

Knowledge Brief

Health, Nutrition and Population Global Practice

EQUITY AND TARGETING ADOLESCENTS AND YOUTH IN HEALTH SERVICE DELIVERY

Meaghen Quinlan-Davidson and Rafael Cortez

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KEY MESSAGES:

- Young people (ages 10-24 years) represent one quarter of the world's population, yet in many low and middle income countries the lack of investment in this age group impacts their human capital and ultimately poverty reduction and shared prosperity.
- Adolescents and youth encounter many barriers to seeking health services, including limited health service coverage and a lack of access to adolescent-responsive services, among others. Universal health coverage cannot be achieved without addressing these barriers and ensuring that everyone has equal opportunity and the same resources.
- An equity-based approach and specific targeting of adolescents and youth should lead to improved policies that ensure broader acceptance of young people and their health needs in the public domain.

Introduction

There are 1.8 billion young people (10–24 years of age) in the world today, which represents 24.5 percent of the world's population. Today's generation of young people is the largest cohort in history, and their share of the population is expected to increase through 2065 (UNDESA, 2015). Now more than ever, young people have access to greater opportunities due to technology, education, globalization, and improved health systems. What's more, many countries are currently experiencing—or are expected to experience—a demographic dividend, in which fertility decline and socioeconomic growth lead to accelerated economic development and poverty reduction.

Yet in order for young people to take advantage of these opportunities, substantial investments in the health and human capital of adolescents and youth need to be made, through innovative thinking and by ensuring young people's participation in decisions that affect them. Young people have—until recently—been neglected in the political and public agenda. In fact, improvements made over the past decade in child health and survival have not translated into healthy

development during adolescence and young adulthood. For example, the leading causes of death in this age group at the global level—road injuries, self-harm, violence, and tuberculosis—have declined only slightly between 1990 and 2013. At the same time, adolescent pregnancy, HIV, mental health disorders, and maternal mortality have increased in many countries (Mokdad et al, 2016).

Young people far too often encounter barriers to seeking health services, whether it be a lack of available confidential adolescent-responsive services; fear of being subjected to discriminatory behaviour from health providers; the cost of health services; and/or encountering poor quality health services. In comparison to other age groups, young people have the poorest health care coverage, receive limited resources, and are one of the most vulnerable populations (Walker, 2011). This leads to inequities in health care access, treatment, and outcomes. At the same time, this reveals and strengthens inequities in other areas, illustrating that as a whole, health equity is intrinsic to economic growth and development (WBG, 2006).

The lower a group's economic status, the less it uses and has coverage for health services (Gwatkin et al., 2005). Ultimately, universal health coverage (UHC) cannot be achieved without addressing these barriers and ensuring that all adolescents—

including the poorest 40 percent (as stated in the WBG’s twin goals)—have access to quality and affordable health services. The objective of this Brief is to provide an overview of operationalizing equity and targeting in World Bank Group (WBG) adolescent and youth health service delivery projects. Please refer to the forthcoming Adolescent and Youth Health Guidance Note for further information and details.

Equity in Access and Financing

Equity is defined as having equal opportunities, which allow an individual, regardless of social, economic, and demographic status, to pursue the life they want to lead, without experiencing extreme deprivation in economic, social, cultural, and political outcomes (WDR, 2006). Examples of inequities include the exclusion of out-of-school adolescents and youth from sex education classes in school settings; mental health services that serve young people in urban areas but not in rural areas; and substance abuse programs offered to older adolescents but not younger adolescents.

Equity in access to health care is an objective of most health care systems. As a supply side issue, equity in access to health care means that “equal services are made available to patients in equal need” (Goddard and Smith, 2001). Yet ensuring that the population has equal access to health services is a challenge for most countries. Variations in treatment, meanwhile, results from the interaction between supply and demand, and is influenced by the “preferences, perception, and prejudices of both patient and health care providers”, as well as the quality of services provided. Variations in health outcomes are the result of many factors, including income, education, religion, and gender norms, among others besides the receipt of health care (Goddard and Smith, 2001).

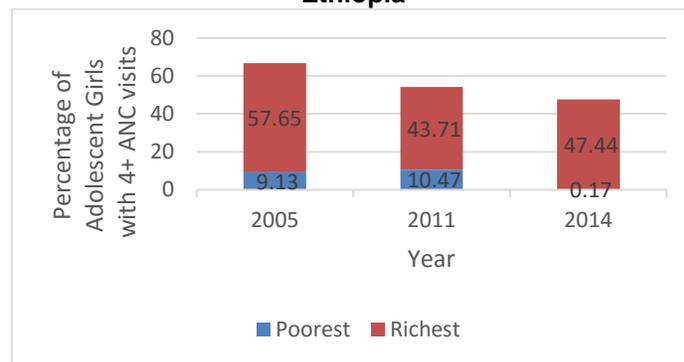
A key limitation to accessing health care services in low- and middle-income countries is the affordability of the services provided, with out-of-pocket payments financing a significant proportion of a country’s health care expenditure. Indeed, individuals and families can be pushed into poverty due to medical expenses and loss of income due to ill health. To address this, health financing systems should be set up to ensure a “fair distribution of the burden of paying for health care according to the ability-to-pay (ATP) and benefits from health care spending according to need” (Asante et al., 2016). To address equity in access and financing of young people’s health services, program managers and policy makers should ensure that a package of essential health services is available, accessible, acceptable, and of good quality.

Inequalities in health are defined as “differences in health status or in the distribution of health determinants between population groups” by income, education, time, access to health insurance, and conditions in households, communities, and workplaces, between the poor and better off (WHO, 2016; O’Donnell et al., 2008).

In Ethiopia, for example, in comparison to women 20-39 years of age, 15-19-year-old girls at the national level were the least likely to have 4+ antenatal (ANC) visits (WHO recommended number of visits). In addition, there were wide gaps seen

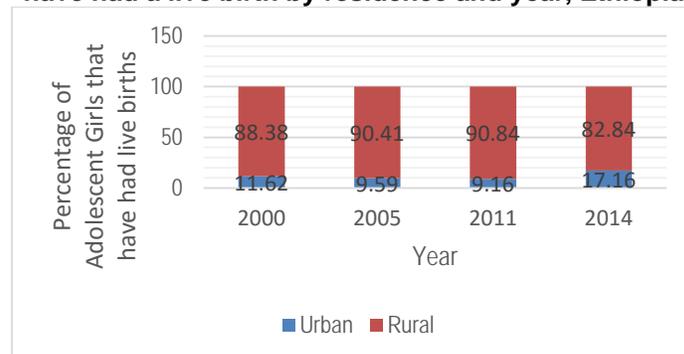
between the poorest and richest quintiles within this age group. In fact, in 2000, adolescent girls in the richest quintile were 6.3 times more likely than their poorest counterparts to have had 4+ ANC visits. This gap widened between 2000 and 2014. (Figure 1). Meanwhile, 15-19-year old females living in rural areas were 4.8 times more likely than their urban counterparts to have had a live birth in 2014 (Figure 2).

Figure 1. Percentage of adolescents (15-19 years) that had 4+ ANC visits by Wealth Quintile and Year, Ethiopia



Source: EDHS 2005, 2011, 2014

Figure 2. Percentage of adolescents (15-19 years) that have had a live birth by residence and year, Ethiopia



Source: EDHS 2000, 2005, 2011, 2014

To determine the most vulnerable group of young people, the inequities that exist, and the magnitude of differences in the country/countries of interest, a health inequality profile must first be developed. The variable(s) of interest should be identified, for example: health outcomes; health care utilization; subsidies received through the use of services; or personal payments made for health care. These variables are analyzed with dimensions of inequality related to income, education, region, residence, age, sex, and occupation, among others. To conduct the analysis, project/program designers and managers will need:

- a suitable dataset (e.g., population-based data sources such as DHS, LSMS, and middle-income countries that have data disaggregated by dimensions of inequality);
- clarity on key measurement variables;
- a set of quantitative methods for measuring inequalities (e.g., pairwise comparisons, slope index of inequality,

concentration curves and index, ordinary least squares, Theil index, among others); and

- additional advanced quantitative techniques if needed.

As the WBG works to support countries in their attainment of UHC, one of the challenges associated with universal coverage is that it does not always work in practice and not all vulnerable young people are reached. For example, out-of-school adolescents and youth might not have knowledge about a health program available to them, while those who are in school have access to the services because they learned about the program in one of their classes. To address this issue, many programs use targeting strategies to reduce these inequality and inequity gaps.

Targeting

Targeting seeks to increase the proportion of a specific population that receives health care resources and benefits, while reducing or eliminating access to those resources by the non-targeted population. To accomplish this with respect to young people, a targeting mechanism, or a set of policy options, is developed and implemented that directs subsidies to specific, pre-identified groups to “achieve certain policy objectives related to enhancing equity in the health sector” (Bitran and Munoz, 2000).

The goals of targeting include increasing young people’s access and coverage to quality health services and reducing inequalities in health status between those who are vulnerable and those who are not. Targeting is successful when the majority of health subsidies reaches the targeted group of young people; and unsuccessful when only a portion of the target population is reached (Bitran and Munoz, 2000). To accomplish this, we should consider supply- or demand-side subsidies and where to implement a universal program or a targeted program (WBG, 2005).

A targeting mechanism encompasses a set of targeting methods, as well as the choice of processes and operating procedures employed to identify, screen, and promote effective targeting outcomes (Conning and Keane, 2011). The aim is to correctly and efficiently identify the eligibility requirements of the target population receiving the subsidy, given available resources (Kuwawenaruwa et al., 2016). When choosing a targeting method, an important distinction should be made between direct and indirect targeting. *Direct targeting* aims to designate benefits to specific individuals through a means test, while *indirect targeting* is broad: focusing on groups of people or types of programs.

The following are targeting methods that Task Team Leaders (TTL) should consider during project preparation; these can be implemented solely or in combination:

- Community-based Targeting: Engaging leaders and members of a community, such as parent-teacher associations or school officials, to determine who in the community should receive subsidies through the health program.

- Individual Assessment: Conducting an assessment of individual characteristics such as income, health status, or nutritional status in order to determine who should receive the subsidy. TTLs can use proxy means tests or means tests to identify the beneficiaries.
- Group Assessment: Targeting young people based on “similar, easily identifiable characteristics such as location, age, gender, or ethnicity” (Bitran and Munoz, 2000).
- Self-targeting: Incentivizing and benefitting young people that belong to a specific group, increasing their health seeking behaviour. This is open to the entire population.
- Targeting by Service Type: Implementing under the assumption that the targeting group of young people has a greater need for a certain type of health service than other young people or population groups. For example, condom distribution or screening and treatment of STIs.
- Geographic Targeting: Identifying the target population based on their location (e.g., neighborhood, district, region, etc.). Most widely used method.
- Demographic Targeting: Providing subsidized health care based on age.

Lack of clarity and specificity about the targeted group of young people can lead to errors in targeting accuracy in the delivery of the subsidy. This can make measuring program performance difficult. There are two features of targeting accuracy that TTLs should keep in mind when developing the mechanism: inclusion error and exclusion error (Gwatkin, 2000; Van Domelen, 2007).

At the same time, before developing a targeting mechanism, there are several issues that the TTL should consider and address as needed. Selecting a targeting mechanism depends upon the resources available, administrative and information costs, incentive costs, political viability, societal support for the use of the public’s resources, elite capture (the better off community receives or shapes the subsidy for their own interest), and the voices and preferences of young people.

To determine if the mechanism is effective and the targeting objectives are being met, a monitoring and evaluation (M&E) framework and system should also be developed. For example, if a project uses geographic targeting for the delivery of adolescent and youth mental health services in a district, the indicators should monitor geographic allocations (see Box 1). Evidence suggests that geographic targeting is easier to monitor and evaluate, whereas individual assessments are more challenging given the need to conduct household surveys to determine the impact (Van Domelen, 2007).

Box 1. Example of Targeting Performance Indicators

Coverage Indicators

- Percentage of vulnerable young people living in urban areas that benefit from the project
- Percentage of vulnerable young people benefiting from improved services in relation to the total population in the targeted area

Geographic Targeting Indicators

- Increased share of project funding going to the communities with the greatest number of vulnerable young people
- Absolute share based on funding formula of project funding going to communities with the greatest number of vulnerable young people

Source: Van Domelen, 2007

WORLD BANK GROUP AND TARGETING

Below is a brief summary of selected, active WBG projects that include adolescent and youth health activities and employ targeting mechanisms.

- The *Population and Health Support Project* (WBG, 2015), implemented in Niger, focuses on increasing the utilization of reproductive health and nutrition services among women, adolescent girls, and children in remote and underserved communities. The targeting mechanisms include proxy means testing, geographical targeting, and community participation.
- The *Great Lakes Emergency Sexual and Gender Based Violence & Women’s Health Project* (WBG, 2014), implemented in the Democratic Republic of Congo, Burundi, and Rwanda aims to expand the provision of services to mitigate the impact of sexual and gender-based violence, and expand the use of a package of health interventions targeted to poor and vulnerable families. Geographic targeting was used to select thirteen health zones.
- The *Youth Opportunities Project* (WBG, 2015) in Liberia aims to improve access to income generation opportunities for targeted youth and strengthen the government’s capacity to implement its cash transfer program. To reach youth, the project is using on-demand

targeting, or a combination of self-targeting and community-based targeting.

TARGETING POLICIES AND LEGAL FRAMEWORKS

If the country does not have policies that target vulnerable young people in the delivery of health services, it is essential to identify and recommend policies that could better serve young people in terms of health services coverage and young people’s access to health services. A distinct policy should be developed to guide investments for this vulnerable group. For example, this would entail ensuring that adolescent and youth friendly health services are available in marginalized and poor areas.

Equitable Health Service Access and Coverage

Building on the health sector’s response to adolescent and youth health, health services, goods, and information that are provided through the project should be of quality. Using an adapted version of Tanahashi’s coverage model for the evaluation of health services (Tanahashi, 1978; Chopra et al., 2012), the following should be considered for effective project design and implementation in health investments for adolescents and youth: availability, accessibility, utilization, continuous coverage, and effective coverage of health services, as well as the human rights principles of participation, non-discrimination and accountability.

Conclusions

This brief provides an overview of equity and targeting and the value-add of using an equity-based approach to adolescent and youth health service delivery. For TTLs, policy makers and program/project managers, applying an equity-based approach to adolescent and youth health services begins with understanding why certain groups of young people are vulnerable, and within that, identifying those at greatest risk. It entails analyzing dimensions of inequality (e.g., income, location, gender) and the interaction between those factors using inequality analytics, and undertaking a comprehensive assessment of health systems and services at the sub-national and service delivery levels. It involves ensuring the participation of vulnerable groups of young people.

This HNP Knowledge Brief highlights part of the key findings from the Bank’s Economic Sector Work “Investing in Adolescent Sexual and Reproductive Health: Standards of Practice in Operations” conducted by the Health Nutrition and Population Global Practice and financed by the Nordic Trust Fund (NTF). This Knowledge Brief was prepared by a team composed of Rafael Cortez (World Bank’s Team Lead), and Meaghan Quinlan-Davidson with contributions from Allison Smith-Estelle.

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