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HEALTH SYSTEMS STRENGTHENING
PRACTICE SPOTLIGHT

ENHANCING EQUITY IN HEALTH SYSTEMS
The Critical Role of Implementation Research

HEALTH EQUITY SERIES

Health equity is a cornerstone of effective and sustainable health system strengthening (HSS). An equitable health system ensures that every individual has a fair chance to achieve their optimal health, irrespective of social or demographic factors. There is a critical need for integrated, systems-based approaches to enhance health equity to accelerate the achievement of Universal Health Coverage. This series of Health Equity HSS Practice Spotlight briefs documents effective approaches to improving health equity within HSS programming. This brief introduces implementation research as an effective means to addressing health equity challenges and offers country examples illustrating how the approach can enhance equity in the broader context of health system strengthening. Implementation research encompasses a range of questions associated with program implementation, drawing on quantitative and qualitative methods to study design and data analysis. The complexities associated with improving equity through specific interventions cannot be overstated. Implementation research can help decision makers and program implementers understand whether the needs of specific marginalized populations are being met and empower disadvantaged groups to influence policies and programs intended for their benefit.

INTRODUCTION

The large-scale delivery of high-quality, integrated, preventive, promotive, and curative health services presents a formidable challenge to health systems. Equity-enhancing implementation research is essential to improving the ability of health systems to provide this care equitably and achieve goals for universal health coverage (UHC). This brief provides examples of how implementation research can address equity challenges and offers recommendations for practitioner consideration.

Health equity is "based on the principle that all people should have a fair opportunity to achieve their health potential," as described in USAID's Health Systems Strengthening Vision 2030.[1] "Health care is equitable when people who need it can access it in trusted ways that are available to all, including to poor, underserved, and vulnerable populations."[1] Health equity is central to strengthening health systems focused on outcomes, along with quality and resource optimization.

Implementation research is "the scientific inquiry into questions concerning implementation."[2] It seeks to address the common program challenge of "how to take proven interventions and implement them in the real world", capturing and learning from information in real time, especially before and during the scale-up of interventions.[3] Implementation research is intended to be a collaborative endeavor engaging stakeholders in the design, implementation, and use of the policy, program or services being studied. It brings a "systematic approach to understanding problems related to policy and program implementation and adoption, then identifying and testing possible solutions for improvement in an adaptive or iterative process."[4] While there are multiple approaches to program improvement, "the purpose of implementation research is to generate generalizable or contextually specific knowledge about a specific research question that should lead to program or policy development or change."[4]

PURPOSE

This brief identifies specific ways implementation research can address health systems equity challenges with emphasis on the following:

- Bridging the often-substantial gap between design and implementation reality of pro-poor policies and strategies
- Increasing accountability for equity-enhancing outcomes as programs scale-up by explicitly measuring and accounting for equity-related variables
- Empowering disadvantaged groups to influence programs and policies intended for their benefit

Case studies illustrate how implementation research conducted in Guinea, Ghana, and India can enhance equity within health systems.

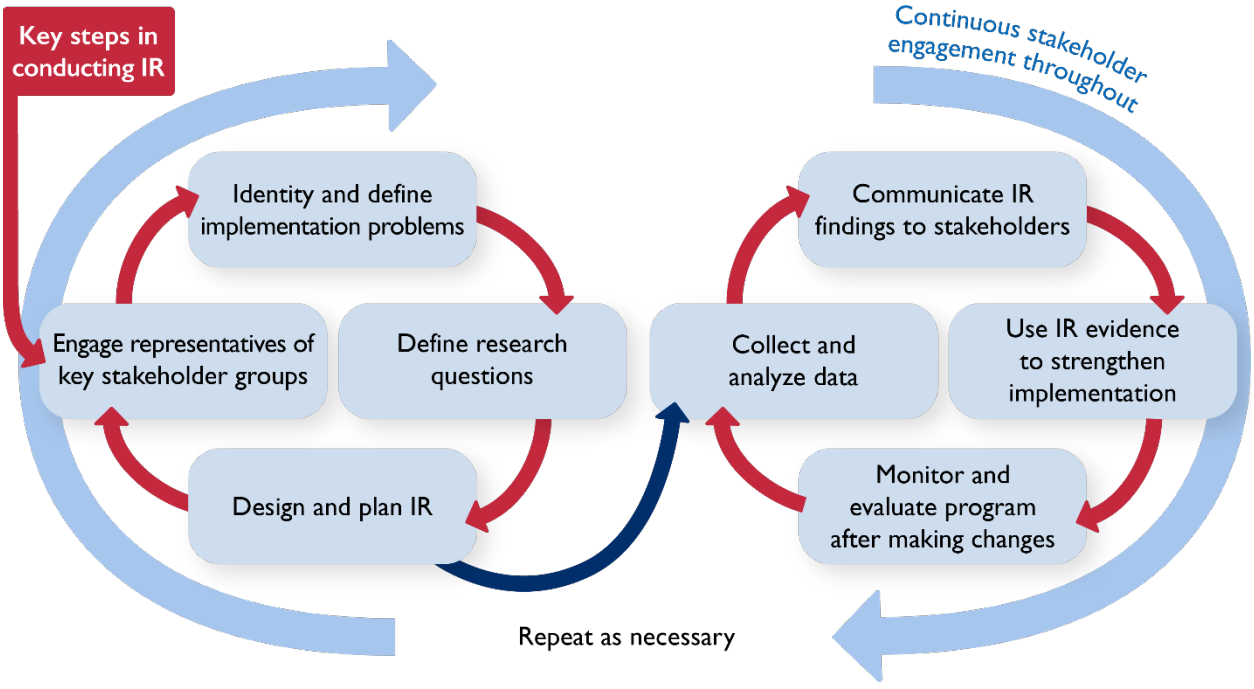
IMPLEMENTATION RESEARCH METHODS AND PROCESS

Implementation research encompasses a broad spectrum of research questions related to implementation, drawing on a wide array of research disciplines and methods, spanning quantitative and qualitative approaches to research design, data collection, and analysis. Methods should be selected to fit with the aims and practical constraints associated with the research. Examples of specific methods and their uses can be found in Implementation Research in Health: A Practical Guide.[3]

Figure 1 illustrates the cyclical process and iterative nature associated with engaging stakeholders and generating evidence in implementation research.

With each iterative re-design of an activity, policy, or process, researchers collect and analyze data, communicate findings to stakeholders, and use evidence to strengthen implementation or inform approaches to scale-up. Implementation research may be conducted at the outset of an intervention or later in the process when there is a recognized need to identify and address implementation challenges.

FIGURE 1. KEY STEPS IN CONDUCTING IMPLEMENTATION RESEARCH (IR)



Adapted from: 10 Tips on Implementation Research for Decision Makers in Low- and Middle-income Countries[4]

BENEFITS OF IMPLEMENTATION RESEARCH FOR HEALTH SYSTEMS AND HEALTH EQUITY

Numerous factors facilitate or impede the impact of public health policies and interventions across diverse geographies and levels of the health system. The interplay of these factors is challenging to discern and anticipate, particularly in terms of their impact on equity. Improving equity through specific interventions is a complex task, making it critical to monitor and adjust accordingly. Implementation research can illuminate whether the specific needs of vulnerable sub-populations are being understood and met, identify whether the perspectives and priorities of marginalized groups are being incorporated effectively, and explore the contextual factors that may be enabling or inhibiting the impact of an intervention on health equity.

Implementation research helps countries strengthen their health systems by addressing the "how-to gap" for achieving health goals in their unique settings. It helps decision-makers identify the root causes of challenges and successes in the implementation of activities, develop, test, and generate buy-in for contextualized solutions, capture and analyze information in real time, and facilitate the scale-up of effective interventions.[2, 4] It can reveal how interventions affect health equity in both intended and unanticipated ways. Equity-related findings can also be used for advocacy and accountability purposes with decision makers.

CASE STUDIES

Examining Guinea's decentralized community health policy implementation from an equity lens: theory vs. reality

This case illustrates how implementation research can help bridge the gap between theory and implementation reality for policies and strategies designed to benefit poor and rural, underserved populations. The study uses a decision space approach, examining the functions and decision-making authority assumed by local officials during a decentralization process.

In 2017, the Government of Guinea adopted a new national policy for community health *(Politique Nationale de la Santé Communautaire)* with a specific focus on rural, underserved communes (sub-districts). This policy was enacted concurrently with the implementation of decentralization reforms which transferred management responsibilities for health services, including community health, to communes. Viewed as a means of strengthening health systems, this reform grants authority and management responsibility for health care services from central-level authorities to officials at lower levels of government.[8] A successful decentralization process can improve equity through shifts in resource allocation, promoting local initiative, information, and feedback loops, and the introduction of social accountability mechanisms.[9]

Guinea's community health policy outlines an integrated set of prevention and care services to be implemented in rural communes by two types of community health workers (CHWs). The first are more highly trained and compensated community health agents, known as *Agent de Santé Communautaire,* or ASCs, who provide a package of basic health services, including for maternal and child health. The second type of CHWs are community organizers, known as RECOs, who operate under the supervision of ASCs to provide health promotion, disease surveillance, and prevention services.[10]

The USAID-funded Health Systems Strengthening Accelerator (the Accelerator) supported the government and its partners in conducting implementation research on execution of the policy using a decision space approach. This approach "defines decentralization in terms of the set of functions and degrees of choice that formally are transferred to local officials" from central authorities.[8] It is a method of systematically mapping out what is thought to be the level of authority and capacity at each health system level relative to the decisions that officials are making in practice. The Accelerator used mixed methods to compare the *de jure* decision space (decision authority, capacities, and accountability) stipulated in official strategies, policies, or laws, in comparison with the *de facto* decision space (the actual implementation practice) at the commune-level. This analysis identifies and explains the gaps between the policy's conceptualization and implementation as it is being rolled out to communes.[10]

The research questions focused on four themes: 1) The extent to which local public actors understand their roles and responsibilities under the policy, 2) The factors

that enable or inhibit the ability of local actors to carry these out, 3) The extent to which services designated to be provided by CHWs (both ASCs and RECOs) are actually being provided at the community level, and 4) Linkages between services delivered by CHWs and routine maternal and child health (MCH) service delivery indicators. The research also assessed perceptions among community members of the effectiveness of integrated services offered by ASCs and RECOs in meeting their health needs. The Directorate of Community Health and Traditional Medicine within the Ministry of Health (MOH) jointly prioritized these research questions with the Accelerator team. Representatives of the Directorate also participated in the training and supervision of data collectors, validation of study findings, and the development of key recommendations.

Findings to date of this ongoing research include evidence that Guinea's new community health policy is associated with increased capacity and accountability scores in communes where the policy has been implemented. Consistent with their higher-level roles, responsibilities, and training, ASCs demonstrated greater capacity and accountability than their RECO counterparts. The rollout of the community health policy was also associated with increases in maternal health service delivery indicators, including ANC1[a] and ANC4[b] consultations, assisted delivery at birth, and the number of live births delivered at health facilities. In contrast, there was no evidence of associated increases in child health indicators, such as vaccination coverage. When surveyed, 99.4 percent of ASCs and RECOs self-reported that they were sensitive to health issues that affect women and men differently, and 97.6 percent of respondents reported sensitivity to issues affecting adolescents and young people. Among local leaders (e.g., mayors, health center directors, and religious leaders) 92.1 percent agreed with the CHWs' self-reports. Regional government and health officials agreed slightly less that ASCs and RECOs were sensitive to the needs of women (86.2% yes), and to the issues affecting adolescents and young people (85.2% yes).

While a limitation of the study includes lack of explicit equity measures related to socioeconomic status, the design of the national decentralization policy is pro-equity in that it uses CHWs to extend the reach of services beyond health facilities, closer to remote populations. Improving execution of the policy through implementation research could logically be expected to convey equity benefits. A separate study on implementation of the community health policy conducted by Gamal Abdel Nasser University of Conakry and London School of Hygiene and Tropical Medicine identified improvements in maternal and child health indicators, including vaccination of children ages 12-23 months[c] and visitation of recently pregnant women during and after pregnancy[d] by RECOs/ASCs, in two districts where the new policy was being implemented.[11]

The Directorate of Community Health applied preliminary findings from the implementation research to inform development of its five-year national community health strategic plan (2023-2027) and ongoing local civil society advocacy efforts to strengthen and finance community health in Guinea.

Measuring and accounting for equity in Ghana's networks of practice prior to scale-up

This case study from Ghana illustrates how explicitly measuring equity-related variables can bolster accountability for equity-enhancing outcomes as programs increase in scale.

[a] ANC1 refers to the percentage of pregnant women who attended at least one antenatal care visit during their most recent pregnancy, typically during the first trimester.

[b] ANC4 refers to the percentage of pregnant women who attended four or more antenatal care visits during their most recent pregnancy.

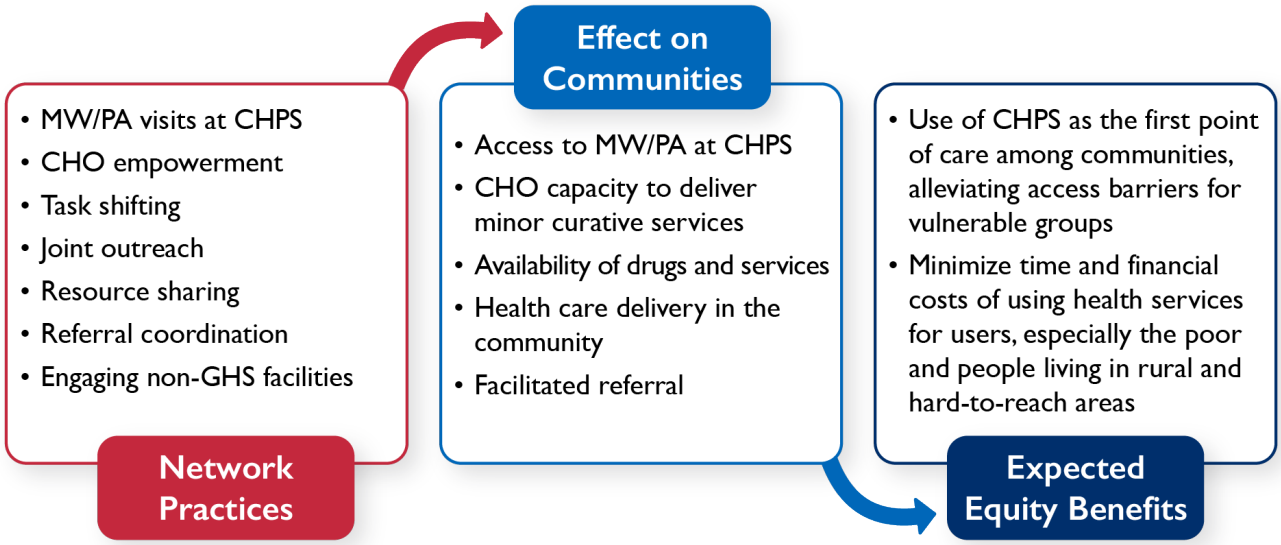
[c] The proportion of unvaccinated children ages 12-23 months decreased from 62.9% to 20.2% in the intervention areas of Télimélé and Kindia districts, as measured in surveys between May 2020 and February 2021.

[d] Recently pregnant women who received a home visit during their pregnancy increased from 40.9% to 53.9%, and women who received a home visit after their delivery increased from 34.9% to 48.2%, as measured in surveys between May 2020 and February 2021.

In Ghana, the primary health care system is built on Community-based Health Planning and Services (CHPS) compounds and health centers. Networks of Practice[e] (NoPs) group multiple primary health care facilities together with the intention of increasing service availability and quality at the community level.[12] A health center or other facility (e.g., a larger CHPS compound in subdistricts without a health center, or subdistricts that have a district hospital with a public health unit) serves as a central hub for other CHPS or nonpublic facilities associated with the local network. Network leaders train and supervise community health officers at the periphery to support them in providing essential preventive and primary care services. Network members share human resources and supplies to improve service readiness and quality of care. They also conduct joint outreach, coordinate referrals, and manage administrative tasks to maximize service delivery efficiency, such as processing National Health Insurance Scheme claims.

The promotion of well-functioning CHPS compounds as the first point of care in communities was expected to minimize opportunity costs and the need for referrals. Raising awareness about the availability of services at the compounds would also alleviate barriers to access, especially among poorer households, those living in remote or hard-to-reach areas, and other vulnerable groups, as reflected in the logic model (Figure 2.).[12] In other settings, interventions similar to those provided by the NoPs have been shown to promote more equitable access to care, such as the services provided via midwife or physician visits to CHPS compounds to deliver basic services and to train and empower community health officers; joint outreach bringing services from facilities to communities; resource pooling and exchange; referral coordination; and engagement with the private sector.[12, 13]

FIGURE 2. LOGIC MODEL OF THE EFFECT OF PCP NETWORKS ON THE EQUITABLE PROVISION AND USE OF HEALTH SERVICES AT THE COMMUNITY LEVEL



Acronyms: CHO, community health officer; CHPS, Community-based Health Planning and Services; GHS, Ghana Health Services; MW, midwife; PA, physician's assistant

The Ghana Health Service, with support from USAID and the Accelerator, conducted implementation research on the role of NoPs in advancing health equity in the communities they serve. The research looked at care seeking and perceptions of service quality. A household survey, using a questionnaire informed by The EquityTool,[14] in combination with qualitative methods, assessed differences in care seeking based on

[e] Known as Primary Care Provider Networks at the time of the research.

household wealth, head of household gender, and household location and distance to health facilities. These three dimensions of equity (wealth, gender, and location/distance) were prioritized by government stakeholders. As part of the participatory research process, the research team held a co-creation workshop with NoP practitioners and managers to formulate concrete recommendations based on the findings, including areas of action at the implementation and policy levels, and the need for further evidence.

Equity related findings associated with care seeking were mixed. Distance to facilities and transportation affected where people sought care.[12] Residents of urban areas, who also tended to be wealthier, were more likely to live closer to and therefore receive care at higher level facilities (e.g., district and sub-district health centers).[12] Similarly, wealthier households were more likely to seek care from district-level facilities compared to those from lower quintiles. With respect to gender, care seeking among female and male-headed households was similar despite lack of female economic empowerment and independence having been identified as a perceived barrier to women seeking care, especially in hard-to-reach areas with relatively high transportation costs.[12]

Despite examples of resource sharing within networks, such as jointly conducted outreach activities, obstacles including lack of supplies (at individual facilities and sometimes across an entire network) and inadequate staffing detracted from overall readiness to provide services. In addition, lack of transport impeded health workers from delivering services in hard-to-reach areas, while transport costs impeded patients from following through on referrals. The research also identified unintended negative consequences of a separate policy related to health facility accreditation and health insurance reimbursement. Namely, lack of credentialing or delayed recredentialing at some CHPS compounds and health centers meant that patients had to pay out of pocket to receive health services from unaccredited facilities, even if the patients had insurance coverage and the sites fell within the NoP.

Study respondents and co-creation workshop participants recommended offering education to clients and communities to leverage the role of local constituents in supporting network implementation. Respondents saw communities, community leaders, and religious and traditional leaders as key resources who can provide venues for outreach clinics, participate in community surveillance, promote appropriate care seeking and referrals, and potentially support overall accountability through monitoring NoP activities and service quality. Additional recommendations for the Ministry of Health and its partners included:

- Working closely with community health management committees to identify priority households for targeted services
- Integrating nonpublic facilities into NoPs to support resource-sharing efforts
- Designating a model health center as the hub in every network
- Defining equity and its indicators for all health service providers
- Reviewing and revising staffing and referral policies
- Monitoring and conducting trend analyses of equity in service utilization as networks are rolled out

Overall, the research findings underscored that addressing supply-side challenges, strengthening NoP facilities at the lower levels, and supporting transportation for referrals, could especially benefit poor and harder to reach populations. These groups are more likely to travel longer distances for care and to be served by less functional sites compared to more affluent individuals. Government leaders who participated in the research have been receptive to applying learning in bringing the networks to scale. Ghana Health Service released Implementation Guidelines for Networks of Practice in 2024. The guidelines reflect several recommendations from the study, including resourcing model health centers to serve as network hubs, and approaches to community engagement, participation, and demand creation.

Using implementation research findings to empower disadvantaged groups in India

This case study from India, adapted from previously published content,[2, 5, 6] illustrates how learning from implementation research in Andhra Pradesh and Karnataka States was used to empower a high-risk, disadvantaged community to collaboratively develop and refine HIV-related interventions in real time. The interventions targeted high risk populations most vulnerable to HIV, including female sex workers (FSWs), and encompassed outreach, condom promotion and

distribution, clinical services, and counseling and testing.[5] Documentation and findings are based on data from multiple studies, surveys, and reports, including a qualitative process evaluation and quantitative analyses of HIV prevalence and new infections in the two states.

Initiating HIV and AIDS outreach programs in India for FSWs, a disadvantaged community that often includes illiterate individuals, posed significant challenges. FSWs faced stigmatization and severe discrimination, including past experiences of police and family violence, in addition to typical power imbalances vis-à-vis men.[5, 6] "The pressing delivery challenge facing the government was how to reach the population of female sex workers and adapt these interventions to their specific needs."[5]

India's National AIDS Control Program, NGOs, and researchers used implementation research to enable FSWs to collaboratively develop and enhance HIV and AIDS interventions that would be most relevant to addressing their priority health concerns. The team used a variety of implementation research methods to refine the interventions based on three major sources of data: periodic surveys and assessments, annual sentinel surveillance, and routine program information. Results were triangulated prior to being used to inform successive improvements to intervention design. An initial needs assessment to better understand the FSW population found that addressing threats of violence and harassment were higher priority than HIV prevention, underscoring the intersectional nature of the population's vulnerability. Over time, FSW roles evolved beyond that of the traditional study population.

Based in part on implementation research findings, FSWs became central to the learning, design, and implementation of the interventions. The outreach strategy required numerous successive refinements. Ultimately, a shift toward using FSWs of various ages as peer educators in place of other outreach workers proved highly successful in engaging FSWs. In addition, peer educators and members of the FSW community participated in conducting site assessments that "informed the program of risk and vulnerability among the female sex workers and revealed information about their mobility and networks with other groups in the districts and beyond."[5 (p.9)] FSW peer educators were also empowered to self-report and compile their own data for inclusion in progress reports, used to make decisions concerning the addition of new services.

The consistent engagement of FSW peer educators encouraged community-led interventions, sparking enthusiasm for FSWs to organize themselves into community-based organizations, and fostering increased community participation.[5] These elements contributed to igniting a social movement to recognize the rights of sex workers, while generating appreciation for the perspectives of FSWs and their important contributions to program improvement.[5]

A separate study using a quasi-experimental design compared changes in HIV prevalence in pregnant women from 2007 to 2011 according to intervention intensity. It found statistically significant declines in HIV prevalence associated with the targeted intervention, suggesting intervention effectiveness[2, 7] above and beyond empowerment of the disadvantaged FSW population.

IMPLEMENTATION CONSIDERATIONS

When designed with an intentional focus on equity, implementation research can unpack obstacles that impede equity enhancing policies from having their intended effect. Even community health and CHW programs, considered "pro-equity" for bringing health promotion and other services closer to the population in need, face many constraints to successful implementation on a large scale, especially in under-resourced, uncoordinated, and poorly regulated public health systems.[10] Implementation research can provide vital information to overcome these constraints. While good practices for implementation research are widely applicable to equity-focused studies, the following recommendations can advance equity-specific aims.

Define equity in the context of the program approach and identify how equity factors into the underlying logic model, framework, or theory of change used in the implementation research

Equity can be considered from many perspectives, depending on the sub-population(s) of focus. An important step is to define what equity looks like and identify how it factors into the underlying logic model or theory of change in a particular context. In the Ghana case, the intervention was expected to alleviate access barriers for vulnerable groups and to minimize time and

financial costs of using health services, especially for the poor and people living in rural and hard-to-reach areas.

Multiple frameworks[f] can be applied to implementation research, such as EquIR, the Conceptual Framework of Equity-focused Implementation Research.[15] Although not used in any of the case studies presented, EquIR "offers a step-by-step proposal to facilitate the process of embedding equity issues in the implementation research of interventions or programs contained in health policies," including equity focused implementation outcomes.[15 (p.9)]

Include equity-enhancing research questions and measures from the outset of the research design process

Explicitly incorporating qualitative research questions and/or quantitative measures related to equity can help programs shift from making assumptions regarding equity to documenting and understanding the program or policy effects on sub-populations experiencing inequities (e.g., based on place of residence, race, occupation, gender, religion, education, socioeconomic status,[14] or their association with marginalized groups). This contributes to accountability for the equity effects of policies and programs. Several resources merit specific mention here. The WHO Health Inequality Data Repository contains publicly available, disaggregated datasets; it includes over 2000 indicators and 22 dimensions of inequality.[18] Datasets are accessible online through the Health Equity Assessment Toolkit (HEAT and HEAT Plus). Country Equity Profiles from the Countdown to 2030 show the magnitude and trends of health disparities, for consideration of what to measure. The Gender Analysis Toolkit for Health Systems[16] is a helpful resource for consideration of gender. The EquityTool[14] used in the Ghana case study uses a series of questions to determine the country-specific wealth quintile of respondents. Attention to equity measures in a program's preliminary stages has the added benefit of being able to influence scale-up, with equity in focus from the beginning.

Include disenfranchised and marginalized communities and beneficiaries as key stakeholders in implementation research on programs and policies intended for their benefit

A key facet of implementation research is its focus on stakeholder engagement. Relevant disadvantaged or marginalized groups should be empowered to participate in setting the research agenda, implementing the research, and formulating recommendations. Their engagement can help design, implement, and sustain interventions tailored to the needs of vulnerable populations and increase uptake and effectiveness to enhance equity. Marginalized groups may also identify factors that affect the implementation process that should be measured by the research or even become part of the research team. In the case from India, members of the disenfranchised population became part of the solution to reaching their peers and learned to calculate and report data themselves. Engaging health system stakeholders from service providers to decision-makers to disenfranchised or marginalized community members in the implementation research process can foster collaboration, learning, and shared ownership of programs or interventions. Ultimately, their engagement can help ensure that leaders, administrators, and service providers are responsive and accountable to the people they serve.

Disseminate and use learning from implementation research to improve, scale-up, and sustain pro-equity approaches and outcomes

Broad dissemination of learning to all stakeholders can help to promote its application across contexts, as demonstrated in Ghana with the application of findings to the scale-up of NoPs. Learning from implementation research can also be used to promote accountability. Throughout the implementation research process and dissemination of findings, duty bearers and implementers need to be accountable to the populations they serve, and community members and representatives of marginalized populations can be empowered to

[f] Implementation Research: New Imperatives and Opportunities in Global Health by Theobald et al. [2] contains a list of other pertinent frameworks that predate EquIR.

advocate for their needs. In Guinea, evidence of CHW effectiveness has been and will continue to be shared with MOH, other government Ministries, partners, and civil society where advocacy efforts are ongoing to increase financing and sustainability of the community health program using a combination of domestic and external resources. Finally, implementation research should consider and explore the actual ability (or de facto decision space), capacities (including adequate material and financial resources), and accountability among actors at different levels of the health system.

RESOURCES

Equity

Conceptual framework of equity-focused implementation research for health programs (EquIR)

Country Equity Profiles from The Countdown to 2030

Gender Analysis Toolkit for Health Systems

Health Equity Assessment Toolkit (HEAT and HEAT Plus)

Health Inequality Data Repository

Maternal and Child Survival Program Equity Toolkit: A Practical Guide to Addressing Equity in Reproductive, Maternal, Newborn, and Child Health Programs

The EquityTool - Equity Tool

Implementation Research

Implementation research in health: a practical guide

10 Tips on Implementation Research for Decision Makers in Low- and Middle- Income Countries

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About the Health Systems Strengthening Practice Spotlight Series

The Health Systems Strengthening Practice Spotlight series is an initiative of USAID's Office of Health Systems. Practice Spotlight briefs contribute to the global knowledge base in health system strengthening and support implementation of USAID's Vision for Health System Strengthening 2030 and the accompanying Health System Strengthening Learning Agenda. Learn more about how USAID is promoting evidence-based programming for Health Systems Strengthening:

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Health System Strengthening Evidence Gap Map

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