

Discussion Paper on Equity for the HIP Partnership



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Introduction

Equity, one of eight guiding principles of the Family Planning High Impact Practices (HIP) Partnership (Box 1), is an important aspect of family planning programming (UNFPA, 2017; IPPF, 2017). For over 50 years programs have sought to improve equity in access to contraceptives and family planning services by providing free or subsidized services and through innovative programming to reach disadvantaged groups (Shah and Chandra-Mouli (2007).

During the last 20 years, eliminating inequity has been the focus of the Millennium Development Goals (MDG), the Sustainable Development Goals (SDG), and Universal Health Care (UHC) by ensuring equity is a component. For family planning, achieving UHC “entails making services....available to people who have been excluded from them because of cost, gender or geography.” (UNFPA, 2017: 79). To attain universal health care, the Guttmacher-*Lancet* Commission on SRHR noted that “equity in access means that everyone should have access to and receive coverage, not only those who can pay for them... [with] priority to reforms that address inequities from the outset, benefitting less advantaged people to an equal or greater degree than those who are more advantaged” (Starrs et al. 2018: 2651).

Box 1. Equity in the HIP Partnership

“Striving to identify and understand the social, ethnic, financial, geographic, linguistic, age-related and other barriers that may hinder the use of care and the voluntary use of contraceptives, and adjust programs to correct these disparities”¹

While many research papers make claims of effecting equity in family planning by reaching disadvantaged groups, questions have been raised at past HIP Technical Advisory Group (TAG) meetings regarding use of the appropriate methods to make such claims. Questions about how equity for family planning is defined have also been raised in TAG meetings. Given that equity will and should be an increasingly important focus of family planning programs, the HIP Partnership should consider how to communicate the evidence base on what works to address equity. In order to do that, we must first examine how equity is defined, including by the family planning community, and what evidence exists of its successful incorporation into programs. This work is intended to help the TAG think about the issue of equity in reviewing and synthesizing evidence.

This discussion paper, which builds on earlier work presented to the HIP TAG,² is centered around four questions: 1) how is equity defined for health and family planning, 2) what are the frameworks for conceptualizing equity, 3) what are the measures relevant for family planning programs, and 4) what evidence is needed to assess the impact of HIPs on equity. The paper also notes useful resources on equity programming and measurement, and provides references.

¹ In addition to equity, the other seven principles are: volunteering for family planning use, informed choice, choice of contraception, client-centered approach, high quality, continuity of care, and gender equality (<https://www.fphighimpactpractices.org/overview/>)

² Stratton, Askew, and Eber. 2015, “Reaching the Underserved: Guidance for Evaluating Evidence for Inclusion in HIP Briefs.” Unpublished concept note.

Methods

We extensively reviewed literature on equity in health and family planning, such as policy papers and long-term secondary analyses. Additionally, we conducted a literature review in order to determine how equity has been assessed in studies of family planning and other health areas. Bibliographical databases (PubMed, POPLINE, Scopus, Google Scholar, Cochrane Database of Systematic Reviews, Africa Journal Online, USAID DEC, and Lilacs among others) were searched using the following search terms and their derivatives: equity, inequity, marginalized populations, adolescents, youth, young people, and minority. We focused on evaluations and intervention research where the outcomes were related to health and equity outcomes. Equity outcomes focused on behaviors and impacts of behaviors only. Outcomes did not include equitable beliefs or attitudes. For the literature on interventions, papers that did not include basic methodology of how equity was measured were excluded.

There were some limitations to this literature review. The limited search terms may not have picked up studies where equity was a secondary outcome or where other terms were used when discussing the study population, such as underserved. The search was also limited to English-written evaluations and intervention research published between 2000 and 2018 from low or lower-middle income countries.

How Equity Is Defined for Health and Family Planning

Defining Equity for Health

Definitions of equity emanate from the right to health, first articulated in the 1946 Constitution for the World Health Organization, emphasizing equity by noting that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (OCHCR, 2008: 1). The 1948 Universal Declaration of Human Rights and the 1966 International Covenant on Economic, Social and Cultural Rights reiterated the right to health, and included attention to equity. As an extension of the right to health, USAID (ND) writes that “equity in health is the notion that everyone should have a fair opportunity to reach his or her full health potential.”

However, there is some question about the difference, if any, between inequality and inequity (WHO, 2015). While there can be differences in health among different groups of people (e.g. younger people tend to have better health than older people due to the aging process), Whitehead (1992) explained that inequities in health are those that are avoidable, unnecessary and unjust.

Inequities in health are those that are avoidable, unnecessary and unjust (Whitehead, 1992)

Whitehead and Dahlgren (2006) note that the term inequality is used, particularly in Europe, to also connote health differences that are unfair and unjust. They write that “three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are *systematic*, *socially produced* and therefore modifiable, and *unfair*” (Whitehead and Dahlgren, 2006: 2). WHO’s definition of equity reflects these three dimensions.

“Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. ‘Health equity’ or ‘equity in health’ implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential” (WHO, ND).

A WHO publication titled, *State of Inequality Reproductive, Maternal, Newborn and Child Health*, notes that, “overall, inequalities were to the detriment of women, infants and children in disadvantaged population subgroups; that is, the poorest, the least educated and those residing in rural areas had lower health intervention coverage and worse health outcomes than the more advantaged” (WHO, 2015: xii). In its 2017 report, *Worlds Apart Reproductive Health and Rights in an Age of Inequality*, UNFPA also used the term inequality to represent differences that are unfair. UNFPA (2017:19-20) link inequality in family planning with wider inequalities for women, writing that, “unintended pregnancy constrains opportunities that women would otherwise have for education, civic participation and economic advancement.” In the United States the term “disparity” is used to connote the same meaning as inequity. Other terms that have been used related to equity and family planning include ‘underserved,’ and ‘vulnerable’ (IPPF, 2017). Marmot (2006) describes a social gradient in a range of health outcomes in both developed and developing countries that favors the wealthy and those in more favored social positions (e.g. more highly educated). This social gradient often appears in analyses of contraceptive use (Malarcher et al., 2010; WHO, 2015).

Defining Equity for Family Planning

Building on the right to the highest attainable standard of health, WHO (2014) and FP2020 (2014) articulated what equity means as it relates to family planning and contraceptive services. Box 2 shows the definition of equity provided by the FP2020 Rights and Empowerment Working Group.

Equity in family planning does not mean that all groups use contraception – or certain methods of contraception – necessarily at equal rates. Equity for family planning implies that all groups have the same access to information and services, and to all available methods of contraception, and that they are able to make decisions about their fertility and their use of contraception and act on those decisions. Equity implies that all groups have the same access to quality services, including removal of contraceptives, and that there are no differences in how they are treated by providers.

Box 2. Equity and Non-Discrimination for Family Planning

“Individuals have the ability to access quality, comprehensive contraceptive information and services free from discrimination, coercion and violence. Quality, accessibility and availability of contraceptive information and services should not vary by non-medically indicated characteristics, such as age, geographic location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital or other status.” FP2020, Rights and Empowerment Working Group, 2014: 3.

In this regard family planning differs from other aspects of health. For example, uniformly high use of bed nets for malaria prevention, or use of skilled attendance at birth for improved maternal health outcomes,

are both equitable outcomes. Uniformly high use of contraception is equitable only if it adheres to the choices of individuals in the groups covered with the family planning services.

Gillespie et al. (2007) used Demographic and Health Surveys (DHS) data to examine whether higher fertility and lower contraceptive use among the poorer segments of society in 41 countries is an inequality (based on different fertility desires) or an inequity (based on being prevented from achieving fertility desires to the same degree among groups). The authors analyzed unwanted fertility (the difference between wanted fertility and actual total fertility) and availability of family planning services (radio exposure to family planning messages; knowledge of a family planning source, contact with a family planning fieldworker) for poorer and wealthier segments. They note four characteristics that must be present for a condition to be an inequity:

1. It must be disproportionately present in a disadvantaged population relative to better-off population segments;
2. It must be amenable to effective interventions;
3. It must be undesirable; and
4. Interventions to relieve or lessen this condition are less available to the disadvantaged than to wealthier populations.

Frameworks for Conceptualizing Equity

There are three types of frameworks that are useful for conceptualizing equity, including those that define equity, those that identify the dimensions of equity, and those that assist in operationalizing programming, along with research and evaluation. The context and purpose will help determine which framework is most appropriate to use in a given situation.

Framework for Defining Equity

The predominant framework for defining equity is a human rights frame and a fairness lens, as noted in the previous section of this paper. “From an ethical and human rights perspective, narrowing avoidable disparities in health is imperative” (Wirth et al., 2006: 519). Frameworks for addressing equity need to take into consideration its multiple dimensions.

Framework for Identifying the Dimensions of Equity

While poverty most often comes to mind when thinking about inequity, in fact there are many dimensions of disparities that can lead to inequities. Many authors note the need to address these multiple dimensions as disparities generally compounded in people’s lives (Braveman and Gruskin, 2003; Ahmed et al., 2009; MCHIP, 2011).

Evans and Brown coined the acronym PROGRESS to refer to the dimensions of health inequity, including by **P**lace of residence, by **R**ace, by **O**ccupation, by **G**ender, by **R**eligion, by **E**ducation, by **S**ocio-economic status, and by **S**ocial Capital. Gwatkin (2007: 348) notes that this list is “an important reminder that health equity has many significant dimensions beyond the gender and economic ones that have come to dominate the literature” (Gwatkin, 2007: 348).

A useful framework that categorizes the various dimensions of inequity comes from Healthy People 2020 In the United States, which defined health disparities as: “a particular type of health difference that is closely linked with economic, social, or environmental disadvantage” (Braveman, 2014: 2). This framework is useful to categorize the dimensions of inequity noted in relation to the right to the highest attainable standard of health (Table 1) and to help identify relevant methods for measuring outcomes of interventions to reduce inequities.

Table 1. Types of Inequity/Disadvantage		
Economic	Social	Environmental
Wealth/ poverty/ socio-economic status	Sex	Geographic location (e.g. rural, remote, slum)
	Age	Environmentally degraded area
	Education	Humanitarian setting
	Marital status	
	Race/ethnicity	
	Language	
	Sexual orientation	
	Disability	
	Other social marginalization	

Frameworks for Operationalizing Equity in Programming

A number of frameworks exist for operationalizing equity in programming. These frameworks generally call for identifying groups that face disparities and analyzing the disparities, designing programs to address them, and evaluating the results. By benchmarking the disparities compared to a better-off group, improvements in equity can be assessed.

WHO Priority Public Health Conditions Analytic Framework

WHO’s Priority Public Health Conditions Analytic Framework was developed for its work on the social determinants for health (Blas and Kurup, 2010). The framework, shown in Figure 1, operates at five levels that require analysis and (potentially) interventions. These include:

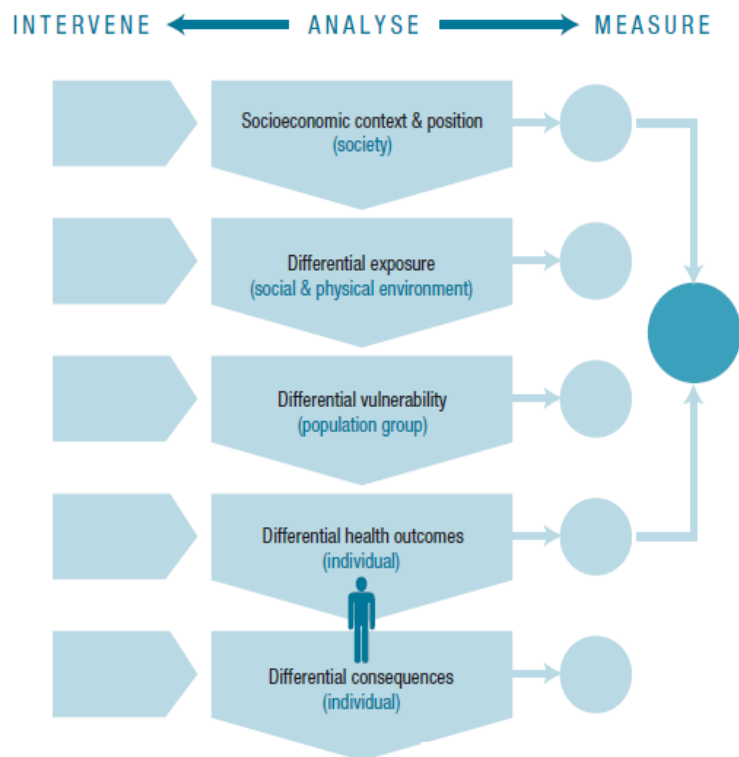
- Socioeconomic context and position, which addresses the influence of power, laws and policies, and social position on health in society and differential health status among groups within society.
- Differential exposure, which implies that groups in societies face varying exposure to risk (material, psychosocial and behavioral) in relation to their social position.
- Differential vulnerability, which means that the same level of exposure can have different effects on groups of people depending on their circumstances, including their social, cultural, and economic factors, and to individual circumstances and life experiences. Gender dynamics play a critical role in issues related to vulnerability and exposure and vulnerability.

➤ Differential health outcomes.

“Equity in health care ideally implies that everyone in need of health care receives it in a form that is beneficial to them, regardless of their social position or other socially determined circumstances. The result should be the reduction of all systematic differences in health outcomes between different socioeconomic groups in a way that levels everyone up to the health of the most advantaged” (Blas and Kurup, 2010: 7).

➤ Differential consequences, implying that different groups, depending on their circumstances, will face differing consequences of poor health outcomes.

Figure 1. WHO Priority Public Health Conditions Analytical Framework



Source: Blas and Kurup, 2010.

For its analysis on the social determinants of health for different health areas, the framework calls for analysis to establish and document:

- Social determinants at play and their contribution to inequity, for example pathways, magnitude and social gradients;
- Promising entry-points for intervention;
- Potential adverse side-effects of eventual change;
- Possible sources of resistance to change; and
- What has been tried and what were the lessons learned.

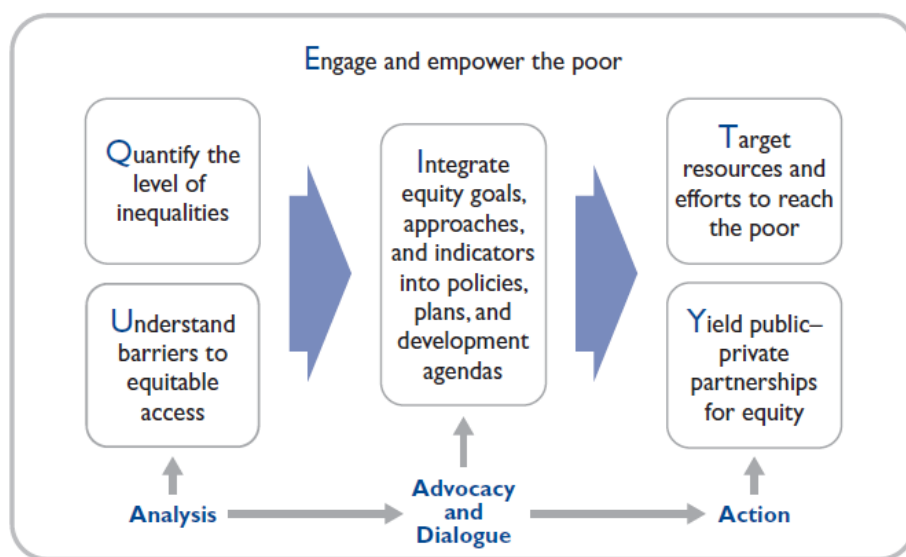
Malarcher et al. (2010) used this framework to assess equity and social determinants associated with unintended pregnancy and pregnancy outcome. They found that the poor are disproportionately affected by the consequences of unwanted pregnancy and childbearing and that vulnerability to unintended pregnancy is closely linked to access to contraceptive information and services in addition to experience of unwanted sex. They note that addressing unintended pregnancy and improving outcomes will require intentional interventions designed to achieve equity, “especially targeting the poor and disadvantaged for access to contraceptive and skilled birth attendant services” (Malarcher et al., 2010: 178).

EQUITY Framework

The EQUITY framework was developed by the USAID-funded Health Policy Initiative (HPI), to promote a pro-poor focus in reproductive health and family planning policy and programming. The framework, shown in Figure 2, has six elements: **E**ngaging and empowering the poor in addressing disparities; **Q**uantifying the levels of inequalities faced by the poor; **U**nderstanding the barriers they face in accessing services equitably; **I**ntegrating equity into policies, programs and development agendas; **T**argeting resources to focus on pro-poor strategies; and **Y**ielding to public-private partnerships to ensure that the total market is served. While this framework was developed as a pro-poor strategy, the framework is adaptable to use to address disparities in addition to poverty (e.g. residence, age, ethnicity, etc.).

The EQUITY Framework was used in Kenya to help guide programming starting in the late 1990s. Using that framework among other sources, the government of Kenya and development partners implemented a strategy to reach the urban poor; in contrast to the period 1993-1998, between 2003-2008/09 there was a significant change in contraceptive use that resulted in “virtually no gap between the poor and the rich in 2008/09” (Fotso et al., 2013: 1). They found that this narrowing of poor-rich gap in Kenya has also been seen in other health outcomes.

Figure 2. EQUITY Framework



Source: Health Policy Initiative.
http://www.healthpolicyplus.com/archive/ns/pubs/hpi/1271_1_EQUITY_Overview_Poster_FINAL_Sept_2010_acc.pdf

Other useful resources for programming and monitoring and evaluation to address equity are found in the resources section.

Measures of Equity Relevant for Family Planning Programs

This section discusses analyses to define the three dimensions of inequities and measures of equity relevant for family planning. The section begins with a discussion of studies from the literature that measure inequities in family planning but do not focus on interventions. The methods used to measure changes in the three dimensions of equity are also described. The section then presents findings from the eight studies that included family planning in the literature search on interventions to improve equity. The section concludes with an analysis of equity in existing HIP briefs.

Analyses and Methods Used to Measure Changes in the Dimensions of Equity – Economic, Social, and Environmental

Economic

Although the HIP briefs suggest that family planning programming addresses the various dimensions of equity, most studies have focused on economic inequity. Measurement of wealth quintiles in the DHS has rendered economic equity straightforward to measure (Rutstein and Saveteig, 2014); its use is widespread in family planning studies.

A number of studies use wealth quintiles to assess equity gaps. Ross (2015) assessed changes in the gap in contraceptive use, total and wanted fertility, and ideal number of children between the wealthy and the poor over time in 46 countries over a roughly 14-year period and assessed the findings in relation to family planning effort scores. Ross concludes that “it is heartening that the ‘equity gap’ in contraceptive use is narrowing in most countries and narrowing more where program efforts, especially for access to methods, are stronger” (Ross, 2015: 434). Ross posits that “stronger” programs are mostly those that have been around longer and thus are now also more effectively reaching the poor, whereas national programs in earlier stages often initially reach urban, wealthier clients first. Indeed Ross found that inequity has risen in some African countries with programs that are in more nascent stages.

Assessment of changes in demand satisfied for modern contraception among groups (e.g. the lowest and highest wealth quintiles) over time is an indicator of progress in reducing inequity. In such an analysis of around 155 developing countries roughly over a 10-year period for each country, UNFPA (2017) showed that in most countries, progress is being made both in increasing demand satisfied and in reducing the gap in demand satisfied between the highest and lowest wealth quintiles. They show, using equiplots, changes in the gaps among wealth quintiles in demand satisfied.

Alkenbrack et al. (2015), in an analysis of equity in reproductive and maternal health service coverage (including mCPR and demand met for modern contraceptive methods) in 74 lower- and middle-income countries during the Millennium Development Goals era, found that higher education and greater political commitment (measured as the share of government spending for health) were associated with increased equity in service coverage. Their analysis, which had in its denominator women with a need for the respective services, measured use relative to need, in other words, demand satisfied.

Many studies of equity include use of the Concentration Index. As explained by Chakraborty et al. (2013), the Concentration Index uses one summary value to capture the magnitude of socioeconomic inequality in a health outcome. The concentration index ranges from -1 to +1, based on a Lorenz concentration curve that orders the population by SES on the x-axis and plots the cumulative percentage of a health outcome on the y-axis. With zero signifying perfect equality, a negative value represents the health outcome’s concentration among the poor; a positive value denotes concentration among the wealthy. As the concentration index moves further away from zero, either positively or negatively, there is greater inequity in the health outcome. The concentration index offers advantages as a metric of health equity because it is statistically comparable across time periods and geographic regions. Thus a concentration index can measure whether family planning use is greater among the poor or non-poor and the degree of inequity between them.

Involving the private sector has been promoted as a means to increase access to family planning. Hotchkiss, et al. (2011) explored the effect of expansion in private sector provision of contraceptive supplies on what they term “horizontal inequity” in use of modern contraceptives. They defined horizontal inequity as unequal use for equal need for family planning. They used DHS data from four countries, Nigeria, Uganda, Bangladesh and Indonesia, to assess the degree of both inequality and inequity over time using the Concentration Index among wealth quintiles. The study controlled for differences in the need for family planning in relation to household wealth. Need was controlled by deriving need-expected probabilities of using modern contraceptives, which were used to calculate need-standardized contraceptive indices. The study found that expansion of contraception through the private commercial sector, thus increasing access, decreased inequity in use of contraceptives over time in Nigeria and Uganda, and that inequity, which was already low, fluctuated over time in Bangladesh and Indonesia. They note that “a contribution of the study is that we control for the need for family planning services, which could potentially vary by socio-economic status and as a result, lead to differences between mCPR inequality, which is based on actual use, and mCPR inequity, which is based on need standardized use” (Hotchkiss et al., 2011: 8).

Other poverty assessment, or poverty grading, tools have also been developed. These tools can be used to screen for eligibility to benefit from or be “served by” a program – such tools have been commonly used in voucher and

similar programs. Assessments of the proportion of beneficiaries who are classified as poor can indicate the efficiency of the screening tool and program in reaching its desired beneficiaries (see Box 3).

Social

While many family planning studies control for social factors, fewer studies have assessed shifts in equity based on social factors. Social inequities, such as by sex or gender, by age or marital status, by education, by race/ethnicity, by migrant status, by disability, by sexual orientation, or by some other social marginalization, can also be assessed through absolute and relative gap analysis.

Box 3: Tools for Assessing Equity

Poverty Assessment Tool

MSI uses a poverty assessment tool to guide their programming to reach the poor through mobile outreach teams to reach remote and rural areas along with social franchising, static clinics, and vouchers. (Wumenu et al., 2013). The poverty assessment tool relies on the Progress out of Poverty Index (PPI) developed by the Grameen Foundation and, as an alternate, the Multidimensional Poverty Index (MPI), which is part of the Oxford Poverty and Human Development Initiative. MSI measures poverty through client exit interviews and compares the proportion of clients that they assess are poor compared to national measures of people living in poverty. MSI combines use of the poverty assessment tool with use of their model IMPACT 2.

Vulnerability Assessment Tool

IPPF has a vulnerability assessment tool that assesses multiple dimensions of inequity. IPPF’s tool, which its affiliates can use to monitor their provision of services to vulnerable populations, defines vulnerability as groups living below the poverty line, those facing social exclusion or marginalization, and those underserved because of lack of capacity or political will (IPPF, 2017). The vulnerability assessment, which can be adapted to the country context, is implemented through a random survey of clients that includes questions about these dimensions of vulnerability (Taylor et al., 2012).

Differences in contraceptive use by women with different levels of education are fairly consistently found in studies, with some exceptions. WHO (2015) found that across 71 countries, median mCPR, at 35.3 percent, was nearly twice as high among women with secondary or higher education than among women with no education (18.9 percent). Yet, looking at changes over time, among women in 38 countries, mCPR increased at a faster rate among women with no education (0.7 percentage points annually over roughly a 10-year period), compared to the increase among women with secondary education or higher (0.2 percentage points) (WHO, 2015). This finding suggests that women with lower levels of education are making progress in catching up with more educated women, a reflection of improved equity.

Environmental

While many family planning studies control for urban and rural residence, there are fewer examples of studies that have assessed shifts in environmental equity. Environmental inequities can be studied by assessing geographic remoteness and differential distance from health care facilities or coverage of facilities across geographies (Shiferaw et al., 2017). Geospatial analysis can be used along with surveys and other methodologies. Such studies can assess differences across countries (e.g. urban, rural, mountainous), or within areas (e.g. urban slums). Crisis settings (e.g. humanitarian or natural disaster areas) can also be assessed to ensure that barriers to provision and use of family planning are addressed. A study by PSI (2005) to measure availability of condoms, pills, and the injectable in Cambodia used Lot Quality Assurance Sampling (LQAS) to sample outlets in areas within three geographic categories (rural, urban town, and hyper-urban). The outlets were categorized as traditional, non-traditional, and brothel. The study found inequity in coverage and availability of the methods across the districts identified.

Multidimensional

Some studies addressed more than one dimension of inequity.

Gomez Ponce de Leon et al. (2019) used national surveys from Latin America and the Caribbean to assess use of and demand satisfied for modern contraceptive methods in general and in particular, Long Acting Reversible Contraceptives (LARCs) defined as IUDs and implants. Their analysis stratified by wealth, residence, education, ethnicity, age, and a combination of wealth and area of residence. They found some variations in modern contraceptive use by wealth and large variation in use of LARC. Demand satisfied for contraceptives was presented for all women in each country; thus, equity gaps in demand satisfied were not assessed among groups of women in each country.

Some literature exists on age-based inequalities and inequities in family planning (Neal et al., 2015; Neal et al., 2018). There are a number of different situations with unequal levels of contraceptive use in sexually active adolescents. In some of these situations, the inequality is clearly unjust and remediable, and so they are both unequal and inequitable. In other situations, the situation is less clear as discussed below. If sexually active unmarried adolescent girls in one country are able to easily obtain the contraceptive methods they want and to use them correctly because of advice and support, whereas adolescent girls in the same life circumstances from another country are unable to do so, this inequality can be described as unjust and remediable and so can be classified as inequitable. If sexually active

unmarried adolescent girls who want to obtain contraception but are unable to do so because legal restrictions and/or social stigma prevent them from doing so, whereas sexually active married girls are able to obtain them without hindrance, that too can be classified as both unequal and inequitable. On the other hand, if contraceptive methods are fully available and accessible for all segments of the population, but are not obtained by young married women because of individual reasons (i.e., desire to get pregnant) combined with social reasons (i.e., family pressure to get pregnant), yet are obtained by women in their twenties who have had a child/children, it is not clear that these unequal levels of use can be classified as inequitable. However, while lower levels of contraceptive uptake in a group of young married women may not be due to barriers at the point of provision, they may well be due to inequalities and inequities that they have experienced in other spheres of their lives (e.g. in educational opportunities), which left them with early marriage leading to early childbearing as the only feasible life opportunity (as perceived by them).

Madsen and Greenbaum (2018) assessed family planning equity based on wealth quintiles for youth. Assessing DHS data from 33 countries (represented in 76 surveys between 2003 and 2016), they found that across the countries, while inequity remained high, levels of demand satisfied generally improved over time. Over the roughly 13 years, the gap in demand satisfied between the poorest and wealthiest quintiles decreased from 16 to 13 percentage points. Further multivariate analysis found that wealthier women were much more likely to have their demand for family planning satisfied. In their analysis of adolescents, Madsen and Greenbaum (2018) found that education and marital status have at least as great of an impact on the probability of demand satisfied for modern family planning as wealth quintile.

Neal et al. (2016) assessed geographic differences among adolescent pregnancies in Kenya, Tanzania, and Uganda. Their analysis showed marked geographic differences among adolescent first births, particularly among young women under 16 years and with wider disparities in Kenya and Uganda than in Tanzania. The analysis found “pockets” of high prevalence of first births linked to poverty and with differences between neighboring districts. This analysis shows that “geospatial techniques can identify these inequalities and provide policy-makers with the information needed to target areas of high prevalence and focus scarce resources where they are most needed” (Neal et al., 2016: 1).

Literature Review on Interventions to Improve Equity in Family Planning

Here we discuss the results from the literature review on intervention research on equity and health that was conducted for this paper, which resulted in 86 studies of interventions, some of which covered multiple countries. Each study was reviewed twice and categorized by equity focus, health topic, and results. Classified using the framework of economic, social, and environmental dimensions of equity, there were 79 intervention studies that focused on economic equity, 34 intervention studies that focused on social equity, and five intervention studies that focused on environmental equity. There were some studies that focused on more than one type of equity. In terms of health topic, 47 studies focused on maternal and neonatal health (MNH)/maternal and child health (MCH), 20 studies focused on malaria, 11 studies focused on nutrition/vitamin A, eight studies focused on voluntary family planning, six studies did not specify, five studies focused on measles, three studies focused on HIV, two

studies focused on education, two studies focused on gender, and one study focused on eye care. Some studies focused on more than one health outcome (e.g. MCH and family planning).

The studies yielded mixed results in terms of the equity outcome. Thirty-six studies demonstrated improved equity, 29 studies demonstrated mixed results, 21 studies demonstrated no improvement in equity, and three studies could not be classified.

Of the eight studies that measured equity through voluntary family planning interventions, eight focused on economic equity, two focused on social equity, and none focused on environmental equity. Some studies focused on more than one type of equity, and the results for all were mostly mixed (see Table 2 below for a summary of each of the studies).

Table 2. Equity Intervention Studies on Family Planning					
Intervention and Country	Equity Focus	Methodology	FP Outcome	Equity Result	Reference
Multiple interventions in health systems and social marketing, coverage, targeting with subsidies (Kenya)	Economic	Equity assessed using data drawn from: <ul style="list-style-type: none"> • MAP studies on health system coverage; • Individuals accessing a risk pool or financial products (PSI/PSK quarterly reports 2011-2014); Subsidy targeting (PSI/PSK quarterly reports 2011-2104); • TRaC surveys, (2011-2014 conducted by PSI). 	Access to and use of family planning	Improved	IBTC, 2015
Performance based Financing (PBF) for maternal health care and modern contraceptive use (Burundi)	Economic	Repeated cross- sectional surveys in intervention and control districts, comparison of indicators by socioeconomic status	Modern contraceptive use	No effect “A supply-side intervention such as performance-based financing without accompanying access incentives aimed at the poor is unlikely to improve equity” (p. 2186)	Bonfer et al., 2014
PBF - for MCH services provided (including FP) (Afghanistan)	Economic	Contraceptive use in intervention area served by the PBF scheme and comparison areas, at baseline and endline	Modern contraceptive use	No effect	Engineer et al., 2016
PBF - for ANC, facility-based delivery, modern contraceptive use (Rwanda)	Economic	No specific intervention to target the poor. Cluster level panel dataset created for intervention/control using 2005 (pre) and 2007/8 (post) surveys. Used a difference-in-differences model with community fixed effects. Interaction terms between wealth quintiles and PBF were estimated to identify the differential effect of PBF among poorer women.	Contraceptive use	No effect “If the equity gap is extreme or service use is sub-optimal among the poorer populations, then a non-targeted supply-side programme like Rwanda’s will likely do little to alleviate disparities” (p. 833)	Priedeman et al., 2013
PBF - Maternal and child immunization scheme by targeted/ non-targeted services (Tanzania)	Economic	A controlled before and after study design was employed. Surveys were conducted in January 2012 and 13 months later. Sampled households of women who had delivered in the 12 months prior to interview; and patients attending health facilities for targeted and non-targeted services at each round of data collection. Difference-in-difference regression analysis was employed.	Contraceptive use	No effects on contraceptive use	Binyaruka et al., 2015

Table 2. Equity Intervention Studies on Family Planning					
Intervention and Country	Equity Focus	Methodology	FP Outcome	Equity Result	Reference
Voucher for LARCs (Cambodia)	Economic and Social (education, occupation and age)	Quasi-experimental study design and data from before-and-after intervention cross-sectional household surveys (2011 and 2013) in nine voucher program districts and nine controls, to evaluate changes in use of modern contraceptives and particularly LARCs in the 12 months preceding each survey. Difference-in-differences (DID) analyses were used to examine the impact of the family planning voucher.	LARC uptake	LARC increase higher in intervention areas; greatest increases in lower SES and educational groups “A family planning voucher program can increase access to and use of more effective long-acting methods among the poor by reducing financial and information barriers” (p. S109).	Bajracharya et al., 2016
Social Franchising (MSI) - contraceptive services and use (17 countries in Africa and Asia)	Economic and Social (age)	Analyzed MSI’s social franchising program against the four intended outputs of access, efficiency, quality, and equity. For equity, exit interviews captured demographics (age and poverty), and prior contraceptive use. The MSI “Impact 2” model was used to estimate population-level outcomes by converting service data into estimated health outcomes.	Contraceptive use	Mixed results – particularly for the very poor and youngest “Social has the ability to rapidly scale-up access to high-quality family planning services, including LARCs, for the general population as well as young women and the poor” (p. 195).	Munroe et al., 2015
Social Franchising with/ without voucher, and community midwife for IUD – continuation (Pakistan)	Economic	IUD acceptors from a SF model (with and without vouchers) and a Community Midwife model were enrolled in a 24-month prospective client follow-up. Participants followed-up by female community mobilizers every second month. Probabilities of IUD continuation and the risk factors for discontinuation estimated by life table analysis and Cox proportional-hazard techniques, respectively.	IUD discontinuation rates	Voucher/ non-voucher clients in SF model had similar IUD discontinuation rates. “Trained mid-level private providers and outreach workers, supported with vouchers for free IUD services [for those in need], in social franchising programmes can effectively promote IUD continuation. The findings also reveal that CMWs and Lady Health Visitors are equally capable of providing quality IUD services and ensuring higher method continuation” (p. 8).	Hameed et al., 2015

In reviewing these studies, there were variations in how equity is defined and the family planning outcomes for measuring equity, though contraceptive use is the most common. For example, in the Bajracharya et al. (2016) study on vouchers for LARCs, the article suggests an inequity in modern contraceptive use, particularly LARCs in low- and middle-income countries. Inequity is not explicitly defined, but it states that there are financial barriers for the poor in Cambodia in accessing modern contraceptives, especially LARCs. In Cambodia, a person is considered poor if they hold an IDPoor card which allows them to be eligible to participate in the Health Equity Fund program, “a strategy to improve access to health care for the poor” (Bajracharya 2016). The primary outcome variable was use of modern contraceptives among currently married women of reproductive age in the 12 months preceding each survey. However, analysis focused on LARC uptake. The study found greatest LARC increase following the voucher intervention among women with the lowest levels of education and in the poorest wealth quintile. The study suggests that vouchers may be an effective way of giving access to LARCs to women who may not otherwise be able to access LARCs due to socioeconomic barriers. However, the concern in this study is differentiating between equal use of LARCs across socioeconomic status and equitable access to LARCs. Additionally, the study does not address all aspects of equity as it focuses on addressing only possible financial barriers.

Another example of varying definitions of equity and outcomes is the Munroe et al. (2015) evaluation of social franchising networks run by Marie Stopes International (MSI). This study analyzed MSI’s social franchising program across 17 countries against four outcomes, including equity. In this case equity was explicitly defined as “the extent to which a program ensures all potential clients have an equal or fair opportunity to obtain services” (Munroe 2015). The indicators for measuring this outcome were 1) proportion of family planning clients who newly adopt a modern contraceptive method, defined as not using a modern method during the three months prior to their visit, 2) proportion of clients under 25 years old and proportion under 20 years old, and 3) proportion of clients living below US\$1.25/day and proportion living below \$2.50/day. The study drew a number of conclusions in terms of “bridging equity gaps.” For example, results led to the conclusion that MSI has the ability to reach the underserved group of younger populations; however, it concedes that the fee structure of a social franchising program may not be the most appropriate channel to reach youth because of their possible financial barriers. The study also found mixed results in reaching poor clients due to financial barriers. Finally, the study had positive results in reaching women who were considered new adopters. Unlike some of the other studies, Munroe et al. (2015) provided a definition of equity and indicators from which to draw more succinct conclusions (see definitions and indicators above). This also dispelled confusion between equity of access to contraceptives and equality of use of contraceptives across groups.

This review found surprisingly few intervention studies on equity in family planning, compared to the richer literature on studies of changes in equity using national surveys. Perhaps the time horizon of the national surveys, which measured in the decades, rather than those of the intervention studies, which tended to be one to two years, is more suited for detecting changes in equity.

Some useful common themes emerged among the 86 studies in the literature review that covered all health topics. One common theme is that improving equity takes time. Another theme in the studies, including some of the family planning studies, is the need for demand-side interventions along with supply-side interventions to address the multiple dimensions of inequity. Finally, a number of the studies in the literature review called for implementation science to investigate which aspects of interventions improve equity.

While each had limitations, these studies, along with those examining equity using national or other survey data, and the broader evidence on equity used in existing HIP briefs, are useful for making recommendations on how equity should be addressed in the HIP Partnership and HIP briefs.

Review of Equity in Existing HIP Briefs

Finally, we reviewed the 20 HIP briefs (service delivery, social behavior change, enabling environment, and enhancements) developed as of January 2019. Equity is mentioned in 12 out of 20 of the briefs (see Annex 1). Aspects of economic, social, and geographic equity are all mentioned. The briefs that particularly focus on addressing equity include the service delivery briefs on vouchers, mobile service outreach and community health workers, and the enabling environment brief on educating girls.

Recommendations on How Equity Should be Defined for the HIP Partnership and Appropriate Measures for Examining Equity Issues

Measures of Equity Relevant to Family Planning

In designating a “high impact practice” the HIP Partnership has as its primary outcome of interest use of modern methods of contraception. Interventions associated with each high impact practice are assessed for evidence of impact on the basis of whether the intervention improved use of contraception. While use of contraception can be assessed with an equity lens, it should not be the only outcome assessed to measure if programs and services are equitable.

While studies that assess differences in contraceptive use and fertility can help shed light on differences that could be inequitable and require further investigation and potential shifts in programming, additional analysis is required to assess where the differences are inequitable. Ugaz et al. (2016: 53), noted as much in a study of use of long acting and permanent methods (LAPM), saying that “The positive relationship between wealth and LAPM use is an issue of concern as it may indicate that there is an inequity in access to LAPMs in developing countries....It is also possible that poorer women simply have different preferences” (Ugaz et al., 2016: 52). In their analysis of mCPR, demand satisfied, and fertility trends in four countries, Patierno, Feranil and Reidy (2018: 3) note that in Ghana and Ethiopia, “Wealth-based disparities in fertility appear to be partially driven by poorer women’s desire for more children.” Thus the differences may not only reflect inequities. Indeed, unlike many health issues, contraception use or use of a particular method could be highly influenced by cultural beliefs and values with the result that group differences may not reflect inequity. Determining what proportion of group differences are actual inequities requires rigorous analysis. In addition to using the framework of the

right to health with a fairness lens, it is also important to assess differences in group exposure to family planning interventions and exposure to quality family planning information and services.

To assess equitable progress towards project, national, or global goals, it is important to be able to show that the outcomes of disadvantaged groups improve at the same or faster rates as the outcomes for more well off groups, thus establishing the need for a baseline (Wirth et al., 2006). Whitehead and Dahlgren (2006) call this “leveling up,” or working towards the least endowed group moving towards the outcomes of the most endowed group. Using national survey data from six countries, Wirth et al. (2006) show that there are no consistent patterns of mCPR stratified by wealth, education and residence, illustrating the need to assess multiple dimensions of inequity rather than drawing inferences from a single indicator. Studies on family planning support the need for assessing multiple indicators (Patierno et al., 2018; WHO, 2015; Madsen and Greenbaum, 2018).

Hosseinpour et al. (2014: 1) offer strategies for monitoring multiple inequities in health related to universal health coverage. They note that both gaps and absolute measures of inequality should be examined. In stressing the importance of assessing multiple dimensions of equity, they state that “the extent of inequality may vary considerably across different dimensions such as economic status, education, sex, and urban/rural residence.” In both monitoring and evaluation systems and research on interventions to improve equity, sufficient data should be collected to be able to disaggregate or control for different dimensions of inequity that are relevant for the context in which the data are being collected. In its list of Family Planning and Reproductive Health indicators, MEASURE Evaluation includes a discussion of poverty and equity related to the indicators mCPR and unmet need for family planning (note that demand satisfied is not included in the list of indicators).

Experts writing on equity concur that programs need a focus on equity—it does not just happen as a result of other development efforts (MCHIP, 2011). Alkenbrack et al. (2015:17) report that “best examples of improvements in health equity are not from countries in which economic growth has been highest, but instead from countries where targeted reforms have been put in place to cover the poor, e.g. Cambodia.” Likewise, UNFPA (2017) notes that addressing inequity may require attention to laws, policies and programs, in addition to social and gender norms. Gillespie et al. (2007) explain that using an equity lens for programming should be done with care. In some countries, inequities among groups clearly need to be addressed; in other countries, improvements in family planning programming are needed for all groups.

Therefore, based on the overall content of this discussion paper, the HIP TAG equity working group has this overarching recommendation:

Family planning faces many unique challenges related to assessing and responding to issues of equity. Therefore, the international family planning community would benefit from platforms and groups that could provide ongoing, in-depth thinking to address outstanding issues such as, further exploration of how inequities related to family planning are defined and assessed, what are appropriate methods and indicators for assessing inequity in contraceptive provision and access to information, how can equity analysis take into account preferences, choice, and voluntarism? How can equity analysis incorporate aspects of social position beyond wealth, such as gender dynamics,

educational opportunities, geographic differences, etc.? Connecting with current efforts on understanding and addressing inequities, such as those supported by WHO and PAHO will be important.

The group recommends the HIP TAG adopt the following as it relates to findings from the discussion paper:

Defining and measuring inequity:

It is beyond the scope of the HIP TAG to define how inequities are determined and the TAG encourages the family planning community to continue work on this issue (see overarching recommendation above). In the meantime, the group suggests the TAG adopt the WHO definition of equity to guide future discussions and work:

“Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other means of stratification. ‘Health equity’ or ‘equity in health’ implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.” https://www.who.int/topics/health_equity/en/

Specifically, the TAG adopts this framework that defines inequity as when differences in outcomes are **avoidable, unnecessary, and unjust**. Further, the TAG finds specific measures outlined in Gillespie et al. (2007) useful:

- Outcomes must be disproportionately present in a disadvantaged population relative to better-off population segments;
- Outcomes must be amenable to effective interventions;
- Outcomes must be undesirable; and
- Interventions to relieve or lessen this condition are less available to the disadvantaged population

Recognizing that this definition and recommended measures will be refined over time and the TAG should incorporate improvements as appropriate.

Equity should be addressed in all briefs, given its centrality in expanding universal access and fulfilling the right to the highest standard of health. The frameworks for equity will be important for authors to use as they are developing the briefs to assure that equity is carefully considered and accounted for in the briefs as appropriate. Annex 1 Table A1, which provides a summary of how equity is addressed in current HIP briefs, can provide useful background to authors. If equity is not a focus of the practice that should be stated in the brief.

The TAG recognizes that there may be little evidence about equity to include in briefs, but we expect all authors to explore this topic as they develop the brief. Specifically:

When developing and writing HIP Briefs, authors should respond to specific measures outlined in Gillespie et al. (2007):

- Disadvantaged population and comparison “better-off” population segments should be clearly defined.
- The condition or cause of the observed inequity should be explicit and evidence provided that the condition is less available to the disadvantaged than to better off population.
- It must be clear that the Practice relieves or lessens this condition.

The TAG should advocate for researchers, data analysts, and authors to include more robust approaches to equity analysis and to use the points above from Gillespie et al. (2007) and those below to inform their analyses:

- Incorporate measures of equity that go beyond modern contraceptive use. Other measures could include: demand satisfied for contraception (which includes a dimension of demand - unmet need), unintended or mistimed pregnancy/childbearing, and fertility above ideal family size.
- Include measures that track conditions or causes of inequity such as **access** to services, methods, and information; and **quality** as measured by client satisfaction, respectful care, and equitable treatment.
- Additional social determinants, including gender inequity, could also be included, as appropriate.

A final recommendation is that this discussion paper would benefit from being accompanied by a HIP Partnership Strategic Planning Guide on equity that will help programs better understand how to assess equity and identify evidence-based responses to reducing/addressing inequities.

Resources on Equity Programming and Measurement

Programming:

Achieving Health Equity: A Guide for Health Care Organizations - Wyatt R, M Laderman, L Botwinick, K Mate, and J Whittington. 2016. *IHI White Paper*. Cambridge, MA: Institute for Healthcare Improvement. <http://www.ihl.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx>

Considerations for Incorporating Health Equity into Project Design: A Guide for Community-Oriented Maternal, Neonatal and Child Health Programs - MCHIP. 2011. http://resources.jhpiego.org/system/files/resources/Equity%20guidance_090111_formatted_final_0.pdf

Equity and Health Sector Reform in Latin America and the Caribbean from 1995 to 2005: Approaches and Limitations - International Society for Equity in Health – Chapter of the Americas. 2006. Report with a useful table of interventions for equity. <http://www.bvsde.paho.org/bvsacd/cd53/equity.pdf>

Equity Framework for Health - Health Policy Project (HPI) http://www.healthpolicyplus.com/archive/ns/pubs/hpi/1271_1_EQUITY_Overview_Poster_FINAL_Sept_2010_acc.pdf

Priority Public Health Conditions Analytic Framework - Blas, E., and A.S. Kurup. 2010. Equity, Social Determinants and Public Health Programs. Geneva: WHO. https://apps.who.int/iris/bitstream/handle/10665/44289/9789241563970_eng.pdf?sequence=1&isAllowed=y

Measurement:

Addressing Poverty. A guide for Considering Poverty-related and Other Inequities in Health - MEASURE Evaluation. 2012. MS-08-27. <https://www.measureevaluation.org/resources/publications/ms-08-27>

Health Equity Assessment Toolkit Plus (HEAT Plus): software for exploring and comparing health inequalities using uploaded datasets - Ahmad Reza Hosseinpoor, Anne Schlottheuber, Devaki Nambiar and Zev Ross. *Global Health Action*, 2018 Vol. 11, 1440783 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6041818/pdf/zgha-11-1440783.pdf>

Quick Poverty Score - MEASURE Evaluation. ND. <https://www.measureevaluation.org/resources/tools/poverty/quick-poverty-score>

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Annex 1 Mentions of Equity in the HIP Briefs

A number of HIP briefs developed as of June 2019 mention equity. A review of how equity is included in the briefs is instructive for guiding more systematic inclusion of equity moving forward. As shown in Table A1, of the eight service delivery HIP briefs, five mention that the practice improves various dimensions of equity (the briefs on Community Health Workers, Social Marketing, Mobile Outreach Services, Social Franchising, and Drug Shops and Pharmacies mention equity while the briefs on Postpartum Family Planning, Postabortion Care, and Family Planning and Immunization Integration do not mention equity). Of the six enabling environment HIP briefs, three mention equity (the briefs on Domestic Finances, Supply Chain Management, and Educating Girls mention equity while the briefs on Galvanizing Commitment, Policy, and Leadership and Management do not mention equity). Of the three Social Behavior Change HIP briefs, Mass Media; Digital Health for Social and Behavior Change; and Community Group Engagement, none mention equity. The three HIP Enhancements (Vouchers, Adolescent Friendly Contraceptive Services and Digital Health for Systems Strengthening) all mention aspects of equity. The evidence summary on educating girls also mentions equity.

Economic, social, and geographic equity are mentioned in the HIP briefs. For example, among the Service Delivery HIPs, the Community Health Worker brief notes the importance of the practice in addressing geographic access barriers caused by health worker shortages, financial barriers, social barriers that inhibit use and mobility constrained by social norms. The Social Marketing, Mobile Services and Drug Shops and Pharmacies briefs state that those practices address both geographic and social economic (age and gender) barriers. The Social Franchising brief mentions reaching youth, and the Voucher brief² mentions addressing age and education barriers in addition to economic equity. Among the Enabling Environment briefs, the Domestic Resources brief includes equity in its theory of change, noting that increasing equity will be one of the outcomes of increasing domestic resources (although the brief does not say how). The brief on educating girls notes that doing so “helps improve gender equity by increasing agency and empowering girls to engage in decision-making that affects their families and the development of their communities.” Of the two Enhancements, the Adolescent Friendly Contraceptive Services brief mentions gender equity and the Digital Health for Systems brief mentions segmenting users into groups, which touches on equity.

Table A1. Mentions of Equity in HIP Briefs Developed as of January 2019

HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
Service Delivery¹			
Community Health Workers	<ul style="list-style-type: none"> Geographic access barriers caused by health worker shortages Financial barriers Social barriers that inhibit use Mobility constrained by social norms 	“CHW are particularly important to reducing inequities in access to services by bringing information, services, and supplies to women and men in the communities where they live and work rather than requiring them to visit health facilities, which may be distant or otherwise inaccessible” (<i>Background</i>)	<p>Guatemala: women who used CHW were more likely to be indigenous.</p> <p>Ethiopia and Uganda: clients of CHW more likely to be single than clients of clinics.</p>
Social Marketing	<ul style="list-style-type: none"> Geographic access Socio-economic (age, gender) 	“Social marketing helps reduce geographic and socio-economic disparities in family planning use” (<i>Why the practice is important</i>)	DHS data show that even among the poorest people in the poorest countries, a significant number receive services from the private sector - much of it from social marketing.
		“Social marketing helps reach underserved young people” (<i>Why the practice is important</i>)	<p>Adolescents generally prefer to receive contraceptives from the private sector, considered more private.</p> <p>Social marketing provides subsidized services to improve accessibility for the poor and young (e.g, in Bangladesh).</p>
Social Franchising	<ul style="list-style-type: none"> Socio-economic equity (age-reaching youth) 	“Social franchising helps private providers incorporate adolescent-friendly contraceptive services.” (<i>Evidence that the practice is high impact</i>)	Studies in Kenya and Madagascar demonstrate that training franchisees on youth-friendly principles and including young people in the marketing strategy can increase modern contraceptive use, including the voluntary use of LARCs among youth - both male and female.

Table A1. Mentions of Equity in HIP Briefs Developed as of January 2019

HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
Mobile Outreach Services	<ul style="list-style-type: none"> Geographic equity- to services and to providers Socio-economic equity 	Mobile outreach services address inequities in access to family planning services and commodities in order to help women and men meet their reproductive health needs (<i>Background</i>)	
		Mobile outreach services serve communities with limited access to clinical providers and supplies (<i>Which challenges does the practice address</i>)	The World Health Report (2006) identified 57 countries facing critical shortages in health personnel. In addition to deploying trained clinical providers, mobile outreach service delivery models ensure a reliable supply of contraceptive commodities, medical supplies, and equipment needed to deliver a full range of family planning options.
		Mobile outreach services reach new and underserved populations by bringing health services closer to the client (<i>Which challenges does the practice address</i>)	In sub-Saharan Africa in 2012, 42% of mobile outreach clients of one international nongovernmental organization (NGO) lived on less than US\$1.25 per day, compared with 17% and 13% of clients of static clinics and social franchises, respectively.
		When implemented at scale, and with attention to providing high-quality services, communities served by mobile outreach services increase use of modern contraceptives. (<i>What is the impact?</i>)	<p>A study in Zimbabwe concluded that mobile outreach services “have a powerful effect” on use of contraceptives. After controlling for social and economic characteristics, researchers found that exposure to mobile outreach services had the same magnitude of effect on current and ever contraceptive use as having a general hospital in the area. The study also found that mobile family planning units had their greatest impact among the poor as they seem to serve women with little education.</p> <p>In Tunisia, a study concluded that although one-fourth of the national family planning operating budget supported the mobile outreach program, the mobile units contributed one-third of the total output of the national program. More importantly, the mobile units</p>

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			contributed an even greater share of the national program's activities in rural areas and played a critical role in expanding the geographic coverage of family planning services.
Drug Shops and Pharmacies	<ul style="list-style-type: none"> Geographic equity - underserved areas Socio-economic equity - age (reaching youth) and gender (reaching men) 	Drug shops, in particular, remove barriers to family planning access in underserved areas (<i>Why is this practice important?</i>)	<p>In countries where drug shops are permitted, they are usually more common than pharmacies, which can reduce travel and distance barriers. Studies show that clients often find private providers, such as drug-shop operators, more acceptable than public sector clinics.</p> <p>Private providers offer clients proximity, expediency, flexibility in operating hours, and responsiveness to the client's needs compared to public sector clinics.</p>
		Drug shops and pharmacies are preferred by some marginalized or underserved populations, including males and youth (<i>What is the impact?</i>)	<p>Drug shops are convenient for men and boys who may be less willing to go to clinics or pharmacies, especially if they have to travel longer distances.</p> <p>Men in India cited pharmacies as their primary source for obtaining condoms.</p> <p>Studies from Zambia, El Salvador, the United States, and the United Kingdom have shown that youth are more comfortable obtaining contraceptives from pharmacies than from clinics, which they consider more intimidating and judgmental.</p> <p>In Bangladesh, the majority of adolescents aged 10-18 use socially marketed contraceptives obtained through pharmacy outlets compared to less than a third of women 19 years of age and older.</p>

Table A1. Mentions of Equity in HIP Briefs Developed as of January 2019			
HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
Enabling Environment²			
Domestic Resources	Not specified	The Theory of Change notes that increasing equity will be one outcome of increasing domestic resources.	
Supply Chain Management	Not specified	Strengthen supply chains to the last mile. Community-based distribution (CBD) offers the potential to significantly increase access to and use of family planning services, particularly by underserved groups. Although these programs often have established mechanisms to train and supervise CBD workers, they usually devote limited resources to SCM. CBD programs have inherent characteristics that require unique supply chain considerations, including the distributor's educational level, volunteer or part-time status, and access to resupply. <i>(How to do it. Tips from implementation experience)</i>	
Educating Girls	Social	Although gender disparities in education are narrowing [they still require attention]. Governments and their partners can invest in structural changes that facilitate access to formal education, such as equitable gender norms, economic empowerment, and promoting healthy behaviors. <i>(Background)</i>	UNESCO estimates that only 29% of primary-school-age children live in countries that have achieved gender parity (that is, equal participation for girls and boys in school) at the lower secondary level, and only 15% live in countries with gender parity at the upper secondary level.

Table A1. Mentions of Equity in HIP Briefs Developed as of January 2019

HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
		Complementary investments in education and family planning can accelerate the fertility transition and facilitate development. <i>(What is the impact?)</i>	A demographic projection model using data from India predicted that investments in both education and family planning programs will have the largest impacts on slowing population growth compared with investing in only one aspect, and that together these investments will have far-reaching effects on gender equity and economic growth.
		Engage communities to change social norms that devalue girls and their education. <i>(What works to keep girls in school?)</i>	<p>In a study of seven African countries, nearly half of all surveyed parents believed there are certain disadvantages to schooling girls.</p> <p>Lack of social support discourages girls from attending school, such as staff providing more support to boys than girls; teachers believing that subjects such as math are less important for girls than boys; harassment by boys; and boys not recognizing that girls are not treated equitably.</p> <p>Community engagement approaches can address these barriers by emphasizing the value of girls and the benefits of girls' education; promoting a gender-equitable distribution of household work; engaging parents, girls, and communities to ensure girls' safety; and providing a support structure for girls to pursue education.</p>
		Policy Environment. The health sector also has an important role to play in creating a policy environment that is supportive of girls'	

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HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
		<p>education. Examples of areas in which the health sector can contribute include:</p> <ul style="list-style-type: none"> • Advocating gender-equitable universal education policies • Advocating with the Ministries of Education, Gender, and Youth to remove policy barriers that prevent girls from returning to school after dropout, marriage, or pregnancy • Working with the Ministries of Education and Health to implement policies to eliminate the practice of child marriage, which is a barrier to girls' education; encourage development of such policies; and support programs that prevent child marriage or address the needs of married adolescents <p>School Environment. Efforts to improve the quality of the educational environment fall mainly outside the purview of the health sector. Areas in which the health sector may contribute to an improved learning environment in collaboration with the education sector include:</p> <ul style="list-style-type: none"> • Reducing gender-based violence in schools to help create supportive learning environments for girls • Training teachers in gender-equitable teaching methods • Supporting programs that promote teachers and women as mentors for girls in communities 	

Table A1. Mentions of Equity in HIP Briefs Developed as of January 2019			
HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
		<i>(How Can the Health Sector Support Keeping Girls in School?)</i>	
Social Behavior Change ³		No Social Behavior Change brief mentions equity	
Enhancement			
Vouchers	<ul style="list-style-type: none"> Economic and social inequity (e.g. education) 	Provide vouchers to clients to facilitate equitable access to and choice of voluntary contraceptive services (Definition of the practice)	
		[Vouchers] are used as a financing mechanism and programmatic tool to improve equitable access and increase the use of key health products and service (Background)	Ensor T, Ronoh J. Effective financing of maternal health services: a review of the literature. Health Policy. 2005;75(1):49-58. doi: 10.1016/j.healthpol.2005.02.002
		In addition to reducing financial barriers, vouchers that focus on specific population groups help ensure subsidies reach individuals who may be less likely to have access to and ability to use family planning services and products (Background)	
		Vouchers can support implementation of a number of HIPs. In general, they can help family planning programs remove financial or other barriers and expand client access to more contraceptive options including those that may be too expensive or otherwise difficult for them to access; improve key population groups' access	Even when family planning services are presumed to be free, financial barriers may exist. For example, a survey of seven countries in Latin America and the Caribbean, where family planning is largely mandated free of charge to clients in public-sector facilities, found that client

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		to contraception (How can vouchers enhance HIPs)?	out-of-pocket expenditure was a significant source of family planning financing.
			A systematic review concluded that “vouchers can expand client choice by reducing financial barriers to contraceptive services and making private providers an option for disadvantaged clients previously restricted by cost.”
			Evidence from voucher programs consistently shows that when a voucher program reduces or removes the client’s cost for provider-dependent methods, through a voucher that covers either specific or all contraceptive methods, use of provider-dependent methods increases while use of other methods either remains the same or increases
		Vouchers improve access to contraceptives for key population groups (How can vouchers enhance HIPs)?	A review of 24 NGO-supported voucher programs across 11 countries in Africa and Asia between 2005 and 2015 found that most programs were successful in reaching subgroups, such as the poor and young consumers (under 25 years), although this outcome depended on the targeting approach and how beneficiaries were identified.

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HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
		Vouchers can also reach other disadvantaged groups, such as those with little or no education (How can vouchers enhance HIPs)?	For example, in Uganda, where only 23% of women with no education and 34% of women with a primary education use a modern method, a voucher program facilitated family planning access for 330,826 women, 79% of whom had no education or only primary education.
		Vouchers facilitate access to private providers (How can vouchers enhance HIPs)?	Vouchers can expand access to the private sector for groups who may face access challenges due to prohibitive user fees, such as low-income individuals or adolescents.
			Engaging the private sector can also expand geographic coverage
		Do voucher programs create equitable access to family planning services? (Research gaps)	

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HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
Adolescent Friendly Contraceptive Services (AFCS)	<ul style="list-style-type: none"> • Social 	Gender norms (<i>Which challenges can AFCS help countries address</i>)	<p>Gender norms that idealize sexual ignorance for girls and sexual prowess for boys are found globally and can impede young people's access to information and services and their ability to negotiate sexual relationships.</p> <p>Providers often reinforce these inequitable gender norms by refusing to provide unmarried adolescent girls with contraception even when requested.</p> <p>Married adolescent girls often face different gender-related barriers due to their social isolation, lack of power, limited mobility, and pressures to prove fertility by becoming pregnant early and often.</p> <p>As a way of upholding these social and gender norms, providers may not provide contraception to married adolescent girls or restrict long-acting methods until they have had a child.</p> <p>Young men are expected to be knowledgeable about sex, making it difficult for them to seek information, and they may also face structural barriers to accessing services, which are typically targeted to women.</p>

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		Gender norms (<i>Which challenges can AFCS help countries address</i>)	Failure to address issues such as women's lower social status, economic dependence and limited agency, transactional sex as an important economic resource for young girls, and social norms of masculinity was identified as one reason a large service delivery improvement effort in Tanzania failed to demonstrate an impact on contraceptive use among young people.
		Pay attention to gender and social norms to ensure successful investments in AFCS. (<i>Tips</i>)	Adolescent girls will access contraception in settings where gender norms have been transformed to allow girls to know about sexual and reproductive health and to feel empowered to access services (McCleary-Sills et al., 2012). Adolescent boys will access contraception in settings where boys feel some sense of responsibility to plan pregnancies.
Digital Health for Systems Strengthening	• Multiple	Gather information about and from the intended users of the digital interventions.	<p>This includes questions related to how stakeholders currently understand and use technology (including the types of technology they use and prefer and how they pay for technology use), as well as the barriers they face that a digital solution might address.</p> <p>Segmenting users into sub-categories (e.g. men/women, educated/noneducated) can provide insight into important differences that could influence the design of the digital health intervention.</p>

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HIP Brief	Dimensions of Equity	Key Statements on Equity and Section of the HIP Brief	Evidence
			Once it has been established that a digital solution is appropriate for solving a given problem, engage users, as well as other key stakeholders, in the design and testing of the tool. Doing so can help create more appropriate and user-friendly interventions that are more likely to be adopted, while failing to do so can mean costly and timely revisions later down the line.
¹ Service Delivery briefs that do not mention equity: Postpartum FP; PAC; and FP and Immunization Integration. ² Enabling Environment briefs that do not mention equity: Galvanizing Commitment, Policy, and Leadership and Management. ³ No Social Behavior Change brief mentions equity.			