

Health Equity Programs of Action: An Implementation Framework

SUMMARY VERSION



JANUARY 2019

**O'NEILL
INSTITUTE**
FOR NATIONAL & GLOBAL HEALTH LAW
GEORGETOWN LAW

The full version of The Health Equity Program of Action: An Implementation Framework is available through: <http://oneill.law.georgetown.edu/projects/tuberculosis-law-and-human-rights-project/health-equity-programs-of-action/>

Table of Contents

Introduction	4
Human Rights and Health Equity	7
Principle 1: Empowering Participation and Inclusive Leadership	7
Principle 2: Maximizing Health Equity	8
Principle 3: Health Systems and Beyond: All Social Determinants of Health	8
Principle 4: Every Population Counts	9
Principle 5: Actions, Targets, and Timelines	10
Principle 6: Comprehensive Accountability	11
Principle 7: Sustained High-Level Political Commitment	13
Annexes	13
Endnotes	14

Introduction

In countries around the world, the life expectancy of residents of different neighborhoods — perhaps only miles apart — may differ by 10 years, 20 years, or even more. Certain populations — ethnic and religious minorities, indigenous peoples, people who are disabled, homeless, or simply very poor, for instance — may see similar dramatic differences in their chances for a long and healthy life. Feeding into these patterns of inequity, the rates of diseases — diabetes, tuberculosis, and many others — may be three, four, five, or even hundreds of times higher in some segments of the population.

Today’s reality represents extreme violations of social justice and the right to the highest attainable standard of health. Central to the imperatives of social justice and human rights is that people should have the opportunity to live long and healthy lives regardless of the happenstance of their birth. And so it is that the world’s leaders put the promise “that no one will be left behind” at the heart of the 2030 Agenda for Sustainable Development, committing as well to reach first those now furthest behind. A focus on health equity could serve as the central organizing principle for meeting these promises and organizing national action across the 17 Sustainable Development Goals (SDGs) and their 169 targets. For when people are left behind across the many domains of the SDGs — from the health sector to housing, nutrition, sanitation, inclusive growth, a healthy environment, access to justice, and more, all affecting health — people are also left behind when it comes to their health.

The causes underlying health inequities are too diverse for a single sector to address on its own. Nor can addressing these inequities focus only on a single metric, like wealth. Many populations experiencing health inequities face particular challenges, perhaps arising from historical experience, cultural barriers, or legal circumstances. Government leadership is vital — but so too is engaging and empowering the populations who experience health inequities, who best understand their circumstances and the policies and practices that could change their lives. Addressing health inequities requires national mobilization — involving all sectors, engaging and attentive to the overlapping and diverse needs of all populations who experience health inequities, and enabling marginalized and disadvantaged populations or those living in situations of vulnerability¹ to be at the center of the response.

The many dimensions of life affecting health equity will require careful planning, as demonstrated by the fact that even after the era of the Millennium Development Goals (MDGs) and the significant overall health improvements those goals contributed to, vast health inequities persist. The MDGs lacked an equity focus. Achieving health equity requires such a focus, with integrated, inclusive, and comprehensive actions. Here, we offer just such an approach: health equity programs of action.

A singular focus

Health equity programs of action stand out for their singular, systematic focus on reducing health inequities in each population experiencing them, bringing to the center of national policymaking the concerns and rights of all people who face discrimination or other obstacles that exclude them from equal opportunities for good health.

These programs of action would build on decades of recognition of the importance of health equity, stretching back to the World Health Organization’s (WHO) constitution and the Declaration of Alma-Ata

several decades later. The focus accelerated with the final report of the Commission on Social Determinants of Health in 2008 and in the years that followed. Yet the MDG era saw little progress towards health equity, and few countries have comprehensive approaches to addressing health equity. Current efforts are frequently piecemeal, covering only certain populations or health issues, yet a great diversity of populations experience health inequities. Such inequities pervade the many domains of diseases and health threats, whether infectious diseases, non-communicable diseases, mental health, maternal deaths, or injury. What is required, instead, is a systematic approach with the empowering participation and robust accountability that health equity programs of action would entail. Now, the SDGs, WHO’s push for universal health coverage, and a growing number of WHO resources — such as *Innov8*, a resource to help incorporate health equity into individual health programs — offer a window of opportunity to change this. Health equity requires equitable health systems, as well as broader societal systems organized for health and equity.

Principles of health equity programs of action

Health equity programs of action would be developed based on and would follow seven principles. This guide will be framed around these principles, focusing on what they entail and possible ways to implement them. The body of evidence around the particular actions needed to improve health equity, overall or for particular populations, is outside this guide’s scope, though an annex does include selected references to such evidence.

The seven principles are as follows:

- *Empowering participation and inclusive leadership*, with people from marginalized and disadvantaged populations as part of the leadership of all processes related to these programs of action;
- *Maximizing health equity*, which requires addressing all health issues and structural determinants of health inequities;
- *Health systems and beyond*, covering the health sector and the full array of social (including cultural), environmental, economic (including commercial), and political determinants of health, including through intersectoral actions;
- *Every population counts*, which means systematically and comprehensively addressing each population experiencing health inequities;
- *Actions, targets, and timelines*, with specific actions linked to timelines for carrying them out, along with measurable targets;
- *Comprehensive accountability*, encompassing but extending well beyond monitoring and evaluation to also establish or strengthen a comprehensive suite of health accountability mechanisms, and;
- *Sustained high-level political commitment*, which is necessary for intersectoral action and coordination as well as successful implementation.

Applying these principles in all health programs, in all sectors, at all levels

Health equity programs of action would be integrated into existing strategies and policies — across sectors, and with ministries in many different areas involved in developing these programs of action — and could be developed as part of national health plans or other

national plans (e.g., on development, social inclusion, or the SDGs), or could be established separately. While we encourage countries to undertake health programs of action as national efforts, we also encourage provinces (states), districts, and municipalities to develop such programs of action.²

In addition to, or as an initial step towards, this comprehensive approach, countries could use these seven principles to guide strategies for a particular disease or health condition, or for the overall health system or a particular component of the health system. These principles could also inform individual sectors, as any ministry whose actions may affect health equity could incorporate these principles into its own plans and strategies. Countries may also choose to focus on health systems and certain other key determinants of health that are judged to be priorities, rather than a more complete set of determinants.

Meanwhile, until health equity programs of action are developed, various actors could help lay the groundwork. For example, civil society or a human rights commission could create a health equity program of action to inform advocacy and guide policymakers, while stimulating a national conversation. Civil society organizations can focus on health equity. And individuals and entities involved in data collection could endeavor to collect more disaggregated data, while policymakers could better use disaggregated data to inform policies and program design and monitoring.

Health equity programs of action would help government officials meet SDG and other commitments. For instance, by increasing productivity, they could help generate inclusive economic growth and reduce poverty, while measures that are part of these programs of action will contribute to healthier environments, reduced hunger, decent housing, and so forth. The equality, participation, and accountability that are core aspects of SDGs 5, 10, and 16 are core aspects of health equity programs of action as well. Health equity would also directly benefit the health of members of marginalized and disadvantaged populations while affording them central roles in decision-making processes, advance the missions of civil society organizations and enhance their accountability efforts, help create an enabling environment for service providers while providing them greater voice, and contribute to the goals of development partners.

Getting started

To initiate and help guide the health equity program of action, countries could establish a multi-stakeholder, multi-sector steering committee to drive the process, perhaps with co-leadership from a member of a marginalized or disadvantaged community and a government official. The committee could organize a National Health Equity Dialogue, a national forum with broad participation to inform people of the upcoming process to develop the health equity program of action and to enable them to provide initial input, as well as to finalize decisions on the parameters for and process of developing the health equity program of action. The dialogue could also be a forum for members of marginalized and disadvantaged populations to plan for how they will participate in developing the program of action, as well as to engage the media so that they may raise the issue of health equity in the public consciousness. A country may choose to hold several such dialogues.

HEALTH EQUITY PROGRAMS OF ACTION



Even though people overall are becoming healthier, many people are being left behind.



Black South Africans live 16 years less than white South Africans.*



56 years of life

73 years of life

In many countries, impoverished women are far less likely to be attended by a skilled birth attendant.**



Poorest 20%



Wealthiest 20%

Members of the Inuit people in Canada are over 300 times more likely to have tuberculosis than non-indigenous Canadians.



Inuit

Non-indigenous Canadians



HEALTH EQUITY PROGRAMS OF ACTION

Countries should develop comprehensive, inter-sectoral, human rights-based plans to reduce health inequities, possibly through national health plans or development strategies.

These health equity programs of action would follow 7 principles.

- 1 Empowering Participation and Inclusive Leadership:** Prioritizing perspectives of marginalized and disadvantaged populations and including these populations in leadership structures
- 2 Maximizing Health Equity:** Covering a broad range of health issues and addressing deeply-rooted structural determinants of health
- 3 Health Systems and Beyond:** Addressing major social, environmental, and commercial determinants of health, with inter-sectoral approaches
- 4 Every Population Counts:** Systematically addressing each population experiencing health inequities
- 5 Actions, Targets, and Timelines:** Being action-oriented, with actions integrated into sector strategies
- 6 Comprehensive Accountability:** Encompassing a continuous process of monitoring progress and remedying shortcomings, and strengthening health accountability at national and sub-national levels
- 7 Sustained High-Level Political Commitment:** Enabling a long-term focus, sufficient resources, and inter-sectoral actions

SOCIAL, POLITICAL, AND ECONOMIC MOBILIZATION

Reduced disparities in life expectancy



73 years of life

73 years of life

Women, whatever their wealth, have access to skilled birth attendants

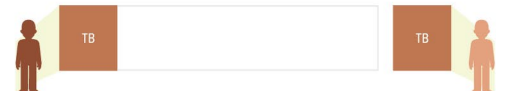


Poorest 20%



Wealthiest 20%

Marginalized and disadvantaged populations no longer have disproportionately high levels of disease



Inuit

Non-indigenous Canadians

EVERYONE HAS A FAIR AND JUST OPPORTUNITY TO LIVE A LONG, HEALTHY LIFE.

FOR MORE INFORMATION, PLEASE CONTACT ERIC FRIEDMAN (EAF74@LAW.GEORGETOWN.EDU) OR SEE ONEILLINSTITUTE.ORG

* Numbers do not add up due to rounding. ** In a number of countries, including Cameroon, Guinea, Haiti, Kenya, Madagascar, Nepal, Niger, Nigeria, Senegal, and Timor-Leste, only 10-20% of births to women in the poorest quintile are delivered with the assistance of a skilled birth attendant, compared with 70-90% of women in the wealthiest quintile.

Human Rights and Health Equity

The health equity program of action would support the responsibility that all countries have to meet their human rights obligations, including the right to health. This right requires all health goods, services, and facilities — including the underlying determinants of health — to be available, accessible to everyone, acceptable, and of good quality. The health equity program of action can help ensure that these health needs are in fact available to the entire population. The program of action would intersect with such core obligations of the right to health as non-discrimination, ensuring the equitable distribution of health goods, services, and facilities, and developing a health plan that meets the needs of the whole population and gives particular attention to marginalized and disadvantaged populations. The health equity program of action would also advance — and should be developed in accordance with — overarching human rights principles, including equality and non-discrimination, participation, and accountability. And it would advance other rights linked to the broader determinants of health, such as rights to education, to safe workplaces, and to benefit from scientific progress.

The health equity program of action would be aimed at health equity, a concept synonymous with substantive equality in human rights terminology. Achieving health equity will mean that all people have “a fair and just opportunity to be as healthy as possible,”³ requiring the elimination of all health disparities that are unfair, the result of discrimination or other injustices. Within the context of limited resources, determining what fairness requires will not always be a straightforward matter. Questions of what is fair and just should be resolved through inclusive, participatory processes, the type of processes that are integral to developing and implementing the health equity program of action.

Principle 1: Empowering Participation and Inclusive Leadership

People’s right to participate in the decisions that affect their health is a core value that all aspects of the health equity programs of action and associated processes should incorporate, empowering people in populations experiencing health inequities and enabling them to have central roles in the health-related policy decisions that will affect their lives. This means that people experiencing health inequities should be part of, and have the opportunity to take leadership positions in, these processes. Their priorities and perspectives should receive privileged consideration. Along with the value of their input, the centrality of marginalized and disadvantaged populations to health-related policymaking itself stands to be empowering, an affirmation of the dignity of marginalized and disadvantaged populations, a response to the political and social exclusion that is often an underlying factor in health inequities. Besides being a core element of the right to health, such participation will also help ensure that the health equity program of action will incorporate the most impactful solutions.

Diverse communities

Recognizing that even particular communities are not homogenous, diverse members of the community should be able to participate. Migrants, for example, include men and women of all ages, those who are legally present and those who lack proper documentation, refugees and asylum seekers (who receive special protections under international law, and are thus sometimes referred to as a distinct population from other migrants), and people from different countries, among other sub-groups. Where possible, all community members would have opportunities to express their views, by means such as interviews, focus groups, meetings, surveys, and mobile phone technology.

Meaningful participation, accountable representation, and empowerment

To be meaningful, participation should be informed, fair, transparent, respectful and nonjudgmental, and attentive of power dynamics. It should also enable marginalized and disadvantaged populations, who may distrust authorities, to have safe spaces for discussion. And since not everyone who would be affected by the health equity program of action would be able to participate, principles of accountable representation should be implemented to the degree possible, so that participants can genuinely represent their communities and be answerable to them. In addition, to enable members of marginalized and disadvantaged communities to effectively participate, civil society organizations or empowered members of these populations could train people in their rights and the skills that would enable them to effectively and confidently engage in the process.

Joint and inclusive governance

While the participation and leadership of populations experiencing health inequities is foundational, inclusiveness should extend throughout the range of stakeholders who are affected and those who have a role in developing and implementing health equity programs of action. Structures associated with these programs of action would operate according to principles of joint and inclusive governance, in which members of the government and other stakeholders take decisions jointly. Such joint and inclusive governance should also help engender understanding between populations experiencing health inequities, policymakers, and service providers.

Approaches to empowering participation and inclusive leadership

There are a variety of approaches that countries could take to facilitate empowering participation and leadership of populations experiencing health inequities in developing the health equity program of action. Some approaches offer a more thorough process of engaging marginalized and disadvantaged population than others. These more thorough approaches may better contribute to developing sustained, empowering processes, but they may also be more resource intensive.

One approach would be for the process to be led by the steering committee or a health equity program of action task team, which may be newly developed or be a multi-stakeholder, multi-sector body that already exists. It would be comprised, in significant part, of members of populations experiencing health inequities.

Another approach would be, along with this task team, also establishing population teams, which would be comprised of members of populations experiencing health inequities. One could be developed for each

population experiencing health inequities, with each developing the components of the health equity program of action particular to that group. Such teams, which may also include civil society, academics, or others who work with these populations, could either self-organize or form with the assistance of the steering committee or civil society.

Combinations of these two approaches are also possible and could take many different forms. For example, each population team could be comprised of several different populations, there could be one population team comprised entirely or almost entirely of members of different populations experiencing health inequities, or the task team itself could be comprised primarily of members of marginalized and disadvantaged populations.

Whatever the exact structures and processes that countries utilize, one critical result of the proposed approaches is that policymakers, civil society, and people from populations experiencing health inequities would be working closely together, and thus have the opportunity to learn from one another and understand one another's realities.

Just as an initial National Health Equity Dialogue could enable broad public participation and input at the beginning of the process to establish the health equity program of action, a second National Health Equity Dialogue could be held to affirm the final health equity program of action or decide upon any revisions. As with the first National Health Equity Dialogue, the media should be invited so that they may share information with the public about the program of action. The second such dialogue could also be a forum for other activities, such as meetings among stakeholders to initiate the process of implementing the program of action and for train-the-trainers human rights sessions for health workers.

Capacity building

Capacity-building measures may be needed to enable members of some marginalized and disadvantaged populations to fully and confidently participate in developing health equity programs of action, including skills building and education on their rights. Solutions may also be needed to resolve practical obstacles to participation, such as low levels of education and poverty.

Principle 2: Maximizing Health Equity

Health inequities are, by definition, unjust — the result of systematic, remediable differences across populations. Countries ought, therefore, to seek to achieve the maximum possible progress in reducing them, with the ultimate aim of eliminating them entirely. This means that health equity programs of action should cover a comprehensive array of health issues (though most of the framework for these programs of action could be applied on a narrower basis, to particular diseases or health conditions, for example).

Maximizing health equity also requires addressing deep, structural determinants of health, affecting the distribution of power and income and the control over economic and social resources. It would be necessary to address, for example, where power lies within the health, education, criminal justice, and other systems, whether everyone has an equal voice in the political system and equal access to policymaking positions, and whether any populations are excluded

from these systems. Issues of governance and corruption, too, cannot be outside the scope of health equity programs of action. Steps to counter societal and structural health determinants that contribute to health inequities may be the most challenging aspect of health equity programs of action.

Such fundamental changes would likely take some time to accomplish and for the effects to translate into improved health outcomes. And this would need to be an ongoing process. The first health equity program of action to be implemented is unlikely to be able to fully address all of these areas. But it can, and should, begin.

Maximizing health equity also requires an evidence base to guide actions, and creating and harnessing political will, with empowered populations who experience health inequities central to creating this will.

Principle 3: Health Systems and Beyond: All Social Determinants of Health

Health systems significantly impact people's health and, in turn, health equity. Ensuring equity throughout the health system is necessary and would significantly affect overall health equity. Yet the environment in which people live and work affects their health even more than the clinical health services they receive. Health equity programs of action should, therefore, be intersectoral, addressing the full range of social, environmental, economic, and political determinants of health. Improvements in many areas would affect multiple diseases and health conditions, making interventions both necessary for health equity and highly impactful. If necessary due to resource or other practical constraints, the programs of action may focus on only certain determinants deemed priorities in the country context. For some positive determinants of health — for example, adequate housing, sufficient food and good nutrition, and clean water and sanitation — health equity requires universal access, achieved through equitable pathways. For other determinants — such as income and the natural environment — greater equity within these areas would contribute to greater health equity, whether directly (as with protecting marginalized and disadvantaged populations from disproportionate levels of pollution) or indirectly (such as access to many health-related goods and services based on income, as well as effects on stress of insufficient income). Just as negative experiences with social determinants of health can negatively affect people's health, poor health can have negative ramifications for the social determinants (for example, inability to work), which can then further harm health.

Systematic assessments

Systematic assessments of these determinants and how they are contributing to health inequities would form the basis of health equity programs of action. These would include population-by-population assessments with respect to the social and other determinants of health, and could also include systematic reviews of each major determinant of health and its contribution to health inequities at a population-wide level. These assessments would also encompass laws, policies, and

programs aimed at increasing equity for each determinant and cutting across determinants, both in general and for particular populations. If possible, the review of laws, policies, and programs would also include information on implementation and enforcement. Assessments could also cover the nature and quality of governance as it relates to health equity, such as intersectoral collaboration, an enabling environment for civil society and the media, and government structures that foster participation and accountability.

The analyses undertaken during this phase should incorporate into their considerations how transnational factors, such as climate change and trade policies, may affect health equity domestically, and even how country actions may undermine — or enhance — health equity in other countries.

Multi-sector engagement

Different sectors bear chief responsibility for different determinants. Therefore, the principle of addressing a comprehensive set of social and other determinants of health also entails engaging multiple sectors. This engagement is necessary for developing, implementing, and assessing progress on the health equity programs of action, developing mechanisms to ensure sustained and effective intersectoral communications and actions, drawing on past lessons of intersectoral actions, and making sure that all sectors recognize the importance of health equity and their own roles in achieving it.

Principle 4: Every Population Counts

While many reasons for health inequities are shared by populations who experience these inequities, such as low income, less education, and a history of discrimination, many are also related to the characteristics and historical experiences of different populations. Health equity programs of action should, therefore, systematically examine health inequities in each population that is experiencing them and develop actions to address them.

Identifying populations experiencing health inequities

At least six sources of information can be used to identify populations experiencing health inequities:

1. Existing data, both in the health sector and in other sectors that may contribute to or detract from health. Besides revealing health inequities, these data may indicate the size of these inequities and key areas of focus for different populations. They may be supplemented by findings of rapid assessments and sampling methods.
2. Marginalized and disadvantaged populations identified in existing laws, strategies, and policies, as well as judicial decisions. Populations identified as marginalized or disadvantaged or that require particular protections against discrimination are likely to be experiencing health inequities.
3. Key populations and those of heightened risk of disease as delineated by international bodies, such as for HIV and AIDS and tuberculosis.

4. Populations against whom discrimination is prohibited, based on the list of categories in General Comment 20 on freedom from discrimination by the Committee on Economic, Social and Cultural Rights, as well as classifications WHO identifies as commonly used categories for monitoring health inequities.
5. Input from participatory approaches.
6. Adapting populations used in other countries' health equity programs of action, particularly in neighboring countries. Some populations (such as indigenous peoples and people with disabilities) experience health inequities in all or virtually all countries, and should be included in all health equity programs of action with few or no exceptions.

Addressing sub-populations

One key question in identifying populations to be included in the health equity programs of action is how to address sub-populations, such as people with different categories of disability, different indigenous populations, and migrants of different categories and countries of origin. There is no single answer, though in general, pragmatism will need to be balanced with important differences across sub-populations. One approach is to address an overall population (such as people with disabilities) along with particular issues that sub-populations face that are not reflected in the concerns that cut across that population, or sub-populations experiencing particularly high levels of inequity. The process used in developing the health equity program of action should seek to include different sub-populations.

Layered discrimination

Closely related to the matter of sub-populations is the issue of layered discrimination, in which people's multiple identities (such as being an indigenous, rural woman living in poverty) may lead to a unique set of obstacles to health equity. There is, again, no single right approach to how health equity programs of action should address this. One possibility would be to address populations experiencing layered discrimination where certain causes of the inequities they face and the responses to them would otherwise not be addressed.

Considerations regarding the children, adolescents and youth, the elderly, and people who are poor

Special considerations may be needed for determining how health equity programs of action should approach children, adolescents and youth, the elderly, and people who are poor. People who are young or elderly will have disproportionate levels of certain illnesses and health conditions based on their age, unrelated to discrimination. Youth and old age are life phases that everyone will experience (unless they die prematurely), unlike disparities other populations experience. Yet younger and older people may be marginalized, contributing to avoidable negative health outcomes. These populations might or might not be specifically included in a health equity program of action. One possibility is including them as sub-populations for certain other groups where particularly relevant to health inequities (such as an elderly indigenous woman or a young undocumented immigrant).

Meanwhile, while people who are poor universally experience some degree of health inequity, most of their concerns would be captured through other populations the health equity program of action covers, as many of these populations would themselves experience disproportionate levels of poverty. It may, however, be necessary to ensure that general issues of poverty and health inequity are not inadvertently

neglected if population-based analyses focus more on the distinctive issues that each population faces. Many health inequity generators that people who are poor experience would be addressed through analyses and corresponding actions in systematic assessments of the social and other determinants of health that the health equity program of action covers, many of which are linked to poverty. If people who are poor are included as a distinct population, sub-populations might be limited to those with concerns that would not otherwise be addressed, to avoid considerable overlap with other populations.

Regional inequities and marginalized and disadvantaged populations

Often, there are considerable health inequities across regions within a country, with worse health indicators in areas with populations who have higher levels of poverty or experience other causes of health inequity. Countries may want to consider whether to include region-specific analyses and actions in their health equity programs of action.

Analyzing health inequities population-by-population

When analyzing the extent and nature of health inequities for each population, countries could consider for each population:

1. each determinant of health, this time assessing how it may impede health equity for that population;
2. diseases or other health conditions that disproportionately burden that population;
3. behavioral factors contributing to health inequities for that population;
4. biological factors amendable to intervention that contribute to health inequities for that population, and;
5. inadequate research and knowledge related to diseases or health conditions that disproportionately affect that population or that may affect that population differently compared with other populations.

Another five-factor framework analyzes health inequities based on:

1. socioeconomic position;
2. differential exposure to health risks;
3. differential vulnerability to the same level of exposure;
4. differential health outcomes from the same condition, and;
5. differential consequences for the same health outcomes.

Information sources

Information could come from a number of sources, including health and demographic data; laws, regulations, and policies; reports, articles, and other written analyses; a review of current accountability mechanisms; international reviews related to health equity, and; interviews, meetings, focus groups, and surveys of members of marginalized and disadvantaged populations and other stakeholders.

Health equity research

The health equity program of action could set the stage for developing a national health equity research plan to better understand existing health inequities within and across populations and actions that aim to address them. While the program of action might not itself incorporate a research plan, it could include actions to catalyze development of a research plan by identifying the lead institution or institutions that will develop the plan, key research questions, the date by which the plan should be completed, an estimate of any costs associated with developing the plan, and any principles that should be incorporated (such as involving people from marginalized and disadvantaged populations as researchers and in research-related decision-making).

Principle 5: Actions, Targets, and Timelines

Determining the actions

Actions could address, for each population, obstacles to health equity related to 1) major determinants of health; 2) diseases and health conditions; 3) behavioral factors; 4) biological factors, and; 5) inadequate research and knowledge. Actions could address one, several, or many populations, might cut across these areas and different determinants of health, and can build on one another. Since many actions will respond to health inequities that multiple populations experience, it will be important to harmonize actions into a single set of measures. To ensure that potential actions that would benefit many populations but are not specific to any one population, or to a small group of populations, are not neglected with this population-based approach, countries would be advised to review the systematic, nationwide assessments of each determinant of health and its contributions to health inequities to ensure that actions have been identified to respond to each of them.

Actions may include pilot programs, and national health equity programs of action should include measures to catalyze sub-national actions towards equity, such as targets, health equity mandates, funding, recommendations on sub-national action, and establishing networks. Actions should also incorporate responses to transnational considerations that have been identified. This can involve both methods for countries to mitigate the ways transnational factors undermine health equity domestically and ways to help create an international environment more conducive to health equity both within their own countries and in other countries. Actions could include key steps to initiate a national health equity research plan, and they should include accountability measures (discussed in the chapter on comprehensive accountability).

Prioritizing actions

Resource and institutional constraints, capacity limitations, political realities, and other factors would almost surely preclude the possibility of immediately and fully undertaking all of the actions determined necessary to address health equity. This makes it necessary to prioritize among them. It may be desirable to include among the priorities “quick wins,” as well as initiating actions needed for long-term, structural changes.

The perspectives of people in populations experiencing health

inequities should be central to determining the priorities. Forums should be available for members of different populations to discuss their views on priorities, particularly when levels of priority that different populations place on similar actions diverge significantly.

Ten factors to consider in this prioritization are:

1. priorities identified by populations experiencing health inequities;
2. populations with the most severe health inequities;
3. actions likely to lead to the greatest reductions in health inequities;
4. cost-effectiveness;
5. actions achievable within current and anticipated resources;
6. actions acceptable to affected communities;
7. actions that can be implemented in an acceptable timeframe;
8. actions most likely to be effective;
9. actions consistent with local and national priorities, and;
10. actions significantly contributing to people's well-being beyond health effects.

In some areas, priority-setting might be most effectively done at sub-national levels.

“SMART” actions

Actions should be “SMART”: specific, measurable, achievable, realistic, and timebound. Deciding which actions are realistic, particularly in the short-term, would include considering political will and resource requirements. Creating timebound actions will include determining whether they are for the near-, medium-, or longer-term, which would be linked to how they are prioritized. Responsible actors should be attached to each action, as should, where possible, estimated costs. Actions may include funding or other measures to catalyze local health equity initiatives.

Targets and indicators

Action plans should also have targets, which may relate to individual actions, several related actions, or the entire action plan. Targets may address structural changes, inputs (such as resources) required to achieve one or multiple actions, outputs from an action, outcomes of the action, or impact on health equity. Targets, in turn, may have benchmarks, as well as indicators to track progress towards the targets. In selecting indicators, countries would need to find a balance between what may be the ideal indicators and what is possible to track with available information.

Principle 6: Comprehensive Accountability

A robust approach to accountability is vital to ensuring that health equity programs of action are successfully implemented, with input from members of populations experiencing health inequities and individuals and organizations that might not otherwise be engaged in developing the program of action. These may include NGOs working on accountability and academic, international, and governmental experts in accountability. The program of action should be widely disseminated in accessible forms. These may include non-written forms.

Incorporating actions and health equity into strategies, budgets, monitoring, and sector missions

A critical step for implementing and ensuring accountability for the health equity program of action is to integrate it into the strategies, plans, processes, budgets, and monitoring and evaluation mechanisms of different ministries. Processes for this may already be in place, particularly if the program of action is part of the national health plan or national development strategy. Sub-national health sector and other strategies should similarly incorporate pertinent aspects of the health equity program of action, as should plans of non-governmental entities. Relevant entities and individuals — including ministry officials in numerous sectors, government officials at the sub-national level, and non-governmental entities — should be invited to participate in National Health Equity Dialogues to lay the groundwork for incorporation. Targeted outreach to them may also be necessary to ensure this incorporation.

Beyond the health equity programs of action, governments should incorporate the goal of health equity into the mission of all relevant sectors. Training, sector-specific targets, coordinating structures, regular reviews, and health equity impact assessments may facilitate carrying out this goal.

Monitoring and evaluation, disaggregated data, and reporting

Monitoring and evaluation is a central part of any accountability regime. Monitoring and evaluation should be built into individual policies and programs that are included among the actions of the health equity program of action. Effective monitoring and evaluation of the health equity program of action will be greatly facilitated if it is based on quality, disaggregated data. Yet the disaggregated data and information needed to understand health inequities may be lacking. Sometimes it will be possible to use proxy indicators for which data is available. However, often, new quantitative and qualitative information will be needed. Data related to inequitable health financing might also be unavailable.

Non-representative rapid assessments using qualitative methods and sampling methods to collect quantitative data locally and extrapolate this information to the national level are two possible forms of supplemental data collection to quickly gather disaggregated data and other information on health inequities. All data collection should adhere to ethical and human rights standards. Over time, though, different dimensions of health inequities should be routinely and systematically collected and reported. This will require enhancing

national health information systems — including with respect to health status, services, and outcomes — as well as information systems of other sectors that affect health equity. Information systems should be open and transparent. In determining measures to improve disaggregated data collection, reporting, and use, key individuals and entities to engage include health information units of the ministry of health and comparable units in other ministries, the national statistics office, health and other researchers, and public health institutions. Health workers and others on the front lines of data collection should be trained on data collection and how to use this data, and informed about ways in which other actors would use this data, which would demonstrate the importance of data collection.

The government should provide public annual reports on progress. Other stakeholders, including civil society and members of marginalized and disadvantaged populations, should be able to contribute to these reviews, which should include information on why progress is or is not occurring and on why targets are or are not being met, as well as recommendations on how to improve implementation.

Forums for accountability for health equity programs of action

Accountability measures should also include structured forums for input from civil society and members of populations experiencing health inequities on progress in implementing the program of action and in acting on recommendations from annual progress reports and other reviews and forums. Four possible forums are:

1. Annual National Health Equity Dialogues, enabling participants to offer their perspectives. These may provide insights into reasons for any shortcomings in implementation. Participants should have the opportunity to question public officials, and the media can share information from the dialogue on progress in implementing the program of action with the general public.
2. Continuation of the steering committee, or a similarly constituted multi-stakeholder, multi-sectoral body, which may also issue recommendations on improving implementation and possible adjustments to the health equity program of action based on progress and lessons.
3. Enabling members of civil society and populations experiencing health inequities to join relevant government structures, such as an interministerial committee addressing Health in All Policies.
4. Establishing separate bodies comprised primarily or exclusively of members of populations experiencing health inequities and civil society, which may provide their views on implementation and offer recommendations, to which the government and other responsible actors would respond.

Meanwhile, along with issuing regular reports, government-led accountability processes and forums could include parliamentary hearings, as well as reviews and recommendations for action from individual ministries, national human rights institutions, and interministerial committees addressing Health in All Policies.

Building capacity to improve accountability for health equity

Health equity programs of action should include establishing new or strengthening existing health accountability mechanisms and processes (or both establishing new ones and strengthening existing

ones) and improving capacity for health accountability and health equity, including accountability for the right to health. Capacity-building measures could include incorporating human rights training into health worker pre-service and in-service education, enhancing the understanding of government officials and others of the daily realities of people experiencing health inequities, training local officials in health inequity monitoring, hiring additional staff, clearly delineating who is responsible within agencies to implement health equity actions that are within their mandates, and using technology to improve transparency. Countries could also identify and use underutilized capacity, especially the knowledge, skills, and other capacities of populations experiencing health inequities. Academics, businesses, members of the country's diaspora, and parliamentarians may also be able to contribute their capacities towards successfully implementing the health equity program of action.

Health equity accountability mechanisms

Accountability mechanisms that countries might develop or strengthen, with corresponding actions included in the health equity program of action, include village health committees, community scorecards, health promoters, annual health assemblies (like National Health Equity Dialogues), human rights commissions, laws guaranteeing people the right and means to participate in health-related decision-making, complaint mechanisms, safeguarding the right to access information and the freedoms of expression, peaceful assembly, and the press, ensuring an enabling environment for civil society organizations, ensuring access to the courts, civil society capacity-building, laws or policies requiring health equity impact assessments, developing policies for real-time monitoring of health inequities (e.g., maternal and child mortality audits, with a focus on differences across populations), annual statements from each sector on measures to address inequities and audits of sector strategies against the health equity program of action, public education on the right to health, covering transportation and other costs for members of marginalized and disadvantaged populations to meet with policymakers, and using mobile phone technology.

Updating health equity programs of action

The health equity program of action should be periodically updated, reflecting progress, changed circumstances, and improved information. Along with the above processes and forums for understanding progress and challenges, operations research and additional research may inform these revisions.

In addition to updates or full revisions of health equity programs of action, government ministries should incorporate a health equity lens into their regular planning processes. Ministries might establish multi-stakeholder committees to offer input into maximizing equity within their sectors, which will generally, in turn, contribute to health equity. Meanwhile, to provide advice, guidance, and framing for how each sector can incorporate health equity into their plans, along with input from National Health Equity Dialogues, countries could establish a standing multi-stakeholder, intersectoral national health equity committee, which might be linked to any SDG structures that countries have developed. Such national health equity committees could:

1. provide overall advice and guidance;
2. assist in determining cross-sector priorities;
3. ensure collaboration and coordination across ministries;

4. engage with other key political actors;
5. work with non-governmental entities, and;
6. establish national and corresponding sector targets, which could be endorsed at the highest levels of government.

Countries could also periodically update their health equity program of action through this type of process, combining overall guidance from a national health equity committee with action plans established through each sector to contribute to health equity. Leadership by members of marginalized and disadvantaged populations within the national health equity committee and in the planning processes of each ministry would remain critical. It would also be necessary to incorporate non-governmental actors that may have responsibilities under the health equity program of action into these processes.

Principle 7: Sustained High-Level Political Commitment

Health equity programs of action would require effective intersectoral coordination and collaboration and likely entail significant policy changes and require legislative action and resource allocation. All of this can only happen with high-level political commitment. Health equity would need to be a continuing national priority to successfully implement the health equity program of action. Strategic approaches — such as tailoring messages and who delivers these messages to different leaders, developing regional and international forums and processes to reinforce and motivate action, and building a government-wide culture that values health equity — could help foster and sustain political leadership for health equity.

Along with the review processes and accountability measures discussed in the chapter on accountability, which could also help create and sustain political will, the president or prime minister could establish the position of a national health equity coordinator who reports directly to the president or prime minister. Alternatively, the president or prime minister could appoint a national SDG advisor, with health equity as a key part of their portfolio.

Media organizations could structure health equity into their reporting and, along with civil society, support citizen journalists. Civil society organizations could form health equity coalitions, proactively hire members of marginalized and disadvantaged communities, and engage in sustained health equity advocacy. People from marginalized and disadvantaged communities, along with health workers and others working with members of these communities, can share their experiences of persisting barriers to health equity and the progress they experience and witness. Media organizations and civil society could help transmit their messages to the public and to policymakers. Collectively, such actions through the media and civil society, and leadership from within marginalized and disadvantaged communities, could build public support — and demand — for health equity, creating strong and sustained political pressure for prioritizing health equity.

Endnotes

- 1 We appreciate that different population views themselves differently with respect to these terms. Some may view themselves as marginalized, others as disadvantaged, others as living in situations of vulnerability — and others might use still different terminology. We do not intend any of these terms (or anything else in this guide) to give the impression of any such population being defined by these characteristics or lacking agency, or that they should view themselves in any ways other than as they in fact do view themselves and that they feel to be most empowering. For purposes of this guide, we generally use the terminology “marginalized and disadvantaged” to refer to all such populations. We hope that populations who are experiencing health inequities but use different terminology to describe their situations (such as living in situations of vulnerability) will recognize that we intend that they are fully included as populations referred to throughout this guide as among the populations who are experiencing health inequities, who should be full participants in developing health equity programs of action and included in associated leadership structures, and so forth.
- 2 For simplicity, the discussion in the implementation guide largely treats health equity programs of action as national creations. We stress, however, that leaders at more local levels can also follow this framework, applying references in this guide to national structures (e.g., countries, health ministries, and presidents) to their contexts (e.g., cities, health departments, and mayors).
- 3 Paula Braveman, Elaine Arkin, Tracy Orleans, Dwayne Proctor and Alonzo Plough, *What Is Health Equity? And What Difference Does a Definition Make?* (Princeton, New Jersey, USA: Robert Wood Johnson Foundation, 2017). http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf437393.



Georgetown University Law Center
600 New Jersey Avenue, NW, Washington, DC 20001

Phone: (202) 662-9203
oneill.law.georgetown.edu