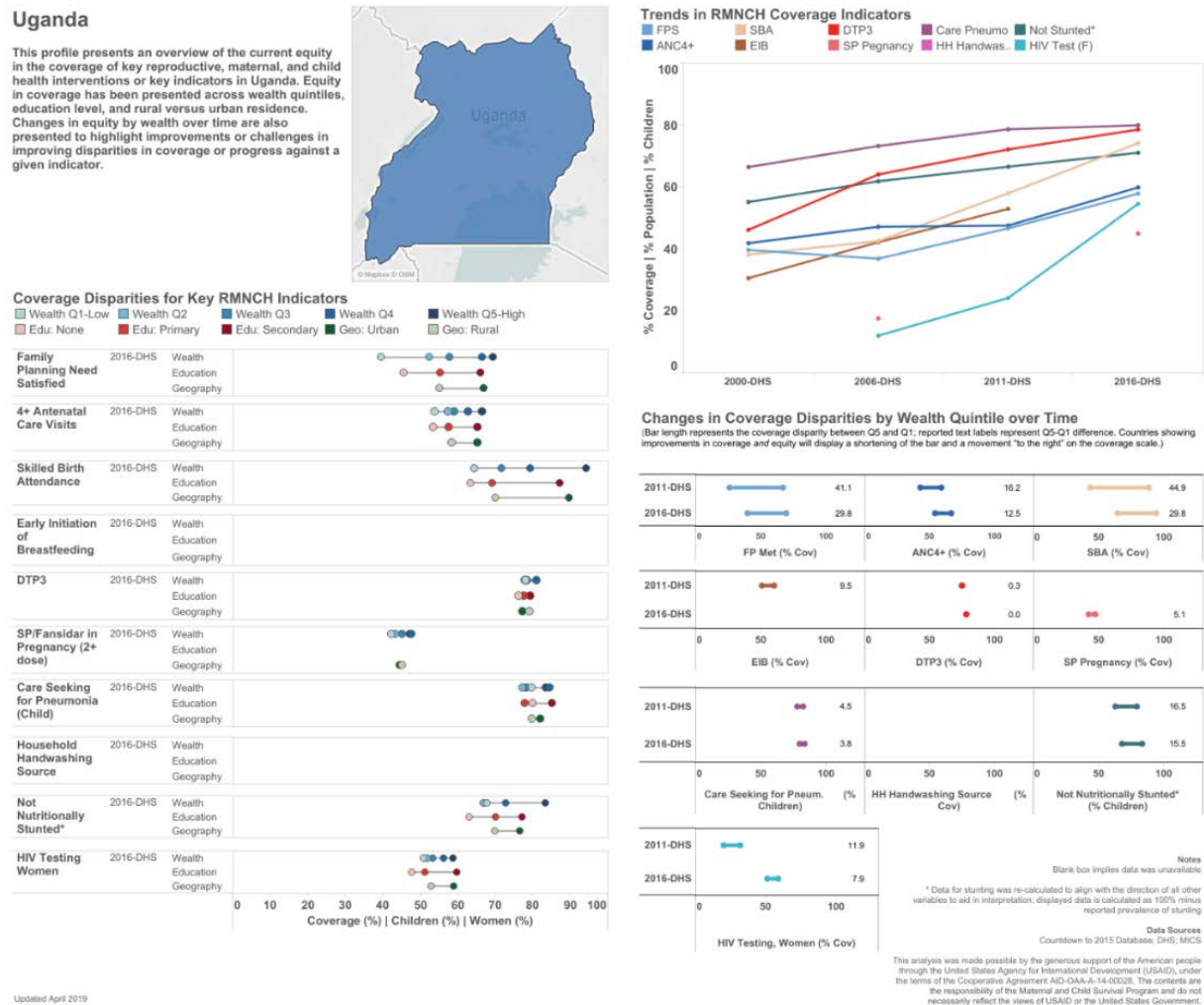
MCSP developed a comprehensive set of resources and tools in [A Practical Guide to Addressing Equity in RMNCH Programs](#). The toolkit aids implementing and country partners on approaches that can lead to the development of a coherent equity strategy as part of program design; the resource also includes tools for measuring inequities as part of programmatic implementation.

⁹ Liu L, Oza S, Hogan D, et al. 2015. Global, regional, and national causes of child mortality in 2000–13, with projections to inform post-2015 priorities: an updated systematic analysis. *Lancet*. 385(9966):430–40. doi: 10.1016/S0140-6736(14)61698-6

¹⁰ MCSP. 2019. *Increased Use of Child Health Services in Bas-Uele and Tshopo Provinces in DRC*. Washington, DC: MCSP.

health facilities. The dashboards are intended to help a range of stakeholders (e.g., USAID Missions, governments, and implementing partners) succinctly understand inequities in RMNCH intervention coverage and develop programmatic strategies to address them.

Figure 3. MCSP equity analysis dashboard, Uganda example



- In **DRC, Kenya, Mozambique, Nigeria, and Tanzania**, MCSP incorporated asset questions into [knowledge, practice, and coverage \(KPC\) household surveys](#) to construct a socioeconomic profile of survey respondents—usually mothers of children under 2 years old—and examine differences in KPC across different socioeconomic groups. The data from the surveys provided important knowledge to governments, implementing partners, and other key health-sector stakeholders in understanding national and/or subnational inequities among different socioeconomic groups, allowing for tailoring of programmatic strategies to help address them. One challenge of using KPC household surveys to measure equitable intervention coverage is that some high-impact interventions cannot be validly measured using household surveys (e.g., interventions at time of birth, such as newborn resuscitation), and they require substantial program implementation timelines to be able to conduct an endline survey that measures changes at the population level.
- In **Burma**, MCSP assisted the government to construct an [asset index tool](#) based on census data from over 10 million households, which allowed for the development of asset indices by state, region, and urban versus rural residence. The tool has been used by a social franchise network to determine the socioeconomic profile of its beneficiaries and in a study of out-of-pocket payments for health

expenditures to understand inequities in health expenditures. The tool can ultimately be used to inform targeting of a variety of social programs to key beneficiaries.

- In **Nigeria**, MCSP developed and tested multiple geospatial methods to improve planning to better reach underserved communities. In northern Nigeria's Bauchi and Sokoto states, which lack recent census data on population size and distribution, MCSP worked to apply geospatial modeling techniques to conduct [digital immunization micromapping](#) as part of the RED/REC microplanning. This technique provided 272 primary health care facilities with higher-quality data on their surrounding communities, affording them with actionable data to strengthen immunization outreach services to underserved and hard-to-reach communities. These two states scaled the geospatial mapping approach to all LGAs in their respective states. MCSP also developed and tested a [methodology using geospatial modeled surfaces](#) from the DHS and facility-level maternal health service availability data in Nigeria as a technique to identify areas of likely underserved communities through which to target pro-equity programming. The technique demonstrated promise as an activity implementing partners could conduct at the beginning of programs to reveal socioeconomic characteristics of communities near to health facilities and potential inequities in service availability.
- In **Nigeria** and **Guatemala**, MCSP examined women's experience of maternity care among underserved populations defined not only by wealth but also other characteristics—such as ethnicity, religion, and age—to tailor future respectful maternity care (RMC) approaches to better reach and improve the quality of care for these populations. These formative assessments triangulated qualitative and quantitative data from multiple sources (i.e., women, providers, community members, and managers) and revealed the mistreatment experienced by women giving birth in facilities and by the health workers who work in these facilities. Analytically, a bivariate analysis examining the relationship between indicators of RMC and sociodemographic characteristics of women and girls surveyed after giving birth in facilities in Guatemala (n = 140) and in Nigeria (n = 428) did not demonstrate any statistical difference among examined indicators (including report of verbal abuse and of receiving respectful care) and women's age, marital status, educational status, number of births, or primary language spoken at home (approximately 80% of survey respondents in Guatemala speak Ixil or K'iche' at home). However, one-third of Guatemalan women interviewed in the community (n = 38) cited belonging to an indigenous group as a reason for mistreatment in childbirth (34.2%). Some women interviewed and participating in community focus groups mentioned that Ladina (non-indigenous) women are treated better in childbirth and that poor women are more likely to be mistreated. In Nigeria, some women participating in community focus groups noted that certain groups of women are more likely to be mistreated in childbirth in facilities, including poor women, women belonging to a certain religion, and women who speak certain languages; specific results varied between Kogi and Ebonyi states. In Nigeria, the assessment provided important information to implementing partners and state-level officials on the current status of RMC and offered recommendations to incorporate stronger respectful care approaches into future programming. In Guatemala, a multistakeholder consultation brought together community members, facility health workers, and regional managers to review findings from the formative assessment, explore local drivers of mistreatment and person-centered care, and prioritize a set of local interventions to reduce mistreatment of women and health workers and improve respectful care for all women giving birth in facilities. More detailed quantitative and qualitative results are included in the forthcoming manuscripts, including implications for future RMC programming in the study settings.
- In **Kenya** and **Nigeria**, MCSP conducted analyses to identify equity gaps in routine immunization among urban poor in select cities. In Kisumu County, Kenya, an [assessment](#) helped county officials understand the routine immunization situation in poor areas of the city, challenges faced by health facilities providing services in slums, and barriers faced by the urban poor when accessing services. The findings provided critical information to county officials to tailor immunization approaches to better reach these populations. MCSP also conducted an urban immunization assessment in the [Bauchi](#) metropolitan area. As a result of the findings, the State Primary Health Care Development Agency began additional integrated outreaches to these communities to help increase equitable coverage. Experiences in both countries contributed to the development of urban-specific strategies with global, regional, and national policymakers through the UNICEF/Gavi-led Global Urban Immunization Working Group.

- MCSP also promoted the use of the [EquityTool](#)—a simplified measurement tool to assess the socioeconomic status of program beneficiaries or survey respondents using a simplified asset index from DHSs to generate wealth quintiles—in program assessments in select countries and refined training materials for the tool’s use. For example, MCSP employed the EquityTool in an assessment of the beneficiaries of a combined social and behavior change and community-based FP intervention in two regions in **Tanzania** through facility exit interviews. The assessment showed that community outreach on FP by community health workers tended to reach more women of lower socioeconomic status compared to those of higher socioeconomic status in one region.
- MCSP incorporated equity and gender as priority themes in the [Rapid Health System Assessment in Mozambique](#) and included information on equity considerations in assessments 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 was no routine data to monitor utilization by various groups beyond periodic DHSs, and there was no regular data to monitor whether equity was improving. Since aggregation of data in most low- and middle-income countries is done manually at the facility level, disaggregation by equity variables (e.g., age groups, location of residence) is often laborious or not possible given the lack of data collection on sociodemographic characteristics of patients in routine forms and the lack of equity disaggregators in national health management information systems.

Key Learnings

MCSP supported countries to design and implement high-impact pro-equity interventions and supported scale-up of those interventions to reach underserved populations. MCSP also facilitated the use of equity-related data to assess programmatic approaches to determine if these approaches were able to address barriers in accessing RMNCH services.

- MCSP provided support to 13 countries to introduce and/or scale up pro-equity interventions, which demonstrated the importance of shifting delivery channels of key RMNCH services to community-level platforms with appropriate referrals to higher-level care and engaging private providers to increase access channels among underserved communities. Key enabling factors of the scale-up of these interventions included engagement in national policy dialogue and policymaking processes, coupled with targeted support on health worker capacity development and system preparedness to introduce and scale them up.
- MCSP employed a variety of measurement-oriented strategies to generate evidence on the status of RMNCH inequities in supported countries while developing analytical techniques and tools, including institutionalizing many at country and subnational levels, to better measure characteristics of the beneficiaries of MCSP support. These measurement techniques were implemented across multiple RMNCH technical areas—including maternal health, FP, immunization, and child health—to provide evidence on the persistent equity gaps that must be addressed to achieve global RMNCH targets and goals.
- While MCSP worked to scale up pro-equity interventions at the community level, opportunities existed to better tailor the expansion of these services to the hardest to reach within a given district or administrative area. While MCSP worked within districts with populations of the lowest socioeconomic status or low geographic accessibility, there were challenges in expanding services to these populations. Increased measurement at the start of program could help to inform the development of clearer expected results related to reaching the most marginalized or difficult to reach in supported geographies.

Way Forward

More could be done to mainstream pro-equity and measurement approaches into regular program monitoring to better assess the equity impacts of interventions and approaches to reach underserved women and children. Rapid scale-up of recognized pro-equity interventions and more routine use of equity measurement strategies at national and subnational levels are needed to help countries reduce these persistent inequities in

RMNCH services. Institutionalization of these approaches will support progress on Sustainable Development Goals and countries' journeys to self-reliance. Specific strategies to achieve these goals include:

- Incorporate pro-equity targeting during initial program design, including identifying opportunities to support the scale-up process of pro-equity interventions at early stages.
- Identify equity gaps by socioeconomic status, geographic location, membership in religious or ethnic minorities, gender, age, or other characteristics at the beginning of program implementation to increase coverage of critical RMNCH interventions.
- Provide synthesis of extant equity data to ensure stakeholder buy-in, including country officials and USAID Missions, on the importance of equity, and to agree on equity and learning objectives at the beginning of programs.
- Incorporate equity measures into a broader program measurement strategy, including baseline, midline, and endline equity measurement, to assess program contributions to narrowing coverage inequities.
- Advocate for the inclusion of equity disaggregators into national health management information systems, if feasible, and support appropriate use of data.
- Support managers to use disaggregated routine data to identify underserved geographical areas and develop strategies for reaching those populations.
- Engage national and subnational private-sector entities to identify opportunities to provide key RMNCH services through private-sector entities to increase access to underserved communities.
- Where improved equity is an explicit program objective or expected result, employ more advanced equity measurement techniques, such as disaggregation of intervention coverage by wealth deciles to reveal more granular differences among different socioeconomic groups, use of absolute income in creating wealth quintiles/deciles, and examining data disaggregated by multiple dimensions of intersectionality (e.g., intervention coverage duly disaggregated by socioeconomic status and urban versus rural residence), to reveal more nuanced understandings of inequities to be addressed through programming.¹¹

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¹¹ Victora C, Boerma T, Requejo J, et al. 2019. Analyses of inequalities in RMNCH: rising to the challenge of the SDGs. *BMJ Glob Health*. 4: e001295. doi: 10.1136/bmjgh-2018-001295.