**Equity Oriented Health Research**

The Alma Ata declaration of Health for All in 1978 was underpinned by an explicit commitment to equity in both health and health care. In the years since, equitable access and resource distribution in health systems around the world continue to be a challenge. Yet, equitable health systems are a pre-requisite to achieving the Millennium Development Goals. In order to achieve equity in health, health research must be equity-oriented.

This module focuses on two key concepts:

1. Equity in health requires that we address differences in access to health care and health status that are unnecessary, avoidable, and unfair

2. Equity oriented health research is central to addressing disparities in access to health care and health status

**LEARNING OBJECTIVES**

1. To understand the role of equity oriented health research for describing, evaluating impact, and determining what works to improve equity;

2. To explore the different levels and axes of inequity that cause disparity in access to health services and health status;

3. To encourage reflection on how an equity perspective can be incorporated into research
**Key Messages**

- Equity oriented health research has traditionally focused on descriptions of inequity and disparity. More recently, movements have been made to evaluate the equity impacts of interventions and increasingly more work is now being done to identify interventions and policies which work to improve equity.

- To apply an equity lens to research, one must consider the multiple forces acting to create inequity including place of residence, race/ethnicity, occupation, gender, religion, education, socioeconomic status, social capital.

**Defining some terms**

Equity: fairness

Equality: sameness

Health Equity: the absence of systematic disparities in health between groups with different levels of underlying social advantage or disadvantage. Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair\(^1\). Health inequities put disadvantaged groups at further disadvantage. In Southern Africa, these typically relate to disparities across:

- racial groups;
- rural/urban status;
- socio-economic status;
- gender;
- age; and
- geographical region.

Horizontal Equity: the allocation of equal or equivalent resources for *equal need*\(^2\)

Vertical Equity: the allocation of different resources for *different levels of need*

The difference between inequality and inequity:

“...we expect young adults to be healthier than the elderly population. Female newborns tend to have lower birth weights on average than male newborns. Men have prostrate problems, while women do not. It would be difficult, however, to argue that any of these health inequalities is unfair. However, differences in nutritional status or immunization levels between girls and boys, or racial/ethnic difference in the likelihood of receiving appropriate treatment for a heart attack, would be causes for grave concern from an equity perspective.”\(^3\)

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\(^1\) EQUINET Definition – The Regional Network for Equity in Health in East and Southern Africa ([www.equinetafrica.org](http://www.equinetafrica.org))


**TOPIC 1: Why equity oriented health research?**

The ‘trickle-down’ framework\(^4\) of development and economic growth in the 1980s clearly failed in reaching the poor. Similarly, we can not assume knowledge and the impact of health research will trickle down to the most marginalized – therefore we must orient our work and analysis to specifically consider equity.

An equity orientation has the capacity to bring about significant changes in the health and well-being of poor communities globally.
- Health equity promotes national development
- Efficiency is improved when countries focus on those carrying the greatest burden
- Small investments and application of existing knowledge can create significant improvement for marginalised communities

COHRED\(^5\) highlights two elements of equity to consider:

**Equity in Health**
Marginalised communities bear a disproportionately large share of the global burden of disease. The benefits of health knowledge and research must become available and relevant to them. This is the fundamental challenge of all health research for development and should underpin actions to strengthen the health research system.

**Equity in Health Research**
Health research is inequitable. Disparity exists between developed and developing countries in terms of resources (human, financial, infrastructure) as well as in the capacity to interact and influence action at international and global levels. The challenge here is to ensure that research systems in developing countries have access to the resources they need to address their priority problems and to interact meaningfully on the global stage.

**EXERCISE 1**

Think about a population group that you know well (for example, a district or region in your country). How is health equity or inequity manifested? For example, in economic terms? Along gender lines?

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\(^4\) A term coined by US President Ronald Regan which suggests that economic growth and business success among the wealthy will ultimately trickle-down to benefit lower-income and more marginalized communities.

**TOPIC 2: What is equity oriented health research?**

Underpinning the Health for All movement at the 1978 Alma-Ata Conference, health equity has been part of the poverty reduction, reaching the poor, poverty-oriented programming and approaches over the last fifteen years. Initially, research focused on describing disparities:

- **A study of gender and health service use in Ghana highlighted the multiple axes of inequity between women and men: health status of women in the Ashanti region is lower than men, men are generally paid higher than women yet women are charged more for health services; finally health services are more inaccessible to women due to distance and required travel.**

Increasingly, research is tackling the impact of health interventions and policies on equity and disparity between groups:

- **A South African study of three districts implementing HIV services (VCT/PMCTC) found that use of services as well as support to these services were significantly higher in the urban district; rural and remote districts struggled to implement the services fully and were unable to expand access.**

Beyond description and measuring disparities, equity-orient research has the potential to investigate what works to improve equity.

- **Methods for achieving equity in allocating antiretroviral have been investigated using an optimal equitable allocation strategy (OEAS) in resource-constrained regions. This strategy is designed using the ARV rollout plan of the Government of South Africa and significantly improves equity in treatment accessibility in comparison with three other allocation strategies.**

Recently, the push has been toward integrating equity into health policy development. The WHO Task Force on Research Priorities for Equity in Health and the WHO Equity Team launched priorities for research to push forward the health policy agenda in December 2005.

**WHO Priorities for Research in Health Equity**

1. Global factors and processes affecting health equity;
2. The societal and political structures and relationships that differentially affect people’s chance to be healthy within a given society;
3. The interrelationships between individual factors and social context that increase or decrease the likelihood of achieving and maintaining good health;
4. Factors within the health care system that influence health equity; and
5. How to influence factors 1-4 effectively – such as the identification of policy interventions with the potential to reduce inequities in the determinants of health and health care.

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There are many ways in which health care access and health status can be inequitable; these include income level (poverty), urban/rural location, gender, race or ethnicity, and other minority status. These may be layered to form multiple levels of marginalization (for example gender and race can interact with poverty so that within the poor, women in general and minority women in particular have poorer health status). They have complex effects on health seeking behaviour, access to services, ability to adhere to treatment and other determinants of health status, all of which need to be understood in order to make health systems more equitable.

"At this stage, equity is a vision which is certainly not easy to achieve. In addition, many of the inequities in our society remain masked rather than obvious to those who administer or manage the health services, and those who use them. It is important therefore to establish ways of looking at existing data and service provision in such a way that inequities become apparent. This is done by adopting what has been called an Equity Lens or perspective." (GEGA 2004 - emphasis added)

Exploring the effect of stratifiers on health is the principal role of an equity lens. An equity lens provides a perspective which moves analysis beyond population averages toward analysis of social groups compared to targets and to each other.

Equity Stratifiers – an example of an equity lens
- Place of residence (e.g., rural, urban, inner-city);
- Race/ethnicity/culture
- Occupation
- Gender
- Religion;
- Educational Level;
- Socioeconomic Status;
- Social Capital (e.g., availability of neighbourhood support, social stigma, civil society)

An equity lens may be used at multiple levels: local; district/province; national; continent; global. Data sources which can be analysed with an equity lens include Household surveys (World Health Survey, MICS), Vital Registration Systems, and Demographic and Health survey data.

**Exercise 2**

Think about the population group you identified in Exercise 1. Review the equity stratifiers and decide which 1 or 2 are most relevant for this population? Why is this the case?

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10 This topic note developed from: GEGA. 2004. Health Equity – Research to Action : Course Reader. Global Equity Gauge Alliance, South Africa
**Topic 4: Benchmarks of Fairness**

The Benchmarks of Fairness instrument is an evidence-based policy tool to evaluate the effects of health system reforms on equity, efficiency and accountability.

“The Benchmarks of Fairness instrument is a method for evaluating the fairness of health-sector reforms. The concept of fairness in health systems is broad, integrating the goals of equity in access and financing, clinical and administrative efficiency, and accountability. The Benchmarks address the complaint that “it is unfair” when the system treats some patients differently from others with similar needs, when some needs are not met because of administrative inefficiency, or when people have no say in how the system treats them. Fairness involves various claims about what people are owed as a matter of justice.” (p. 534)

There are nine benchmarks:
1. Intersectoral public health
2. Financial barriers to equitable access
3. Non-financial barriers to access
4. Comprehensiveness of benefits and tiering
5. Equitable financing
6. Efficacy, efficiency and quality of health care
7. Administrative efficiency
8. Democratic accountability and empowerment
9. Patient and provider autonomy

**Adapting Benchmarks Locally**

In Cameroon district medical officers, Ministry of Health officials, and academics came together in 2002 to adapt the benchmarks. In the process the focus was on 7 of the benchmarks and 70 criteria – 73 indicators were selected for these criteria. Indicators were restricted to data that could be collected by medical students – an important element for cost as well as educational value.

In order to use the benchmarks and associated criteria it is expected that an interdisciplinary team will be brought together within a country. The intent is for the team to be comprised of policy makers, academics, health-systems personnel, clinicians and civil society groups. This team then considers the purpose of using the benchmarks (for example, measuring comprehensive health sector reforms, or district variation in implementation of reforms). The benchmarks thus become locally-adapted; cross-country comparisons are not possible.

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This topic note developed from:
ILLUSTRATIVE STORY FROM AFRICA

Monitoring Equity in Health and Health Care in Developing Countries
The Development of Zambia’s Health Equity Gauge

"An Equity Gauge is an approach to promoting equity which includes monitoring of key indicators, coupled with advocacy and community participation to ensure that information is acted upon."

The Equity Gauge initially began as a national project in South Africa to help measure improvement in health as well as whether health and health care is provided in a fair and equitable manner. In 2000, twelve new Equity Gauges joined (Chile, Ecuador, Peru, Burkina Faso, Kenya, Zambia, Zimbabwe, Bangladesh, China, Thailand, India, and Cape Town City Equity Gauge).

In Zambia, the development of an Equity Gauge has the purpose of working at district, provincial and national levels, to monitor health and health service delivery across social strata including: gender, socio-economic status, religion, geographical location, provinces and districts. Specifically, the Gauge advocates equity in health and monitors the policies on and provision of health services in Zambia. The ultimate aim of which is to ensure that issues of equity in health and health service delivery are considered and taken into account both at the policy, planning and implementation levels.

In the years since it’s creation, the Zambian Equity Gauge has successfully developed quantitative and qualitative methods for capturing community perceptions of unmet health needs and quality of health services. McCoy et al. 2003 captured the story:

“Following public dissemination of the Zambia Gauge's assessment of health equity in four districts (Chama, Lusaka, Choma, Chingola), health-sector decision-makers withdrew a proposal to raise user-fees, and a fascinating saga has subsequently unfolded. Based on the publicity engendered by the Zambia Gauge's work, the Health Committee of the Zambian Parliament called for ending user-fees altogether. This move, however, met resistance from health workers in urban areas, who saw the user-fees as the only feasible means of maintaining services. The Gauge has responded with renewed efforts, involving drama, dance, songs, and poems, to make officials aware of people's perspectives on health equity. This story continues--a top official in one district was so moved by the people's testimony captured by the Gauge that he has committed to instituting measures to increase health workers' sensitivities to people's concerns. The Portfolio Committee on Health sees the dramas as a mechanism to strengthen advocacy for health equity within the legislature, since it provides a form of public feedback on priorities and creates political pressure for response.”

LEARNING MODULE MINI-ASSIGNMENT

The World Bank Health, Nutrition & Population program has a series of country profiles on health, nutrition and population status in most low-income countries, by quintile.


Using your reflections from Exercise 1 and 2 – look through the available data and indicators.

- What indicators capture equity?
- What do these indicators illustrate about health equity in your country?
- What are the significant gaps in the data in your country? In the indicators?
- What indicators could be added to improve the health equity measurements?
- Are there indicators that would allow you to go beyond the common or the above description of equity and better analyse the impact of an intervention? What would be needed in the way of indicators to do such an analysis?
**Annotated Readings**

- Reviews the Benchmarks of Fairness instrument and uses case studies from Cameroon, Ecuador, Guatemala, Thailand and Zambia.

- Argues that health systems can be made more equitable by:
  - improving health financing systems
  - revising national health system objectives that are more relevant to the conditions of the poor (including women, men and children);
  - applying the lessons learned from several innovative efforts to reach the poor more effectively (than traditional approaches)
  - empowering poor potential clients of health systems to play a more central role in the design and operations of systems

- This book provides perspectives on the scale and nature of health inequities in 13 countries and assessments of relevant policy developments and their implications. It explores the ways that health status is affected by gender, broader social determinants and globalization.

- A course reader focused on health equity with key references as well as details on the Global Equity Gauge approach.

- Highlights the need for health systems research, the importance of engaging citizens, and the need to address the power imbalance within the global research community.

**Tools and Resources**

1. The Network for Equity in Health in Southern Africa (Equinet)
   - Initiated in 1997, Equinet is dedicated to influencing both national and regional policies of the countries of the Southern Africa Development Community (SADC). It does so by networking professionals, civil society and policy makers
to promote policies for equity in health, undertaking research, initiating conferences and workshops, conducting internet-based discussions, and providing inputs at the SADC forums. An extensive body of reports is available through its website.

Website:  www.equinetafrica.org

2. GEGA: The Global Equity Gauge Alliance
This alliance supports teams (called “Equity Gauges”) in 11 countries, engaged in monitoring health inequalities and promoting equity within and between societies. African teams include: the African Population Health Research Council (Kenya); University of Western Cape (South Africa); University of Ouagadougou (Burkina Faso). Also included are political bodies such as the Parliamentary Committee on Health (South Africa) and the Urban Slums Development Project (Nairobi, Kenya).

Website:  http://www.gega.org.za/

3. Governance Equity and Health, International Development Research Centre
GEH examines health systems through a governance lens and, conversely, uses health as an entry point to approach challenges of governance – how power is exercised, how decisions are taken, how citizens have their say.
Available at:  http://www.idrc.ca/en/ev-3073-201-1-DO_TOPIC.html
Also in French:  http://www.idrc.ca/fr/ev-3073-201-1-DO_TOPIC.html

Research Matters in Governance, Equity and Health – an initiative of GEH/IDRC and the Swiss Agency for Development Cooperation – brings together researchers and research users to explore how research is used? Implemented?
Available at:  http://www.idrc.ca/en/ev-54056-201-1-DO_TOPIC.html
Also in French:  http://www.idrc.ca/fr/ev-54056-201-1-DO_TOPIC.html

4. INDEPTH Network: An International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries
INDEPTH aims to harness the collective potential of the world's community-based longitudinal demographic surveillance initiatives in resource constrained countries to provide a better, empirical understanding of health and social issues, and to apply this understanding to alleviate the most severe health and social challenges. INDEPTH has 26 sites in Africa, in the countries of Burkina Faso, Gambia, Ghana, Guinea Bissau, Senegal, Ethiopia, Kenya, Tanzania, Uganda, Malawi, Mozambique, and South Africa.

Website:  http://www.indepth-network.org/
What did you think of the module?

Evaluation and Feedback

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