

Policy Brief

June 2012

Learning from stakeholders for health equity

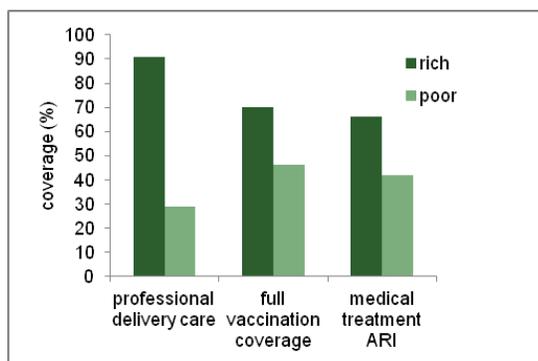
Background

Progress towards the Millennium Development Goals (MDGs) has been highly uneven. Marginalised groups lag behind others for most MDGs, particularly in maternal and newborn health.

While effective interventions are known, they rarely reach those most in need. Fresh evidence is needed to understand what works, where, and why. Policy-makers and practitioners have valuable experience of what does and does not work to reduce health inequalities. Unfortunately, this tacit knowledge is rarely written up and shared.



Roundtable meeting with stakeholders in Nepal



Global inequalities in health care use

We collected, synthesized, and shared experiential evidence of a large group of stakeholders with real-life experience in policy-making and implementation. We conducted 7 roundtable discussions in India, Nepal, Bangladesh, and Malawi, and 11 in-depth interviews with international stakeholders, including health policy analysts, medical experts, funders, national and international NGO heads, and government representatives.

Key findings

Stakeholders recognised the existence of health inequalities and the importance of addressing them. While the aims of some organizations were explicitly to reduce inequalities, others were framed within the broader goal of improving average outcomes.

Barriers to reaching lower socioeconomic groups

- *Availability of services, access to care and quality*

In rural and isolated areas, inadequate distribution of health institutions makes it difficult to provide interventions and access to health services. Increases in urban populations have not been met with a proportionate rise in infrastructure.

Poverty, cost and quality of health services are key barriers preventing marginalised groups from accessing care. Services not covered by subsidised schemes are often unaffordable to lower socioeconomic groups. Poor quality care deters some from seeking care at public institutions and others go to private providers, where costs are also high and quality is unknown.

EquiNaM uses an integrated approach to support equitable improvement in newborn and maternal health, by (i) **generating evidence** using high-quality data, and (ii) **learning from and engaging with stakeholders**.

<http://equinam.global-health-inequalities.info/>

- **Programme planning and implementation**

Some programmes suffer from a limited capacity of management to plan, innovate, scale up, learn from mistakes, and take corrective action to meet programme objectives. Policy makers and programme planners often fail to tailor strategies to different groups.

- **Social and cultural barriers**

Class, caste, gender, illiteracy, and poor awareness of entitlements contribute to inequality and access to health interventions. Poor perceptions and experiences of services are also potential barriers to seeking care.

What works well to reach lower socio-economic groups?

- **Identifying vulnerable groups**

Stakeholders generally agreed on the importance of identifying vulnerable groups in order to implement appropriate interventions.

- **Improving health services**

Increasing the availability of facilities, starting with poor urban and remote rural areas, will improve access to health services. The provision of free or inexpensive services helps removing financial barriers to seeking care. Improving the quality of provider-patient interaction, in particular for patients from lower socio-economic strata, e.g. by working with community-based organisations to monitor quality of care, can encourage care-seeking.

- **Community-based strategies, participation and engagement**

Community or 'frontline' workers are able to reach out to marginalised populations. Their common background and characteristics mean that residents can identify with them. In addition, programmes which focus on the home and community can effectively facilitate upward linkages to health services. Intervention strategies have been successful in several countries when communities were engaged at all levels using a bottom-up approach. Some stakeholders felt it was important for communities to implement and monitor programmes aimed at them.

Gaps in evidence

- **Information on equity**

More, good quality, disaggregated data are required to understand, monitor and address inequalities and ensure that benefits reach those most in need.

- **Evidence of 'what works'**

There is a clear need for more evidence on which health programmes and interventions 'work' and about areas where health systems and programmes are functioning well. More evidence is needed on what projects look like when they are scaled up, and what their requirements and impacts are.

- **In-depth qualitative research**

There is a need to understand how local beliefs and practices, and experiences of health interventions deter some people from using services.

Conclusion

A number of supply- and demand-side barriers prevent health interventions from reaching lower socioeconomic groups. At the same time, there is evidence of effective strategies to reduce inequalities. We need to harness, expand and share this experiential knowledge to make further progress.

Recommendations

Our key recommendations are:

- Identify vulnerable communities at the country, state and district level, and design programmes bearing their needs and circumstances in mind.
- At the national and local level, and in programs and projects, collect disaggregated data by socio-economic position and monitor the equity impact of interventions.
- Take services to people's 'doorsteps', for example using frontline or community-based health workers.
- Engage with the community throughout interventions, to ensure its needs are met and that program design corresponds with local realities, and to create awareness about available services.
- Governments should target lower socio-economic groups within a framework of universal coverage.

Project partners:

Centre for International Health & Development, University College London; SNEHA (India); Ekjut (India); PCP-BADAS (Bangladesh); MIRA (Nepal); MaiMwana (Malawi).