# REGIONAL EQUITY WATCH 2012

## Assessing progress towards equity in health
## East and Southern Africa

**EQUINET**
Regional Network for Equity in Health in East and Southern Africa

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This report is produced under the auspices of the EQUINET Steering Committee. The principal author was Rene Loewenson, with contributions across sections by Charlotte Zikusooka, Marie Masotya, Di McIntyre, Shepherd Shamu, Jane Chuma, Bona Chitah, Gertrudes Machatini, Stephen Lagony, Christabel Abewe, Lydia Akao, Mulumba Moses, Itai Rusike, Yoswa Dambisya and Ranga Machemedze.

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c/o Training and Research Support Centre
Box CY651, Causeway, Harare, Zimbabwe
For all queries or orders please email admin@equinetafrica.org

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# KEY MESSAGES

*There has been social, political and policy support for health equity in East and Southern Africa for several decades. There is a social expectation that these policies will be delivered on.*

*Recently enacted constitutions formalise these values in more comprehensive provisions on rights to health care and the social determinants of health. They include provisions for holding the state accountable for its duties.*

*In reality, there are wide differences in how far these rights are achieved between different social groups within countries and between different countries of the region.*

*Encouraging signs of aggregate progress in health mask persistent or even widening social inequalities.*

*For example, within some countries of the region, there is evidence that:*

- *Nearly one in five children under five years die in the poorest households;*
- *Social inequalities in child mortality have widened even when overall mortality has improved;*
- *Fertility rates are higher in adolescents from rural, poorer households; and*
- *Children of mothers with lowest education are five times more likely to be under-nourished than those with highest education and those living in the poorest households are three times more likely to be undernourished than those living in the richest households.*

*Across the countries of the region there are seven-fold differences in under five year mortality and a 22-fold difference in the rate of women dying due to pregnancy and childbirth. This gap is even wider globally, with women in Africa having 39 times higher levels of maternal mortality than those in high-income countries.*

*Why shouldn't all children, adolescents, mothers or households expect the nutrition, health and mortality outcomes of the most educated, wealthiest households or best performing geographical region of their country?*

*We live in an integrated regional community and global economy. How can such enormous differences between communities and countries be acceptable, particularly for conditions that are preventable?*

*Closing the gap calls for political, economic and social action on the causes of these differences, including policies and services that ensure that resources for health reach those with greatest health need.*

*There are examples of positive interventions that tackle inequality in the East and Southern African region, around food production, education, employment, reducing urban poverty, strengthening primary health care and access to safe water.*

*For example, investments in smallholder food production reduce inequalities in nutrition. Measures to encourage female children to enrol and stay in primary education reduce gender disparities. Activities that enhance employment, services, living conditions and participatory planning in unplanned urban settlements reduce urban poverty. There are initiatives that have aligned national and international resources to support community management of safe water or to fund and support primary health care services and community health.*

*These examples show positive benefit for disadvantaged groups and for society as a whole. They also point to the possible.*

*Despite this, access to health resources is often lower in those with higher health need. Some of the most critical areas where this was found are in access to safe water and sanitation, low and unequal coverage of early childhood education and care and secondary education; and the inadequate public investment in improving access to land and other inputs for female smallholder food producers.*

*Health systems are uniquely placed to monitor and use evidence on inequities to lever attention and action from other sectors. To tap this potential, they need to better monitor these inequalities, including in routine data and through community-led processes. Household surveys need to capture social differences in maternal mortality and non-communicable diseases.*

*Lower access to health resources, to reproductive and maternal health services and to HIV prevention and treatment interventions found in poorer households and disadvantaged communities warn that these communities suffer 'diseases of inequity'.*

*Higher levels of inequality in access occur even in more highly-resourced programmes.*

*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 is promising practice in the region on this – in overcoming geographical differentials in access to health care systems, such as in 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.*

*Evidence from the region consistently points to the potential gain to be made by giving more concerted attention to strengthening the primary and community level of the health system.*

*The measures for universal health coverage with equity are not 'quick fix' solutions. They call for strategies and capacities that can be built and applied over more than a decade, that build the social participation, cross-party political support, public leadership and domestic public financing that will sustain implementation.*

*Positive economic growth across most countries of the region in the whole of the 2000s suggests a potentially favourable context for financing and implementing the policies that improve health equity.*

*For example, the progress – albeit slow – towards meeting the Abuja commitment of government financing to heath could be enhanced and supplemented by new tax options to strengthen domestic financing. There is evidence of gains in health outcomes during periods of increased public spending on health. Confidence would be strengthened if these gains, together with evidence that resources are reaching and benefiting those with greatest health need, were more effectively documented and widely reported.*

*There is also a significant threat to such sustained, self-determined action. There are warning signs that economic growth is occurring with increasing poverty and inequality in the region, generating social disadvantage and limiting access to the returns from growth, including in terms of improvements in health. Rapid, unserviced urbanisation, inadequate investment of profits and surpluses in new jobs, and significant disparities in access to agricultural resources, are common pathways for this.*

*Economic policies that generate exclusion are a risk to health and a barrier to delivering on universal health coverage.*

*Inequality within the region is overshadowed by the scale of inequality globally. At current rates of progress in narrowing the global gap in incomes, it would take more than 800 years for the bottom billion people – many of whom live in the region – to achieve even 10 per cent of global income.*

*There continue to be net outflows of resources for health from the region, including through debt servicing, skilled worker out-migration, unfavourable terms of trade and extraction of unprocessed minerals, biodiversity and food. The pro-cyclical deflationary macroeconomic model that has dominated economic policy globally is not yielding the sustained, inclusive or equitable growth needed to achieve social goals. It underlies unacceptable depths of deprivation and unacceptably wide and avoidable gaps in survival, health, social and service outcomes in the region.*

*It is necessary and timely for equity to be explicitly aimed for and assessed in global development policies, including in the Millennium Development Goals post-2015.*

*Within the region, there is need to audit and track the distributional impact of policies, and opportunity to make political and policy choices that will build a more cohesive healthy society.*

*Giving visibility to social inequalities in health, within and across countries, informs the political demand for more just alternatives and makes clear who the bears the costs and burdens of not implementing them.*

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# About the regional Equity Watch

The Regional Network on Equity in Health in East and Southern Africa (EQUINET) is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health.

EQUINET networks people to overcome isolation, give voice and promote exchange and cooperation using bottom-up approaches built on shared values. We have come together in a spirit of self-determination and collective self-reliance, working through existing institutions in East and Southern Africa and with regional organisations, including inter-governmental forums (Southern African Development Community – SADC; East, Central and Southern African Health Community – ECSA), parliament forums (Southern and East African Parliamentary Alliance of Committees of Health – SEAPACOH) and professional and health civil society forums.

EQUINET defines equity as:

> *Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. Equity-motivated interventions seek to allocate resources preferentially to those with the worst health status. This means understanding and influencing the redistribution of social and economic resources for equity-oriented interventions, and understanding and informing the power and ability people (and social groups) have to make choices over health inputs and to use these choices towards health.*
>
> EQUINET steering committee, 1998

In 2007, EQUINET analysed progress towards health equity in East and Southern Africa, documenting inequalities in health and the measures being taken to address them (EQUINET SC, 2007). The analysis identified areas where it is relevant and possible to track trends in health inequalities and in progress made in addressing them. We called this an *Equity Watch*.

An Equity Watch is a means of monitoring progress on health equity by gathering, organising, analysing, reporting and reviewing evidence on equity in health. Equity Watch work is being implemented in countries in East and Southern Africa in line with national and regional policy commitments. In February 2010, the Regional Health Ministers Conference of the ECSA Health Community resolved that countries 'report on evidence on health equity and progress in addressing inequalities in health'.

Using available secondary data, the country Equity Watch is implemented by country personnel with support and input from EQUINET. The aim is to assess the status and trends in a range of priority areas of health equity and to check progress on measures that promote health equity against commitments and goals.

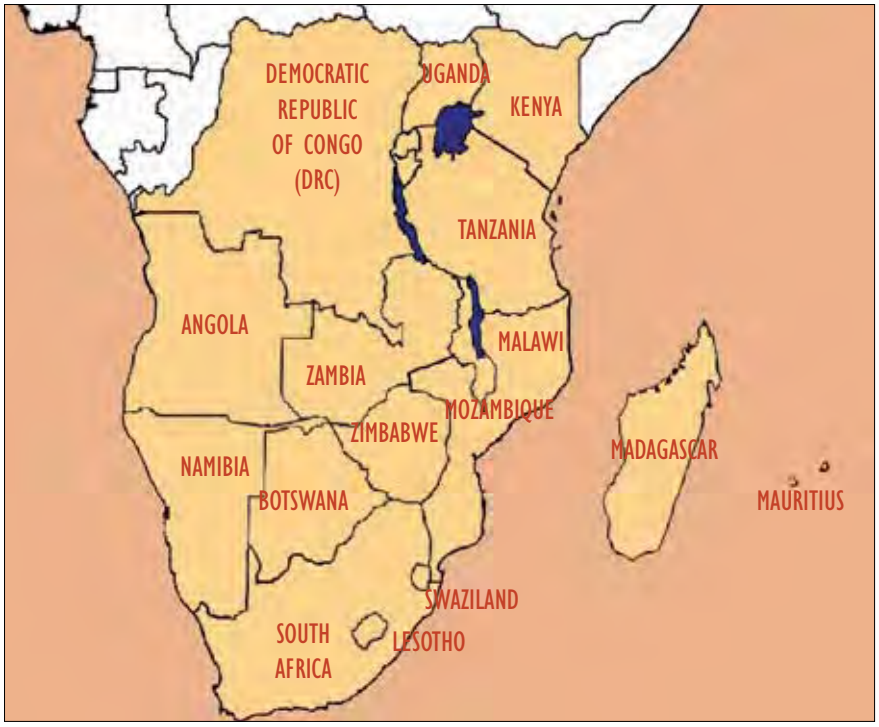
This regional equity analysis updates the 2007 EQUINET regional analysis of equity in health, drawing on the Equity Watch framework developed by EQUINET in cooperation with the East, Central and Southern African Health Community and in consultation with WHO and UNICEF, with some modifications given its regional nature.

The report provides evidence from 16 countries in East and Southern Africa on:

- Policy, political and legal commitments to equity in health
- The current situation with respect to equity in health outcomes
- Economic opportunities and challenges for health equity
- Household access to the resources for health and the social determinants of health
- Challenging inequities through redistributive health systems
- A more just return from the global economy

It shows past levels and current levels (most current data publicly available) and comments on the level of progress towards health equity. It raises the factors affecting progress and the challenges to be addressed. It shares approaches being taken in the region to advance equity that appear to be yielding progress.

The regional analysis also reflects on the evidence from and experience of implementing the country Equity Watch reports, and raises issues for countries to institutionalise planning and monitoring for health equity, including in relation to global commitments, such as the Millennium Development Goals.




**Map of East, Central and Southern Africa, showing countries**

Source: EQUINET SC, 2007

# 1

# Policy, political and legal commitments to equity in health

# KEY ISSUES

Values that identify socially produced and avoidable health differences as unfair, underpin progress in health equity across all the areas discussed in this report. Health equity is a matter of social justice and is protected through constitutions, laws, policy commitments and the social actions that assert ethical norms.

Social values for health equity are deeply rooted and have been sustained through various political and policy changes in the region. There has been a consistent policy commitment to health equity. Most East and Southern African countries have signed and ratified key international treaties and conventions on the right to health.

There is evidence that reaching the Millennium Development Goals (MDGs) will not be possible unless equity is addressed and poor people benefit from the process. The challenge is thus to move from policy commitment to practice.

One step towards this is in giving formal expression to the right to health. Social rights to health are increasingly expressed in constitutions and have increasingly become the focus of civil society action. Some countries have been cautious about including social and economic (including health) rights in their Bill of Rights due to debates on how they are enforced by the courts. Other countries have included clauses that specify the state's obligation to progressively and equitably realise these rights within its available resources.

There has been social and civil society advocacy around rights to land, water, food and treatment, and more and more around the right to health and health care. The right to health has also recently been used in landmark civil society supported litigation on access to medicines and maternal health care. Yet the situation suggests that many further steps need to be taken: to tackle the asymmetry of information, power and resources; and to build the participatory mechanisms and state capacities to implement these rights and policy commitments, particularly in the socio-economic and health contexts described in the next sections.

# Formal recognition and social expression of equity and universal rights to health

East and Southern African (ESA) countries have for many decades valued and made explicit policy commitments to equity in health. The liberation movements of the region challenged unfair and avoidable inequalities in health, particularly those along the lines of race and social class. Values of equity and solidarity were incorporated into the founding health policies and programmes of independent governments in the region. A content analysis of the policies of countries in the region, such as those implemented in the country *Equity Watch* reports, highlights a long-term policy commitment to health equity.

The Southern African Development Community (SADC) and the Regional Health Ministers in East, Central and Southern Africa (ECSA) have also both made policy commitments to health equity (EQUINET SC, 2007). In February 2010, the ECSA Regional Health Ministers' Meeting resolved to track and report on evidence relating to health equity and on progress in addressing inequalities in health. They also resolved to strengthen their capacities in this regard. This followed a similar resolution at the 62nd World Health Assembly on 'Reducing health inequities through action on the social determinants of health'. The ministers acknowledged findings from the 2009 United Nations (UN) Committee for Development Policy that attaining the Millennium Development Goals would not be possible unless equity is addressed and poor people benefit from the process (UN Committee for Development Policy, 2009).

The challenge is thus to move from policy commitment to practice.

A foundation for this lies in including the right to health in the constitution and in other law. Since 2005, greater attention has been given to the right to health in East and Southern Africa, motivated by wider constitutional debates, civil society advocacy and south to south learning on the role of constitutional rights in building and safeguarding universal health systems (Mulumba *et al*, 2010).

The International Covenant on Economic and Social Rights (ICESR), an international human rights instrument to which all countries in the region are signatory, obliges states to satisfy minimum essential levels of each of the rights it covers. These include the right to health and its determinants (UN, 1976). Article 12 of the Covenant states that every human being is entitled to enjoy the highest attainable standard of health needed to live with dignity.


*Marching for health, Lilongwe, 2007* ©P Kawale

General Comment 14 of the Covenant elaborates on the core state obligations with regard to the right to health as ensuring the following:

1. Access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
2. Access to the minimum essential food that is nutritionally adequate and safe, to ensure freedom from hunger for everyone;
3. Access to basic shelter, housing and sanitation, and an adequate supply of safe water;
4. Provision of essential drugs, as defined in the World Health Organisation's Action Programme on Essential Drugs;
5. Equitable distribution of all health facilities, goods and services; and
6. Adoption and implementation of a national public health strategy and plan of action that addresses the health concerns of the whole population, devised and periodically reviewed in a participatory and transparent process (UN, 2000).

The African Charter on Human and Peoples' Rights (ACHPR), a uniquely African human rights document adopted by the Organization of African Unity in 1979, similarly provides that 'Every individual shall have the right to enjoy the best attainable state of physical and mental health' and that government must '… take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.'

Table 1.1 shows that most countries in the region had signed and ratified these and other key treaties on health rights by 2011. Further, as reported in the 2007 regional equity analysis, all 16 countries have ratified the Convention on the Rights of the Child (1989) and the Convention on the Elimination of all forms of Discrimination against Women (1979). High levels of child and maternal mortality and of adolescent fertility in some countries, discussed later, make realising the commitments in these two conventions a priority. Once countries have committed themselves to international treaties, they are

**Table 1.1: Ratification of human rights treaties, East and Southern Africa, 2011**

| Treaty | Angola | Botswana | DRC | Kenya | Lesotho | Madagascar | Malawi |
|---|---|---|---|---|---|---|---|
| African Charter on Human and People's Rights ACHPR (1981/1991)** | Mar-90 | Jul-86 | Jul-87 | Jan-92 | Feb-92 | Mar-92 | Nov-89 |
| International Covenant on Economic, Social and Cultural Rights ICESCR (1966) | Jan-92a | – | Nov-76a | May-72a | Sep-92a | Sep-71a | Dec-93a |
| African Charter on the Rights and Welfare of the Child ACRC (1999) | Apr-92 | Jul-01 | Feb-10* | Jul-00 | Sep-99 | Mar-05 | Sep-99 |
| Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa ACRW (2003) | – | – | Dec-03* | Dec-03* | Oct-04 | Feb-04* | May-05 |

UCT, TARSC, SEAPACOH, 2008; UN Treaty website updated Nov 2011; http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en
African charter status as found at www.achpr.org/english/ratifications/ratification_african%20charter.pdf; www.africaunion.org/root/au/documents/treaties/List/African%20Charter%20on%20the%20Rights%20and%20Welfare%20of%20the%20Child.pdf

expected to pass laws, allocate budgets and put policies and programmes in place to progressively realise the rights they cover.

There is some variation in how far countries in the region have included health rights in their constitutions (Mulumba *et al*., 2010). In relation to the social determinants of health, five constitutions (Kenya, Malawi, Congo, South Africa, Mozambique) provide for the right to shelter and safe water, and six (Kenya, Malawi, Congo, South Africa, Uganda, Namibia) for rights to food, with Uganda, Namibia and Malawi including more detailed provisions on this. Malawi's constitution, for example, in article 13, obliges the state to progressively adopt and implement policies and laws that aim to achieve adequate nutrition for all in order to promote good health and self-sufficiency.

Seven constitutions (Angola, Kenya, Malawi, Congo, Mozambique, South Africa, Uganda) provide for rights to health care services and the equitable distribution of health facilities, goods and services. In South Africa, for example, under article 27, everyone has a right of access to health care services, including reproductive health care and no one may be refused emergency medical treatment. While the constitutions do not specifically refer to 'essential drugs', they do provide for 'treatment', 'medical care' or 'health care' services that would include this. Vulnerable groups are given specific attention in some constitutions. Angola points to obligations in relation to child, maternity, disability and old-age care, and care in any situation causing incapacity to work, while the Malawi constitution obliges the state to ensure equality of opportunity for all in their access to basic health services.

Angola, Malawi, Swaziland and Zambia oblige the state to provide for public health policy and strategy and include a general duty to public health. Madagascar's constitution makes reference to international human rights instruments that spell out the right to health, allowing for these to be invoked to remind the state of its obligations. Most constitutions also include clauses that restrict rights to protect public health, such as restricting freedom of movement or prohibiting conduct injurious to health. In Botswana, for example, several articles of the constitution justify that rights to property, to privacy, to freedoms of expression, assembly and movement can be limited to protect public health.

| Mauritius | Mozambique | Namibia | South Africa | Swaziland | Tanzania | Uganda | Zambia | Zimbabwe |
|---|---|---|---|---|---|---|---|---|
| Jun-92 | Feb-89 | Jul-92 | Jul-96 | Sep-95 | Feb-84 | May-86 | Jan-84 | May-86 |
| Dec-73a | – | Nov-94a | Oct-94* | Mar-04a | Jun-76a | Jan-87a | Apr-84a | May-91a |
| Feb-92 | Jul-98 | Jul-02 | Jan-00 | Jun-92* | Mar-03 | Aug-94 | Dec-08 | Jan-95 |
| Jan-05* | Dec-03* | Aug-04 | Dec-04 | Dec-04* | Nov-03* | Dec-03* | Aug-05* | Nov-03* |

KEY: – = country has not acted yet; Date = date ratified; * = signatory only; a = accession; d = succession;
** = first date refers to date adopted at AU level and second to date registered with the UN; country dates refer to accession/ ratification

## Examples of best practice

A review of constitutions in the region suggested that 'best practice' examples from the region that can inform constitutional review processes include:

1 With regard to the right of *access to health facilities, goods and services on a non-discriminatory basis*, article 116 of Mozambique's constitution states:

> *Medical and health care for citizens shall be organised through a national health system, which shall benefit all Mozambican people. To achieve the goals of the national health system, the law shall establish the ways in which medical and health care are delivered. The State shall encourage citizens and institutions to participate in raising the standard of health in the community. The State shall promote the expansion of medical and health care and the equal access of all citizens to the enjoyment of this right. The State shall be responsible for promoting, supervising and controlling the production, the sale and the use of chemical, biological and pharmaceutical products and other forms of treatment and diagnosis, and the medical and health care activities run by collective and private entities shall be carried out in accordance with the law and be subject to the supervision of the State.*

2 On *access to food* that is nutritionally adequate and safe, and to ensure freedom from hunger for everyone, the Uganda constitution, objective XXII provides that:

> *The State shall: take appropriate steps to encourage people to grow and store adequate food; establish national food reserves; and encourage and promote proper nutrition through mass education and other appropriate means in order to build a healthy State.*

3 The South African Constitution on *access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water*, in section 26 and section 27 provides that:

> *Everyone has the right to have access to adequate housing. No one may be evicted from their home, or have their home demolished, without an Order of Court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.*
>
> And, in section 27:
>
> *Everyone has the right to have access to sufficient food and water.*

4 Section 43 of Kenya's constitution provides for *health care, food, water and social security*:

> *Every person has the right (a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;(b) to accessible and adequate housing, and to reasonable standards of sanitation; (c) to be free from hunger and to have adequate food of acceptable quality; (d) to clean and safe water in adequate quantities; (e) to social security; and (f) to education; that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.*

5 In terms of *equitable distribution of all health facilities, goods and services*, section 116(4) of Mozambique's constitution provides:

> *The State shall promote the expansion of medical and health care and the equal access of all citizens to the enjoyment of this right.*

6 Regarding the *national public health strategy*, article 13(c) of Malawi's constitution provides:

> *The State shall actively promote the welfare and development of the people of Malawi by progressively adopting and implementing policies and legislation … to provide adequate health care, commensurate with the health needs of Malawian society and international standards of health care.*

7 Article 20 of Kenya's constitution provides useful clauses, shown earlier, to make socio-economic rights justiciable in ways that oblige the state but also protect it against unfair suit. Mozambique's article 81 introduces the right of popular action for citizens to advocate the prevention, termination or prosecution of offences against public health (Mulumba *et al.*, 2011).

There does appear to have been a political shift, as more recently enacted constitutions provide more comprehensive provisions on the right to health, such as is found in the South African constitution (2005) and the Kenyan constitution (2010). In the latter, articles 42 and 43 provide for rights to a clean and healthy environment; to the highest attainable standard of health, which includes the right to health care services, including reproductive health care; to accessible and adequate housing, and to reasonable standards of sanitation; to be free from hunger, to have adequate food of acceptable quality; and to clean and safe water in adequate quantities. Article 43 also provides that a person shall not be denied emergency medical treatment. Similar clauses found in the South African constitution suggest shared social norms across two countries at each end of the region in relation to fundamental rights in health.

The adoption of less comprehensive provisions in other countries has in part been due to debates on whether social and economic rights can be enforced by the courts, and what this means for resource-constrained states. States have raised the possibility that those with more resources and power may be more likely than vulnerable communities to sue the state over their constitutional rights. While the validity of this assertion is untested, it has led some countries, like Lesotho, to locate the right to health as a principle of state policy and objective, rather than in the Bill of Rights, to limit its enforcement in courts of law.

Some constitutions in the region have addressed these concerns about how the realisation of health rights can be aligned to resources and about their justiciability. For example, provisions have been included that:

- oblige the state to allocate resources to ensure the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals;
- refer to the principle of progressive realisation, obliging the state to take reasonable legislative and other measures within its available resources; and
- allow the state to show, if contested by individuals through a court, tribunal or other authority on the implementation of the rights, that the resources are not available.

*Meals for schoolchildren scheme, Zimbabwe* *© UNICEF, Zimbabwe*

## Zimbabwe's constitutional review

In Zimbabwe, where the constitution was under review at the time of writing, the government's *National health strategy 2009–2013* advocated for 'the protection of health rights in the constitution' as a national priority (Zimbabwe MoHCW, 2009). In 2008, national civil society at the Community Working Group on Health 15th National Conference demanded that the right to health be included in the new constitution (CWGH, 2008). Communities also voiced this demand in public meetings during the 2010 national consultations on the new constitution.

Recognising Zimbabwe's status as signatory to the International Covenant on Economic and Social Rights and the inclusion of the right to health in constitutions across the region, the Public Health Advisory Board, a national stakeholder body, proposed that the new constitution under debate include:

- a general right to the highest attainable standard of health for everyone;
- the right to access to health facilities, goods and services, including essential drugs, reproductive health care and emergency care;
- the right to the social determinants of health (food, shelter, sanitation and an adequate supply of safe water) and information;
- freedom from discrimination or interference in achieving the right to health and provisions ensuring equity and protection of vulnerable groups;
- prohibition of conduct injurious to health; and
- principles for judging application of the rights and delivery of the state's obligations (PHAB, 2010).

## Zambia's reservations

Zambia is an example of a country that has taken a more cautious position on the inclusion of the right to health in the constitution. When Zambia ratified the International Covenant on Economic, Social and Cultural Rights in 1984, it posted a reservation specifically on the right to primary education, which argued that, while it…

> *'…fully accepted the principles embodied … and undertakes to take the necessary steps to apply them in their entirety, the problems of implementation, and particularly the financial implications, are such that full application of the principles in question cannot be guaranteed at this stage'* (Kamupira and London, 2005).

The constitution-making process in Zambia between 2006 and 2010 recognised the importance of meeting economic, social and cultural rights in realising political and civil rights. The Human Rights Commission of Zambia observed:

> *'…the rights pertaining to the improvement of the welfare of the citizenry such as education, health, housing, employment and social security are not placed in the Bill of Rights even though economic, social and cultural rights have been recognised to be important in the realisation of political and civil rights' (*Zambia Human Rights Commission, 2010).

Zambia's 2010 National Constitution Conference recommended that rights to education, health, housing, employment and social security be included in subsidiary legislation, not in the Bill of Rights. In contrast, the Constitution Bill on the website of the National Assembly of Zambia, in section 67 provides for the right to health in the same form as in the more recent South African and Kenyan law, stating:

> *'67. (1) Every person has the right to health, which includes the right to health care services and reproductive health care.(2) A person shall not be refused emergency medical treatment'* (GoZambia, 2010).

The Bill further provides in clause 63:

> *'Parliament shall enact legislation which provides measures which are reasonable in order to achieve the progressive realisation of the economic, social and cultural rights referred to in articles 65, 66, 67 68, 69, 70 and 71.'*

The outcome remains uncertain until the Bill is debated (UNZA *et al.*, 2011).

*A cholera centre in Zambia* *© Idah Zulu, February 2009*

## Kenya and state obligations

In relation to socio-economic rights, article 20 of the Kenyan constitution provides that if the state claims that it does not have the resources to implement a right, a court or other authority shall be guided by principles that:

> *(a) the State has responsibility to show that the resources are not available;*
>
> *(b) in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and*
>
> *(c) the court, tribunal or other authority may not interfere with a decision by a State organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion.*

*A clinic queue in Kenya* *©DfID, Creative Commons licence*

These constitutional developments and, particularly, inclusion of social rights and equity, both reflect and depend for their implementation on social awareness, action and policy engagement, and solidarity with those who are most disadvantaged (EQUINET SC, 2007). There is a tradition for this in the region, with African philosophies and traditions giving central focus to collective rights, such as those raised in the right to health (LNHHR, 2010).

There has been significant social and civil society advocacy around treatment rights or rights to social determinants of health like land, water and food. In recent years the right to health has also become more prominently voiced by civil society. The People's Health Movement, globally and in Africa, has led a civil society campaign on the right to health, noting that 'it is mostly the poor who are the victims and they have too little voice and no influence, let alone rights. It is inequities of power that prevent the poor from accessing the opportunities they need to move out of poverty' (Shuftan *et al.*, undated).

The most well-known civil society campaign in Africa was that for access to medicines for HIV, particularly as led by the Treatment Action Campaign between 1998 and 2008. The campaign used a mix of human rights and treatment literacy, demonstration, and litigation to reduce the price of medicines and force significant additional resources into the health system towards poor people (Heywood, 2009).

The People's Health Movement in South Africa, the Community Working Group on Health in Zimbabwe and others have widened the pressure from treatment access to rights in relation to primary health care and other inputs to health. However such campaigns are still of variable strength within the region. Even where progressive clauses exist in constitutions, they may not be well known or used, particularly by those who have greatest health need.

Rights-based approaches imply processes that include participation, information sharing and accountability in setting priorities, planning and design, implementing and monitoring policies and programmes. They imply that states and others charged with duties have the resources and capacities to meet their obligations and that social groups, particularly vulnerable groups across gender, race, social class and other social dimensions, have the information and capacity to claim their rights. The box on the next page highlights promising practices in Kenya to take the necessary steps.

Accountability also calls for redress mechanisms in politics, law (such as national human rights commissions), administration and policy (policy reviews, audits). Litigation has not been a commonly used route to claim rights to health. However it may be gaining ground.

In 2011, the Centre for Health, Human Rights and Development (CEHURD) petitioned the constitutional court in Uganda seeking declarations that maternal deaths due to non-provision of health care in government health facilities are an infringement on rights to life and health. The case, ongoing at the time of writing this report, reinforced wider civil society advocacy over high levels of maternal mortality, adding pressure on government to accelerate action on maternal and neonatal mortality (CEHURD, 2011). In 2012, three petitioners living with HIV contested clauses in the Kenya Counterfeit Act that restrict availability and access to generic drugs, deemed under the Act as counterfeit goods and therefore liable to seizure. In April 2012, the judge found for the petitioners, observing that the Anti-Counterfeit Act gave more attention to enforcement of intellectual property rights than issues of sub-standard counterfeit medicines and in limiting access to generic medicines violated the state's duty to protect the right to life and health (Republic of Kenya, 2012).

*Gender equality* refers to equal chances or opportunities to access and control social, economic and political resources (including protection under the law). It refers to women and men having equal conditions and opportunities to realize their rights and potential to be healthy, to contribute to health development and benefit from the results.

*Gender equity* refers to fairness and considers men and women's different needs to achieve gender equality. In health it refers to the process of reducing unjust and avoidable inequality between women and men in health status and in access to health services.

## Kenya's constitutional process

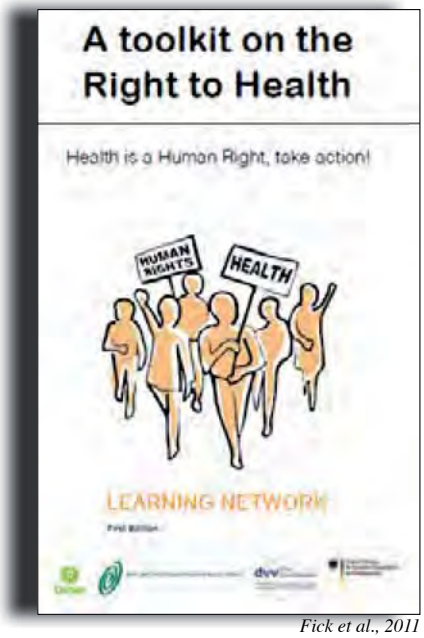
Kenya has made a major commitment to the right to health in its new constitution passed in August 2010 (Republic of Kenya, 2010). The relevant clauses are highlighted earlier. To implement these rights, article 59 establishes the Kenya National Human Rights and Equality Commission whose main function is to promote gender equality and equity generally and to coordinate and facilitate gender mainstreaming in national development.

The constitution provides for the progressive realisation of the rights contained in the Bill of Rights and binds all state organs and all persons. Article 20 provides that, in applying a provision of the Bill of Rights, a court shall adopt the interpretation that most favours the enforcement of a right or freedom and promotes the values that underlie an open and democratic society based on human dignity, equality, equity and freedom.

In applying the economic and social rights under article 43, if the state claims that it does not have the resources to implement the right, it has the responsibility of showing that the resources are not available. In allocating the resources, the state shall give priority to ensuring the widest possible enjoyment of the right or freedom, having regard to the prevailing circumstances, including the vulnerability of particular groups or individuals. Anyone can bring a suit to enforce his or her right when it is violated, directly or through other persons or civil society.

There shall be no fee or a reasonable fee that does not impede access to legal proceedings, to avoid cost barriers.

The devolved system of government set in the new constitution is likely to support the devolution of mechanisms, capacities and processes in health and other sectors, such as through the constituency development fund and through community participation mechanisms from village level upwards. Widespread civic education during the constitution-making process means that people are relatively well informed about their constitutional rights. Line ministries and civil society also held seminars on the new constitution. A Committee for the Implementation of the New Constitution has a mandate to ensure the constitution is correctly implemented and interpreted, with some court cases already held on interpretation of provisions (KEMRI *et al.*, 2011).




*Fick et al., 2011*

*An example of civil society materials designed to build people's capacities to claim their health rights*

These landmark cases are emerging as signs of citizens organising to claim entitlements. It is, however, equally common to find the situation noted in the Mozambique *Equity Watch* where, despite having amongst the most comprehensive provisions for the right to health in the region, there was limited evidence of civil society and parliamentary awareness of or use of these rights in promoting and protecting health (MoH Mozambique *et al.*, 2010).

*Social values for health equity are deeply rooted and have been sustained through various political and policy changes in the region. Social rights to health are gaining increasing expression in constitutions and have become an increasing focus of civil society action and litigation. Yet the situation suggests that many further steps need to be taken to tackle the asymmetry of information, power and resources and build the participatory mechanisms and the state capacities for these rights and policy commitments to be implemented, particularly in the socio-economic and health context described in the next sections.*

# 2

# Equity in health outcomes

# KEY ISSUES

While population growth and fertility have fallen in most countries in the region, adolescent fertility is still higher where children grow up in poorer households with mothers at lower education levels. Rapid urbanisation presents new challenges given widening social and health differences within urban areas. Child survival, HIV prevalence and access to immunisation and HIV prevention services have risen overall but progress in child nutrition has been slower and non-communicable disease levels are rising.

Aggregate data does not reflect, for example, the following social crises:

- Nearly one in five children under five years dying in the poorest households in two countries in the region;
- Seven-fold differences in under five year mortality between countries in the region;
- Wide differences in nutrition by wealth in all countries in the region;
- A 39-fold gap between mothers in Africa and those in high-income countries in maternal mortality and a 22-fold gap across countries in the region;
- Lower coverage of reproductive and maternal health services in many countries in the region that have higher maternal mortality;
- Wider social and geographical inequalities in access to reproductive health and maternal health services within countries than for many other areas of health service delivery;
- Lower HIV prevention and treatment coverage among poorer, rural people with lower education levels, signalling future HIV concentration in disadvantaged communities.

Child nutrition both reflects and affects social development and is a good measure of the distributional performance of public policy.

Aggregate improvements sometimes occur with widening inequalities, such as in child mortality, so specific attention is needed to reduce these inequalities. Countries need to gather evidence on social differences in maternal mortality and non-communicable diseases to better plan, target and monitor needs and services.

Rural–urban inequalities in child survival have been reduced by improving access to safe water, adequate food and health services. Service inequalities narrow as coverage improves but additional measures are needed to overcome access and uptake barriers due to social disadvantage. Community outreach through health and other sectors to address social barriers needs to be backed up by sufficient resources being provided for the scale up of effective primary care level services.

Focusing on lifestyles and curative services for non-communicable diseases, often delayed in uptake, may leave poor households less protected. Integrated primary health care approaches and actions on the ‘causes of the causes’ are needed to avoid non-communicable diseases adding to already high levels of other health burdens in vulnerable groups.

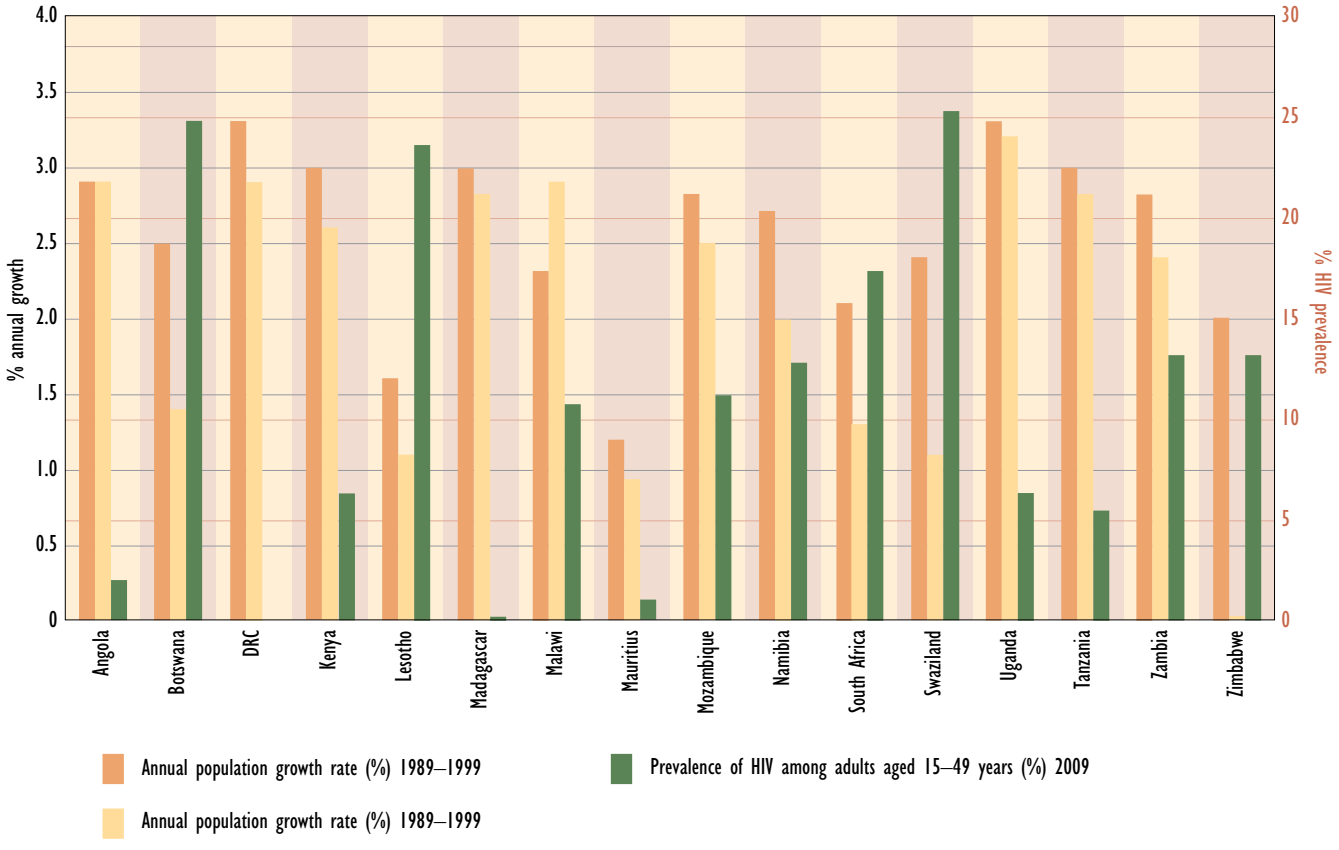
# A young, diverse and increasingly urbanised population

The 16 countries covered in this review together have a total population of 343 million, 5 per cent of the global population. The population of the region is younger than the African and global average, with 41 per cent of people under 15 years (see Statistical appendix table A2.1).

Population growth has fallen in most countries of the region, except for in Angola and Malawi. It fell minimally in Uganda but the greatest decline in population growth has been in Botswana, Namibia, South Africa, Swaziland and Zimbabwe, the higher income countries in the region. As shown in Figure 2.1 below, there is no obvious (or statistically significant) relationship between population growth and HIV prevalence, suggesting that HIV prevalence has had less impact on population trends in more recent years than it had in the early 2000s. Changes in population growth have also been associated with other factors, including economic status, social and gender norms, availability of contraception, child mortality and in and out migration due to political or economic conditions.

Fertility has also fallen in all countries in the region since 1990. It remains high, however, in Uganda, Zambia, Democratic Republic of Congo (DRC) and Angola. In these countries, and in Mozambique and Malawi too, adolescent fertility is also high at levels of between 127 and 185 per

**Figure 2.1: Population growth and HIV prevalence, East and Southern Africa, 2009**




Source: WHO, 2011

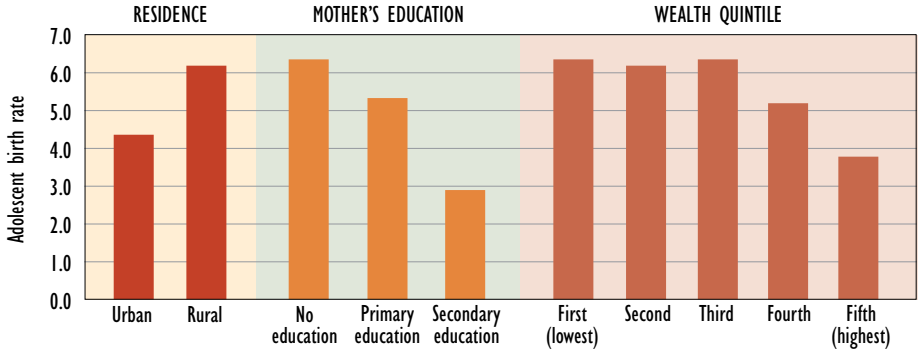
1,000 girls aged 15–19 years (see Statistical appendix table A2.1). In Malawi, more than half of women in all age groups have given birth by the age of 20 and almost all women (90 or more per cent) have given birth by 25, with higher fertility among rural, poorer and less educated adolescents (NSO [Malawi], UNICEF, 2008).

The social differentials in adolescent fertility appear to be higher when overall adolescent fertility is higher (and vice versa). As shown in Figure 2.2, for example, Mozambique, with higher adolescent fertility, also had a higher social gradient in adolescent fertility by area, education and wealth than Kenya, where overall adolescent fertility was lower. The mother's education level appears to affect adolescent fertility, despite their own improved access to education and significant improvements in gender parity in primary education (reported later).

*In countries with high adolescent fertility, specific additional measures appear to be needed to understand and address the drivers of adolescent fertility in poorer households and in children of mothers with lower education levels.*

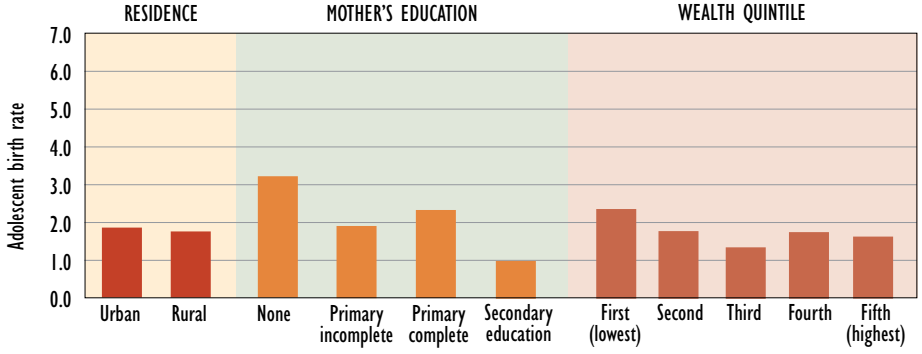
An important demographic context for health equity in the region has been rapid urbanisation. Levels of urbanisation have increased from a 28 per cent share of the population in 1990 to 35 per cent in 2009, a growth of 7 percentage points and faster than the global or African average. Only Mauritius and Zambia have seen trends in the opposite direction. For Lesotho, Malawi and Mozambique the urban share has almost doubled in two decades (Figure 2.3 and Statistical appendix table A2.1).

**Figure 2.2a: Differentials in adolescent birth rate, Mozambique, 2003**




Source: INE (Mozambique), ORC Macro, 2003

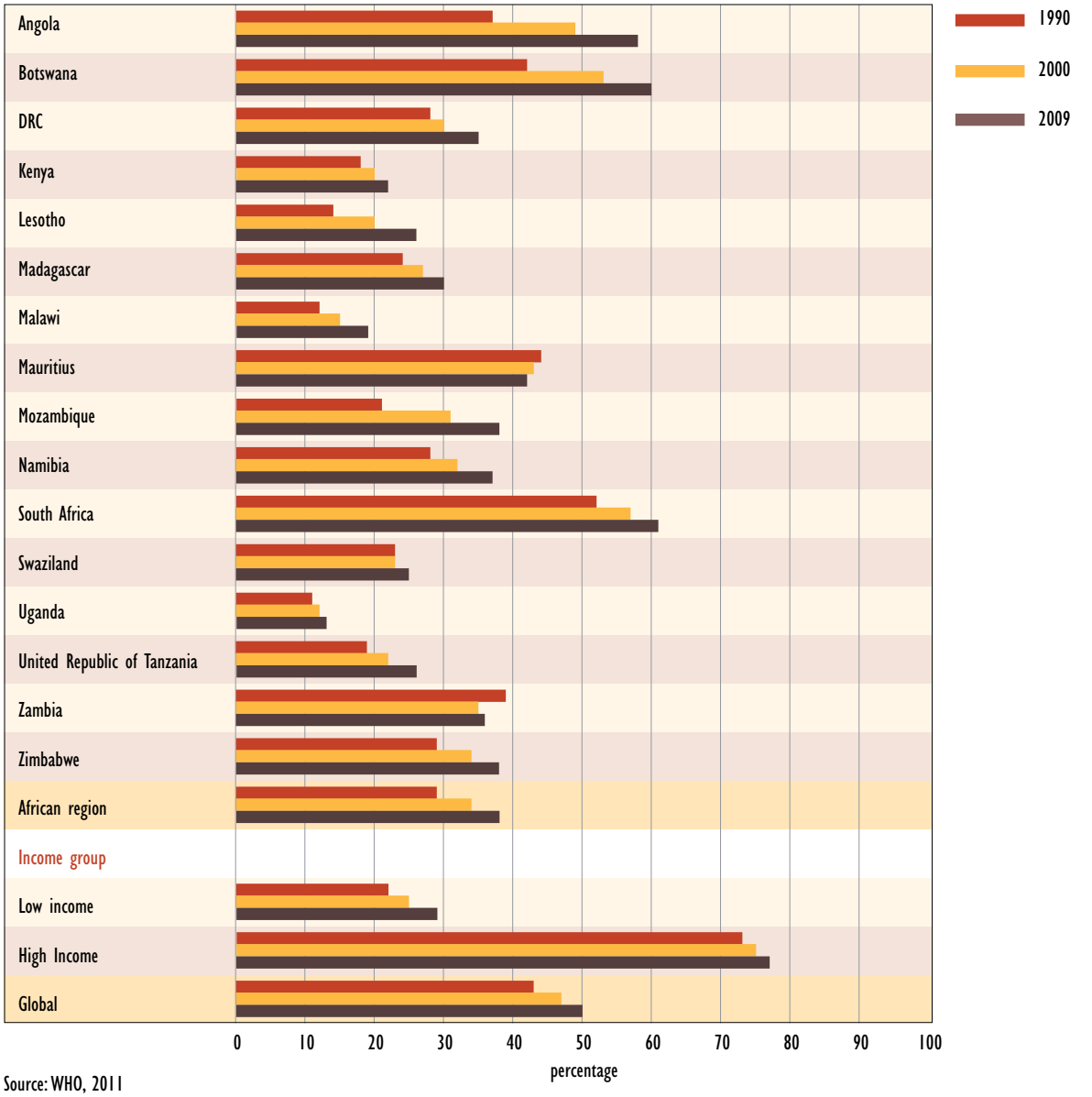
**Figure 2.2b: Differentials in adolescent birth rate, Kenya, 2010**




Source: KNBS and ICF Macro, 2010

*The increased urban share of the population regionally and the rapid rate and nature of urbanisation in many countries in the region, draws attention to the social differences that are emerging within urban areas. This is discussed further in subsequent sections, together with the challenge this raises for a model of urban primary health care that addresses the unique and diverse situations of urban households.*

**Figure 2.3: Percentage of the population living in urban areas, East and Southern Africa, 1990-2009**




Source: WHO, 2011

*Matthew Goniwe Clinic, Khayalitsha, Cape Town*

*©Dorette Baatjies, March 2009*

# Improved child mortality rates but with high rates in the poorest communities

Life expectancy globally has showed steady improvements in the past two decades (Statistical appendix table A2.2). Between 1990 and 2000, largely as a result of the AIDS epidemic, many countries in the region lost a decade of the improvements in life expectancy experienced in other regions, with Lesotho, Swaziland and Zimbabwe having losses of over 10 years. Angola, Madagascar, Mauritius and Mozambique did not have this decline in life expectancy between 1990 and 2000. After 2000, life expectancy rose again, with Botswana showing the strongest recovery (an increase of 10 years between 2000 and 2009) and most other countries experiencing a smaller increase of three to four years.

*Neonatal mortality* refers to deaths in the first 28 completed days of life per 1000 live births in a given year or period. Infant mortality refers to deaths in the first year of life per 1000 live births in a given year or period. Child mortality refers to deaths between age one year and age four years per 1000 children in that age group in a given year or period. Under five year mortality refers to deaths between birth and exact age of 5 years per 1000 children aged 0-5 years in a given year or period.

While early adult mortality due to AIDS profoundly affected life expectancy, so too has child mortality. Child, infant and neonatal mortality similarly rose between 1990 and 2000 in seven countries in the region (Botswana, Kenya, Lesotho, Swaziland, Tanzania, South Africa and Zimbabwe) but fell in all the countries in the region in the 2000s (Statistical appendix table A2.3; Figure 2.4). All countries in the region have shown aggregate improvements in child, infant and neonatal mortality rates.

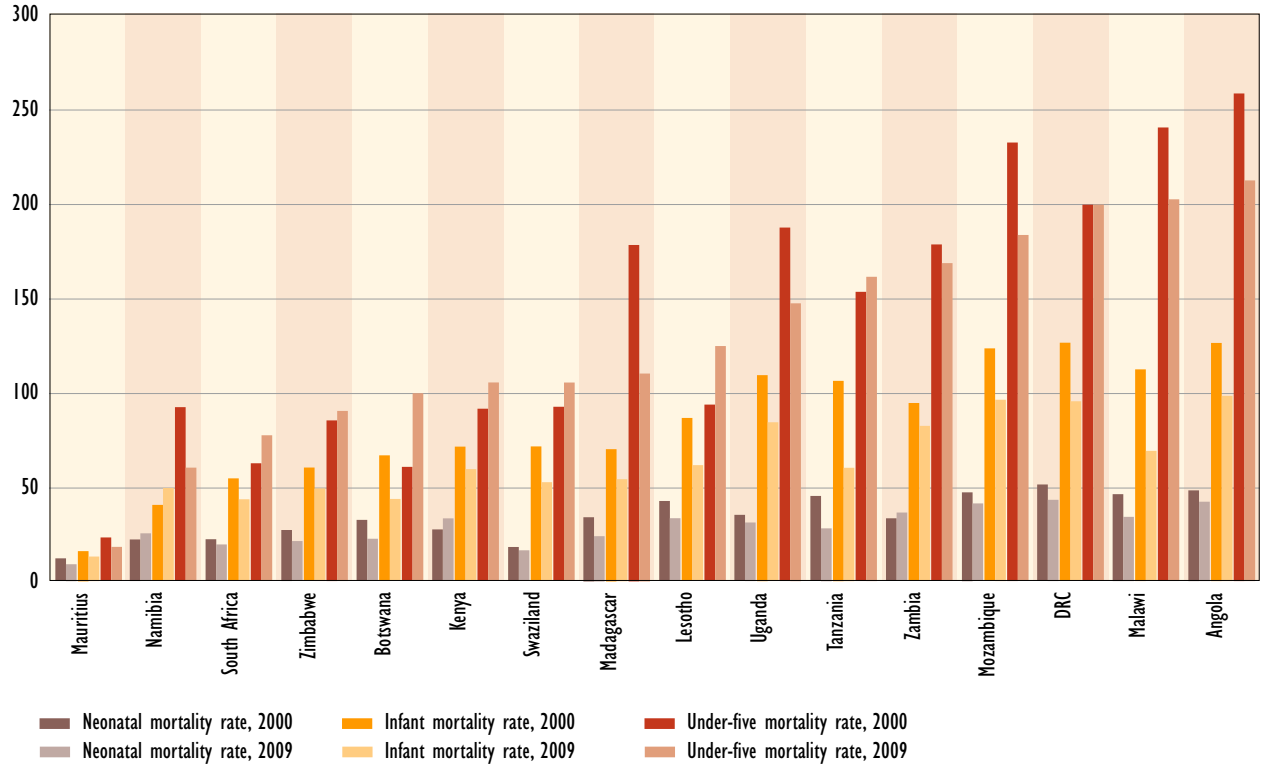
Figure 2.4 highlights the high share of the infant mortality rate (IMR) that is due to neonatal mortality at lower rates of infant mortality, particularly in the higher income countries of the region. Neonatal mortality reflects factors associated with the first weeks of life, such as maternal and foetal nutrition and effective coverage of maternal health care services.

Aggregate improvements do not, however, tell the full story. There are wide inequalities across social groups and more so in under five year mortality than in infant mortality. Madagascar, Mozambique, Uganda and Namibia have widest differentials (see Figure 2.5). Wide ranges in Mozambique and Uganda, for example, mean that the poorest wealth quintiles have infant mortality rates of 143 and 102 per 1,000 respectively, and under five year mortality rates of 196 and 172 per 1,000. These rates are almost double the rates of highest wealth quintiles.

*Focusing only on aggregate mortality in children is not sufficient. It misses social crises that merit urgent attention, such as extremely high rates of nearly one in five children under five years dying in the poorest households in two countries in the region, almost double the rates of the wealthiest groups in those countries. It also misses the wide regional inequalities, where a child in the poorest household in Mozambique has seven times the risk of dying in its first five years of life as one in the highest wealth group in Namibia.*

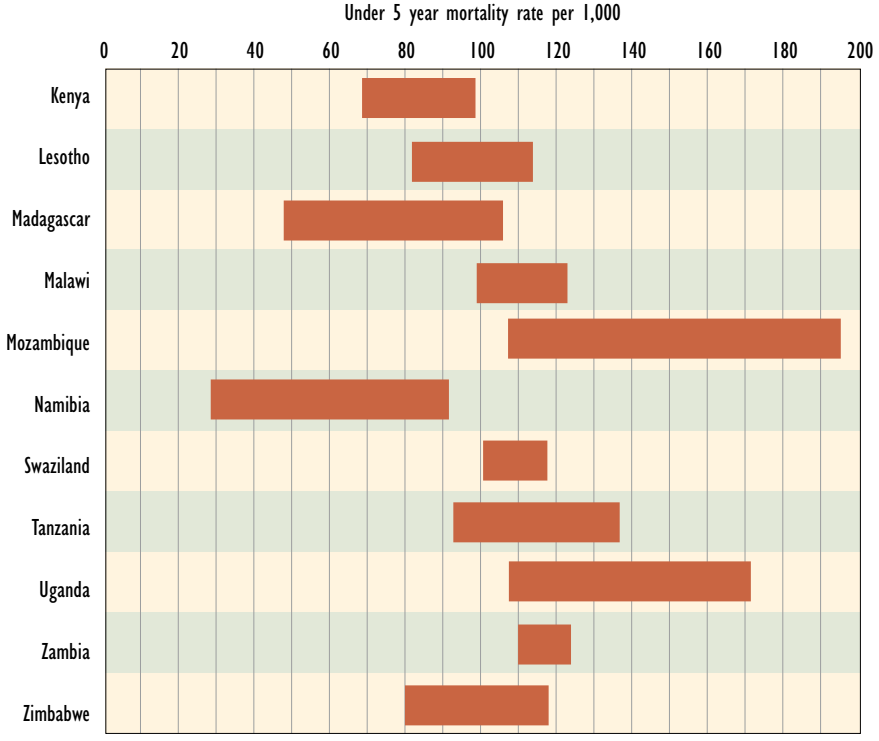
*© UNICEF Uganda*

## Figure 2.4: Millennium Development Goal 4: Child mortality in East and Southern Africa, 1990–2009




Source: WHO, 2011

## Figure 2.5: Wealth differentials in under five year mortality in East and Southern Africa, 2000s




The bar for each country shows the under five year mortality rate for the highest wealth quintile on the left to the lowest wealth quintile on the right and indicates the rich:poor range.

DHS data used for closest year as at http://www.statcompiler.com/; Data was not available for Angola, Botswana, DRC, Mauritius and South Africa.
Source: WHO, 2011

**Table 2.1: Under five year mortality by wealth, selected countries, East and Southern Africa, 1995-2009**

| Country | Under 5 year mortality * | | | Poorest to richest quintile under 5 mortality rate ratio | | | | DHS survey year | |
|---|---|---|---|---|---|---|---|---|---|
| | Year 1 | Year 2 | % change | Year 1 | Year 2 | Change | % change | Year 1 | Year 2 |
| Kenya | 112.7 | 83.7 | -34.65 | 1.64 | 1.41 | Decrease | 16.39 | 2003 | 2008-9 |
| Madagascar | 111.3 | 82.0 | -35.73 | 2.86 | 2.22 | Decrease | 28.57 | 2003-4 | 2008-9 |
| Malawi | 202.7 | 157.6 | -28.62 | 1.49 | 1.64 | Increase | -8.96 | 2000 | 2004 |
| Mozambique | 218.7 | 178.2 | -22.73 | 1.92 | 1.82 | Decrease | 5.77 | 1997 | 2003 |
| Namibia | 60.2 | 69.0 | 12.75 | 2.13 | 3.13 | Increase | -31.91 | 2000 | 2006-7 |
| Tanzania | 161.1 | 132.2 | -21.86 | 1.18 | 1.47 | Increase | -20.00 | 1999 | 2004-5 |
| Uganda | 156.8 | 143.9 | -8.96 | 1.82 | 1.33 | Decrease | 36.36 | 2000 | 2006 |
| Zambia | 167.9 | 136.8 | -22.73 | 2.08 | 1.12 | Decrease | 85.42 | 2001 | 2007 |
| Zimbabwe | 90.3 | 69.3 | -30.30 | 1.59 | 1.27 | Decrease | 25.40 | 1999 | 2005 |

*Using the under five mortality rates in the DHS survey database http://www.statcompiler.com

Within East and Southern African countries, the under five year mortality rate has improved at different rates for people with different levels of wealth. Using the wealth quintile as an indicator and data from repeated demographic and health surveys, Table 2.1 above shows that there have been improvements in child mortality in the past decade in almost all countries in the region, except Namibia. Yet for two countries, Malawi and Tanzania, the improvements were also associated with widening differences by wealth quintile, suggesting that higher-income groups had greater gains than lower-income groups.

Child mortality rates have recently improved in some countries and differences between social groups have been reduced. The Zambia *Equity Watch* report showed that child mortality and under five mortality fell between 2002 to 2007. In that period the differences between rural and urban under five mortality rates also closed to almost parity, due to reduced rural mortality. Zambia also has relatively low wealth inequalities in child mortality (Zambia CSO *et al*., 2003; 2009). While the factors would need to be further explored, the Zambia *Equity Watch* reports in the same period a reduction in rural-urban inequalities with regard to social determinants such as access to safe water, child nutrition and primary health care services, including immunisation. This may have contributed to the changes, despite a widening gap in poverty levels between rural and urban areas in the period (UNZA, MoH Zambia, TARSC, 2011). Zambia's experience points to the critical role primary health care plays in child survival in the early years of life.

*A reduction in both total child mortality and in social inequalities in child mortality is not a given and needs to be ensured. It appears that child survival in poorest and rural households can be levelled up by improving access to safe water, improved child nutrition and access to primary health care services.*

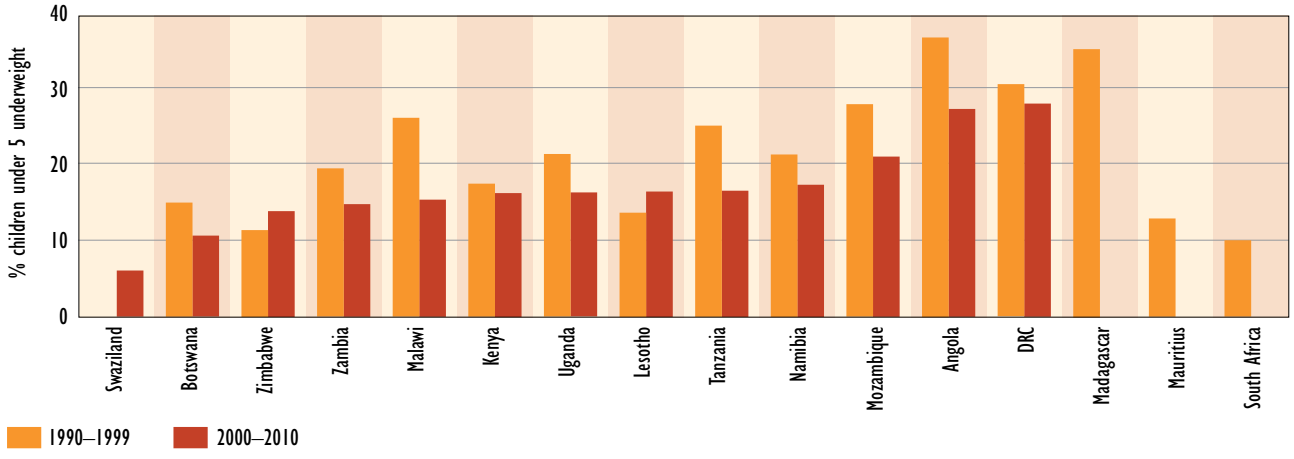
# Differentials in child nutrition as a litmus test of social (in)justice

There was little change in child under-nutrition levels between the 1990s and the early 2000s for most East and Southern African countries, although Angola, Malawi, Uganda and Tanzania showed some improvements from relatively high levels of under-nutrition (Statistical appendix table A2.4; Figure 2.6). For those East and Southern African countries that have had repeat demographic and health surveys before and after 2005, none showed marked changes in the level of underweight children. By 2009 about one in five children under five years were undernourished in the region, with lower levels reported in Botswana and Swaziland.

The aggregate information on nutrition tells only part of the story. As Table 2.2 on page 20 shows, there are extremely wide differences in nutrition by wealth in all East and Southern African countries. Child under-nutrition is three times more common in the poorest fifth of households than in the wealthiest in Kenya, Mozambique and Namibia, and about two times more common in poorest households in the other countries. Similarly wide differences are found by geographical region (see Figure 2.7 on page 21) and by education of mothers.

*Despite recent policy attention to nutrition and food security, levels of under-nutrition have shown limited gains since 2005 and extremely wide differences in nutrition by wealth persist in all East and Southern African countries. The interaction between social inequality in child under-nutrition may be two way – poor nutrition reflects social inequalities but, in its contribution to poor development of the child and poor health outcomes, also exacerbates social inequalities. Child nutrition may thus be one of the best indicators in the region for assessing the distributional performance of public policy and the distribution of the benefits of growth and social investments.*

**Figure 2.6: Millennium Development Goal 1: Children under five years underweight, East and Southern African countries, 1990–2010**




Source: WHO 2010; WHO 2011

## A way of measuring inequities in health needs, outcomes and resources

Table 2.2 below shows a number of indicators of inequity in the relationship between needs and health outcomes or resources used in this report. The *concentration index* summarises how a health-related variable is distributed in relation to a variable that measures socio-economic status. If the health variable is found more among the poorest households, the concentration index will be negative and vice versa. The index takes value from 0 to 1 (or -1) with 0 representing equality in the distribution of the health outcome across economic groups and 1 or -1 highest inequality in the distribution of the health outcome across economic groups. The rate ratio of poorest to richest quintile compares the level of the health outcome in the poorest 20 per cent of the population with the level in the richest 20 per cent. Selected assets are used to represent wealth in a manner that is relatively standard across countries. Other ratios compare health or health care outcomes in those with highest and lowest levels of mothers' education, between urban and rural households and between provinces or regions within countries.

*Kasipul, Kenya – local day schools are working with parents and partners to provide lunch for children*

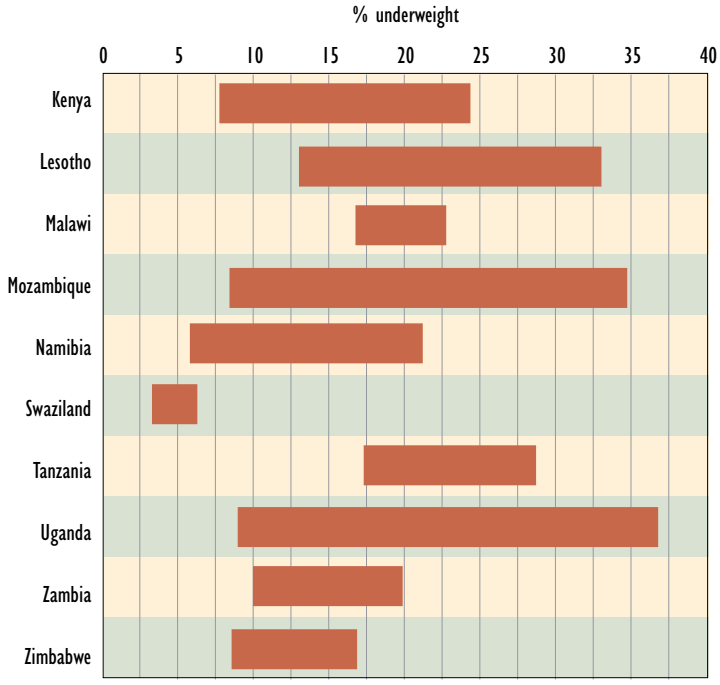
*© Samson Juma, March 2009*

**Table 2.2: Inequalities in nutrition outcomes in children with weight for age <2SD, selected countries, East and Southern Africa**

| Country | DHS survey year | Median level | Concentration index | Ratio*** poorest: richest quintile | Ratio *** highest : lowest region | Ratio*** highest: : lowest education |
|---|---|---|---|---|---|---|
| Kenya | 2009 | 16.20 | -0.203** | 2.86 | 3.10 | 3.70 |
| Lesotho | 2004 | 22.60 | -0.163 | 2.38 | 2.59 | 1.56 |
| Malawi | 2006 | 19.50 | -0.067 | 1.52 | 1.36 | 1.82 |
| Mozambique | 2003 | 21.05 | -0.162 | 3.45 | 4.33 | 2.56 |
| Namibia | 2007 | 14.20 | -0.167 | 3.13 | 3.37 | 5.88 |
| South Africa | 2003 | 16.45 | * | * | 3.63 | 1.47 |
| Swaziland | 2007 | 5.20 | -0.093 | 1.96 | 1.81 | 7.69 |
| Uganda | 2006 | 22.30 | -0.110 | 2.44 | 4.31 | 2.44 |
| Tanzania | 2005 | 23.00 | -0.101 | 2.04 | 1.66 | 2.00 |
| Zambia | 2007 | 14.65 | -0.056 | 1.47 | 2.02 | 2.94 |
| Zimbabwe | 2006 | 12.35 | -0.118 | 2.27 | 2.01 | 2.50 |

*= disaggregation by wealth not included in the survey ** = p<0.05 *** in terms of share <2SD weight for age
Source: most recent DHS and MICS surveys post 2000 (see reference list)

**Figure 2.7: Range: Highest-lowest region levels for children <2SD weight for age (underweight), East and Southern Africa, post-2000**




The bars show the lowest (on the left) to highest (on the right) percentage underweight across the regions within countries and indicates the geographical range.
Disaggregated data for Angola, Botswana, DRC, Madagascar, Mauritius not available.
DHS data used for closest year as at http://www.statcompiler.com/
Source: WHO, 2011 and most recent DHS and MICS surveys post 2000 (see reference list)

*© UNICEF, Zimbabwe*

*The patterns of under-nutrition and child mortality point to the need for a more comprehensive focus on the critical first three years of cognitive, physical, emotional and social development in children to improve health. We need to address factors within the household, such as mothers' education, as well as wider community and service determinants, such as living environments, primary health care services, early childhood education and care services, and public investments in food sovereignty.*

There are some reports of progress in closing social gaps in child nutrition. The 2011 Zambia *Equity Watch* reported, for example, that rural to urban differentials in stunting closed significantly up to 2007 due particularly to improvements in nutrition in rural areas. The gap between children of mothers with higher and lower levels of education was also narrowed between 2002 and 2007. The bases for the closing of these gaps need to be explored. Notably, 2007 was the same year that the budget allocation to agriculture in Zambia peaked at 8.8 per cent, higher than in many other countries of the region, with reports of increasing production of key crops, such as maize and groundnuts in recent years (UNZA *et al.*, 2011).

In later sections we discuss a number of the key determinants of early child development that may be important for this focus on the first three years of life as the road map in countries for meeting Millennium Development Goal 1 and Millennium Development Goal 4 would need to include measures to close differentials in access to all of these determinants.

# Massive global and regional differentials in maternal mortality

In Millennium Development Goal 5, countries committed themselves to reducing their maternal mortality ratios by three-quarters, achieving universal access to reproductive health and ensuring globally that 90 per cent of all births are assisted by skilled attendants. These commitments are to be fulfilled by 2015 (WHO, 2008).

However, there are real difficulties in tracking progress on these commitments. Many countries do not include maternal mortality in their household surveys and rely on less accurate facility estimates. Those that survey maternal mortality use different definitions and do not provide the disaggregations by wealth, region or other factors to identify those with highest health need.

*Global inequalities in maternal mortality rates are wide. In 1990, low income countries had 66 times the level of maternal mortality as high income countries, widening to 78 times by 2005, although WHO data suggest that it has since narrowed to 39 fold in 2008. More than half of maternal deaths globally occur in sub-Saharan Africa.This wide gap in survival between mothers in Africa and those in high income countries is a massive social injustice.*

There are similarly wide differentials within the region, although less pronounced than those that exist globally. In 1990, there was a 14-fold difference between maternal mortality ratio estimates in Mauritius (72/100,000 births) and Mozambique and Angola (1,000 /100,000 live births) (see Table 2.4). In the decade of the 2000s, the maternal mortality rate fell by an average of 11 per cent, short of the annual 5.5 per cent reduction needed to achieve the Millennium Development Goal targets but the difference between the highest and lowest country in the region widened to 22 fold, indicating uneven progress in the region.

**Table 2.3: Maternal mortality ratio by country income, 1990 and 2005**

| | Maternal mortality ratio per 100 000 births | | |
|---|---|---|---|
| Country income | 1990 | 2005 | % change |
| Low income | 790 | 780 | 1.27 |
| Lower middle income | 380 | 300 | 21.05 |
| Upper middle income | 98 | 97 | 1.02 |
| High income | 12 | 10 | 16.67 |
| Lowest : highest income rate ratio | 65.8 | 78.0 | -18.48 |

Source: World Bank, 2010

## Mozambique's success story in reducing maternal and infant mortality rates

One of the most consistent declines in maternal mortality has been in Mozambique. The Mozambique *Equity Watch* reported that the maternal mortality rate decreased from 692 in 1997 to 340 in 2008 (Govt of Moz, 2008b). This is attributed to the national plan and strategy for the reduction of maternal and newborn mortality instituted from the year 2000 which meant better diagnosis and treatment of obstetric complications and greater access to quality health services, including in antenatal consultations and family planning (Govt of Moz, 2008b). The health sector has launched a national logbook and expanded the integrated care strategy for child diseases (AIDI) for the newborn within the first week of life.

A presidential initiative to support infant, newborn and maternal health was launched and a strategic plan on infant and newborn health was developed (PESNI, 2008–2012). Health staff in general have had updated training and mother-and-child health nurses, medical and surgical technical staff and doctors in particular, have been trained to assist in childbirth and emergency obstetric care. As a result, the proportion of births taking place in health units with qualified staff rose from 44 per cent in 1997 to 48 per cent in 2003 and 55 per cent by 2009 (INE, 1997, 2003, 2009).

There are gaps to address between social groups – deliveries at a health facility were 2.3 times more likely among mothers from the highest wealth quintiles than those from the lowest wealth quintiles and 2.1 times more likely in mothers with secondary or higher education than those with no education (Govt of Moz,UNICEF, 2010).

*Trained staff addressing patients at a clinic in Mozambique*

*© UNICEF Mozambique/G. Pirozzi*

**Table 2.4: Maternal mortality ratio, East and Southern Africa, 1990–2008**

| | Maternal mortality ratio (per 100 000 live births) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1990 | | 2000 | | 2008 | | % change 1990-2000 | % change 2000-2008 |
| Angola | 1000 | [410–2500] | 880 | [390–2000] | 610 | [270–1400] | -12 | -31 |
| Botswana | 83 | [30–230] | 310 | [120–610] | 190 | [84–380] | 273 | -39 |
| DRC | 900 | [470–1600] | 850 | [450–1600] | 670 | [340–1300] | -6 | -21 |
| Kenya | 380 | [220–650] | 560 | [340–850] | 530 | [320–850] | 47 | -5 |
| Lesotho | 370 | [210–640] | 470 | [280–710] | 530 | [260–850] | 27 | 13 |
| Madagascar | 710 | [440–1100] | 580 | [360–920] | 440 | [270–700] | -18 | -24 |
| Malawi | 910 | [530–1500] | 770 | [470–1200] | 510 | [300–760] | -15 | -34 |
| Mauritius | 72 | [62–84] | 28 | [24–32] | 36 | [30–41] | -61 | 29 |
| Mozambique | 1000 | [540–1900] | 780 | [430–1400] | 550 | [310–870] | -22 | -29 |
| Namibia | 180 | [99–320] | 220 | [120–320] | 180 | [93–270] | 22 | -18 |
| South Africa | 230 | [130–390] | 380 | [240–600] | 410 | [240–610] | 65 | 8 |
| Swaziland | 260 | [68–700] | 340 | [180–650] | 420 | [180–800] | 31 | 24 |
| Uganda | 670 | [360–1100] | 640 | [360–940] | 430 | [240–670] | -4 | -33 |
| Tanzania | 880 | [500–1500] | 920 | [550–1500] | 790 | [470–1300] | 5 | -14 |
| Zambia | 390 | [170–740] | 600 | [320–850] | 470 | [250–680] | 54 | -22 |
| Zimbabwe | 390 | [190–740] | 670 | [340–1000] | 790 | [410–1200] | 72 | 18 |
| African region | 850 | [590–1300] | 780 | [570–1150] | 620 | [460–910] | -8 | -21 |
| Income group | | | | | | | | |
| Low income | 850 | [590–1300] | 740 | [530–1090] | 580 | [420–840] | -13 | -22 |
| High Income | 15 | [14–19] | 13 | [11–15] | 15 | [14–18] | -13 | 15 |
| Global | 400 | [290–590] | 340 | [260–490] | 260 | [200–380] | -15 | -24 |

Trends in maternal mortality: 1990 to 2008. Estimates developed by WHO, UNICEF, UNFPA and the World Bank, Geneva, WHO, 2010 (http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf).
Wide ranges in the data shown in the table make comparisons difficult and some anomalously large changes (for example, for Botswana 1990–2000, may be related to measurement issues).
Source: WHO, 2011

*The 39-fold differences globally and 22-fold differences in maternal mortality rates between countries in the region indicate that it is also essential for countries to collect evidence on social differences in maternal mortality rates within countries to better plan, target and monitor maternal health.*

Standardised indicators need to be collected on maternal health, including on maternal mortality, and adolescent fertility. Indicators are needed to track and measure the availability of maternal and reproductive health care and the access, uptake and effective coverage of these services. This is particularly important given the role identified for the three delays – in making the decision to seek care, in reaching a facility and in receiving adequate and appropriate care. The relationship between maternal mortality and access to maternal health services is discussed further later.

# Advancing universal access and equity in HIV prevention and care

As noted earlier, while AIDS had the greatest impact on mortality across almost all of the countries of the region in the late 1990s, increases in mortality in the past decade have been more associated with social determinants of health. These include food insecurity; poor access to safe water, sanitation, energy, transport and shelter; high burdens of communicable and non-communicable diseases; and illness and mortality related to reproductive roles (SADC, 2003; WHO Afro, 2006). In terms of underlying diseases, mortality in the region is primarily attributed to communicable diseases, with 80 per cent of years of life lost attributed to these causes, 13 per cent to non-communicable diseases and 7 per cent to injuries. Amongst children, 29 per cent of mortality is attributed to neonatal causes, 20 per cent to diarrhoea, 18 per cent to pneumonia, 16 per cent to malaria and 4.3 per cent to AIDS (Black *et al.*, 2010).

AIDS, tuberculosis (TB) and malaria have had a high profile since the 1990s. Tuberculosis was declared an emergency in 2005 in Africa, with the annual number of new cases more than quadrupling in most African countries, and multi-drug resistant tuberculosis in Southern Africa dramatically increasing treatment costs and duration. Tuberculosis is projected to deprive the world's poorest countries of an estimated US$1 to $3 trillion over the next 10 years and loss of productivity attributable to tuberculosis is projected to lead to GDP losses as high as 7 per cent (WHO cited in AU, 2010). Malaria, one of the major causes of under-five mortality (20 per cent) is estimated to cost Africa more than US$12 billion every year in lost GDP, although the disease could be controlled for a fraction of this amount (AU, 2010). While there has been a more common focus on sexual and reproductive health aspects of women's health, it would also be important to identify and address gender inequalities in these major communicable diseases and their burdens.


*'Displaying my message', Matthew Goniwe Clinic, Khayalitsha, Cape Town*

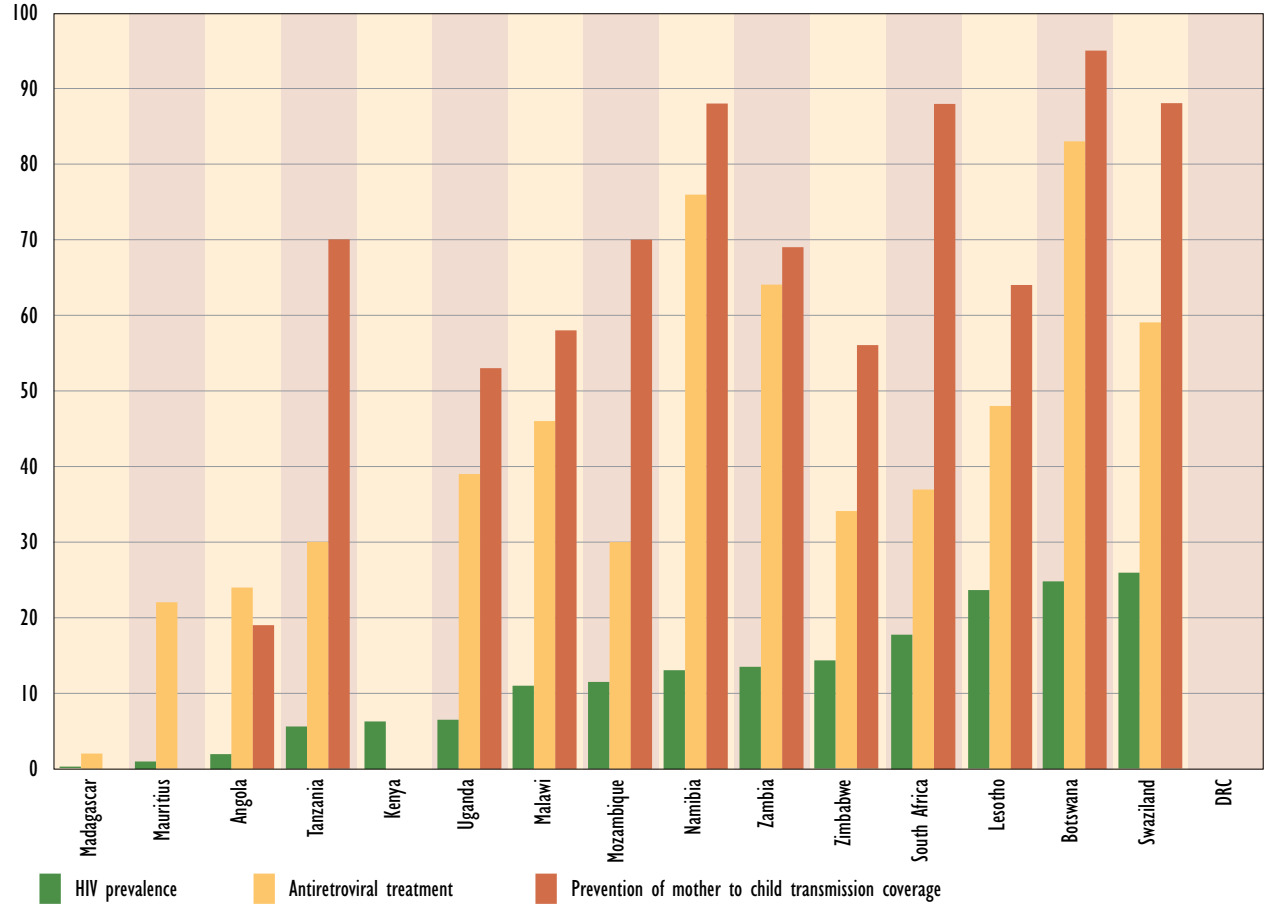
*© Dorette Baatjies, March 2009*

HIV and AIDS statistics for East and Southern Africa have been staggering throughout the decade. However, by 2009, HIV prevalence had fallen in all countries. East African countries had lower HIV rates than southern African countries and AIDS-related mortality was still high in the latter, including in children under five years (Statistical appendix table A2.5; Figure 2.8).

AIDS has had differential effects on different socio-economic groups. Urban people have generally been more affected than rural, although this gap is closing. The HIV prevalence in young women aged 15-24 years is more than twice that of their male counterparts throughout the region (SADC, 2003b). Not all countries in the region disaggregate adult HIV prevalence by wealth, region or education but for those that do, the evidence suggests that adult HIV prevalence is higher in wealthier, more educated and urban groups, although the differentials are not large, except for in Zambia (Table 2.5). Geographical differentials are greater than wealth differentials.

Analyses of demographic and health survey data (not limited to Africa) have found that the positive association between wealth status and HIV is stronger for women, and is considerably diminished when other factors are taken into account, including underlying factors (education, urban/rural residence and community wealth) and mediating proximate factors (sexual risk taking, condom use and male circumcision). Much of the positive association between wealth and HIV is thus due to these underlying or mediating factors. Yet even after accounting for these various factors, in most countries, wealthier adults remain at least as likely as the poorer to be HIV-infected, if not more likely. This may be due to wealthier groups having urban residence where HIV is more prevalent, longer lives with HIV due to better nutritional status and uptake of services, and greater mobility (Mishra *et al.*, 2007).

**Figure 2.8: HIV prevalence and coverage of antiretroviral therapy and prevention of mother to child transmission services, East and Southern Africa, 2009**




Data for DRC not available
Source: WHO, 2011

**Table 2.5: Summary information, adult HIV prevalence, selected countries, East and Southern Africa, post-2005**

| Country | Year of DHS and MICs | Median level survey | Concentration Index | Ratio richest : poorest quintile | Ratio highest : lowest region | Ratio highest : lowest education |
|---|---|---|---|---|---|---|
| Kenya | 2008 | 7.40 | 0.063 | 1.57 | 15.44 | 0.89 |
| Lesotho | 2005 | 23.70 | 0.033 | 1.27 | 1.68 | 0.88 |
| Malawi | 2007 | 12.05 | 0.145 | 1.98 | 2.71 | 1.11 |
| Swaziland | 2004 | 26.00 | -0.007 | 0.95 | 1.25 | 0.83 |
| Tanzania | 2005 | 7.25 | 0.112 | 1.90 | 3.53 | 0.82 |
| Zambia | 2007 | 12.15 | 0.169* | 2.28 | 2.57 | 1.93 |
| Zimbabwe | 2009 | 17.95 | 0.005 | 0.98 | 1.38 | 0.68 |

*=p<0.05

Source: Countries for which information is available from WHO, 2011, Zimstat, UNICEF, 2009 and DHS survey data at http://www.statcompiler.com/

Access to antiretroviral therapy (ART) has greatly expanded in the region. As Figure 2.8 indicates, however, antiretroviral therapy coverage and prevention of vertical transmission (PMTCT) do not necessarily correlate with HIV prevalence. There is also no clear inverse relationship between AIDS mortality and antiretroviral therapy coverage, as shown in Statistical appendix table A2.5. Antiretroviral therapy coverage rates in Zimbabwe, Zambia and Lesotho are lower than the burden of their epidemics would appear to demand.

*While social differentials are low in HIV prevalence, the distribution of prevention and treatment interventions follows the more typical social differentials in the region, with lower coverage levels among rural, poorer people with lower education levels. Inverse care and inequity in access to prevention and treatment resources relative to need may lead to a future concentration of risk in disadvantaged communities, making equity a necessary feature of programmes aimed at universal access to prevention treatment and care in East and Southern African countries.*

*A mothers2mothers clinic in Swaziland*

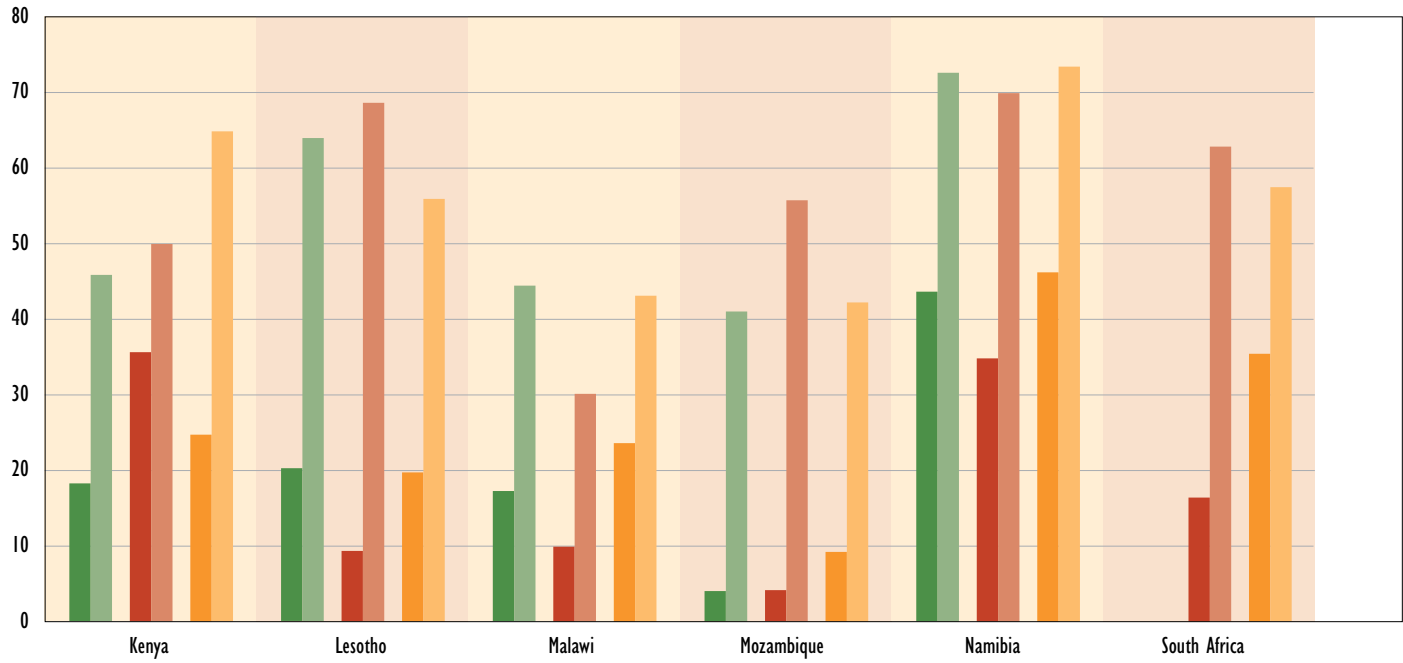
*© Nick Edwards, mothers2mothers*

*The inverse care law* was first described by Julian Tudor Hart in 1971. It states that the availability of health care tends to vary inversely with the need for it in the population served. It describes the inequity that those who need healthcare least use the services more, and more effectively, than those with the greatest need. This can be seen in both health promotion and the treatment of illness and disease.

Figure 2.9 shows, for example, the differences in condom use by wealth, residence and mothers' education. Similar differences are found in other services, such as prior HIV testing. Across many countries, HIV prevention interventions appear to have wider levels of inequality than uptake and coverage of those for malaria treatment and acute respiratory infection. This is a cause for concern, given the significant resources applied to HIV. In the country-specific *Equity Watch* reports, differentials in access were found to be wider where services were not provided to primary care level. In Kenya, for example, despite the rapid expansion of services and the significant growth in service coverage in rural areas, wealthier, urban groups continue to have higher coverage of HIV testing, the entry point for other services. They also have better knowledge of these services (NASCOP, 2011). Social inequalities in access to HIV prevention and antiretroviral therapy access could lead to future new cases being concentrated in lower income rural groups with lower education levels, as for other 'diseases of poverty'. Countries would need to track and ensure equity in access to antiretroviral therapy (at least by region, gender and age) to avoid this.

There are some indications of measures that enhance equity in service uptake and delivery. In Kenya, for example, the proportion of pregnant women tested for HIV during antenatal care visits increased substantially from 59.3 per cent in 2006 to 78.6 per cent in 2007, when HIV services were integrated into local antenatal care clinics (KNBS and ICF Macro, 2010). A systematic review of literature found that in most East and Southern African countries proportionally more females than males were on antiretroviral therapy, attributed to women's access to HIV tests and treatment through antenatal care (Muula *et al.*, 2007).

**Figure 2.9: Range: Highest-lowest wealth, education and region for condom use at last high risk sex, East and Southern Africa, post-2000**

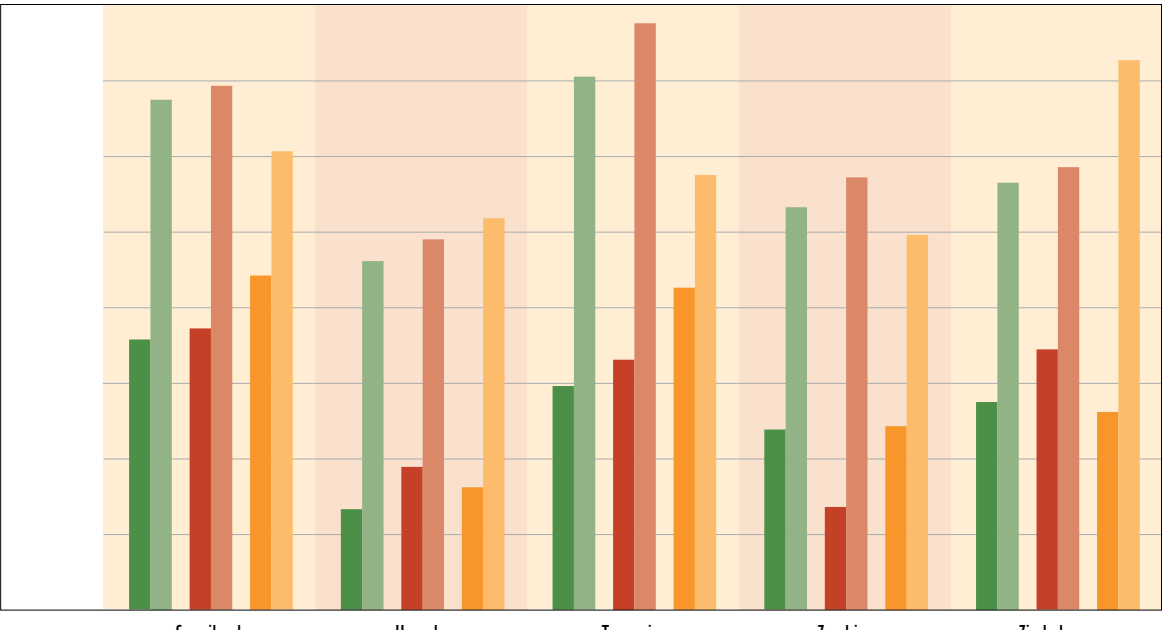



Source: DHS and MICS survey

*Social differentials in access to interventions for HIV and AIDS appear to be more likely to be reduced when coverage is scaled up by integrating with services close to communities and particularly with primary care level services. This also links HIV responses to promoting more comprehensive health management in people living with HIV and AIDS, including a focus on nutrition and management of other diseases. While social barriers to uptake persist and need to be addressed, these barriers become more pronounced when services are distant, costly and time consuming to reach.*

*© Nick Edwards, mothers2mothers*

*A mothers2mothers trainer explaining how to use a female condom in South Africa*




The bars for each country shows the percentage of condom use according to the following criteria:

Quintile
- lowest
- highest

Education
- no/lowest
- highest

Province
- lowest
- highest

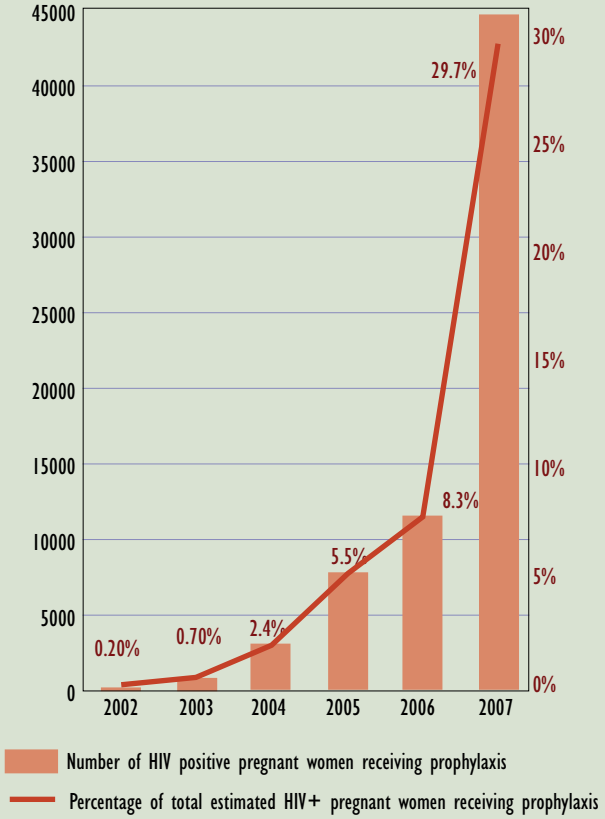
## Prevention of vertical HIV transmission in Mozambique

Mozambique has made significant strides in expanding prevention of mother to child transmission coverage at health centre level. In 2006 there were significant geographic disparities in the proportion of women who received HIV counselling as part of their antenatal consultation. This varied from only 28 per cent in Zambézia province to 94 per cent in Maputo City. Roll out of antiretroviral therapy treatment and care expanded thereafter to primary care level, closer to communities.

In 2007, adult antiretroviral coverage rose to 30 per cent and treatment of pregnant women rose to 29.7 per cent, above the regional average of 24 per cent. In 2008, out of 738,793 women attending antenatal care, 63 per cent were tested for HIV and 54,749 received antiretroviral therapy at 504 prevention sites across the country.

The 2004-2008 national strategic plan to combat sexually transmitted infections, HIV and AIDS integrates all the components of care, making counselling, voluntary testing, laboratory examinations, antiretroviral therapy and treatment for opportunist infection fully subsidised by the state for the network of people living with HIV and AIDS. The number of health centre units integrating prevention of mother to child transmission services rose significantly from 286 in 2007 to 504 in 2008 and 800 in 2009 (Mozambique MoH, TARSC/EQUINET, 2010).

### Pregnant women receiving antiretovirals, Mozambique, 2002-2007



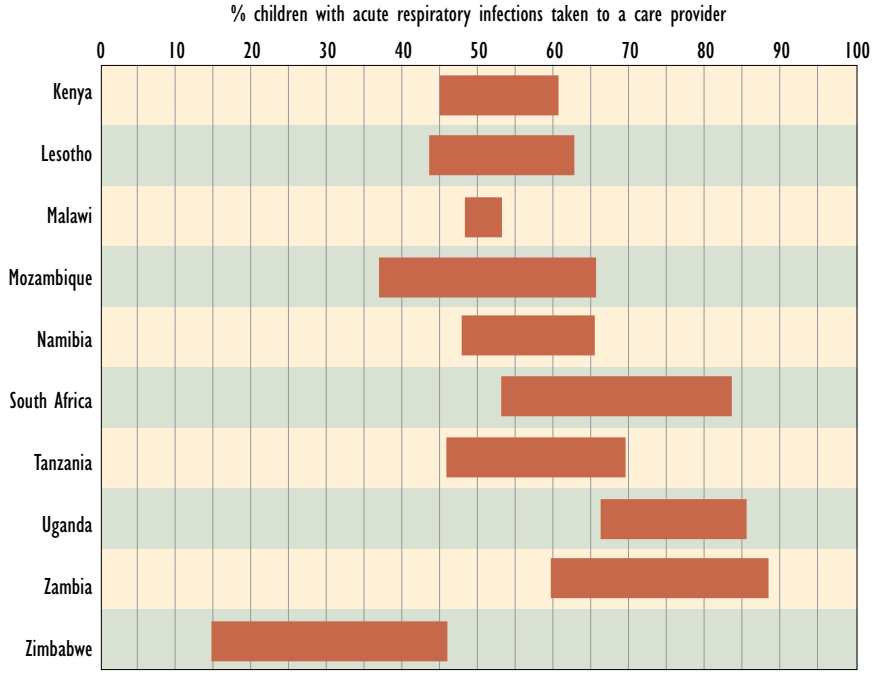

Source: MISAU/PMTCT programme, 2007

*Village women learning how to protect their family's health in Mozambique*

*© USAID*

Differentials in use of health facilities for acute respiratory infections are lower than for HIV interventions in East and Southern African countries (see, for example, Figure 2.10), as are those for the share of children under five years sleeping under an insecticide-treated net and the share of children with fever treated for malaria. Where coverage rates for these interventions were low, the differentials were wider. As shown in Table 2.6, there has been both an increase in children with acute respiratory infections taken to health services in most countries in the region over the past 15 years, as well as a reduction in social differentials in coverage (for example, by wealth). In Madagascar and Zimbabwe, the only two countries where wealth differentials grew, uptake of services for acute respiratory infections also fell.

**Figure 2.10: Range of highest to lowest region levels for children with acute respiratory infections or suspected pneumonia taken to health provider, East and Southern Africa, post-2000**




The bar for each country shows the percentage of children with acute respiratory infections taken to a care provider for the region, showing the lowest levels on the left to the highest levels on the right indicating the range across regions within the country.

Data is missing for countries not included.
Source: DHS data used for closest year as at http://www.statcompiler.com/

**Table 2.6: Share of children with acute respiratory infections or suspected pneumonia taken to a health care provider, by wealth, selected countries, East and Southern Africa**

| | % children with ARI taken to a health provider | | | Richest to poorest quintile children with ARI taken to a health provider rate ratio | | | | DHS survey year | |
|---|---|---|---|---|---|---|---|---|---|
| Country | Year 1 | Year 2 | % change | Year 1 | Year 2 | Change | % change | Year 1 | Year 2 |
| Kenya | 53.0 | 57.3 | 7.50 | 1.41 | 0.98 | Decrease | 30.50 | 2003 | 2008-9 |
| Madagascar | 54.4 | 47.0 | -15.74 | 1.45 | 1.84 | Increase | -26.90 | 2003-4 | 2008-9 |
| Malawi | 27.6 | 36.6 | 24.59 | 1.94 | 1.44 | Decrease | 25.77 | 2000 | 2004 |
| Mozambique | 38.5 | 57.7 | 33.28 | 2.66 | 1.53 | Decrease | 42.48 | 1997 | 2003 |
| Namibia | 54.3 | 71.7 | 24.27 | 1.45 | 1.36 | Decrease | 6.21 | 2000 | 2006-7 |
| Zimbabwe | 51.8 | 24.8 | -108.87 | 1.06 | 3.72 | Increase | -250.94 | 1999 | 2005 |

ARI = acute respiratory infection
Source: DHS and MICS survey data used for closest year post 2000 as at http://www.statcompiler.com/

# Closing gaps in non-communicable diseases

Non-communicable diseases are a further rising problem. African countries face a double burden of communicable and non-communicable disease. Communicable diseases remain the major contributor to mortality in Africa and interact with non-communicable diseases. For example, patients with HIV have a higher prevalence of insulin resistance, diabetes, cancer and cardiovascular diseases (Amuyunzu-Nyamongo, 2011). While the prevalence of non-communicable diseases will increase globally by 17 per cent in the next ten years, in the African region it is projected to increase by 27 per cent. Already burdens are high, with surveys showing, for example, a prevalence level of between 30 and 60 per cent for hypertension in West and Southern Africa (Amuyunzu-Nyamongo, 2011). The lifestyle determinants of non-communicable diseases arise within the economic and social conditions in African countries and include aggressive trade and marketing of unhealthy products, rapid unplanned urbanisation, unhealthy transport systems, insecure jobs, and so on (WHO, 2010f).

While there has been awareness of the growing importance of non-communicable diseases, more analysis needs to be carried out on their distribution to guide effective responses. Equity concerns arise across a number of dimensions of these diseases:

- Population-based evidence on non-communicable diseases has been limited so the distribution patterns in the population are not known and responses are not necessarily reaching those with highest health need.
- Hospital-centred care for non-communicable diseases is expensive and ineffective with patients presenting late with complications. This denies them the benefits of early intervention and raises financial burdens for households and the health sector, especially when the medicines and diagnostics to manage these diseases are not available at primary care level (AFENET, 2010; KEI *et al.*, 2011). At a meeting in Kampala in 2009, the International Alliance of Patients' Organisations also raised the need for better interaction between health professionals and patients and suggested that people with non-communicable diseases need to be more involved in shaping service practices (IAPO, 2009).
- Relying on health sector and behavioural responses and not giving adequate attention to the risks posed by environments and the wider cross-sectoral policies that affect them, places heavy burdens on poor households. African ministers of heath have noted that while 'globalisation, trade and urbanisation' are important for human development, they are also major external drivers of health problems and widening health inequities (WHO AFRO, 2011b).

*Future equity analyses should assess where the burdens of non-communicable diseases are greatest. Focusing on lifestyles and curative services, often delayed in uptake, may leave poor households less protected, and widen social differentials in the consequences of these diseases. Primary health care approaches and actions by health and other sectors on the 'causes of the causes' have been found to improve equity in health outcomes for communicable diseases and it is important to draw on this learning in strategies for managing non-communicable diseases.*

# Eliminating differentials in maternal and child health services

If inequalities in wealth and social conditions underlie inequalities in health, with consequences for the length and quality of life for different social groups, then health care availability, accessibility and use should reflect the resulting health care needs. Earlier discussions on HIV services suggested that health care services do not always reach those with greatest need but they are more likely to if comprehensive services are provided close to communities and barriers to uptake are overcome. Given the high levels of child and maternal mortality, achieving vertical equity means ensuring higher coverage levels for those in the lowest wealth quintiles, for mothers with least education and in regions where mortality rates are highest.

The coverage of services for acute respiratory infections, malaria treatment and antiretroviral therapy were discussed earlier as elements of child health care. Immunisation is a further key area for child health and immunisation coverage has risen in most countries in the region since 1990 (Statistical appendix table A2.6). Hepatitis B vaccine was introduced in 2009 and has rapidly scaled up to above 70 per cent coverage in most countries, indicating the value of immunisation as a technology for universal health coverage. The evidence from recent household survey reports indicates that coverage rates for measles immunisation, for example, are generally above 75 per cent and inequalities in immunisation coverage, as a key dimension of primary health care, are much lower than those for child and infant mortality, across all stratifiers (see Table 2.7).

**Table 2.7: Measles immunisation rates 12–23 years, East and Southern Africa, post-2000**

| | Median for for regions | Concentration index | Ratio richest : poorest | Ratio urban : rural | Ratio high : low region | Ratio high : low education |
|---|---|---|---|---|---|---|
| Botswana | 91.9 | * | * | * | 1.14 | * |
| Kenya | 83.5 | 0.044 | 1.24 | 1.08 | 1.15 | 1.17 |
| Lesotho | 82.2 | 0.002 | 1.03 | 1.09 | 1.28 | 1.15 |
| Madagascar | 63.3 | 0.115 ** | 1.76 | 0.82 | 2.15 | 1.84 |
| Malawi | 84.4 | 0.008 | 1.06 | 1.03 | 1.09 | 1.19 |
| Mozambique | 74.4 | 0.098 ** | 1.59 | 1.28 | 1.87 | 1.51 |
| Namibia | 79.3 | -0.045 | 1.36 | 1.05 | 1.60 | 1.61 |
| South Africa | 64.5 | * | * | 0.87 | 1.67 | 0.92 |
| Swaziland | 92.9 | 0.012 | 1.04 | 1.05 | 1.06 | 1.02 |
| Uganda | 72.4 | 0.023 | 1.10 | 1.14 | 1.42 | 1.27 |
| Tanzania | 77.7 | 0.063 | 1.39 | 1.15 | 1.45 | 1.39 |
| Zambia | 82.1 | 0.010 | 1.07 | 1.10 | 1.31 | 1.21 |
| Zimbabwe | 79.3 | 0.055 | 1.30 | 1.15 | 1.36 | 1.45 |

No data available for Angola, DRC and Mauritius. *=missing data **p<0.05

Source: DHS and MICS surveys post-2000

Some countries (Mozambique, Madagascar) show poorer coverage and significant inequalities by wealth. The Mozambique *Equity Watch* highlights some of the supply and uptake reasons for this in that country. In the early 2000s, the constraints were reported in both supply and uptake. Only 75 per cent of facilities offering child immunisations had all vaccines in stock in a 2003 survey (Lindelöw *et al.*, 2004). The report also notes that while non-state actors are involved in supporting uptake, this needs to be widened and intensified to address the demand side barriers to immunisation (MoH Moz, TARSC/EQUINET, 2010).

Generally in countries in the region, while wealthier, urban and more educated groups have marginally higher levels of immunisation coverage, differences across area, wealth or education are

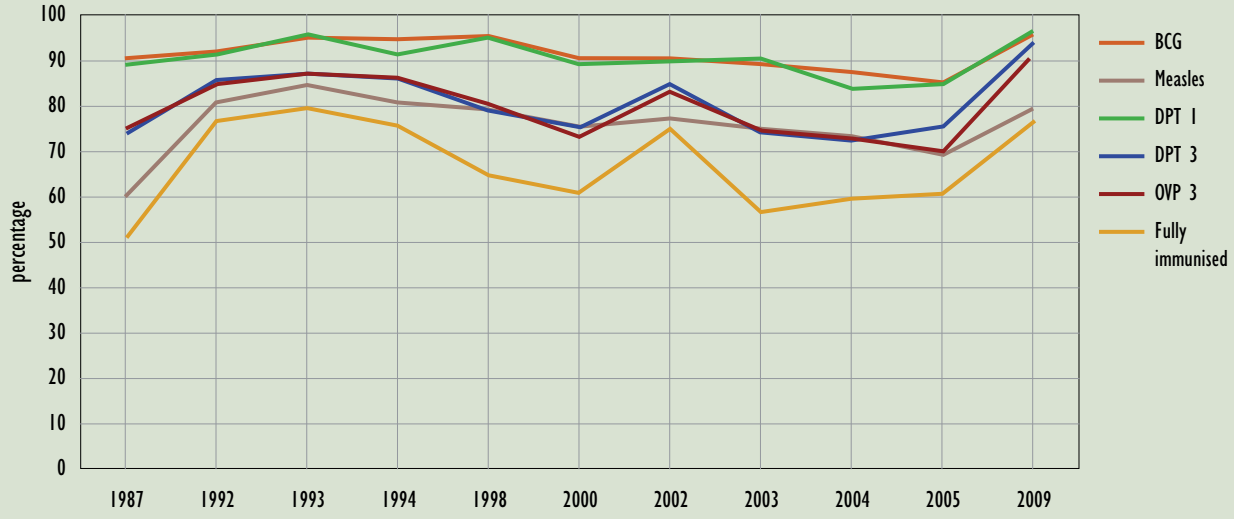
## Kenya's progress in immunisation coverage

Kenya has made recent improvements to its immunisation coverage and, by 2009, immunisation coverage rates had improved overall and for all vaccines. The low level of 59 per cent of children fully immunised in 2003 had risen to 77 per cent by 2009 (see the graph below).

While rural to urban and wealth differentials narrowed during the period of the increase, wide regional variations in coverage persist. Full immunisation in 12–23 month olds ranged from 86 per cent in Central province in 2009 to 48 per cent in North Eastern province (KNBS and ICF Macro, 2010). North Eastern province is arid with pastoralists who migrate across provinces in search of pasture, undermining outreach and coverage of interventions. This suggests the need for a specific approach to improve coverage among these groups (KEMRI *et al.*, 2011).

*© UNICEF Kenya/2011/Modola*

### Trends in percentage of children fully immunised, Kenya, 1987–2009




Sources: NCPD et al., 1994, 1999; CBS, 2003; CBS, MoH et al., 2004; KNBS, ICF Macro, 2010

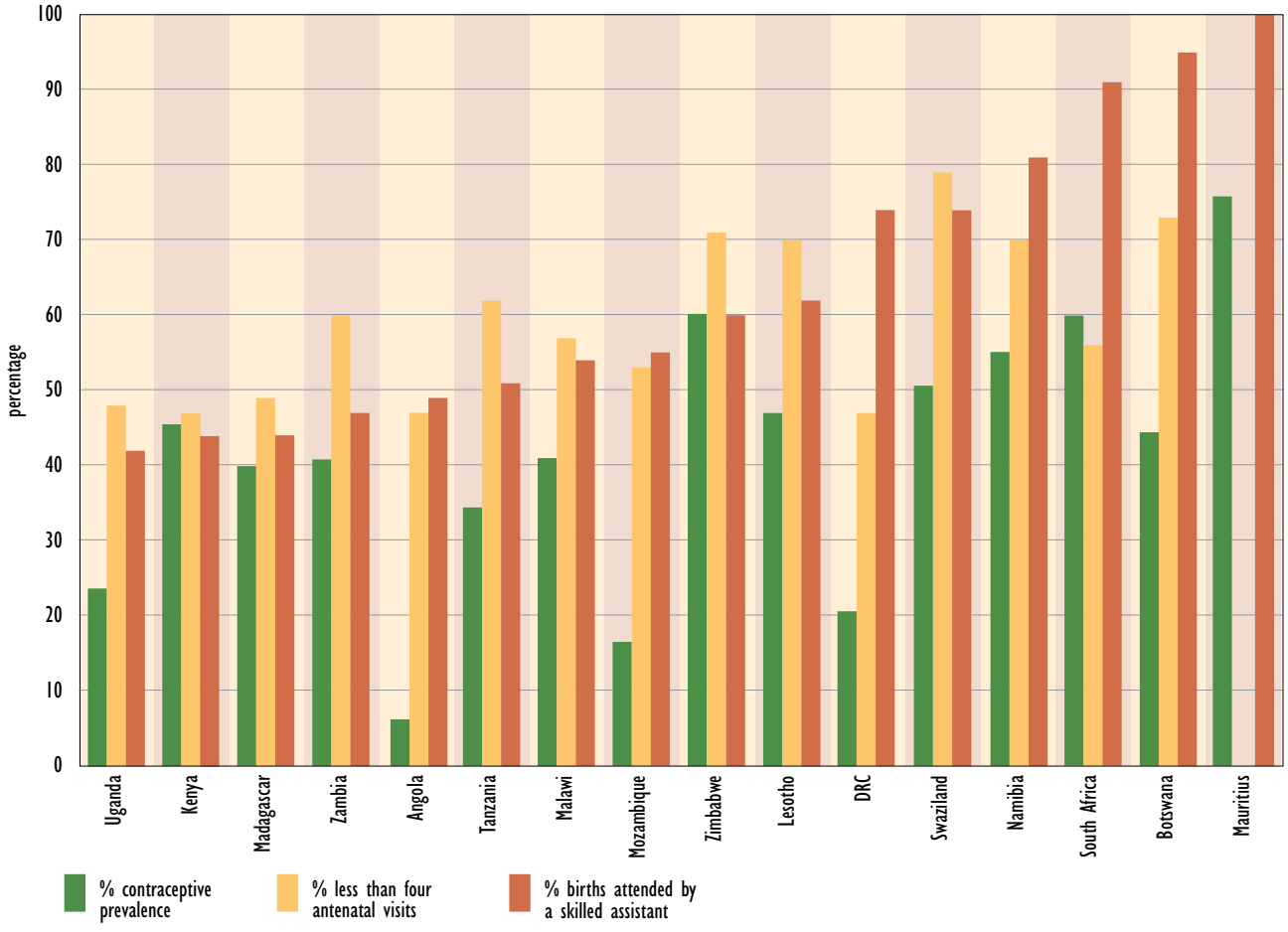
low or insignificant. South Africa shows evidence of both rural and less-educated groups having even higher immunisation coverage than their urban, educated counterparts.

Maternal health services intervene along a pathway of reproductive health choices and conditions, across which both risk and coverage may accumulate. The 'choice' to become pregnant is both socially determined, including by gender and cultural norms, and dependent on available, accessible and acceptable services. Women in countries and communities where coverage rates are higher have significantly greater possibilities of exercising reproductive choice and having positive outcomes than in those countries and communities with low coverage rates.

*Women in East and Southern African countries with poorest outcomes are at a disadvantage since there are 70 per cent point or ten-fold differences in contraceptive prevalence across countries in the region and two-fold differences in coverage of at least four antenatal care visits and in assisted deliveries (Statistical appendix table A2.7). Of particular concern for equity, as Figure 2.11 shows, is that many of the countries with high maternal mortality (for example, Angola, DRC, Mozambique, Tanzania and Zimbabwe) also have lower reproductive health services coverage.*

The social differentials in coverage of the reproductive and maternal health services shown below are much wider than those noted earlier for immunisation. One analysis of 2008 data from African countries found that, in 26 countries, within-country wealth-related inequality accounted for more

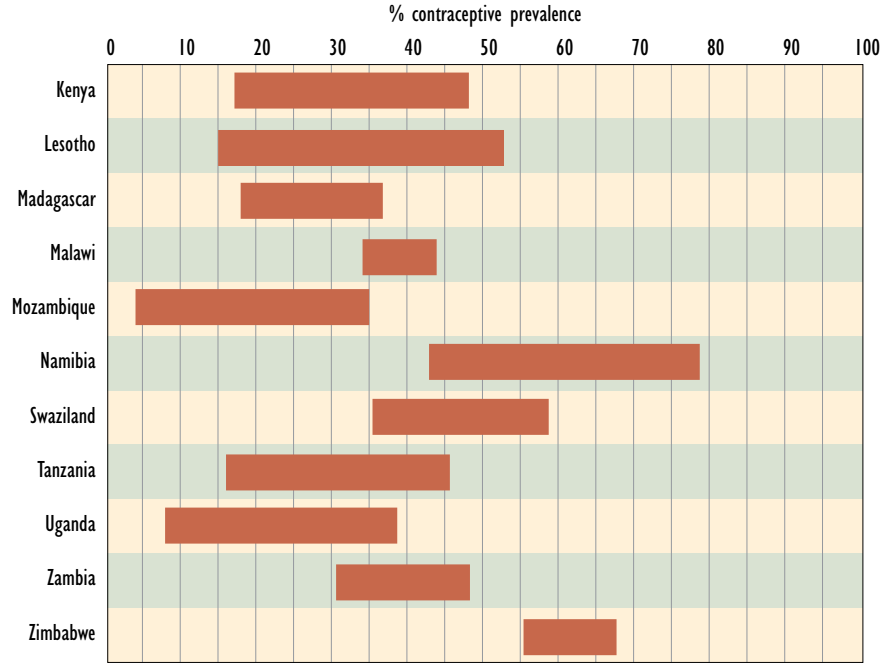
**Figure 2.11: Millennium Development Goal 5: Reproductive health coverage, East and Southern Africa, 2000–2010**




Source: WHO, 2011

than a quarter of the national overall coverage gap in maternal health services (Hosseinpour *et al.*, 2011). Demographic and health surveys indicate wide wealth, social and geographical inequalities in contraceptive prevalence and in unmet need for family planning (see Figures 2.12a and 2.12b) and similar differences are found for mothers' education and region of residence.

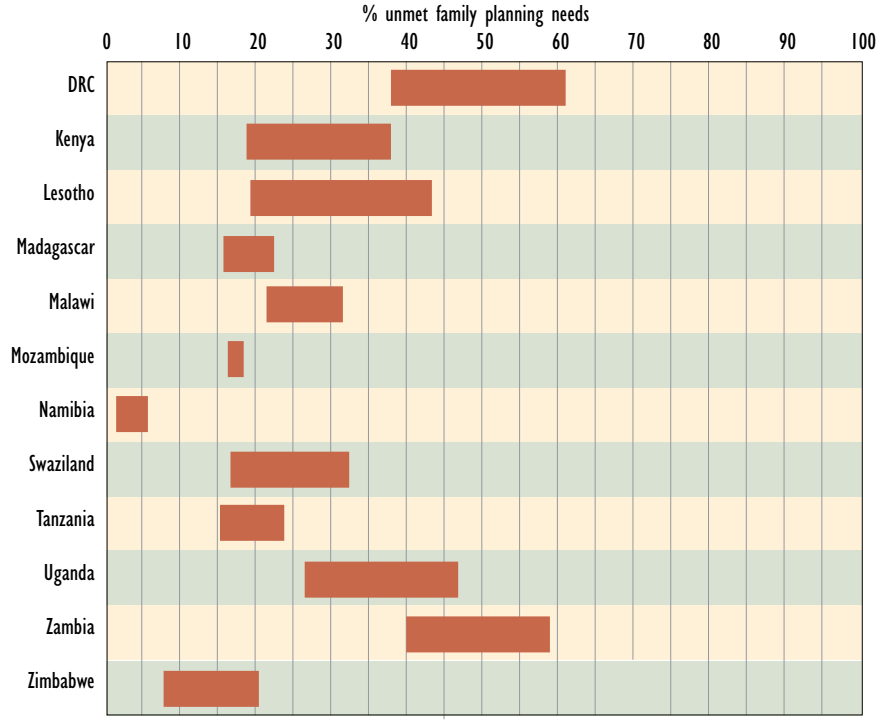
**Figure 2.12a: Wealth differentials in contraceptive prevalence (highest and lowest quintiles), East and Southern Africa, post-2000**




The bar in Figure 2.13a for each country shows the contraceptive prevalence for the lowest wealth quntile on the left to the highest on the right and indicates the rich to poor range.

Source: DHS and MICS surveys post 2000 (see reference list)

**Figure 2.12b: Wealth differentials in unmet need for family planning (highest and lowest quintiles), East and Southern Africa, post-2000**




The bar in Figure 2.13b shows unmet need for the highest wealth quintile on the left to the lowest on the right.

Source: DHS and MICS surveys post-2000 (see reference list)

Improving overall coverage rates is important to address these gaps. Creanga *et al.* (2011) found that wealth-related inequalities in the reported met need for contraception declined most sharply in Namibia and Mozambique where contraceptive coverage increased significantly. However, with extremely low levels of contraceptive prevalence in the poorest groups (below 20 per cent in six countries), enhancing access and uptake may necessitate further specific measures beyond those to simply improve availability.

The measures needed may range from legal to social or to institutional interventions. It is estimated, for example, that 90 per cent of deaths from unsafe abortions and 20 per cent of obstetric mortality could be averted by universal access to modern family planning methods (MacPhearson *et al.*, 2012). Where barriers to access arise in gender and social norms, it is important to see how far laws and policies challenge these norms and widen options for accessing reproductive health services. Table 2.8 shows, for example, the range of legal prescriptions governing abortion in East and Southern African countries. The provisions range from more liberal prescriptions in South Africa, Namibia, Zambia and Botswana to more restrictive rules in DRC, Lesotho, Madagascar, Malawi and Mauritius.

This affects the distribution of abortion-related complications, given the high frequency of unsafe illegal abortions in countries with restrictive abortion laws (WHO, 2003). As contrasting evidence, the Choice on Termination Act in South Africa allows abortion on request up to the first trimester, permits midwives to conduct abortions and allows adolescent girls the right to access abortion without parental consent. The legal reform was reported to have led to a 91 per cent reduction in deaths from unsafe abortion (Jewkes and Rees, 2005). Gender and sexual violence also affect women's ability to exercise

**Table 2.8: Legal conditions governing abortion, East and Southern Africa**

| Abortion laws on the ground permitted | Economic or social reasons | Foetal impairment | On request | Rape or incest | To preserve mental health | To preserve physical health | To save the woman's life |
|---|---|---|---|---|---|---|---|
| Angola | √ | x | x | x | x | x | √ |
| Botswana | x | √ | x | √ | √ | √ | √ |
| DRC | x | x | x | x | x | x | √ |
| Kenya | x | x | x | x | √ | √ | √ |
| Lesotho | x | x | x | x | x | x | √ |
| Madagascar | x | x | x | x | x | x | √ |
| Malawi | x | x | x | x | x | x | √ |
| Mauritius | x | x | x | x | x | x | √ |
| Mozambique | x | x | x | x | √ | √ | √ |
| Namibia | x | √ | x | √ | √ | √ | √ |
| South Africa | √ | √ | √ | √ | √ | √ | √ |
| Swaziland | x | √ | x | x | √ | √ | √ |
| Tanzania | x | x | x | x | √ | √ | √ |
| Uganda | x | x | x | x | √ | √ | √ |
| Zambia | √ | √ | x | x | √ | √ | √ |
| Zimbabwe | x | √ | x | √ | x | √ | √ |

Source: UN, 2007

reproductive choice. Studies on sexual violence in Ethiopia, Kenya, Namibia, Tanzania, Zambia, and Zimbabwe estimated that 14 to 59 per cent of women experienced sexual violence at some point during their lives (UNICEF, 2011).

Wide differences in coverage also exist across countries in the region for antenatal care and births assisted by a skilled health worker. From 2000 to 2008 fewer than half of all pregnant women made the WHO-recommended minimum of four antenatal visits and, in Africa, fewer than half of all births had skilled assistance, with 2008 estimates indicating 34 per cent in East Africa and 89 per cent in Southern Africa (WHO, 2008). With wide social inequalities in coverage of assisted deliveries, aggregate data is inadequate to assess progress on this indicator (Table 2.9; Figure 2.13).

*There is a 36 per cent coverage gap against the target of universal coverage of assisted deliveries for the sixteen countries in the region. For those in the lowest wealth quintiles in five countries, however (Kenya, Madagascar, Mozambique, Uganda and Zambia), the gap is double that or more than 70 percentage points. The social and geographical inequalities in access to reproductive health and maternal health services appear to be wider than for many other areas of health service delivery. Inequalities close with improved coverage but the gaps are so wide that additional measures are needed to overcome barriers in access and uptake due to social disadvantage. Included in this is the need to tackle the underlying gender and social norms and other social determinants that undermine women's control over their reproductive health and their use of services.*

*'I do what I can to ensure my wife gets the care she needs during her pregnancy', Kamwenge district, Uganda*

*© Joseline Kabasiime Musigye, 2009*

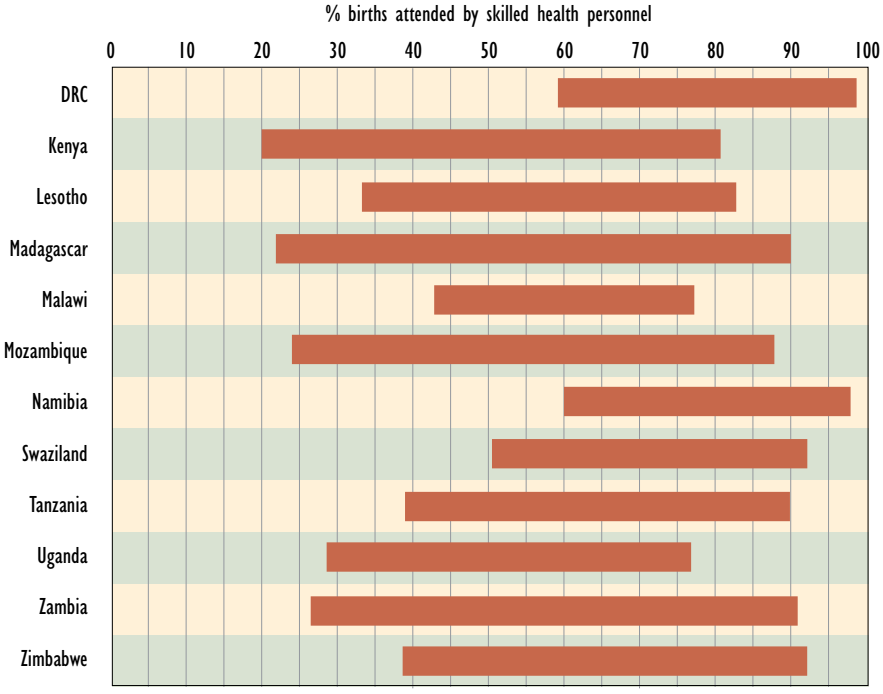
## Table 2.9: Social differentials in births attended by skilled personnel, East and Southern Africa, 2009

| Country | Median level | Concentration index poorest | Ratio richest : region | Ratio high : low education | Ratio high : low |
|---|---|---|---|---|---|
| Angola | 55.5 | * | | 2.31 | 3.88 |
| Botswana | * | * | * | * | 1.22 |
| DRC | 74.0 | * | 1.65 | 1.89 | 1.68 |
| Kenya | 57.4 | 0.240** | 3.99 | 3.45 | 3.78 |
| Lesotho | 51.8 | 0.179** | 2.47 | 1.56 | 3.50 |
| Madagascar | 43.1 | 0.278** | 4.11 | 6.00 | 3.37 |
| Malawi | 54.3 | 0.107 | 1.81 | 1.15 | 0.83 |
| Mozambique | 60.4 | 0.258** | 3.57 | 2.83 | 3.02 |
| Namibia | 74.9 | 0.094** | 1.63 | 1.75 | 1.98 |
| South Africa | 89.4 | * | * | 1.14 | 1.29 |
| Swaziland | 72.9 | 0.112 | 1.82 | 1.21 | 1.80 |
| Uganda | 53.9 | 0.197** | 2.70 | 4.96 | 2.88 |
| Tanzania | 59.7 | 0.154 | 2.32 | 1.71 | 2.22 |
| Zambia | 53.5 | 0.267 | 3.39 | 2.64 | 4.18 |
| Zimbabwe | 68.8 | 0.186 | 2.39 | 2.15 | 3.05 |

* = data not available ** = p<0.05 AF = adolescent fertility

Source: DHS and MICS surveys post-2000 (see reference list). No data for Mauritius

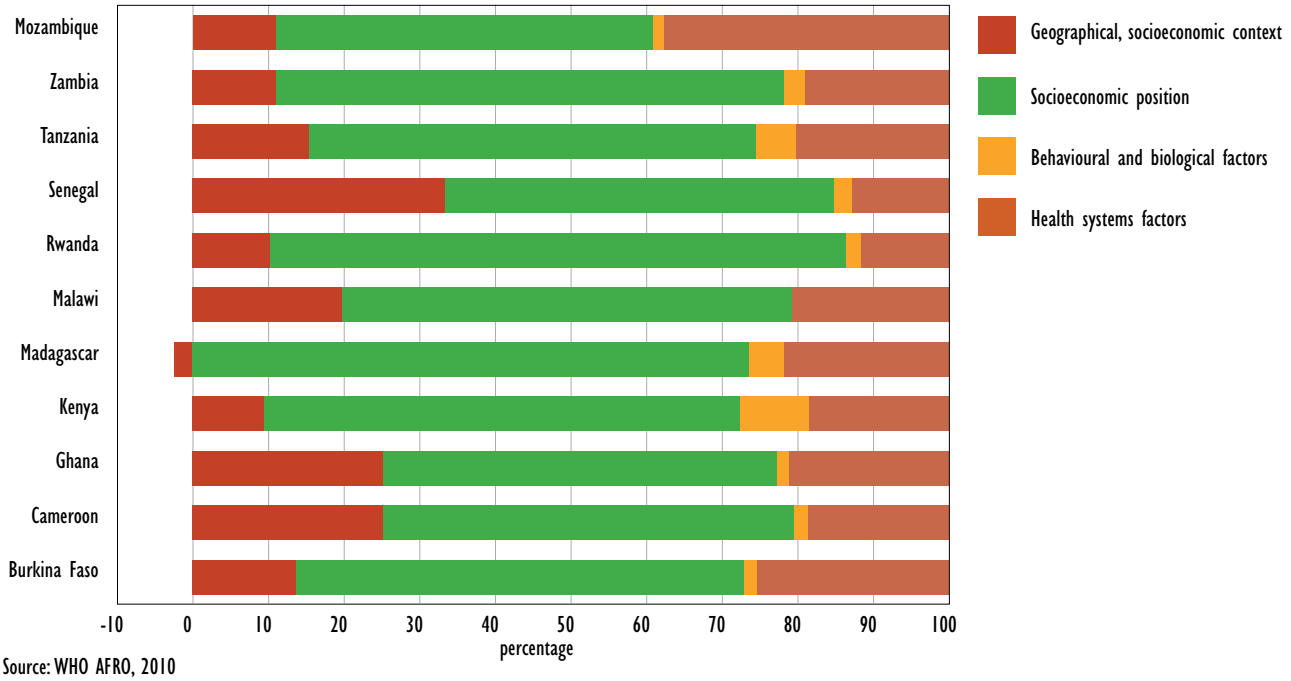
## Figure 2.13: Wealth differentials in percent of births attended by skilled health personnel, East and Southern African countries (highest and lowest quintiles)




The bar for each country shows the % births attended by skilled personnel for the lowest wealth quntile on the left to the highest on the right and indicates the rich to poor range

Source: DHS and MICS surveys post-2000 (see reference list)

**Figure 2.14: Contribution of broad factors to inequalities in skilled birth attendance, selected countries, Africa, 2010**




Source: WHO AFRO, 2010

In a review of evidence in 2010, WHO AFRO found that in each of the eleven countries shown in Figure 2.14, socio-economic position accounts for at least half of the inequality in skilled birth attendance, with socio-economic position contributing from 50 per cent in Mozambique to about 78 per cent of inequality in Madagascar (WHO AFRO, 2010).

Simply addressing aggregate coverage appears to be necessary but insufficient to close these differentials and inequity has increased even where coverage has increased (see Figure 2.15).

**Figure 2.15: Trends in average in skilled birth attendance and equity in most recent demographic and health surveys, selected countries, Africa, 2000s**


Source: WHO AFRO, 2010

These differences in specific interventions cumulate as women seek to manage their fertility, have healthy pregnancies and safe deliveries. Table 2.10, based on demographic and health surveys as well as multiple indicator cluster surveys after 2000, shows the cumulative delivery effectiveness for the unmet need for family planning, contraceptive prevalence and skilled attendance at delivery. The poorest women in Mozambique moving through the health system for the spectrum of reproductive health needs face as much as 36-fold differences in their combined coverage compared to the wealthiest which intensifies disadvantage to extreme levels for those whose health need is greatest.

Beyond supply side factors, a chain of disadvantage applies at different stages in people's efforts to use health services (Smithson, 2006; Figure 2.16).

For countries to address the sometimes substantial inequalities in various health outcomes described in this section, the chain of disadvantage and drivers of inequality need to be mapped onto the country roadmaps for reaching reproductive and maternal health goals. This will ensure that no particular regions or social groups are left behind.

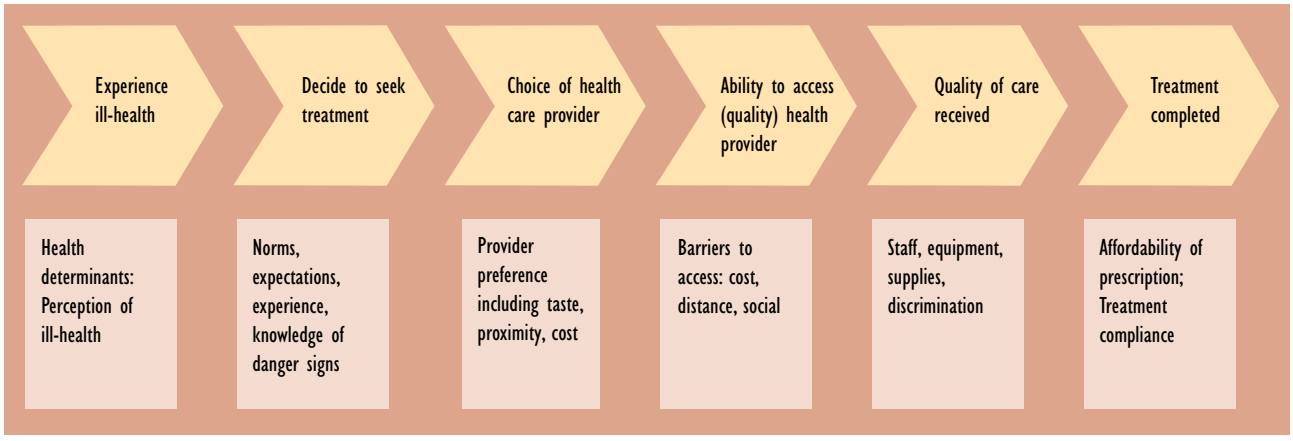
It would also be important to understand the success stories. What measures did Malawi, Namibia and Zimbabwe (in 2009) take to narrow these cumulative differences, as shown in Table 2.10?

*Antenatal care, Zimbabwe* *© UNICEF Zimbabwe*

**Table 2.10: Ratio of richest to poorest quintile in delivery effectiveness for unmet need for family planning, contraceptive prevalence and skilled attendance at delivery**

| Kenya | Lesotho | Madagascar | Malawi | Mozambique | Namibia | Swaziland | Uganda | Tanzania | Zambia | Zimbabwe |
|---|---|---|---|---|---|---|---|---|---|---|
| 5.6 | 3.8 | 6.0 | 1.6 | 35.9 | 0.6 | 1.6 | 8.0 | 4.3 | 3.9 | 1.1 |

**Figure 2.16: Chain of disadvantage from morbidity to treatment outcomes**




Source: Smithson, 2006

## Turning things around in Thyolo district, Malawi

Thyolo district in southern Malawi has a population of 600, 000, an HIV prevalence of 21 per cent and a total fertility rate of 5.7 in 2004. More than two-thirds of the people live in extreme poverty.

Between 2007 and 2010, antiretroviral therapy and prevention of transmission from mother to child activities were increasingly integrated into general health services and provided wherever possible at the same clinics, during the same hours and by the same staff who provided general care.

While initially delivered in a largely vertical fashion, once district-wide provision of antiretroviral therapy services and a substantial increase in the uptake of prevention of transmission from mother to child services were achieved in 2007, HIV care was integrated within general health services.

Measures to improve uptake and outcomes of reproductive health services were also implemented, including providing postpartum, non-monetary incentives, such as soap, a baby blanket and a traditional wrap to encourage women to attend a health facility for delivery. At the same time, contraception became more widely available and was promoted in all outpatient departments in Thyolo district, for both HIV-positive and HIV-negative people. By late 2008, most antiretroviral therapy and prevention of transmission from mother to child care was provided in an integrated manner.

An evaluation was carried out on the use of reproductive health care services and the effects of integrating these HIV-related services into general health services. It revealed a marked increase in the uptake of perinatal care. Pregnant women in 2010 were 50 per cent more likely to attend at least one antenatal visit, were twice as likely to deliver at a health care facility and were more than four times as likely to present for postpartum care. Family planning consultations increased by 40 per cent and the number of women receiving treatment for sexually transmitted infections doubled. Between 2007 and 2010, the number of HIV-exposed infants who underwent testing for HIV went up from 421 to 1599 per year and the proportion testing positive decreased from 13.3 per cent to 5.0 per cent, with infants 62 per cent less likely to test HIV positive.

The authors concluded that the availability of HIV funding broadly benefited the overall health system and contributed to the improved use of reproductive health care services. At the very least, scaling up prevention of mother to child transmission and antiretroviral services did not hinder improvements in other health priorities. They argue that investments in district health services that take into account both HIV-related and reproductive health needs may produce significant improvements, and that maternal mortality and HIV should be tackled together by the same services (van den Akker *et al.*, 2012).


© mothers2mothers

*Nodice, a mothers2mothers Mentor Mother at Bwaila Hospital, Malawi, discusses the importance of HIV testing and counselling with a group of mothers and some of their children.*

*As for HIV services, cumulative differences in reproductive and maternal health services appear narrow where services are made available at levels closer to communities and where these services are sufficiently resourced to ensure consistent service provision, particularly through security of commodities and adequate staffing. Gaps are also closed where community outreach and additional measures ensure that social disadvantage is not a barrier to uptake of the resources available in and beyond the health system, whether that disadvantage relates to wealth, culture, gender, education or other factors.*

# 3

# Household access to the resources for health and social determinants of health

# KEY ISSUES

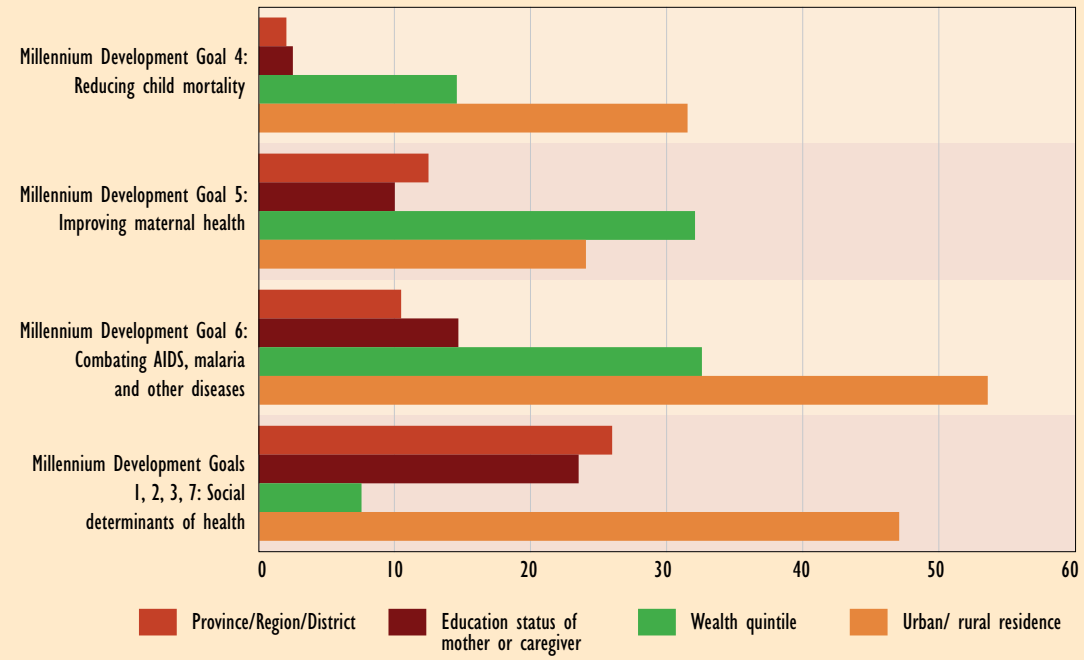
The differences in people's social status lead to differences in their living, working and social conditions, and to the inequalities in health described earlier. These differences are shaped and mediated by policies, services and systems. This section tracks the progress in closing inequalities in household access to the resources for health, particularly in relation to education, living environments, employment and incomes.

Figure 3.1 below is extracted from an analysis of household demographic and health survey data on Millennium Development Goals 1–7 from 19 East and Southern African countries (Loewenson *et al.*, 2010) and shows the share of different stratifiers (geographical, mother's education, wealth or residence) that led to widest differences in health outcomes in these countries. While geographical inequalities were more pronounced in child mortality, inequalities by social status and wealth seemed to be more pronounced in other health outcomes and in access to the social determinants that affect health.

Improved literacy and gender parity in primary education have had a positive impact on health. For health equity, girl children also need to complete secondary education and high social disparities in access to early childhood education and care need to be closed. More rapid progress is also essential in safe water and sanitation.

Despite the persistent under-nutrition shown earlier, only one country in the region has met the African Union commitment of spending 10 per cent of the government budget on agriculture, although all eight African countries that met the target in the 2004-07 period reduced the share of people in food poverty. This points to a need for greater public investment in local food production, especially by women farmers.

**Figure 3.1: Social differentials in Millennium Development Goals in health and social determinants, East and Southern Africa, post-2000**



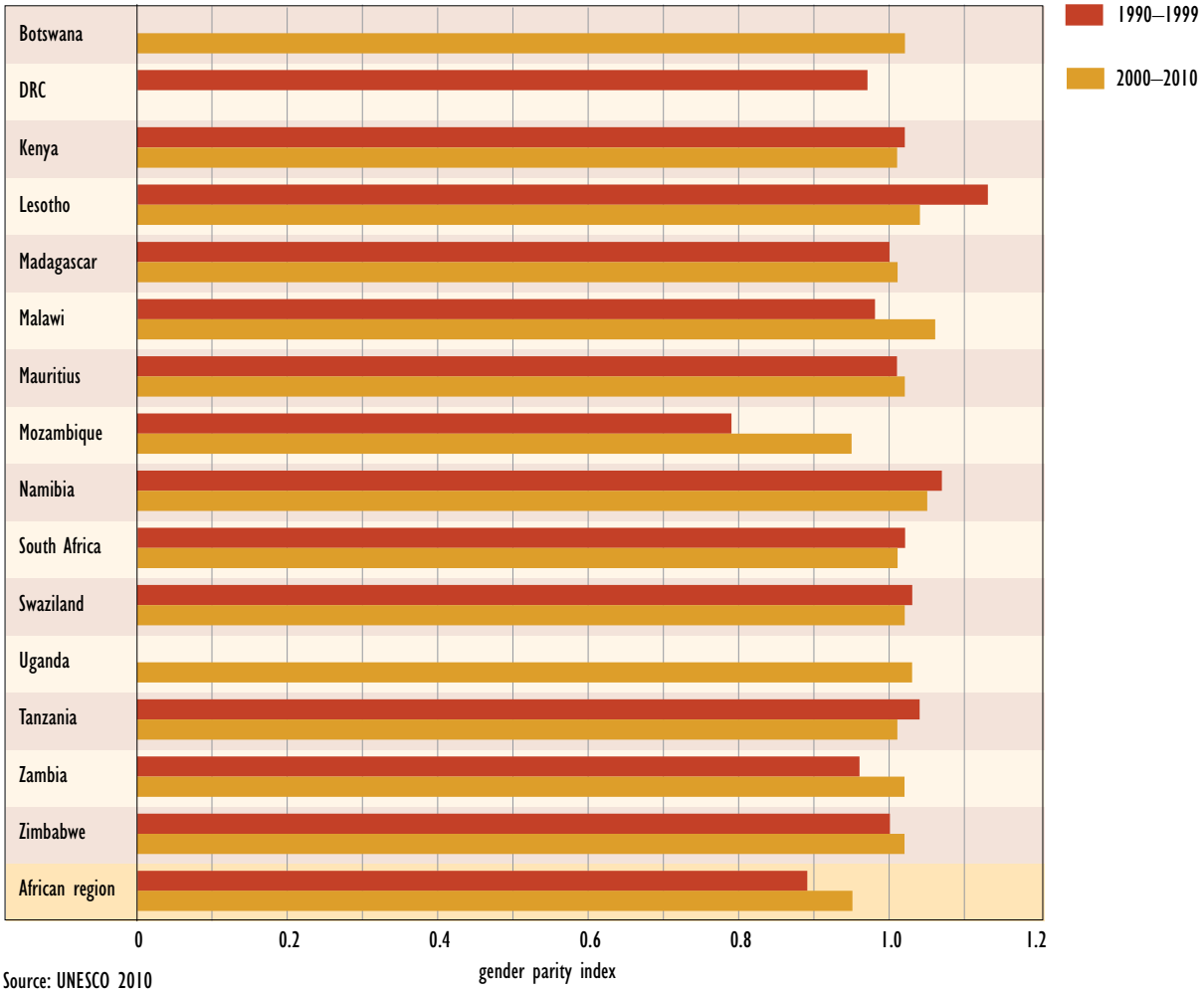

Source: DHS and MICS surveys post-2000 in Loewenson et al., 2010

# Achieving and closing gender differentials in attainment of universal primary and secondary education

As shown in the earlier section, education, particularly women's education, is one of the key social factors that affects other health outcomes. It is thus a positive outcome that primary school enrolment is high in East and Southern Africa and that both adult literacy and primary education improved to levels above 90 per cent in most countries between 1990 and 2010. Furthermore, gender parity in education is high (Statistical appendix table A3.1; Figure 3.2). Mozambique, with the lowest gender ratio in the 1990s, improved its ratio from 0.79 to 0.95 in the 2000s.

East and Southern African countries generally have higher geographical than wealth inequalities in primary school attendance (see Table 3.1 on page 46). The positive finding from the country-specific *Equity Watch* reports of low inequalities by wealth in primary education attendance appears to be founded on social values supporting education, households prioritising education costs in their use of funds, public sector leadership and funding of primary education and 'no-fee' policies in many countries to ensure universal primary education in the public sector.

**Figure 3.2: Gender parity in primary school enrolment, East and Southern Africa, 2000-2009**




Source: UNESCO 2010

**Table 3.1 Children's net primary school enrolment, East and Southern Africa, post-2000**

| Country | Median level | Ratio richest: poorest quintile | Ratio highest: lowest region |
|---|---|---|---|
| Kenya | 89.80 | 1.36 | 1.26 |
| Lesotho | 85.80 | 1.17 | 1.16 |
| Madagascar | 71.75 | 1.30 | 1.76 |
| Malawi | 89.50 | 1.16 | 1.13 |
| Mozambique | 66.80 | 1.94 | 2.17 |
| Namibia | 76.45 | 1.07 | 1.72 |
| Swaziland | 83.20 | 1.17 | 1.14 |
| Uganda | 65.35 | 1.23 | 2.02 |
| Tanzania | 73.00 | 1.51 | 1.30 |
| Zambia | 79.25 | 1.23 | 1.25 |
| Zimbabwe | 92.30 | 1.14 | 1.13 |

No data from South Africa
Source: DHS and MICS surveys post-2000 (see reference list)

## Mozambique's strides in primary education

Mozambique made significant progress in closing gender gaps in education in the last decade. The five-year government programme, PARPA II, the gender policy and implementation strategy, the national progress plan for women and the strategic plan for education (2006–2010/11) focused on integrating gender equity in education. The Ministry of Social and Women's Affairs, the National Council for the Progress of Women, the female Members of Parliament, Cabinet and the Social Welfare Commission for Gender and Environment (Parliament) and selected civil society organisations are all supporting the implementation of these policies.

Between 2005 and 2007, 20.8 per cent of the government budget was allocated to education, with the highest expenditure on general education. With these policies, the construction of schools and investments in better quality education, the average net primary school enrolment index rose and the gender gap closed, as shown in the summary table above. The Ministry of Education recorded a significant increase in children completing grades 1–5 (EP1), from 38.7 per cent in 2003 to 72.6 per cent in 2007.

The Millennium Development Goal target for reducing gender gaps in grades 1–5 of primary school are likely to be achieved by 2015 although 100 per cent completion of primary education for boys and girls by 2015 is unlikely.

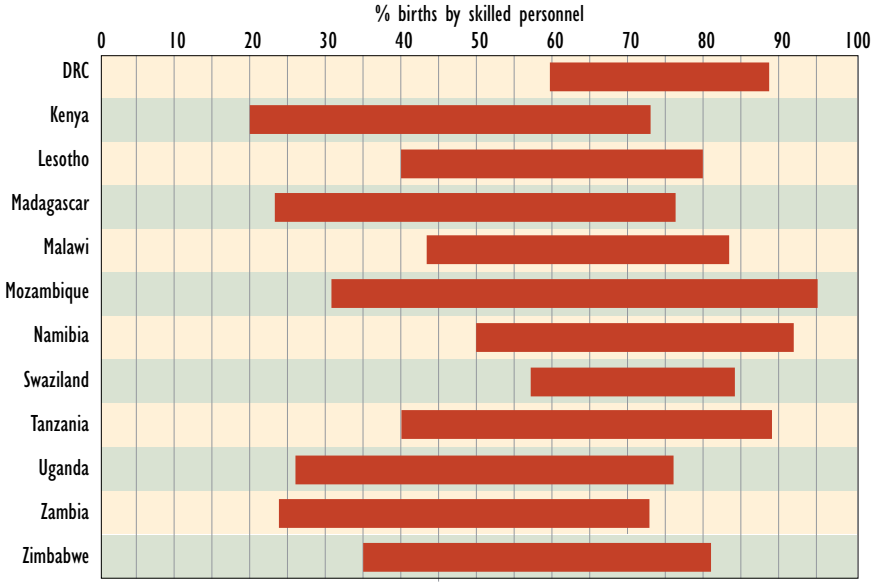
*© UNICEF Mozambique/R. Lemoyne*

The country still has challenges to address the gender gap at secondary levels and primary school completion, and in addressing geographical disparities in gross enrolment and completion rates in primary school (MoH Moz, TARSC/EQUINET, 2010).

States have invested in improving the enrolment of girl children but gaps remain. Adult literacy gains are mainly among younger people while women and older adults have lower literacy levels with a gender parity index for sub-Saharan Africa of 0,75 in 2008 (UNESCO, 2010). Figure 3.3a and b show the range of indicators of children and women's health outcomes at different levels of mothers' education.

*The investments in literacy and gender parity in primary education have been important investments in health equity and need to be sustained and widened to cover quality improvements and investments in ensuring that children, especially girl children, stay in school to complete secondary education.*

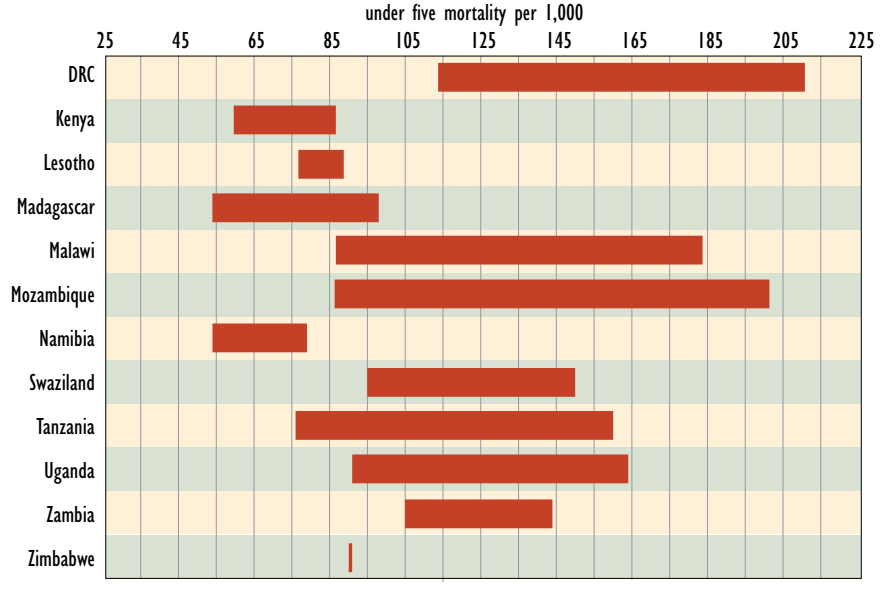
**Figure 3.3a: Range in health outcomes by lowest to highest mothers education: deliveries assisted by a health worker, East and Southern Africa, post-2000**




The bar in (a) shows the percentage of births with the assistance of a health worker, by mother's education. The percentage of mothers with more education having assistance at delivery is on the right and the percentage of mothers with little or no education having assistance at delivery is on the left.

Source: DHS and MICS surveys post-2000 (see reference list)

**Figure 3.3b: Range in health outcomes by lowest to highest mothers education: under five mortality*, East and Southern Africa, post-2000**




The bar in (b) shows the number of under-five deaths per 1,000 by mother's education. The number of deaths of children of mothers with more education is on the left and the number of deaths of children of mothers with little or no education is on the right.

* highest to lowest except Lesotho

Source: DHS and MICS surveys post-2000 (see reference list)

The progress needs to be sustained. By 2010, UNESCO reported that no country in sub-Saharan Africa had achieved the Education for All Development Index, an index of basic education coverage (UNESCO, 2010). Rising primary enrolment and completion rates have increased the demand for post-primary education. However, the coverage and quality of secondary education remains a challenge in terms of financing, quality, relevance, equity and access.

The quality of education can be improved. One study in 21 countries in sub-Sahara Africa found 40 per cent illiteracy among adults of 22–24 years, even though they had had five years of education (UNESCO, 2010). Education systems that cannot ensure basic reading, writing and numeracy skills in those who complete five years leave children with a lifetime of disadvantage. This suggests that the education capacities, quality of teachers, curricula and modes of learning need to be improved and those not yet accessing education need to be reached. There are promising practices in East and Southern Africa, combining universal approaches with further measures to overcome the barriers faced by marginalised groups and improve quality, as shown in the example from Namibia below.

## An integrated approach to education for the San communities in the Ohangwena and Caprivi regions, Nambia

The San of Namibia are the most marginalised people in the country. They continue to be nomads and hunter/gatherers and their children continually move with their parents. So their marginalisation is due to their lifestyle but also a result of discrimination by the non-San population. With Namibia now classified as a middle-income country, it will have more resources to target the education of disadvantaged groups.

The main objective of the new early childhood care and education initiatives is to provide an integrated education support programme for the San communities, addressing in particular the following challenges:

- providing quality early childhood care and education for San children aged 4 to 6 years;
- enrolling, retaining and supporting San children from primary education through to completing secondary education;
- supporting families in creating safe and healthy environments for their children's development.

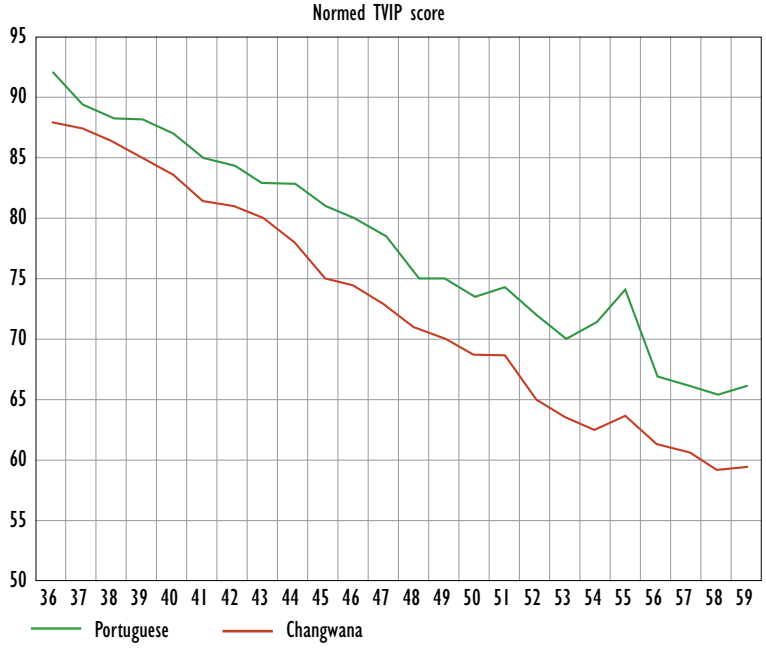
The new programme has made some progress as the following list of achievements shows:

- Eight early childhood care and education centres have been established in Eenhana, Ekoko, Eendobe and Onamatadiva. The centres employ 28 caregivers to teach the children and provide social support as well as cooks to prepare the daily meals.
- An early childhood care and education resource centre has been established for the Onamatadiva resettlement area. It is fully equipped with training materials and is used to train early childhood care and education practitioners as well as to provide a resource centre for the Ohangwena region
- A community hostel has been set up at Hainyeko primary school focusing on first grade children.
- Learning materials have been provided for the centre and for schools in the area.
- The primary schools feeding programmes have been supported and school uniforms and basic toiletries have been provided for the pupils.
- Financial support has also been given to pay school and hostel fees and, as a result, enrolment levels have increased and more San children are completing primary school.
- Support has also been given to young grade 10 'near misses' to complete their studies. They also work part time with the local government schools as mentors for young pupils who may be at risk of dropping out of school.
- Support was also given to secondary school learners to form coherent groups or committees of village activators who can liaise with government ministries and agencies, with the regions, councils, non-government organisations and local community structures and work within the villages to develop self-sustaining projects.

For sustainability, the Ohangwena Regional Council and the Ministry of Education are currently in the process of registering three community hostels at three primary schools which were built and managed by UNESCO. In Caprivi region, the Ministry of Education has already taken over the management of one of the three early childhood care and education centres, Mut'iku, and the second centre in Chetto is gradually being transferred to the community (UNESCO, 2010).

One of the most significant gaps is in early childhood education and care. This area is often given limited attention, including by health systems, despite its importance in health and development outcomes. In one of the first randomised studies outside high income countries to measure this, the World Bank and Save the Children found that children lacking exposure to early childhood education and care programmes in Mozambique had lower than expected vocabulary skills between the ages of 3 and 5, as they were not engaging in activities that encouraged their use and expansion of language (UNESCO, 2010; Figure 3.4).

**Figure 3.4 : Scores of children on the Peabody picture vocabulary test, Mozambique**




Source: UNESCO, 2010

The figure shows scores on the Peabody picture vocabulary test which measures receptive vocabulary. It shows falling competency for age in vocabulary skills.

*© UNICEF Mozambique/T. Delvigne-Jean*

Despite the contribution of early childhood education and care to child development, a UNESCO report in 2010 noted that only two in five children in sub-Saharan Africa access these programmes. African countries do not collect comparable data on indicators of pre-primary and early childhood education coverage and have no clear, all-inclusive approach to programmes to promote young children's physical, cognitive, social and emotional development. These services are not at all standardised (UNESCO, 2010). The median percentage of 0.3 per cent of public spending on pre-primary programmes in sub-Saharan Africa compares poorly with the 4.4 per cent globally in 2008 (UNESCO, 2010). There are many operational issues to address to overcome gaps in early childhood education and care, especially for low-income communities. The health system can play a role by linking it with post-natal care and child health programmes and encouraging public-public partnerships between local communities, local authorities and services to strengthen the provision of these services.

*Early childhood education and care programmes in sub-Saharan Africa have been found to be ignored and highly inequitable, with economic, geographical, social and cultural disparities, particularly due to poor public provisioning and the reliance on private sector services. This is despite the critical importance of child development in the early years of life noted in the previous section. A starting point appears to be in having clear public policy and leadership to expand the public-led provisioning of early childhood education and care, supported by strategic information to plan services and assess progress. The health system can encourage the provision of these services through public-public partnerships with communities.*

# Halving the share of people with no sustainable access to safe drinking water by 2015

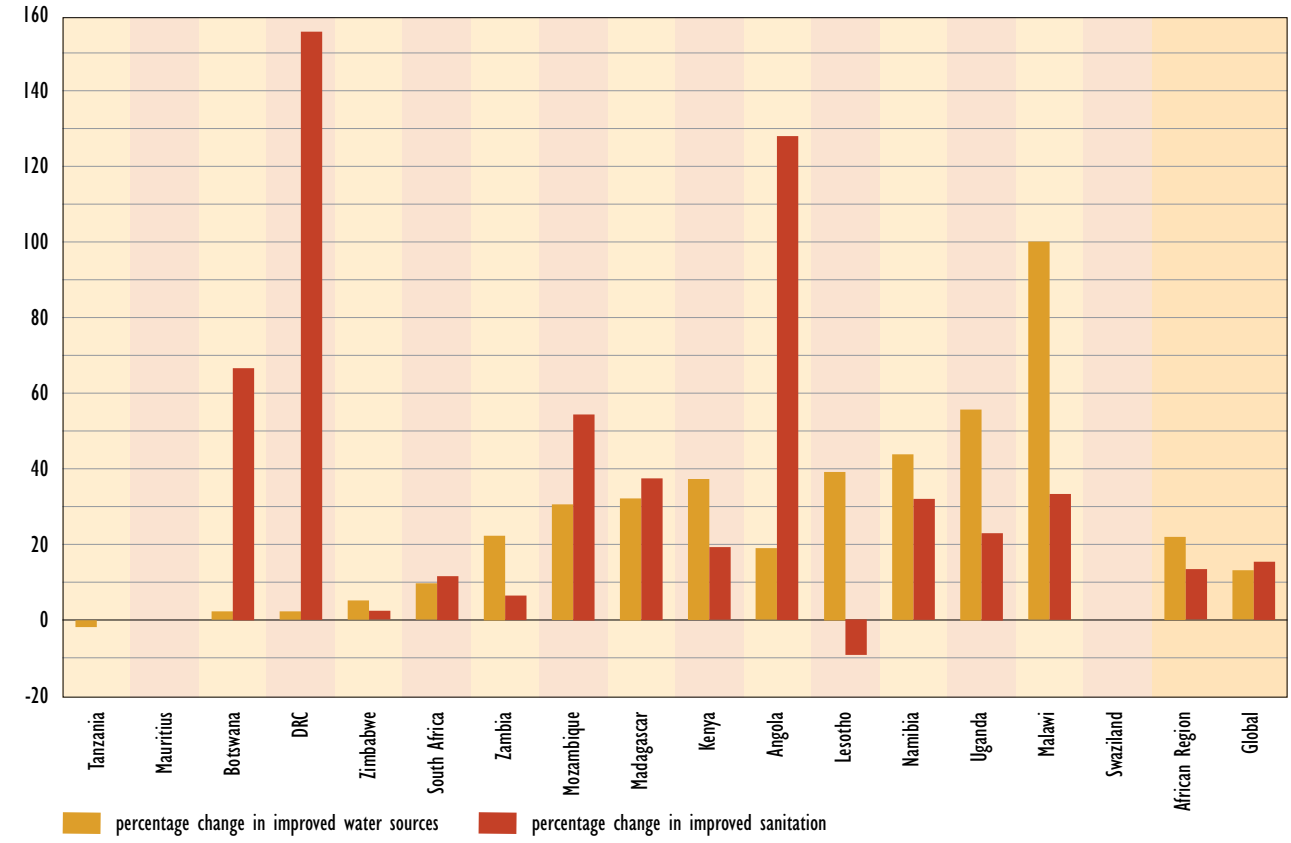
Water is a crucial resource. In terms of availability, in 2006 less than 4 per cent of Africa's renewable water resources were withdrawn for agriculture, domestic supply, sanitation and industry. There are thus reasonable water resource levels available, if developed and managed sustainably, to reach the Millennium Development Goal and African Union 'Water Vision 2025' goals on safe water. Ensuring that this translates to access, however, is a greater challenge and particularly reaching the goal of halving the number of people without access to safe water and sanitation by 2015 or the more ambitious target of reducing the number without access by 70 per cent reduction by the same year set by the Africa Water Vision (UN ECA, 2006).

**Table 3.2: Access to safe water and sanitation, East and Southern Africa, 1990–2008**

| | Population using improved drinking-water sources (%) | | Population using improved sanitation (%) | | % change in improved water sources | % change in improved sanitation |
|---|---|---|---|---|---|---|
| | 1990 | 2008 | 1990 | 2008 | | |
| Angola | 36 | 50 | 25 | 57 | 38.9 | 128.0 |
| Botswana | 93 | 95 | 36 | 60 | 2.2 | 66.7 |
| DRC | 45 | 46 | 9 | 23 | 2.2 | 155.6 |
| Kenya | 43 | 59 | 26 | 31 | 37.2 | 19.2 |
| Lesotho | 61 | 85 | 32 | 29 | 39.3 | -9.4 |
| Madagascar | 31 | 41 | 8 | 11 | 32.3 | 37.5 |
| Malawi | 40 | 80 | 42 | 56 | 100.0 | 33.3 |
| Mauritius | 99 | 99 | 91 | 91 | 0.0 | 0.0 |
| Mozambique | 36 | 47 | 11 | 17 | 30.6 | 54.5 |
| Namibia | 64 | 92 | 25 | 33 | 43.8 | 32.0 |
| South Africa | 83 | 91 | 69 | 77 | 9.6 | 11.6 |
| Swaziland | … | 69 | … | 55 | … | … |
| Uganda | 43 | 67 | 39 | 48 | 55.8 | 23.1 |
| Tanzania | 55 | 54 | 24 | 24 | -1.8 | 0.0 |
| Zambia | 49 | 60 | 46 | 49 | 22.4 | 6.5 |
| Zimbabwe | 78 | 82 | 43 | 44 | 5.1 | 2.3 |
| African region | 50 | 61 | 30 | 34 | 22.0 | 13.3 |
| Global | 77 | 87 | 52 | 60 | 13.0 | 15.4 |
| Low income | 57 | 67 | 27 | 42 | 17.5 | 55.5 |
| High Income | 99 | 100 | 100 | 100 | 1.0 | 0 |

Source: WHO, 2011

**Figure 3.5: Percentage change in water and sanitation, East and Southern Africa, 1990–2008**




Source: WHO, 2011

Table 3.2 and Figure 3.5 show that access to safe drinking water improved by an average of 27.8 per cent in the two decades between 1990 and 2008, although this rate was not fast enough to meet the Millennium Development Goal target. It leaves an average of 30 per cent of households in the region without safe water. In relation to safe sanitation, while there was a 37.4 per cent improvement between 1990 and 2008, an average of 54 per cent of households still do not have access to safe sanitation. Progress in this area has been slow and insufficient.

*'No time for rest,' Bunia, DR Congo*

*© Amuda Baba, 2009*

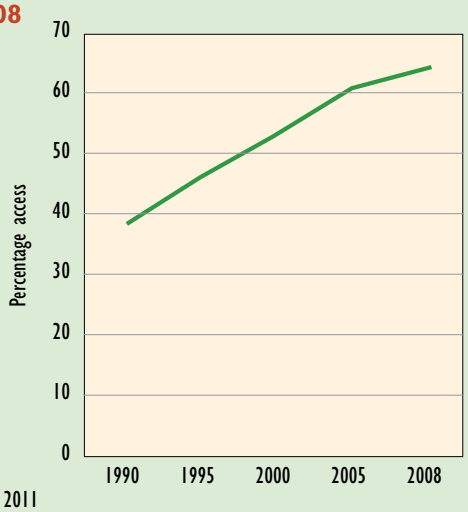
## Making water and sanitation accessible in Uganda

Although access to safe water improved in Uganda between 1990 and 2003, the urban population still had greater access than the rural population. One of government's objectives on water resource management, instituted in 2004, was: 'a sustainable provision of safe water within easy reach and hygienic sanitation facilities, based on management responsibility and ownership by the users', to 77 per cent of the population in rural areas and 100 per cent in urban areas by 2015 with an 80–90 per cent effective use and functionality of facilities.

Access to safe water has steadily improved in both urban and rural areas, and the rural to urban differential has closed. By 2009/10, 74 per cent of households had access to improved water sources, highest in urban areas (90 per cent) but with gains in rural areas up to 70 per cent. (UBOS and Macro Int., 2007, 2010).

A combination of factors has helped drive progress. These include: a strengthened sector policy and institutional framework; improved development cooperation; development financing and enhanced resource allocation; and national leadership and political support, particularly up to the mid-2000s (O'Meally, 2011).

**Access to improved rural water, Uganda, 1990–2008**




Source: O Meally, 2011

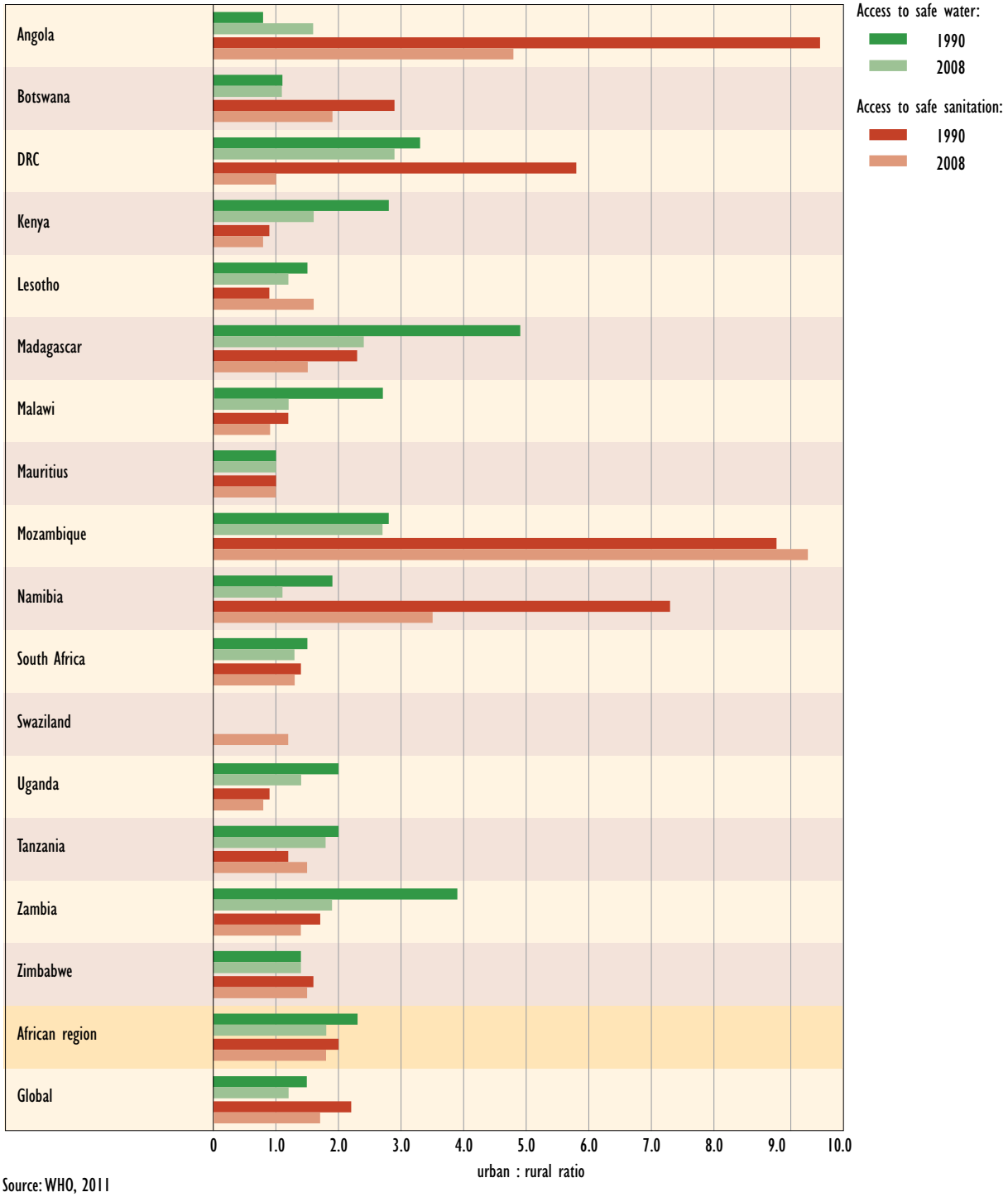
There are still gaps to address, overall and in the lower access to safe water in some districts and small towns, at half the level of large towns. Most households (58 per cent) do not treat their drinking water, although more urban households than rural ones do.

There are difficulties in assessing the social distribution of these critical resources for health. Wealth disaggregations cannot be obtained as access to safe water is used in composing the wealth index. While Figure 3.6 shows household survey data on the changes in urban-rural differences between 1990 and 2008, access is not uniformly defined across countries and the indicator 'time taken to the nearest improved water source used' does not tell whether the water source functions as a consistent supply. Distance to safe water may not adequately capture issues such as cost barriers in urban, commercialised supplies.

With these caveats on the data in mind, it appears that while urban areas generally had two-fold better access up to 2008, the urban–rural gap in access to both safe water and sanitation has narrowed. This is more marked in relation to safe water for Kenya, Madagascar, Namibia, Uganda and Zambia, and in relation to safe sanitation for Angola, DRC and Namibia. Some countries showed the reverse – widening urban-rural gaps (in Angola for access to safe water and in Lesotho and Tanzania for access to sanitation). In Malawi, Uganda, Namibia and Lesotho, improved access to safe water was achieved with reduced urban–rural differentials, suggesting that the greatest gains were made in under-served rural areas. The same happened in Angola, DRC and Botswana in relation to safe sanitation. The evidence, including from the Uganda case described above, indicates that there are still wide gaps to address in most countries in access to safe water and sanitation.

Poor living environments affect a wide range of health outcomes and can lead to recurrent epidemics, such as of cholera and typhoid. They also affect people's quality of life and the time and work needed to collect water, a task often carried out by women and children. There are gender differences in the consequences of gaps in access to safe water. Women and men have different exposure to water-borne diseases because of their gendered roles within society. Women's role in collecting water places them at an increased risk of water-borne diseases. In secondary schools, inadequate provision of toilets can deter menstruating girls from attending school (UN Water, 2006).

**Figure 3.6: Urban: rural ratio for access to improved sanitation and safe water, East and Southern Africa, 1990–2008**




Source: WHO, 2011

*The progress in safe water and sanitation has been slow. There is need to develop more valid indicators of effective coverage with safe water and sanitation, that also reflect cost barriers and reliability of supplies. The evidence suggests that the urban-rural gap has closed in safe water and sanitation in the past decade, although not for all countries in the region. More rapid progress in coverage has been achieved by aligning policies, resources and community roles, particularly in rural areas.*

# Allocating at least 10 per cent of public budgets to agriculture, particularly for investment in smallholder and women producers

Evidence presented earlier showed limited improvement in child nutrition and social inequalities in the distribution of under-nutrition. As noted, poor nutrition is affected by social disadvantage and its developmental consequences can exacerbate disadvantage.

*Improving nutritional outcomes depends on access to affordable, quality foods, supported by household food production and local markets. Yet the evidence that follows shows that despite policy commitments to the contrary, significant levels of rural landlessness, high inequalities in landholding and in access to production inputs, and inadequate public and private investment in smallholder food production continue. This is in spite of measures taken by some East and Southern African countries to diversify food production and subsidise inputs. This especially affects women. Only one country in the region has met the African Union and SADC commitment of allocating 10 per cent of the government budget to agriculture.*

Improvements in nutrition can be sustained if policies reinforce local markets and household food production (EQUINET SC, 2007). Yet a 2006 Food and Agriculture Organisation study determined that only 5 per cent of the US$3.7 billion worth of cereals imported annually by African countries is produced by African farmers (Jayne, 2007).

In the predominantly agricultural economies of the region, improving food production implies that peasant and smallholder producers have access to the land, water, forests, fishing areas and other productive resources needed for food and other farm production. However, distribution of available land in the region is highly inequitable, with severe land inequalities between smallholder, large-scale and state farms. Redressing inequalities between these farm groupings is thus important to reduce rural poverty. Inequality in landholdings is reflected in the maize marketing systems in much of East and Southern Africa. Marketing is segmented into two systems. 'Formal' marketing channels link large-scale farmers and international suppliers to large grain trading, processing and retailing firms with subsidiary distribution networks throughout southern Africa. 'Informal' marketing channels link small-scale farmers with weak infrastructure, poor services for managing market risk or processing, limited coordination with credit and finance and limited voice in determining the regulations governing the sector. It is argued that rather than a focus on regional expansion of the formal marketing channels, improving small-scale farming and its contribution to food security depends on strengthening the investment in and performance of this 'informal' marketing system (Jayne, 2007).

The disparities in landholding distribution within the small farm sector itself, found in national household survey data in Kenya, Malawi, Mozambique and Zambia, are not widely acknowledged (Jayne, 2007). In each country, the bottom 15-20 per cent of small-scale farm households were found to be approaching landlessness, controlling less than 0.5 hectares. In Malawi, for example, 80 per cent of all smallholder households possessed less than one hectare of land. Land-poor households lack access to non-farm employment, intensifying inequalities within the small-scale sector (Jayne, 2007).

Beyond this inequity in access to land, countries in the region continue to face unresolved market access issues in global trade. Producer subsidies and import tariffs protect producers in high income countries, while African countries face pressures to scrap the same subsidies and tariff measures to protect local producers. Within the region, trade barriers and cumbersome procedures block intra-regional trade in food (Jayne, 2007). Smallholders have been affected by large and often transnational corporate involvement in the food supply chain, occupying fallow land and controlling marketing and patents. The findings revealed that six transnational corporations account for 85 per cent of world trade in grain, four transnational corporations own nearly 45 per cent of patents for staples, such as rice and maize, and three large retailers are responsible for over 70 per cent of total food sales in the region. The corporate dominance of marketing has been effective in driving down producer prices, increasing consumer prices and shifting profits away from production to processing and retailing operations, supported by the liberalisation of food production and marketing (Chopra, 2004).

Furthermore, local seed banks, held by smallholder farmers or within state institutions, may be compromised by the adoption of imported hybrid and genetically modified seed stocks. While these promise returns in improved yields, they shift control over seed to large corporates and may threaten local biodiversity. Ten firms currently dominate over two thirds of the world's proprietary seed sales, giving them significant power in controlling seed prices (Gonzalez, 2010).

There is some evidence of countervailing trends. Food production and consumption patterns in the region have changed markedly over the past decade. The former dominance of white maize has given way to more diversified food systems. In many rural areas of Malawi, Zambia and Tanzania, cultivation of cassava, a more drought-tolerant crop that can be stored in the ground, has increased dramatically, providing new potential to stabilise food security in the face of maize production shortfalls (Jayne, 2007). There are also reports of limited programmes in Africa to encourage the quality of local seed stock produced and held by women and smallholder farmers (FAO, IFAD, ILO, 2010).


*© Joseline Kabasiime Musigye, April 2009*

*'Valuing women's work and health: women play an important role in ensuring food security at home', Kamwenge district, Uganda*

## Malawi – prioritising agriculture

Malawi is now one of Africa's highest spenders on agriculture. In 2009/10, the government allocated K33.5 billion to agriculture (about US$218 million), amounting to 13 per cent of the government budget. Spending has averaged 13 per cent since 2004, with the election promise made at that time to re-prioritise agriculture. Most of this budget funds Malawi's subsidy programme. The fertiliser subsidy programme, implemented using fertiliser coupons, led to a significant rise in maize production and a fall in net imports of maize between 2005/6 and 2008/9.

While the subsidy was criticised, poor households are reported to have seen increases in income of 10–100 per cent (Pretty *et al.*, 2011). Between 2004 and 2007, Malawi reduced the proportion of people in food poverty from 45 per cent to 29 per cent (Curtis, 2010).

*© John Duffell, Creative Commons licence*

*Nankhunda, Zomba, Malawi*
*Both fields were planted around the same time but the maize on the right has been treated with fertiliser.*

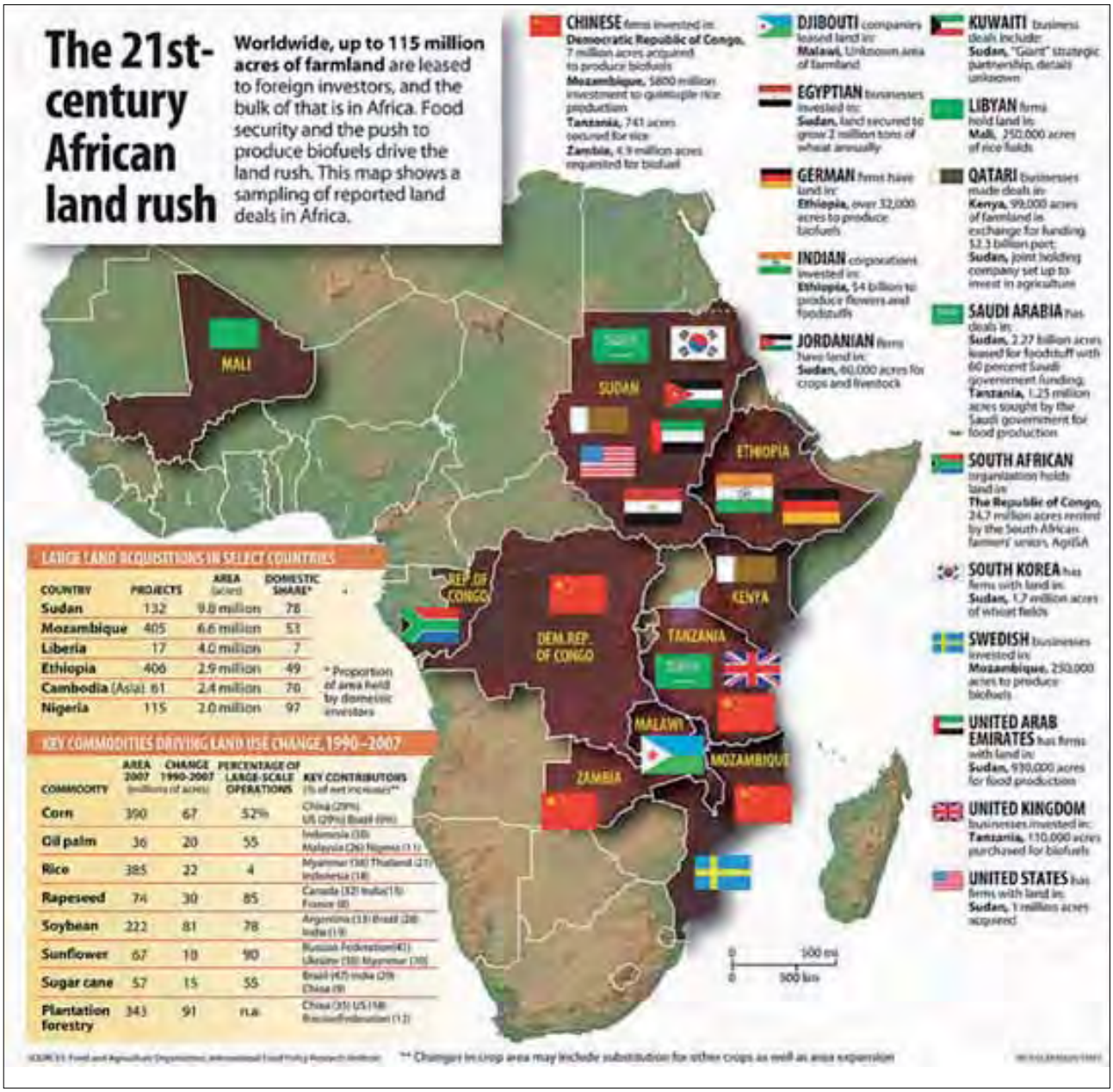
Input subsidy programmes are now being reintroduced in Malawi, Kenya, Tanzania and other countries outside the region, such as for fertiliser and other inputs. These aim to kick-start production where farmers are trapped in a vicious cycle of low yields, vulnerability to shocks and low and insecure income – and where farmers struggle to find funds to invest in increasing production. No matter how sophisticated the targeting, leakage of these subsidies to wealthier groups is inevitable. There is also a risk that poor farmers may sell fertiliser and seed vouchers for cash. Nevertheless, there is some record of success, such as in Malawi's subsidy programme cited in the case study above. Spending on 'public goods' such as extension, research, drip irrigation and rural roads is argued to be less easily captured by the better-off for individual use (Curtis, 2010).

Global pressures add impetus to the need to reinvest in smallholder production. Studies report that climate change is undermining conditions for an already vulnerable subsistence-farming sector, with more extreme temperature events, later onset of the rainy season, a general decline in rainfall and increased frequency of drought and other extreme weather events (Drimie and Gillespie, 2010). A recent meta-analysis of climate risks for crops in twelve food insecure regions found that South Asia and Southern Africa will suffer negative impacts on food crops that are important to food insecure populations, particularly if sufficient adaptation measures are not adopted (Vincent and Cull, 2009). Yields for maize, the staple crop of the region, are projected to fall by nearly 30 per cent by 2030 and wheat yields by almost 15 per cent, with particular hardship falling on subsistence producers and negative consequences for food security (Drimie and Gillespie, 2010). Higher temperatures and higher peak temperatures are projected to directly affect health through increased time for mosquitoes and other disease-carrying insects to breed (Collier *et al.*, 2008).

At the same time, global capital markets and production trends have made African land a sought-after investment resource for high-income countries. With biofuels proposed as one long-term solution to energy and ecological challenges and limited land for agriculture in high-income countries, institutions and corporations from various sectors (automobiles, oil, biotechnology, agribusiness, banks) are seeking large tracts of land in Africa for biofuels, for sugar substrates for biogenetics, to secure food needs of acquiring countries, or as an investment resource (See Figure 3.7 below).

For instance the Sweden-based companies Biomassive and Sekab are growing crops in Mozambique and Tanzania for biofuel production. Sekab has already planted 20,000 hectares in Tanzania's coastal region and has plans to expand this to 400,000 hectares, with the ambition to use this to replace all petrol and diesel used by cars in Sweden and Norway.

**Figure 3.7: Land acquisition, East and Southern Africa, post-2000**




Source: FAO, 2010

It is reported that 15-20 million hectares of farmland in the region were acquired by foreign interests between 2006 and 2009, although the publicly reported evidence is likely to be less than the actual acquisitions, given the lack of transparency in many such transactions (Chinweze *et al.*, 2011; Von Braun and Meinzen-Dick, 2009; Friis and Reenberg, 2010). Worldwatch and others warn of the potentially negative effects of this on already precarious food systems (Worldwatch Institute, 2011; Friis, and Reenberg, 2010).

*Climate change and large-scale foreign land acquisitions for biofuels, for investment or other purposes can threaten indigenous farming rights, displace food producers and lead to increased food prices. These acquisitions can change property relations and absorb smallholders into large agribusinesses, with negative consequences for domestic food production and food security. Given this, states would need to ensure that foreign land deals are assessed and scrutinised by parliament for the extent to which they protect land use for food production and for their impact on indigenous land rights, access to water and health.*

There is a gender dimension to this marginalisation of smallholder food production. Women are responsible for 80 per cent of food production in Africa, including the most labour-intensive work, such as planting, fertilising, irrigating, weeding, harvesting and marketing. Women make up the majority of small-scale farmers, and produce 60-70 per cent of the food crops (Gawaya, 2008). Women's work extends to food preparation, as well as nurturing activities. Where women's productivity improves, the household gains are found to be more likely to be used to improve the wellbeing of children in the household, with a positive impact on childhood nutritional status (Chopra, 2004). Although the evidence is limited, the broader trends described above appear to have widened gender inequalities, further weakening women's ability to produce food for household needs (Chopra, 2004).

*There are deep gender disparities in agriculture. Women have unequal access to land (less than 1 per cent of land is owned by women), to inputs like credit (less than 10 per cent of credit provided to small farmers goes to women) and to information and markets. They have poor access to improved seeds and fertiliser and low participation in the leadership of farmer organisations. This de facto gender inequality conflicts with commitments made to eliminate discrimination against women in the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).*

Women face biases in access to training, inputs, capital, credit and transportation, receiving 7 per cent of agricultural extension services and less than 10 per cent of the credit offered to small-scale farmers. Lack of land ownership gives women less incentive to make long-term investments in their farms. Limited access to transport, information, social networks, social capital and mobility biases against women in production and marketing (Holmes *et al.*, 2009; Curtis, 2010). Women mainly sell food in micro-level markets, by the roadside, or, at most, transporting food to city markets.

Organised farmers' groups are one of the key fora women can use to influence policy debates. However, time constraints, biases in gender roles and lack of recognition of women's concerns are reported to lead to low female leadership in farmer organisations, particularly for women from poorer households. For example, in Mozambique women form the majority of members in farmer organisations but the leadership is dominated by men (Hilhorst and Wennink, 2010; Gawaya, 2008). Not being landowners leads to women not being perceived as farmers even when they do much of the farm work. Lack of gender-disaggregated data on inputs and performance also increases the invisibility of women (Curtis, 2010).

While the global level biases in trade and market access are under dispute at the World Trade Organisation, African governments recognise their own role in reviving food security through local production. In order to halve poverty and hunger by 2015, the International Food Policy Research Institute estimates that African governments need to more than double spending on agriculture to over US$22 billion per year (in constant 2007 dollars) through government budget and external funder allocations (Curtis, 2010). There is room for improvement in domestic spending. African countries spend 4–5 per cent of national budgets on agriculture, compared with 8–14 per cent in Asia (Pretty, *et al*., 2011).

In 2003, African governments approved the Comprehensive African Agricultural Development Programme (CAADP) that committed member states to increasing their allocation to agriculture and rural development to at least 10 per cent of national budgets within five years (NEPAD Secretariat, 2009). This target was also adopted by SADC in 2004, together with a reaffirmation of SADC citizens' right to access safe, adequate and nutritious food. SADC also committed to promoting gender parity in access to land, credit and agricultural inputs and to recognising and valuing the role of women in agriculture and food security. (SADC, 2004).

As Statistical appendix table A3.2 and Figure 3.8 overleaf show, this commitment has been poorly delivered on. By 2007 only eight African governments were devoting 10 per cent or more of their budgets to agriculture. Since then the budget shares have risen slightly but only Malawi in the East and Southern African region has reached the 10 per cent commitment (UNECA, 2010). Senior civil servants identified the constraints as inadequate high level political will or sanction for non-compliance, preference given to investments in manufacturing, inadequate agricultural sector policy strategies and capacity shortfalls to absorb increases (Somma, 2008).

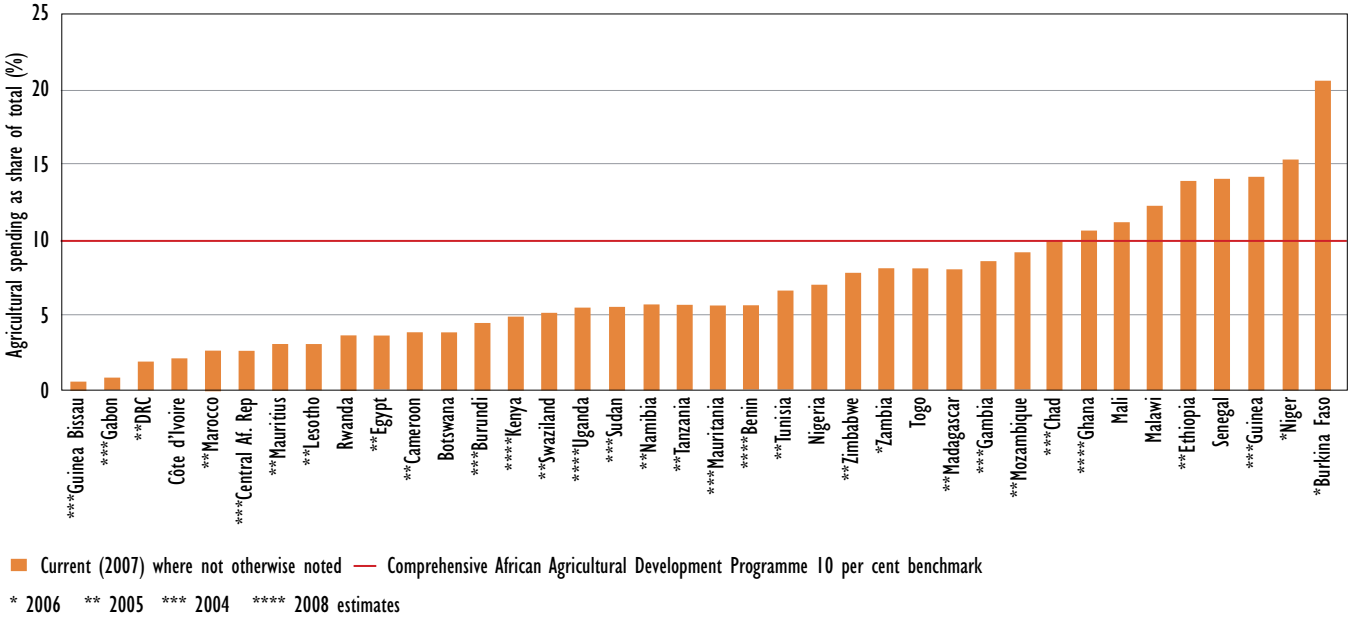
*Nevertheless all eight African countries that met the Comprehensive African Agricultural Development Programme target in 2004-07 achieved reductions in the proportion of people in food poverty (Curtis, 2010). In contrast, low investment has been associated with variable returns from agriculture.*

In the six countries with budget figures where value added agricultural returns rose between 1996 and 2009, four increased their budget share to agriculture. For the eight countries that recorded declining value added, six made no increase in the share of the budget to agriculture.


*© Samson Juma, 2009*

Food market, *Kasipul, Kenya*

**Figure 3.8: Agricultural spending as a share of government budget, Africa, 2006-2008**




Source: Calculated using data from IMF's government finance statistics (various issues), NEPAD/AU/FAO/World Bank 2006 budgetary tracking surveys which also adopted COFOG measure standards. From preliminary in-country surveys by ReSAKSS nodes with in-country network partners (Zambia, Nigeria) and in some cases as part of broader public expenditure review studies undertaken in collaboration with the World Bank and national government agencies (for example, Uganda, Malawi). For Nigeria the 2006 figures are preliminary estimates based on the Federal budget. Rwanda figures from Diao et al., 2007 (IFPRI)

By late 2010, 22 African governments had reaffirmed their commitment to investment in agriculture, signing compacts to increase the share of government spending for agricultural development from 4 per cent to more than 10 per cent within five years (UNECA, 2010). Governments are now expected to hold consultations with farmers' organisations, technical experts, researchers, donor officials, business representatives and others to develop detailed, multi-year investment plans The United Nations Economic Commission for Africa identified the following priorities for these plans: to ensure an increase in irrigated land, to rehabilitate degraded land through soil and water conservation measures; to improve security of land tenure; and to ensure equity in land distribution. They also identified the need for measures to improve land use, restrict encroachment of cultivation into fragile ecosystems and improve water management (UNECA, 2010). The commission also called for better capitalisation of agriculture, including through microfinance institutions for small-scale farmers, with increased funding for agricultural research and technology and strengthened domestic marketing and infrastructure (UNECA, 2010).

*Beyond tracking the overall spending towards the commitment of 10 per cent, it is necessary to transparently budget, resource and monitor the support to women farmers.*

To date, the evidence of this is limited. In 2008/9 Malawi had a budget line targeting women specifically, for 'agricultural gender roles and support services', with 3 per cent of the extension budget and 0.2 per cent of the total agriculture budget. In Kenya the only mention of women in the agriculture budget is a 'mainstreaming gender' budget line for 2008-12, with 0.007 per cent of spending. In Uganda there were no noticeable agriculture budget lines supporting women farmers in 2009 (Curtis, 2010). While policies and strategies for agriculture recognise women's empowerment in the text, they do not yet appear to do so in the budget lines.

# 4

# Economic opportunities and challenges for health

# KEY ISSUES

While the resources to meet the basic needs of safe water, sanitation, food and education exist within the region, they do not reach all households.

There are warning signs that while growth is occurring in East and Southern Africa, poverty and inequality are increasing and are limiting access to basic rights to health resources. Poverty, including urban poverty, is growing at the same time as gross domestic product is growing and if poverty is to be reduced, inequality needs to be addressed.

Inequality is widest at the global level. Existing rules in the global economy benefit most those countries and individuals that already have economic power. The richest 2 per cent of the world adult population owns more than half of global household wealth, while the bottom 50 per cent owns barely 1 per cent.

At current rates of progress in narrowing this gap, it would take more than 800 years for the bottom billion to achieve even 10 per cent of global income.

This creates a challenging context for efforts to reduce inequality and poverty within the region.

Given Africa's position in providing resources for an increasingly unequal and crisis-ridden global economy, often to the cost of a large share of its own populations, the policy choices countries make are critical for both growth and wellbeing. Experiences from within the region suggest that:

- Widening employment opportunities and economic and social protection helps address poverty and inequality;
- Concerted, cross-sectoral, collaborative and participatory approaches reduce urban poverty;
- Improvements in national income need to more directly translate into improved employment and wage incomes, particularly given the fall found in wages relative to profit shares in countries that have tracked this indicator.

# Expanding economic opportunities for health

In 2009, the sixteen countries covered in this analysis had a combined gross domestic product (GDP) of US$516 billion for the region's population of 362 million, with an average per capita GDP of $1,530 – ranging from US$100 to US$5,800. Economies in the region grew by an average of 5.8 per cent and have significant genetic, biodiversity, mineral and other natural resources (World Bank, 2011; Statistical appendix table A4.1). The resources exist within the continent to satisfy the basic social determinants of health described earlier.

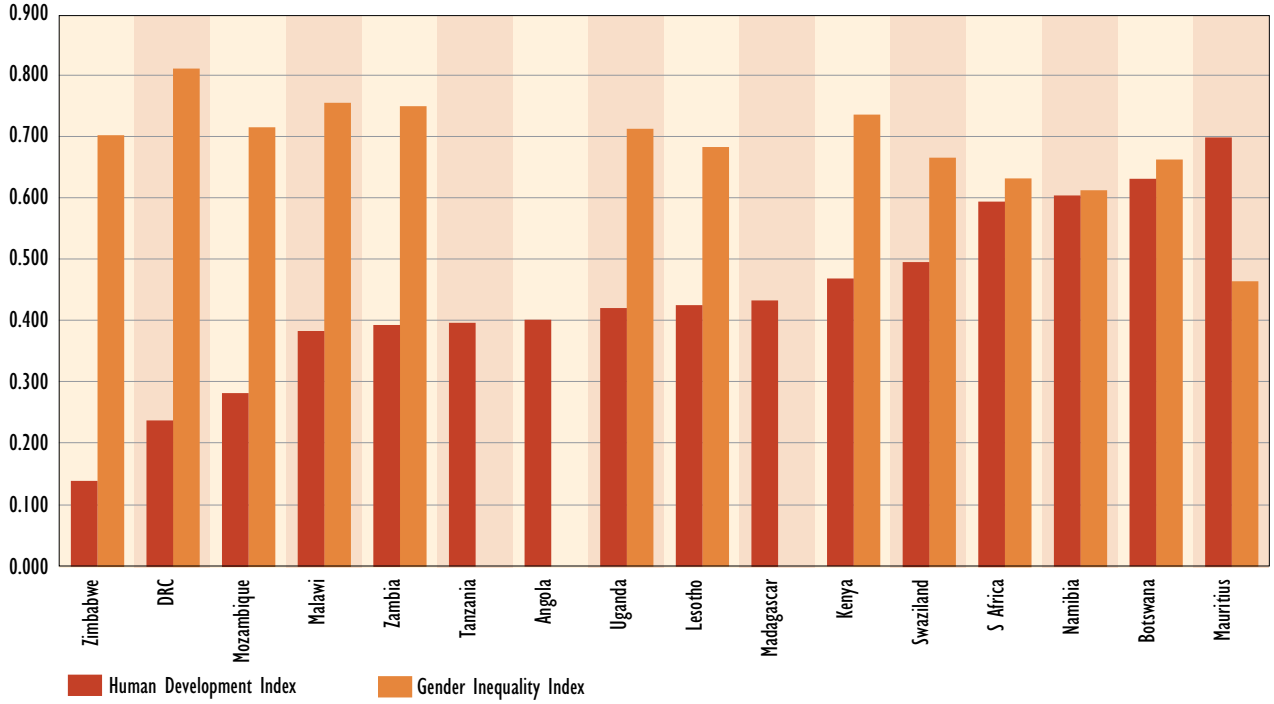
Evidence presented in the prior sections suggests that gaps arise in the social distribution of the resources for health. The human development index (HDI), a measure of life expectancy, adult literacy and GDP per capita, improved in only five of the sixteen countries in the region between 1997 and 2005, despite economic growth in most. Only four countries in the region have human development index values greater than the midway point of 0.500. The gender inequality index, described in the box adjacent, is high and only lower than the 0.5 mid-point in Mauritius (Figure 4.1). It appears that positive economic performance is not directly translating into human development or gender equity outcomes. This section explores further the broader economic factors underlying the pattern of living and social conditions and health outcomes described earlier.

The 2010 *Human Development Report* introduced the *gender inequality index*, which is a composite measure reflecting inequality in achievements between women and men in three dimensions: reproductive health, empowerment and the labour market. It varies between zero (when women and men fare equally) and one (when men or women fare poorly compared to the other in all dimensions).

The health dimension is measured by maternal mortality and adolescent fertility. The empowerment dimension is measured by the share of parliamentary seats held by each sex and by secondary and higher education attainment. The labour dimension is measured by women's participation in the work force.

The gender inequality index is designed to reveal the extent to which national human development achievements are eroded by gender inequality.

**Figure 4.1: Human development index and gender inequality index, East and Southern Africa, 2010**




Source: UNDP, 1999; 2002; 2005; 2006, 2011

# Achieving the Millennium Development Goal of reducing by half the number of people in poverty

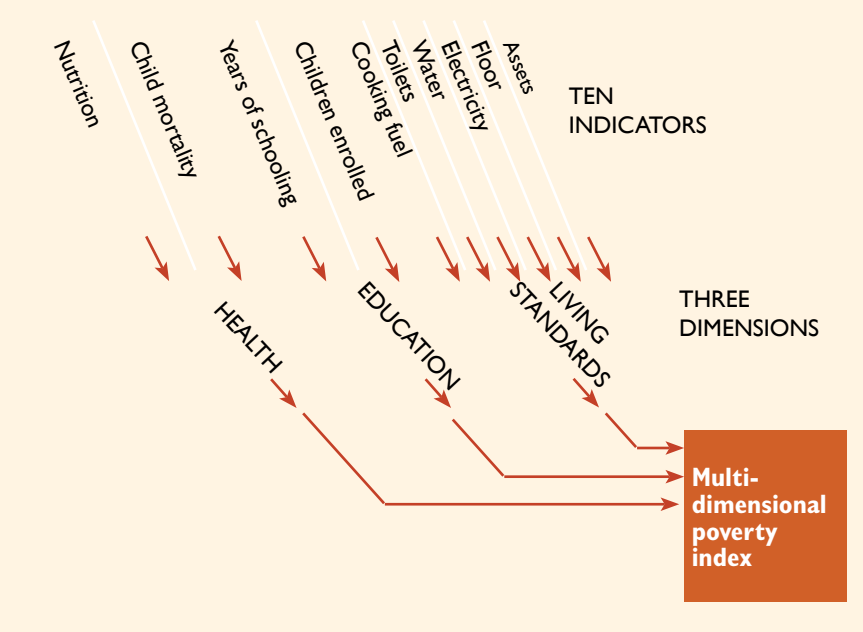
Income poverty is high across most of the region and increased between 1990 and 2010 (Statistical appendix table A4.2). Instead of being associated with reduced poverty, an increase in GDP per capita appears to be associated with increased income poverty, even in countries where the GDP per capita has shown a large increase in the past two decades. There are thus warning signs that growth is occurring with increasing income poverty. This may be happening due to inequalities in the opportunities for generating incomes (for example, in access to employment and production resources), in the distribution of incomes and in the distribution of the benefits of growth (for example, in the wage and market price returns for labour and production). This is further explored in the next progress markers.

Countries in the region use different indicators for poverty, including the share of people below the US$1, US$1.25 or US$2 income threshold, the share below a defined national poverty line and the share below the level needed to purchase basic calorific food needs for households or the food poverty line. Income-based poverty measures may underestimate other dimensions of deprivation. For example, using the multidimensional poverty index, deprivation in living standards appears to be most pronounced, confirming the need, raised earlier, to improve living conditions to close social inequalities in health (Figure 4.2).

Aggregate measures do not show how poverty is distributed within countries, which is important to better understand the distribution of disadvantage in health, as outlined, for example, in the Mozambique *Equity Watch*, summarised in the box on page 66.

The *multidimensional poverty index* shows deprivation aggregated across three dimensions: health, education, and standard of living, measured using ten indicators, with each dimension equally weighted. Using data from household surveys, each person in a household is classified as poor or non-poor depending on the number of deprivations in their household. Individuals are multidimensionally poor if the weighted indicators in which they are deprived add up to at least 33 per cent. The index is the proportion of the population that is multidimensionally poor adjusted by the intensity of the deprivations. It ranges from 0 to 1, the highest level reported in 2010 being Niger (0.642 , 2007 data).

**Figure 4.2: The multidimensional poverty index**




Source: UNDP, 2011b

**Table 4.1: Multidimensional Poverty Index, East and Southern Africa, 2000-2008**

| | Multi-dimensional poverty index | Intensity of deprivation | Health ** | Living standards** % * | % below PPP US$1.25 a day | % below national poverty line |
|---|---|---|---|---|---|---|
| | 2000–2008 for all indicators | | | | | |
| Namibia | 0.187 | 47.2 | 37.2 | 60.8 | … | … |
| South Africa | 0.014 | 46.7 | 8.1 | 10.8 | 26.2 | 22.0 |
| Swaziland | 0.183 | 44.4 | 33.5 | 66.3 | 62.9 | 69.2 |
| Kenya | 0.302 | 50.0 | 41.4 | 86.2 | 19.7 | 46.6 |
| Madagascar | 0.413 | 58.5 | 49.6 | 83.7 | 67.8 | 68.7 |
| Lesotho | 0.220 | 45.8 | 22.1 | 82.4 | 43.4 | 56.3 |
| Uganda | … | … | … | … | 51.5 | 31.1 |
| Angola | 0.452 | 58.4 | 60.8 | 82.0 | 54.3 | … |
| Tanzania | 0.367 | 56.3 | 35.5 | 90.6 | 88.5 | 35.7 |
| Zambia | 0.325 | 51.1 | 51.3 | 78.3 | 64.3 | 68.0 |
| Malawi | 0.384 | 53.2 | 45.2 | 93.9 | 73.9 | 52.4 |
| Mozambique | 0.481 | 60.3 | 52.7 | 86.4 | 74.7 | 55.2 |
| DRC | 0.393 | 53.7 | 48.2 | 85.5 | 59.2 | 71.3 |
| Zimbabwe | 0.174 | 45.2 | 29.6 | 64.5 | … | … |

* % suffering from overlapping deprivations in 2 of 10 indicators of the Multidimensional poverty index

** As shown in Figure 4.2. The national poverty line is the poverty line set for a country by its authorities.

Source: UNDP, 2011

*© Meso Ulola, 2009*

Several months in the year we couldn't reach the health centre when the river flooded. So we made a plan to change the wooden bridge to a durable stone and cement bridge. Bembeyi

The distribution, dimensions and determinants of poverty *within* countries help to explain the pattern of inequalities in health. In Kenya, for example, large family size, lack of education and frequent economic and other 'shocks' were associated with household poverty. In Malawi, poor living conditions were relatively widespread and poverty was associated with inequity in access to food, education, land and asset ownership (World Bank, 2007a). In Uganda, higher poverty levels in the Northern and Eastern regions have been associated with conflict and displacement (Zikusooka *et al.*, 2011). Rural residence is consistently associated with higher poverty in the region. According to the *Kenya integrated household budget survey* (2005/6) data, for example, 85 per cent of those in poverty lived in rural areas (World Bank, 2009). Rural poverty levels in Uganda in 2002/03 were three times higher than urban poverty levels (Zikusooka *et al.*, 2011). The rural-urban gap in poverty has narrowed in many countries in the region, such as in Uganda and Mozambique as shown in the box on page 68. It has, however, also widened in others (such as Kenya after 2005) and the reduction is in part due to a rise in urban poverty.

The drivers of the relative increase in urban poverty demand attention. Three quarters of the urban population living under slum conditions globally are in sub-Saharan Africa with the density in the region shown in Figure 4.3 (UNFPA, 2008). Many informal settlements are built on land poorly suited to housing and without basic services as they are not recognized by municipal authorities. This leads to a vicious loop where poor urban dwellers lack services because they live in informal settlements and their areas are seen as informal because they lack services (Misilu, 2010).

## The struggle against poverty in Mozambique

In 1997 poverty in Mozambique was greater in rural than in urban areas. However, by 2003, the human poverty index had come down considerably in rural areas, while it had remained virtually constant in urban areas, narrowing the rural-urban gap.

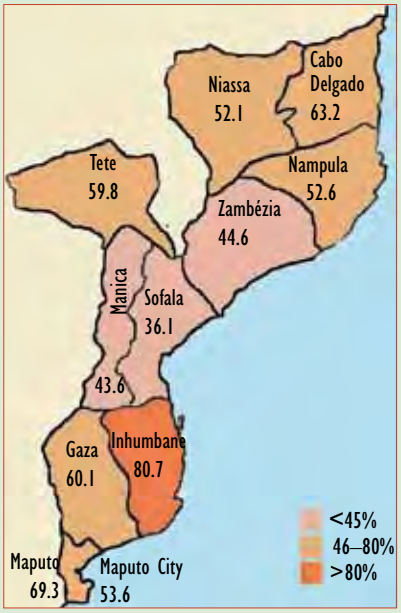
While growth was accompanied by a decline in the incidence of absolute poverty, inequality in wealth increased during this period of growth. High gross domestic product growth in the 2000s was not shared equally over the population. Half of the growth went to the top 20 per cent and yet half the rural people who had been above the poverty line in 2002, fell below the line in 2005.

The shift from rural–urban differentials to a range of economic and social differentials was noted in government policy. In the government's first poverty reduction strategy paper (2001–2005) (PARPA I), it acknowledged the economic and social inequalities between the Maputo-Matola conurbation area and the rest of the country. Government considered this a 'most noticeable characteristic' of the country and ascribed it to various factors, including the civil war.

The government's second poverty reduction strategy paper (2005–2009) (PARPA II) observed that both consumption-based poverty measures and non-income related measures varied considerably from province to province. Dealing with regional disparities was a priority objective in both PARPA I and PARPA II. Disparity thus became a key concern in poverty reduction.

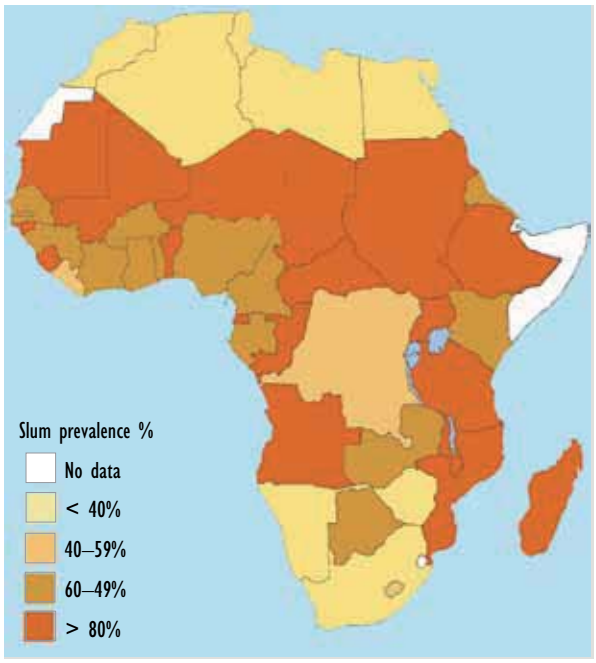
Despite higher access to basic social services in the south of the country, poverty increased in the south in that period, particularly in Maputo Province and urban Maputo City. Mozambique thus has a mix of historical underdevelopment in the north and new urban poverty in the south (MoH Mozambique, TARSC 2010).

### Incidence of poverty by province, 2003




Source: Govt of Mozambique, 2005

**Figure 4.3: Percentage of urban population living in slums, Africa, 2001**




Source: Arimah, 2011

*The evidence suggests that growth alone will not automatically reduce poverty in the region and poverty has grown in situations of GDP growth.*

*Rural areas have higher poverty levels, and the rural–urban poverty gap has narrowed. In part, this is due to rising urban poverty. Rapid and unmanaged urban growth, job insecurity and rising food prices are common causes of urban poverty.*

*While urban poverty is an outcome of economic inequality, the close proximity of visible wealth is also linked to social conflict.*

External debt, high inequality as well as unplanned and unmanaged urban growth have contributed to the prevalence of urbanisation, informal settlements and urban poverty, to high urban food prices and to loss of secure formal jobs (Gardener, 2006; Ssewanyana, 2010; World Bank, 2007b; Misilu, 2010; KEMRI Wellcome Trust *et al.*, 2011; UBOS, 2010; Fallavier *et al.*, 2005). Rising food prices are a particularly significant factor in urban poverty, as almost half (49.6 per cent) of total expenditure by poor urban households was found to be on food (Frayne *et al.*, 2010). In South Africa, for example, food inflation was 16.7 per cent between October 2007 and October 2008, outstripping overall inflation (at 12.1 per cent). The poorest urban households would have had to raise their incomes by at least 22 per cent to maintain the same food basket between April 2007 to October 2008 (Frayne *et al.*, 2010).

These conditions have had negative social and economic outcomes for urban workers and their families. In Zambia, urban workers who had lost secure jobs were struggling to access food, transport, housing and other services, especially with rising prices, and were found to have higher levels of depression and harmful alcohol use (Zambia Fallavier *et al.*, 2005). In DRC, urban poverty has been linked to social insecurity, crime and social conflict, particularly in the context of visible nearby signs of wealth (Sumich, 2010; Misilu 2010).

Efforts to alleviate urban poverty are not well studied or documented in many countries in the region, making this a priority issue for policy and programme attention. Some countries (Uganda and Kenya) are focusing on stabilising macro-economic indicators (inflation, exchange rates, bank lending rates) with the hope that these will have a positive impact on urban poverty (Fallavier *et al.*,2005). The impact of such approaches will need to be assessed. There are also examples of more direct interventions, such as the case study in Luanda, Angola, described on page 70, that organise concerted, cross-sectoral, collaborative and participatory approaches. These appear to have been associated with improved outcomes in deprived urban areas. The evidence suggests that there should be far greater investment in and exchange on such approaches and on urban primary health care.

## Addressing urban poverty in Angola

Urban poverty has increased in Angola. The capital city, Luanda, has seen its population increase from approximately 1 million in 1985 to an estimated 5 million in 2006. Planned urban infrastructure is available only in the 'concrete city' that is the city centre and a small suburban area, which accommodates a population of just 500,000. A further four million people live in unplanned slums known as 'musseques', which lack basic urban services, with poor social infrastructure and conditions.

*Luta contra pobreza urbana* (LUPP – Luanda's urban poverty programme) implemented a series of measures to address the specific dimensions of urban poverty between 2003 and 2006. The programme, supported by international agencies, was set up in four municipalities in Luanda – Cazenga, Sambizanga, Kilamba Kiaxi and Cacuaco. The aim was to strengthen the allocation of public resources to priority areas for poor people and strengthen urban civil society to act and engage with government around urban poverty issues.

The programme has promoted community water supply management in the musseques with support from area-based development committees and it has motivated investment in a major community-based water and sanitation programme for a musseque population of 1.3 million in Luanda. The urban poverty programme has worked with MINEA and EDEL to provide electricity to the musseques. In Kilamba Kiaxi, it has built a participatory planning approach and community-based micro-finance to make electricity affordable for urban poor communities. This is now being scaled up.

A model for community-managed crêches provided a vehicle for early childhood development and the government is now replicating this in two provinces with plans to replicate it in all 18.

LUPP has developed a series of models for community-based savings, micro-finance and business development services, with the National Bank of Angola's micro-finance unit developing the policy, legal and regulatory framework for micro-finance. The programme has strengthened mechanisms for inclusive, participatory local governance, supporting decentralisation in Angola. The programme has been able to demonstrate successful models of community engagement in local government through the Kilamba Kiaxi Development Forum and the Hoji-Ya-Henda and Ngola Kiluange communal consultative councils.

The success of the initiatives has encouraged the Ministry of Territorial Administration to pursue a pilot programme of decentralisation in 41 municipalities throughout Angola, with support from UNDP.

LUPP has developed a critical mass of evidence and cross-learning of field-based experience, including between state agencies and the three international partners (DW/OWA, CARE and SCUK). It has also been possible with participatory urban management approaches in other countries, such as Brazil. Through linking with media, government officials and political representatives, the profile of Angolan urban poverty has been raised, while the perception of LUPP as a national (Angolan) rather than international programme has facilitated engagement and uptake of new ideas (Gardener, 2006).

*A 'musseque' (slum), Luanda*

## Uganda tackles regional disparities in poverty levels

Uganda has managed to reduce significant regional disparities in poverty. Levels were persistently higher in the north of the country, where there are many internally displaced people due to civil war but had lower poverty levels in the West and Central regions.

A five-year Uganda poverty eradication action plan (PEAP), developed in 2004, recognised the need to address regional inequity. A poverty monitoring and evaluation strategy and a working group were set up, focusing on cross-cutting issues, including gender, environment, AIDS, employment, population, social protection, income distribution and regional equity. In the 2000s, income poverty declined more in rural areas than in urban areas, reducing the rural to urban ratio from 3.1 to 2.6, and the gap across regions also narrowed.

Poverty fell in Northern region in 2009/10, partly due to peace and state and non-state agency efforts to improve living conditions, including through resettling internally displaced people back to their villages (Zikusooka *et al.*, 2011).

# Reducing the gini coefficient to at least 0.4

A further reason for the gap between economic growth and people's access to the living standards, food and other resources for health, lies in levels of economic inequality that limit access to the benefits of economic growth and, as raised in the discussion on women's role in agriculture, also limit people's opportunities to generate wealth.

The gini coefficient is one measure of income inequality. Inequality is high in the region. Southern Africa has the least equal income distribution in Africa. Eight countries from the sub-region – Botswana, Namibia, Angola, South Africa, Lesotho, Swaziland, Zambia and Zimbabwe – rank in the top ten of the most unequal countries in Africa (Anyanwu, 2011). Eight of the sixteen countries in the region in 2003 had gini coefficients of 0.50 or more. By 2010 this share had not changed, although with rising inequality in Angola and falling inequality in Malawi (see Table 4.2). Between 2003 and 2010, inequality remained the same or rose in six countries, fell by very small amounts in five countries and fell more substantially in only three countries (Lesotho, Malawi and Swaziland).

**Table 4.2: Inequality, East and Southern Africa, 1990-2010**

| | GDP/capita US$ | | Gini co-efficient | |
|---|---|---|---|---|
| | 2003 | 2009 | 2003 | 2010 |
| Angola | 919 | 4,081 | 0.38 | 0.59 |
| Botswana | 4,366 | 6,064 | 0.63 | 0.61 |
| DRC | 105 | 160 | n.a. | 0.44 |
| Kenya | 459 | 738 | 0.43 | 0.48 |
| Lesotho | 592 | 764 | 0.63 | 0.53 |
| Madagascar | 311 | 438 | 0.48 | 0.47 |
| Malawi | 143 | 310 | 0.50 | 0.39 |
| Mauritius | 4,288 | 6,735 | 0.48 | n.a |
| Mozambique | 251 | 428 | 0.40 | 0.47 |
| Namibia | 2,252 | 4,267 | 0.71 | 0.74 |
| South Africa | 3,626 | 5,786 | 0.58 | 0.58 |
| Swaziland | 1,722 | 2,533 | 0.61 | 0.51 |
| Tanzania | 279 | 503 | 0.38 | 0.35 |
| Uganda | 233 | 490 | 0.43 | 0.43 |
| Zambia | 384 | 990 | 0.53 | 0.51 |
| Zimbabwe | 615 | 449 | 0.57 | 0.51 |

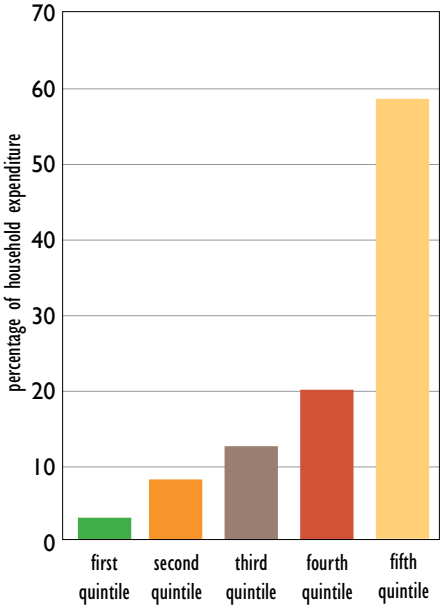
n.a = not available

Source: World Bank, 2009; UNDP, 2005, 2010; UN Stats, 1990–2010; Equity Watch Zambia, 2011 and Equity Watch Mozambique, 2010 for percentage of population living on less than $1 a day

The *gini coefficient* is the distribution of income (or consumption) among individuals or households in a country. A value of 0 represents perfect equality, a value of 1 perfect inequality.

*'Who cares about my health?', Bunia, DR Congo* ©Meso Ulola, 2009

**Figure 4.4: Share of general household expenditure by wealth quintile, Zambia, 2002**

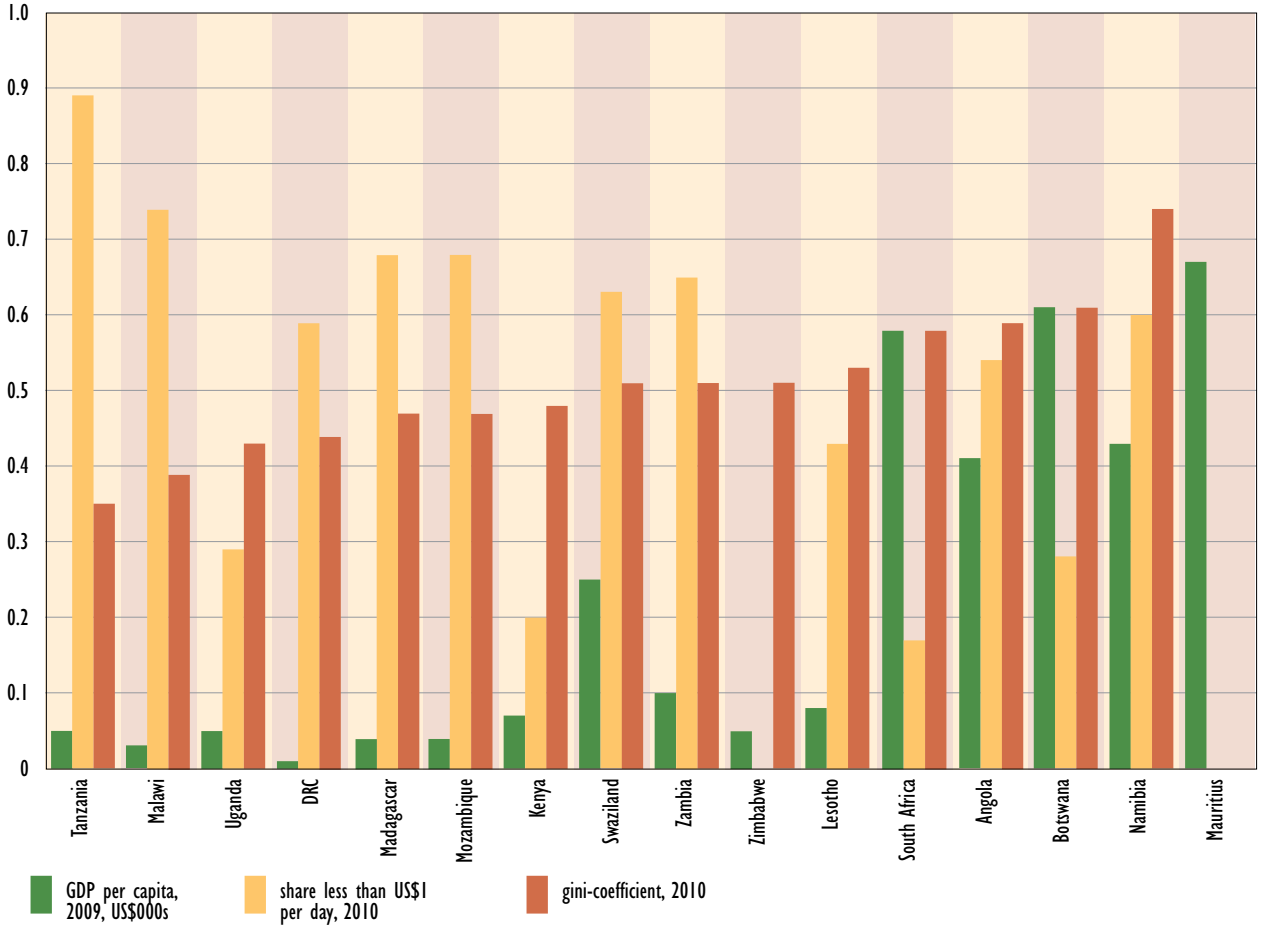



Source: UNDP, 2003

The extent of inequality in wealth is exemplified in Zambia, where the poorest 20 per cent (quintile) in 2002 spent only 3 per cent of total household expenditure, while the richest 20 per cent spent 57 per cent of total household expenditure (UNZA *et al.*, 2011; Figure 4.4). As Figure 4.5 shows, ordering countries by increasing levels of inequality, countries with higher levels of inequality also appear to have higher levels of wealth (and vice versa), suggesting that growth paths may be intensifying inequality. In one study of panel data from African countries over the 1960-2006 period, the inflation rate appeared to be the strongest factor fuelling income inequality in situations of GDP growth (Anyanwu, 2011).

*There are thus warning signs in East and Southern Africa that growth is occurring with increasing poverty and inequality, and that this is a determinant of disadvantage and inequality in health, limiting access to basic rights to health resources. Reducing such wide inequality in wealth appears to be important to facilitate economic participation, for growth to translate into poverty reduction and for economic growth to translate into human development.*

**Figure 4.5: Poverty, gini coefficient and gross domestic product, East and Southern Africa, 2009/10**




Source: World Bank, 2009; UNDP, 2005, 2010; Equity Watch Zambia, 2011; Equity Watch Mozambique, 2010

## Growth, inequality and poverty reduction in Uganda

Ssewanyana *et al.* (2006) argued for Uganda, for example, that growth alone would not adequately improve the incomes of less advantaged people between 2006 and 2015 and that any increase in inequality hurts the 'ultra' poor more than the poor.

They proposed a direct cash transfer scheme to curb the further marginalisation of this group. In 2010, Ssewanyana (2010), examining the factors behind the reduced poverty levels between 2005/6 and 2009/10 in Uganda found that growth contributed more to the reduction in poverty levels than to any redistribution of income. On the other hand, income inequalities were the key factor limiting poverty reduction in the Western and Central regions. The national development plan 2009/10–2014/15 articulated the need to balance wealth creation with sustainable poverty reduction through growth and equity. The plan suggested linking improving socio-economic indicators to reducing the number of people below the poverty line and reducing infant mortality, with creating employment a critical mediating factor.

*©Department for International Development/Pete Lewis, Creative Commons licence*

*'Now that peace has returned to his area in northern Uganda, Christopher Lutara has plans to make sunflower oil from his own sunflowers, with help from a UKaid match-funding scheme, which will provide 40 per cent of the money he needs to buy the machinery to begin processing oil, and thereby providing jobs to the local economy.'*

Poverty reduction is integrated into many development aid programmes in the region. However, the average level of overseas development assistance per capita in the region of $52.70 is low relative to the average levels of GDP of about $1,400 per capita. Addressing poverty and inequality cannot thus be left to development aid and must be tackled through the broader economic resources and policies of the countries in the region. In particular this calls for growth strategies that reduce inequality.

A 2005 World Bank paper analysing 70 developing and transition country economies in the 1990s found that rising relative inequality 'appears more likely to be putting a brake on poverty reduction than to be facilitating it' (Ravallion, 2005: 1). In 2006, an analysis of inequality in Uganda, South Africa, Namibia, Mozambique and Ethiopia all found that current rates of growth would not produce a sufficient rate of poverty reduction to meet Millennium Development Goals unless there was also a reduction in income or asset inequality (Okojie and Shimeles, 2006). Using 1990s data for urban and rural sectors of African economies, Fosu (2010) also found that a more equitable distribution of income would enhance the rate at which growth might be transformed into poverty reduction. There is a range of experience to draw from within the region on the strategies for doing this.

A comparison of the experience from Mauritius and South Africa on page 74 shows the relationship between widening employment opportunities and economic and social protection in addressing poverty and inequality. Other drivers of inequality identified include international migrant remittances (associated with increased inequality) and education (found to significantly reduce income inequality) (Anyanwu, 2011).

## Relationships between growth, poverty and inequality in two middle-income East and Southern African countries: Mauritius and South Africa

Duclos and Verdier-Chouchane (2011) used data from two household surveys separated by five and ten year intervals to conduct a pro-poor growth analysis in Mauritius over the period 2001-2006 and in South Africa over the period 1995-2005. The poverty line was set at a reference threshold of US$3 per day to reflect Mauritius and South Africa's status as middle-income countries.

Mauritius started with a relatively low level of national poverty while, between 1995 and 2005, 42 per cent of South African citizens were living on less than US$3 per day. In Mauritius, the incidence of poverty below US$2 a day is negligible but the head count rises rapidly at poverty lines higher than US$4. In South Africa, poverty emerges at consumption levels as low as US$0.5 a day and rises rapidly below US$3 per day. The poverty head count has declined significantly in Mauritius but not in South Africa. With a national gini coefficient of around 0.36 in 2006, Mauritius' level of inequality is also relatively low in comparison to other African countries. In contrast, South Africa's national gini coefficient of around 0.67 in 2005 positioned it among the least equal countries in the world. Mauritius's development in the early 2000s succeeded in reducing poverty through growth with a relatively modest poverty cost through an increase in inequality. South Africa did not change poverty levels between 1995 and 2005, consumption increased substantially and inequality also rose, cancelling the positive poverty effects of growth. While economic change in Mauritius decreased absolute poverty up to 2006, the same was not the case for South Africa. South Africa's inequality, already one of the highest in the world in 1995, was increased considerably by growth.

The policy choices in the two countries have been different in terms of employment opportunities and human development. Mauritius' poverty reduction strategy has been to expand employment opportunities and modernise its economy while maintaining an elaborate social safety net. The country has also directed significant public resources to education and health. Mauritius in the early 2000s improved employment opportunities and labour market conditions for its large skilled and educated work force, such as in export-oriented manufacturing, although not for the unskilled workforce. In South Africa, government has relied on a market-based approach to foster growth and create jobs. Government has tried to boost productivity, long-run employment and growth through privatisation, despite short-term costs. More recent official policy has tried to reorient government spending to fight deprivation in areas such as access to improved health care and quality education, provision of decent work, sustainability of livelihoods as well as development of economic and social infrastructure.

*'I come regularly to queue for my chronic medication – every time from 4:30am in the cold', Matthew Goniwe Clinic, Khayalitsha, Cape Town*

*©Dorette Baatjies, March 2009*

While Mauritius thus focused its poverty reduction strategy on education and health services and targeted the most vulnerable segment of the population through improved social safety nets, South Africa only shifted to fighting deprivation more recently and has not yet succeeded in providing quality health care and education services across the entire country. South Africa's promotion of market-based growth and job creation was not pro-poor between 1995 and 2005. It improved living standards only among the top third of the population without sufficiently integrating poorer South Africans or rural workers into productive labour markets and with an increase in urban poverty.

The comparison suggests that growth which is not accompanied by an inclusive development programme can lead to social instability. It raises a policy challenge to define and set, specific to different national contexts, an adequate inclusive growth strategy. Beyond investing in infrastructure development, economic and social inclusion and social protection is important for growth to address inequality and, in doing this, reduce poverty (Duclos and Verdier-Chouchane, 2011).

Inequality in wealth within the region is dwarfed by inequality in wealth at global level. Namibia, with the highest gini coefficient in the region at 0.74 still does not reach the global wealth gini across countries of 0.892 (Davies *et al*., 2006). Wealth is heavily concentrated in North America, Europe and high income Asia-Pacific countries whose populations collectively hold almost 90 per cent of total world wealth. High income countries tend to have a bigger share of world wealth than of world gross domestic product (Davies *et al*., 2006).

*The richest 2 per cent of adults in the world own more than half of global household wealth, while the bottom 50 per cent of the world adult population own barely 1 per cent of global wealth. At current rates of progress in narrowing this gap, it would take more than 800 years for the bottom billion to achieve even 10 per cent of global income (Ortiz and Cummins, 2011).*

These gaps are widening (UNDP, 2005). Between 1960 and 1997 the income of the fifth of the world's people living in the richest countries rose from 30 times to 74 times the income of the fifth of people in the poorest countries (UNDP, 1999). In 2007, Ortiz and Cummins (2011) estimated that the top 20 per cent of the population globally enjoyed more than 70 per cent of total income, contrasted by two paltry percentage points for those in the bottom quintile. Rich classes in rich countries have the greatest concentration of the world's income.

A global economic model that generates this increasing level of inequality appears to be dysfunctional. It creates a challenging context for efforts to reduce inequality and poverty within East and Southern Africa, as a basis for widening opportunities for growth and human development. Rapid economic growth in China, India and South Asian countries moved a large share of people globally from poorest to less poor and is invoked by proponents of globalisation as a success. However, high-income country economies have grown much faster than low-income country economies, most of the latter being in Africa, with widening inequality between countries. Global markets reward more fully those countries and individuals with more of the most productive assets. Existing rules benefit most those countries and individuals who already have economic power (Birdsall, 2005).

African countries have not yet had the employment-intensive productive development push that benefited high-income countries. The financial and economic crisis after 2008 raises even more demand on East and Southern African countries to choose policies that do not exacerbate this inequality. Worldwide, the 'triple F'(financial collapse, food and fuel price) crisis is projected to have increased the number of people living in extreme poverty by 55 to 90 million. This varies across regions and countries. In 2009 the United Nations Department for Economic and Social Affairs estimated that the crisis could keep 12 to 16 million more people in poverty in Africa. Given Africa's position in providing resources for an increasingly unequal and crisis-ridden global economy, often to the cost of a large share of its own populations, the policy choices made in response to this global crisis are critical for both growth and wellbeing.

Women involved in a community project, *Lusaka,* *© Idah Zulu, 2009*

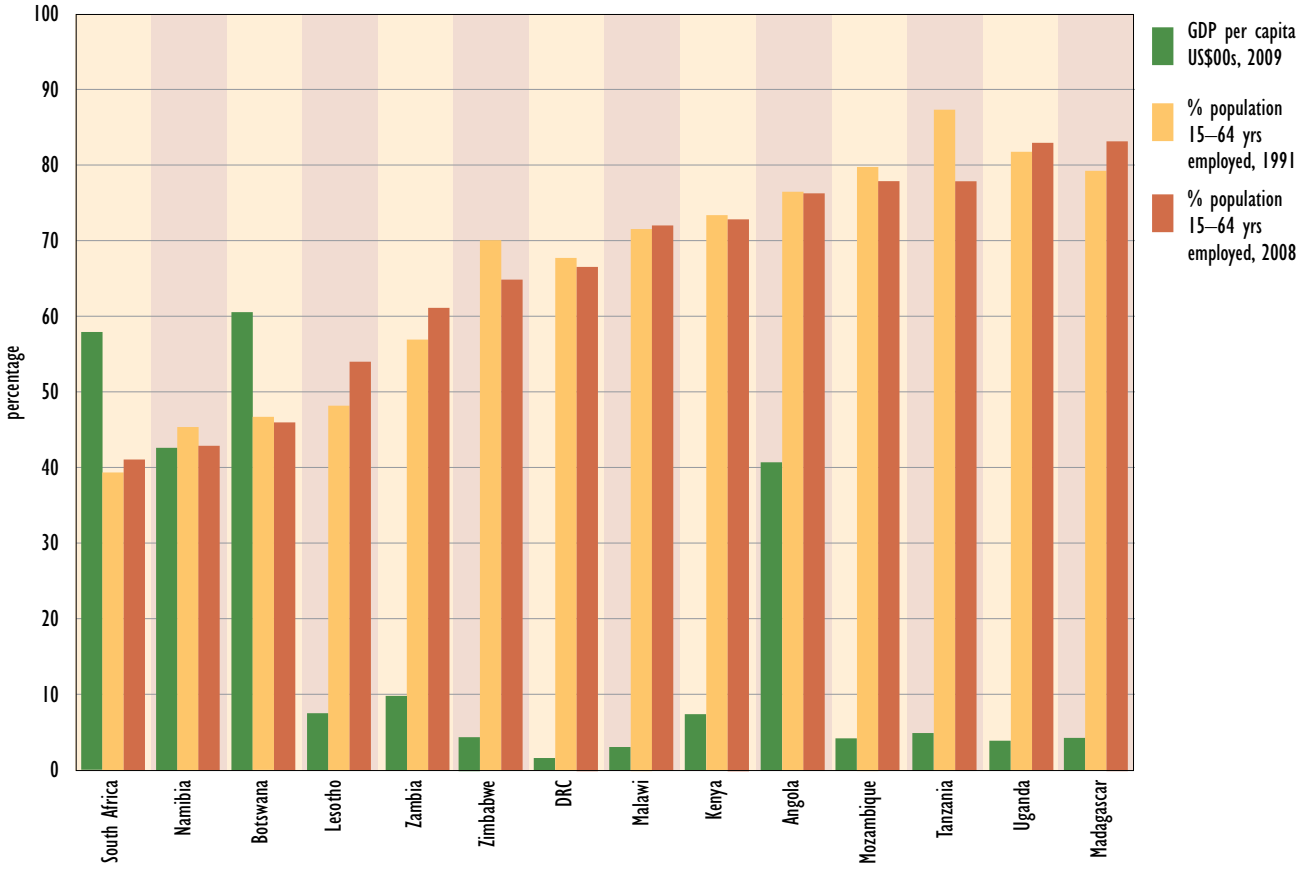
## Increasing the ratio of wages to gross domestic product

Employment was raised in the previous section as an important means for widening the distribution of the benefits of economic growth. The gross annual minimum wage in East and Southern Africa ranges widely from US$247 (PPP) in Malawi to $1,788 (PPP) in South Africa. Countries with higher per capita GDPs have a lower share of people earning below poverty levels and lower levels of vulnerable employment but formal wage earnings are only 21-34 per cent of GDP per capita across all countries (World Bank, 2011; IMF, 2010). Figure 4.6 indicates that the share of the population employed is higher in the lower-income countries than in the higher-income countries of the region, suggesting that improved national income is not directly translating into improved employment and wage incomes.

*Evidence from the few countries that have tracked wage and profit shares suggest that wages have fallen relative to profit shares in these countries, without the benefits of wider employment creation, limiting household access to the resources for health.*

While economic growth in Kenya translated into an improved share of wages to GDP in the 1990s, this was reversed after 2007.

**Figure 4.6: GDP and employment, East and Southern Africa, 2008**



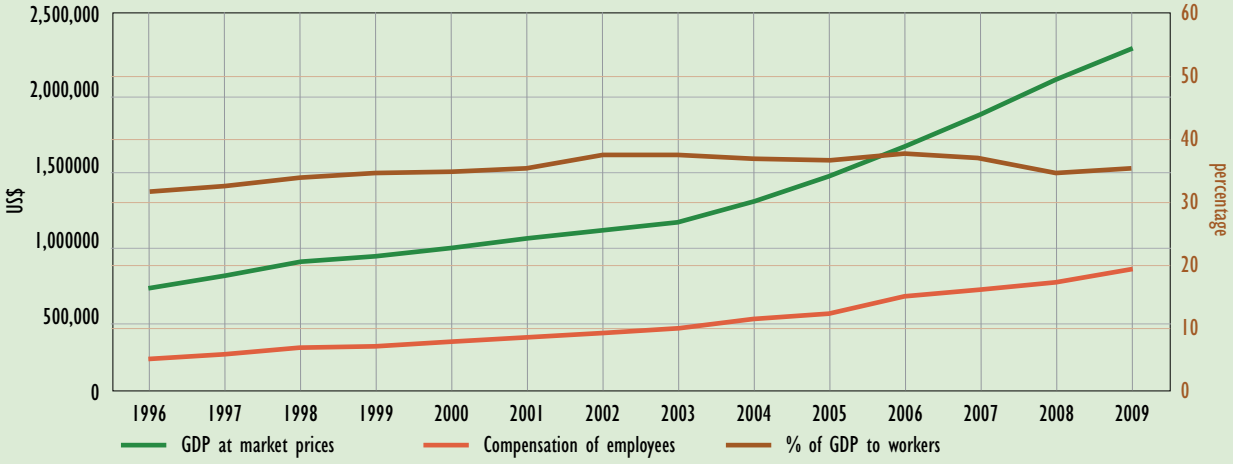

Source: UNDP, 2011

## Tracking Kenya's wages as a share of GDP

In Kenya, as shown in the figure below that tracks wages and GDP between 1996 and 2009, there was a gradual increase in the share of wages to GDP from 31.4 per cent in 1996 to 37.4 per cent in 2002. The level plateaued after that. There was a strong positive correlation between GDP and the share to wages from 1996 to 2005 (R=0.874) indicating that improvements in the economy translated into improved wage incomes.

The figure shows the share of GDP paid to workers between 1996 and 2009. The share of wages in GDP declined after 2007, with a growing gap between GDP and the share to wages. The gap between economic performance and the share of wages in GDP after 2006 indicated a decline in the returns to workers from growth (KNBS, 1996-2009;CBS Kenya, 2004).

### Share of gross domestic product paid to workers, 1996–2009




Source: KNBS, 1996-2009; CBS, 2004


*Gilgil, Kenya*

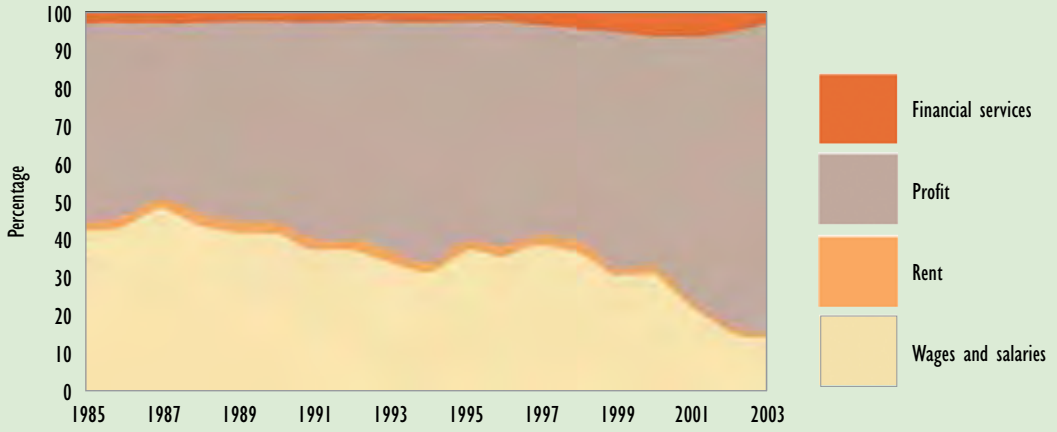
## Inequalities in workers' wages in Zimbabwe

In Zimbabwe growth in formal employment from 1980 to1990 was relatively low, at 1.8 per cent, declining to 1.6 per cent in the 1990–1994 period. While there was some growth in formal employment in the public sector in the early 1980s, the structural adjustment reforms in the 1990s were associated with a planned reduction in public sector employment and a drop in real wages. As shown in the figure, the wages and salaries share of gross domestic income (GDI) fell between 1987 and 1995, and again between 1997 and 2003, while the profits share increased. As the wage share fell, poverty levels increased between 1995 and 2003.

The increased profit share, on the other hand, was not associated with increased investment, due to macroeconomic instability. It did not lead to job creation and may thus have been a driver of widening inequality.

With substantial earnings and profits within informal markets and through remittances it is difficult to track the share of wages and profits in the GDP. Based on a recent all-industry salary survey using a Paterson job evaluation system, top (E5) executives in Zimbabwe were found to earn an annual median total package 100 times higher than that of lowest grade workers, compared to a ratio of 21 in Botswana. This suggests wider executive to worker wage gaps in Zimbabwe than in neighbouring countries, primarily driven by the low real wages of ordinary workers. This is a matter that the Zimbabwe Congress of Trade Unions has protested against (TARSC, MoHCW, 2011).

### Gross domestic income at current prices by factor (%)




Source: CSO National Accounts in UNDP Zimbabwe, 2008

*Building a home, Honde Valley, Zimbabwe*

*©IM Individuell Människohjälp / Foto Erik Törner*