A COMPENDIUM OF TOOLS AND METHODS TO ADDRESS SOCIAL INEQUITIES AFFECTING THE HEALTH AND WELL-BEING OF WOMEN, CHILDREN, AND ADOLESCENTS IN LATIN AMERICA AND THE CARIBBEAN

PAHO
Pan American Health Organization
World Health Organization
Americas

UNFPA

EVERY WOMAN EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN, CHILDREN AND ADOLESCENTS
LATIN AMERICA AND THE CARIBBEAN

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Contents

Preface ..... **v**

Acknowledgments ..... **vi**

Abbreviations and acronyms ..... **vii**

Introduction **1**

Tools and methods to address social inequities affecting the health of women, children, and adolescents **3**

1. Equitable Impact Sensitive Tool (EQUIST) 4
2. INNOV8 5
3. Health Equity Assessment Toolkit (HEAT) 6
4. Health Equity 2020 Toolkit 7
5. Urban Health Equity Assessment and Response Tool (Urban HEART) 8
6. Gender Analysis Toolkit for Health Systems 9
7. Organizational Self-Assessment for Addressing Health Inequities Toolkit 10
8. Gender-Equitable Men (GEM) 11
9. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE) 12
10. iScreen Social Screening Questionnaire 13
11. Social Environment Inventory (SEI) 14
12. WellRx 15
13. Strategizing National Health in the 21st Century: A Handbook 16
14. Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence 17
15. Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-income Countries 18
16. Step-by-step Guide for Measuring Social Inequalities in Health 19
17. Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care 20
18. Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) 21
19. Global Accelerated Action for the Health of Adolescents (AA-HA!) 22
20. Demand for Health Services: A Human-Centred Field Guide for Investigating and Responding to Challenges 24
21. Strengthening the Adolescent Component of National HIV Programmes through Country Assessments: Adolescent Assessment and Decision-Makers' (AADM) Tool 25

22. Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty 26
23. Leaving no one behind: Methodology to set Health Inequality Reduction Targets for Sustainable Development Goal 3 28
24. UN Advocacy Tool 29
25. Assessment of Countries' Readiness to Provide Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) during a Humanitarian Crisis 30
26. The Lives Saved Tool (LiST) 32

References **35**

Glossary of terms **37**

Annex A **39**

Annex B **40**

Annex C **41**

Preface

Equity is a central theme in the Sustainable Development Agenda and in the Global Strategy for Women's, Children's, and Adolescents' Health 2016–2030. Considering the persisting social inequities in health affecting women, children, and adolescents in Latin America and the Caribbean (LAC), pursuing health equity is very important to the region. To support the achievement of health equity in the region, the regional interagency movement Every Woman Every Child Latin America and the Caribbean (EWEC-LAC) advocates for and supports the use of equity- and evidence-based policies, strategies, and interventions to accelerate equitable progress in the health of women, children, and adolescents.

A significant number of tools and methods have been developed that can support national and local strategies to identify, analyze, and address social inequities affecting the health of women, children, and adolescents. These tools and methods can assist governments and partners in making the Sustainable Development Goals' (SDGs) commitment to leaving no one behind operational. This compendium is intended to present resources and examples of application to further contribute to this goal.

The main purpose of this publication is to present an overview of existing tools and methods that can be used by policymakers, program managers, development partners, nongovernmental organizations (NGOs), academia, and civil society partners to strengthen systematic identification and analysis and respond to social inequities in the health of women, children, and adolescents in LAC. The tools and methods included were identified through a systematic search process described in the document.

While these tools and methods bring new insights and support to aid countries in identifying and reducing social inequities, they will not bring change unless they are accompanied by political commitment, targeted investment, and social engagement. Therefore, the tools should not be considered or used in isolation from other national and local efforts, processes, and resources that also aim to bring change and support countries in achieving the SDGs.

This list of tools and methods is not exhaustive, but rather a result of the search strategy applied, which includes an extensive literature review and key informant interviews. Furthermore, all tools and methods presented here are considered "living resources" and are continuously being revised and updated in response to feedback and lessons learned. The aim is to periodically update this compendium with new or newly identified tools and methods.

There is a great need to identify and monitor inequities affecting the health and well-being of women, children, and adolescents, and to implement innovative strategies to reduce these inequities in LAC. The aim of this publication is to contribute to these efforts.



Acknowledgments

This compendium of tools and methods to address social inequities affecting the health and well-being of women, children, and adolescents in LAC is the result of an effort coordinated by the regional interagency movement EWEC-LAC and was developed by the EWEC LAC working group on policies, strategies, and interventions (PSIWG).

Special thanks to the following individuals who contributed to the development of this document: Isabel Espinosa (Pan American Health Organization [PAHO]), Sonja Caffé (PAHO), Vanessa Victoria (PAHO), Oscar San Roman (PAHO), Virginia Camacho (United Nations Population Fund [UNFPA]), Sol East (UNFPA), Daniel Tobón García (consultant), Ashley Ambrose (consultant), and Maria Dolores Castro (consultant).

We gratefully acknowledge the resource persons from PAHO, UNFPA, the United Nations Children's Fund (UNICEF), the World Bank, and the Inter-American Development Bank (IDB) who shared their insights and experiences related to the application of the tools and methods included in this document.

Abbreviations and acronyms

AHSBA	Handbook for Conducting an Adolescent Health Services Barriers Assessment
CEQ	commitment to Equity Assessment
EQUIST	Equitable Impact Sensitive Tool
EWEC LAC	Every Woman Every Child Latin America and the Caribbean
HEAT	Health Equity Assessment Toolkit
LAC	Latin America and the Caribbean
LiST	Lives Saved Tool
OHCHR	Office of the High Commissioner for Human Rights
MISP	Minimum Initial Service Package
PAHO	Pan American Health Organization
SDGs	Sustainable Development Goals
SEI	Social Environment Inventory
SRH	sexual and reproductive health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

Although progress has been made in improving the health of women, children, and adolescents in Latin America and the Caribbean (LAC), great inequities persist. Women from the LAC region's poorest countries are almost four times more likely to die from complications during childbirth than those living in the wealthiest countries. Compared to children living in the wealthiest countries, children from the poorest countries in the region are three times more likely to die before their fifth birthday. Additionally, social inequalities place certain vulnerable groups of adolescents throughout the region at increased risk of pregnancy, HIV, and committing and experiencing violence.

Through the years, several tools and methods have been developed by global, regional, and country partners that can be used to conduct systematic equity-based analyses and/or redesigns of health systems, programs, strategies, and interventions. Some tools are designed to specifically identify and/or address social inequities in the health of women, children, and adolescents, while others aim to guide strategic health planning with an equity focus. Other tools and methods aim to systematically assess and address the extent to which programs respond to the health needs of specific populations, focusing on identification, analysis, and addressing barriers to health, promoting accountability, and strengthening equity-based planning processes. Lastly, some tools and methods have been designed to be applied in a variety of programmatic contexts, while others were designed for specific programs.

The main purpose of this document is to present an overview of existing tools and methods that can be used by policymakers, program managers, development partners, nongovernmental organizations (NGOs), academia, and civil society partners to strengthen systematic identification, analysis, and response to social inequities affecting the health of women, children, and adolescents in LAC. The tools and methods included were identified through a systematic search process described in the next chapter. The aim is to periodically update this compendium with new or newly identified tools and methods.

The methodology for the development of this compendium followed a descriptive-exploratory approach. The development process consisted of two stages: an extensive literature review followed by qualitative interviews with key stakeholders.

The literature review aimed to compile an initial inventory of tools and methods designed and/or implemented with the objective to identify and/or address social inequities in health. The review was executed using indexed databases such as Medline, Embase, and LILACS. The search strategy was based on the Borrel and Malmusi strategy (*1*). Additional resources (published or unpublished) were identified using a snowball approach. Controlled terms and free language were included, and the results summarized by a PRISMA diagram. Annex A provides details on the inclusion/exclusion criteria and the search strategy.

In the second phase, semi-structured interviews were conducted with two objectives:

1. To identify additional tools and methods not identified through the literature review.

2. To collect information on the design, implementation, and/or evaluation of the tools and methods. Persons to be interviewed were identified through the EWEC-LAC partners following a snowball strategy.

The interviews were conducted via teleconference. Interview questions were related to key elements of the tools and methods, and their application; documentation and evaluation of application; insights about implementation including strengths, challenges, facilitating factors, and barriers for successful application; and resources required for application. The key informant interview guide can be found in Annex B.

Tools and methods to address social inequities affecting the health of women, children, and adolescents

The tools and methods are presented in summary tables to facilitate easy navigation through the document. This also allows users to better compare and make decisions about the tools and methods that are most suitable for their specific needs, context, and capacities. A matrix listing the included tools and methods is available in Annex C.

1. Equitable Impact Sensitive Tool (EQUIST)

Name	Equitable Impact Sensitive Tool (EQUIST)
Author	UNICEF
Year of design	2016
Description	**Goal:** To support analysis and strategic prioritizing and planning to address maternal, newborn, and child health and nutrition inequities in developing and middle-income countries. **Objective:** To identify cost-effective interventions, prioritize key bottlenecks that constrain their coverage, and target the most effective and equity-focused strategies to increase maternal, newborn, and child health intervention coverage. **Design:** EQUIST is a web-based, free-access, analytical platform. It is a seven-step tool based on the WHO Innov8 tool. The seven steps of the EQUIST tool include: 1. Identifying priority populations based on patterns of deprivation. 2. Determining which diseases explain inequitable death and malnutrition rates among children and women. 3. Determining the right balance of interventions by service delivery packages. 4. Identifying challenges or bottlenecks that disrupt service delivery. 5. Pinpointing root causes of bottlenecks within a population. 6. Empirically evaluating and selecting from a host of effective strategies to mitigate the causes of key bottlenecks. 7. Comparing the impact and cost–effectiveness of intervention scenarios. EQUIST incorporates the functionality of Lives Saved Tool (LiST) to model lives saved and uses data and principles from the Marginal Budgeting for Bottlenecks (MBB) tool for its costing component. **Intended users:** EQUIST was designed to be used by public health specialists from different stakeholders including government at national and subnational levels, academia, donors, mulitilateral agencies, the private sector, civil society, and health workers themselves.
Reference link	https://equist.info/#/
Requirements for implementation	EQUIST is suitable for national and subnational implementation. For implementation, EQUIST must be set up and customized for each country before it can be used. The customization needs to happen as frequently as the intended use of the tool by using secondary data from different sources. Implementation requires financial and human resources for the convening of dialogues, data analysis, and prioritization of strategies. Estimated costs for start-up are approximately USD 100 000. Time needed for start-up depends on the given context. Once the tool has been customized for a given country, it can be implemented in less than a month at little cost.
Previous implementation countries and sites	EQUIST has prepopulated data from multiple indicator cluster surveys for 76 countries and territories worldwide. More than 35 countries have fully implemented EQUIST.
Implementation, experiences, and lessons learned	EQUIST highlights the complexity of interactions between equity, cost-effectiveness, and their determinants, also reinforcing important suggestions for future policy such as the significant effect on cost-effectiveness of increasing efficiency and quality of interventions in poorer quintiles. For effective implementation, the tool should be equipped with a robust set of data to increase the accuracy of EQUIST-based estimates. It is useful to conduct a training workshop on the tool before its implementation.
Case studies	Waters D, Theodoratou E, Campbell H, Rudan I, Chopra M. Optimizing community case management strategies to achieve equitable reduction of childhood pneumonia mortality: An application of Equitable Impact Sensitive Tool (EQUIST) in five low and middle-income countries. J Glob Health. 2012 Dec;2(2):020402. Available from: https://doi.org/10.7189/jogh.02.020402. Uneke CJ, Sombie I, Uro-Chukwu HC, Johnson E, Okonofua F. Using equitable impact sensitive tool (EQUIST) and knowledge translation to promote evidence to policy link in maternal and child health: report of first EQUIST training workshop in Nigeria. Pan Afr Med J. 2017;28:37. Available from: https://doi.org/10.11604/pamj.2017.28.37.13269.

2. INNOV8

Name	INNOV8
Author	WHO
Year of design	2016
Description	**Goal:** To support efforts in operationalizing the SDGs and the "leave no one behind" movement. **Objective:** To improve program performance through concrete action to address health inequities, support gender equality and the progressive realization of universal health coverage and the right to health, and address critical social determinants of health. **Design:** Innov8 is an eight-step program review process undertaken by multidisciplinary teams. The steps can be undertaken in their entirety or partially. The eight steps include: 1. Completing a diagnostic checklist; 2. Understanding the program theory; 3. Identifying who is being left out by the program; 4. Identifying the barriers and facilitating factors that subpopulations experience; 5. Identifying mechanisms generating health inequities; 6. Considering intersectoral action and social participation as central elements; 7. Producing a redesign proposal to act on the review findings; 8. Strengthening monitoring and evaluation. This method can be applied to evaluate programs aimed at women, children, and adolescents. Innov8 is usually facilitated by an external consultant, but its main implementors are stakeholders in charge of implementing the program or intervention being evaluated. **Intended users:** Primary target users are national health program managers and staff at central and subnational levels. The review team, assembled by program staff, should include representatives from other relevant parts of the health ministry, research institutes, civil society and NGOs, and other sectors and stakeholders as appropriate. The review team should also include representatives with expertise in equity, gender, human rights, and social determinants of health.
Reference link	https://apps.who.int/iris/handle/10665/250442
Requirements for implementation	Innov8 can be implemented at the national and subnational levels. It can be implemented in a variety of ways, either by full or partial application of steps, in synergy with national program reviews or revisions, municipal level healthcare planning, or in basic sensitization on "leaving no one behind." Usually, it requires a multidisciplinary review team to conduct the activities, depending on the scope of implementation, which results in recommendations for entry points and actions to address identified program gaps and challenges. Estimated cost of implementation is between USD 30 000 and USD 40 000. Estimated time required for implementation is approximately six months.
Previous implementation countries and sites	Chile, Dominican Republic, Honduras, Jamaica, Indonesia, Morocco, Nepal, Philippines
Implementation, experiences, and lessons learned	The application of Innov8 has contributed to the strengthening of the capacities of individuals, work teams, and institutions. Participants in the implementation of Innov8 reported gaining knowledge and skills to apply it in their daily work, helping them to identify entry points to improve processes, including on areas where progress was perceived to have stagnated. With regard to institutions, the implementation promoted the effectiveness of processes by pairing services and solutions with identified public health problems. Innov8 has also successfully informed the development of programs, plans, and strategies. While the Innov8 method requires significant time and commitment from stakeholders, it empowers stakeholders to learn more about the effectiveness of their program and change the paradigm of their program to focus on equity. Innov8 can be applied to any program and is relatively affordable.
Case study	Koller TS, Saint V, Floranita R, Koemara Sakti GM, Pambudi I, Hermawan L, et al. Applying the Innov8 approach for reviewing national health programmes to leave no one behind: lessons learnt from Indonesia. Global health action. 2018;11(sup1):1423744. Available from: https://doi.org/10.1080/16549716.2018.1423744.

3. Health Equity Assessment Toolkit (HEAT)

Name	Health Equity Assessment Toolkit (HEAT)
Author	WHO
Year of design	2016
Description	**Goal:** To facilitate the assessment of in-county health inequalities. **Objective:** To determine the latest situation of health inequality, the change in inequalities over a period of time, and compare the situation in one setting of interest with the situation in other settings. **Design:** HEAT consists of a software application to be used in desktop computers, laptops, and mobile devices. The software, which can be used at different levels (national, provincial, or district), is a free licensed software that results in data ready for interpretation. HEAT assesses inequalities using disaggregated data and summary measures that are visualized in a variety of interactive graphs, maps, and tables. The software, which contains the WHO Health Equity Monitor database, uses over 30 reproductive, maternal, newborn, and child health indicators and five dimensions of inequality (economic status, education, place of residence, subnational region, and child's sex, where applicable). Results can be exported and saved in different formats. The software is open source, operates on Windows and Macintosh platforms, and is readily available for download from the WHO website. Following user demand, an Upload Database Edition of HEAT, HEAT Plus, was developed. Launched in July 2017, HEAT Plus allows users to upload their own databases and assess inequalities at the global, national, or subnational level for a range of health indicators and dimensions of inequality. **Intended users:** HEAT is intended to be used primarily by those who are familiar with health information systems and have basic skills in interpreting health-related data. This may include technical staff (for example, in ministries of health and statistical offices), public health professionals, policymakers, researchers, and students.
Reference link	https://www.who.int/gho/health_equity/assessment_toolkit/en/
Requirements for implementation	HEAT can be used for monitoring health inequalities at global and national levels, which requires personnel experienced in data analysis for interpretation. Preparing data sets to upload to HEAT Plus requires good data management skills and familiarity with Excel. Once prepared and uploaded, data can be used for health inequality assessments in HEAT Plus by anyone with data interpretation competence. Use of the HEAT tool is available at no cost, and required time for implementation is less than one month.
Previous implementation countries and sites	Implemented in a minimum of 94 countries worldwide.
Implementation, experiences, and lessons learned	For accurate health inequality monitoring, it is essential to have raw data sets, from which calculation of standard errors and 95% confidence intervals is possible. Further, collaboration across various government agencies, specifically data management units, is essential to allow this sharing and use of data. Greater synergy and interaction between data analysts (especially those from different agencies) is also highly desirable. More practical support is required as the work teams advance in the stages of preparation, analysis, interpretation, and presentation of data.
Case study	Hosseinpoor AR, Nambiar D, Schlotheuber A. Monitoring health inequality in Indonesia. Glob Health Action. 2018;11(sup1):3–6. Available from: https://doi.org/10.1080/16549716.2018.1475041.

4. Health Equity 2020 Toolkit

Name	Health Equity 2020 Toolkit
Author	Erasmus University Medical Center
Year of design	2016
Description	**Goal:** To assist country regions in drawing up evidence-based action plans to address socioeconomic health inequalities. **Objectives:** To explore potential action areas and make the case (including economic evidence) for investments to reduce inequalities through regional actions within and beyond the health sector. **Design:** The Health Equity 2020 Toolkit provides a step-by-step approach toward developing action plans to address socioeconomic health inequalities. The toolkit consists of four phases that are important in developing evidence-based action plans: Phase 1 is the needs assessment; Phase 2 covers capacity assessment; Phase 3 assists in selecting entry points; and Phase 4 describes the impact assessment. In addition, the toolkit's Action Database provides examples of action that would reduce socioeconomic inequities in health, and the action plans section provides examples of action plans developed by regions as a source of inspiration for users. The toolkit is available in PDF form, with links to additional supporting tools for the needs assessment, identifying entry points for action, and the health and economic impact assessment. The toolkit can be used to identify gaps for specific populations such as women at the national and subnational levels. **Intended users:** The targeted end-users of the toolkit are local/regional inter-sector action groups that can influence regional development plans and strategies.
Reference link	https://hcn.eu/wp-content/uploads/2017/12/1_Health-Equity-2020-Toolkit-Edition-1.0.pdf
Requirements for implementation	The Health Equity 2020 Toolkit is friendly for users with different knowledge levels, although some basic knowledge of health and health determinants is required. Furthermore, in order to meet the end goal of developing and implementing evidence-based action plans to address socioeconomic health inequities, intersectoral support and collaboration is necessary. The toolkit is available at no cost. The processes to develop action plans require human resources and financial support, and vary according to the country context.
Previous implementation countries and sites	Pomurje (Slovenia), Lodzkie (Poland), Vysočina (Czech Republic), Northern Great Plain (Hungary), Trenčín (Slovakia), Klaipėda District (Lithuania), Stara Zagora (Bulgaria), Covasna (Romania), Latvia, Tallin (Estonia).
Implementation, experiences, and lessons learned	The Health Equity 2020 Toolkit assists regions in drawing up evidence-based, innovative, and collaborative action plans to reduce health inequalities.
Case study	Buzeti T, Beznec P, Makovec Halozan M, Ohr M. The capacity audit for addressing health inequalities and socioeconomic determinants of health-experiences from Slovenia: Tatjana Buzeti. *Eur J Public Health*. 2013 Oct; 23(suppl_1):ckt126–061. Available from: https://doi.org/10.1093/eurpub/ckt126.061.

5. Urban Health Equity Assessment and Response Tool (Urban HEART)

Name	Urban Health Equity Assessment and Response Tool (Urban HEART)
Author	WHO
Year of design	2010
Description	**Goal:** To facilitate decisions on viable and effective strategies, interventions, and actions that should be used to reduce inter- and intra-city health inequities. **Objectives:** 1. To guide policymakers and key stakeholders to achieve a better understanding of the social determinants of health and their consequences for people living in a city. 2. To stimulate policymakers, program managers, and key stakeholders to make strategic decisions and prioritize specific actions and interventions that are tailored to the needs of vulnerable and disadvantaged groups in cities. 3. To assist communities to identify gaps, priorities, and required interventions to promote health equity. 4. To support program managers in improving intersectoral collaboration and communication strategies relating to the social determinants of health. **Design:** Urban HEART, available as a PDF document, consists of a standardized procedure for gathering relevant evidence and planning efficiently for appropriate actions to tackle health inequities. It first identifies inequities between different population groups and then facilitates decisions on viable and effective strategies, interventions, and actions that should be used to reduce inter- and intra-city health inequities. **Intended users:** Urban HEART is intended for policymakers, government chief executives, and community members interested in jointly recognizing and taking action on health inequities.
Reference link	https://apps.who.int/iris/handle/10665/79060
Requirements for implementation	Urban HEART is suitable for implementation at the national and subnational levels. For implementation, it is recommended to integrate it into the planning cycle of the local or national government or authority as it is meant to be a circular rather than linear process. However, since the steps to be undertaken in developing policy and implementing the program phases are likely to be strongly locally specific and beyond the scope of guidance, the toolkit focuses on assessment and response. The tool comes with a user manual and should be led by a team in each jurisdiction where the tool will be implemented. Given the breadth of the tool, implementation requires resource allocation to carry out prioritized interventions, and for the evaluation of the process.
Previous implementation countries and sites	Guarulhos (Brazil), Jakarta, Denpasar (Indonesia), Tehran (Islamic Republic of Iran), Nakuru (Kenya), State of Sarawak (Malaysia), Mexico City (Mexico), Ulaanbaatar (Mongolia), Davao, Naga, Olongapo, Paranaque, Tacloban, Taguig, Zamboanga (Philippines), Colombo (Sri Lanka), Ho Chi Minh City (Viet Nam).
Implementation, experiences, and lessons learned	A limitation of the Urban HEART tool is the lack of accountability measures related to the process, resulting in a heavy reliance on the team leading the process to ensure that a collaborative and equitable partnership is implemented throughout all phases of Urban HEART. The tool can, however, be a facilitator in establishing partnerships similarly dedicated to a long-term process of addressing social determinants of health in other urban settings.
Case study	Mehdipanah R, Schulz AJ, Israel BA, Gamboa C, Rowe Z, Khan M, et al. Urban HEART Detroit: A Tool to better understand and address health equity gaps in the city. J Urban Health. 2018 Oct 15;95(5): 662–671. Available from: https://doi.org/10.1007/s11524-017-0201-y.

6. Gender Analysis Toolkit for Health Systems

Name	Gender Analysis Toolkit for Health Systems
Authors	Jhpiego in partnership with USAID Maternal and Child Survival Program
Year of design	2016
Description	**Goal:** To provide research questions to guide data collection when performing a project-level gender analysis to identify the evidence of gender inequalities relevant to programs focused on different levels of the health system. **Objectives:** To provide illustrative questions related to the five domains described in USAID's Automated Directive System 205, which are: 1. laws, regulations, and institutional practices; 2. cultural norms and beliefs; 3. gender roles, responsibilities, and time used; 4. access to and control over assets and resources; 5. patterns of power and decisionmaking. **Design:** The toolkit presents illustrative general and health area-specific questions organized in matrices to guide staff in developing baseline knowledge, attitude, and practice studies that include gender-related information. The toolkit is suitable for implementation at the national, subnational, healthcare facility, and community levels. It contains a different set of guiding questions that are specific for the level in which the analysis will take place. Additionally, it has a table of questions pertinent to a specific health area (e.g., family planning). These inform what kind of information should be gathered using a combination of qualitative and quantitative methods by adapting them to the context, but are not intended to be directly transferred to a survey or interview guide. The toolkit also has sample data collection tools and further resources. **Intended users:** The toolkit is intended for program officers, managers, and technical staff that develop program objectives, design activities, formulate and monitor indicators, and support implementation.
Reference link	https://gender.jhpiego.org/analysistoolkit/
Requirements for implementation	The toolkit can be implemented by a program/technical officer at any level but also by a consultant. However, it is recommended to engage other project actors in development of the scope of work and review of findings from primary and secondary sources. The toolkit is available at no cost, but financial and human resources are needed to implement the processes outlined in the toolkit.
Previous implementation countries and sites	Afghanistan and Yemen
Implementation, experiences, and lessons learned	This tool facilitates conducting a gender analysis, which entails understanding and addressing gender inequalities of power and privileges, as well as the use of tactics, including violence, to uphold inequitable rights and privileges. It also helps staff to understand the projects' contributions to promoting gender equality. All in all, the questions developed through the support of this toolkit are much more specific than most gender assessment guides or checklists, which mostly ask about gender inequalities more broadly.

7. Organizational Self-Assessment for Addressing Health Inequities Toolkit

Name	Organizational Self-Assessment for Addressing Health Inequities Toolkit
Author	Bay Area Regional Health Inequities (BARHII)
Year of design	2015
Description	**Goal:** To provide insights into steps local health departments can take to ensure their organizations can have an impact on health equity. **Objectives:** To provide public health leaders with tools and guidelines that help identify the skills, organizational practices, and infrastructure needed to address health equity. **Design:** This toolkit is intended to: 1. serve as the baseline measure of capacities to support health equity-focused activities; 2. inventory the presence of characteristics that support the ability to perform effective health equity-focused work; 3. provide information to guide strategic planning processes and/or the process of developing and implementing strategies that improve capacities; 4. serve as an ongoing tool to assess progress toward identified goals developed though the assessment process. The toolkit includes a compendium of instruments that address various elements of a matrix of organizational and staff competencies needed to address health inequities, and the guidelines to help local health departments determine if, when, and how to carry out the self-assessment. Although not specific to social inequities in the health of women, children, and adolescents, it can be adapted to these groups. **Intended users:** This toolkit is intended for senior managers and staff in local health departments.
Reference link	https://www.barhii.org/organizational-self-assessment-tool
Requirements for implementation	The self-assessment toolkit is to be implemented at an organizational level. Implementation requires the designation of a project coordinator and a team to oversee and conduct the assessment exercise. This team should include 4 to 7 staff from various functions and areas of the agency. A timeline and implementation plan should be developed prior to launching the assessment. As the toolkit contains different tools and resources to use, an agency can use all or a combination of tools and resources depending on the circumstances. The staff survey provides information about the organizational practices and culture; the collaborating partners' survey provides information about the ability to work with external partners to address health inequities. Other instruments deepen understanding on specific topics and all questions can be reworded and reordered, as it is recommended to identify domains and indicators of interest.
Previous implementation countries and sites	San José, San Francisco, Oakland (United States)
Implementation, experiences, and lessons learned	It is important for local health departments to engage members of priority populations in their organizational efforts to further their understanding and practice of health equity. While all local health departments identified similar barriers to engaging priority populations, local health departments that identified facilitators more comprehensively engaged members of the priority population in program planning, implementation, and evaluation. Additionally, this tool encourages staff participation, strengthens the team's implementation capabilities, and establishes communication channels between levels that allow the flow of information throughout the process.
Case study	Sokol R, Moracco B, Nelson S, Rushing J, Singletary T, Stanley K, Stein A. How local health departments work towards health equity. Eval Program Plann. 2017 Dec; 65:117–123. Available from: https://doi.org/10.1016/j.evalprogplan.2017.08.002.

8. Gender-Equitable Men (GEM)

Name	GEM
Authors	Population Council/Horizons and Promundo
Year of design	2008
Description	**Goal:** To determine concrete evidence-based measures to address the gender-based inequities observed in each country. **Objectives:** To provide information about the prevailing gender norms in a community and the effectiveness of programs that seek to influence gender norms. **Design:** The GEM scale uses a collection of statements developed to measure attitudes toward gender norms in intimate relationships. The original GEM scale consisted of 24 statements across various domains such as gender norms, violence, sexuality, masculinities, reproductive health, etc. Although the scale was developed for young men living in low-income countries, it has also been successfully used with adult men, women, and girls. The instrument can be targeted to orient health programs. **Intended users:** This tool is intended for management and staff of programs to address gender-based inequities.
Reference link	https://promundoglobal.org/wp-content/uploads/2014/12/Measuring-Attitudes-toward-Gender-Norms-among-Young-Men-in-Brazil-Development-and-Psychometric-Evaluation-of-the-GEM-Scale.pdf
Requirements for implementation	This is a tool that requires primary data to be collected from individual men at the community level. It takes around 45 minutes to conduct the survey and requires resources for data collection and analysis.
Previous implementation countries and sites	Brazil, China, Ethiopia, India, Kenya, Tanzania, Uganda
Implementation, experiences, and lessons learned	Experience from Brazil suggests the GEM scale is a sensitive and cross-culturally relevant tool that has good predictive validity. The "inequitable" subscale is more consistently reliable than the "equitable" subscale. Adaptations in multiple contexts have worked well. Items that relate to homosexuality have often been removed in adaptations of the scale.
Case study	Pulerwitz J, Barker G. Measuring attitudes toward gender norms among young men in Brazil: development and psychometric evaluation of the GEM scale. Men Masc. 2008 Apr;10(3): :322–338. Available from: https://doi.org/10.1177/1097184X06298778.

9. Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)

Name	Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education (WE CARE)
Author	Arvin Garg (Boston Medical Center)
Year of design	2007
Description	**Goal:** To identify and respond to the immediate attention needs of parents visiting a pediatric healthcare facility. **Objectives:** To assess parents' needs in six domains of social determinants of health and provide appropriate referrals to address these needs. **Design:** WE CARE is a clinic-based screening and referral system developed for pediatric settings. The 12-question screening tool assesses parent needs in six domains: parental educational attainment, employment, childcare, risk of homelessness, food security, and household heat and electricity. If parents say that they have a need they are asked if they would like help and, for food, homelessness, and household utilities, if they are in need of immediate assistance. Families who report having a need and wanting help are provided with the corresponding WE CARE Community Resource Information Sheet that is adapted locally. One option for augmenting the WE CARE model is to utilize patient navigators or other support staff to help link families to community resources. **Intended users:** This tool is intended for staff at pediatric healthcare facilities.
Reference link	https://www.bmc.org/pediatrics-primary-care/we-care/we-care-model
Requirements for implementation	Use of the screening tool and community resource information sheet is free. This is a tool that requires the cooperation of human resources to implement the tool. Optional provision of a community health worker or health navigator is an additional expense.
Previous implementation countries and sites	United States
Implementation, experiences, and lessons learned	A study which tested the tool showed that brief family psychosocial screening, as per WE CARE, is feasible in pediatric practice. Furthermore, Boston Medical Center documented several lessons learned in implementing WE CARE. First, clinic buy-in at every level, including front-office staff and medical providers, is important to successful implementation. Second, a clear process for administration of the survey, discussion of survey responses with families, and provision of the Community Resource Information Sheets is important and should be reassessed and improved as needed. Lastly, listening to patient feedback is important to optimizing the WE CARE model for a clinic's unique patient population.
Case studies	Garg A, Toy S, Tripodis Y, Silverstein M, Freeman E. Addressing social determinants of health at well child care visits: a cluster RCT. Pediatrics. 2015 Feb;135(2):e296–304. Available from: https://doi.org/10.1542/peds.2014-2888. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well child care visits: the WE CARE Project. Pediatrics. 2007;120(3):547–558. Available from: https://doi.org/10.1542/peds.2007-0398.

10. iScreen Social Screening Questionnaire

Name	iScreen Social Screening Questionnaire
Authors	Laura M. Gottlieb, Danielle Hessler, and Dayna Long (University of California, San Francisco)
Year of design	2014
Description	**Goal:** To better understand the social needs of a population seeking care. **Objectives:** To screen for health-related social and environmental risk factors of children's caregivers and to identify and respond to their immediate attention needs. **Design:** The iScreen Social Screening Questionnaire consists of a screening questionnaire to be applied in healthcare settings. This is a tool that can be implemented in both physical and electronic formats at healthcare facility level. **Intended users:** This screening questionnaire is intended for use by staff and providers at pediatric health facilities.
Reference link	https://clinicaltrials.gov/ct2/show/NCT02197052
Requirements for implementation	This tool requires pediatric healthcare providers to complete a screening questionnaire with information provided by children's caregivers. This requires cooperation from human resources, as well as financial and technological resources for successful implementation.
Previous implementation countries and sites	Children's Hospital Oakland, Oakland, California (United States)
Implementation, experiences, and lessons learned	The study that provided evidence for the use of iScreen shows that the use of the tool is helpful for identifying both children at high risk who may need more intensive clinical attention and conditions affecting children's health that may be addressed through linkage with on-site or community social services. Additionally, they found that the use of the electronic version increased disclosure of social and mental health situations by users.
Case study	Gottlieb L, Hessler D, Long D, Amaya A, Adler N. A randomized trial on screening for social determinants of health: the iScreen study. Pediatrics. 2014 Dec;134(6):e1611–1618. Available from: https://doi.org/10.1542/peds.2014-1439.

11. Social Environment Inventory (SEI)

Name	Social Environment Inventory (SEI)
Authors	Suezanne Orr, Sherman James, and Evan Charney
Year of design	1989
Description	**Goal:** To facilitate the prevention of various behavioral, school, and other problems among children. **Objectives:** To assess maternal exposure to stressors which can disproportionally affect the health of women, children, and adolescents. **Design:** The Social Environmental Inventory consists of a self-administered 35-item questionnaire for use in the pediatric setting. **Intended users:** This tool is intended for staff and healthcare providers in pediatric healthcare facilities.
Reference link	https://psycnet.apa.org/record/1990-13456-001
Requirements for implementation	This self-administered questionnaire requires the use of human and financial resources for its implementation, as it entails training staff to provide support, conduct analysis, and coordinate follow-up efforts.
Previous implementation countries and sites	Baltimore (United States)
Case study	Janicke DM, Finney JW. Children's primary healthcare services: social-cognitive factors related to utilization. J Pediatr Psychol. 2003 Dec.28(8):547–548. Available from: https://doi.org/10.1093/jpepsy/jsg045.

12. WellRx

Name	WellRx
Authors	Janet Page-Reeves, Will Kaufman, Molly Bleeker, Jeffrey Norris, Kate McCalmont, Veneta Ianakieva, Dessislava Ianakieva, and Arthur Kaufman
Description	**Goal:** To screen for social determinants at primary healthcare facilities. **Objectives:** To identify and address non-medical social needs experienced by patients seen in a clinic setting. **Design:** WellRx is a short questionnaire to be used in primary healthcare facilities. It can be used to focus on groups of women, children, and adolescents. **Intended users:** This tool is intended for staff and healthcare providers in primary healthcare facilities.
Reference link	https://www.jabfm.org/content/jabfp/29/3/414.full.pdf
Requirements for implementation	This tool can be self-administered or administered by medical assistants and is to be used at healthcare facility level. For implementation, this tool requires personnel to coordinate the implementation of the tool, as well as to conduct analyses of the data to orient decisionmaking.
Previous implementation countries and sites	Albuquerque, New Mexico (United States)
Implementation, experiences, and lessons learned	The WellRx pilot demonstrated that it is feasible for a clinic to implement such an assessment system, that the assessment can reveal important information, and that having information about patients' social needs facilitates healthcare practice.
Case study	Page-Reeves J, Kaufman W, Bleecker M, Norris J, McCalmont K, Ianakieva V, et al. Addressing social determinants of health in a clinic setting: the WellRx pilot in Albuquerque, New Mexico. J Am Board Fam Med. 2016;29(3):414–418. Available from: https://doi.org/10.3122/jabfm.2016.03.150272.

13. Strategizing National Health in the 21st Century: A Handbook

Name	Strategizing National Health in the 21st Century: A Handbook
Author	WHO
Year of design	2016
Description	**Goal:** To provide up-to-date and practical guidance on national health planning and strategizing for health. **Objectives:** To provide guidance in the development of national health policies, strategies, and plans from a new pluralistic perspective, and to advocate for policy dialogue as a means to ensure inclusiveness and the participation of both service providers and the population in debates and the decisionmaking process with the government, as well as in the follow-up, monitoring, and evaluation of national health policies, strategies, and plans. **Design:** This handbook establishes a set of best practices to support strategic plans for health and represents the wealth of experience accumulated by WHO on national health policies, strategies, and plans. The handbook is structured around the health policy and planning process, with each chapter of the handbook relating to each stage of this process. The handbook additionally includes four independent chapters on issues which are considered cross-cutting to the entire process. The handbook can be read in its entirety, but each chapter is stand-alone, so it can be easily understood and used by relevant stakeholders. Although not specifically designed for women, children, or adolescents, it can be used in the analysis of programs focused on these population groups. **Intended users:** This handbook is intended for health ministries and other relevant stakeholders involved in national health planning.
Reference link	https://apps.who.int/iris/handle/10665/250221
Requirements for implementation	This is a method that is intended to be used for medium-term national planning processes of 3–7 years. As such, it requires the use of primary and secondary data, as well as human, financial, and technological resources for policy dialogue processes and multisectoral participatory approaches.
Implementation, experiences, and lessons learned	This handbook showcases innovative country examples of participatory national planning, and aims to inspire countries through what has been done elsewhere, and potentially draw parallels with their own contexts to see which planning approaches might or might not work.

14. Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence

Name	Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence
Authors	WHO, the Office of the High Commissioner for Human Rights (OHCHR), and the Swedish International Development Cooperation Agency (SIDA)
Year of design	2011
Description	**Goal:** To enhance coherence between international obligations and commitments; national legal, policy, and institutional frameworks; and health sector strategies with respect to human rights and gender equality. **Objectives:** 1. To assess the extent to which health sector strategies are consistent with and promote human rights standards and principles, including gender equality. 2. To identify gender equality and human rights-related gaps and opportunities with respect to national commitments and health sector strategies, in order to facilitate effective relevant and strategic health sector interventions. 3. To generate a multistakeholder process and cross-disciplinary dialogue to address human rights and gender equality in relation to health. **Design:** The scope of this tool is focused on health sector strategies and is meant to support the review of or preparation for a new health sector strategy, as well as other studies to evaluate or assess an existing health sector strategy. This tool is based on three assessment levels: 1. State obligations and commitments made on human rights and gender equality; 2. Translating human rights and gender equality obligations and commitments in the national legal, policy, and institutional framework; 3. Identifying human rights and gender equality obligations and commitments in national health sector strategies. The tool consists of three parts. Part A includes an introduction and an overview of the approach. Part B includes practical guidance on how to implement the tool. Part C includes the analysis tables with background information and additional guidance to support the review of health sector strategies. **Intended users:** The tool addresses various actors in health planning, policymaking, implementation, and/or monitoring of health sector strategies. This includes health policymakers and planners, national human rights institutions, development partners, and civil society organizations (CSOs).
Reference link	https://www.ohchr.org/sites/default/files/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf
Requirements for implementation	This tool is suitable for implementation at the national level. It requires the use of primary and secondary data. Ample time should be allotted for data collection, analysis, and report writing. Additional time will be required for report presentation, preparation, and sharing. Implementation of this tool also requires availability of human and financial resources. Capacity-building of team members in the areas of human rights and gender equality may be needed before and during the review.
Previous implementation countries and sites	Uganda, Yemen, and Zambia

15. Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-income Countries

Name	Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-income Countries
Author	WHO
Year of design	2013
Description	**Goal:** To serve as a comprehensive resource to clarify the concepts associated with health inequality monitoring, illustrate the process through examples, and promote the integration of health inequality monitoring within health information systems of low- and middle-income countries. **Objectives:** To enable countries to better monitor and evaluate their progress and performance with a high degree of accountability and transparency and allow them to use the results to formulate evidence-based policies, programs, and practices to tackle inequalities in an effective manner. **Design:** This handbook provides an overview of the health inequality monitoring process and its implications, and highlights considerations that underlie the selection of health indicators and equity stratifiers. It discusses issues related to finding appropriate data sources for inequality monitoring, including the types of data sources, their strengths, limitations, and areas for improvement, and the process of data source mapping. Furthermore, it presents several measures used to calculate health inequality, the challenges that arise in their application, and approaches to overcome these challenges; and presents the guiding principles for reporting inequality monitoring. It provides guidance, from theoretical to methodological, about how to conduct health inequality monitoring by explaining the continuous cycle of health monitoring, which can be broken down into five steps: identifying the relevant health indicators; obtaining data about the indicators; analyzing the data; reporting the results; and implementing changes when warranted. **Intended users:** This handbook is intended for technical staff at health ministries, but can also be used by public health professionals, researchers, students, and others.
Reference link	https://apps.who.int/iris/handle/10665/85345
Requirements for implementation	The handbook is suitable for implementation primarily at the national level, and implementation requirements are dependent on the specific context, including availability of data, human resources, and finances.
Previous implementation countries and sites	Philippines
Implementation, experiences, and lessons learned	The use of real-life examples throughout the handbook brings what could otherwise be a fairly technical subject to life, providing motivation to the reader as well as helping to clarify the material. Another key strength in the handbook is the provision of additional information within boxes alongside the main text. "Tips" boxes provide short explanations of how to apply concepts in practice; "Extra Information" boxes expand on key points of the main text; "Highlights" boxes summarize topics; and "Read More" boxes list key references for further reading. These lists of key references are likely to be particularly useful for early-career researchers. Furthermore, this handbook shows how various subgroups within a country are performing in regard to health, and permits comparisons between subgroups. It demonstrates how a country is progressing toward its equity goals and targets, and whether pathways toward universal health coverage exacerbate or reduce inequalities.
Case studies	Hosseinpoor AR, Bergen N, Schlotheuber A, Boerma T. National health inequality monitoring: current challenges and opportunities. Glob Health Action. 2018;11(sup1):1392216. Available from: https://doi.org/10.1080/16549716.2017.1392216. Howe LD. Handbook on Health Inequality Monitoring. *Int J Epidemiol*. 2014;43(4): 1345-1346. Available from: https://doi.org/10.1093/ije/dyu124.

16. Step-by-step Guide for Measuring Social Inequalities in Health

Name	Step-by-step Guide for Measuring Social Inequalities in Health
Author	Every Woman Every Child Latin America and the Caribbean (EWEC-LAC)
Year of design	2018
Description	**Goal:** To facilitate the measurement and monitoring of social inequalities in health. **Objectives:** To help calculate the simple measures (absolute and relative inequality gaps) and the complex measures (slope index of inequality and concentration index of health) of inequalities. **Design:** This toolkit includes methodological orientations and easy-to-use tools for the measurement and monitoring of health inequities. The tools, which measure levels of inequities for data available at the subnational level, are available in Microsoft Excel. The toolkit also provides technical support to institutionalize the measurement and monitoring of inequalities in national health information systems. To complement the roll-out of this toolkit, EWEC-LAC has implemented national workshops to support countries in the development of capacities of national and subnational actors in data analysis. **Intended users:** This tool is intended for ministries of health, researchers, students, and other global health actors interested in quantitative analysis of social inequalities.
Reference link	https://www.everywomaneverychild-lac.org/e/publication/measuring-social-inequalities-health/
Requirements for implementation	The guide and toolkit are suitable for implementation at the national and subnational levels, depending on the availability of data. For implementation, it is important to create a sound database including the three dimensions required for inequality analyses: 1. Health and morbimortality indicators: outcome variables; 2. Equity stratifiers: socioeconomic variables used to rank the population and define the groups whose health status is to be compared; 3. Demographic variables: (usually the denominators of the health indicators) needed to calculate the weighting terms according to the relative size of the population. Human and financial resources are also needed to implement this toolkit.
Previous implementation countries and sites	Bolivia, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, Ecuador, Guatemala, Honduras, Mexico, Panama, Paraguay, Peru.
Implementation, experiences, and lessons learned	The step-by-step guide for measuring social inequalities in health is very easy to use, as it incorporates tools that are available to any user with Microsoft Excel. While this tool is intended to be suitable for beginners, results can be difficult to interpret if one is not familiar with the terms used, in which case additional training or collaboration with those knowledgeable in the area of health monitoring should be sought.

17. Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care

Name	Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care
Authors	Center for Reproductive Rights and Black Mamas Matter Alliance
Year of design	2016
Description	**Goal:** To distill outcomes from the Black Mamas Matter conversations (on race, reproduction, parenting, and rights) into concrete steps to improve the maternal health of African American women in the southern United States. **Objectives:** To present a collection of resources that advocates can use and adapt to their own needs. **Design:** Through a series of separate but related briefs, this toolkit presents a collection of resources that advocates can use and adapt to their own needs, at different levels. It begins by explaining the human rights framework as it applies to maternal health, and then examines the data and research on maternal health in the United States, with a special focus on racial disparities. Moving from an assessment of maternal health challenges to an exploration of potential solutions, the toolkit contains an overview of policy recommendations proposed by various stakeholders. This snapshot of the policy landscape is not intended as a one-size-fits-all prescription for action, but rather a menu of options for advocates to explore and adapt to their local priorities. The policy brief is followed by a list of resources that advocates can consult for more information, a set of talking points on maternal health, and a set of suggestions for building connections and dialogue with other stakeholders engaged in Black maternal health across the country. **Intended users:** This toolkit is intended for human rights advocates.
Reference link	https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages.pdf
Requirements for implementation	Implementation is dependent on the specific context and how actors want to use it, according to their advocacy objectives.
Previous implementation countries and sites	United States
Implementation, experiences, and lessons learned	This toolkit has helped lay the groundwork for policy change while highlighting Black mamas' human rights to safe and respectful care. The toolkit has been used to train doulas and maternity care providers, sensitize state and federal policymakers to the issue, inform local legislation, and equip stakeholders to effect change.
Case study	Planned Parenthood of Greater Texas Family Planning and Preventative Health Services, Inc. v. Charles Smith, US Court of Appeals for the Fifth Circuit. No. 17-50282 (2017). Available from: https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Amici-Brief-on-Behalf-of-Black-Mamas-Matter.pdf

18. Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA)

Name	Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents.
Author	WHO
Year of design	2019
Description	**Goal:** To outline how governments can assess health service equity and barriers at national and subnational levels in order to identify which adolescents are being left behind, and why. **Objectives:** 1. To build in-country capacity to identify barriers which prevent disadvantaged adolescents from having effective coverage with health services. 2. To trigger remedial action to address the barriers in order to promote high levels of program performance and more equitable health outcomes among adolescents. 3. To catalyze integration of a focus on who is being left behind and why into ongoing country-level monitoring and evaluation (M&E) of health services for adolescents. **Design:** The handbook is grounded in the Tanahashi framework, which describes five dimensions of effective health service coverage: availability, accessibility, acceptability, contact/use, and effective coverage. This is a handbook that can be implemented in full or in modular components, depending on context and need, at the national and subnational levels. Also, it can be implemented as a stand-alone exercise in response to an adolescent health-specific problem, as a component of a routine review of a health program, as a component of a broader national adolescent health program review, or as part of a multisectoral adolescent and youth services review. Furthermore, the handbook has in its appendix a generic plan for each of the modules which explains the activities that should be conducted as well as the costs and times that should be incorporated in the planning of the exercise. During Phase 1, existing quantitative data are mapped through a desk analysis and reviewed, and preliminary conclusions are made. During Phase 2, focus groups are conducted with stakeholders who then contribute to final analysis and the development of recommendations. **Intended users:** AHSBA is intended for national governments and nongovernmental partners.
Reference link	https://apps.who.int/iris/handle/10665/310990
Requirements for implementation	AHSBA relies heavily on local expert involvement. A local team of experts who are experienced in desk review and analysis of quantitative and qualitative data is needed to develop a research protocol. Financial resources are also needed for implementation. The estimated cost of implementation is USD 50 000 and the timeline for implementation is dependent on the context and needs. Appendix 1 of the handbook shows expected costs per module and activity, as well as expected times per module and activity.
Previous implementation countries and sites	Pilots of the AHSBA tool were completed in Nigeria and Tanzania. AHSBA was partially applied in Chiapas, Mexico, in 2019, but was interrupted by political unrest.
Implementation, experiences, and lessons learned	AHSBA creates a thorough report that combines quantitative and qualitative data enabling a good understanding of the barriers to health. Results can be extrapolated to other similar communities, but it is intended to be community specific.
Case study	World Health Organization Regional Office for Africa. Assessment of barriers to accessing health services for disadvantaged adolescents in Tanzania. Brazzaville: WHO Regional Office for Africa; 2019. Available from: https://apps.who.int/iris/handle/10665/324924.

19. Global Accelerated Action for the Health of Adolescents (AA-HA!)

Name	Global Accelerated Action for the Health of Adolescents (AA-HA!)
Authors	WHO in collaboration with UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, World Bank, Every Woman Every Child (EWEC) initiative, and the Partnership for Maternal, Newborn, Child & Adolescent Health (PMNCH)
Year of design	2017
Description	**Goal:** To assist governments in developing a plan to respond to the health needs of adolescents in their country. **Objectives:** To provide more detailed guidance on prioritization of adolescent health programs based on epidemiological scenarios, country target setting, delivery strategies, programming, monitoring approaches, and research. **Design:** AA-HA! serves as a reference document for national-level policymakers and program managers to assist them in planning, implementing, and M&E of adolescent health programs. After a brief introduction which summarizes the main arguments for investing in adolescent health, the guidance document details the key steps in understanding a country's epidemiological profile: undertaking a landscape analysis to clarify what is already being done and by whom; conducting a consultative process for setting priorities; and planning, implementing, monitoring, and evaluating national adolescent health programs. It ends with key research priorities. The document includes examples of how to involve adolescents and young people meaningfully in the different steps, and includes more than 70 case studies from across the globe to provide concrete examples of how countries have done what is being promoted. **Intended users:** The primary audience for the AA-HA! guidance is policymakers and program managers who are responsible for adolescent health programming in countries – both within the health sector and in other key sectors.
Reference link	https://apps.who.int/iris/handle/10665/255415
Requirements for implementation	The guidance can be used in full or in part, depending on the specific needs of the country. Appropriate reference data on adolescents are needed as evidence to support the planning of effective interventions. Human and financial resources are needed for implementation. Investment from multiple agencies and groups in both public and private sectors is often needed to implement strategies developed using the AA-HA! guidance. Continuous political commitment and accountability for all key sectors are other factors upon which the sustainability and operationalization of the strategies depend. The process of fully implementing AA-HA!, from the initial stakeholders workshop to the completion of multiple technical working group meetings, takes on average one year and requires funding for the convening of main stakeholders at multiple times throughout the year.
Previous implementation countries and sites	Early adopter countries include: Bahrain, Barbados, Belize, Botswana, Gabon, Guyana, Haiti, Rwanda, Saint Vincent and the Grenadines, Saudi Arabia, Somalia, Sudan, United Arab Emirates (UAE). In 2017–2019, six intercountry workshops took place with the aim to provide technical support for implementation of the Global AA-HA! guidance in regions and countries. Teams from 76 countries in Africa, the Americas, the eastern Mediterranean and Southeast Asia regions were trained in how to apply the AA-HA! guidance for national priority-setting, programming, and M&E.
Implementation, experiences, and lessons learned	Implementation experience in Barbados and Sudan showed that AA-HA! guidance is comprehensive, systematic, and adaptable, and enabled the development of national capacities in planning and implementation and motivated related sectors to carry out detailed analysis, prioritization, planning, and investment for adolescent health and sectoral interventions. AA-HA! guidance offered direction with regard to identifying and analyzing health priorities and helped build consensus around national priorities, programming, and interventions. Furthermore, following the AA-HA! guidance contributed to improving adolescents' participation in national planning and the resulting adolescent health programs and plans. The provision of the menu of evidence-based interventions within the AA-HA! guidance contributed to discussion on the need for more locally applicable interventions, and also helped decisionmaking for what to include in overall strategies. It is recommended that AA-HA! guidance be used together with a facilitators' manual and sufficient stakeholder training. Implementers emphasized the importance of having additional workshops/training for all implementation levels, especially the local level, so that everyone is confident and competent to contribute to strategy development and implementation.

Case studies	World Health Organization. Lessons learned from applying the Accelerated Action for the Health of Adolescents (AA-HA!) guidance for policy development in early adopter countries. Sudan. Geneva: WHO; 2019. Available from: https://apps.who.int/iris/handle/10665/326593 World Health Organization. Lessons learned from applying the Accelerated Action for the Health of Adolescents (AA-HA!) guidance for policy development in early adopter countries. Barbados. Geneva: WHO; 2019. Available from: https://apps.who.int/iris/handle/10665/326594 United Nations Children's Fund. Developing a National Adolescent Health Strategic Plan for Belize: Country Experience and Lessons Learned. New York: UNICEF; 2019. Available from: https://spark.adobe.com/page/75Z3TpiUyN22V/.

20. Demand for Health Services: A Human-Centred Field Guide for Investigating and Responding to Challenges

Name	Demand for Health Services: A Human-Centred Field Guide for Investigating and Responding to Challenges
Author	UNICEF
Year of design	2016
Description	**Goal:** To address situations where health services are available but a subset of the intended population of clients are not actively seeking them. **Objectives:** To help health professionals apply human-centered design approaches to investigate, understand, and respond to opportunities and challenges (drivers and barriers) related to health-seeking behaviors. **Design:** The Demand for Health Services guide introduces human-centered design as an approach to addressing challenges related to community demand for basic health services. Human-centered design is a problem-solving process that begins with understanding the "human factors" and context surrounding a challenge and works directly with the intended clients or consumers of services to develop solutions that are viable and appropriate in a given context. The guide follows different steps to address challenges to uptake of health services, starting with a planning exercise (from a systems perspective), a diagnosis (which includes methodologies for in-depth interactions with people), a design phase (generation of innovative solutions), and implementation. Throughout this iterative process, five big questions are answered: 1. What is our objective? 2. What do we think we know? 3. What stands in our way? 4. How could we respond? 5. How could we improve? **Intended users:** This field guide is intended for any health professional interested in finding new solutions to health service demand.
Reference link	https://www.unicef.org/innovation/reports/demand-health-services
Requirements for implementation	This guide should be used in full and requires a three-to five-member team with different skills and an advisory panel made up of people with strategic roles (influence and closeness to strategic priorities). Additionally, it may be necessary to engage consultants for specific tasks. Processes outlined in the guide can be conducted in weeks rather than months, but it does require proximity to the field to directly assess the context. Using the human-centered design methodology, the document will guide the team to conduct different activities until an innovative solution is found and implemented. The cost of implementing this guidance depends on the context and needs being addressed.

21. Strengthening the Adolescent Component of National HIV Programmes through Country Assessments: Adolescent Assessment and Decision-Makers' (AADM) Tool

Name	Strengthening the Adolescent Component of National HIV Programmes through Country Assessments: Adolescent Assessment and Decision-Makers' (AADM) Tool
Author	UNICEF
Year of design	2015
Description	**Goal:** To facilitate country assessments aimed at strengthening the adolescent component of national HIV programmes. **Objectives:** To support country teams in the identification of equity and performance gaps affecting adolescent HIV programming and define priority actions to improve the effectiveness of the national adolescent HIV response. **Design:** The document Strengthening the Adolescent Component of National HIV Programmes through Country Assessments guides users through three country assessment phases: 1. Rapid assessment of adolescent programme context at national and subnational levels. 2. In-depth analysis of bottlenecks affecting coverage of priority HIV interventions in priority geographic locations identified in Phase 1. 3. Evidence-informed planning to accelerate corrective actions to address bottlenecks and data gaps, and improve intervention coverage, quality, and impact. The associated AADM tool provides countries with the necessary analytics to inform decisionmaking during the country assessments. This user-friendly Excel-based dashboard is used to disaggregate HIV data according to age to enable analysis of the data specific to adolescents. Adolescent participants are engaged in the planning, identification, and analysis of data, as well as policy discussions. **Intended users:** The guidance document is intended for use by national governments, implementing partners, United Nations (UN) agency counterparts, and UNICEF in support of an inclusive process that seeks to optimize multisectoral collaboration and engender national ownership.
Reference link	https://data.unicef.org/resources/guidance-document-strengthening-adolescent-component-national-hiv-programmes-country-assessments/#
Requirements for implementation	The United Nations Joint Team on HIV/AIDS (UNJT) and partners should be prepared to support the national process led by governments to initiate country assessments. A technical working group should be constituted to provide leadership for the assessments and be supported by a multisectoral national steering committee, which includes adolescents, to validate assessment outputs. Strategic entry points to initiate country assessments need to be considered by the technical working group to ensure the use of findings and implementation of recommendations. The team should be supported by a dedicated consultant. Financial resources are needed to hire the consultant and implement working group and stakeholder meetings.
Previous implementation countries and sites	Jamaica
Implementation, experiences, and lessons learned	Following application of this tool in Jamaica, the Ministry of Health was able to better understand HIV among adolescents and prioritize adolescent HIV prevention and treatment. The impact is lasting: country-level survey data now include- adolescents, and since the implementation of the tool Jamaica has implemented new programs that support adolescent sexual health, as evidenced by more than 40 public health facilities that are delivering services in accordance with adolescent standards, and the development of a growing adolescent-centered "Teen Hub" model. Availability of data to country assessment has proven difficult, as many facilities have data on adolescent girls seeking prenatal care, but facilities lack data on other high-risk populations who are less inclined to seek health care. Furthermore, original surveys were not originally designed to be collected down to the suggested level of disaggregation, and there continues to be insufficient data for the 10–14 age group.

22. Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty

Name	Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty
Author	Tulane University Commitment to Equity Institute
Year of design	2018
Description	**Goal:** To explain in detail the theory and practice of fiscal incidence analysis and determine the impact of fiscal policy on inequality and poverty. **Objective:** To provide a step-by-step guide to applying fiscal incidence analysis. **Design:** The Commitment to Equity (CEQ) Assessment described in this handbook is a diagnostic tool that uses fiscal incidence analysis to determine the extent to which fiscal policy reduces inequality and poverty in a particular country. The CEQ Assessment is designed to address the following four main questions: 1. How much income redistribution and poverty reduction is being accomplished through fiscal policy? 2. How equalizing and pro-poor are specific taxes and government spending? 3. How effective are taxes and government spending in reducing inequality and poverty? 4. What is the impact of fiscal reforms that change the size and/or progressivity of a particular tax or benefit? This handbook has four parts. Part 1 on methodology describes CEQ Assessment and presents the theoretical underpinnings of fiscal incidence analysis and the indicators used to assess the distributive impact and effectiveness of fiscal policy. Part 2 on implementation presents the methodology on how taxes, subsidies, and social spending should be allocated. It includes a step-by-step guide to completing the CEQ Master Workbook, a multisheet Excel file that gives detailed information on the country's fiscal system and the results used as inputs for policy discussions, academic papers, and policy reports. Part 3 presents applications of the CEQ framework to low- and middle-income countries and includes simulations of policy reforms. Lastly, Part 4 includes the CEQ Assessment Tools, available online only, which contain the CEQ Master Workbook (a blank version), as well as examples and additional support tools . **Intended users:** This tool is intended for policymakers, social planners, and economists.
Reference link	https://commitmentoequity.org/publications-ceq-handbook
Requirements for implementation	A CEQ Assessment requires a household income and expenditure survey (HIES), or a household income (employment) survey, or a household budget survey (HBS), and a (preferably) audited/confirmed national budget (of the same year as the HIES). Financial and human resources are needed for implementation.
Previous implementation countries and sites	As of mid-2018, CEQ Assessments were available for 44 countries: Albania, Argentina, Armenia, Belarus, Bolivia, Brazil, Chile, China, Colombia, Costa Rica, Croatia, Dominican Republic, Ecuador, El Salvador, Ethiopia, Georgia, Ghana, Guatemala, Honduras, India, Indonesia, Iran, Jordan, Mexico, Namibia, Nicaragua, Panama, Paraguay, Peru, Poland, Russia, Senegal, South Africa, Sri Lanka, Swaziland, Tanzania, Togo, Tunisia, Turkey, Uganda, the United States, Uruguay, Venezuela, and Zambia.
Implementation, experiences, and lessons learned	Implementation experiences demonstrate that analyzing tax and spending simultaneously is necessary. Furthermore, to assess the impact of the fiscal system on people's standard of living, it is crucial to measure the effect of taxation and spending not only on inequality but also on poverty. This handbook highlights two main lessons for policymakers that emerge from utilization of this tool. First, the fact that specific fiscal interventions can have countervailing effects underscores the importance of taking a coordinated view of both taxation and spending rather than pursuing a piecemeal policy reform. Efficient regressive taxes (such as value added tax), when combined with generous well-targeted transfers, can result in a net fiscal system that is equalizing and poverty-reducing. Second, governments should design their tax and transfers system so that after taxes and transfers the incomes (or consumption) of the poor are not lower than their incomes (or consumption) before fiscal interventions. If the policy community is seriously committed to eradicating income/consumption poverty, governments will need to explore ways to redesign taxation and transfers so that the poor do not end up as net payers.

Case studies	Bucheli M, Lustig N, Rossi M, Amábile F. Social Spending, Taxes, and Income Redistribution in Uruguay. Public Finance Rev. 2013;42(3):413–433. Available from: https://doi.org/10.1177/1091142113493493. Higgins S, Lustig N, Ruble W, Smeeding T. Comparing the Incidence of Taxes and Social Spending in Brazil and the United States. Rev Income Wealth. 2016;62(S1):S22–S46. Available from: https://doi.org/10.1111/roiw.12201. Bucheli M, Rossi M, Amábile F. Inequality and Poverty in Uruguay by Race: The Impact of Fiscal Policies. J Econ Inequal. 2018;16(3):389–411. Available from: https://doi.org/10.1007/s10888-017-9373-7. Cabrera M, Lustig N, Morán H. Fiscal Policy, Inequality and the Ethnic Divide in Guatemala. World Dev. 2015;76:263–279. Available from: https://doi.org/10.1016/j.worlddev.2015.07.008.

23. Leaving no one behind: Methodology to set Health Inequality Reduction Targets for Sustainable Development Goal 3

Name	Leaving no one behind: Methodology to set Health Inequality Reduction Targets for Sustainable Development Goal 3
Authors	Antonio Sanhueza, Isabel Espinosa, Oscar Mújica, Jarbas Barbosa da Silva Jr.
Year of design	2020
Description	**Goal:** To strengthen institutional capacities for measuring and monitoring social inequalities in health and identify specific territories and population groups in situations of greater vulnerability, where health inequalities are disproportionately concentrated. **Objective:** To formulate quantitative targets that reflect both the improvement in the national average of a Sustainable Development Goal 3 (SDG3) health indicator (average goal) and the reduction of its geographic inequality (distributional goal). **Design:** The methodology consists of a five-step algorithm. Step 1 consists of calculating the national average annual percentage change of an SDG3 indicator for a known time series, with a baseline value and an annual value reference. Step 2 includes defining the geographic strata. In Step 3 the criterion of proportional progressivity of the national average annual percentage change is applied to each defined stratum. Step 4 is to define the average goals at the subnational and national levels. Step 5 includes defining goals to reduce geographic inequality gaps. Specific instructions are provided to achieve each step of the algorithm. **Intended users:** The methodology for setting health inequality reduction targets for SDG3 was designed to be used by public health specialists from different stakeholders, including government at national and subnational levels.
Reference link	https://iris.paho.org/handle/10665.2/53115
Requirements for implementation	The methodology requires the availability of data on SDG3 health indicators disaggregated geographically at the subnational level (for example, by states, departments, provinces, cantons, municipalities, districts, communes, or colonies) for a given period. This data can come from household surveys or administrative records. The level of geographic disaggregation (i.e., by territorial units) depends on the availability of data and its temporal consistency.
Previous implementation countries and sites	Guatemala
Implementation, experiences, and lessons learned	The methodology for setting health inequality reduction targets for SDG3 is a practical and flexible guide to promoting specific institutional actions based on the quantification of the desired and feasible changes in the distribution of health and wellbeing, and informing the decisions oriented to fulfill SDG3. The flexibility inherent in this algorithm concerns at least three central aspects: 1. The level of disaggregation of the data; 2. The criterion of stratification of the territorial units; 3. The criteria of proportional progressivity applied to the speed of the projected change of the health indicator by 2030. These three central aspects, among others, can be considered as direct opportunities for dialogue and interdisciplinary and intersectoral consensus at the corresponding levels, necessary to implement this method. The formulation of goals to reduce inequalities in health should not be seen as a mathematical-statistical exercise, but as a collaborative work.
Case studies	Sanhueza A, Espinosa I, Mújica OJ, da Silva Jr. JB. Sin dejar a nadie atrás: una metodología para establecer metas de reducción de desigualdad en salud del Objetivo de Desarrollo Sostenible 3. Rev Panam Salud Publica. 2020;44:e155. Available from: https://doi.org/10.26633/RPSP.2020.155.

24. UN Advocacy Tool

Name	UN Advocacy Tool
Authors	International Planned Parenthood Federation Western Hemisphere Region and the Sexual Rights Initiative
Year of design	2013
Description	**Goal:** To facilitate access to politically agreed language and expert guidance for advocates at the national, regional, and international levels to support progressive policy outcomes and hold governments accountable for their international obligations and commitments. **Objective:** To provide real-time access to internationally agreed language and relevant UN expert guidance from special procedures, treaty bodies, and technical resources. **Design:** The UN Advocacy Tool is a database of UN resolutions and expert guidance on sexual and reproductive health and rights. It is divided into two sections: 1. A searchable database of agreed language, expert body guidance, and resources on sexual and reproductive rights. 2. A curated list of key sexual and reproductive health and rights terms with additional guidance, definitions, and selected examples of UN-agreed language from UN bodies in New York and Geneva for these terms. Users can conduct searches based on agreed language, expert bodies, key documents, and additional resources. **Intended users:** This tool is intended for advocates, diplomats, and experts at the national, regional, and interventional levels involved in intergovernmental negotiations.
Reference link	https://www.unadvocacy.org/#/en/
Requirements for implementation	The UN Advocacy Tool has no requirements for users. It is available to the public online at no cost.
Previous implementation countries and sites	Worldwide
Implementation, experiences, and lessons learned	The UN Advocacy Tool has proven useful in conducting negotiations with multiple governmental bodies to ensure that all parties are aligned with the most updated terms and guidelines. It streamlines the delegation of responsibilities for meetings with multiple actors. The effectiveness of the tool depends greatly on local planning and implementation efforts, and the tool must be maintained regularly with updated terms and conditions.

25. Assessment of Countries' Readiness to Provide Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) during a Humanitarian Crisis

Name	Tool for the Assessment of Countries' Readiness to Provide Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) during a Humanitarian Crisis
Author	Inter-Agency Working Group on Reproductive Health (RH) in Crises
Year of design	2013
Description	**Goal:** To gauge the extent to which a country is ready to develop and implement an adequate response to SRH needs in emergency situations; and monitor and evaluate progress toward MISP for RH service provision. **Objective:** To identify a country's readiness to respond to urgent SRH needs in an emergency and assist in the development of an action plan involving the essential partners in SRH in the country. **Design:** The Tool for the Assessment of Countries' Readiness to Provide MISP consists of a questionnaire and an analysis and action planning table. The questionnaire is to be completed by all participating partners. It is organized according to the following five objectives: 1. Coordination; 2. Prevent sexual violence and give assistance to survivors; 3. Reduce HIV transmission and meet STI needs; 4. Prevent excess maternal and neonatal mortality and morbidity; 5. Plan comprehensive RH services integrated into primary health care. Once the questionnaire has been completed, the partners analyze their answers using an outline that indicates whether individual indicators satisfy a recommended level of readiness. Partners then decide on actions to be undertaken, such as collecting information, conducting advocacy, engaging other partners, implementing preparedness activities, planning for training, etc. The analysis and planning step can be conducted after completion of the full questionnaire or after answering the questions with regard to one objective. **Intended users:** This assessment tool is intended for use by national SRH stakeholders, familiar or not with the concept of MISP.
Reference link	https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations
Requirements for implementation	Implementation of the Tool for the Assessment of Countries' Readiness to Provide MISP relies on commitment from country teams from the very onset of the process.
Previous implementation countries and sites	Eighteen countries in eastern Europe and central Asia and various countries in Latin America and the Caribbean.

Implementation, experiences, and lessons learned	Implementation of this tool in Latin America and the Caribbean revealed various challenges in the region related to SRH response in humanitarian settings. Gaps in SRH services and supplies were identified, particularly in relation to the migrant population and other vulnerable population groups, like the LGBTQ population and Indigenous groups. Use of this tool in Latin America and the Caribbean also revealed promising approaches to SRH work in humanitarian settings, including increasing access to family planning services though mobile campaigns, establishing strategies that bring SRH services and supplies closer to those who use them, adapting activities so they are culturally relevant, and increasing awareness of available services. Collaboration among governments, agencies, and organizations involved in the implementation of this tool favors coordination, prioritization, and mobilization of resources for SRH response during emergencies. Overall, the assessment process creates a clear picture on where each country stands with regard to SRH preparedness and is a useful tool to increase knowledge and awareness on MISP and on emergency preparedness in general. The structure of the tool, with questions phrased as simply as possible, and indicators deduced from the questions, proves to be appropriate and successful. Successful implementation requires commitment and coordination from all actors. While conducting the assessment, assistance is needed from an outsider to ensure a good understanding of the process and to correct possible discrepancies, gaps, or divergent interpretations. Furthermore, it may be useful to consider using a web-based tool for a future version of the MISP Readiness Tool; this would allow regular updates from the country teams. The tool could also be used by the country teams to monitor their progress and action plans.
Case studies	International Planned Parenthood Federation (IPPF), UNFPA. Assessment of countries' readiness to provide Minimum Initial Service Package for SRH during a Humanitarian Crisis in the Eastern Europe and Central Asia Region: Report – October 2014. Available from: https://eeca.unfpa.org/en/publications/assessment-countries%E2%80%99-readiness-provide-minimum-initial-service-package-srh-during.

26. The Lives Saved Tool (LiST)

Name	The Lives Saved Tool (LiST)
Author	Institute for International Programs at Johns Hopkins Bloomberg School of Public Health
Year of design	2003
Description	**Goal:** To promote evidence-based decisionmaking and aid in planning or prioritization of scale-up of maternal, newborn, and child health and nutrition (MNCH&N) interventions. **Objective:** To estimate the impact of scaling up on MNCH&N interventions in low- and middle-income countries. **Design:** LiST calculates changes in cause-specific mortality based on changes in intervention coverage, intervention effectiveness, and the percentage of cause-specific mortality sensitive to that intervention. LiST describes fixed relationships between inputs and outputs. The primary inputs are coverage of interventions, and the outputs include changes in population-level risk factors (e.g., wasting or stunting rates, birth outcomes such as prematurity or size at birth) or cause-specific mortality (e.g., neonatal or child mortality [1-59 months], maternal mortality, and stillbirths). The relationship between changes in inputs (intervention coverage) and one or more outputs is specified in terms of the effectiveness of the intervention for reducing the probability of that outcome. Outcomes of interest include either cause-specific mortality or a risk factor for mortality. LiST is housed within Spectrum, a software package maintained by Avenir Health, and is now available online. **Intended users:** This assessment tool is intended for use by NGOs, government partners, researchers, project planners, and graduate students for advocacy, evaluation, and strategic planning.
Reference link	https://www.livessavedtool.org/
Requirements for implementation	LiST is free and available in the public domain. For the specified geographic area, the LiST model requires several types of information: mortality, risk factors, and current coverage of interventions and behaviors. For all measures for which data are regularly available (based on sources such as the UN, WHO, and nationally representative household surveys such as the Demographic and Health Survey and the Multiple Indicator Cluster Survey), this information is preloaded at the country level in the LiST default database. For subnational regions, the users must input their own data wherever they differ from the national average. Human resources are also needed for implementation of the LiST tool.
Previous implementation countries and sites	Worldwide.

Implementation, experiences, and lessons learned	LiST has been used extensively as a tool to model the effects of scaling up interventions on maternal and child health and nutritional status outcomes. Another, perhaps even more important use of LiST, has been assisting countries in developing program plans. LiST has several aspects that make it relatively simple to use in program planning. First, part of the continued work on the model includes continuous updating of not only assumptions about efficacy but also data on intervention coverage and prevalence of risk factors. The software comes with a large default database that includes publicly available baseline information such as mortality rates, cause-of-death structure, risk factor prevalence, and coverage of interventions. The database contains information for the years 2000–2016 and covers more than 120 countries. The software also includes additional tools and "wizards" that allow users to quickly carry out standard analyses with little effort. Furthermore, there is an increasing amount of support available for use of the tool, including numerous videos and training modules for using LiST that are available on the website. LiST does not have the ability to understand why the observed changes are occurring. However, the user can explicitly state the assumptions of what would probably have occurred without the new program. This is an advantage when trying to interpret mortality rates which may be unchanged or increase in the study area and/or the comparison area. It should also be noted that LiST, which focuses on mortality, only generates one type of data for understanding the impacts of any health program. These results should be used in combination with other data types, such as qualitative and quantitative data on program users as well as the costs of implementation, among others. Together, a broader understanding of total impact can inform all aspects of the relevant discussions on whether expansion is warranted, and benefits are being accrued. In 2020, UNFPA Latin America and the Caribbean Regional Office (LACRO) promoted the use of LiST to assess the scaling up of maternal health interventions necessary to achieve the first Transformative Outcome of "Ending preventable maternal deaths" (SDG 3.1) by 2030. LiST and LiST Costing (a module to examine costs) were successfully used in Peru and Paraguay to estimate national gaps, both in coverage of maternal interventions and in the financial resources required to achieve the goal of SDG 3.1 by 2030. The use and implementation of LiST in LAC countries is still limited, and the learning curve is long, particularly for national consultants. Training LAC countries teams is recommended to expand the use of LiST. LiST Visualizer (https://listvisualizer.org/), a similar interactive tool intended to support users, should be part of the costing model.
Case studies	Huicho L, Tavera M, Huayanay-Espinoza C, Bejar-Diaz M, Rivera-Ch M, Tam Y. Drivers of the progress achieved by Peru in reducing childhood diarrhoea mortality: a country case study. J Glob Health. 2019;9(2). Available from: https://doi.org/10.7189/jogh.09.020805 Jo Y, Labrique AB, Lefevre AE, Mehl G, Pfaff T, Walker N, et al. Using the Lives Saved Tool (LiST) to Model mHealth Impact on Neonatal Survival in Resource-Limited Settings. PLoS ONE 2014;9(7):e102224. Available from: https://doi.org/10.1371/journal.pone.0102224. Keita Y, Sangho H, Roberton T, Vignola E, Traoré M, Munos M, et al.. Using the Lives Saved Tool to aid country planning in meeting mortality targets: a case study from Mali. BMC Public Health 2017;17(Suppl 4):777. Available from: https://doi.org/10.1186/s12889-017-4749-y. Luna A, Lavado, P. Estudio de Inversión Nacional para el logro de los dos Resultados Transformadores relacionados a Mortalidad Materna y Planificación Familiar en Perú. 2020. MIMEO. Fondo de Población de las Naciones Unidas, UNFPA Peru. Spanish. Gaete R. Estudio de Inversión Nacional para el logro de un Resultado Transformador en Paraguay: Cero Muertes Maternas Prevenibles (ODS 3.1). 2020. MIMEO. Fondo de Población de las Naciones Unidas, UNFPA Paraguay. Spanish.

References

1. Borrell C, Malmusi D, Muntaner C. Introduction to the "Evaluating the Impact of Structural Policies on Health Inequalities and Their Social Determinants and Fostering Change" (SOPHIE) Project. Int J Health Serv. 2017;47(1):10–17. Available from: https://doi.org/10.1177/0020731416681891.

2. Waters D, Theodoratou E, Campbell H, Rudan I, Chopra M. Optimizing community case management strategies to achieve equitable reduction of childhood pneumonia mortality: An application of Equitable Impact Sensitive Tool (EQUIST) in five low and middle-income countries. J Glob Health. 2012 Dec;2 (2):020402. Available from: https://doi.org/10.7189/jogh.02.020402.

3. Uneke CJ, Sombie I, Uro-Chukwu HC, Johnson E, Okonofua F. Using equitable impact sensitive tool (EQUIST) and knowledge translation to promote evidence to policy link in maternal and child health: report of first EQUIST training workshop in Nigeria. Pan Afr Med J. 2017;28.

4. Office of Internal Oversight Services. List of Key Oversight Terms. New York: OIOS; 2013. Available from: https://oios.un.org/resources/2015/01/list_key_oversight_terms.pdf.

5. World Health Organization. Health equity. Geneva: WHO; 2019. Available from: https://www.who.int/topics/health_equity/en/.

6. Whitehead M. The concepts and principles of equity and health. Health Promot Int. 1991;6(3):217–228. Available from: https://doi.org/10.1093/heapro/6.3.217.

7. World Health Organization. Social determinants of health: key concepts. Geneva: WHO; 2013. Available from: https://www.who.int/social_determinants/thecommission/finalreport/key_concepts/en/.

8. World Health Organization. Health Impact Assessment: Glossary of terms used. Geneva: WHO; 2019. Available from: https://www.who.int/publications/m/item/glossary-of-terms-used-for-health-impact-assessment-hia.

9. World Health Organization. Contributing to social and economic development: sustainable action across sectors to improve health and health equity (follow-up of the 8th Global Conference on Health Promotion); 17 January 2014. Geneva: WHO; 2015. Available from: https://apps.who.int/iris/handle/10665/173013.

10. United Nations Development Programme. Multi-stakeholder Engagement Processes: A UNDP Capacity Development Resource. UNDP; New York; 2015. Available from: https://www.undp.org/publications/multi-stakeholder-engagement-processes.

11. World Health Organization. Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva: WHO; 2021. Available from: https://www.who.int/publications/i/item/9789240027794.

12. Every Woman Every Child Latin America and the Caribbean. A Sustainable Development Goal baseline for women, children, and adolescents. Washington, DC: Pan American Health Organization and United Nations Children's Fund; 2022. Available from: https://doi.org/10.37774/9789275125748.

13. United Nations Children's Fund. Health Equity Report 2016: Analysis of reproductive, maternal, newborn, child and adolescent health inequities in Latin America and the Caribbean to inform policymaking. Panama City: UNICEF; 2016 November. Available from: https://www.unicef.org/lac/media/386/file/Publication.pdf.

Glossary of terms

Accountability: The obligation to be answerable for all decisions made and actions taken, and to be responsible for honoring commitments, without qualification or exception. Accountability includes achieving objectives and obtaining high-quality results in a timely and cost-effective manner. Accountability frameworks can be applied to commitments made by governments in ensuring health for every woman and every child.

Health equity: Health equity is achieved when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.

Health inequities: Unnecessary, preventable, and unfair differences in the health status between groups. These inequities are the result of social and economic inequalities in societies and have important effects on the lives and health of the population, determining the risk of disease and death.

Health inequalities: Differences in health status or in the distribution of health determinants between different population groups. Some health inequalities are attributable to biological variations or free choice, and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned.

Tool/instrument: A device that communicates, denotes, detects, indicates measures, observes, records, or signals a quantity or phenomenon, or controls or manipulates another device. These terms are used as synonyms in the literature.

Method: An established, habitual, logical, or prescribed practice or systematic process of achieving certain ends with accuracy and efficiency, usually in an ordered sequence of fixed steps.

Multisectoral action: A recognized relationship between part or parts of different sectors of society, which has been formed to take action on an issue to achieve health outcomes or intermediate health outcomes in a way that is more effective, efficient, or sustainable than might be achieved by the health sector acting alone.

Multisectoral dialogue: Aims to bring relevant stakeholders together to enhance levels of trust between different actors, share information and institutional knowledge, and to generate solutions and relevant good practices.

Social participation: Social participation can take several different forms including:

- informing people, providing them with balanced, objective information;
- consulting the affected community and obtaining feedback;
- involving or working directly with communities;
- collaborating with affected communities by involving them in each aspect of the decision to be made, including the identification and development of alternative solutions to problems;
- empowering communities, by ensuring that they retain ultimate control over the key decisions that affect their wellbeing.

Annex A
Inclusion/exclusion criteria and search strategy

1. Inclusion and exclusion criteria

Inclusion criteria	Published after the year 2000 in English, Spanish, or Portuguese. Population: women, children, adolescents, or general population. Actors: national organizations (ministries of health, planning departments), agencies for international cooperation. Outcomes: proposed in the PICO strategy. Design: systematic reviews, observational analytical studies, qualitative studies. Publication status: published or unpublished studies. Report of results: individual estimates of the effect (for each primary study) or combined estimates (meta-analysis), from studies with the same design, which are attributable to the technology of interest to at least one comparison and an outcome object of the evaluation.
Exclusion criteria	Language restriction: Spanish, English, Portuguese. The study is not available in full text. The study is included in a selected systematic review. The study is a previous version of a systematic review and updated. Papers, posters. Year of publication: before 2000.

2. Search strategy

Search evidence	The search strategy was based on that of Borrel and Malmusi: (social depriv*[Title/Abstract]) or (social disadvantage*[Title/Abstract]) or (health equit*[Title/Abstract]) or (income[Title]) or (job insecurit*[Title/Abstract]) or (material depriv*[Title/Abstract]) or (occupational status[Title/Abstract]) or (poverty[Title/Abstract]) or (social exclusion[Title/Abstract]) or (socioeconomic circumstanc*[Title/Abstract]) or (socioeconomic factor*[Title/Abstract]) or (socioeconomic position[Title/Abstract]) or (socioeconomic status[Title/Abstract]) or (socioeconomic variable*[Title/Abstract]) or (standard of living[Title/Abstract]) or (living standards[Title/Abstract]) or (inequalit*[Title/Abstract]) or (inequit*[Title/Abstract]) or (social class*[Title/Abstract]) or (social status[Title/Abstract]) or (socioeconomic determinant*[Title/Abstract]) or (socioeconomic circumstanc*[Title/Abstract]) or (socioeconomic factor*[Title/Abstract]) or (socioeconomic position[Title/Abstract]) or (socioeconomic status[Title/Abstract]) or (socioeconomic variable*[Title/Abstract])
Selection of studies	The screening of references based on title and abstract and the selection of documents for review was carried out by two reviewers independently. Disagreements between peers were resolved by joint review. The results were summarized by a PRISMA diagram.
Quality evaluation of studies	Two reviewers evaluated the quality of evidence through the application of standardized instruments.
Data extraction and synthesis	A reviewer extracted the data. The findings were presented in evidence tables, separately for each type of study. The characteristics of the studies were described using a standard format.

Annex B

Key informant interview guide

1. Key informant information

- Full name
- Organization
- Position
- Contact details

2. Tools developed by key informant's organization or known by informant

- Through desk review we identified the following tools and methods developed by your organization that can be used to identify and/or address inequalities affecting the health of women, children, and adolescents (list the tool or method). Do you agree with this statement? (i.e., that these are equity-based tools).
- Are there additional tools developed by your organization that can be used toward this purpose? (Please list: name, reference, details, etc.)
- Are there additional tools not developed by your organization that can be used toward this purpose that you are aware of? (Please list)
- Do you have experience with the application of any of the tools and methods mentioned in the three previous questions? (If yes, continue with interview section 3 for each of these tools or methods).
- Are there other people within or outside of your organization you can recommend interviewing for additional information on the existence and application of such tools and methods?
- Are there any peer-reviewed articles regarding these tools and methods that you can share or recommend?

3. Application experience

We will now review the application of (name of tool):

- Please describe the tool or method briefly and define its key elements and application method.
- Are there any peer-reviewed articles regarding the application of this tool or method that you can share or recommend?
- Please provide details of its application (country or countries), location, geographical scope, actors, implementation process, etc.
- What exactly was your role in the application of this tool or method?
- Was this application documented? Please share reports/documents if possible.
- Please share your insights about the implementation in terms of:
  a) strengths and challenges; b) conditions, facilitating factors, and barriers for successful application; c) resources required (financial and human); d) fit for purpose.
- Has there been an evaluation of this tool or method? (If yes, please share or refer to evaluation reports).

Annex C

Summary matrix of tools and methods

#	TOOL	ORGANIZATION/AUTHOR	SHORT DESCRIPTION	REFERENCE LINK
1	**Equitable Impact Sensitive Tool (EQUIST)**	UNICEF	Web-based analytical tool designed to support analysis and strategic prioritizing and planning to address child and maternal health and nutrition inequities in developing and middle-income countries. Identifies cost-effective interventions, prioritizes key bottlenecks that constrain their coverage, and targets the most effective and equity-focused strategies to increase maternal, newborn, and child health intervention coverage. This tool is focused on women and children.	https://equist.info/#/
2	**INNOV8**	WHO	An eight-step review process designed to support efforts to operationalize the SDGs and "leave no one behind," undertaken by multidisciplinary teams. Helps improve program performance through concrete action to address health inequities, support gender equality and the progressive realization of universal health coverage (UHC), the right to health, and address critical social determinants of health (SDH). This method can be applied to evaluate programs aimed at women, children, and adolescents.	https://apps.who.int/iris/handle/10665/250442
3	**Health Equity Assessment Toolkit (HEAT)**	WHO	Software application to be used on desktop computers, laptops, and mobile devices that facilitates the assessment of within-country health inequalities. The software, which can be used at different levels (national, provincial, or district) can determine the latest situation of health inequality as well as the change in inequalities over a period of time. This is a free licensed software that results in data ready for interpretation.	https://www.who.int/gho/health_equity/assessment_toolkit/en/
4	**Health Equity 2020 Toolkit**	Erasmus University Medical Center	A toolkit that provides a step-by-step approach toward developing action plans to address socioeconomic health inequalities. It can be used for specific populations, such as women, to identify gaps.	https://hcn.eu/wp-content/uploads/2017/12/1_Health-Equity-2020-Toolkit-Edition-1.0.pdf
5	**Urban Health Equity Assessment and Response Tool (Urban HEART)**	WHO	Guides local policymakers and communities through a standardized procedure of gathering relevant evidence and planning efficiently for appropriate actions to tackle health inequities. It identifies inequities between different population groups and then facilitates decisions on viable and effective strategies, interventions, and actions that should be used to reduce inter- and intra-city health inequities.	https://apps.who.int/iris/handle/10665/79060
6	**Gender Analysis Toolkit for Health Systems**	Jhpiego in partnership with USAID Maternal and Child Survival Program	Provides research questions with a data collection guide when performing a project-level gender analysis which helps to identify the evidence of gender inequalities relevant to programs focused on different levels of the health system.	https://gender.jhpiego.org/analysistoolkit/

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7	**Organizational Self-Assessment for Addressing Health Inequities Toolkit**	Bay Area Regional Health Inequities (BARHII)	Provides public health leaders with tools and guidelines that help identify the skills, organizational practices, and infrastructure needed to address health equity and provide insights into steps local health departments can take to ensure their organization can have an impact on negative policies.	https://www.barhii.org/organizational-self-assessment-tool
8	**Gender-Equitable Men (GEM)**	Population Council/ Horizons and Promundo	Provides information about the prevailing gender norms in a community and the effectiveness of programs that seek to influence gender norms. The use of this instrument helps to determine concrete evidence-based measures to address the gender-based inequities observed in each country and can be targeted to orient health programs.	https://promundoglobal.org/wp-content/uploads/2014/12/Measuring-Attitudes-toward-Gender-Norms-among-Young-Men-in-Brazil-Development-and-Psychometric-Evaluation-of-the-GEM-Scale.pdf
9	**WE CARE (Well Child Care, Evaluation, Community Resources, Advocacy, Referral, Education)**	Arvin Garg (Boston Medical Center)	Semi-structured assessment designed to identify and respond to the immediate attention needs of parents visiting a pediatric healthcare facility. It assesses parents' needs in six domains: parental educational attainment, employment, childcare, risk of homelessness, food security, and household heat and electricity in order to inform parents about all the community resources available for them.	https://www.bmc.org/pediatrics-primary-care/we-care/we-care-model
10	**iScreen Social Screening Questionnaire**	Laura M. Gottlieb, Danielle Hessler, and Dayna Long (University of California, San Francisco)	Semi-structured questionnaire designed to screen for health-related social and environmental risk factors of children's caregivers and to identify and respond to their immediate attention needs. It can be used to identify and/or address gaps in the health of women and children.	https://clinicaltrials.gov/ct2/show/NCT02197052
11	**Social Environment Inventory (SEI)**	Suezanne Orr, Sherman James, and Evan Charney	To identify maternal exposure to stressors that can disproportionally affect the health of women, children, and adolescents.	https://psycnet.apa.org/record/1990-13456-001
12	**WellRx**	Janet Page-Reeves, Will Kaufman, Molly Bleeker, Jeffrey Norris, Kate McCalmont, Veneta Ianakieva, Dessislava Ianakieva and Arthur Kaufman	This is an 11-question instrument used to screen for social determinants at primary healthcare facilities. Designed to identify and address non-medical social needs experienced by patients seen in a clinic setting and can be used to focus on groups of women, children, and adolescents.	https://www.jabfm.org/content/jabfp/29/3/414.full.pdf
13	**Strategizing National Health in the 21st Century: A Handbook**	WHO	Method designed to provide up-to-date and practical guidance on national health planning and strategizing for health. It can be used to both identify and address health needs and social inequalities in health. Although not specifically designed for women, children, or adolescents, it can be used in the analyses of programs focused on these population groups.	https://apps.who.int/iris/handle/10665/250221

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14	**Human Rights and Gender Equality in Health Sector Strategies: How to Assess Policy Coherence**	WHO, the Office of the High Commissioner for Human Rights (OHCHR) and the Swedish International Development Cooperation Agency (SIDA)	Tool designed to generate a national multistakeholder process and a cross-disciplinary dialogue to enhance coherence between international obligations and commitments; national legal, policy, and institutional frameworks; and health sector strategies with respect to human rights and gender equality, which has benefits for the health of women and children.	https://www.ohchr.org/sites/default/files/Documents/Publications/HRandGenderEqualityinHealthSectorStrategies.pdf
15	**Handbook on Health Inequality Monitoring with a Special Focus on Low- and Middle-income Countries**	WHO	To enable countries to better monitor and evaluate their progress and performance and allow them to use the results to formulate evidenced-based policies, programs, and practices to tackle inequalities in an effective manner. Although not specifically focused on women, children, and adolescents, these populations can be selected as a focus in the implementation of the method.	https://apps.who.int/iris/handle/10665/85345
16	**Step-by-step Guide for Measuring Social Inequalities in Health**	Every Woman Every Child Latin America and the Caribbean (EWEC-LAC)	This tool includes methodological orientations and tools for the measurement and monitoring of health inequities. It also provides technical support to institutionalize the measurement and monitoring of inequalities in national health information systems.	https://www.everywomaneverychild-lac.org/e/publication/measuring-social-inequalities-health/
17	**Black Mamas Matter: A Toolkit for Advancing the Human Right to Safe and Respectful Maternal Health Care**	Center for Reproductive Rights and Black Mamas Matter Alliance	Provides a comprehensive overview of information and resources on maternal health within the Black and Afro-descendant populations and identifies actions policymakers can take to address maternal health within the human rights and reproductive justice frameworks.	https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/USPA_BMMA_Toolkit_Booklet-Final-Update_Web-Pages.pdf
18	**Handbook for Conducting an Adolescent Health Services Barriers Assessment (AHSBA) with a Focus on Disadvantaged Adolescents**	WHO	This tool outlines how governments can assess health service equity and barriers at national and subnational levels in order to identify which adolescents are being left behind, and why. The tool aims to achieve the following three objectives: 1. To identify barriers which prevent disadvantaged adolescents from having effective health service coverage. 2. To trigger remedial action to address the barriers. 3. To catalyze integration of those being left behind in country-level M&E.	https://apps.who.int/iris/handle/10665/324924
19	**Global Accelerated Action for the Health of Adolescents (AA-HA!)**	WHO in collaboration with UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, World Bank, Every Woman Every Child initiative, and The Partnership for Maternal, Newborn, Child and Adolescent Health	This tool aims to assist governments in deciding what they plan to do – and how they plan to do it – as they respond to the health needs of adolescents in their countries. It is intended as a reference document for national-level policymakers and program managers to assist them in planning, implementing, and M&E of adolescent health programs.	https://apps.who.int/iris/handle/10665/255415

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20	**Demand for Health Services: A Human-Centred Field Guide for Investigating and Responding to Challenges**	UNICEF	Helps with understanding the barriers and drivers that hinder uptake of services by specific populations. The guide follows different steps to address these challenges, starting with a planning exercise (from a systems perspective), a diagnosis (which includes methodologies for in-depth interactions with people), a design phase (generation of innovative solutions), and implementation.	https://www.unicef.org/innovation/reports/demand-health-services
21	**Strengthening the Adolescent Component of National HIV Programmes through Country Assessments: Adolescent Assessment and Decision-Makers' (AADM) Tool**	UNICEF	Guides users through three country assessment phases: 1. Rapid assessment of adolescent program context at national and subnational levels. 2. In-depth analysis of bottlenecks affecting coverage of priority HIV interventions in priority geographic locations identified in Phase 1. 3. Evidence-informed planning to accelerate corrective actions to address bottlenecks, data gaps, and improve intervention coverage, quality, and impact. The associated AADM tool provides countries with the necessary analytics to inform decisionmaking during the country assessments.	https://data.unicef.org/resources/guidance-document-strengthening-adolescent-component-national-hiv-programmes-country-assessments/#
22	**Commitment to Equity Handbook: Estimating the Impact of Fiscal Policy on Inequality and Poverty**	Tulane University Commitment to Equity Institute	Provides a step-by-step guide to applying fiscal incidence analysis. The CEQ Assessment described in this handbook is a diagnostic tool that uses fiscal incidence analysis to determine the extent to which fiscal policy reduces inequality and poverty in a particular country.	https://commitmentoequity.org/publications-ceq-handbook
23	**Methodology to Set Health Inequality Reduction Targets for SDG3**	Antonio Sanhueza, Isabel Espinosa, Oscar Mújica, Jarbas Barbosa da Silva Jr.	Guides the development of quantitative goals that reflect both the improvement in the national average of an SDG3 health indicator (average goal) and the reduction of its geographic inequality (distributional goal). The methodology consists of a five-step algorithm and includes specific instructions to achieve each step of the algorithm.	https://iris.paho.org/handle/10665.2/53115
24	**UN Advocacy Tool**	International Planned Parenthood Federation Western Hemisphere Region and the Sexual Rights Initiative	The UN Advocacy Tool is a database of UN resolutions and expert guidance on SRH and rights. It is divided into two sections: 1. A searchable database of agreed language, expert body guidance, and resources on sexual and reproductive rights. 2. A curated list of key SRH and rights terms with additional guidance, definitions, and selected examples of UN agreed language from UN bodies in New York and Geneva for these terms.	https://www.unadvocacy.org/#/en/
25	**Assessment of Countries' Readiness to Provide Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH) during a Humanitarian Crisis**	Inter-Agency Working Group (IAWG) on Reproductive Health (RH) in Crises	The Tool for the Assessment of Countries' Readiness to Provide MISP aims to gauge the extent to which a country is ready to develop and implement an adequate response to SRH needs in emergency situations and monitor and evaluate progress toward MISP service provision. The tool itself consists of a questionnaire and an analysis and action planning table.	https://www.unfpa.org/resources/minimum-initial-service-package-misp-srh-crisis-situations

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26	**The Lives Saved Tool (LiST)**	Institute for International Programs at Johns Hopkins Bloomberg School of Public Health	The Lives Saved Tool estimates the impact of scaling up on maternal, newborn, and child health and nutrition interventions in low- and middle-income countries. LiST calculates changes in cause-specific mortality based on intervention coverage change, intervention effectiveness for that cause, and the percentage of cause-specific mortality sensitive to that intervention.	https://www.livessavedtool.org/

A COMPENDIUM OF TOOLS AND METHODS TO ADDRESS SOCIAL INEQUITIES AFFECTING THE HEALTH AND WELL-BEING OF WOMEN, CHILDREN, AND ADOLESCENTS IN LATIN AMERICA AND THE CARIBBEAN

This publication presents an overview of existing tools and methods identified through a systematic search process that can be used by policymakers, program managers, development partners, nongovernmental organizations, academia, and civil society partners to strengthen systematic identification and analysis and respond to social inequalities in the health of women, children, and adolescents in Latin America and the Caribbean.

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