Regional Network for Equity in Health in east and southern Africa

DISCUSSION Paper NO. 107

Literature Review: Essential health benefits in east and southern Africa

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In the Regional Network for Equity in Health in east and southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 107

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With support from IDRC (Canada)

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Cite as: Todd G, Mamdani M, Loewenson R, (2016) Literature Review: Essential health benefits in east and southern Africa, EQUINET Discussion paper 107, IHI, Tanzania, TARSC, EQUINET, Harare.

Acknowledgement to The document was sent to team members from Zambia, Swaziland, Uganda and Tanzania for peer review and we acknowledge review comments, especially from Dr I Kadowa. We acknowledge support from IDRC Canada.

EXECUTIVE SUMMARY

An Essential Health Benefit (EHB) is a policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. Many east and southern Africa (ESA) countries have introduced or updated EHBs in the 2000s. Recognising this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), is implementing research to understand the role of facilitators and the barriers to nationwide application of the EHB in resourcing, organising and in accountability on integrated health services. This literature review provides background evidence to inform the case study work and regional dialogue. It compiles evidence from published and public domain literature on EHBs in sixteen ESA countries, including information on the motivations for developing the EHBs; the methods used to develop, define and cost them; how they are being disseminated and communicated within countries; how they are being used in budgeting, resourcing and purchasing health services and in monitoring health system performance for accountability; and the facilitators and barriers to their development, uptake or use.

The literature review indicated that EHBs are widespread across the region, with thirteen of the sixteen ESA countries having them, albeit with different names applied to them and at different stages of implementation. All thirteen countries have designed an EHB or are in the process of updating it, ten have included them explicitly in policies; nine have implemented them and five have evaluated them. The majority apply them in the public sector at national scale. The development of an EHB was motivated by efforts to clarify health entitlements, to identify prioritised health interventions with cost benefit to meet priority population health burdens and to align resources to implement these services universally to all.

EHBs are largely initiated and designed by central ministries of health, with involvement of external funders in some countries, and limited consultation with other stakeholders or communities. Most applied analysis of health burdens and cost-benefit interventions to identify services for inclusion, and some included a focus on specific areas of policy commitment, such as maternal and child health, where there was also sector-wide funding from external partners. It was not always apparent that those developing the EHB had adequate, quality population health information and costing data for this. In general, the methods and assumptions used for both prioritisation of services or their costing do not appear to be comparable across the region.

The EHBs in ESA countries generally apply to all social groups and cover services from community to primary care to hospital level. The different EHBs in ESA countries cover specific communicable and non-communicable disease programmes, maternal and child health and public health interventions, although with less common inclusion of laboratory, paramedical and allied services. Primary health care was a focus in all.

EHB costs were differentiated by level of care, type of service provided and whether in the public or private sector. The estimated cost for public sector provision of the EHB of approximately $14-$25* per capita at primary care level and $40-$74 per capita, including referral hospital services, compares well with the $60 per capita estimated by the World Health Organisation (WHO) in 2008 for health system costs, if this is adjusted for inflation. (* all dollar figures refer to US dollars)

While the EHBs are largely tax funded from government budgets, in most countries in the region the amount allocated from ministries of finance is insufficient to cover the benefit. If the cost of the EHB is estimated at about $70 per capita, then only seven of the sixteen countries had a total health expenditure post-2010 that covers this, and far fewer if only government expenditure/capita is used. In part, therefore, the costing of the EHB provides an estimate for ministries of finance on what budget would be needed to deliver what is regarded as an 'essential benefit' and the size of the public sector funding gap. The funding gap means that in most ESA countries out-of-pocket spending (OOP) and external funding in sector-wide approach (SWAp) type arrangements have been used to support delivery of the EHB. Such OOP spending, however, is often being collected through fee charges that contradict policy and raise barriers to care for poorest groups. External funding makes countries dependent on unpredictable sources for core services.

The demand to raise additional domestic revenue has led ESA countries to explore other earmarked taxes and mandatory national insurance. Some countries have focused on delivery of specific priorities within the overall benefit package in the EHB, intending to roll out others as resources increase. Others have proposed to use fee charges for non-EHB services to fund those in the EHB.

The EHB can play a key role in active and strategic purchasing of health services, widening performance funding from a narrow range of disease-specific outputs to a wider service package. This would be important also in decentralisation approaches being applied. However, the literature provided limited evidence of this use of the EHB, including with local government, private, mission sectors, and other non-state providers, to align their services to priority benefits and monitor performance. The role of the EHB in purchasing (contracting and performance and equity monitoring) strategies would appear to be an area that needs further review within the region.

From the five countries where evaluations have been implemented on their EHBs, there was some evidence of an implementation gap. The evaluations suggest that improvements in health and healthcare may arise from the use of EHBs, but that this depends on lower income groups accessing the services covered and on benefit packages being funded, available and effectively provided at primary care level and in district hospitals, with additional measures to ensure uptake in lower income groups and to control cost escalation. Designing and implementing an EHB was enabled by having access to capacities, methods and adequate quality data for the design, by collaboration across state and non-state actors, by having personnel and resources to implement it and by having the information and expenditure tracking systems to primary level to monitor it. The evaluations pointed to barriers within all these areas. These facilitators and barriers can be located within a wider demand for strengthening the health system.

The limitations of this review are noted in *Section 2*, some of which can only be addressed through country-level assessment. Following the production of this review, the EQUINET programme on this area will be working with country teams led by ministries of health in four ESA countries to carry out more detailed case studies to assess the motivations for and methods used in developing and costing EHBs; the manner in which EHBs have been disseminated and used; promising practice, learning and the key issues for follow up, including bringing back wider regional exchange.

The issues raised in the discussion point to areas for inclusion in the protocols for the more detailed assessment within countries, particularly since some work on EHBs is in progress or not documented in published literature.

The follow-up could thus give attention to:

a. The method used to assess and prioritise the benefits in the EHB, paying attention to programme areas and health system elements;
b. The method used for prioritising services and costing of the EHBs and its alignment to ministry of finance, external and other funders;
c. The methods of and challenges in blending funds from different sources for the EHB, how funding shortfalls are addressed and how new funding sources proposed or under policy dialogue will be pooled to provide the EHB for all;
d. The factors enabling/disabling implementation, from design to monitoring and review, noting inclusiveness of participation in the design; collaboration between state and non-state/private actors; quality of information and expenditure on tracking systems;
e. The use of the EHB in purchasing strategies with providers and the factors affecting this;
f. The measures for governance, management of and accountability for the EHB and for managing the role of other sectors in the delivery of the EHB; and
g. The areas of impact and methods used/suggested for evaluation of the EHB for strategic review.

1. BACKGROUND

The Essential Health Benefit (EHB) is a package and policy intervention designed to direct resources to priority areas of health service delivery to reduce disease burdens and ensure equity in health. The priority areas vary across countries, depending on the criteria and strategies used to define them. They may reflect areas of high public health burden, or areas that are key to meeting development commitments, or they may be areas with high cost-benefit. Waddington (2013) identifies motivations from different countries for setting EHBs in terms of their role in:

1. Contributing towards equity and poverty reduction by providing basic service entitlements.
2. Increasing value for money by identifying cost-effective interventions for priority health needs.
3. Making clear to citizens what services are to be made available and thus holding states, providers and funders to account for this.

Overall, an EHB thus aims to define a fair benefit package that will reduce the population's burden of disease and against which providers and state can be held accountable. This involves multiple dimensions of health systems, from service delivery to governance and financing.

1.1 Defining EHBs

Essential Health Benefits are frequently referred to by different terminologies. Within this document review, we use the term of Essential Health Benefits (EHB). Alternative terminologies used include: Essential Health Packages; Basic Health Package; Core Health Services; Package of Essential Health Services, and Minimum Health Package.

Defining the benefit package as an EHB in part responds to health (and thus access to healthcare) as a human right, as outlined in the World Health Organisation (WHO) Constitution (WHO, 2006) and as promoted through health for all and primary healthcare in the Alma Ata Declaration (WHO, 1978). As noted earlier, it responds to the demand to identify the service entitlement that addresses this right to health care.

Within insurance arrangements, EHBs helped clarify the benefit package funded. They have been applied as either entitlement or insured package in Europe since the 1800s. In 1883, the German parliament mandated compulsory national health insurance to address social welfare in the age of rapid industrialisation (Busse, 2000). Initially, the benefits covered work-related accidents and invalidity, but were extended to unemployment and long-term nursing care in the 20th century. From the mid-1900s, European countries extended EHBs in light of the development of national health service and national health insurance reforms. England's 1946 National Health Service Act guaranteed preventive, primary and hospital care to its people (Boyle, 2011).

In 1993, the World Bank introduced the concept of 'minimum health package' into the international discourse in the 1993 World Development Report (World Bank, 1993), arguing that inefficient and poorly allocated funding in health care excluded poor people from access to services and inflated health expenditure. The report proposed health investment based on cost-effective interventions, using disability-adjusted life years gained as a measure (World Bank, 1993). This shifted from comprehensive primary healthcare as a basis for defining the services to a more selective, economically driven model to prioritise selected interventions. It set (and costed) a 'minimum' health package that in the context of structural adjustment programmes became a 'maximum' of what was funded. It raised questions of who defines the package, what its goals are and who funds it.

This shift in thinking about the benefit package from comprehensive to selective healthcare and from public health need to 'cost-effectiveness' as a basis for prioritisation led to significant debate on both the role and definition of the 'core/minimum benefit package' (EQUINET, 2012). This economic rationale continues to influence the interaction between ministries of health and ministries of finance up to today.

The inclusion of the right to health in many constitutions of the region, the demand to integrate specific disease programmes within a wider platform of health system strengthening (EQUINET, 2012) and the global commitment in the Sustainable Development Goals to achieve Universal Health Coverage (UHC), draw new attention to what comprehensive package of services should be provided to ensure all people can obtain the health services they need without suffering financial hardship when paying for them (WHO, 2010). McIntyre et al. (2012) argue for UHC to be based on the values of universality and social solidarity, within an inclusive approach where health is recognised as a human right and where access is not determined by class or health status. At the same time, debates on how to achieve and fund this draw many different viewpoints (McIntyre et al., 2012; Frenk and Ferranti, 2012; Rodin and Ferranti, 2012).

These debates imply that the EHB can be examined as a policy intervention, used to guide where resources should be concentrated for achieving multiple goals, including: equity, efficiency, relevance, solidarity, fair process, universalism, accountability and effective and integrated care (Waddington, 2013; McIntyre, 2012). This means that beyond the technical analysis of the content and costing of the EHB, there is a values-based and policy relevant process to understand how services are prioritised and included, and how far the EHB is used, applied and engaged with to reinforce key policy goals, including equity in health, value for money in health, universal health coverage and health as a right.

This has relevance to the east and southern Africa (ESA) region. Many ESA countries have introduced or updated EHBs in the 2000s. Recognising this, the Regional Network for Equity in Health in East and Southern Africa (EQUINET), through Ifakara Health Institute (IHI) and Training and Research Support Centre (TARSC), is implementing research to understand the role of facilitators and barriers to nationwide application of the EHB in resourcing, organisation of and accountability for integrated health services. Based on case studies in four ESA countries (Tanzania, Uganda, Zambia and Swaziland), this work aims to draw from cross-country learning with policy actors for input to national planning and regional policy dialogue on:

1. The motivations for and methods used in developing and costing EHBs; and
2. The manner in which EHBs have been disseminated and used for pooling and allocating resources and commodities; for integrating programmes; co-ordinating providers; and for monitoring and accountability of services;

1.2 Objectives of the review

This literature review provides background evidence from desk review to inform the case study work and regional dialogue. It is a first product of the EQUINET work, co-ordinated by IHI and TARSC. It seeks to capture evidence from published literature and sources on EHBs in the sixteen ESA countries covered by EQUINET, viz: Angola, Botswana, Democratic Republic of Congo, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Uganda, Zambia and Zimbabwe.

It compiles evidence from published literature in public domain on EHBs in the ESA region in terms of:

a. their context
b. the motivations for developing them
c. the methods used to develop, define and cost them
d. how they are being disseminated and communicated within countries
e. how they are being used in budgeting, resourcing and purchasing health services and in monitoring health system performance for accountability
f. facilitators and barriers to their development, uptake or use.

2. METHODS

The literature review used three key sources: online databases, country websites and literature search. *Figure 1* shows a flowchart mapping how the literature review was conducted and data obtained on the sixteen ESA countries.

The search first began to include sources across ESA to gain understanding of the overall context. Then focus was placed on the sixteen ESA countries individually, using the search terms shown in *Table 1* overleaf. Three search engines were used: Google, Google Scholar and HINARI Pub Med. Sources were included if they were published post-1995, written in English and referred to either ESA or one of the specific 16 ESA countries identified. The requirement for only using publications in English limited the information obtained and available for some countries. For example, all national documents for Angola, DRC, Mauritius and Madagascar are written in the national languages – Portuguese and French.

Figure 1: Flowchart of background review search.

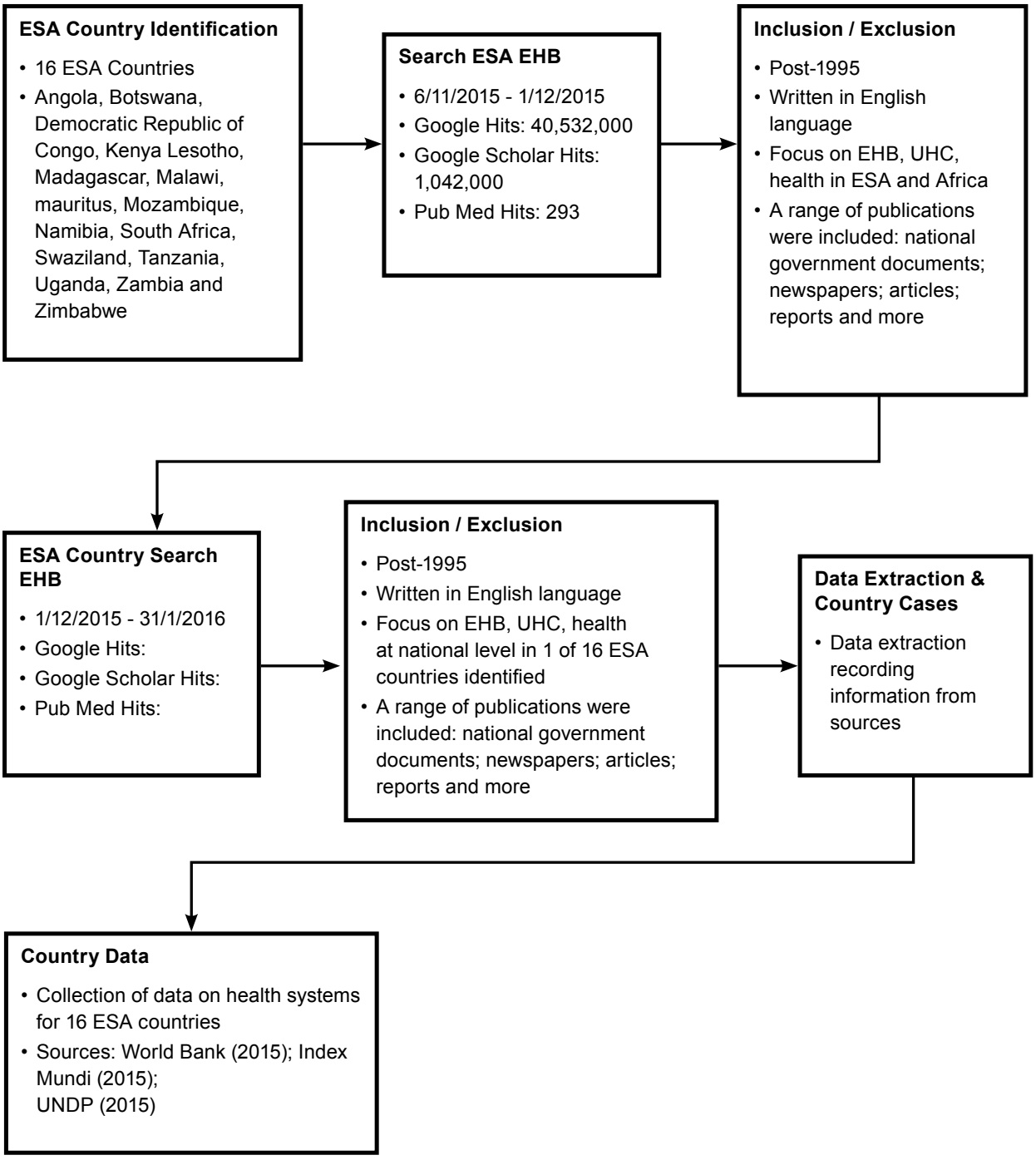


Table 1: Summary of key search terms used in the background review

Time Period	Location	Key Terms
'1995' 'Unspecified'	'Africa' East and Southern Africa" Angola, Botswana, Democratic Republic of Congo, Kenya, Lesotho, Madagascar, Malawi, Mauritius,	'Universal health care' 'Essential health benefit' 'Core health service' 'Health package' 'Essential benefit' 'Benefit package' 'Health', 'Health care', 'Health system', 'Health services', 'Public health'

Table 2 provides a summary of the literature sourced, included and excluded as per search criteria. Literature was excluded on the following criteria: it did not meet the inclusion guidelines; it was already found or was duplicated in the search; it was identified as not relevant for the review objectives, or the sources of verification were not clear.

A final set of 118 papers were included in the review, and further exclusions made during the work on the literature review as the papers did not include relevant information on the EHBs. A final set of 81 papers was included.

Table 2: Summary of country literature sourced

Country	Search hits	Reviewed	Included
Angola	9,952,683	18	6
Botswana	12,990,002	27	9
DRC	1,138	4	4
Kenya	1,024,318	27	11
Lesotho	287	14	8
Madagascar	2,693,000	13	3
Malawi	14,777,281	24	8
Mauritius	21,734,169	21	2
Mozambique	23,386,798	9	8
Namibia	21,734,169	21	2
South Africa	12,001,100	12	9
Swaziland	1,489	6	6
Tanzania	340,958	19	19
Uganda	730,500	18	8
Zambia	796,100	14	7
Zimbabwe	1,584,400	11	8
TOTAL		258	118

3. THE CONTEXT: HEALTH SYSTEMS IN THE ESA REGION

The 2012 Regional Equity Watch (EQUINET, 2012) outlines the health system context for the sixteen ESA countries and is not repeated in this report. In many ESA countries the health information and vital registration systems are still being improved and have gaps in coverage and data quality. *Table 3* summarises 2014 data on health and health systems indicators for the sixteen ESA countries. Life expectancy in the region has a wide range, from 47 years (Malawi) to 73 years (Mauritius). Such aggregate indicators however do not show the inequalities within population groups, and wide social and area inequalities were noted within countries in the 2012 Regional Equity Watch in some areas of health service coverage, such as in maternal health care.

Lower access to health resources, to reproductive and maternal health services and to HIV prevention and treatment interventions were found in poorer households and disadvantaged communities, suggesting that these communities suffer 'diseases of inequity'. Strategies for achieving universal health coverage cannot be assumed to address equity. It needs to be explicitly addressed in universal health coverage with equity. There are some promising practices in the region in overcoming geographical differentials in access to health care systems. These include widening infrastructure and health worker and medicine availability, especially at primary care level, and in facilitating access and uptake in and providing financial protection for disadvantaged groups, such as through community health workers, community outreach, social organisation and participation, moving away from fee payments at point of care and integrating specific programmes within comprehensive primary care services (EQUINET, 2012).

Seven of the sixteen ESA countries have the right to health within their constitutions and elaborate this further in health laws. The National Health Act No. 61 (2003) of South Africa, for example, states that ministers must ensure resources are available to provide essential health services, thus making the ministries responsible for providing essential and equitable healthcare.

At the same time many ESA countries are facing shortfalls in the adequacy of health funding. There has been slow progress towards meeting the Abuja commitment of 15% government financing to heath despite evidence of gains in health outcomes during periods of increased public spending on health (EQUINET, 2012). Many countries in the region have international funding off-budget. OOP as a percentage of private expenditure is high, above 50% in nine ESA countries, and does not seem to fall in countries with higher levels of total health expenditure per capita (*Table 3*). While some attention has been paid to mobilising resources linked to performance-based funding for selected maternal health and disease outputs, mobilising additional resources for health for many ESA countries and integrating fragmented financing pools may call for budget bids that are based on clearer costed plans for wider areas of service delivery, where purchasing and performance can be assessed on a more holistic package of services.

In addition, a wide range exists in the capacities to deliver services. The density of nurses and midwives, per 10,000 people, ranged from 63 in Swaziland to 2.4 in Tanzania. In southern Tanzania, Mrisho et al., (2007) identified labour shortages as a determining factor leading to women not delivering in health services. Eleven countries in the region have staffing levels below the WHO recommended minimum threshold of 23 doctors, nurses and midwives per 10,000 population density to deliver essential maternal and child health services. Hence, even while this WHO norm itself needs updating, including in the face of new demands from non-communicable diseases, the health workforce in the region is clearly inadequate, raising pressure on the quality and competence of available health workers to deliver services.

Table 3: Health system indicators, east and southern Africa, post-2010

	Life Expectancy (years)	Constitutional Right to Health	Total Health Exp. /capita USD	Health Exp. as % of Total Expenditure	Out-of-pocket exp. as % of Total health expenditure	Density Nurses and Midwives per/10,000	Hospital Beds per/10,000	Pregnant women with at least 4 ANC Visits (%)
Angola	52	◆	148	6.8	19	13.5	8	na
Botswana	61		530	16.6	5	28.4	18	73.3*
Democratic Republic of Congo (DRC)	49	◆	13	17.5	39	5.3	8	48.0
Kenya	60	◆	33	5.8	27	11.8	14	57.6
Lesotho	48		60	8.2	17	6.2	13	74.4
Madagascar	65		22	14.6	31	3.2	3	51.1
Malawi	47	◆	18	12.1	13	2.8	11	44.7
Mauritius	73		402	8.3	47	37.3	33	na
Mozambique	49	◆	21	12.6	7	3.1	8	50.6
Namibia	57		284	12.1	7	27.8	27	62.5
South Africa	54	◆	459	10.4	7	40.8	28	87.1*
Swaziland	49		141	8.5	10	63	21	76.0
Tanzania	55		22	18.0	23	2.4	11	42.8
Uganda	52	◆	44	10.5	39	13.1	4	47.6**
Zambia	48		68	15.3	30	7.1	19	55.5
Zimbabwe	49	◆	79*	8.2	34	7.2	30	70.1

(*) for 2007, ** key informant reported 30% for this indicator from national health accounts; na= not applicable
Sources: EQUINET, 2014; WHO, 2011, 2016a, 2016b; MoHCC et al.,2015; TARSC and MoHCC, 2014

In addition, a wide range exists in the capacities to deliver services. The density of nurses and midwives, per 10,000 people, ranged from 63 in Swaziland to 2.4 in Tanzania. In southern Tanzania, Mrisho et al., (2007) identified labour shortages as a determining factor leading to women not delivering in health services.

Eleven countries in the region have staffing levels below the WHO recommended minimum threshold of 23 doctors, nurses and midwives per 10,000 population density to deliver essential maternal and child health services. Hence, even while this WHO norm itself needs updating, including in the face of new demands from non-communicable diseases, the health workforce in the region is clearly inadequate, raising pressure on the quality and competence of available health workers to deliver services.

4. FINDINGS ON ESSENTIAL HEALTH BENEFITS IN THE ESA REGION

Of the sixteen countries, thirteen had an EHB in place at the time of review, albeit at different stages. Some countries were implementing their EHB, while others had just concluded the design and were due to launch it. In three countries literature on an EHB was not found, viz Madagascar, Mauritius and Mozambique; however, this may also relate to the searches being done in the English language, thus not capturing the terms used in these countries. In the Democratic Republic of Congo (DRC) and Angola EHBs *were* identified, but not as nationally led government initiatives. In these occasions the EHBs found were initiated and implemented by international funders (Department for International Development (DFID), World Bank, and United States Agency for International Development (USAID). An Angolan Ministry of Health (MoH) Health and Nutrition Package set up with external funders in 2002 was not included in the review, also due to language issues.

4.1 Names and objectives of the EHBs in east and southern Africa

Table 4 provides the names used and objectives for the EHBs found in ESA countries.

Table 4: Summary of the names and defined objectives of EHB in the 16 east and southern Africa

Countries	EHB name	EHB objective
Angola	Essential Health Services Package (EHSP)	Strengthening the health system. To increase use and availability of priority services in Luanga/Huambo provinces
Botswana	Essential Health Services Package (EHSP)	Establishing promotive, preventative, curative and rehabilitative health interventions to achieve UHC
DRC	Essential Health Care Services	"provide essential health care services for the whole population, whilst strengthening government health management teams"
Kenya	Essential Package for Health (KEPH)	"creating an affordable, equitable, accessible and responsive health system"
Lesotho	Essential Service Package	"health interventions that address priority health and healthrelated problems that result in substantial health gains at low cost"
Madagascar	No information found	–
Malawi	Essential Health Package (EHP)	EHP to tackle three pillars: equity, cost-effectiveness and systems-strengthening and efficiency
Mauritius	No information	–
Mozambique	No information	–
Namibia	Minimum health service package	Basic social welfare and health care is the right of all citizens
South Africa	Prescribed Minimum Benefits Package (PMB)	"… the minimum level of care that is to be funded by all private medical insurers… aimed at increasing access to predominately private services"
Swaziland	Essential Health Care Package	Enabling "effective and equitable health service delivery"
Tanzania	National Package of Essential Health (NPEH)	Integrating cost-effective interventions that address the main health problems and risks
Uganda	Minimum Health Care Package (MHCP)	Cost-effective intervention to meet health needs and services, particularly of women and rural populations
Zambia	Basic Health Care Package	Strengthening the health system and achieving equity, costeffectiveness and quality health
Zimbabwe	Essential Health Benefit/ Core Health Services	All citizens of Zimbabwe should have the highest level of Health and quality of life

Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2004; RoN, 2010; RoZ, 2011; Taylor et al., 2007; TARSC and MoHCC, 2014; URT, 2000, 2013.

The EHBs have each been introduced at different times and are currently at different stages (see *Table 5*). South Africa, followed by Malawi and Tanzania, were the first countries to introduce EHBs, although the package is not always clear. In South Africa, for example, several core packages have been defined: the Primary Health Care Package guides what clinics delivering primary healthcare should deliver; the Essential Drugs List (which other countries also have) identifies medicines to be procured for secondary and tertiary care; and there is also a Prescribed Minimum Benefits package. The first two are more standards/guidelines for improving services, albeit without legal force, and the last is a minimum benefit package to be delivered by medical insurers (Taylor et al., 2007).

Table 5: Summary table of EHBs in east and southern Africa

Key: Impl. = Implementation; Eval. = Evaluation; Spe.Loc = Specific Locations

Country	EHB	Stage of EHB				Initiators of EHB		Scale	
		Design	*Policy*	*Impl*	*Eval*	*Government*	*External Funder*	*National Package*	*Spe. Loc.*
Angola	**2006**	◆		◆			◆		◆
Botswana	**2010**	◆	◆	◆		◆	◆	◆	
DRC	**2012**	◆		◆			◆		◆
Kenya	**2005**	◆	◆	◆	◆	◆		◆	
Lesotho	**2003**	◆	◆			◆		◆	
Madagascar	**–**								
Malawi	**1999**	◆	◆	◆	◆	◆		◆	
Mauritius	**–**								
Mozambique	**–**								
Namibia	**2010**	◆	◆			◆		◆	
South Africa	**1997**	◆	◆	◆	◆	◆		◆	
Swaziland	**2010**	◆	◆			◆		◆	
Tanzania (*)	**2000**	◆	◆			◆	◆	◆	
Uganda	**2010**	◆	◆	◆	◆	◆		◆	
Zambia	**2015**	◆				◆		◆	
Zimbabwe	**2014**	◆	◆	◆		◆	◆	◆	

Year stated is when the EHB was first implemented, initiated or defined. (*) = An EHB was piloted in 1996.
Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a,b; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2004; RoN, 2010; RoZ 2011; Taylor et al., 2007; URT, 2000, 2013.

Table 5 shows the stage of the EHB by country, viz: planned; designed; implemented and rolled out. Thirteen countries had designed EHBs; ten had set them in policy; nine had implemented them; and five had evaluated them. For example, Kenya's Essential Package for Health (KEPH) was conceptualised in 2005 to ensure affordability, equity, accessibility and responsiveness in the health system. The right to health care is included as a constitutional right in Kenya. The KEPH has undergone design and conceptualisation; has been embedded in policy as defined in its national package; has been implemented nationally and evaluated by government stakeholders. The DRC and Angola have undergone design and implementation by external funders in specific locations.

In some countries the EHBs have undergone a transition. In Tanzania, the national EHB was based on a pilot introduced and implemented by external funders, with the intention of scaling up. Between 1996-9 the Tanzania Essential Health Interventions Project (TEHIP) was introduced and piloted, funded by International Development Research Centre (IDRC) and Canadian International Development Agency. It was piloted in two rural districts: Rufiji and Morogoro. Evaluations of these pilots informed the national package designed in 2000, and further revised in 2013. In Tanzania the pilot had three key policy contributions before being scaled up to national level. It involved the development of guidelines for district health plans (i.e. Comprehensive Council Health Planning Guidelines, 2011) and a national surveillance system for evidence-based planning. It focused at national level first on malaria programmes, antimalarial drug policy and distribution of insecticide- treated bednets (ITNs); and thereafter an Essential Health Minimum Package was set (Neilson and Smutylo, 2004).

4.2 Structure and benefit package included

The EHBs each have different structures in terms of the benefits included, how they are costed and the social groups covered. *Tables 6* and *7* summarise this information as described in the literature, noting that there may have been grey literature updates not available to us and that the practical implementation may differ, discussed further in Section 6.

Eleven EHBs were explicitly national packages, and a further EHB in Angola indicated the intention to ultimately cover the entire population. The EHBs were largely intended to apply in the public sector and to all service levels. As noted earlier, South Africa's EHB initially related to private voluntary insurance. A Prescribed Minimum Benefits (PMBs) for all providers was initially applied only in hospitals and in 2002 extended to include primary healthcare services and those in the private sector (Taylor et al., 2007). South Africa is now implementing national health insurance covering the whole population. This will also influence the benefit package provided as an entitlement for all, although we were not able to access formal policy documentation on this. Zimbabwe updated its EHB in 2014, but to date this update is only developed for community, primary care and district hospital services (MoHCC et al., 2015). At the same time, those countries applying the EHB across service levels did not always state how the package differed across different service levels. Some EHBs (such as in DRC) were more disease specific, while others included broader measures to improve and fund services and their governance. *Table 7* highlights that many EHBs are broadly stated and comprehensive. This signals the policy intention to cover the broad range of population health needs, but also points to the challenge the public sector faces in implementing the defined benefits in a situation of resource constraints. In Zimbabwe, for example, there has this been some differentiation between the broadly stated package in the EHB and the immediate commitment to clarify, ensure delivery and provide financial protection for specific services, such as for maternal and child health based on available resources (MoHCC et al., 2015). How countries reconcile the intended benefit package with the resources available is discussed further later in the report.

Table 6: Structure of EHBs in east and southern Africa

Country	Population covered				Number of priority service areas in the EHB	Service		Service level		
	All	Children <5 yrs	Women	Elderly >65 yrs		Public	Private	Community (i.e. health centres)	Primary healthcare	Hospitals (diff. levels)
Angola	◆				na					
Botswana	◆				4	◆	◆	◆	◆	◆
DRC		◆	◆		4	◆		◆	◆	◆
Kenya	◆				6	◆		◆	◆	◆
Lesotho	◆				5	◆		◆	◆	◆
Malawi	◆				11	◆	◆	◆	◆	◆
Namibia	◆				12	◆		◆	◆	◆
South Africa	◆				5	◆	◆		◆	◆
Swaziland	◆				4	◆	◆	◆	◆	◆
Tanzania*	◆				5	◆	◆	◆	◆	◆
Uganda	◆				4	◆		◆	◆	◆
Zambia	◆				11	◆		◆	◆	
Zimbabwe	◆				7	◆		◆	◆	

*Tanzania National Package of Essential Health (2000) and revised NEHIP (2013)
Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2004; RoM, 2005; RoM, 2011; RoN, 2010; RoZ, 2011; Taylor et al., 2007; URT, 2000, 2013.

Table 7: Categories included as priority in the EHBs in east and southern Africa

Country	Service areas included in the EHB								
	Sexual and reproductive health	Maternal and child health	Child health	Non-communicable diseases	Communicable diseases	Public health interventions (*)	Clinical health interventions **	Allied health interventions ***	Unspecified
Angola		◆	◆				◆		
Botswana	◆	◆	◆	◆	◆	◆			
DRC	◆	◆	◆						
Kenya	◆	◆	◆	◆	◆	◆	◆	◆	
Lesotho	◆		◆	◆	◆	◆	◆		
Malawi	◆			◆	◆	◆			
Namibia	◆	◆	◆	◆	◆	◆	◆		
South Africa									◆
Swaziland				◆	◆	◆	◆	◆	
Tanzania****	◆	◆	◆	◆	◆	◆			
Uganda		◆		◆	◆	◆			
Zambia		◆	◆	◆	◆	◆			
Zimbabwe		◆		◆	◆				

* Includes vaccines, health prevention and promotion, education
** Refers to specialised clinical services, surgery and related laboratory testing
*** Includes laboratory services, blood transfusions, paramedical services and procurement management
**** Tanzania National Package of Essential Health (2000) and revised NEHIP (2013).
Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2004, 2005,2011; RoN, 2010; RoZ, 2011; Taylor et al., 2007; URT, 2000,2013.

4.3 Policy motivations for the EHB

Each of the thirteen EHBs identified were produced to broadly promote universal access and equity in health, respond to national priority health burdens and to promote cost-effective interventions. In the specific country documents three major policy motivations were expressed, as shown in *Table 8*:

- To identify the cost of healthcare services to advocate for health funding;
- To purchase services or ensure service delivery at system scale;
- To clarify and support equitable access to entitlements, to realise rights to health care.

No ESA country reported the EHBs as a response to population demand, even when the right to health was a motivation. Rather, they EHBs were defined within health and social welfare policies and as part of the national strategic plan. Within this policy framework, the countries intend to set and cost the services to achieve the national health strategy, taking cost benefit into account. Three countries (Kenya, South Africa and Namibia) reported the development of the EHBs to clarify state duties in response to inclusion of rights to healthcare in the constitution, and this also informed the 2013 updating of the EHB in Zimbabwe (MoHCC et al., 2015). This explicit reporting of the EHB defining state duties and population entitlements in healthcare was found only in half the ESA countries that include this right in their national constitutions.

Two countries (Tanzania and Kenya) consulted with and involved stakeholders from all levels in setting the benefit package. Botswana, Angola, DRC and Zimbabwe involved other state, non-state and community stakeholders and evidence from them in the process (see *Table 9*). In Kenya, an innovative community manual on EHBs was used for communities to prioritise services to include, capacity building process (RoK, 2006; Muga et al., 2005). In Tanzania, TEHIP as a pilot used the health information system, the essential medicines programme and the Demographic Surveillance Systems as sources of evidence on health needs.

Table 8: Motivations for establishing EHBs in east and southern Africa

Country	Financial			Service				Entitlement		
	Cost-effective spending	Affordable service	Cross-subsidisation	Increase access	Equity	Improve skills and quality	Accountability	Constitution	Health policy	Population demand
Angola					◆					
Botswana	◆			◆	◆	◆			◆	
DRC		◆		◆	◆					
Kenya	◆	◆		◆	◆	◆		◆	◆	
Lesotho	◆			◆	◆	◆			◆	
Malawi	◆	◆		◆	◆	◆			◆	
Namibia				◆	◆		◆	◆	◆	
South Africa	◆		◆		◆	◆		◆	◆	
Swaziland	◆	◆		◆	◆				◆	
Tanzania*	◆			◆	◆				◆	
Uganda	◆				◆	◆			◆	
Zambia	◆				◆	◆			◆	
Zimbabwe				◆	◆	◆			◆	

Country Health Policies: Kenya (RoK, 2005; 2015); Tanzania (URT, 2007; 2010; 2011); Uganda (GoU, 2010); Botswana (GoB, 2011); Lesotho (GoL, 2011); Malawi (RoM, 2004; 2011), Namibia (RoN, 2010), South Africa (Pearmain, 2000; GoSA, 1997), Swaziland (GoS, 2009), Zambia (RoZ, 2011), Zimbabwe (GoZ, 2009).
*Tanzania National Package of Essential Health (2000) revised NEHIP (2013). *Sources:* Chemonics, 2015; DFID, 2012; GoB, 2010a; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2004, 2005, 2011; RoN, 2010; RoZ, 2011; Taylor et al., 2007; URT, 2000, 2013.

The TEHIP analysed district budgets and services, invited communities to share their opinions on health needs and worked with PHC committees and district health boards to set the final local needs and priorities. This was an intensive exercise, with some caution on the extent and rigour with which it is being scaled up to national level. Tanzania's revised 2013 National Package of Essential Health used disease burdens, intervention effectiveness and costing results as tools for setting priorities (URT, 2013). Cost data were seen to be important to price treatment and facility budgets, reimbursement rates of insurance and to identify what consequent OOP burdens may arise. In Zimbabwe, a study was implemented to systematise community views on what should be included in the EHB, and the ministry of health used this in revisions when the core health service package was updated in 2014 (TARSC, 2012).

There is not a uniform standardised norm applied to define priorities. Agencies have defined different priorities for the package based on using a needs-based approach, the burden of disease or inclusive participation from multiple stakeholders (see Khosa et al., 1997). All ESA countries use some form of burden of disease approach in the process, although through different sources of evidence. There is less consistency on how other approaches and sources of evidence are used, including for costings, cost benefit, equity and progressive realisation of the right to health (Baltussen and Niessen, 2006). Further, *Table 9* indicates little consultation with stakeholders outside ministries of health in the ESA region in defining what is included in the EHB. This raises questions on how widely it is known and 'owned'. In the ESA region, no uniform method is used to define or costing priorities, with needs based-approaches, burden of disease approaches and varying levels of inclusion of stakeholder and community input (Khosa et al., 1997). This runs contrary to a TARSC (2012) study in Zimbabwe which found that communities held strong opinions about what should be included in their service entitlements, and in South Africa a desire from stakeholders to be part of the process of defining priorities (McLoed et al., 2003).

Table 9: Stakeholders consulted in the development of the EHB, east and southern Africa

Country	Stakeholder Participation			
	Ministry	Other stakeholders	Local government	Communities
Angola	◆	◆		
Botswana	◆	◆		
DRC		◆		
Kenya	◆	◆	◆	◆
Lesotho	◆			
Malawi	◆			
Namibia	◆			
South Africa	◆			
Swaziland	◆			
Tanzania*	◆	◆	◆	◆
Uganda	◆			
Zambia	◆			
Zimbabwe	◆			◆

*Tanzania National Package of Essential Health (2000) and revised NEHIP (2013)
Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2005, 2011; RoN, 2010; RoZ, 2011; Taylor et al., 2007; URT, 2000, 2013.

4.5 Costing and funding the EHB

Generally, countries with insurance funding define benefit packages as positive lists of what insurance will cover. EHBs are included in insurance as "people want to know what services will (and will not) be funded by a particular insurance scheme in return for insurance contributions…" (Waddington, 2013:2). In tax-funded systems the benefit package is less directly linked to individual contributions, and as funding is pooled may be more commonly defined as a negative list of what the tax-funded service will exclude, based on budget limitations and equity considerations.

Few countries reported specific costing methodologies or cost calculations for their EHBs. Some form of cost calculation was found in seven countries (Kenya, Tanzania, Uganda, Malawi, South Africa, Swaziland and Zimbabwe), although it was not always clear exactly what it covered, what assumptions were used, and the methods used were not the same across countries (See *Table 10*). Costs varied from US$4-$25/capita for first-level services to US$22-$74 / capita for all services.

Tanzania has recently published a detailed costing for the revised essential health package (URT, 2013). It uses estimates based on the type of facility (public/private for-profit/private not-for-profit), the level of facility (dispensary to hospital), the treatment sought (in/out patient) and the type of disease being treated. The results show wide variations in the unit cost, with median total costs of care in a level-1 hospital 30 times higher and in a regional hospital 121 times higher than in a dispensary (GoT. 2013). It showed the need to differentiate inpatient and outpatient services for the same health problems, the need to differentiate by level and the wide differences in costs between public and private providers. In Kenya and Tanzania, costing studies highlighted the differentiation of salary, activity, commodity and capital costs, with 37% total costs as salaries in Kenya, and 50%¬60% total for this in Tanzania (Flessa et al., 2011; URT, 2013).

While costing studies in many countries may exist and still be in the grey literature or not in public domain, this makes the EHB less well understood or transparent. If the EHB is to be used in budget negotiations, health service financing, purchasing agreements with providers, in any new forms of insurance arrangements blended with tax funding for UHC, or to demonstrate performance and limits against constitutional entitlements, then costing the EHB would appear to be key. This is an area for further investigation and for exchange of methods within the region, including the development of comparable methods for costing, discussed later.

Table 10: Costing method and estimations for EHBs in east and southern Africa

Country	Method	Costs	
		Estimation	Year
Angola	na	na	na
Botswana	• SWOT analysis on Health Sector and Plan for Health Financing (2010)	–	
DRC	na	na	na
Kenya	• Kenya Health Sector Costing Model 2006/7 • Kenya Health Sector Strategic and Investment Plan 2012-2017	$13/capita for KEPH	2011
Lesotho	na	na	na
Malawi	• The Joint Programme of Work for Health SWAp 2004-2010 costed predictions for 6 EHP programmes. Analysed requirements, annual costs and predicted total	$22/capita for EHP health care across levels $28.6/capita for EHP healthcare	2004 2007/8
Namibia	na	na	na
South Africa	• Costing based on package criteria from 1995 National Health Insurance calculation of cost of minimum essential hospital care benefit • Independent research on indirect household cost for joining Medical Schemes.	$31/capita $111-$272	1998 2003
Swaziland	• Costing of National Health Sector Strategic Plan 2009 and Social Health Insurance plan	na	na
Tanzania*	• Resource allocation: 70/10/10/10 • NEHCIP costing exercise (2013)	$4-$64 for benefit package across levels.	2015
Uganda	• Costing of Health Sector Strategic Plan 1999/2000 and 2004/2005; • National Health Insurance Bill (2007)	$28/capita for MHCP	2004
Zambia	na	na	na
Zimbabwe	• Health Sector Investment Case (2010-2012) • Cost estimates based on facility cost, utilisation data for the 2014 EHB	$16-$25/capita for primary care; $40-$74 for district hospital services	2014

All $ figures in USA dollars based on conversion using exchange rate at year of costing; Na=not available
Sources: Bowie and Mwase, 2011; Flessa et al., 2011; GoB 2010b; Khosa et al., 1997; McLeod et al., 2003; RoK, 2012; RoM, 2004; GoS, 2010; Pearson, 2010; Soderlund, 1999; Ssengooba, 2004; TARSC and MoHCC, 2014; URT, 2013; Zikusooka et al., 2009.

Finance for the EHB can be categorised into: revenue collection (or the funding of systems), pooling (or the blending of different funds for income and risk cross subsidies) and purchasing (on how services are paid for from providers).

Table 11 presents how countries fund revenue collection for the EHBs. It was not always clear in the literature how the EHB was funded, and this document does not intend to discuss the wider issue of health financing in ESA, beyond its relevance to the EHB. ESA countries largely seek to fund services through mandatory prepayment (taxes or mandatory national insurance), but as noted earlier have high levels of OOP (McIntyre, 2012; EQUINET, 2012).

The evidence indicates a mix of funding strategies, all primarily based on tax funding from government budgets (in Angola and DRC the use of external funding relates to the more limited, pilot nature of the benefit). Countries also commonly apply external funding to their EHB when these are blended in sector-wide approaches (SWAp) or system funds. OOP funding was a major funder in many countries, indicating some contradiction with the idea that the EHB be provided as an entitlement without financial barriers. In Malawi and Botswana it was stated that the EHB be free, and in Zimbabwe it is free in policy at primary care level, but there is some indication that fees may still be charged in practice by providers if the budget allocation does not meet the costs (Ssengooba, 2004; TARSC and MoHCC 2014).

Table 11: Financing EHB in east and southern Africa

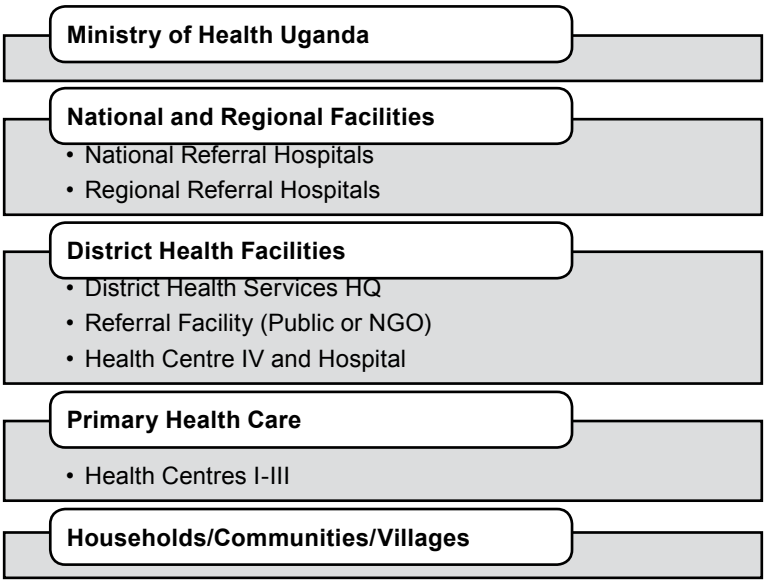
Country	Financing EHB				
	Government tax/budget	National health insurance	Out of pocket	External funders	Private insurance
Angola (*)				◆	
Botswana	◆		◆	◆	
DRC (*)				◆	
Kenya	◆		◆	◆	◆
Lesotho					
Malawi	◆			◆	
Namibia	◆		◆		◆
South Africa	◆	◆	◆		◆
Swaziland	◆	◆		◆	◆
Tanzania*	◆		◆	◆	
Uganda	◆		◆		
Zambia	◆				
Zimbabwe	◆			◆	

(*) relates to an EHB that is not national
Sources: Chemonics, 2015; DFID, 2012; GoB, 2010a; GoB, 2010b; GoL, 2003; GoS, 2010; GoU, 2010; GoZ, 2009; Khosa et al., 1997; RoK, 2012; RoM, 2005, 2011; RoN, 2010; RoZ, 2011; Taylor et al., 2007; URT, 2000, 2013.

Some ESA countries are now considering various forms of innovative financing (earmarked taxes) and social/national health insurance, largely to improve revenue. In South Africa the National Health Insurance Committee has played a role in the changes in their EHB, within the wider discussions on national health insurance proposals. These proposals seek to blend mandatory prepayment to insurance for formal sector workers with incomes over a defined threshold with tax funding for those below the threshold and those out of employment into one fund, to cover the benefit package for all. This is a policy dialogue in progress. Swaziland is proposing to introduce social health insurance, in which all citizens will pay for equal access to the same benefit package, with contributions according to ability to pay, and some benefits such as for antiretroviral therapy excluded due to their being externally funding (Mathauer et al., 2011; GoS, 2010:7). Other countries are also reported to be considering SHI. This is largely work under policy debate and not yet documented in public domain literature. The wider policy debate on the costs and benefits of SHI and the manner in which it needs to be pooled with other funding for UHC is also not the focus of this paper. It does however make it even more important to know how any new, earmarked or segmented insurance funds will be blended with wider tax funding to provide the EHB for all, as is being planned in South Africa. If SHI when added to tax funding does not meet the EHB costs, as found in some simulations (Mathauer et al., 2011), having it as a segmented fund can create pressure from more vocal and organised SHI contributors to ensure that they are fully covered, such as through additional tax subsidies, to the cost of poorer groups. This is further discussed in *Section 6*.

Several countries, including Botswana and Uganda, are documented to have observed the need to close the gap between their calculated EHB costs and their current revenue for health through a financing strategy. Botswana has, for example, estimated that a minimum of $4.6 million is needed to finance its EHB (termed the EHSP) over the five-year period 2013-2018, particularly if OOP costs are to be reduced. One option raised in Botswana was for increasing revenue collection through user fees from non-EHSP services (GoB, 2010b). Strategies to address the gap rely centrally on tax funding working with willing private insurers; setting high, medium and low priorities to better direct resources to key services, and identifying vulnerable groups to ensure that they access the EHB (GoB, 2010b). Uganda has also identified a funding shortfall for its EHB (termed the MHCP), with only 29% of the suggested spending per capita available for it (Ssengooba, 2004). This was used to set up a re-prioritisation exercise for its EHB, as seen in HSSP 3 (2010-2015) following initial costing predictions, to ensure delivery in health centres IV and district hospitals, within the overall structure shown in *Figure 2* (GoU, 2010).

Figure 2: Uganda's healthcare structure



Source: Adapted from Kamwesiga, 2011.

SWAps have been an important means of pooling external funds for the EHB. In Malawi, the EHB (termed the EHP) was developed within sector-wide policies and planning to enable cost-benefit and equity analysis to be applied in performance monitoring to a wider range of EHP interventions. Over the period of the SWAp in Malawi, 33 of the 55 interventions were reported as 'cost-effective', although with large variations found between different programme areas in coverage vs need (Pearson, 2010).

This points to the need for effective purchasing strategies in applying the EHB, whether through contracting, wider performance financing than the currently largely targeted approaches and/or more effective needs-based resource allocation of both tax and SWAps funding. The need for effective purchasing was highlighted for example in relation to the allocation of SWAps funding in Tanzania (Boex and Selemani, 2013), and both tax and external funding in Zimbabwe (MoHCC et al., 2014). The 'purchasing' of health services determines how the available, pooled resources are used and whether funds translate into effective health services for all.

Purchasing of health services implies an explicit or implied contractual relationship between the purchaser (funder) and the provider that clarifies the benefit funded, the population covered and the proportion of the total cost met from the funds. Achieving UHC calls for active purchasing of health services. While performance-based financing is being rolled out in some ESA countries (Tanzania, Zambia, Kenya, DRC, Zimbabwe), it is often for very specific output targets, and not the wider EHB (Fretheim et al., 2012). The literature had relatively limited discussion of wider purchasing strategies in relation to the EHB. As this is an important area for monitoring effective and equitable use of both tax and external funds, it needs further assessment in the follow-up country case studies and in dialogue within and across countries. This is further discussed in *Section 6.*

4.6 Dissemination and use of the EHB

Information on dissemination and use of the EHB was largely found through evaluation reports. Nine of the thirteen ESA countries were reported in the literature to be within the 'implementation' stage of their EHB (as shown in *Table 5*), with one (DRC) an external agency-led initiative and one a pilot (Tanzania). Five countries had implemented some form of evaluation of the implementation. *Table 12* presents the findings on dissemination and use of the EHB from these evaluation reports. The information from other countries would need to come from further field assessment.

Table 12: Dissemination and use of EHBs from evaluation reports in selected ESA countries

Country	Date	Evaluation aim	Evaluation method	Findings on dissemination and use of the EHB
Kenya	2010	To assess if community health strategy empowering citizens to influence health	21 districts Household interviews FGDs	Increased demand for health services Need to better mobilise resources Services not addressing needs of all people. Content of training needs improving
	2013-2017	Review the design and operationalising of KEPH during NHSSP II	Review of KEPH as per NHSSP objectives of UHC	Not all cohorts receiving services Lack of information to plan and monitor Interventions provided not guided by KEPH
Malawi	2011	Evaluate whether EHP available to population	Independent research and evaluation	Constraints identified in rolling out EHP in staff shortages and drug supplies. Attention needed to strengthen health system to deliver it
South Africa	2003	Impact of Prescribed Minimum Benefit (PMB) Package on affordability of contributions	Assess private sector impact on household income for benchmark family of 4; and utilisation of schemes	Variations in cost of packages, with more work needed for affordability. Range of package costs in private sector: R3,797.50 cost option for older 'white' members and R1,551.47 for younger 'black' members. Monthly cost of R640.33 per month for the package, for a family of four. Cost of packages offered by industry exceed cost of PMB
	2007	Impact of PMB on equity	Independent evaluation and review of PMB	PMB not resulting in equity: due to lack of affordability and exclusion of patients due to underlying disease.
Tanzania*	2004	TEHIP had influence on public policy for health	Framework of analysis used by IDRC (funders) to evaluate project	TEHIP influenced health policies by expanding policy capacities, broadening policy horizons and affecting policy regimes. Influenced the process of policy formulation/ implementation/reform and content
Uganda	2004	Independent research to evaluate priority setting of MHCP	Analysis of priority setting context	Uganda's MHCP approach used (health sector strategic plan) outstrips the available resources in the short and medium term, and cannot be guaranteed by the state Sources: Bowie and Mwase, 2011; McLeod et al., 2003; Neilson and Smutylo, 2004; RoK, 2013;

Sources: Bowie and Mwase, 2011; McLeod et al., 2003; Neilson and Smutylo, 2004; RoK, 2013; Taylor et al., 2007; UNICEF, 2010; Wright, 2015a.

The inclusion of stakeholders in the development of the EHB is a key method of ensuring ownership and dissemination. (The limited level of stakeholder involvement was already noted in Section 4.3.) 'Decentralisation' was a further method of dissemination of the EHB, albeit with decision making still centralised and districts and local governments more involved in the implementation and operationalisation of EHBs. There is a wider debate on the costs and benefits of decentralisation not addressed in this paper, including in relation to capacities to absorb funds and decision-making powers at local level.

Decentralisation reforms have raised attention to planning and budgeting at district and local levels and the capacities for this, within which the EHB is raised and reviewed, as for example in Tanzania (Neilson and Smutylo, 2004). In Botswana, the MoH defined services and districts are informed and decide how services would be provided.

Many ESA country reports on their EHBs adopt decentralised approaches as a means of strengthening the system and reaching the population more effectively. One of the main means of applying this is by providing service guidance to all levels of the system. Lesotho's Ministry of Health and Social Welfare identified through its ESP that it would be 'reinvigorating' the district health system by improving access and strengthening local health activities (GoL, 2003). Accompanying Lesotho's EHB, a Primary Health Care Revitalisation Action Plan (2011-2017) was thus developed to improve service delivery, promote accountability, community ownership and opportunities for improved collaboration at all levels.

At the same time, few countries reported more active training and communication for stakeholders at different levels on the EHB. Training was noted in Kenya and Malawi however, where practice/ guidance manuals were reported to be used in more active training sessions (RoK, 2006; RoM, 2004). In DRC's and Tanzania's TEHIP pilot, both more local applications, EHBs were disseminated through district, facility and local capacity building (DFID, 2012; ODI, 2010). In countries where the EHBs operated in both public and private sectors (Tanzania, Botswana, Malawi, Swaziland) public/private partnerships were also used as a means of dissemination, although without more detailed information on how this was done.

5. FINDINGS ON THE IMPACT OF EHBS IN THE ESA REGION

5.1 Monitoring and evaluating impact

Information on the impacts and outcomes of using EHBs is available from the five ESA countries where evaluations have been conducted, viz: Uganda, Malawi, Kenya, Tanzania, and South Africa (see *Table 12*). In some countries the EHBs are new while others have not been evaluated. The areas of possible positive and negative direct/indirect impact are outlined in *Table 13.*

In the main, the literature discusses impacts on service delivery, use and resourcing, with some impacts on social accountability and referral systems.

Table 13: Potential direct and indirect impacts of EHBs in east and southern Africa

Direct impact/outcome	Indirect impact/outcome
• Health outcomes • Delivery to vulnerable groups • Health system changes: financing, information, • service delivery, policy, supplies, etc. • Equity and equality • Universal coverage/coverage	• Impact across public sectors i.e. education, • water, planning etc. • Impact on structure of government • Impact on private sector (services and • financing)

In Tanzania, evaluation of the TEHIP found reduced morbidity and mortality within the two districts where it was applied (ODI, 2010; Savigny, 2003), together with improved medicine distribution to villages/ dispensaries, reduced response time to treatment and improved stakeholder communication (Neilson and Smutylo, 2004). The positive evaluation led to reforms in the health sector, taking interventions to national scale, although with some caution on whether the same intensity of planning input could be applied more widely and whether the health gains found apply across all socio-economic groups (Schellenberg et al., 2003). Not all countries found such health gains.

In South Africa, where the benefit package was applied in private sector schemes, Taylor et al., (2007) found schemes excluded patients with underlying disease, who may in fact have greater need for care. The introduction of an EHB for these private voluntary schemes was implemented in 1998 to address such inequities and require non-discrimination, but with continuing inequalities in services and funding levels between private and public sectors and in access to schemes by low-income groups (McIntyre et al., 2003; McLeod et al., 2003). This is now being addressed by the wider policy measure of national health insurance, discussed earlier, although many aspects are still undergoing policy dialogue.

Many of the EHBs focused on the primary healthcare system and delivery at local and district levels. The EHSP in Botswana was reported in a 2012 evaluation to have increased health facility access, but mainly for hospitals and with inequities in access to beds and variations in quality and use of services (Health Research for Action, 2012). In Malawi, the evaluation found improved service provision and increased outpatient attendance, particularly for lower income groups, and with high cost effectiveness, as noted earlier (Bowie and Mwase 2011). Improved access was reported to result from targeting low-income groups with the SWAp and removing user fees, albeit with some remaining cost barriers (Gwatkin et al., 2006; Bowie and Mwase 2011).

Adequate funds remained a barrier to adequate implementation in Malawi, and in Uganda, as noted earlier, leading to poorer coverage in lower income groups in the latter country (GoU, 2010). In South Africa, unless there are accompanying measures to control cost escalation, service and administration costs will increase, especially in application in the private sector (Taylor et al., 2007).

Additional factors that were noted to affect direct health impacts included user and medical practitioner knowledge on the package (noted in South Africa, McLeod et al., 2003) and intensive communication and capacity building to support its use in service planning and delivery (noted in Tanzania, Neilson and Smutylo, 2004). These factors point to the EHB being embedded within a wider 'culture of planning' at all levels, with collaboration across all levels and different providers, supported by guidance, tools, training in district planning capacities, and a functional health information and disease surveillance system.

5.2 Facilitators and barriers in using EHBs

Information on the facilitators and barriers in applying the EHBs in ESA countries is drawn largely from reports from those countries that have implemented their EHBs, although there are also facilitators and barriers across all stages of the EHB process, from the decision on whether to have an EHB onwards. In more resource-constrained countries -Mozambique and Madagascar - the decision appears to have been taken to have an EHB and the barriers may relate to capacities to design and cost the benefit. Madagascar has incorporated the EHB as a concept within a social protection package in an externally funded project (Republic of Madagascar et al, 2015; Wright, 2010b). In Mauritius, with a small population and higher GDP than many other ESA countries, comprehensive health care is tax funded and provided free to the entire population at point of use, from primary to tertiary care level (Devi, 2008); and vulnerable groups are identified for specific treatments based on need (RoMau., 2002; 2010).

All countries designing their ESA need to organise the capacities and evidence to design and cost their EHBs (Hansen and Chapman, 2008). This tools and resources of a SWAp has supported the design, costing and adoption of the EHB and the institutional reforms to implement it, as was noted in Malawi, Zambia and Tanzania.

In countries piloting the EHB for specific services or in specific districts, as raised earlier for TEHIP and the pilots in DRC and Angola, barriers may arise in the time, evidence, resources and capacities to take it to national scale or to widen it to a more comprehensive package of services. While more focused approaches, or pilots within specific districts, enable collaborations with a variety of non-state actors, providers and funders to support implementation, it is not always clear that this exists in all districts, or that the same intensity of support can be provided at national scale. Setting and implementing a national EHB in a standardised manner across a country with health disparities, as is found in many ESA counties, may need to integrate specific measures to address the variation in service access, uptake, capacities and governance across districts.

The barriers to coverage and financial protection noted more generally in ESA health systems also apply in implementation of the EHB. These include the adequacy of health funding and the removal of user fees barriers and high OOP spending in health. The funding gaps that many countries face, noted earlier, both raise a demand to clarify the EHB and may challenge its implementation. *Section 4.5* reported the range of financing issues that facilitate - or impede - implementation of EHBs in ESA countries: the adequacy of domestic financing and meeting the staffing, medicine, commodity and equipment costs. Inadequate funding may lead to user fees being applied, raising barriers to access to services, even when policies fund these services free at point of care or provide exemptions for specific groups, possibly leading communities to have less confidence in the EHB.

Systems to track expenditure need to be established at primary-care level to link expenditure to EHB service provision for effective purchasing (Menon et al., 2015). A number of countries are involved in policy dialogue on national or social health insurance, as discussed in *Section 4.5*, where the work on the benefit package may also contribute to design and costing work for the EHB. For such schemes to support universal application of the EHB, it is important to ensure pooling with other funding and cross-subsidy across risk and income groups, such as by pooling insurance and tax-based contributions.

EHBs require a multisectoral approach. In operationalising Kenya's EHB (the KEPH), difficulties were identified in terms of planning for services delivered by different sectors and departments (RoK, 2006; 2012). This can lead to deficits in inclusion of budgets for or delivery of specific services, such as those for elderly persons or adolescents.

Multisectoral approaches are also important to deal with social dimensions of services, such as addressing stigma and community perceptions of HIV. In Botswana, uptake of antiretroviral therapy has been undermined by stigma around HIV, even where the services are available (Wolfe et al., 2008). Letamo and Rakgoasi (2003) report that uptake of maternal health services is influenced by age, socio-economic status, education and other social factors. The EHB may include health promotion services to address these factors, but such social factors may also need to integrate education, finance, local government and other sectors.

The ability to implement a multisectoral approach also depends in part on the level of decentralisation, and how far the decentralisation in health is accompanied by similar levels in other sectors (as for example was argued in Zambia by Jeppsson and Okuonzi, 2000; Van der Geest et al., 2000). Integrating the services of other sectors with the EHB calls for stronger systems, to ensure sometimes complex, joint, planning, co-ordination and reporting processes between sectors.

Implementation of the EHB is intended to strengthen the health system, but also depends on health system strengthening to support its implementation. In Botswana, HERA (2012) pointed to the staff, equipment, management capacities, referral system functioning and trained staff needed for implementation of the EHB. Evaluations of Malawi's EHP identified supply side issues affecting its implementation and impact, including human resource management and medicines availability (Mueller et al., 2010). Under-supply can, as was found in Malawi, lead to districts overspending resources on supplies at higher prices from the private sector, undermining the funds available for delivery on the EHB (RoM, 2011). Similarly in Kenya, implementation of the EHB (the KEPH) was noted to call for health system strengthening (UNICEF, 2010), including for community-level inputs, such as community health workers.

6. DISCUSSION

The literature review indicated that EHBs are widespread across the region, with thirteen of the sixteen ESA countries having them, albeit with different names applied to them and at different stages of implementation. This commonality of practice makes it pertinent to explore how these EHBs are being framed and used in the region.

All thirteen countries have designed the EHB or are in the process of updating it, ten have included them explicitly in policies, nine have implemented them and five have evaluated them. The majority apply EHB in the public sector at national scale. South Africa applied it in the private voluntary insurance sector and Angola and DRC have applied them to specific pilot areas. Those applied at national scale apply across all levels of the health system, although Zimbabwe's recent update has only been completed for primary and secondary care levels at the time of writing.

The development of an EHB is motivated by efforts to clarify health entitlements, in some cases responding to the right to healthcare in the constitution, as well as by efforts to address health equity, to identify prioritised health interventions to meet priority population health burdens to be delivered to all, within UHC. They are also motivated by intentions to align resources and services, whether by clarifying the funding needs or applying resources to interventions that are cost benefit and responsive to need. They can be used to ensure strategic and active purchasing of services, although there was limited evidence of this being applied.

They are largely instigated and designed by central ministries of health, with involvement of external funders in some countries, and limited consultation with other stakeholders or communities. Most countries applied analysis of health burdens and cost-benefit interventions to identify services for inclusion, and some included a focus on specific areas of policy commitment, such as to maternal and child health, where there was also sector-wide funding input from external partners. Only three countries reported consulting a wider group of stakeholders. This lack of wider engagement on what is included in many countries may also limit the wider awareness, ownership, dissemination and use of the EHB.

It was not always apparent that those developing the EHB had adequate quality, population health information and costing data for the definition of the EHB. In general, the methods and assumptions used for both prioritisation of services or their costing do not appear to be comparable across the region. Some use costing methods developed for more specific SWAp or disease programmes. Given that both data and skills for this may be barriers to developing the EHB, and that its credibility with ministries of finance, funders, providers and the public depends in part on fair and credible method, this would appear to be an area for regional exchange and harmonisation. This is especially the case if new insurance arrangements are to contribute to the EHB.

In general the EHBs in ESA countries apply to all social groups (as would be expected as this is the purpose of an EHB), and largely cover services from community, to primary care to hospital level. The different EHBs in ESA countries cover specific communicable and non-communicable disease programmes, maternal and child health and public health interventions, although with less common inclusion of laboratory, paramedical and allied services. Primary healthcare was a key focus in all.

EHB costs were differentiated by level of care, type of service provided and whether in the public or private sector. There was an estimated cost for public sector provision of the EHB of approximately $4-$25/capita at primary care level and $22-$74/capita, including referral hospital services, suggesting wide variation in calculated costs across countries. The total costs calculated compare with the $60 per capita estimated by WHO in 2008 for health system costs, noting that this still needs to be adjusted for inflation. Indeed, it can be anticipated that these cost estimates will also increase in ESA countries with a rising share of chronic diseases and an ageing population, as is projected for the region.

While the EHBs are largely tax funded from government budgets, the evidence indicates that in most countries in the region ministries of finance allocate insufficient funds to cover the benefit. If the cost of the EHB is estimated at about $70 per capita, then only seven of the sixteen countries had a *total* health expenditure post-2010 that covers this, and far fewer if only government expenditure/capita is used. In part, therefore, the costing of the EHB provides an estimate for ministries of finance on what budget would be needed to deliver what is regarded as an 'essential benefit' and the size of the public sector funding gap. The funding gap means that in most ESA countries out-of-pocket spending and external funding in SWAp type arrangements has been used to support delivery of the EHB. Such OOP spending, however, is often being collected through fee charges that contradict policy and raise barriers to care for poorest groups. External funding makes countries dependent on unpredictable sources for core services.

The demand to raise additional domestic revenue has led ESA countries to explore other earmarked taxes and mandatory national insurance (blended with tax funds, as in South Africa, if used for the EHB for all). In both cases any additional collections from the public demand clarity on the rationale, raising further pressure for a credible costed EHB. In the interim, some countries (Uganda, Zimbabwe) have focused on delivery of specific priorities within the overall benefit package in the EHB, intending to roll out others as resources increase. Others (Botswana) have proposed to use fee charges for non-EHB services to fund those in the EHB. The question of how the EHB will be funded, and how the service benefits will be progressively realised over time, is an issue that the eight countries already including the right to healthcare in their constitutions would need to clarify and make transparent to avoid lawsuits over services provided.

The EHB can play a key role in active and strategic purchasing of health services, widening performance funding from a narrow range of disease-specific outputs to a wider service package. This would be important also in decentralisation approaches being applied. However, there was limited evidence in the literature of this use of the EHB, including with local government, private, mission sectors, and other non-state providers, to align their services to priority benefits and monitor performance. The role of the EHB in purchasing (contracting and performance and equity monitoring) strategies would appear to be an area that needs further review within the region.

From the five countries where evaluations have been implemented on their EHBs, there was some evidence of an implementation gap. The evidence from these evaluations suggested that improvements in health and healthcare may arise from the use of EHBs, but that this depends on lower income groups accessing the services covered, on benefit packages being funded, available and effectively provided at primary care level and in district hospitals, with additional measures to ensure uptake in lower income groups and to control cost escalation.

The facilitators for design and implementation of an EHB included having access to capacities, methods and adequate quality data for the design, the collaboration across state and non-state actors, personnel and resources to implement it, and the information and expenditure tracking systems to primary level to monitor it. The evaluations pointed to barriers within all these areas. These facilitators and barriers can be located within a wider demand for health system strengthening. It may be useful at regional level to identify monitoring and evaluation tools that can be used in ESA countries, both for internal monitoring and to support exchange of promising practice and capacities.

6.1 Issues for the follow-up research

The limitations of this review are noted in *Section 2*, some of which can only be addressed through country-level assessment. Following the production of this review, the EQUINET programme on this area will be working with country teams led by ministries of health in four ESA countries to carry out more detailed case studies to assess the motivations for and methods used in developing and costing EHBs; the manner in which EHBs have been disseminated and used; promising practice, learning and the key issues for follow up, including wider regional exchange.

The points raised in the discussion point to areas for inclusion in the protocols for this more detailed assessment within countries, particularly given that some key aspects of work in relation to EHBs are in progress or not documented in published literature. The questions raised for the follow-up remain pertinent with some pointers on areas for deeper attention on:

a. The method used to assess and prioritise the benefits in the EHB, paying attention to programme areas and health system elements;

b. The method used for prioritising services and costing of the EHBs and its alignment to practices of key health system funders (ministry of finance, contributors, external funders);

c. The methods of and challenges in blending funds from different sources for the EHB, how funding shortfalls are addressed and how new funding sources proposed or under policy dialogue will be pooled to provide EHB for all;

d. The factors enabling/disabling implementation, from design to monitoring and review, noting issues raised in the discussion in this section, such as inclusiveness of participation in the design, collaboration between state and non-state/private actors, quality of information and expenditure tracking systems;

e. The use of the EHB in purchasing strategies with providers and the factors affecting this;

f. The measures for governance, management of and accountability on the EHB and for managing the role of other sectors in the delivery of the EHB; and

g. The areas of impact and methods used/suggested for evaluation of the EHB to be used for strategic review.

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ACRONYMS

DRC	Democratic Republic of Congo
EHP	Essential Health Package
EHSP	Essential Health Services Package
ESA	East and Southern Africa
GoB	Government of Botswana
GoL	Government of Lesotho
GoSA	Government of South Africa
GoS	Government of Swaziland
GoU	Government of Uganda
GoZ	Government of Zimbabwe
HIV	Human Immunodeficiency Syndrome
HSSP	Health Sector Strategic Plan
KEPH	Kenya Essential Health Package for Health
MHCP	Minimum Health Care Package
MoH	Ministry of Health
MoHSS	Ministry of Health and Social Services
MoHSW	Ministry of Health and Social Welfare
NHSSP	National Health Sector Strategic Plan
OOP	Out-of-Pocket Payments
PHC	Primary Health Care
PMB	Prescribed Minimum Benefits
RoK	Republic of Kenya
RoM	Republic of Malawi
RoN	Republic of Namibia
RoZ	Republic of Zambia
SWAp	Sector-wide approach
TEHIP	Tanzania Essential Health Interventions Project
UHC	Universal Health Coverage
UNICEF	United Nations Child Rights and Emergency Relief Organisation
WHO	World Health Organisation

Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Promoting public health law and health rights
- Social empowerment and action for health
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Series Editor: Rene Loewenson
Issue Editor: V Knight
DTP: Blue Apple Projects
ISBN: 978-0-7974-7160-3
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