# 5

## Challenging inequities through redistributive health systems

# KEY ISSUES

Health systems can confront socio-economic inequality and stratification when:

- they promote population health;
- they address differential exposure and vulnerability to ill health through inter-sectoral action and primary health care;
- they ensure that people with higher health need can effectively access resources and services;
- they invest in strategies for social empowerment.

Financing and provision arrangements can modify the effect of differences in health risks and vulnerability to ill health and address the different access, use and experience of health care that may arise due to social disadvantage. The system may also be influential in building support for actions that promote health equity.

To achieve this, health systems need to be redistributive. The package of benefits every person is entitled to should be made clear, available, accessible and acceptable, so people are aware of their entitlements and can claim them and parliaments can monitor them too. Individuals should not be prejudiced in access to, use or experience of essential health care due to social factors. Governments need to take any social and health disparities into account when they allocate resources; no one in need of health services should be denied access due to inability to pay. Households' livelihoods should not be threatened by the costs of health care. Those with greater ability to pay should contribute a higher proportion of their income for services than those with lower incomes. Health systems should provide cross-subsidies from the healthy to the ill and from the wealthy to the poor.

How far has East and Southern Africa built these features of redistributive health systems? While countries in the region have set service entitlements these do not always incorporate comprehensive primary health care or recognize the role of other sectors or of community input. Inequalities have closed where services, medicine and staff reach primary care and community level, accompanied by measures to remove cost and social barriers, attract health workers to disadvantaged areas and support community health workers and mechanisms for public participation. Given the higher benefit for disadvantaged communities, greater focus needs to be given to ensuring the resources for the primary level of the health system and the effectiveness of this level in the system.

Although health outcomes have improved when public spending on health rises, improvements in public spending have been slow. Raising the level of tax financing, including through new tax options, is necessary to reduce out of pocket spending.

Scaling up services towards universal health coverage cannot be assumed to support equity; the process needs to address the rights, entitlements, access and financing measures discussed earlier. There is no universal formula for this. As it will take some years to achieve, there is need to build the social awareness, demand and cross-party political support that will sustain the strategies for universal health care with equity.

# Establishing and ensuring a clear set of comprehensive health care entitlements for the population

Comprehensive health care entitlements for the population can be defined as the set of services people are entitled to, including the type of provider (Loewenson *et al*., 2010). Countries in East and Southern Africa share a similar understanding of this concept and many governments in the region have set up a health benefit package that people can access at no or at subsidised cost. More than three decades after the Alma-Ata Declaration and despite challenges and obstacles, there is a widely shared view in the region that revitalising primary health care is critical to addressing inequity in health (WHO Afro, 2010a). A review of primary health care and other health outcomes in low and middle-income countries since Alma-Ata found that scaling up comprehensive primary health care, as distinct to a smaller package of selective interventions, was associated with progress in health and mortality outcomes, even in contexts of low individual incomes, political instability and high HIV prevalence in some countries (Gilson *et al*., 2007). There is thus a broad policy perception that any entitlement would need to cover comprehensive primary health care.

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*'I could be a health worker when I grow up.' A school health visit, Mambilima School, Lusaka, Zambia*

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In the context of the constitutional commitments discussed earlier, Table 5.1 outlines how far countries are setting, costing and delivering comprehensive health care entitlements. In policy, South Africa, Mozambique, Tanzania and Zimbabwe give citizens access to a full range of health services from primary care clinics to referral hospitals through the public system, without specifically defining the services. As noted in the first section, delivery on this entitlement is variable across regions and social groups. Kenya, Uganda and Zambia have set essential health care packages, in some cases linked to insurance options, that are costed and subject to review. These three countries all have policy commitments to comprehensive primary health care but do not explicitly include it in the basic package.

**Table 5.1: Health care entitlements, East and Southern Africa**

| Health care entitlement | Comment |
|---|---|
| ANGOLA | |
| Government has prioritised and increased funding for primary care services, built health centres to improve geographical access, raised clinical standards to improve quality and abolished fees at primary care level. | As a result coverage of health care services increased from 32 to 42 per cent between 2005 and 2009 |
| KENYA | |
| The national health strategic plan provides for a Kenya Essential Package of Health. The National Hospital Insurance Fund benefit package covers diseases, with proposals to broaden it in 2011. | Challenges are: limited availability of public services; poor quality of care; fund co-payment of KES15,000 at discretion of the facility. New package awaits review. |
| LESOTHO | |
| The Ministry of Health and Social Welfare is responsible for the health care system and works with private and non-state agencies. The country is organised into health service areas, each with a referral hospital, responsible for village health centres and clinics with nurses and health practitioners. | Health care centres and clinics offer immunisation services, family planning consultation, antenatal and postnatal care and primary medical services. There are over 5,000 community health care workers in villages across Lesotho. |
| MALAWI | |
| The *Health sector strategic plan 2011–2016* defines an Essential Health Package and no fee services in all public health facilities to ensure access to the package. The plan committed to ensure quality, essential promotive, preventive, curative and rehabilitative services for all people in Malawi. | In 2010, the essential health package included services for HIV/AIDS, acute respiratory infections, malaria, diarrhoea, perinatal conditions, NCDs, TB, malnutrition, cancers, immunisable diseases, mental illness, neglected tropical diseases, eye, ear and skin infections. |
| MOZAMBIQUE | |
| In 2005, provisions were set for essential health services and the measures to reinforce primary health care. | The *Health sector strategic plan 2007–2012* commits to universal coverage and primary health care |
| SOUTH AFRICA | |
| A tax-funded comprehensive benefit package gives citizens access to a full range of health services from primary care clinics through to referral hospitals. Private medical schemes have to cover a prescribed minimum benefit package which includes inpatient care, certain specialist services and chronic care. | Considerable co-payments on other services and large out of pocket payments for care outside the benefit package. Actual service provision limited by inequity in resources versus need between public and private sectors. |

NCD = non-communicable diseases
Information for DRC, Madagascar, Mauritius, Malawi not available

*Two broad approaches exist to defining and costing health service entitlements – comprehensive service provision and a more specific costed benefits package. Both approaches are used in the region. In both, it would be useful to make more explicit how they will provide for comprehensive primary health care, how they will integrate the role of other sectors, build health worker capacities and ensure that communities participate in the design and implementation of entitlements.*

Community meeting, Kasipul, Kenya © Samson Juma, 2009

| Health care entitlement | Comment |
|---|---|
| SWAZILAND<br>The Ministry of Health and Social Welfare coordinates all health policies, laws, standards and systems. There is no specified benefit package but a policy statement to improve and expand comprehensive primary and reproductive health care programmes. Private and traditional medical practitioners are registered but not well regulated. Health centres are not required to register and benefits not well standardised between public and private facilities. | The national development strategy stipulates the state's duty to set national, regional and health facility level mechanisms to manage, coordinate, plan, monitor and evaluate health services, improve health delivery, ensure access to quality health services for most people and to harmonise the interaction between traditional and modern medicine. |
| TANZANIA<br>Users of tax-funded health have access to a comprehensive benefit package. Guidelines and assessment tools have been set for a National Essential Health Package. Priority areas for implementation incorporated in council plans in 2010/2011. A National Hospital Insurance Fund benefit package includes inpatient and outpatient care from primary care to referral level. National Social Security Fund benefit package includes outpatient services, admissions and referral hospitals. Community Health Funds cover primary care services. | Resource shortages in public facilities mean that benefits are not always available. A health systems assessment and costing study on health services is informing a review of the financing strategy. Definition of health services delivery levels, roles and activities, cadres required and criteria to determine numbers of health workers has been done for dispensary, health centre and referral regional hospitals. |
| UGANDA<br>The 1999 National health policy defined a minimum health care package which was used in resource allocation. The *Health services strategic plan II (2005/06–2009/10)* committed to a minimum National Health Care Package for all levels. | Scaling up the plan's targets has been inhibited by inadequate resources to implement plans at all levels. Poor public information and accountability on delivery of the minimum package. |
| ZAMBIA<br>A Basic Health Care Package was set in 1996 and revised in 2008 as an instrument for rationing, prioritising and setting free health services. | The basic package estimated cost of US$34 is feasible for highest burden health problems. Not yet approved or used by Ministry of Health. |
| ZIMBABWE<br>*National health strategy (1997–2007)* stated a policy to guarantee a package of core health services. *National health strategy 2009–2014* proposed to review the benefits package | No public document yet elaborates on what the health entitlements are. |

Source: MoH Mozambique, TARSC, 2010; KEMRI et al., 2011; Zikusooka et al., 2011; UNZA et al., 2011; TARSC, MoHCW, 2011; Zimbabwe MoHCW, 1999; Zambia MOH, 2004; MISAU, 2008; McIntyre et al., 2008; Govt of Uganda MoH, 1999, 2004, 2007; Tanzania MoHSW, 2010

# Overcoming the barriers disadvantaged communities face in accessing and using essential health services

A key step in redistributive systems is ensuring that services are available. In Uganda, for example, while there are 8,785 people per facility on average (including public, private and non-governmental organisation facilities), this varies from 20,376 people per facility in some rural districts to 5,295 per facility in Kampala, the capital city (Nabyonga and Zikusooka, 2010). In Zambia, household surveys show that the poorest people have to travel furthest to access care, raising additional transport and time costs for those who can least afford it (CSO, Zambia MoH, Macro International, 2002, 2009). One response to this has been to identify under-served areas and build new health posts or facilities to reduce distances to services (MoFNP, 2010; UBOS and Macro Int, 2010).

Beyond infrastructure, service availability also depends on reliable supplies of medicines and staff. Country *Equity Watch* reports found shortfalls in the supply of health workers and medicines in Uganda, Zambia, Mozambique, Kenya and Zimbabwe, leading clients to pay more in informal charges or privately for services or medicines (MoH Mozambique *et al*., 2010; UNZA *et al*., 2011; Zikusooka *et al*., 2011; TARSC, MoHCW, 2011; KEMRI *et al*., 2012). Poor households have fewer resources to pursue alternatives and may delay seeking treatment and harm their health (Bloom *et al*., 2000).

Financial barriers exist even where services are available. User fees are discussed later but, even where fees are not charged, there are cost barriers. Mozambique does not have user fees but, in a 2005 survey, half the households surveyed reported transport cost barriers due to distances to services (MoH Mozambique, TARSC, 2010). In Tanzania, maternity services carry no charges but Kruk *et al*., (2008) found in a survey that people still made unofficial payments for services. Such costs are more burdensome for the poorest in the community, as outlined in the Zimbabwe case opposite. Poor households may dispose of assets and become indebted to meet health needs (Goudge and Govender, 2000).

Expanding availability of services, staff and supplies and removing cost barriers is essential but may not be sufficient to overcome unequal access. People from marginalised or disadvantaged groups lack the information and power to demand effective services from the health system (Bernal and Meleis, 1995). In Zambia, for example, knowledge and acceptability of services as well as cultural and traditional barriers were found to affect health-seeking behaviours (UNZA *et al*., 2011). In Zimbabwe, stigma, marginalisation, intolerance and sexual abuse impede service uptake among people with disabilities, while religious and cultural barriers and poor male involvement affect uptake of reproductive health services in low-income communities (TARSC, MoHCW, 2011).

Countries have developed social interventions to overcome these barriers. In Malawi, the National Malaria Control and TB Programme improved information outreach by training storekeepers, volunteers and community members in health promotion and referral skills (REACH Trust, 2005). In Mozambique, primary level services and community health councils improved uptake through social mobilisation and information outreach as well as by building waiting-mother shelters near facilities and involving men in programmes (MoH Mozambique, TARSC, 2010).

Community health workers complement frontline staff and encourage primary care services uptake as the first point of entry into the health system in many countries (UNZA *et al*., 2011). The term

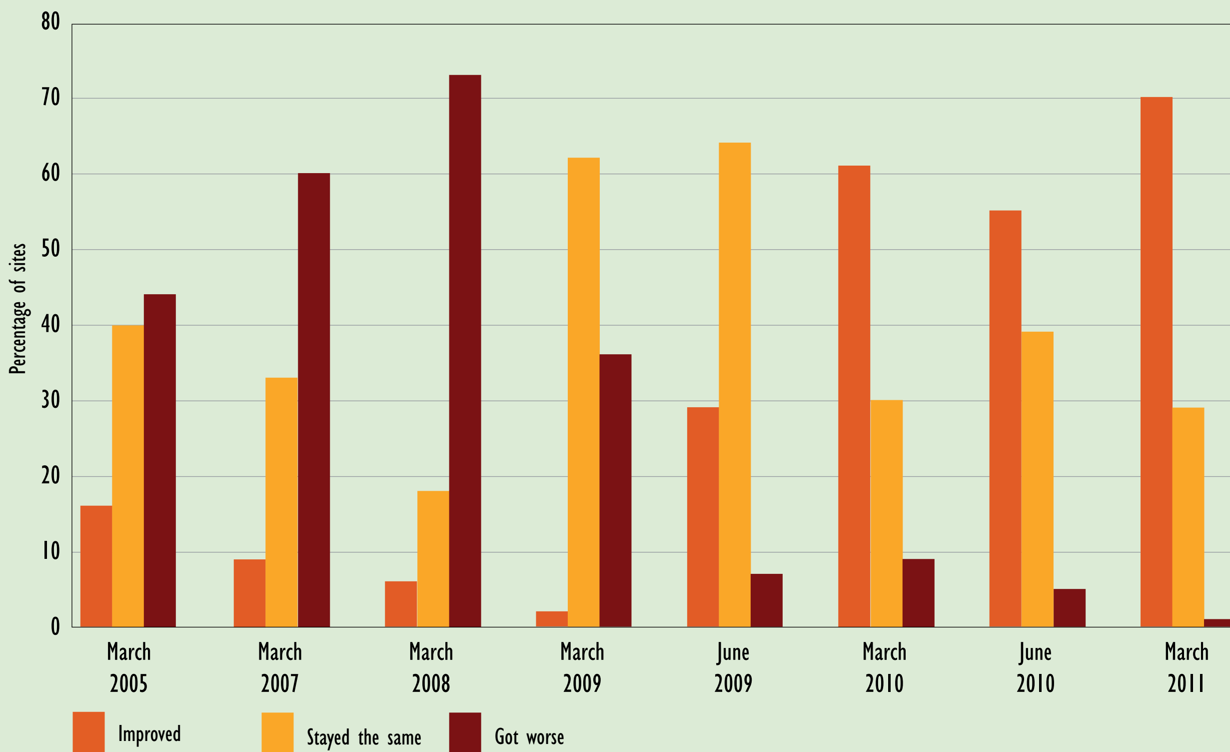
‘community health worker’ covers a wide scope of workers, roles and tasks. In a review of practice, Lehmann and Sanders (2007) found that community health workers improve communities access to and coverage of basic health services and motivate and implement actions that improve health. This is more likely when they themselves are adequately supported, resourced and supervised. However, this is not always the case and the review found evidence of programmes with unrealistic expectations and poor planning that underestimated the effort and input needed. Community health worker programmes were noted to be vulnerable unless they were driven, owned by and firmly embedded in communities. Challenges were encountered in: institutionalising and mainstreaming community health workers within health services and community health committees; resolving whether they should be volunteers or paid; and sustainably and adequately resourcing their role, given the largely poor communities and underfunded primary care services they work with (Lehmann and Sanders, 2007).

## Improving quality accessible health services in Zimbabwe

In Zimbabwe, supply constraints reportedly affected particular groups more. Women were more affected by numerous barriers, including treatment fees, drug availability, transport and distance to facilities. People with disabilities faced problems, particularly as economic conditions and health services declined after 2000, hyperinflation eroded the value of the state disability allowance and assistive devices (wheelchairs, crutches) became unavailable or unaffordable. There were also access barriers. Financial barriers were cited by 75 per cent of women in the lowest income quintile compared to 35 per cent in the highest income quintile and stigma reportedly continued to be a barrier to access.

After 2009, these factors were addressed by improving medicine and staff supplies at primary care level, increasing public investment in village health workers and promoting health literacy and health service uptake through civil society activities. Efforts were made to make services more accessible, including by converting farmhouses into health centres, through immunisation outreach, staff incentives to accept district posts and by institutionalising traditional medicine. Since 2010, community sentinel site monitors have reported a marked increase in the use of public clinics and less use of hospitals and private clinics, associated with wider reports of improved quality of services (TARSC, MoHCW, 2011).

### Share of sites reporting changes in quality of health services in community monitoring




Source: CMP, 2011

*Overcoming barriers to service access calls for a range of measures: expanding service infrastructure and availability in selected communities; ensuring adequate reliable supplies of medicines and staff in services close to communities; and removing cost and social barriers to service uptake, including transport costs. Community health workers and other community outreach programmes play an important role in enhancing uptake in disadvantaged groups.*

## The community health worker programme in Uganda

Uganda has a range of community health worker initiatives. The Healthy Child Uganda volunteer community health worker model was developed and initiated in 2004 as a community-based intervention, with child health promotion provided by trained community health workers. The intervention was implemented between 2006 and 2009 and evaluated through a baseline and post-intervention survey in areas with and without community health workers. The evaluation showed that in areas with community health workers, there were lower levels of childhood diarrhoea, fever or malaria, under-nutrition and child deaths and improved care-seeking practices (Brenner *et al.*, 2011).

In collaboration with WHO and UNICEF, the Ministry of Health also developed and implemented the Home-based Management of Fever/Malaria programme which encourages prompt treatment of malaria in children. In this programme, community drug distributors dispense free age-specific, pre-packaged Fansidar, targeted at under fives who are treated presumptively for fever. The drugs distributors counsel caregivers on the importance of completing treatment and complying with referral and danger signs that require immediate care. They verbally refer severely ill children to health facilities.

The drug distributors are democratically selected by community members, with the assistance of parish and village leaders. One man and one woman are selected per village and many are involved in other community-based health programmes.

The community health workers, who are trained and given identity badges and job aids, are supervised by local leaders and health workers from the nearest facility and given incentives by local authorities. The facility-based health workers also provide feedback to drug distributors based on the collection of health registers.

An evaluation found that children living in the areas covered by programme activities were five times more likely to receive an appropriate anti-malarial than children in comparison districts (UNICEF, 2006).

The AIDS Support Organisation (TASO), a Uganda non-state agency, has also deployed community 'field officers' to ensure patients adhere to antiretroviral therapy, to refill patients' medications and perform various activities, from voluntary counselling and testing and education to promoting family and community support. The programme adherence rates have been over 95 per cent for most clients and there has been a 90 per cent drop in mortality (Benavides, 2006).

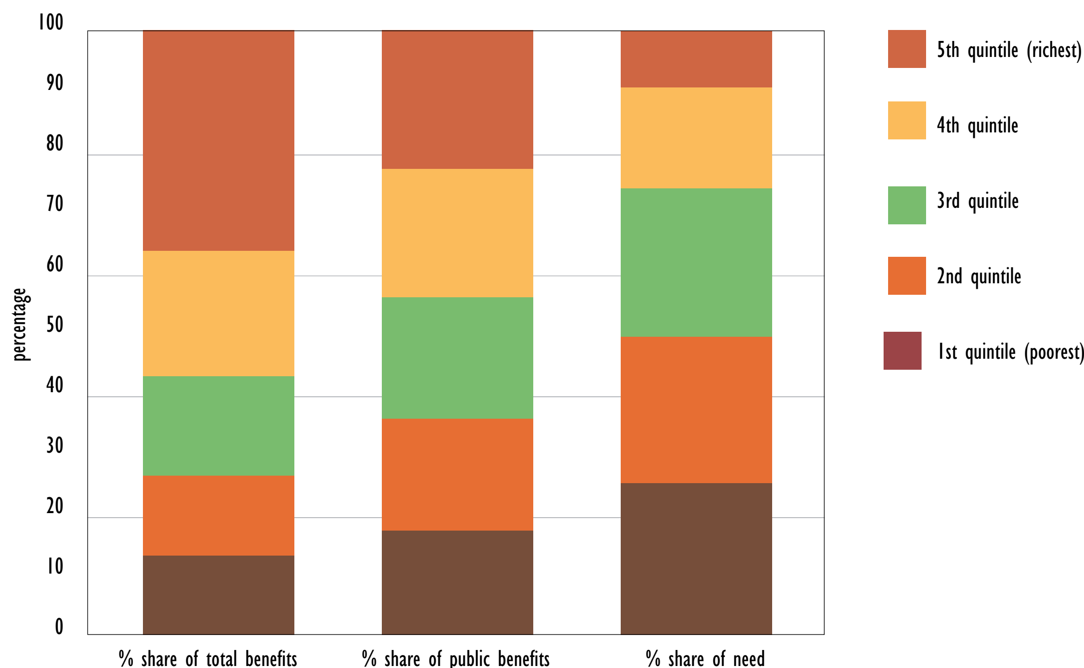
*UNICEF, Uganda*

In Section 2 inequalities in service coverage were reported to be lower for those services provided at community and primary care level, and to increase where communities have to travel to higher level hospitals, such as for antiretroviral therapy or safe deliveries. To enhance equity, resources should flow towards primary and community level services and to those with highest health need. Studies in Africa found, however, that the share of spending that went to the poorest fifth of households was significantly less than the share that went to the richest fifth (Gwatkin *et al*., 2004; Castro-Leal *et al*., 2000; Schellenberg *et al*., 2003). As shown in Section 2, while the poorest groups have about double the level of morbidity and mortality as the wealthiest, the inverse holds for health care, where the wealthiest groups have double the access to some services, such as assisted delivery. Some services, like immunisation and acute respiratory infection treatment, show more equitable access but, for many, coverage rates are inverse to need.

*South Africa, Kenya and Tanzania conducted recent assessments of the distribution of health service benefits in 2008/9 and 2010 respectively. The studies estimated the value (cost) of the services used by different wealth groups. The studies showed that apart from public sector primary care (clinic) services, wealthier groups benefited considerably more from services at other levels.*

In a 2008/9 study, health care in South Africa was found to be 'pro-rich', with the richest 20 per cent of the population receiving 37 per cent of total health service benefits and 23 per cent of public sector health service benefits (despite having a 'health need share' of less than 10 per cent) while the poorest 20 per cent receive only 13 per cent of total health service benefits and 17 per cent of public sector service benefits (despite having a 'health need share' of over 25 per cent) (Ataguba and McIntyre, 2012; see Figure 5.1). Within the public sector, the poorest groups benefited relatively more than those in the wealthier groups from outpatient services at district hospitals and at clinics and community health centres, while wealthier groups benefited considerably more than poorer groups from central hospital services (both inpatient and outpatient services) and from private sector services, with the exception of traditional health care provider services.

**Figure 5.1: Comparison of share of health service benefits with share of health care need across socio-economic groups, South Africa, 2008**




Source: Ataguba and McIntyre, 2012

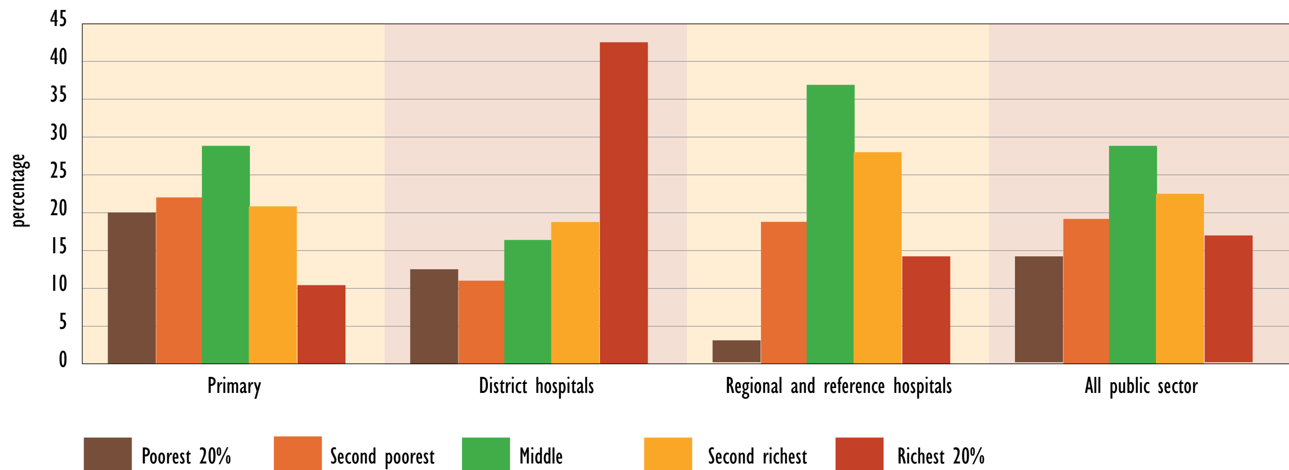
*Immunization outreach, Kenya*

© UNICEF Kenya/2011/Modola

In Kenya, in 2007, larger pro-rich disparities were recorded for inpatient compared to outpatient benefits at the hospital level but primary health care services were pro-poor (Chuma *et al*., 2012). In Tanzania, health care in public primary facilities (clinics and health centres) was pro-poor. The same was not true, however, for outpatient care at district hospitals where the richest 20 per cent obtained over 40 per cent of benefits or at regional and referral hospitals where the benefit was greater in wealthier groups (Makawia *et al*., 2010; Figure 5.2).

While faith-based services had a similar pattern to public services, in the private for profit services, richer groups had higher benefit for all levels of care (Makawia *et al*., 2010). Poorer groups benefited less from public hospitals and private services, and mainly used lower cost primary public facilities and local pharmacies. Poor communities faced barriers in meeting the costs of medicines, laboratory tests and transport as well as due to staff attitudes and medicine stock-outs. Costs were higher for rural patients, for those travelling to referral facilities or where clients had to buy drugs unavailable at lower-level services. They were especially high for those with chronic conditions who needed to visit services regularly (Makawia *et al*., 2010).

**Figure 5.2: Distribution of the benefits of public outpatient services in Tanzania**




Source: Makawia et al., 2010

## Formally recognising and supporting mechanisms for public participation in all levels of health systems

The adoption of primary health care in all countries in the region means that public participation is central to the design and implementation of health systems. Health systems can take into account and influence the power imbalances in society, for example by how they treat women. They can facilitate people's control over resources that affect their exposure to disease, for example, in how they promote nutrition. Health systems can also influence access, uptake and experience of health care, for example, through primary health care and outreach approaches. They can modify the consequences of ill health through the way they provide patient-centred care for chronic diseases (Gilson *et al*., 2007). Health systems can, in contrast, withhold information, reduce autonomy and weaken local control of resources. The governance of health systems promotes improved performance when: there are clear standards; providers have incentives for good practice; information is available to the public; and mechanisms ensure public and financial accountability (Lewis and Pettersson, 2009).

Countries in East and Southern Africa have implemented various measures to mobilise communities for health in the past three decades, often to support the implementation of programmes funded and designed at higher levels of the health system (EQUINET SC, 2007). They have set up mechanisms to facilitate social participation, including committees and boards at primary care and hospital facilities. There is wide policy support for participation but this has not yet translated into formal laws, recognition, resources or capacities to support meaningful forms of participation.

Lack of legal backing for community roles and authorities, unclear reporting structures and role definition combined with the unwillingness of some health officials to provide information have weakened effective participation (Uganda MoH, 1999). Some countries have set up legal provisions to support participation. For example, in 1992, by Legal Notice No 162 of the Public Health Act (Chapter 242), Kenya established district health management boards with duties to oversee all health sector activities and funds (Kenya MoH, 2004). Zambia revised the National Health Services Act 1995 to provide for district and hospital management boards and neighbourhood health committees. Training was initiated and guidelines developed to orient members to their expected roles. A distance education radio programme for neighbourhood health committee members, entitled 'Our Neighbourhood', provided weekly 30-minute courses on health interventions and community mobilisation techniques and offered ongoing support and encouragement over six months. The Central Board of Health endorsed the programme as an official distance learning programme, certifying graduates as qualified in community mobilisation (Macwan'gi and Ngwengwe, 2004). However the 2006 Health Services (Repeal) Act dissolved the district health and hospital management boards and the Central Board of Health and the neighbourhood health committees were re-designated as neighbourhood advisory committees with reduced authority.

Despite the ambivalent support they received, these participatory mechanisms have played a positive role in primary health care and in service access and use. A 2004 study in Zimbabwe found that health centre committees improved health outcomes, even in highly under-resourced poor communities and clinics. They obtained and communicated community needs, organised primary health care services, such as shelters for pregnant mothers, water tanks and toilets, provided health information to communities and supported health workers (Loewenson *et al*., 2005).

Participatory research by the Tanzania Essential Health Intervention Project also found that community support significantly improved communication and care from health workers. The project, with the Ministry of Health in Tanzania, developed a community voice tool that uses participatory action research to give communities the opportunity to reflect on their service and development preferences and to be involved in identifying and solving their own problems (Semali *et al*., 2005).

Over the 2007-2009 period, participatory action research in twenty sites in nine countries in a learning network in EQUINET showed that frontline health systems are able respond to community priorities but do not always do so, do not link well across sectors and perceive community roles narrowly. Health services were found to have high legitimacy but weak capabilities for social roles. Their ability to foster participation was limited by inadequate resources, an organisational culture of top–down planning and limited rewards for health workers' social roles, even though social barriers to health service uptake led to resource inefficiencies and poor adherence to treatment (TARSC, 2009).

However, the work also showed that these issues are amenable to change. Communication gaps between communities and health workers were closed by changes in work organisation at services and involving client networks. Increased awareness within communities was found to support early detection of and response to problems and uptake of services. When joint mechanisms functioned there was increased cooperation and trust between communities and health systems. Shared diagnosis of problems and action planning improved cooperation and coordination across agencies, actors and sectors, improving resource inflows for promotion, prevention and care and uptake of and adherence to services (TARSC, 2009). This local-level participatory work was not able to tackle deeper structural determinants of health, particularly on inputs outside the control of local health workers or communities.

A systematic review of evidence on the effectiveness of participatory mechanisms found that they can improve the quality and coverage of health care and have a positive impact on health outcomes (McCoy *et al*., 2011). Community-led actions, such as service performance monitoring, including through mobile phones and other communication technology, and community-based research on local health priorities, can support social networking and dialogue on service performance and may improve service performance in areas amenable to local change. At the same time, this positive effect can be limited by ambivalent authorities, poor information flow, limited training and weak accountability or representativeness of members selected (Loewenson *et al*., 2005; Lusaka Health Board, Equity Gauge Zambia, 2006; Macwan'gi and Ngwengwe, 2004; Malimo, 2005; Querol 2005). In a review of reports from East and Southern African countries, Baez and Barron (2006) found that effective participation is also influenced by the effectiveness of the wider district and local governance and management, the level of communication to and from the district level, the primary health care orientation of the health system, the organisational culture of the public health sector and the flexibility to innovate at district level, within policy parameters. With a complex and multiple set of factors influencing their functioning, there is no 'one size fits all' approach to participation. Nevertheless a bottom line seems to be that community members should be representative and trained, mandates should be clear, health care workers positive, capacitated and rewarded, and higher level support and facilitation should be evident (McCoy *et al*., 2011; Baez and Barron, 2006).

*There is policy support for public participation in health systems and mechanisms exist with evidence of their positive health impact. Nevertheless, mechanisms for public participation are not backed by legal provisions or resources, implementation is inconsistent and skills support limited. There are many examples of innovative good practice but they are often localised. Meaningful systems-wide progress is yet to be made to institutionalise these examples, through capacitating, strengthening, informing, resourcing and giving meaningful roles to mechanisms for community participation in health across the whole health system.*

## Strengthening dialogue between health workers and communities in Zambia

In 2006 a team representing Zambia Equity Gauge and Lusaka District Health Board with EQUINET carried out a pilot participatory reflection and action process in Lusaka city and rural Chama district to strengthen community health centre partnership and accountability. The pilot was targeted at health providers and community health volunteers from two health centres from each district. The action research had a positive impact on the health workers' attitude towards community members as partners in health planning and on information sharing between them.

In 2007/8, the team applied the approach more widely. Experiences, issues and areas for change were elicited from health workers and communities, followed by jointly-planned activities. Regular review meetings were held to reflect on the activities and outputs achieved, followed by the further action identified to be necessary. A pre and post intervention questionnaire was administered to assess change. The review discussion and assessment indicated better interaction between health workers and community members, more confidence in community members' contribution to planning processes and a positive spillover effect of improved interaction between health workers and clients. Community plans were now included in overall plans. Participatory reflection and action tools were used to resolve emerging issues and other centres were interested in the process. Sustaining these gains called for formalising the process in mechanisms and meetings, involving local leaders, orientating new health workers at the health centres, disbursing funds for planned health centre activities efficiently and drawing up guidelines to support the process and briefs to disseminate information on outcomes more widely in the system.

When the process spread to new health centres, the same problems as those found in 2006 emerged – lack of communication and information flow between health workers and community members in planning processes. The process also uncovered simmering tensions between communities and health workers that were addressed as the process progressed. Both groups began to articulate a mutual appreciation of each others' roles in shared goals and an awareness of the importance of communication and the need to involve affected communities in the planning stages of activities. A series of information-sharing activities were planned to integrate community inputs into the 2008 planning cycle and discuss the use of the 25 per cent share from the monthly user-fees collections allocated to health centres.

The work demonstrated that while such participatory action work could demystify the district and health centre planning process, removing suspicions surrounding it, and strengthen dialogue between communities and health workers in planning and budget processes, the changes take time. They need continuous mentoring and resource support in the early stages and are best integrated within routine work, with support from the authorities, and they need to be included in new health worker orientation (Mbwili Muleya *et al.*, 2008).

*Community involvement in the health centre*

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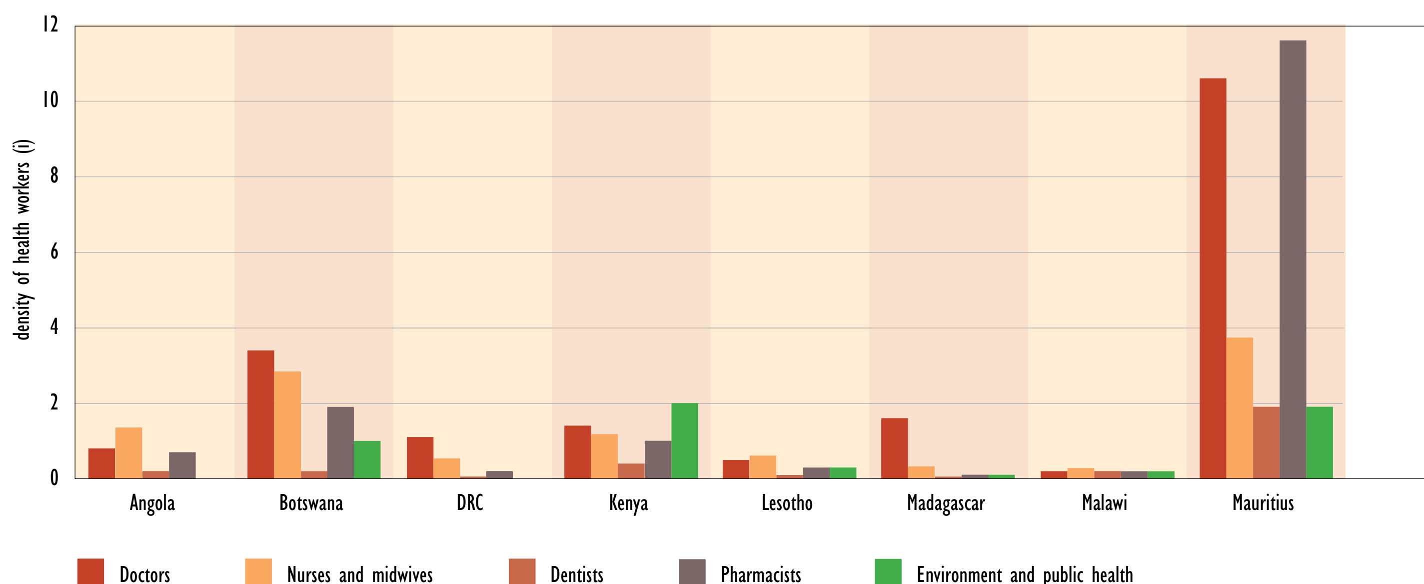
# Adequate provision of health workers at primary and district levels of health systems

The health workforce is central in any health system and gaps in adequate health workers are cited as one barrier in efforts to achieve health and development goals in Africa (Chen *et al*., 2004). Both for quality and equity, health systems need highly-motivated health workers who are satisfied with their jobs, stay at their stations, deliver quality services and communicate well with clients (Dambisya *et al*., 2010).

Achieving this is a challenge in many East and Southern African countries. As Table A5.1 in the statistical appendix and Figure 5.3 below show, the densities of skilled public health and health care workers are extremely low for most countries in the region, the exceptions being Botswana, Mauritius, Namibia, South Africa and Swaziland. The ratios are least favourable for public health personnel which would appear to have negative equity impacts, given the importance of public health determinants shown earlier in the health and survival of low-income communities.

Of the 57 countries experiencing health worker crises worldwide, 36 are within Africa. Most of these countries have absolute shortages of health workers, poor work environments and a maldistribution of health workers between urban and rural facilities, between private and public sectors, between levels of the health system and between regions (Dambisya *et al*., 2010). The causes of these shortages vary from country to country, ranging from: limited training capacity or output (Lesotho, Namibia, Swaziland, Tanzania and Botswana); public sector employment freezes (Malawi and Tanzania); high levels of out-migration due to economic or political uncertainty (Zimbabwe); or poor conditions in rural facilities (South Africa, Uganda) (Dambisya *et al*., 2010). Even in the face of low health worker

**Figure 5.3: Health worker densities, East and Southern Africa, 2000–2010**



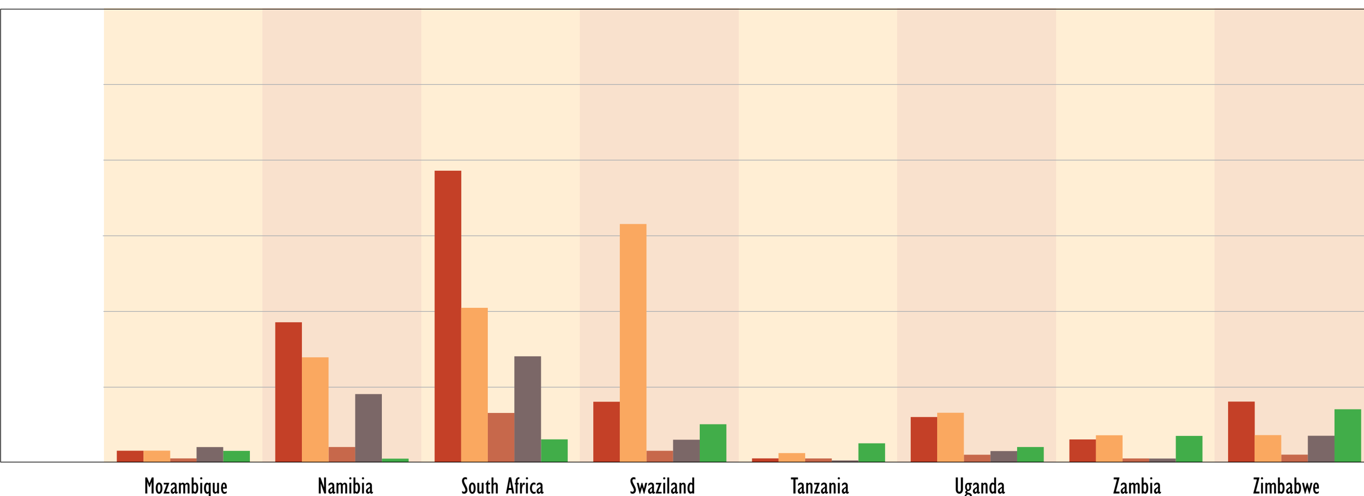

(i) All densities per 10,000 people, except for nurses and midwives which is per 1,000 people
Source: : WHO, 2011

densities, there is an 'excess' of health workers over posts in some East and Southern African countries, often due to a freeze on employment of health professionals. This large pool of unemployed nurses and the relatively low nurse to population ratios has been termed the 'Kenyan paradox' (Kingma, 2007).

*Almost all East and Southern African countries have a shortfall of public sector health workers and a maldistribution of health workers. All have 'hard-to staff' areas – typically poor, rural areas with poor infrastructures. Many have experienced a loss of health workers, although the specific cadres affected and the responsible factors for losses vary across countries.*

Virtually all health systems lose staff from rural to urban areas and from the public to the private sector. In Kenya in 2000, for example, the density of doctors in the capital city, Nairobi at 1:25,000 was twelve times that of Mandera district at 1:308,878 (Mwaniki and Dulo, 2008). Tanzania, with about 80 per cent of the total population living in rural areas, has only one third of its doctors working in rural areas (Khan *et al*., 2006). Health workers are often unwilling to work in post-conflict areas where infrastructure has been eroded or destroyed (Kruk *et al*., 2010).

In Zimbabwe, South Africa, Malawi, Lesotho, Swaziland and Zambia there has been significant outward migration of health workers (Dambisya *et al*., 2007a, Hagopian *et al*., 2005). In 2004, more Angolan-born doctors were reported to be in Portugal than in Angola (Stilwell *et al*., 2004). Low wages, inadequate financial benefits, poor working conditions, lack of recognition and poor career development opportunities are all identified as factors in health workers' low morale and push factors in internal and external migration (Dambisya *et al*., 2010). As shown in the Zimbabwe case on the next page, countries have had to apply a mix of training and incentive strategies to address the losses, often with limited resources. A recent paper by Mills *et al*. (2011) reported that African countries lost an overall estimated return from investment of US$2.17 billion for all the doctors currently working in destination countries, with costs per country ranging from $2.16 million for Malawi to $1.41 billlion for South Africa and with South Africa and Zimbabwe having the largest losses as a share of gross domestic product. There was a significant cost benefit to destination countries in recruiting migrant doctors, to a level of $2.7 billion in the United Kingdom and $846 million in the United States.



## Efforts to retain health workers in Zimbabwe

In Zimbabwe in 1980, government applied a range of measures to produce, deploy and redistribute health workers, including the training of new para-professional cadres. Adequacy and internal migration were the main constraints. By 1992, still only 46 per cent of registered doctors practised in the public sector, with 64 per cent of these at central hospitals and only 21 per cent at district level. In the 2000s, external migration of health workers rose due to poor pay, low savings, poor living conditions, under-resourced health services, job stress and workers' lack of confidence in their future. Staff vacancies rose to high levels between 2001 and 2003, doubling for pharmacists and nurses and rising six-fold for doctors. A massive internal and external brain and skills drain in the 2000s led to a loss of experienced, qualified health professionals from the public health sector. Some institutions, particularly at district level, were found to be staffed by untrained or junior cadres.

In 2006, various incentives were used to address internal distribution, including more favourable bonding policies in district hospitals, a primary care nursing programme and scaling-up nursing training. Increased training, including of primary health care nurses, has been the main strategy to counteract the brain and skills drain, although with constraints in the lack of lecturers and tutors across all fields. Cadres such as environmental health personnel are trained in stages and are deployed after initial training. In 2008 there was some improvement in deployment of doctors to rural services and in 2009 the number of trained nurses at rural health centres reached the approved establishment levels.

While the situation has started to improve, challenges remain. Only 33 per cent of villages countrywide were found to have access to facilities with nurses or midwives providing antenatal care according to national standards, with poor pay and conditions of service, a harsh macro-environment and inadequate training capacity limiting this area (TARSC, MoHCW, 2011).

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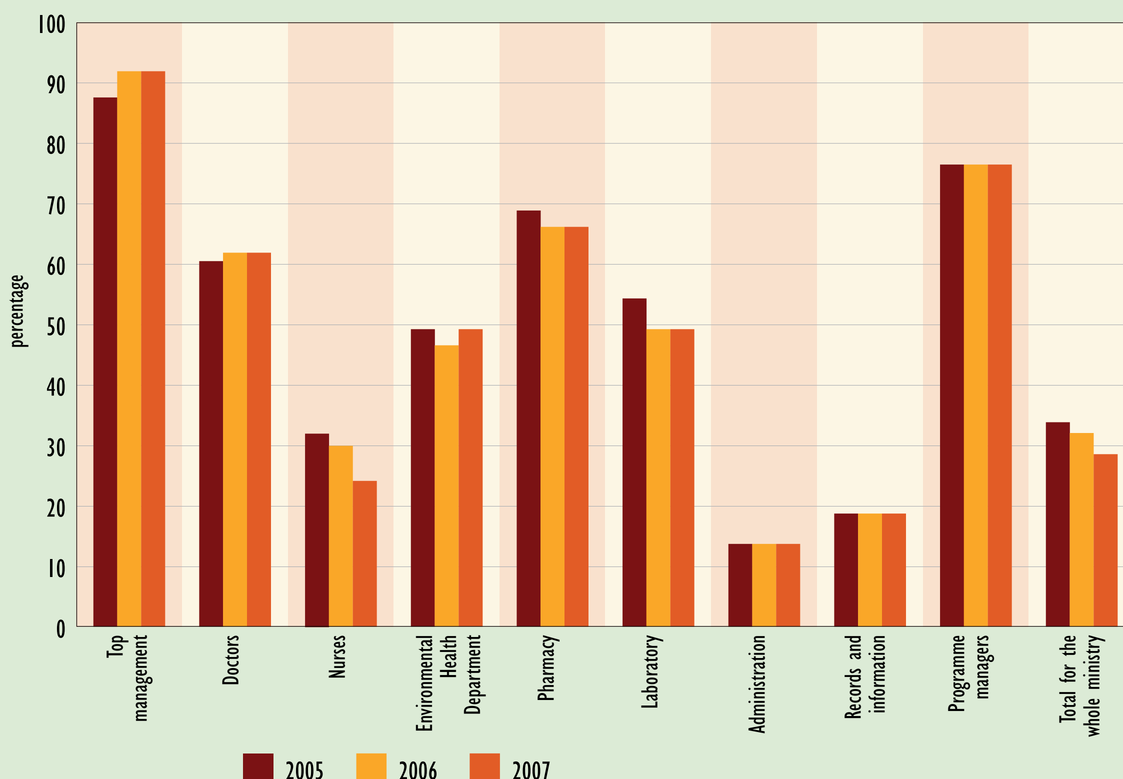
### Vacancy status of health workers, 2005–2007




Source: MoHCW, 2009

The ‘perverse subsidy’ of public resources for health worker training in East and Southern Africa benefiting health systems in high-income countries raises issues of how return funding will flow to support health worker training and how these countries more fairly benefit from their investments. As further discussed in Section 6, this has been raised by African health ministers since the 2001 SADC ministerial statement that ‘recruitment from developing countries…could be seen as looting’ (Gilson and Erasmus, 2005).

While the global issues are discussed later, within the region, countries have given increasing policy attention to these shortfalls and areas of maldistribution, through national policies and strategies, decentralised health worker management, extensive needs assessments and various training, deployment and incentive programmes (Windisch *et al.*, 2009). A five-country EQUINET study covering Zimbabwe, Tanzania, Uganda, Swaziland and Kenya found a range of policies in place but their implementation varied across the countries (Iipinge *et al.*, 2009). While some countries, like Malawi, have intensified their efforts within a relatively short time and applied support from external funders, including the Global Fund to Fight AIDS, Tuberculosis and Malaria, other countries have not yet translated policies into strategies with defined targets, budgets and operational plans (Windisch *et al.*, 2009; Iipinge *et al.*, 2009).

Many countries (Kenya, Tanzania, Malawi, Zambia, Uganda, Zimbabwe and Zambia) have developed health worker strategies and incentives, discussed next, within the context of wider health sector strategies. Some (like Zimbabwe) have set new legal and institutional frameworks to give government greater flexibility in setting and applying measures for managing health workers. However, countries have experienced challenges in implementing these strategies due to unstable political and economic conditions, poor management capacities and systems as well as limited resources to improve incentives (Iipinge *et al.*, 2009).

*Training nurses in Zimbabwe*

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# Implementing a mix of non–financial incentives for health workers

East and Southern African countries attract and motivate health workers to work and stay in key areas of health systems through a range of incentives. While pay is fundamental to attracting and retaining health workers, non-financial incentives, such as career paths and working conditions also make a difference. Improving the quality and resourcing of services, as discussed earlier, are themselves motivational factors for health workers. In the absence of planned incentives, health workers may implement unplanned incentives, such as under the table payments or unofficial user fees at health facilities, discussed later. The range of planned financial incentives in the region is shown in Table 5.2.

## Attracting and retaining health workers in Zambia

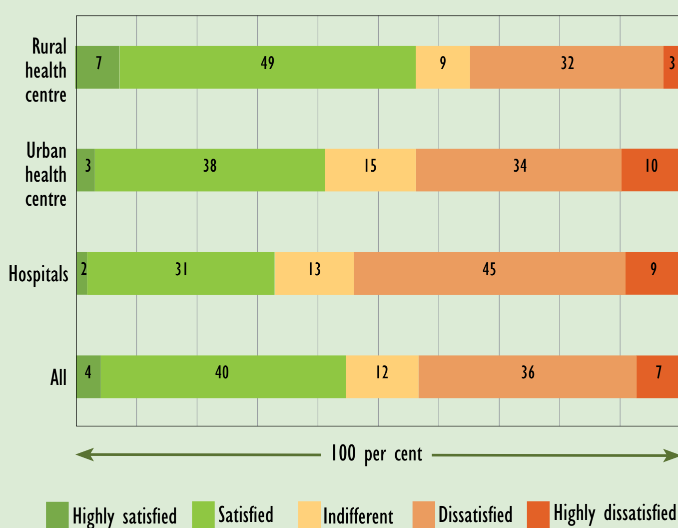
Zambia's policy commitment to address the health worker crisis is expressed in its *Fifth national development plan 2006–2010*, the *National health strategic plan 2006-2010* and the *Human resources for health strategic plan 2006–2010*. This latter, costed, five-year plan seeks to ensure an adequate and equitable distribution of an appropriately skilled and motivated health workforce through effective planning, increased health workforce development, improved workforce productivity and stronger management and governance structures.

By 2006, health worker dissatisfaction was evidently higher at hospital level and in urban health centres (see figure below). Working conditions and resources were lower in rural services and at primary care level although investments were made at these levels. The government of Zambia, with external funders, supported initiatives to provide non-financial incentives to health workers, including housing and import duty exemptions for vehicles. An expanded health worker retention scheme in the Ministry of Health, funded by a consortium of donors under the sector-wide approach (SWAp), provided for various incentives, including health staff training, housing and transportation services to medical personnel, as well as upgrading health facilities and facility equipment.

The Zambia Health Workers Retention Scheme was expanded to include tutors, lecturers, Zambia-enrolled nurses and midwives, environmental health technologists and clinical officers. Despite these interventions, low staff morale persisted, leading to absenteeism (Picazo and Kagulula, 2008).

Since 2005, Zambia has had some success in retaining health cadres and in attracting cadres to remote rural settings. However, shortfalls and inequalities in geographical distribution persist and low staff morale remains a significant problem. Many facilities, particularly in rural areas, still lack the clean water, reliable source of electricity, vehicles, drugs and working equipment that health workers need to perform their jobs. Beyond the specific incentives, continued efforts are needed to improve health services and retain health workers. Budget support for incentives and integrating incentives within the sector-wide approach facilitates linkages across health worker incentives and these wider investments (UNZA *et al.*, 2011).

### Percentage of health worker satisfaction by level of care, 2006




Source: Picazo and Kagulula, 2008

**Table 5.2: Financial incentives for health workers, East and Southern Africa, 1996–2010**

| COUNTRY | APPLIED BEFORE 2005 | APPLIED 2006–2010 |
|---|---|---|
| Angola | Direct exposure subsidy, overtime pay, evening and night shift subsidies | Salary top-ups, allowances |
| Botswana | Reasonable salary levels, overtime pay, with higher rates for nurses than doctors | Allowances |
| DRC | Dual employment, performance-based bonuses, overtime pay | |
| Kenya | Dual practice, extraneous allowance, risk allowance, salary adjustment | Improved salary, housing, risk allowances; life Insurance, loan facilities |
| Lesotho | Accelerated increment for rural workers, overtime and night duty allowances, mountain allowance, housing subsidy, top-up pay for church hospital workers | Improved salaries, training |
| Madagascar | No data available | |
| Malawi | Salary top-ups, professional allowances, retirement packages (earlier for church hospitals; more generous for government), housing and car allowances, subsidized utilities, loans, dual practice, assistance with school fees, medical expenses | |
| Mauritius | Reasonable salary, disturbance allowance for Rodrigues and outer islands, higher pay from savings | |
| Mozambique | Dual employment, medical assistance fund, salary top-ups, housing and fuel subsidies, per diems, extra-hour contracts. 50 per cent bonus for long service for rural staff | National provisional incentive scheme set up to identify and reward performance |
| Namibia | Reasonable salary, end of service benefits, housing schemes, medical aid, car ownership schemes | |
| South Africa | Salary increase, scarce skills, rural allowances, limited dual practice, education support, medical insurance | Proposed new pay structure for health workers |
| Swaziland | 60 per cent pay rise for health workers; car and housing allowance | |
| Tanzania | Differential salary structure for health workers compared to other civil servants, dual practice, selective accelerated salary enhancement scheme, stipend and end-of-service bonus | Proposal to introduce rural incentives |
| Uganda | Enhanced salaries, lunch allowances, dual practice, sponsorship for further training | Hardship allowances for health workers, especially in remote areas |
| Zambia | Salary levels, housing subsidy, hardship allowance, children's fees, end-of-contract bonus, loans, salary top-ups for rural workers; bonus for best performing and best improved health centre (district pilot study) | Plan to extend rural incentives to other health workers |
| Zimbabwe | Salary reviewed for all health workers, call allowance, rural allowances higher than urban, dual practice, part-time work in non-health sector. | Loans; educational and school fees support; housing allowance |

Sources: EQUINET SC, 2007; Ndetei et al., 2008; Munga and Mbilinyi, 2008; Masango et al., 2008; Chimbari et al., 2008, Connor et al., 2010, GoMoz, 2008; Iipinge et al., 2009

*While budgets may constrain the pay levels for personnel, countries have found ways of supplementing with other cash payments, including practice allowances, welfare allowances and performance bonuses. Some financial incentives specifically attract workers to disadvantaged areas, such as the top-ups for rural workers in Zambia or accelerated increments for rural workers in Lesotho. Dual practice in contrast carries a potential risk for inequity as it can be difficult to regulate and control.*

**Table 5.3: Non-financial incentives for health workers, East and Southern Africa, 1999– 2010**

| COUNTRY | APPLIED BEFORE 2005 | APPLIED 2006 –2010 |
|---|---|---|
| Angola | Functional health information system; expanding and upgrading facilities | Management and information systems, working conditions |
| Botswana | Performance-based incentives, upgrading facilities, training and career development, human resource management (HRM) and human resource information systems (HRIS); health care and antiretroviral treatment (ART) access | |
| DRC | Continuing professional development, supervision, improved communication | |
| Kenya | Strengthened management, HIV and AIDS workplace programme, pyscho-social support groups, speedy recruitment of staff<br>Information systems introduced | Training, medical education, recognition of higher qualifications, housing, shorter working hours, national security fund, medical cover, improved working conditions, assistance for child education, decentralised recruitment |
| Lesotho | Accelerated grade policy, continuing professional development, higher promotion prospects for rural health workers, bonding | Improved facilities, equipment, IT, housing, security, transport, employee support centres, sabbatical leave, career management, human resource management and and human resource information systems |
| Madagascar | Recognition of community health worker achievements | |
| Malawi | Workplace HIV support, training, improved conditions, staff rotation, human resource management, transport for visits and shopping, free housing, medical care; bonding for training | |
| Mauritius | Improved workplaces, continuing professional development programme, decentralised management, HRIS. | |
| Mozambique | Use of service cars, free housing, food, HRM initiative with free AIDS treatment, better communication; human resources information systems | Continuous training;, specialization, rapid promotions, bicycles, motor cycles, staff rotation, television, internet access, solar panels, performance appraisal |
| Namibia | Job security, career paths, training opportunities, performance appraisal | |
| South Africa | Improved working conditions and infrastructure, performance appraisal, career progression, community service, bonding, certificate of need, recreational facilities, HRM, medical care | |
| Swaziland | Private sector provides lower workload, training opportunities, supervision, good facilities; government offers accommodation, childcare facilities, ART and health care | Medical cover for nuclear family, supervision and support, training, continuing medical education, recognition of higher qualification |
| Tanzania | Open performance appraisal and management, housing, Mkapa fellows programme for skills enhancement, alumni association membership | Training, continuing medical education, recognition of higher qualification, housing/ housing allowance, medical cover for nuclear family, ART, improved working conditions, regular promotion, personnel appraisal, recognition and respect |
| Uganda | Training opportunities, promotions, management, increased research capacity, decentralization, HIV and AIDS treatment and care, HRM and HRIS. | Training, continuing medical education, higher qualification recognized, housing / housing allowance, improved working conditions, child education support |
| Zambia | Health care and ART, improved services, training, performance-based contracts, transport, accommodation, electrification, trophy and plaque awards (pilot study) | HRM, HRIS., training and career path support, social needs support, minimum conditions of work |
| Zimbabwe | Bonding, training, performance management system, improved numbers to reduce workload, community – improvements in housing and working environment | Improved working conditions, ART, housing / housing allowance, training, continuing medical education, higher qualification and years of service recognized |

Sources: EQUINET SC, 2007; Ndetei et al., 2008; Munga and Mbilinyi, 2008; Masango et al., 2008; Chimbari et al., 2008, Connor et al., 2010, GoMoz, 2008; Iipinge et al., 2009

Health workers not only seek financial incentives but also personal development, better housing, specialisation and the guarantied welfare of their children. Such incentives create a stabilising influence, compared to the more rapid effects of financial incentives, as they sustain health worker commitment, send signals that health workers are supported and reduce feelings of personal and professional isolation. Such incentives, shown in Table 5.3 on page 96, include good infrastructure, opportunities for social interaction, children's schooling and spouse's employment. Professional incentives include opportunities to advance careers, to network, to use tele-health as well as public recognition of the services they provide to communities (WHO, 2010; Dambisya *et al.*, 2010).

A range of non-financial incentives are being applied in East and Southern African countries supporting health worker social needs, for example, staff transport, housing, childcare, working condition improvements, treatment and care for AIDS, improved management and support, and training and professional recognition, with new options introduced after 2005. Some incentives specifically address improving equality of access to education, housing and professional conditions in under-served areas. The manner in which they are applied, reviewed and updated may be as important for their effectiveness as their content.

Housing is possibly one of the most important incentives, its absence most often triggering refusal or acceptance to take up a posting. While bonding and compulsory service have been used to support equitable returns to public sector training investments, they are difficult to implement (Frehywot *et al.*, 2010). For instance, in Zimbabwe, a buy-out clause was ineffective when professionals were able to pay for years not served using a small fraction of their foreign earnings when the Zimbabwe currency collapsed (Chimbari *et al.*, 2008).

Leadership and management support appear to be pivotal. In one survey in Zimbabwe, health workers based in remote areas were found to be highly motivated to perform well as long as they had good leadership and supportive management (Stiwell, 2001). The Zambia case on page 94 also demonstrates that successfully applying incentives calls for good feedback and responsiveness to changing circumstances.

A recent WHO report (Dolea *et al.*, 2010) highlights the paucity of research evaluating retention strategies and incentives. With decisions on their application affected by a range of sectors and authorities, evidence on the effectiveness of incentives is needed to support negotiations with other sectors, dialogue with health workers and strategic reviews.

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# Achieving the Abuja commitment of 15 per cent government spending on health

In 2001 African Union heads of state meeting in Abuja, Nigeria, committed to allocating at least 15 per cent of their domestic public budgets to the health sector, and simultaneously called upon donor countries to honour their commitment to allocating 0.7 per cent of their gross national product (GNP) as official development assistance (ODA) to developing countries and to cancelling Africa's external debt in favour of increased investment in the social sector (AU heads of state, 2000; AU, 2010). In 2006, the African Union renewed its commitment to the 15 per cent target at the Special Summit on HIV/AIDS, Tuberculosis and Malaria, particularly considering that, with a few exceptions, countries had lagged behind on this commitment (Govender *et al*., 2008).

As shown in Table 5.4, two countries (Madagascar and Mozambique) met the commitment in 2000 and the share of the government budget was below 10 per cent in ten countries in the region. By 2005, three countries – Botswana, Malawi and Mozambique – had met the commitment and the share of the government budget was below 10 per cent in eight countries.

**Table 5.4: Health as a share of government expenditure, East and Southern Africa, 2000–2009**

| Country | Per capita government expenditure on health (US$ PPP) | | Govt spending on health as % of total government expenditure (including domestic and external funds) | | | | Govt spending on health excluding external funds as % of total govt expenditure | |
|---|---|---|---|---|---|---|---|---|
| | 2000 | 2008 | 2000 | 2005 | 2008 | 2009 | 2000 | 2009 |
| Angola | 54 | 183 | 3.2 | 4.4 | 6.8 | 11.3 | … | … |
| Botswana | 401 | 1 053 | 7.6 | 16.9 | 16.6 | 16.7 | … | … |
| DRC | 9 | 23 | 1.3 | 6.5 | 17.5 | 17.0 | … | 3.3 |
| Kenya | 47 | 66 | 9.1 | 7.6 | 5.8 | 5.4 | … | 3.5 [1] |
| Lesotho | 68 | 119 | 6.5 | 6.8 | 8.2 | 8.2 | … | 8.2 [1] |
| Madagascar | 29 | 46 | 15.5 | 11.6 | 14.6 | 15.1 | 4.2 | 1.5 [1] |
| Malawi | 36 | 49 | 9.0 | 20.0 | 12.1 | 12.1 | … | … |
| Mauritius | 299 | 681 | 8.7 | 9.4 | 8.3 | 7.9 | … | 7.5 [1] |
| Mozambique | 26 | 39 | 17.9 | 18.2 | 12.6 | 14.2 | … | 8.0 [2] |
| Namibia | 248 | 440 | 13.1 | 12.5 | 12.1 | 12.1 | … | 9.2 [1] |
| South Africa | 552 | 843 | 10.9 | 10.4 | 10.4 | 9.3 | 9.4 | 11.4 |
| Swaziland | 199 | 287 | 11.6 | 14.1 | 8.5 | 9.3 | 6.9 | 8.7 |
| Tanzania | 45 | 112 | 7.3 | 9.3 | 10.5* | 18.1 | … | 5.8 |
| Uganda | 28 | 57 | 9.1 | 10.4*** | …. | 11.6** | 1.6 | 8.2 [2] |
| Zambia | 49 | 80 | 5.0 | 6.8 | 9.7 | 9.8 | 5.0 | 5.5 [2] |
| Zimbabwe | … | … | … | 8.9 | … | 9.5 | … | … |

*Tanzania MoHSW, (2010) sets this at 13.9% ** Uganda Equity Watch sets this at 10% *** WHO, 2012 data … = data not provided on WHO 2012 website
Data for 2009 except [1] 2008 [2] 2005; Source: WHO, 2009, *WHO, 2011 data; UNZA et al,. 2011

By 2009, four countries – Botswana, Madagascar, Mozambique and Tanzania – had met the commitment and the share of the government budget was below 10 per cent in seven countries. It is, however, noteworthy that the WHO data used to compare the 16 countries includes tax and external funding through government in 'government expenditure'. If based on governments' own spending, excluding external funding, as shown in the last two columns of Table 5.4, no countries will have achieved the 15 per cent level, although some, such as Uganda, South Africa and Swaziland, have improved domestic public spending.

Monitoring Abuja demands reporting across countries on government's own spending, excluding the external share. This is particularly important in Africa, given the high share of external funding in the health sector. The 2007 EQUINET regional analysis discussed the challenges health systems face in ensuring that these significant levels of external funding are aligned to policies that support health equity (EQUINET, 2007). This discussion is not repeated but the challenges are acknowledged and the focus is on improving domestic health financing as an important affirmative response. The later section on harmonising financing examines the challenge in aligning international funding to national mechanisms for domestic resource mobilisation, pooling and risk sharing.

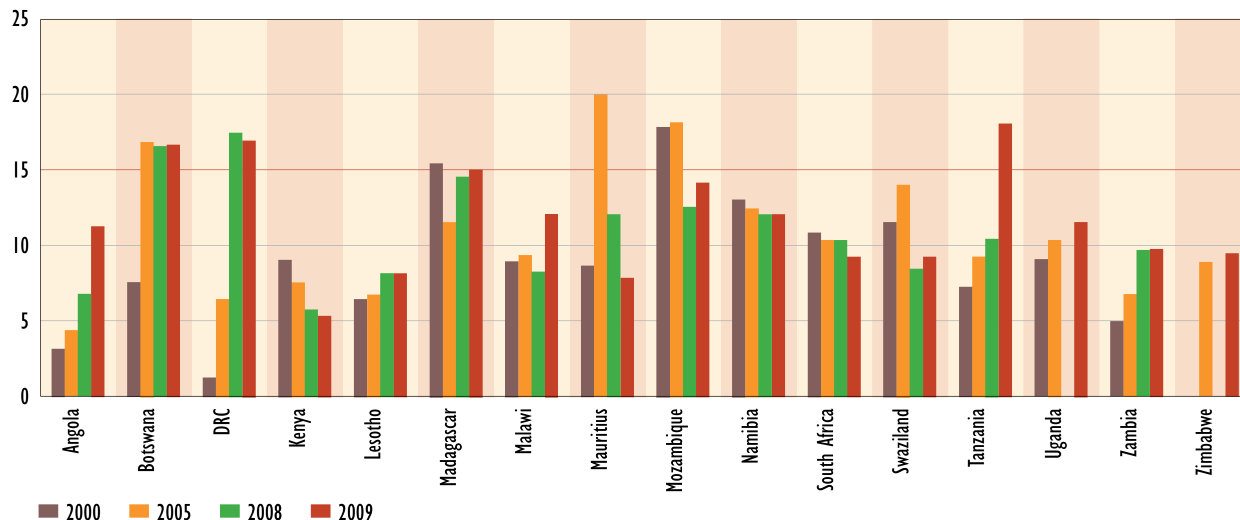
*The progress in meeting the Abuja commitment has been slow but evident, with more countries meeting the commitment or reaching over 10 per cent of government budgets to health.*

Even including external funding, while more East and Southern African countries are moving towards the Abuja commitment, since 2000, some countries (Kenya and Namibia) have moved away from it. Figure 5.4 shows the trends in performance on the Abuja commitment between 2000 and 2009.

In 2003, for ten of the sixteen countries concerned, meeting the Abuja commitment would have brought their public financing to health above the Macroeconomic Commission on Health (MCH) basic funding to AIDS, TB and malaria of US$34 per capita. For eight countries it would have brought public spending above the WHO defined level of US$60 per capita. For Kenya, Angola, Zimbabwe and Mozambique, attaining the 15 per cent target makes the difference between reaching or not reaching these per capita thresholds.

Kenya has been moving away from the Abuja target, with only 6.8 per cent of the government budget allocated in 2008 and only 5.4 per cent in 2009, even though the absolute amount of money spent on health increased (KEMRI *et al*., 2011).

**Figure 5.4: Trends in government expenditure on health as a percentage of total government expenditure, East and Southern Africa, 2000-2009**




Source: WHO, 2006, 2009, 2011; UNZA et al., 2011

**Table 5.5: Health spending as a share of GDP, East and Southern Africa, 2005 and 2009**

| Country | Total expenditure on health as a % of GDP | |
|---|---|---|
| | 2005 | 2009 |
| Angola | 2.0 | 4.6 |
| Botswana | 7.5 | 10.3 |
| DRC | 4.8 | 9.5 |
| Kenya | 4.3 | 4.3 |
| Lesotho | 6.2 | 8.2 |
| Madagascar | 3.7 | 4.1 |
| Malawi | 8.1 | 6.2 |
| Mauritius | 4.6 | 5.6 |
| Mozambique | 5.8 | 6.2 |
| Namibia | 7.3 | 5.9 |
| South Africa | 8.8 | 8.5 |
| Swaziland | 7.3 | 6.3 |
| Tanzania | 3.9 | 5.1 |
| Uganda | 7.8 | 8.2 |
| Zambia | 7.0 | 6.1 |
| Zimbabwe* | 8.9 | n.a |

Sources: WHO, 2009; * TARSC, MoHCW 2011

Lower spending is not attributed to lower perceived health need but to economic constraints and low absorptive capacities. Public expenditure survey reports of 2005, 2008 and 2009 indicated that unspent funds were returned to the treasury at end of the financial year, acting as a disincentive for increased health funding. Poor absorption was itself attributed to delays in transferring funds to the ministry and from the ministry to the districts, while cumbersome procurement processes made it difficult for facilities to implement development plans on time (KEMRI *et al.*, 2011).

By 2009, many countries that had advanced towards attaining the Abuja commitment had also increased the share of their GDP spent on health. Angola funds health largely from domestic financing (89 per cent) with limited reliance on external resources and out of pocket spending. Government health spending as a percentage of GDP rose from 2 per cent in 2007 to 4 per cent in 2009. After 2004, Tanzania consistently increased its public spending on health and it was at 4 per cent of GDP by 2009 (Index Mundi, 2011).

Not all countries have made this progress. A 6 per cent growth in the Zambia economy over the last seven years provided the opportunity to improve public spending on health (Bank of Zambia, 2010) but government's health spending as a share of GDP remained relatively low, at 2.5 per cent in 2009. Kenya's government expenditure on health as a share of GDP has been at 1.5 per cent since 1999. Its health spending has been lower than in neighbouring Tanzania and Uganda, despite its higher income.

*Mothers jostling each other to get their babies weighed at a community growth monitoring point Nazerene Church, Chunga Lusaka, Zambia.*

*© Idah Zulu, 2009*

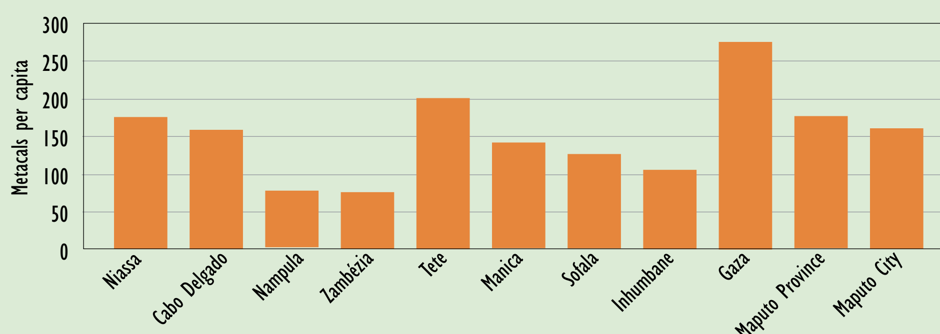
## Tracking health spending in Mozambique

In Mozambique, while government per capita health expenditure rose between 2000 and 2005, in 2004 its spending was 61 per cent of total health expenditure, the balance coming largely from external funding. Per capita health expenditure rose further between 2005 and 2006 and the health budget per capita allocation in 2009 was at US$10. If total health funding available to the sector from the state budget and other off-budget sources is used to calculate per capita health funding, this figure increases to US$17.70 per person. Of this, US$10.40 per person was spent in 2008 (excluding vertical funding outside the budget).

This budget allocation to health is in line with the PARPA II objective to increase per capita health spending to US$15 by 2009. Nevertheless this remains below the US$60 per capita recommended for a functioning health system. It is also below the sub-Saharan Africa average, which was estimated at US$ 31.90 in 2002. As shown in the figure below, the allocations of this budget varied by province and provinces with relatively high health need, such as Cabo Delgado and Zambézia, had low per capita allocations.

While the level of public financing for health falls far short of desired levels, public sector and overall health financing have improved steadily. The shortfall in basic per capita spending reduces the options for redistributive allocations. The geographical variation in health spending per capita, whereby provinces with high health need or shortfalls receive lower shares per capita, suggests the need for a resource allocation process that progressively improves the capacity to absorb and effectively use resources in provinces (and districts) of high health need

### Per capita health allocations per province, Mozambique, 2009




Source: Fundação para o Desenvolvimento da Comunidade (FDC) (Foundation for the development of the community), UNICEF, 2008

There is some evidence of health gains in the ten countries that increased the share of government spending on health between 2000 and 2009. Their annual reports and strategic plans noted:

- Improved health worker recruitment and retention (Uganda MoH, 2009);
- Improved supplies, reduced stock-outs of essential medicines and improved service availability (Uganda MoH, 2009);
- Improved coverage of maternal, child and reproductive health and AIDS treatment services (Uganda MoH, 2009; Lesotho MOHSW, 2007/08);
- Reduction in malaria and tuberculosis cases detected and more treatment success (Lesotho MOHSW, 2007/08);
- Gains in primary care level services due to improved funding (see Angola case study on page 104);
- Improved uptake of services, better coverage for measles vaccinations, antenatal care, more successful tuberculosis treatment and better access to antiretroviral therapy, including for pregnant women to prevent vertical transmission and in child survival (Tanzania MoH, 2010).

*There is evidence of gains in health outcomes from Uganda, Lesotho, Angola and Tanzania in periods of increased public spending on health. There has, however, been limited systematic documentation of the improvements in health care arising from improved funding. This link between health spending, health system performance and health outcomes needs to be more systematically explored.*

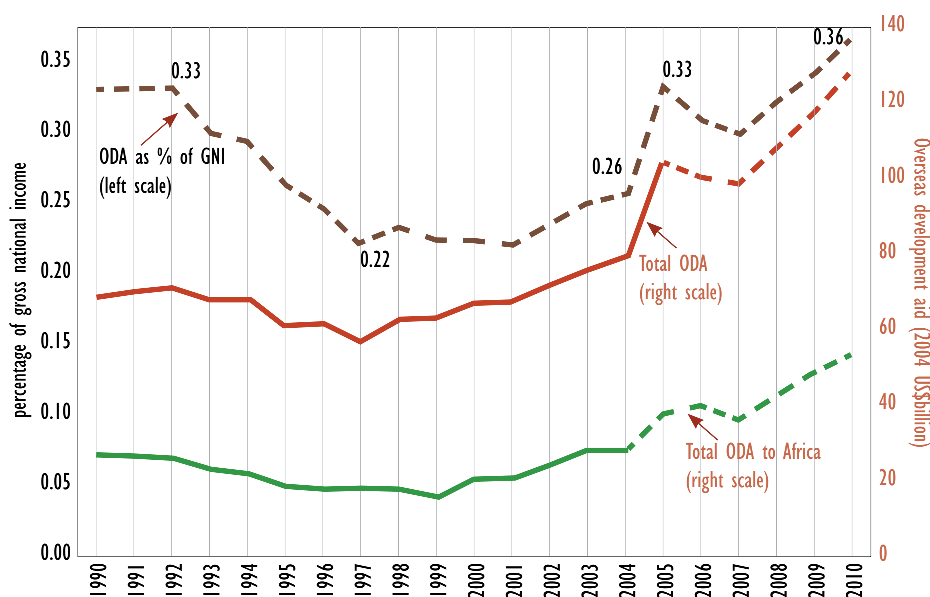
Whatever the case, there has been consistent advocacy from parliaments, civil society and others that African governments must demonstrate their commitment to health services by devoting an increasing share of their resources to the health sector. Nobel Peace Prize winner, Archbishop Desmond Tutu, stated in 2008:

'The African Union Abuja 15 per cent pledge is one of the most important commitments African leaders have made to health development and financing, and our heads of state should strive to meet this pledge without further delay. … Our leaders know what they have to do. They have already pledged to do it. All they have to do now is actually *do* it. This is all we ask of them' (cited in Govender *et al.*, 2008).

Even if countries in the region spend 15 per cent of domestic public funding on health, for many this still leaves a substantial funding gap to achieve a minimally adequate comprehensive set of health services, if government resources are also low. Further measures need to be taken, including debt cancellation, development aid and a review of macroeconomic frameworks and expenditure limits that limit absorption of significant new external resources.

The Abuja commitment included high income countries increasing their development aid support to 0.7 per cent of GDP. As Figure 5.5 shows, while this assistance has increased, it remains well below the 0.54 per cent of gross national income needed to meet the Millennium Development Goals or the 0.70 per cent to fulfil the monetary commitments. With the Abuja commitment reflecting the prioritisation of health in the budget, there is equally need for adequate per capita funding (Nugent, 2006).

**Figure 5.5: High-income country overseas development assistance, 1983–2010**




ODA = Overseas development aid; GNI = gross national income

Source: Nugent, 2006

# Achieving US$60 per capita public sector health expenditure

The 2000 *World health report* estimated that US$60 per capita was needed for a comprehensive health system, including a minimum set of interventions and the infrastructure to deliver them. In 2001 this was revised up to US$80 per capita per year (Govender *et al*., 2008). In both 2000 and 2005, only five of the sixteen countries in the region had achieved a US$60 (PPP) per capita public health sector expenditure (Botswana, Mauritius, Namibia, South Africa and Swaziland; Table 5.7). These countries have higher incomes than others in the region which partially explains their spending levels. In 2008 and 2009, two further countries (Lesotho and Angola) achieved this target and by 2009 another two (Zambia and Uganda) were close to achieving it. Between 2000 and 2008/9 six countries had three-fold or more increases in per capita spending on health (US$PPP). These were Angola, Botswana, Lesotho, DRC, Uganda and Zimbabwe. However, this progress needs to be set against the fact that the level needs to be adjusted upward regularly for inflation. Doing this would reduce the number of countries achieving it.

By 2009, eleven countries had achieved a total per capita spending of US$60 PPP on health, although only seven had achieved this in the public sector.

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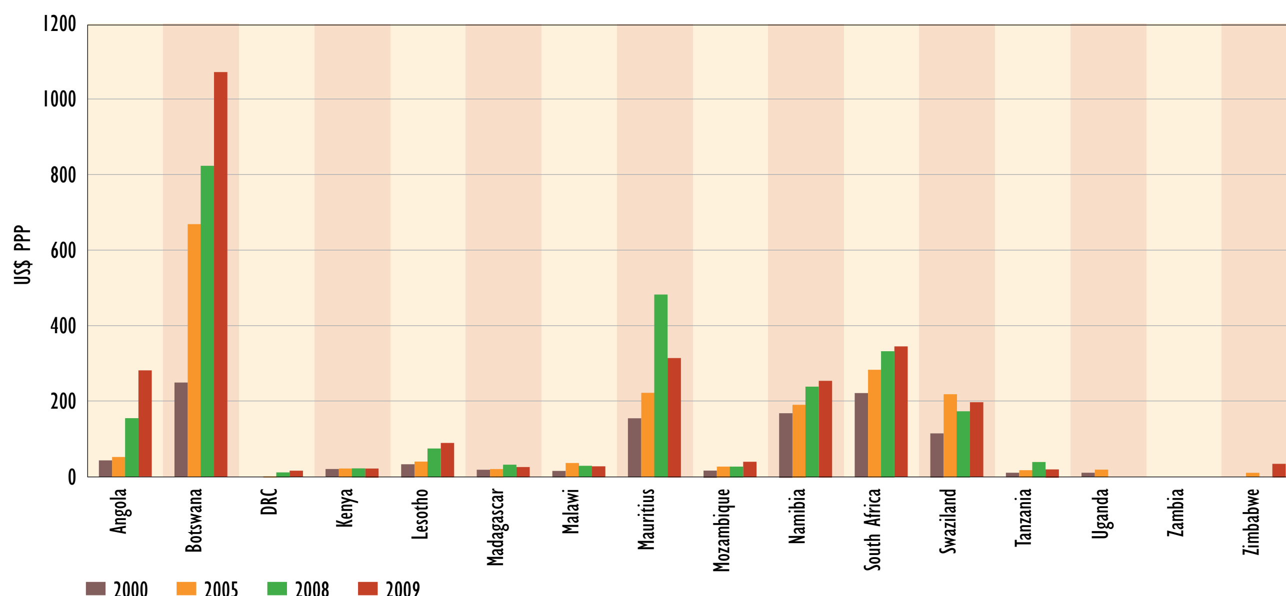
**Figure 5.6: Government per capita expenditure on health, international purchasing power parity (PPP) US$, East and Southern Africa, 2000-2009**




Source: WHO, 2011

## Increasing health spending in Angola

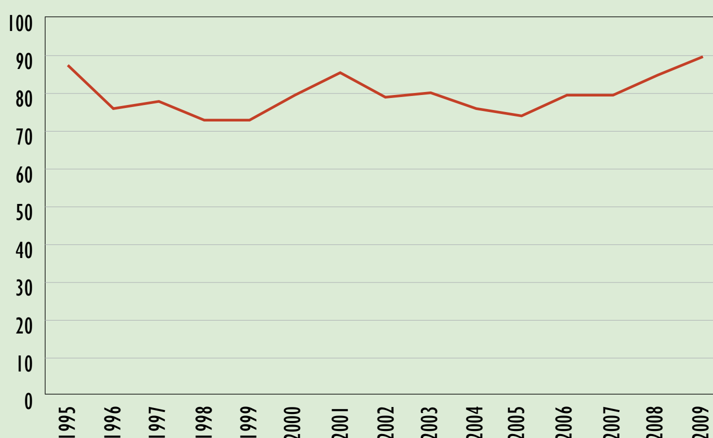
Angola increased its per capita public spending on health substantially from US$43 in 2000 to US$281 in 2009. A large share of this (80 per cent) was domestic financing. Public health expenditure as a percentage of total health expenditure in 2009 was 89 per cent with a significant increase in government share of spending on health after 2003 (see Figures A and B).

Funding of primary care facilities has increased significantly and improved geographic access to basic health services.

The increase in health spending is attributed to a real-term growth of 16 per cent in Angola's economy between 2004 and 2008, due to high oil export prices. Allocation to the health sector increased through the budget. Between 2002 and 2006, total health spending increased from US$ 213 million to an estimated US$800 million and the share of government spending on health grew from 4.4 per cent in 2005 to 11.3 per cent in 2009 (WHO, 2009).

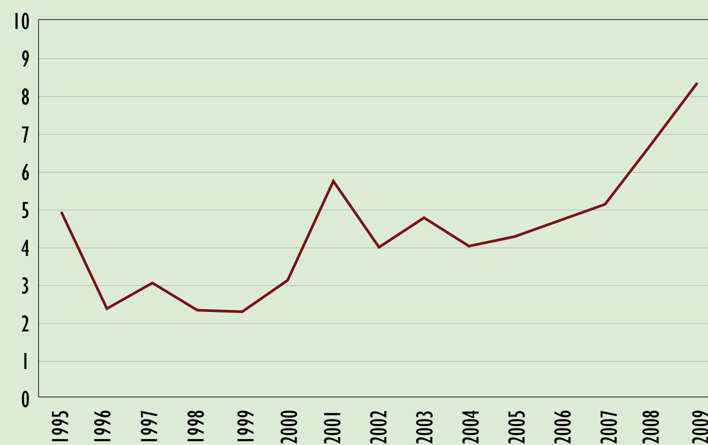
Further, government prioritised increased funding to primary care level from 25 per cent in 2002 to 33 per cent in 2005 and spending at the primary care level grew 415 times faster than that at secondary and tertiary levels of care. This increased funding enabled government to build health centres based on provincial maps, to improve geographical access and raise clinical standards, to improve the quality of service, abolish fees and facilitate primary care level access through the no-fees policy. As a result, coverage of health care services increased from 32 to 42 per cent between 2005 and 2009 (Connor *et al.*, 2010).

**Figure A: Public health spending as a percentage of total health expenditure, 1995-2009**




Source: Index Mundi, 2011

**Figure B: Government health spending as a percentage of total government expenditure, 1995-2009**




Source: Index Mundi, 2011

Angola has used some promising practices, described in the box above, and these are also found in Botswana, where government spending on health as a share of total health expenditure rose from 52 per cent in 1995 to 80 per cent in 2009, with government consistently increasing allocations to the health sector over time. In 2005, Botswana met the Abuja commitment and has maintained it and increased the percentage of its GDP spent on public sector health services from 2.2 per cent in 1996 to 8.2 per cent in 2009 (WHO, 2011).

Despite these signs of overall progress and examples of promising practice, by 2009, nine countries remained below the US$60 public spending needed for health systems and five were below the US$34 the Macroeconomic Commission on Health considers essential for a package of interventions. Some countries (Uganda and Mozambique) have had a rising share of off-budget external funding (MoH Mozambique, TARSC, 2010; Govt of Uganda, 2009), while others (Zambia and Zimbabwe) have had higher increases in private than public spending (UNZA *et al.*, 2011; TARSC MoHCW, 2011). While these other sources increase the sector's resources, for systems to be redistributive, it is the share and levels of public sector funding that matter.

# Increasing progressive tax funding to health and reducing out of pocket financing in health

Progressive tax funding is the most effective way to ensure equity and universality. Public financing is the mechanism of choice for countries in the region, given the need for public sector redistributive systems in a context of high levels of poverty and inequality.

General government expenditure for health derives from taxes on wealth, income and consumption. As shown in Table 5.6 opposite, general government expenditure on health increased consistently between 2000 and 2009 in seven countries (Angola, Botswana, DRC, Lesotho, Mozambique, Tanzania and Zambia), consistently declined in the period in three countries (Kenya, Mauritius, Uganda) and fluctuated over the period in the others. In the three countries where the share of government spending (and the tax share of financing) on health declined, the share of private spending on health rose, with three quarters or more of this out of pocket spending in Kenya and Mauritius and about two thirds out of pocket spending in Uganda. The negative impact of out of pocket funding on access to health care and financial protection is discussed later.

*Generally, just under half of the countries in the region have made consistent progress in strengthening the share of tax funding in the past decade.*

In general, tax revenue comes from personal and company income tax. In most countries in the region, value-added tax (VAT) on consumption of goods and services is charged at a flat rate across all income groups. VAT has been identified as regressive when applied to goods that are purchased by poor people. However, an assessment of health care financing progressivity in Tanzania found that VAT, excise tax and import duty were all progressive, with rich people paying more than poor, although VAT was less progressive than income taxes. Excise tax was found to be progressive overall but more so for tax on alcoholic drinks and fuel and less so for taxes on cigarettes and kerosene (Meti *et al.*, 2010). In South Africa, research also revealed that income tax was progressive but VAT, excise taxes and the fuel levy were regressive (Ataguba and McIntyre, 2012b). Ghana has a range of tax sources, including income tax for the national health insurance fund where 2.5 per cent of the 17.5 per cent of formal sector workers' social security scheme contributions are directed towards health insurance. The health insurance fund also draws from a 2.5 per cent VAT on selected goods and services and an annual allocation of central government funds. In the initial stages there was public resistance to VAT due to poor public information and perceived inadequacy of the capacities to manage VAT resources. A range of goods and services consumed mainly by poor people were then exempted (Akazili, 2010).

*It appears that VAT can be a progressive source of funds for health if it covers commodities consumed more by high income groups but this would need to be assessed in each context. With low levels of formal employment and a large informal sector in most economies of the region, VAT represents one source of tax contributions from this sector.*

**Table 5.6: Health expenditure, East and Southern Africa, 2000-2008**

| Country | Total expenditure on health as % of GDP | | % total health expenditure that is: General government expenditure | | | % total health expenditure that is: Private expenditure | | % private expenditure that is out of pocket | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2008 | 2000 | 2005 | 2009 | 2000 | 2008 | 2000 | 2005 | 2009 |
| Angola | 2.4 | 3.3 | 79.2 | 74.5 | 89.0 | 20.8 | 15.0 | 100.0 | 100.0 | 100.0 |
| Botswana | 4.7 | 7.6 | 62.2 | 75.5 | 80.0 | 37.8 | 21.8 | 36.7 | 31.5 | 34.0 |
| DRC | 4.2 | 7.3 | 3.5 | 26.7 | 51.0 | 96.5 | 45.8 | 87.1 | 85.5 | 76.2 |
| Kenya | 4.2 | 4.2 | 45.3 | 40.6 | 33.8 | 54.7 | 63.7 | 80.1 | 77.4 | 77.4 |
| Lesotho | 6.7 | 7.6 | 50.9 | 52.9 | 68.2 | 49.1 | 36.7 | 73.2 | 68.8 | 68.9 |
| Madagascar I | 3.7 | 4.4 | 66.5 | 66.4 | 67.1 | 33.5 | 29.8 | 52.8 | 61.5 | 67.8 |
| Malawi | 6.0 | 9.1 | 46.3 | 74.7 | 58.0 | 53.7 | 39.4 | 41.3 | 35.3 | 28.5 |
| Mauritius | 3.8 | 5.5 | 52.0 | 47.7 | 36.0 | 48.0 | 65.2 | 74.6 | 84.0 | 88.7 |
| Mozambique | 5.9 | 4.7 | 71.9 | 74.2 | 75.5 | 28.1 | 24.8 | 45.2 | 46.7 | 43.6 |
| Namibia | 6.1 | 6.9 | 68.9 | 48.9 | 66.6 | 31.1 | 45.4 | 18.2 | 7.3 | 17.8 |
| South Africa | 8.5 | 8.2 | 40.5 | 38.3 | 40.1 | 59.5 | 60.3 | 25.0 | 29.8 | 29.6 |
| Swaziland | 5.7 | 5.8 | 58.6 | 69.2 | 63.3 | 41.4 | 39.2 | 42.4 | 42.1 | 42.3 |
| Uganda | 6.6 | 8.4 | 26.8 | 24.4 | 19.0 | 73.2 | 82.6 | 56.7 | 77.6 | 65.1 |
| Tanzania | 3.8 | 4.5 | 43.4 | 48.5 | 73.6 | 56.6 | 27.7 | 83.5 | 62.5 | 65.4 |
| Zambia | 5.7 | 5.9 | 51.3 | 54.9 | 59.5 | 48.7 | 38.0 | 80.5 | 60.7 | 67.2 |
| Zimbabwe | … | … | … | n.a | n.a | … | … | … | 50.5 | n.a |
| African region | 5.5 | 6.0 | 43.7 | | 49.8 | 56.3 | 50.2 | 57.3 | | 60.9 |
| Income group | | | | | | | | | | |
| Low income | 4.6 | 5.4 | 37.1 | | 40.5 | 62.9 | 59.5 | 87.4 | | 85.7 |
| High income | 10.0 | 11.1 | 59.3 | | 62.2 | 40.4 | 36.4 | 38.9 | | 38.0 |
| Global | 8.3 | 8.5 | 56.4 | | 60.5 | 43.5 | 38.4 | 50.7 | | 50.7 |

n.a means not available; data for some indicators only available for 2008 not 2009; private expenditure on health includes spending by households (including out of pocket) and capital spending by private for profit and non-profit health care providers. The final column in the table shows the share of private spending that is out of pocket.
Source: WHO 2009, 2011

Some countries, such as South Africa, Namibia and Uganda, have increased tax revenue dramatically by improving compliance rates. Further tax options that have been proposed include:

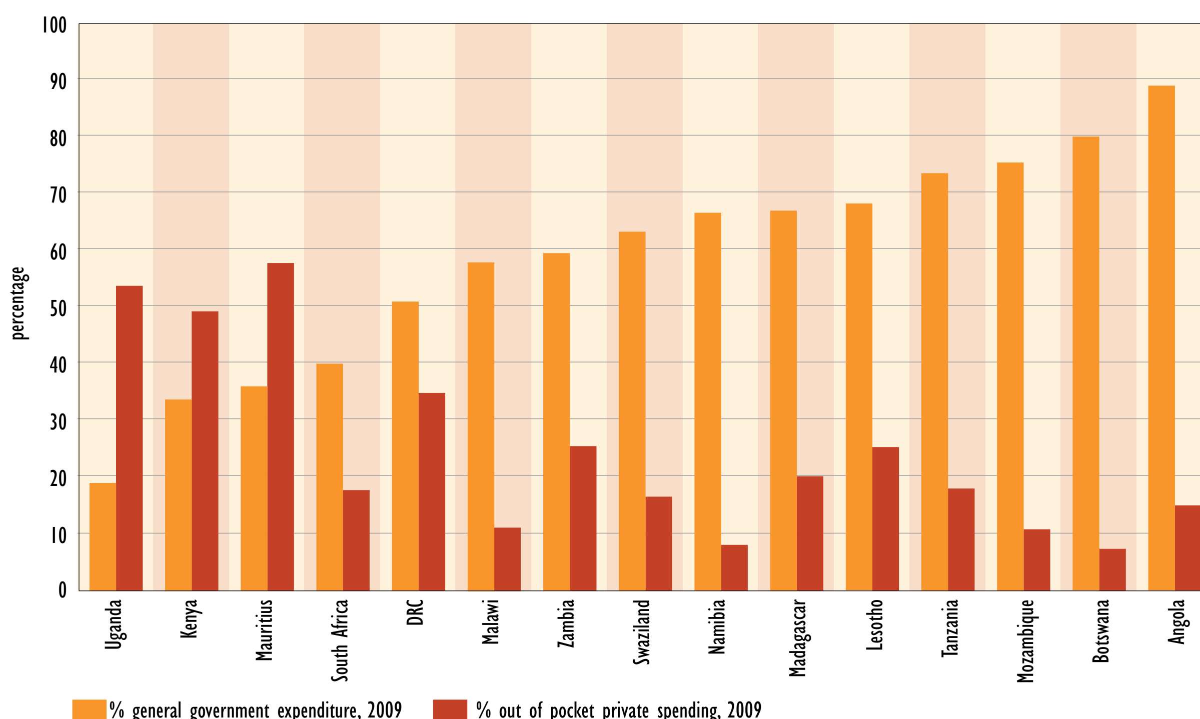
- Improved collection of personal income taxes, where people contribute a higher percentage of their incomes as incomes increase, rather than a flat rate across all incomes.
- 'Sin taxes', as additional earmarked taxes on products that have negative health consequences, such as cigarettes, alcohol or high sugar foods, with the revenue sometimes earmarked for public health programmes that address the problem.
- A range of wealth taxes (for example, taxes on financial transaction flows, luxury airline travel, currency exchanges), like Zimbabwe's 3 per cent levy on top of the existing personal and company income tax rates to fund AIDS interventions (McIntyre *et al*., 2005a).
- Local authority rates and taxes used for public health funding.

In Kenya, in 1999, taxes were used for an earmarked Local Authorities Transfer Fund (LATF), to improve service quality in large urban local authorities and to supplement financing in poorer authorities. It had limited success in these goals due to weak administrative capacities. The Constituency Development Fund (CDF), introduced in 2004, allocates 2.5 per cent of government's annual budget to promote constituency development, with allocations to constituencies based on their population and poverty levels (KEMRI *et al*., 2011). In Uganda, at local government level, districts are allowed to spend 10 per cent of their resources on health, while those districts that were involved in conflict that were implementing the 'Peace and recovery development plan' had the extra flexibility of spending 50–65 per cent of local resources on health between 2006 and 2008 (Zikusooka *et al*., 2011). It will be important to track the extent to which these positive policy intentions were implemented.

Internationally, other revenue streams proposed include an airline ticket levy, used to fund UNITAID, supporting drug procurement in low income countries. A tax on currency transactions or a Tobin Tax has been proposed, given that financial flows increased seven-fold between 2000 and 2010. With a volume of transactions worldwide of about $3.6 trillion daily for foreign exchange, of $210 billion daily for bonds and $800 billion for stocks, a tax levy of five cents for each $1000 exchanged could bring in more than $30 billion per year for health (LGIDF, 2010). Support for the financial currency transaction tax has been mounting and at a side meeting at the 2010 United Nations General Assembly, Helen Clark,. Administrator of the United Nations Development Programme observed that, 'UNDP believes that applying innovative financing mechanisms, such as a financial transaction tax, offers a promising way of complementing overseas development assistance with a potentially significant, sustainable and additional resource flow to achieve the Millennium Development Goals by 2015 and sustain progress in the longer term' (Clark, 2010).

However, options for tax revenue in the region were overshadowed by fees and insurance policies in the past two decades and remain under-explored. As Figure 5.7 shows, there appears to be an inverse relationship between tax-based government spending and private out of pocket spending.

**Figure 5.7: Government percentage shares and private out of pocket spending as a share of total health spending, East and Southern Africa, 2009**




Zimbabwe data not available.
Source: WHO, 2010, 2011

Rural Malawi © F. Machingura 2011

*Given the high poverty levels within African countries, there is an urgent task to reduce all forms of out of pocket spending and to increase tax-based financing, to prevent the impoverishing and inequitable effects of catastrophic spending on health.*

This is further discussed in the next section.

Private insurance of any magnitude is largely restricted to Southern Africa (Botswana, Madagascar, South Africa, Swaziland, Namibia and Zimbabwe) and Kenya in East Africa, mainly through private voluntary coverage of formal sector employees. Community health insurance (pre-payment) schemes have expanded, particularly in East Africa. They remain, however, a small component of overall health care financing at present, with limited coverage levels, fragmented risk pools and rapid and uncontrolled costs threatening their sustainability (McIntyre *et al*., 2008). Recent evidence that the Community Health Fund in Tanzania, as an example of a community-based scheme, is a highly regressive form of financing with higher burdens borne by poorer groups, suggests the need for caution in relation to such schemes (Mills *et al*., 2012). With the expansion of community and private voluntary schemes in the region, improved regulation and capacities are needed to enforce the regulations and incentives to integrate schemes, increase their risk pool, cover low-income populations and contribute to public health services.

Table 5.7 shows the developments in the region with respect to national mandatory insurance. The table highlights that while there is a relatively consistent policy commitment to introducing mandatory health insurance, particularly as a source of new revenue for the health sector, there are opposing public reservations in many countries over the management and use of the funds as well as private sector pressures over the implications for crowding out private insurance funding. In some countries, a fund has been introduced but remains largely confined to formal sector workers. While there is an understanding that any national fund would need to be phased over a reasonably long timeframe to benefit from GDP and income growth, credible plans do not seem to be in place for doing this in a manner that also supports equity and quality in access to services. For many countries in the region, improving revenue and budget allocation from wider payroll and other taxes, discussed earlier, may be a more equitable and feasible option than insurance.

*To increase tax-based financing, the projected revenue streams and distribution of burdens of new tax options need to be explored. These include VAT, earmarked, sin and other wealth taxes. Options for tax revenue have been overshadowed by fee and insurance policies. Replacing high out of pocket payments with tax and prepayment options is now more widely accepted. For many countries, improving revenue and budget allocations from wider payroll and other taxes may be a more equitable and feasible option than mandatory insurance.*

**Table 5.7: Developments in national health insurance, East and Southern Africa, 2000-2012**

| Country | Developments in national health insurance |
|---|---|
| Angola | No public mandatory health insurance. Health services are tax funded. Since 2009 three private voluntary health insurance packages were introduced for worker and individuals. |
| Botswana | No public mandatory health insurance. Health services are tax funded. A medical insurance scheme for civil servants started in 2001 benefits only 3 per cent of the population. |
| DRC | No public mandatory health insurance. Health services are tax funded. |
| Kenya | A National Health Insurance Fund (NHIF) is mandatory scheme for formal sector workers and voluntary for those outside the formal sector but covers only inpatient services. A 2004 National Health Insurance Bill, was not signed into law. Dialogue on mandatory national health insurance is still underway. |
| Lesotho | No public mandatory health insurance. Health services are tax funded. |
| Madagascar | No public mandatory health insurance. Health services are tax funded. |
| Malawi | No public mandatory health insurance. |
| Mauritius | No public mandatory health insurance |
| Mozambique | No public mandatory health insurance. Health services are primarily tax funded. |
| Namibia | No public mandatory health insurance. The Namibia Social Security Commission is exploring options for national health insurance through a long-term, phased introduction of a National Medical Benefit Fund. Stakeholder consultations are underway including to assess synergies between the fund and the existing private medical aid industry. |
| South Africa | No public mandatory health insurance. Earmarked taxes on personal income and employers payroll are to be introduced to improve services for all. |
| Swaziland | No public mandatory health insurance. Government undertook a feasibility study in 2008 to assess the feasibility/possibility of introducing a social insurance scheme. |
| Tanzania | A national health insurance scheme introduced in 2001 covers public sector formal sector workers. A Community Health Fund covers community prepayment for health care but by 2010 enrolled only 6.6 per cent of the population. |
| Uganda | The design of a national health insurance scheme has been debated for five years but there is public resistance due to concerns on management of funds. A process of phased introduction is planned but not implemented. |
| Zambia | No available public or mandatory health insurance schemes. The development of social health insurance is underway but still at early stages. |
| Zimbabwe | No mandatory public health insurance. Private voluntary health insurance covers less than 10 per cent of households. A proposal for national health insurance scheme was devised in 2007 funded by a payroll tax levy but not introduced. |

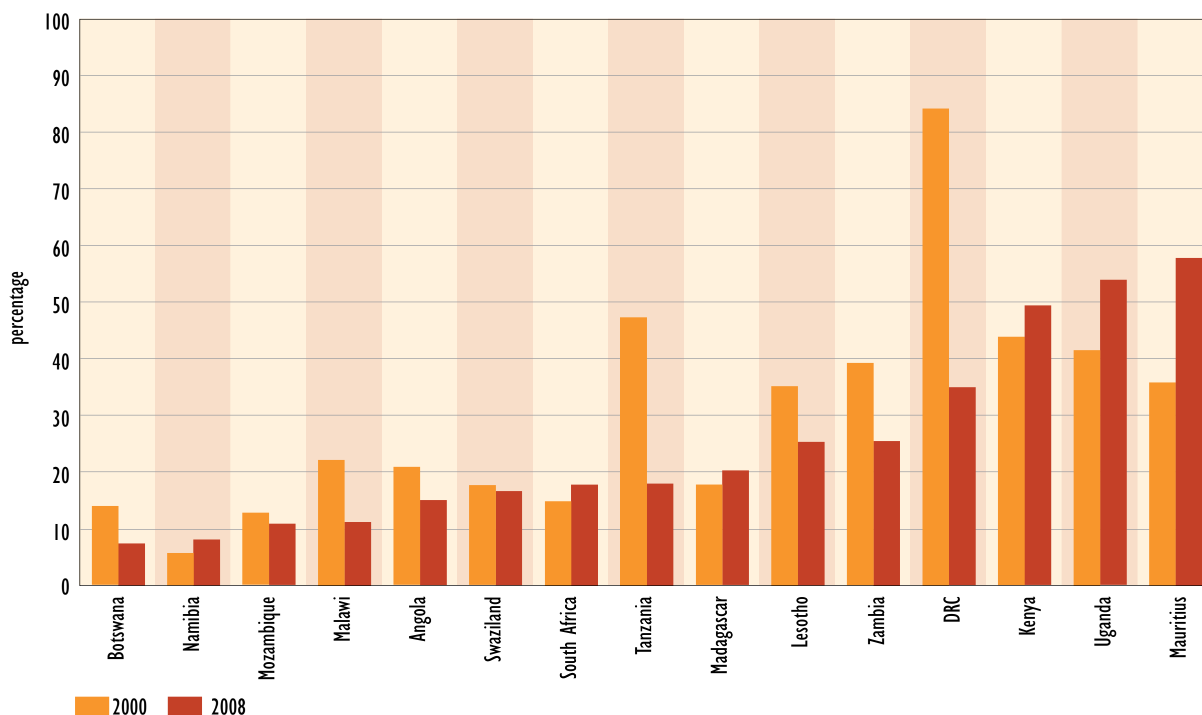
Source: MoH Mozambique, TARSC, 2010; KEMRI et al., 2011; Zikusooka et al., 2011; UNZA et al., 2011; TARSC, MoHCW, 2011; Connor et al., 2010, South Africa Dept of Health, 2011; Save the Children Fund, 2011, Nyaungwa, 2011; Tanzania MoHSW, 2010

# Abolishing user fees from health systems backed up by measures to resource services

As raised earlier, countries enhance equity by moving away from the out of pocket (or point of service fee) payments approach to financing health systems through prepayments, including tax funding and health insurance. Carrin *et al*. (2008) observed from household expenditure surveys in 89 countries that up to 13 per cent of households face financial catastrophe in any given year because of the charges associated with using health services and up to 6 per cent are pushed below the poverty line. Yet, as shown in Figure 5.8 below, out of pocket funding in the region is still high and rose in seven countries between 2000 and 2009, including in the three countries that already had high out of pocket shares of total spending (Kenya, Uganda and Mauritius). This is surprising for Uganda where user fees were officially abolished in 2001.

Out of pocket spending largely derives from user fees charged by public and private providers (including informal drug sellers and traditional healers) and payments in kind for services. Households also spend significant sums on transport and other indirect costs and face opportunity costs such as lost work time. A review of user fees in Africa found that fees contributed little to revenue in public services and relieved pressure on finance ministries to improve health budgets (Yates, 2006). User fees contribute to inequities in access to health care services and to household poverty. In contrast, abolishing user fees has been followed by large increases in services use, especially among poor people (Hutton, 2004; Govt of Malawi MoHP, 2005).

**Figure 5.8: Percentage shares of private out of pocket spending of total health spending, East and Southern Africa, 2000–2009**




Zimbabwe data not available.
Source: WHO 2010; WHO 2011

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A review of health uptake in eight projects providing prevention services such as deworming, bednets and water purification in Kenya, Uganda, Zambia and India, found that even small fee charges discouraged uptake in those who need the services. Free services did not reduce willingness to pay later for benefits if resources were available (J-PAL, 2011). This has led to calls for the removal of user fees in the public health system for both personal care and prevention services (McIntyre *et al*., 2008; J-PAL 2011).

Table 5.8, on pages 112 and 113, summarises the policies and experiences in East and Southern Africa in removing user fees. User fees continue to apply in eight of the thirteen countries for which information was available, although with exemptions for low income and specific vulnerable groups and for particular services. The effectiveness of exemptions can be queried, with only South Africa reporting on them positively out of the countries in this analysis (Witter, 2010). Unofficial charges are reported in a number of countries, often arising where funding is inadequate or supplies and services rationed.

Zambia, Uganda and Kenya set up specific funds to compensate for lost revenue as a way of avoiding informal charges or households having to pay for supplies not provided in public services due to inadequate funding. The case of Kenya in the box on page 114 shows the positive impacts of removing user fees but also the advances and reversals in this.

A multi-country review of the experience of user fees in six countries identified that policies aiming to reduce financial barriers can be effective in improving health service use provided they are well designed, funded and implemented (Meesen *et al*., 2011). Existing experience suggests that fee removal should be undertaken carefully, given the substantial and sustained increases in use which could lead to drug shortages, work stress for staff and a lower quality of care (Pearson, 2005). As fees may have been used by communities to fund their own priorities at local services and by health workers to supplement facility resources, both communities and health workers need to be consulted (Pearson, 2005). Removing user fees needs to be accompanied by improvements in basic services and sustained supplies so that people are not forced to pay for services outside the public sector or to pay informal charges for scarce resources. While there are different ways to implement these changes, these measures need commitment, including from external funders. Policies that change (remove or apply) user fees need to be monitored, not only by routine information systems but also by additional surveys or surveillance. This is necessary to capture the impact on those services that have benefits for the population, such as preventive services, to understand the distribution of costs and benefits of fee policies and to know what their impact has been on the performance of the health system as a whole (Meesen *et al*., 2011).

**Table 5.8: Policies and experiences with user fees, East and Southern Africa**

| Country | User fee policies | Comment |
|---|---|---|
| Angola | Fees officially abolished in the public sector at all levels. | Informal charges are rare. |
| Botswana | Fees officially abolished in the public sector at all levels. | |
| DRC | User fees applied. Some basic health care services offered without charges by non-governmental organisations but with limited coverage. | Exemptions cover poor, people with Leprosy, TB, HIV. Out of pocket spending from user fees at public and private facilities a major source of health financing. |
| Kenya | A policy commitment since 2000 to abolish fees at primary care level. A '10/20 policy' charging low consultation fees is backed by funds to replace lost income (See below). | Exemptions cover poor people, unemployed, elderly orphans, all maternal and child health services, immunisation, services for people with TB, leprosy, HIV. |
| Lesotho | User fees removed for outpatient services. Fees streamlined in 2008. | |
| Madagascar | User fees applied. User fees were temporarily removed on an emergency post-conflict basis but then reintroduced in 2008. | Exemptions apply to poor people, civil servants, people with TB, leprosy, HIV immunisation services. Informal charges are common but low. |
| Malawi | Fees abolished in the public sector at all levels. | Informal charges are rare. |
| Mozambique | User fees are charged in public health facilities in Mozambique, harmonized by law across public health facilities. The law states that emergency treatment cannot be denied on the failure to meet the medical charges. | Exemptions apply to poor people, orphans, people with TB, leprosy, HIV, services for immunisation, childbirth; for minors, people with disability, retirees, pensioners and the unemployed. Informal charges exist. A 2008 study found 70 per cent household health spending on out of pocket costs. |
| South Africa | User fees are charged in public health facilities. Primary health care exempted since 1994. | Exemptions apply to all primary health care services since the mid-1990s. |

No information available for Mauritius

Source: Nomaxhule et al 1996; Witter 2010, MoH Mozambique, TARSC 2010; KEMRI et al 2011; Zikusooka et al 2011; UNZA et al 2011; TARSC, MoHCW 2011

*Out of pocket spending in the region needs to be reduced. User fees are a barrier to uptake of services and their removal, particularly at primary and secondary care level, has had positive equity impacts in service uptake in lower income groups. However, unless adequate resources are provided to compensate facilities for lost income and ensure reliable supplies and services, overworked health workers may raise informal charges or clients may have to pay for services elsewhere. Policies to remove user fees thus need to be consistently applied, supported by consultation with communities and health workers, and followed by consistent provision of funding to primary and district services.*

While attention has focused on user fees in public services, user charges are often higher, with wider income differentials in use of care in the private for profit sector. Private sector use in South Africa was heavily concentrated in the higher income groups (83 per cent of the highest income quintile compared with 37 per cent in the lowest income quintile), although the variation across income groups was much lower in Zambia (22 per cent in the highest income quintile and 16 per cent in the lowest income quintile) (Makinen *et al*., 2000). Fee charges in the private for profit sector make these services unaffordable for most.

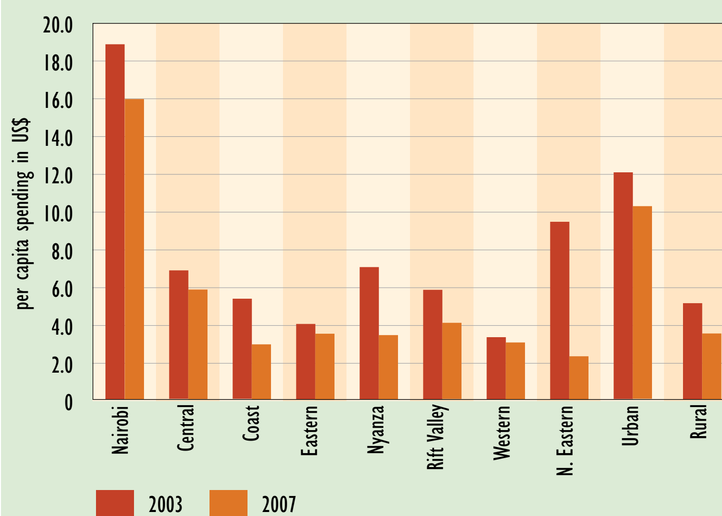
| Country | User fee policies | Comment |
|---|---|---|
| Swaziland | Most patients pay for health services from out-of pocket. Government has a unified fee structure across mission and state services and compensates mission facilities for lost income. | Out of pocket spending is much higher than in neighbouring countries. Patients unable to meet the costs of services are expected to get an exemption certificate / letter from a chief or district officer. |
| Tanzania | Fees applied. New policies being developed, with recent community and social insurance exemptions. | Exemptions for poor people, elderly, services for mothers, children, TB, leprosy, HIV. Low informal charges found. |
| Uganda | User fees abolished in the public sector at all levels in 2001. Government increased funding to district health services to mitigate the loss of revenue from fee abolition. Fee charges in private services are not regulated. | Fee abolition led to an increase in the use of services by lower income earners. Catastrophic health expenditures rose 2001-2006 from 8 per cent to 28 per cent, possibly as medicine stock-outs forced patients to purchase from private pharmacies. Informal charges are common but low. |
| Zambia | Post-independence fee abolition at rural primary care level. Hospital management boards re-introduced fees. User fees were abolished in all rural-based health centres and district hospitals in 2006, starting with the most disadvantaged districts. Increased funding to replace lost revenue. | Exemptions apply to poor people, elderly, orphans, maternal and child health services, people with TB, leprosy, HIV immunisation services, all patients in rural areas. The removal of user fees resulted in increased drug consumption, increased staff–patient contact time as well as increased health facility use. |
| Zimbabwe | Since 1980, a policy of free health care for those on low incomes. User fees were reduced until 1990 when fee collection was intensified. Fees were dropped in rural primary care services after high dropout rates. A policy of free primary care services is still in force. | Pregnant mothers, children under 5 and adults over 65 are fee exempt up to district level. Application has been mixed, with informal charges and consequent cost barriers for poor households. |

## Finding a way forward on user fees in Kenya

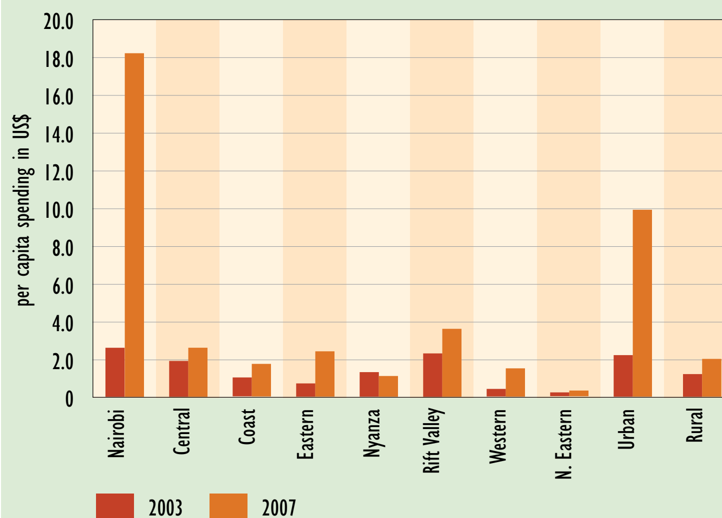
User fees were introduced in Kenya in 1989 but suspended in 1990 due to: problems with the hurried implementation; massive declines in health services use; lack of quality improvements; and poor revenue collection. In 1991 fees were phased into tertiary and provincial hospitals, followed by health centres and dispensaries. Exemptions were provided for children under five and for specific services and conditions such as immunisation, tuberculosis management and fee waivers for poor people, although the criteria for these waivers were not clear. Exemptions were reported to be cumbersome for both health workers and patients to implement. Fee charges reduced use of health care services, particularly for poorest people, widening disparities in health care uptake.

In July 2004, user fees at primary health care facilities (lowest level of care) were abolished and replaced with a flat registration fee of Ksh10 and Ksh20 for dispensaries and health centres respectively – commonly known as the 10/20 policy. Children under five, poor people, specific health conditions like malaria and tuberculosis, HIV/AIDS and other sexually transmitted infections and maternal health services were exempted. An initial evaluation of the policy reported high adherence and use increases of 70 per cent, levelling out to about 30 per cent higher than prior to fee reduction. With the reduction of fees, the revenue collected fell and drug shortages and 'overworked' staff resulted from increased service use.

**Out-of-pocket expenditure on outpatient visits, 2003,2007**




**Out-of-pocket expenditure on hospitalisation, 2003,2007**




Sources: Kenya MoH 2004; MoMS and Ministry of Public Health Kenya 2009

While the policy was popular among patients, it was not supported by health workers. A later evaluation showed that adherence to the policy lapsed, with charges being raised for registration, injections, drugs, deliveries and laboratory services. To address this in 2005 a pilot project in Coast province compensated health centres and dispensaries for lost fees. Under the project, health facilities received money through their bank accounts directly from the treasury.

In 2006, government hospitals were allowed to charge women a delivery fee of US$ 6.5 for normal deliveries. A 2007 survey found that fees charged ranged from the correct levels to up to 22 times the correct levels for dispensaries and up to 12 times the correct levels for health centres, with negative effects on uptake in poor communities. In July 2007, government abolished delivery fees at dispensary and health centre level. Informal charges remained and women had to purchase essential supplies like gloves and cotton wool. To replace lost revenue and discourage informal charges, in December 2007, a health sector services fund was gazetted as an extension of the pilot project compensating facilities for lost income through direct transfers from the treasury. While Kenya has thus had a consistent policy commitment to abolish fees at the primary care level, the challenge has been in the implementation (KEMRI *et al.*, 2011).

This inequity in private sector services adds to other reasons for governments to be cautious about and to manage any expansion in private for profit services. Weak policy frameworks and limited regulation of the private sector can make it difficult for governments to do this. However, a recent study found escalating costs associated with private sector expansion, even where private sector initiatives were designed to cut costs, including by consolidating companies across various areas of the health system and the entry of large foreign companies restricting competition (Doherty, 2011).

*To address equity, the main focus, including of this analysis, is on developing equitable, quality, accessible public services. Governments need to develop comprehensive policies, regulations, enforcement and management capacities to align the private for profit sector to national policies and to avoid negative consequences for the wider system.*

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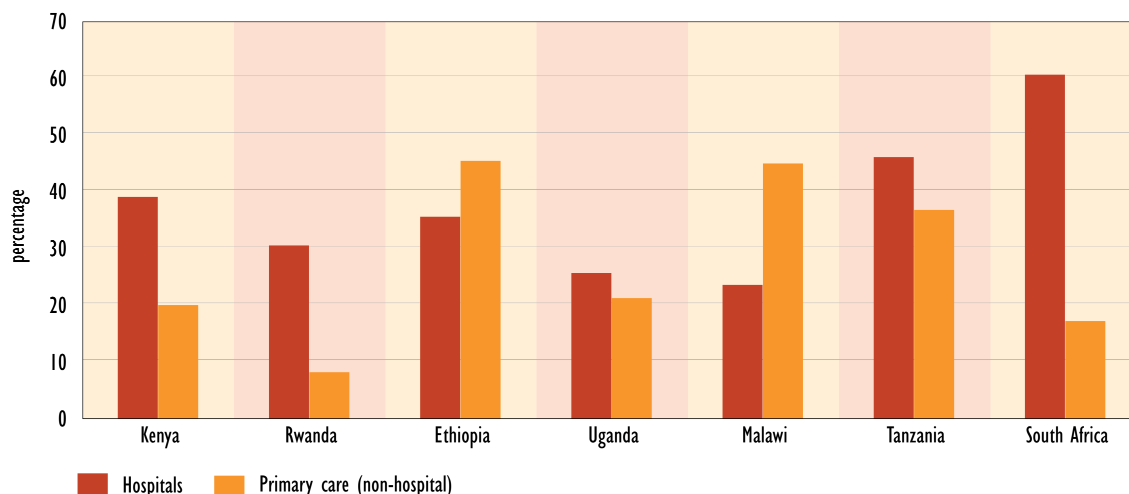
## Allocating at least 50 per cent of government spending on health to district health systems and 25 per cent to primary health care

Until quite recently, government resources were distributed according to existing supply and demand patterns through historical incremental budgeting and similar processes (Pearson, 2005). More recently, risk-adjusted, needs-based resource allocation mechanisms have included indicators of relative need for health care, such as: population size, demographic composition, levels of ill-health, with mortality rates usually being used as a proxy for morbidity, and socio-economic status, given the strong relationship between ill-health and low socio-economic status and that the poor are most reliant on publicly-funded services (McIntyre, 2007).

Resource allocation formulae have aimed to avoid prejudice in access to essential health care on the basis of residence and to promote access on the basis of need. Social factors and deprivation are also important indicators of need and should be factored into needs-based resource allocation formulae. As the discussion in Section 2 on the distribution of health need and outcomes shows, it is not only across geographical areas that more equitable allocation is needed.

Prior discussion has shown the greater benefit of primary care services for low-income and disadvantaged groups, and the lower inequalities in health in services accessed at this level. When resources do not reach the primary care level, poor communities face financial burdens. Despite this, a comparison of public sector expenditures on hospitals and primary care levels in selected East and Southern African countries in the late 1990s, found skewed spending towards hospitals in five of the seven countries, particularly in South Africa, Tanzania and Kenya (see Figure 5.9).

**Figure 5.9: Comparison of hospital and primary care expenditure as a share of total health expenditure, selected countries, East and Southern Africa, 1997/8**




Note: totals are less than 100% due to spending areas outside the care levels shown (e.g. administration and central level, research and teaching, etc.)
Source: ESA NHA, 2001: 20.

*Despite the role community and primary level services play in health equity, many East and Southern African countries do not disaggregate expenditures at community, primary care, district and higher levels in their annual reports. Annual expenditure reporting by level is essential to assess equity in spending and to relate expenditure trends with health outcomes.*

In some countries, clinics and primary health care are included under district hospitals or even under the central level departments. Funds for primary level health care (health centres and clinics) channelled through district hospitals have been found to leak to other uses, often at higher levels of the health system (Conticini, 2004; Lewis, 2005).

For those countries where information is disaggregated to district level and below, some (Mozambique, Uganda, Zimbabwe) report allocations, although these may not translate into expenditures if absorptive capacity is lacking or if systems do not facilitate the release of resources. Only Angola, Kenya and Zambia reported expenditures. The number of countries that had 50 per cent public spending at district level and below decreased from four out of seven before 2005 (Angola, Uganda, Zambia, Namibia) to two out of five after 2005 (Zambia, Kenya), although it was not clear what share of this went to primary care level (Table 5.9).

**Table 5.9: Allocations and expenditures of public spending by level, East and Southern Africa**

| Country | Shares at primary, district level | | Comment |
|---|---|---|---|
| Angola<br>Expenditure at primary care level: | 2001<br>2002<br>2003<br>2004<br>2005 | 20%<br>29%<br>64%<br>49%<br>41% | Priority for funding to primary care level led spending at this level to grow 415 times faster than that at other levels of care. This increased funding enabled government to build health centres, to improve quality and to abolish fees at primary care level. |
| Kenya<br>Expenditure to district level and below | 2005<br>2007<br>2009 | 42%<br>62%<br>61% | Commitment to prevention, promotion and primary care services improved their share of public spending. A 2009 economic stimulus package funded 20 nurses per constituency to support capacities to use funds. |
| Mozambique<br>Allocations to district level and below<br>Allocations to district level only | 1997<br>2008<br>2009 | 49%<br>31%<br>39% | It is noted to be difficult to assess whether allocations to districts that include primary care levels reach this final destination. |
| Namibia<br>Allocations to regional health services | 2000/01<br>2001/02<br>2002/03 | 55%<br>56%<br>54% | |
| Uganda<br>Allocations to district level and below | 2005/6<br>2006/7<br>2007/8<br>2008/9 | 54%<br>58%<br>49%<br>45% | Between 2005 and 2007 overall funding increased and district services were prioritised. After 2007, total funding to health fell and the share to district services fell, while the share to Ministry of Health headquarters rose. |
| Zambia<br>Expenditure to district level and below | 2003<br>2005<br>2007 | 50%<br>59%<br>52% | The Zambian national health accounts indicate increased expenditures and allocations to district and primary level in 2005 and a reduction to 2007. |
| Zimbabwe<br>Allocations to district level and below | 1994 | 41% | Budget allocations are not reported by level and not disaggregated to health centre level. An 'equalisation grant' was used to improve allocations to districts with low income generation. Post -2005 shares allocated to prevention and primary care level fell and to medical care services increased. |

Information for Botswana, DRC, Lesotho, Mauritius, Malawi, South Africa, Swaziland, Tanzania not available. Source: MoH Mozambique, TARSC, 2010; KEMRI et al., 2011; Zikusooka et al., 2011; UNZA et al., 2011; TARSC, MoHCW, 2011; McIntyre et al., 2008, Connor et al., 2010

Kenya has made explicit policy commitments to the primary care and district level, as has Angola, and both have made progress in redistributing public resources to this level (see box below).

## Kenya's Vision 2030

The Kenyan Vision 2030 for the health sector adopts a preventive approach to health, proposing to allocate more resources to preventive and promotive activities and to lower levels of the health system. This has positive implications for equity as lower levels of care are more commonly used by low-income groups than higher levels. Expenditures for preventive and promotive services fell in 2007 and then rose significantly to 13.5 per cent in 2008. Spending at primary care facilities fell markedly in 2008 before rising sharply to 19.4 per cent in 2009. Spending on district hospitals rose in 2008 and then fell to close to 2005 levels. The total spending on districts and primary care levels was, however, still above 50 per cent. The large increase in expenditure at primary care level was partly due to an economic stimulus package that included Ksh5 billion to construct model health centres and recruit 20 nurses in each constituency (personal communication, officials at the MoPHS). Establishing two ministries of health in 2008 (the Ministry of Medical Services and the Ministry of Public Health and Sanitation) focused on the needs of these different levels and stimulated greater budget support.

While this may raise some issues of ensuring non-overlapping mandates and costs, overall spending on health, presented earlier, seems to have only increased marginally despite the creation of two ministries and it has even decreased in some years.

The Kenyan government has made its commitment to a greater focus on prevention, promotion and primary care services clear in its Vision 2030 for the health sector. It has increased the percentage of government resources allocated to these levels, including through the economic stimulus package. In 2009, the combined spending on preventive and promotive services, primary care and district level facilities was above the 50 per cent set in the progress marker. The investment in 20 nurses per constituency will assist in supporting absorptive capacity. Further measures may be needed to ensure that facilities and outreach programmes have essential medicines, supplies and infrastructure, and to monitor the impact on health of these measures, to motivate and sustain the expenditure pattern (KEMRI *et al.*, 2011).

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## Harmonising services and financing schemes into one framework for equitable universal health coverage

Universalism is not simply a matter of the funding, allocation and expanded cover of social benefits and services. It is a principle for organising social and economic reform across all spheres of production, redistribution and protection, to address poverty and inequality (Ilcheong, 2010). Universal health coverage has been defined by the World Health Assembly as access for all to appropriate health services at an affordable cost, with obligations for countries to: expand the number of people covered, expand the scope of services and reduce cost sharing and direct user fee payments (WHO, 2010d). There is consensus that an operational definition of universal health coverage should include access to functioning health services and financial protection (Bump, 2010).

A universal health system values and entitles all citizens, so that everyone within a country can access the same range of services on the basis of need and pay for these services on the basis of their income. While this is achieved through redistribution and cross-subsidies, it also includes efforts to widen geographic access, to make public services more acceptable, to enable social empowerment and to promote health through the actions of other sectors that influence health outcomes (Loewenson *et al*., 2010). Countries in the region are all aiming for universal coverage and equity in their health systems, as discussed earlier.

Universal health coverage cannot be assumed to support equity and the scale-up of services may preferentially benefit more advantaged groups. For universal health coverage to advance equity, it needs certain features. People need to have rights-based entitlements of access to health care, discussed earlier. Specific measures are required to overcome segmentation in the health system and to eliminate inequalities in access to services. The progressive taxes discussed earlier and mandatory public insurance systems are a means of facilitating the risk pooling and solidarity needed for equity through universal coverage. As this can be contested by wealthy groups, there is need to build the demand, power and action within society, and especially in more disadvantaged communities, to support these policies and use the health services.

There is also a question: Is universal health coverage a matter for each state to secure on its own, with ad hoc international assistance for low-income countries whose public revenues are not enough to secure adequate health systems, as is the case now for many East and Southern African countries? Or is there a national and global obligation to guarantee a basic health entitlement for all people and to finance this through more predictable global health funding of health systems than at present?

Table 5.10, on pages 120-121, shows that while many countries have the constitutional provisions that underpin universal health coverage and have policy commitments towards achieving it, in many countries the policy frameworks, principles, design and sequencing of measures to achieve it are still undeveloped. These approaches would need to be well articulated and known within the wider community, as this is necessary for public confidence in the leadership and state accountability in managing the process towards universal health coverage. The South African case, described in the box on page 122, is one example of a country where wide national and policy dialogue on universal health coverage has taken place.

**Table 5.10: Policies and experiences with universal health coverage policies (UHC), East and Southern Africa**

| Country | Universal health coverage policies and measures | Comment |
|---|---|---|
| Angola | Angola's health system 80 per cent publicly funded, with a significant increase in per capita levels since 2000. UHC is a principle of policy. | While the funding basis for UHC has improved, issues of equity of access are now a focus for the country to advance UHC. |
| Botswana | Botswana has a high level of tax-based public financing and free entitlement to health care. | With a reasonable funding basis for UHC, issues of equity of access would be a focus for advancing UHC. |
| Kenya | While constitutional provisions support UHC, low shares of government financing, high levels of out of pocket funding, resistance to tax and national health insurance proposals have weakened application of policy intent. External funds have increased, primarily through direct project funding. A health financing strategy has been developed to guide the country towards UHC that proposes to have all government tax funds and national health insurance contributions channelled to a National Health Services Trust (NHST), through a National health Social Security Revenue Agency (NHSSRA). | A National Health Insurance Bill was passed in parliament in 2004, but not signed by the president. Discussions to establish a sector-wide approach have made slow progress. If implemented, the NHST and NHSSRA will support harmonisation. However proposals also made to encourage private and community health insurance may weaken pooling and equity unless there is regulation and risk equalisation across different pools. Low stakeholder confidence in public funding mechanisms needs to be addressed, through improved and reliable service provisioning and access. |
| Mozambique | A public-funded and provided health system facilitates the harmonisation for UHC. External funding is coordinated through a MoU with common funding partners and a SWAp. | There is less evidence of the emergent private health sector being coordinated and improving access to basic health service entitlements remains a major challenge. |
| South Africa | Measures identified to improve equity in access to comprehensive health care entitlements supported through a tax-funded national health insurance to be phased in over 14 years after 2012. | The process towards UHC is founded on constitutional provisions, and is taking place in steps guided by principles of equity, access, financial protection and solidarity. |
| Tanzania | Several insurance schemes exist, including the National Health Insurance Scheme (NHIF) introduced in 2001 that benefits all public sector formal sector workers, a Community Health Fund which enables households to pre-pay when they have money and other insurance schemes on a smaller scale. | The National Social Security Fund plans to introduce a benefit health care package to its members. |

| Country | Universal health coverage policies and measures | Comment |
|---|---|---|
| Uganda | The national health policy, strategic and investment plan (2010-2012); and the health financing strategy (2010-2015) aim for UHC. Public financing is progressive (tax-based) with fees abolished. The share of external funding is high. Private funding is through many small, fragmented risk pools, in community-based health insurance. Voluntary private prepayment schemes cover urban formal workers and less than 1 per cent of the population. The introduction of national health insurance is being considered. | Medium-term expenditure frameworks show the government budget share fell from 11 per cent in 2004 to 8 per cent in 2009. GBS may have crowded out government funding. Poor quality of services in public health facilities has created a two-tier system in access to services, with higher income people using fee charging private health facilities. Apart from the national health accounts in 1998-2001, no recent estimates of private spending on health have been reported. Government is yet to set benefit packages.. |
| Zambia | Health financing is fragmented, with tax, private, basket funding, earmarked on-budget funding, GBS, sector budget support and off-budget funding. Only the basket fund and sector budget support are aligned and harmonised with public financing, and most external funding is outside these mechanisms. | Efforts to harmonise funding were badly affected by a corruption scandal in 2009. The development of social health insurance is underway but still at early stages. |
| Zimbabwe | *Planning for equity in health* (1980) planned for UHC. Not-for-profit and local government services were coordinated through public grants but from the 1990s falling grants have weakened this. Private health insurance is segmented, covering less than 1 per cent of the population, but 80 per cent of private provider income and 20 per cent total health expenditure. Hyperinflation and devaluation of public funding in 2005–2008 left the public sector relatively weak, although public financing improved in 2010. | Medical aid societies have encouraged the growth of urban private hospital services for employed and wealthier groups. In 2007 a national health insurance scheme was devised funded from a levy on formal sector salaries but not introduced. Low public funding, lack of constitutional commitments, lack of a defined basic entitlement and almost all external funding being outside budget frameworks have weakened public leadership towards UHC. |

UHC = universal health coverage; MoU = Memorandum of Understanding; SwAP = sector-wide approach; GBS = general budget support
Information for DRC, Lesotho, Madagascar, Mauritius, Malawi not available
Source: MoH Mozambique, TARSC, 2010; KEMRI et al., 2011; Zikusooka et al., 2011; UNZA et al., 2011; TARSC, MoHCW, 2011; HealthNet Consult, 2010; Connor et al., 2010; South Africa Department of Health, 2011

## Developing policy for universal health coverage in South Africa

South Africa has perhaps had the most recent intensive dialogue over the policy principles and process towards universal health coverage. To achieve this in the inequitable health financing and service access situation described earlier, principles of equity, access, financial protection and solidarity have been adopted.

Cross-subsidisation will be achieved through a national health insurance scheme that will take effect in 2012 as a means to support measures being implemented to improve access to quality health care services and provide financial risk protection against health-related catastrophic expenditures for the whole population. The National Health Insurance Scheme, to be in phased in over a 14-year period, has prioritised improvements in equity of access in its first phase, delivering on constitutional provisions and state obligations set in 1994. The scheme will aim to achieve accessibility to health by all individuals with free health care at the point of use and according to people's health needs, efficiency and affordability; with cross-subsidy between the rich and the poor (South Africa DoH, 2010).

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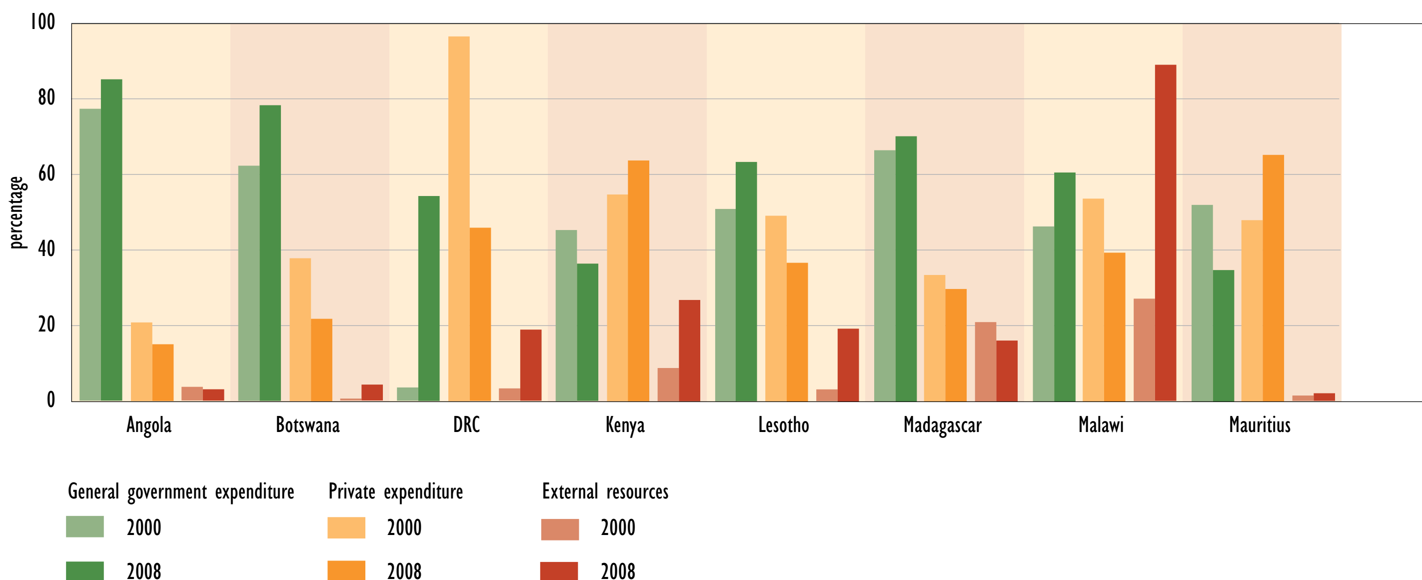
*Collecting cards from TB patients in an overcrowded waiting room – a health hazard for workers and patients, Cape Town*

Many East and Southern African countries are also grappling with multiple, often fragmented current financing arrangements with a wide range of benefit packages and contribution schedules. Figure 5.10 and Table A5.3 in the statistical appendix show the trends in sources of financing.

The share of health expenditure in the GDP has improved but it remains below 5 per cent in several countries so that domestic resources are still inadequately aligned to reach universal health coverage.

**Figure 5.10 Trends in government, external and private funding as a share of total health expenditure, East and Southern Africa, 2000-2008**

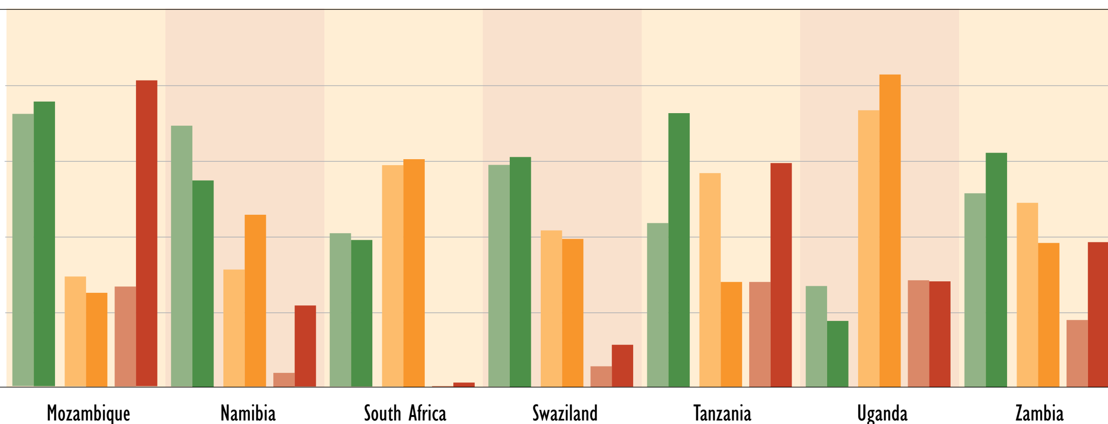



Data for Zimbabwe not available
Source: WHO, 2011

The share of government expenditure increased between 2000 and 2008 but it remains below 50 per cent in five countries, weakening government leadership and public funding for the pooling and risk-sharing arrangements needed. As raised earlier, tax funding options remain limited in many countries and mandatory insurance schemes are at early implementation stages. Further, the increase in private financing as a share in five countries is, as discussed earlier, associated with increased out of pocket spending and weakening financial protection. External resources exceed a quarter of health financing in six countries, creating challenges for the pooling of funds and for aligning them to the long-term financing demands for universal health coverage.

Countries with high shares of external funding (Kenya, Malawi, Mozambique, Uganda, Tanzania, Zambia and Zimbabwe) have a challenge to align international funding to national mechanisms for pooling and risk sharing. External funders do not necessarily identify universal health coverage as a primary goal, often fund specific vertical elements of services and have their own constraints in aligning reporting and administration of their funds towards long-term budget support, especially when there is distrust of public systems.

Sector-wide approaches (SWAp) and general budget support mechanisms have provided opportunities for joint financing for different components within the health sector, pooling funds, coordinated management of external finances and planned resource allocation using external funds in line with domestic policy priorities (McIntyre *et al*., 2005a; EQUINET SC, 2007). An assessment of sector-wide approaches in the region found that government capacity to plan and implement programmes increased, as did ownership of programmes and international agency coordination (Brown, 2001). However, countries in the region have also faced difficulties in negotiating for global initiatives and some bilateral funders to use the sector-wide approach, and in sustaining support for the complex administrative arrangements and reporting systems between government and external funders needed for these approaches (Brown, 2001; SIDA, 2003; EQUINET SC, 2007). The shift by some external funders to general budget support may better align external funds with the national budget process and priorities, contributing to harmonisation within public expenditure frameworks, but it also poses new challenges to the policy authority and leverage of ministries of health (EQUINET SC, 2007).



## Aligning resources for universal health coverage in Mozambique

Mozambique's primarily public funded and provided health system facilitates the harmonisation for universal coverage. Mozambique abolished the private health sector in 1976 but lifted this ban in the 1990s. Nevertheless, in the health sector's strategic plan for 2001–2005, the policy intention of universal coverage is set out and the public sector is cited as the primary source of finance in the health system.

Several documents set the framework for harmonised health financing and universal coverage: the *Strategic plan for the health sector 2007–2012*, the *Social economic plan*, the *Second strategic national plan to combat HIV/AIDS*, the *National plan to combat STIs, HIV/AIDS, 2004–2008*, and *PARPA II 2005–2009*.

Harmonising health financing continues to be a key issue in ensuring appropriate use of funds in line with national goals. Coordinating external funders is important given their significant share of health financing (81 per cent in 2008). Government signed a Memorandum of Understanding with common funding partners in the health sector which outlined a set of clear principles to increase alignment for all partners in the sector-wide approach (SWAp). This reinforces the existing code of conduct which governs both funder and government behaviour in support of the health sector. The common funding partners in Mozambique have committed to providing funds based on performance in the preceding year with no in-year conditionality for fund release. The government needs to demonstrate excellent performance for the following year and the external partners need to ensure funds arrive in good time.

The role of the public sector is key in establishing this framework and in coordinating the other three significant sources of resources and provision – the international community, the private sector and the community. There is less evidence of the emergent private health sector being coordinated to ensure that it aligns to national goals and policies for universal coverage. A community health programme, implemented through community health councils and including social mobilisation, provides a way to harmonise community resources and contributions and reduce more inequitable forms of financing, such as individual out of pocket payments (MoH Mozambique, TARSC, 2010).

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*The experiences of countries moving towards universal health coverage highlights bottlenecks that need to be addressed. These include the multiple, often fragmented, current financing arrangements and the lack of clear entitlements in some countries (discussed earlier). Improving health expenditure as a share of GDP and the share of progressive tax financing will strengthen public-sector leadership in addressing challenges. It is also important to communicate and build confidence in policy measures, and to align private and external funds to public-sector policy measures for achieving universal health coverage.*

Signs of progress towards universal coverage would include: a steady increase in tax funding; a commitment to avoid fees and co-payments; measures to increase risk pools and build in cross subsidies across voluntary insurance schemes; and allocation of funds to improve geographic distribution of services and ensure entitlements equate to real access.

There is no universal formula and, for many of the countries, it will take some years to achieve universal health coverage through a complex path determined by histories, by the way their health financing systems have developed to date and by social preferences relating to concepts of solidarity (Carrin *et al*., 2008). While some countries (Kenya, Uganda) have set health financing strategies, it would appear timely for countries to engage national stakeholders to set long-term health system wide strategies for universal health coverage and, in doing this, to explicitly address equity and build cross-party political commitment and social awareness and support for the strategies, given the longer timeframes needed.

# 6

# A more just return from the global economy

# KEY ISSUES

While the previous sections have identified national determinants of health equity, they have also pointed to significant global inequalities in the resources for health and increasing global influence in the distribution of resources and in policy processes.

Between 1970 and 2002, the continent paid US$10 billion more in principal and interest than it received in loans, and still remained with a debt stock of $295 billion (UNCTAD, 2004). Debt has diverted significant resources that could have benefited health. Measures have been taken to reduce debt-related outflows or avoid new debts and there is some evidence that debt relief has led to areas of spending on health that benefit disadvantaged groups. However, debt-related outflows continue unabated and in some cases are increasing.

Countries cannot take the benefits and development claims of global trade, investment and economic partnership agreements at face value. The evidence points to the need to assess and negotiate a fair distribution of costs and benefits, including to health.

Trade and health sectors need to strengthen dialogue on the health issues in trade, backed by tools such as health impact assessments. Such dialogue has not been consistent or formalised in the region in the past but there is evidence that it is becoming more frequent and institutionalised. The interaction has grown, for example, around access to generic medicines and the role of trade and other sectors. Civil society and parliaments bring important expertise, experience and social input to this dialogue across sectors.

There is evidence that building links across trade and health, across state and non-state actors, and across countries in the region, has had some positive returns at global level. This was the case in the negotiation of TRIPS flexibilities at WTO, or the Global Code of Practice on the International Recruitment of Health Personnel.

The value of these gains at global level lies in their application, such as through new bilateral, regional, multilateral arrangements that address the global injustices that motivated the negotiations. The limited progress and some reversals applying TRIPS flexibilities at country level highlight that gains made in negotiations cannot be taken for granted and need to be acted on and consolidated at regional and country level.

# A context of global inequality

The cartogram in Figure 6.1 below shows the size of countries as a reflection of their share of the richest fifth of people globally. It clearly shows Africa's marginalisation in global wealth. This global maldistribution becomes even more profound in relation to the growth in wealth between 1975 and 2002, using the same approach (Figure 6.2).

In the global community, the cartograms show Africa as the poorest, thinnest child living on the margins of the village. Yet, as described in early sections, the resources for health and wealth exist within the continent and have been tapped for centuries for the wellbeing of populations in other countries. Can countries in the region effectively advance equity within their boundaries without addressing this contradiction in the global environment?

In this final section we explore some of the features of this engagement and what the trends mean for health equity in relation to the resource flows from the region (debt, health workers) and the progress that East and Southern African countries are making in negotiating for health equity at global level. There is a fast moving and widening level of social debate and activism on the demand and measures to address global injustice, including in relation to the right to health.

**Figure 6.1: Global distribution of earnings, 2009**

*Territory size shows the earnings of the richest fifth of the population living there, as a proportion of the earnings of the poorest tenth living in all territories*

Source: Worldmapper www.worldmapper.org/

**Figure 6.2: Global growth in wealth, 1975–2002**

*Territory size shows the proportion of worldwide growth in wealth that occurred there between 1975 and 2002*

Source: Worldmapper www.worldmapper.org/

# Reducing debt as a burden on health

Prior sections have pointed to many ways in which resources flow from the region, including through outflow of biological and natural resources, out-migration of skilled health workers, falling terms of trade for food and other exports and other means. A further outflow of resources is through debt-related flows. Between 1975 and 2005, countries in the region paid an average of US$14 per capita annually in debt servicing.

*The continent has paid back more than it received in loans, receiving US$540 billion in loans and paying back US$550 billion in principal and interest between 1970 and 2002, and still remaining with a debt stock of US$295 billion. Discounting interest and interest on arrears, payment of outstanding debt represents a reverse transfer of resources (UNCTAD, 2004).*

Even in the 1990s under the highly-indebted poor countries initiative (HIPC) and debt relief, when payments fell, debt servicing dwarfed government spending on health (UNDP, 2002). As shown in Table 6.1, debt servicing per capita exceeded health spending per capita in five countries in the region. For example, Lesotho, with an estimated 29 per cent of adults living with HIV and AIDS, spent the equivalent of US$38 per capita on debt servicing, an amount that could have financed the basic health interventions identified by the Commission on Macroeconomics and Health, at a time when the Lesotho health budget was only US$25 per capita.

A number of debt reduction programmes have been undertaken in the past decade. Uganda and Mozambique developed strategies to manage their debt and, in 1996, the HIPC debt initiative was applied in some countries in the region, including in Uganda and Mozambique (World Bank, 2009).

*Resting after food distribution, Chipinge, Zimbabwe*

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**Table 6.1: Debt, debt service and health spending, East and Southern Africa, 2002–2003**

| Country | Total external debt 2003(US$mn)* | Total debt service 1970-2003 (US$mn)* | Debt service per capita expenditure 2002 (US$)* | Health * per capita expenditure 2002 (US$)* | Estimated % adults living with HIV and AIDS*** |
|---|---|---|---|---|---|
| Angola | 9,698 | 13,037 | 106 | 38 | 4 |
| Botswana | 514 | 1,653 | 36 | 171 | 37 |
| DRC | 11,170 | 7,322 | 18 | 4 | 4 |
| Kenya | 6,766 | 16,999 | 17 | 19 | 7 |
| Lesotho | 706 | 805 | 38 | 25 | 29 |
| Madagascar | 4,958 | 3,818 | 4 | 5 | 2 |
| Malawi | 3,134 | 2,388 | 3 | 14 | 14 |
| Mauritius | 2,550 | 4,391 | 207 | 113 | n/a |
| Mozambique | 4,930 | 1,846 | 4 | 11 | 12 |
| Namibia | n/a | n/a | 0 | 99 | 21 |
| South Africa [1] | 37,200 | 42,965 | 103 | 206 | 22 |
| Swaziland | 400 | 758 | 19 | 66 | 39 |
| Tanzania | 7,516 | 9,180 | 3 | 13 | 9 |
| Uganda | 4,553 | 3,161 | 3 | 18 | 4 |
| Zambia | 6,425 | 11,173 | 28 | 20 | 17 |
| Zimbabwe | 4,445 | 10,752 | 8 | 118 | 25 |
| TOTAL | 104,965 | 130,248 | | | |

n/a = not available; [1]South African Reserve Bank, 1970-2003 – unclear whether this figure combines internal and external debt so may not be comparable with other countries where only external debt is shown; *World Bank, 2005.
Source: Adapted from Africa Action, 2005

## Managing Mozambique's debt

In Mozambique, debt cancellation was negotiated under the HIPC and enhanced HIPC initiative in 2001. The total relief received from both initiatives was almost US$2 billion in nominal value or US$4.3 billion in current value. On the basis of its positive economic performance, Mozambique has benefited from successive rounds of debt relief. The International Monetary Fund approved the cancellation of US$154 million (100 per cent) of debt and the World Bank provided debt relief amounting to US$1.3 billion.

Building on the debt cancellation prior to 2005, the Africa Fund for Development cancelled about US$500 million of debt contracted and disbursed up to December 2004. Debt cancellation has been negotiated with multilateral creditors (World Bank, IMF, African Development Bank, Arab Development Bank for Africa, International Fund for Development of Agriculture, Nordic Fund for Development, OPEC Trust Fund and European Bank of Investment) and bilateral creditors in the Paris Club and others.

There are a number of commercial creditors from whom Mozambique has not yet obtained debt relief (Poland, Bulgaria, India, Yugoslavia, Angola, Algeria and Libya). The debt stock decreased from US$4.6 billion in 2005 to US$3.3 billion in 2007 and the annual average debt servicing level fell to US$48 million in 2007. Debt servicing ranges from 2–3 per cent of export earnings, below the 20 per cent identified as unsustainable.

However, while multilateral debt has significantly reduced, internal public debt has grown (MoH Mozambique, TARSC, 2011).

In Uganda, the debt strategy in 2007 aimed to limit the extent to which government was able to acquire debts that could disrupt the activities of social services, such as education and health. External debt fell in 2007/8, as did the cost of servicing the debt, but public domestic debt grew from US$178 million in June 2000 to US$1146 million by June 2007 (Govt of Uganda MoF, 2009). Debt and debt servicing fell in Zambia between 2005 and 2008, a decline attributed to the HIPC initiative and the cancellation of the major part of the external debt in 2006. There is limited evidence that this benefited allocations to the health sector and the 2010 national budget projected US$400 million in new debt for projects in the country (UNZA *et al*., 2011). Kenya also made progress in reducing external debt between 2006 and 2009 but domestic debt rose so total debt did not fall. Kenya does not qualify for debt relief under HIPC so the country engages diplomatically to negotiate debt cancellation and for funds to be channelled to poverty alleviation, including health-related programmes (KEMRI *et al*., 2011).

A WHO debt relief assessment in low-income countries in 2007 provides recent evidence of the extent of debt-relief benefit to resources in the health sector. For the East and Southern African region, this assessment included Madagascar, Malawi, Mozambique, Tanzania, Uganda and Zambia.

**Table 6.2: Use of debt relief resources for health, selected countries, East and Southern Africa, 2000–2007**

| Country | Use of debt relief for health |
|---|---|
| Madagascar | Debt service relief of $1.9bn under HIPC and $2.4bn under the Multilateral Debt Relief Initiative (MDRI) .The resources have largely benefited education and health (17-33 per cent of total resources in 2004 /5) with 702 doctors and 1,127 paramedics recruited, technical equipment, vaccines, fuel for cold chain produced and 150 primary health care centres, district health offices, district hospitals rehabilitated. |
| Malawi | Debt service relief of $1.6bn under HIPC and $1.6bn under the MDRI with a third of resources committed to the health sector. Funding for these protected pro-poor expenditures (PPEs) was protected to ensure uninterrupted service delivery. |
| Mozambique | Debt service relief of $4.3bn under HIPC and $4.3bn under the MDRI and other initiatives. Debt relief was triggered by a new health sector strategic plan, increased shares of health and education expenditure as a share of total and a national plan on HIV/AIDS implemented. Expenditures to health difficult to track. |
| Tanzania | Debt service relief of $3bn under HIPC committed to poverty reduction. Contributed to improved immunisation but no evidence of links to increased health spending. |
| Uganda | Debt service relief of $1.9bn under HIPC and $3.5bn under the MDRI. Uganda established a Poverty Action Fund and a Poverty Eradication Action Plan that debt servicing contributed to and that were allocated mainly to education, with primary health care receiving 4 per cent with an increase up to 2005 and a fall up to 2007. |
| Zambia | Debt service relief of $3.9bn under HIPC since 2000 and $2,8bn under the MDRI. The resources were used for debt service payments, investments in infrastructure, support for small-scale farmers, food security, increased expenditures in education, removal of fees for rural primary health services |

Source: WHO, 2007

The WHO analysis suggests that in Malawi, Madagascar and, to a lesser extent, Uganda, it was possible to see the direct flow of funds from debt relief to areas of health sector spending and benefit. Since these resources went to primary care and district services, to small-scale farmers and to removing health services fees, it is likely that they benefited more disadvantaged groups, although this would need to be further assessed. In the other countries it was not possible to directly track increased health spending emanating from debt relief, as the savings were absorbed within the budget. Increased health spending in these cases would depend on negotiation for the entire budget and the distribution of benefit would depend on how equitable wider health spending is (WHO, 2007).

*It would thus appear that debt has potentially diverted significant resources that could have benefited health. While measures have been taken to reduce debt-related outflows or avoid new debts and while there is some evidence that debt relief has benefited disadvantaged groups in the areas of health spending supported, outflows due to debt appear to be unabated, if not increasing.*

As Figure 6.3 shows, external debt continued to rise between 2006 and 2009 for twelve countries in the region and only fell in the DRC. In Angola, Botswana and Tanzania the external debt more than doubled between 2005 and 2010. Together with the growth in internal public debt, this points to a continued and growing drain of resources away from low-income countries and communities, rather than their deployment to meet global rights and development goals.

**Figure 6.3: Debt (US$), East and Southern Africa, 2006 and 2009**

Source: World Bank, 2010, Lesotho MoFinance and Dev Planning, 2010, Kenya MoFinance, 2009

# Ensuring health goals in trade agreements, including in World Trade Organisation agreements

The rules and policies that determine the distribution of resources are increasingly influenced by global institutions. For example, when the Trade-related Aspects of Intellectual Property Rights (TRIPS) agreement of the World Trade Organisation (WTO) came into effect on 1 January 1995, its protection of patents potentially undermined access to medicines. Civil society pressure and negotiation by African and other countries in the south led to flexibilities being included. TRIPS flexibilities provided for compulsory licensing, parallel importation, exceptions from patentability and limits on data protection. Also, to make cheaper drugs available for public health needs, generic producers are able to obtain health authority approvals before a patent expires. Developing countries have until 2013 and least-developed countries have until 2016 to reform their intellectual property systems so that they conform to the standards set in the TRIPS agreement.

African countries and treatment activists played an important role in negotiating the TRIPS flexibilities at the World Trade Organisation. However it appears that there is less progress and there are even some reversals in applying these flexibilities at country level.

A review of the situation in the region found that most of the intellectual property regimes in place existed before the TRIPS agreement was adopted (see Table 6.3).

**Table 6.3: Use of TRIPS flexibilities, East and Southern Africa, 2010**

| Country and legislation | Compulsory licences and other flexibilities |
|---|---|
| Angola<br>Industrial Property Law 1992 | Pharmaceuticals are excluded from patenting. The law was passed in 1992 before the TRIPS Agreement was adopted. |
| Botswana<br>Industrial Property Act 1996, amended 1997 | Passed before the WTO decisions on TRIPS flexibilities. Section 30 allows the government or an authorised agent to exploit a patent without the consent of the patent holder where it is in the public interest or where the patent holder has used their right for anti-competitive practices. Section 31 allows application for compulsory licences at any time after the expiration of three years from the granting of a patent or four years from the date of application if the market in Botswana is not being supplied on reasonable terms. No compulsory licence has ever been issued. Law contains exceptions for use of invention for research purposes and government can intervene on fair business practices. |
| DRC<br>Law No. 82-001, 1982 | The governing law was passed before the formation of the WTO and is uninformed by TRIPS flexibility developments. |
| Kenya<br>Industrial Property Act, 2001 | Sections 72–78 provide for compulsory licences on the grounds that a market is not being supplied on reasonable terms or where an invention constitutes a technical advance of economic significance. Section 80 allows government to use a patented invention without consent of the patent holder on grounds of national security, health, nutrition or for development of a vital economic sector. Permits the Bolar Provision limited exception. No compulsory licence has been issued to date. A voluntary licence was issued for the manufacture of antiretrovirals. |

| Country and legislation | Compulsory licences and other flexibilities |
| --- | --- |
| Mozambique<br>Industrial Property Code 2006 | Compulsory licences may be granted for reasons of public interest (Article 85). An invention is of public interest if it is important for public health, national defence, economic and technological development. Mozambique granted a compulsory licence for local manufacture of a first-line antiretroviral in March 2004 |
| Mauritius<br>Patents, Industrial Designs and Trade Marks Act, 2002 | Section 23 allows exploitation of a patent by the government or a person authorised on grounds of national interest or because of the use for anti-competitive reasons. Section 24 allows for the application of non-voluntary licences three years after granting a patent or four years from the date of patent application if the patent is not being sufficiently exploited in Mauritius. |
| Namibia<br>Industrial Property Bill, 2008 | Section 17.5 permits government or an authorised agent to use a patent without the consent of the patent holder where it is in the public interest. Non-voluntary licences may be granted three years after the granting of a patent or four years from the date of application on the grounds that the patent holder has failed to sufficiently exploit the invention in Namibia. By the end of 2008, Namibia had not made its intellectual property rights regime WTO compliant. Until the Industrial Property Bill is enacted, TRIPS flexibilities are not exploited in Namibia's laws. |
| South Africa<br>Patents Act, 1978, amended 1988 and 1996 | Section 56 of the Patents Act (1978) permits the use of compulsory licences to remedy abuse, on failure to use the patent, for demand not being met on reasonable terms and on national security grounds. No compulsory licences have been issued. Voluntary licences have been produced as a result of pressure from the Competition Commission. |
| Swaziland<br>Industrial Property Law, No. 6 of 1997 | Section 12(6) permits the government or a designated third party to exploit an invention without the consent of the patent holder where it is in the public interest to do so. In April 2004, the government authorised procurement of medicines for AIDS in the most cost-effective way possible on the international market, irrespective of patent or other intellectual property protection, until it is no longer essential to address the current public health crisis related to HIV and AIDS. |
| Tanzania<br>Patents Act, 1987 | Section 52 allows compulsory licences to be issued on grounds of non-use of the patent, non-reasonable use for the Tanzanian market demands, patented products imported and hindering the working of the invention, refusal of the patent owner to grant licences on reasonable terms and for products vital to the economy (Section 54). Section 61 permits government or a designated third party to exploit an invention without the owner's consent on grounds of public interest, public health or national security. The provisions are not being used. |
| Zanzibar<br>Industrial Property Act, 2008 | Section 3 of the Zanzibar Act provides exclusion of pharmaceuticals from patenting until 1 January 2016. The provisions are not being used. |
| Uganda<br>Patents Act, 1993, amended 2002<br>Industrial Property Bill, 2007 | Section 29 allows the government or persons authorised by the government to exploit an invention without consent of the patent right owner where it is in the vital public interest, including for public health. Section 30 allows for granting compulsory licences on exactly the same terms as for Tanzania above. Use of these provisions remains limited. The Industrial Property Bill incorporates TRIPS flexibilities (patentability, government use, Bolar Provision compulsory licence, parallel imports and extension of transitional periods). |
| Zambia<br>Patents Act, 1958, amended 1980 and 1987 | Section 37 permits granting compulsory licences on grounds of insufficient use or abuse of patent rights. Section 42 permits government to use an invention on grounds of a state of emergency. In 2004, the Zambian government issued a compulsory licence for the manufacture of antiretrovirals to a local producer. |
| Zimbabwe<br>Patents Act, 1971, amended 1994<br>Patents Amendment Bill, 2001 | Compulsory licences may be granted under Section 31 for abuse or insufficient use of the invention. In terms of Sections 34 and 35, the government may use an invention or authorise an agent to do so in a state of emergency. In 2002, the government declared a state of emergency and over-rode patents on antiretrovirals. It issued a compulsory licence to make, use or import antiretrovirals. The period was extended in 2003 up to December 2008. |

These laws provide some flexibilities but in most cases they are not being implemented. There has been wide variation in the use of the TRIPS flexibilities, from Zimbabwe, which makes good use of the flexibilities, to Malawi, which does not. There are a number of constraints, including:

- lack of domestic pharmaceutical research and manufacturing capacities;
- insufficient technical and infrastructural capacities for medicines regulation;
- difficulties in establishing pharmaceutical management and procurement systems;
- bilateral and other political pressures against the use of TRIPS flexibilities;
- lack of capacity to address anti-competitive practices and abuse of patents rights; and
- difficulties in accessing pricing and patent information (Munyuki and Machemedze, 2010).

The past decade has seen numerous challenges in implementing negotiated flexibilities, including in ensuring that bilateral trade agreements do not reverse gains negotiated at multilateral level. More recently, stronger patent protections are being reintroduced through anti-counterfeit laws. In 2008, Kenya passed the Anti-Counterfeit Act, 2008, which came into operation on 7 July 2009. While there are legitimate concerns about falsified, substandard medicines entering Kenya's market without adequate legal protections, the wide definition of 'counterfeits' in the 2008 Act could be extended to include generic drugs and the provisions could nullify the TRIPS flexibilities by making importing such drugs illegal unless agreed to by the patent holder. Ongoing stakeholder consultations in Kenya aim at amending the offending provisions of the Anti-Counterfeit Act, while still ensuring that substandard and falsified drugs are regulated in the appropriate law (KEMRI *et al.*, 2011). Meanwhile, as reported in Section 1, in April 2012, petitioners living with HIV obtained a judgment in their favour against the Act for its breach of their constitutional rights to life. Other countries in the region are in the process of passing similar laws against counterfeits and need to avoid the same problem.

Protecting public health in new agreements and avoiding reversals of gains negotiated multilaterally does not only apply to TRIPS. Increasingly, trade agreements being negotiated at bilateral or international level need to be scrutinised for their impact on health. For example, while the European Union Economic Partnership Agreement (EPA) with Mozambique reduced import tariffs for new farm technologies, it included only limited recognition of the measures needed for these free-trade measures to benefit small-scale women farmers who would have neither the capital nor the knowledge to invest in adopting new technologies to cultivate their plots. By not addressing dimensions of access to capital, credit, information, production technologies and extension services, the agreement has limited the positive impact on women as food producers and thereby on nutrition, as discussed earlier. A study of the costs and benefits of the EPA agreement found that the reduced tariffs on consumption items, such as washing machines and gas cookers, would be regressive in that only households with high incomes and easy access to energy sources can afford them or use them (Fontana, 2011).

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*The results of this gender audit of Mozambique's economic partnership agreement suggest that countries cannot take the benefits and development claims of such trade agreements at face value and need to audit and negotiate on the distribution of costs and benefits, including to health.*

# Bilateral and multilateral agreements to fund health worker training and retention

The loss of public investments made in training health workers through health worker migration from the region was noted earlier, as was the gain to recruiting countries. African countries have in the past made several submissions about this loss and the implications for their health systems at international level. For example, the Regional Health Ministers' Conferences of the East, Central and Southern African Health Community and the March 2008 Kampala Declaration and Agenda for Global Action, resolved or demanded:

- Governments of receiving (destination) countries to notify governments of sending (source) countries on the number of health workers employed, their professional status and their contractual rights and obligations, and to provide equal treatment to health workers recruited from East, Central and Southern African states as for local health workers;
- Support for East, Central and Southern African states to register and monitor their health workers;
- Restrictions on unethical health personnel recruitment and employment practices;
- Compensation, including through investment and tax remittance arrangements, for the losses to African countries of health professionals trained in Africa who migrate permanently to other countries;
- Technical and resource support to health professional training in Africa; and
- External funding support to health programmes in a manner that integrates with national financing arrangements and avoids outflows of critical health personnel from public health services to non-state programmes.

Migration of health workers within the region was managed through regional agreements. For example, a SADC policy for recruitment of health professionals is managed through mutual agreements across member states and through exchange programmes to promote skills circulation and the return of health professionals to their home countries when they have finished their training (SADC, 2008).

The demands from Africa led to a number of initiatives and non-binding codes at international level, including the Commonwealth Code of Practice for the International Recruitment of Health Workers and the United Kingdom National Health Service Code of Practice for the International Recruitment of Healthcare Professionals. At global level, following wide consultations, the WHO Global Code of Practice on the International Recruitment of Health Personnel was adopted through Resolution WHA 63.16 in 2010. Though voluntary in nature, this code is expected to be a 'core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening.'

## Bilateral agreements supporting health worker training in Mozambique

In Mozambique, fourteen multilateral and bilateral funders contribute to the health sector through pooled funding. This funding is used to implement the human resources strategy and expand the training network and includes the Institutes of Health Sciences in Nacala, Tete, Maputo Province (after building the General Hospital) and Gaza as well as training institutions in Chokwe and Chibuto. It also includes developing capacity for distance training and allocating sufficient qualified teachers to training institutions.

Support has been obtained to stimulate the participation of elementary polyvalent agents (APEs) in health promotion. Eighteen cooperation partners, including Germany, the African Development Bank, the World Bank, Belgium, Canada, the European Commission, Denmark, Spain, Finland, France, Holland, Ireland, Italy, Portugal, United Kingdom, Sweden and Switzerland support the government budget and balance of payments which includes payments for personnel.

In 2009, Canada further supported the University of Saskatchewan's partnership with Massinga Health Training Centre, founded by the Mozambican Ministry of Health in collaboration with the University of Saskatchewan. The centre has trained 800 students since 2002, with a five-year goal to triple the training capacity (MoH Mozambique, TARSC, 2010).

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The Code of Practice (the Code) is a voluntary instrument that lays down global principles and practices on the international recruitment and migration of health personnel. Article 4 of the Code, on responsibilities, rights and recruitment practices, identifies the ethical responsibilities of stakeholders to ensure fair recruitment and equitable treatment practices for health workers who migrate. Article 5, on health workforce development and health systems sustainability, discourages active recruitment from countries with critical health workforce shortages. It encourages the use of Code norms as a guide when entering into bilateral, regional and multilateral arrangements to further international cooperation and coordination and identifies the need to develop and support circular migration policies between source and destination countries. It also encourages countries to develop sustainable health systems that would allow domestic health services demand to be met by domestic human resources (WHO Code, 2010).

In Article 6, the Code calls for 'comparable and reliable' data collection for ongoing monitoring of health worker recruitment and migration and reporting to the WHO secretariat every three years. This is an important means to promote implementation and accountability, with the first global review timed for the 2012 World Health Assembly. Within East and Southern Africa, by the end of 2011, Kenya, Mauritius, Swaziland, Uganda, DRC, Angola and Namibia had reported their national authority in relation to the Code to WHO (Zurn, 2011). There has, however, been little reporting on bilateral, regional and multilateral arrangements and on development assistance between destination and source countries for human resource development and training and compensation modalities (SEATINI, ACHEST, TARSC, 2011). The Code, like many other soft law international agreements, highlights the need to move from policy intent to fairly managing the costs and benefits of current global trends.

There is some evidence of countries entering into multilateral agreements around health worker production and migration. For example, Namibia has an agreement with Kenya and Cuba to employ specific categories of health workers, namely nurses from Kenya and Cuba, and doctors from Cuba (EQUINET SC, 2007). Kenya and Namibia have had a memorandum of technical cooperation since 2002, which was renewed in 2009, and it includes cooperation on: health workers' recruitment and deployment; attachment of experts; training attachments and student matters, although funding of training is not included (Govt of Namibia, Govt of Kenya, 2002, 2009). The UK government has in the past provided budget support for expanding and retaining health workers in Malawi (EQUINET SC, 2007). In Zimbabwe, the Global Fund for AIDS, TB and Malaria paid salaries in 26 districts for district medical officers, district laboratory scientists and pharmacists or pharmacist technicians, and United Nations Population Fund (UNFPA) and the European Union have provided support for salaries or top-up incentives for selected provincial and district personnel (Midzi, 2008). The Mozambique example on page 136 highlights the range and level of agreements that have been negotiated in relation to budget support, training, salaries and incentives for health workers in the region.

*The loss of skilled workers from the health systems in East and Southern African countries due to health worker migration and the demands for fair responses led to the Code of Practice on the International Recruitment of Health Personnel. The value of the Code depends on how far countries in the region and destination countries collaborate on health worker development and training, and whether any new bilateral, regional or multilateral arrangements – soft law instruments – on health workers are negotiated between source and destination countries.*

## Health officials included in trade negotiations

As international and global trade, economic and security agreements increasingly cover or impact on health issues, health ministries are being called on to collaborate with their counterparts in trade and foreign affairs. For example, in relation to trade, health ministers are expected to inform pre-negotiation positions, provide input during negotiations, analyse the health costs and benefits of proposed compromises and monitor the health impacts of trade agreements (Drager and Fidler, 2007).

As raised in the Eastern, Central and Southern African Health Community Health Ministers' meeting in October 2010, global health diplomacy in the East and Southern African region has been characterised by a lack of institutional mechanisms, limited policy and implementation frameworks, inadequate human resources capacity and a paucity of information and research resources (ECSA *et al*., 2010). This is despite the greater demand for effective engagement in global health policy and the demand for fairer benefit sharing and technology transfer for health.

Many global health issues with relevance to population health have been motivated or raised from the region, including: access to treatment for HIV and AIDS; the effect of trade agreements on access to essential medicines; global governance in the UN and Bretton Woods institutions; universal access and coverage commitments; innovation and intellectual property; health worker recruitment and migration; technology transfer and neglected diseases.

Countries have reported capacities and challenges in engaging with these global health issues. The information and evidence on the implications of global issues are lacking to guide negotiating positions on the different country positions, arguments and experiences and the economic and health implications and benefit analysis of particular positions on issues. The information gap is partly a result of internet being inaccessible, expensive and slow in many countries, making investment in information technology important for effective negotiation of health issues in global policies (Loewenson *et al*., 2011).

*While formal dialogue between trade and health sectors on health issues in trade has not been consistent or formalised in the past, there is evidence that it is becoming more frequent and institutionalised, particularly given the combined interests on medicines access and trade.*

Parliaments in the region have provided a forum for raising health issues in global trade and economic agreements, while civil society has contributed information and advocacy to protect health in trade agreements (EQUINET SC, 2007). For example, civil society has played an active role in medicine access and intellectual property issues. Civil society has been involved in advocacy on the negotiations of the European Union economic partnership agreements, to explicitly include commitments: to protect public health; to protect TRIPS flexibilities; to exclude any commitments to liberalise health services; and to include provisions to assess the impact on health-related sectors where commitments are proposed. Acknowledging this, the SADC-EC economic partnership agreement explicitly protected health by providing a clear statement in Article 3 that the agreement should in its application take into account the human, cultural, economic, social, health and environmental interests of the population and of future generations (Munyuki *et al*., 2009).

In Uganda, the pharmacy division of the Ministry of Health initiated training and discussions on the impact of intellectual property rights on access to medicines. The health ministry was represented in the East African Community regional meetings on the development of the 'East African Community regional intellectual property policy on the utilisation of public health related World Trade Organisation (WTO) –TRIPS flexibilities and the approximation of national intellectual property legislation' and in 2010 in the negotiations on the Draft East African Community Regional Protocol on Public Health Related WTO–TRIPS Flexibilities (EAC, 2010). Zambia, Tanzania, Zimbabwe and South Africa have health attachés in their embassies in Geneva to provide specific health input to diplomacy at United Nations level, including on trade issues.

Kenya's experience below indicates a promising practice in further institutionalising and developing processes, mechanisms and capacities for diplomacy and representation of health interests in trade and other global negotiations. These processes are not simply a matter for state officials. As found in the 1990s with the TRIPS agreement, civil society, parliaments and technical actors within the region have an interest and may exert leverage in engaging with global policies, processes and institutions towards greater global justice.

## Global health diplomacy in Kenya

Prior to 2005, Kenya had a relatively limited involvement of health officials in trade negotiations, with a past experience characterised by inadequate preparations for key international meetings, uncoordinated follow up of key resolutions and lack of a proper framework to link resolutions passed at the international meetings to national policy formulation for implementation (Kenya MoPHS, 2011).

Concerns regarding these weaknesses led to the establishment of the Department of International Health Relations within the Ministry of Public Health and Sanitation (Kenya MoPHS) in 2005, with a mandate to coordinate all activities related to international health, including regional collaborations and to adequately equip and prepare the ministry officials to handle all matters related to global health diplomacy. With the formation of the department, health officials are now actively involved in trade negotiations through the inter-ministerial Committee on Global Diplomacy and International Health.

The country has built capacity in global health diplomacy and had trained 27 officers by 2009. It has established an Intellectual Property Health Advisory Group which draws its membership from government, the Kenya Industrial Property Institute (KIPI), the Pharmacy and Poisons Board, Health Action International Africa and WHO. Preparations are made for international meetings, especially the World Health Assembly, involving pre-assembly stakeholders' workshops to develop the country position on priority agenda items. Leadership in the agenda is assigned by African group and post-assembly debriefing workshops for stakeholders.

This development has played an important role in disseminating international resolutions and following up with the relevant departments and stakeholders for implementing resolutions and linking with local policy formulation processes (Kenya MoPHS, 2011).

*Dr Gamaliel Omondi, Senior Public Health Officer, Kenya Ministry of Public Health and Sanitation and Dr Maria Neira, Director, Department of Public Health and Environment, WHO, at the 65th World Health Assembly, May 2012*

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# 7

# Conclusions

# SUMMARY TABLE

| PROGRESS MARKER | Zimbabwe 2008 | Zimbabwe 2011 | Mozambique 2010 | Zambia 2011 | Kenya 2012 | Uganda 2011 |
|---|---|---|---|---|---|---|
| EQUITY IN HEALTH | | | | | | |
| Formal recognition of equity and health rights | | | | | | |
| Halving the number of people living in poverty | | | | | | |
| Reducing the gini coefficient of inequality | | | | | | |
| Eliminating differentials in child, infant and maternal mortality and under-nutrition | | | | | | |
| Eliminating differentials in access to immunisation, ante-natal care, skilled deliveries | | | | | | |
| Universal access to prevention of vertical transmission, antiretroviral therapy and condoms | | | | | | |
| HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH | | | | | | |
| Closing gender differentials in access to education | | | | | | |
| Halving the proportion of people with no safe drinking water and sanitation | | | | | | |
| Increasing the ratio of wages to gross domestic product | | | | | | |
| Providing adequate health workers and drugs at primary, district levels | | | | | | |
| Abolishing user fees, backed by improved resources to services | | | | | | |
| Overcoming barriers to access and use of services | | | | | | |
| REDISTRIBUTIVE HEALTH SYSTEMS | | | | | | |
| Achieving the Abuja commitment | | | | | | |
| Achieving US$60 / capita funding for health | | | | | | |
| Improving tax funding and reduce out of pocket spending to health | | | | | | |
| Harmonising health financing into a framework for universal coverage | | | | | | |
| Establishing and ensuring clear health care entitlements | | | | | | |
| Allocating at least 50% public funding to districts and 25% to primary health care | | | | | | |
| Implementing non-financial incentives for health workers | | | | | | |
| Formally recognising and supporting mechanisms for public participation in health systems | | | | | | |
| A JUST RETURN FROM THE GLOBAL ECONOMY | | | | | | |
| Reducing the debt burden | | | | | | |
| Allocating esources to agriculture and women smallholder farmers | | | | | | |
| Ensuring health goals in World Trade Organization (TRIPS, GATS) agreements | | | | | | |
| Including health officials in trade negotiations | | | | | | |
| Funding health worker training through bilateral and multilateral agreements | | | | | | |

# Advancing equity in health in East and Southern Africa

Social values for health equity are deeply rooted in East and Southern Africa. They have been sustained and consistently expressed in policy over many decades. Various dimensions of the right to health are contained in the constitutions of the region, with more comprehensive provisions included after social and political struggle in more recently enacted constitutions.

Despite these values, rights and duties, the political, social, cultural and economic contexts and the asymmetries of information, power and resources they are associated with, have generated, configured and maintained social hierarchies in the region, stratifying populations according to income, education, occupation, gender, race or ethnicity and other factors. There is an expectation that states will address these unfair social inequalities through their policies, laws, services and political roles, nationally and globally. This report examines how far we are meeting these expectations. The summary table on page 142 opposite summarises the rating of progress in equity in the countries made in the various *Equity Watch* reports. Based on an analysis of trends from 1980 to current levels, these reports assessed progress made in implementing measures that improve health equity. In the table, green signals progress, red signals worsening outcomes and yellow or mixed shades indicate mixed outcomes. The regional report provides a wider picture for the sixteen countries in the region.

*The community built a bridge for people to access the local market, Kasipul, Kenya*

*© Samson Juma,, March 2009*

## Social inequalities in health outcomes

The report describes inequalities across various areas of survival and health within countries and across the region. Some areas, such as HIV prevalence, show lower inequalities within countries than others, for example, child mortality and adolescent pregnancy. Overall, however, the report makes it clear that focusing on aggregate changes within or across countries in health and survival is not sufficient. Aggregate improvements in health have sometimes happened together with widening inequalities, such as in the case of child mortality. The aggregate can mask social crises that merit urgent attention, such as the findings for East and Southern African countries in this report of:

- Nearly one in five children under five years dying in the poorest households within two countries in the region.
- Seven-fold differences in under five year mortality between countries of the region.
- Wide differences in nutrition by wealth within all countries in the region.
- A 39-fold gap in maternal mortality between mothers in Africa and those in high income countries globally and a 22-fold gap across countries in the region.

Child nutrition reflects social and geographical differences within countries. There are five-fold differences in child under-nutrition by mothers' education in some countries (Swaziland, Namibia) and three-fold differences by household wealth in other countries (Mozambique, Kenya and Namibia). Poor child nutrition may also damage socio-economic opportunities. The level of progress towards closing wealth and other social inequalities in child nutrition may thus be one of the most effective indicators in countries, in the region and globally, for assessing the distributional performance of public policy.

Specific attention needs to be given to such inequalities, including within the debates in parliament, in civil society advocacy, in reporting on the activities of the state and in global processes, including on the Millennium Development Goals.

Within and across countries we need to expose and respond to evidence of poorer access to health resources for those with higher health need, including in framing approaches to universal health coverage. For example:

- Within countries, wider social and geographical inequalities were found in access to reproductive health and maternal health services than for many other areas of health service delivery.
- Lower coverage of reproductive and maternal health services was found in many of the same countries in the region that have higher maternal mortality.
- There is evidence that coverage levels of HIV prevention and treatment interventions are lower among rural, poorer people. While currently HIV prevalence does not show significant inequalities by wealth, this lower coverage of prevention services among poorer people, sends a warning that HIV will become more prevalent in disadvantaged communities than in their wealthier counterparts in the future.

Equally for emerging challenges, such as non-communicable diseases, we need to better understand their distribution and determinants, so that lifestyle and curative approaches do not leave poor households less protected, creating a future legacy of wide social differentials in the levels and consequences of these diseases.

Household surveys provide valuable evidence for such disaggregations within countries. However, current surveys rarely gather evidence on social differences in maternal mortality and non-communicable diseases and do not provide evidence on what is happening within districts. Routine data rarely reports on more than geographical differences (further discussed later in this section).

The health sector has a critical role to play in raising these issues and making these gaps visible. This is not only an ethical issue. The report gives ample evidence of promising practices that tackle and close unfair avoidable inequalities in people's survival and health. Giving visibility to evidence on social inequalities in health, within and across countries, fuels the necessary political demand for application of these policies, services and programmes and makes it clear who bears the costs and burdens of not doing so.

## Widening opportunities for health

People's health primarily reflects differences in their living, working and community conditions and lifestyles. These conditions lead to differences in people's exposure to risk and vulnerability to disease. The health sector has an important role in making these causes clear, both by pointing to risks to public health and by showing the gains made when they are addressed. There are promising practices presented from East and Southern African countries where inequalities in child survival and health have been reduced by measures that, for example, close gaps in access to safe water (such as in Uganda), that resource support for producing food crops (such as in Zambia and Malawi), for education (such as in Namibia and Mozambique) and for services in poor urban areas (such as in Angola).

The evidence indicates that improvements in literacy and gender parity in primary education continue to be important investments in health equity. It also indicates that to widen progress, such investments need to be sustained and widened in two directions. Firstly, to ensure that children, especially girl children, stay in school to complete secondary education and receive quality education. Secondly, to ensure that education starts earlier. Early childhood education and care, of major importance for child development and health, was found to have large economic, geographical, social and cultural disparities in coverage in the region, particularly due to poor public provisioning and the reliance on private services. Policy leadership is needed to expand the public provisioning of early childhood education and care, including through partnerships with communities.

Two further areas are raised that need more focused attention. The slow or absent progress in safe water and sanitation found across most countries in the region merits urgent attention. More valid indicators of effective safe water and sanitation coverage that also reflect cost barriers and reliability of supplies are needed. These may show even worse outcomes than the current data. Those deprived of safe water and sanitation not only risk illness and death from a range of diseases, they suffer a loss of human dignity and an increase in domestic burdens, especially for girls and women. Improving coverage of such fundamental determinants of health is not infeasible. The report highlights that closing the gap is possible and provides examples from the region of the progress made when policies, resources and community roles are aligned and basic water entitlements are provided at affordable cost. Hutton and Bartram (2008) estimated that an additional US$12 per capita needs to be spent annually to reach the Millennium Development Goal targets for safe water and sanitation globally, both to expand coverage and maintain existing supplies. From global and regional cost–benefit analysis the benefits associated with spending on improved water supply and sanitation coverage is in the order of US$3 to US$34 per dollar invested (Hutton and Bartram, 2008).

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*'It's a struggle to get the water out but I'm happy we have a closed well. Next year we will make sure we have a tap', Magomeni, Bagamoyo*

*A nutrition garden, Masvingo, Zimbabwe* © CWGH, 2010

Secondly, despite the persistent under-nutrition shown earlier, there continues to be inadequate investment in local food production. While some countries in the region have taken measures to diversify food production and subsidise inputs, only one has met the African Union and SADC commitment of 10 per cent of the government budget to agriculture. Again the report indicates that public policy can and needs to make a difference in this area. In addition to the case study examples of promising practice, there is evidence, for example, that all eight African countries that met the African Union target of 10 per cent of government budgets spent on agriculture between 2004 and 2007, also reduced the share of people in food poverty.

## Prioritising health system features that promote equity

Health systems can reflect existing patterns of social inequality but they can also provide a site from which to contest and mitigate them, through the services they offer and the financial protection they can provide. Given their purpose, it is thus a problem when health care resources are distributed inverse to need, as indicated in the example of maternal health services on pages 39–41. Social and geographical inequalities are evident in many areas of both prevention and care of ill health. The inverse care found, for example, in reproductive health and maternal health services, calls for greater attention to equity in the design of these services.

Inequalities in access to services appear to close as coverage improves. However, improving coverage is also apparently not enough to close gaps. Additional measures appear to be needed for services and key programmes (maternal and child health, HIV and disease prevention) to scale up close to communities and to overcome barriers in access, uptake, adherence and coverage due to social disadvantage. Achieving both calls for greater focus to be given to the primary level of the health system.

The policy choices made by states can make a significant difference in this. It appears that social differentials in access to health interventions, including for those that are important for Millennium Development Goals 4, 5 and 6, are lower for the community and primary care services that are closer to communities. Benefit incidence studies confirm the greater benefit of public sector primary care (clinic) services for poorer households, while wealthier groups benefit considerably more from other levels of services. Lower income, less educated and more remote groups drop out from services that incur fee, transport, time and other costs. Hence immunisation and antenatal care coverage provided in clinics shows lower inequalities than the AIDS programmes and deliveries assisted by skilled personnel, both of which are often provided at district hospitals.

East and Southern African country health strategies all refer to the need to ensure adequate reliable supplies of medicines and staff in services close to communities and the need to overcome shortfalls in public sector health workers in 'hard-to staff' areas. They all cite the need to lift user fees and to establish mechanisms for public participation. Some countries have lifted user fees with evidence of equity gains. However, the implementation of these policies is not always sector-wide or consistent. For example, domestic resources are not always tracked and reported on down to primary care level and health information may be poorly analysed and used at this level. Despite the acknowledged importance of community participation in health strategies, meaningful systems-wide progress is yet to be made in capacitating, informing and resourcing such participation.

In contrast, there is evidence of the benefit for health equity from measures that overcome geographical differentials, such as by improving availability of infrastructure, health workers and medicine, when combined with measures that facilitate access and uptake in disadvantaged groups. This links the policy commitments made to primary health care, equity and universal health coverage. These measures include the following:

- Expanding or ensuring service infrastructure at primary care level;
- Allocating, spending, tracking and ensuring that sufficient resources reach primary care and community level services to ensure consistent and reliable provision of commodities and staff;
- Providing financial and non-financial incentives (including housing) to attract and retain skilled health workers in community, primary and secondary care services;
- Orienting health personnel and capacitating and informing meaningful community participation in health;
- Supporting community health workers, community outreach programmes, information and social measures and organisation to facilitate access and uptake in disadvantaged groups; and
- Integrating specific programmes, such as those for HIV and AIDS, within comprehensive primary care services.

## Universal health coverage with equity

The evidence on inequities in health and health care, including in relation to Millennium Development Goals 4, 5 and 6, suggest that universal health coverage goals cannot be assumed to support equity. Higher levels of inequality in access to even more highly resourced programmes for HIV and AIDS suggests that this is not just a matter of increasing the aggregate resources for services. A goal of universal health coverage needs to explicitly include equity. The evidence from the region suggests certain features that need to be embedded in policies and targets for universal health coverage with equity, including:

- Rights-based entitlements to health care and critical social determinants of health, with measures for accountability to the public on their progressive and equitable realisation;
- Entitlements of access to public health and health care services, with a particular (but not exclusive) focus on primary and community levels;
- Goals and measures to monitor and eliminate inequalities in access to and quality of these entitlements;
- Measures for consistent, predictable domestic and international financing that is adequate to cover these entitlements, raised and spent according to needs, and
- Measures to build understanding and support for these policies across society.

Delivering on these features calls for consistent, stable public leadership and strategies that span a decade or more. This public sector leadership is difficult to achieve without adequate domestic public financing, no matter what the level of other funding sources. There has been some progress, even if slow, in meeting the Abuja commitment of 15 per cent government funding to health and in per capita health funding. There is ad hoc evidence of gains in health outcomes in periods of increased public spending on health. Such returns need to be better documented to encourage improved funding and measures to overcome capacity and procedural blocks to the effective absorption and use of funds. With the economic growth found and projected in the region, more attention could be given to tax options to strengthen domestic financing. This calls for work in countries to project the revenue streams and explore the distribution of burdens of new tax options, including VAT, earmarked, sin and other wealth taxes.

## Moving from growth without equity to growth with equity

The regional analysis is a narrative of still unmet opportunities for health. The health problems in the region are largely preventable and the region possesses significant natural, economic and social assets, experience, promising practice and capacities to close social gaps in both health outcomes and in access to needed services.

Increased aggregate GDP growth regionally and positive economic growth across most countries of the region throughout the 2000s set a potentially favourable context for addressing the conditions and services needed to improve health equity. Why then do we find inequalities persisting or widening, even when aggregate performance is improving?

While the policy choices made in the social sectors can make a difference, as outlined earlier, there are warning signs of a deeper issue of economic growth occurring with increasing poverty and inequality, generating social disadvantage and limiting the returns from growth, including in terms of improvements in health. The evidence indicates that growth alone will not automatically reduce poverty in the region, unless inequality is also reduced. The discourse of 'success' in global poverty reduction derives mainly from a few emergent middle-income countries and gains have not been felt in most low-income countries, many of which are in Africa.

Some of the pathways for this are presented in the report:

- *Rapid, unserviced urbanisation* – Rural areas continue to have higher poverty levels and the rural–urban poverty gap has narrowed in the past decade in many countries in the region. However, this is partly due to rising urban poverty, associated with rapid and unmanaged urban growth, job insecurity and rising commercial food prices. Poor urban households may be 'invisible' in areas of higher wealth or 'illegitimate' in informal settlements, challenging service delivery models, including for primary health care.
- *Inadequate investment of surpluses in new jobs* – Evidence from the few countries that have tracked wage and profit shares suggest that wage shares have fallen relative to profit shares in these countries. This suggests that there has been inadequate investment of surpluses in new employment and job creation, limiting the income, wealth and social security returns that come from improved employment.
- *Gender disparities in agriculture* – While investment in local food production is a general challenge, household food security is also constrained by deep gender disparities in agriculture. Women have highly unequal or negligible access to land in their own right, unequal access to inputs, information and markets, and low participation in the leadership of farmer organisations that negotiate these measures, despite their significant role in local food production and in nutrition. Inadequate investment in smallholder food production, large-scale foreign land acquisitions and effects of climate change carry a risk of deepening these inequalities.

The pro-cyclical deflationary macroeconomic model that has dominated economic policy globally does not appear to be yielding the sustained, inclusive or equitable growth needed to achieve social goals, particularly as the benefits from global markets and rules continue to be biased towards those countries and individuals with the most productive assets and economic power. As in the 2007 regional analysis, this regional *Equity Watch* points to a range of continuing resource outflows that lead to greater benefit from regional resources accruing outside the region. These include debt servicing, skilled worker out-migration, extraction of unprocessed minerals, biodiversity, food and other resources, and unfavourable terms of trade, together with new challenges such as the increasing foreign appropriations of land within the region.

East and Southern African countries – both the states and civil society – have in the past decade engaged more actively on trade, investment and other structural policies that disadvantage the region, including on intellectual property, technology transfer, health worker migration and debt relief. It is evident that benefits and development claims within global processes cannot be taken at face value. They need to be assessed and negotiated for from within the region. Experience of justice-oriented negotiations, such as on the Doha Declaration or the Code on the International Recruitment of Health Workers, indicate that even when shifts in policies and institutions are achieved through alliances across states and with civil society, these cannot be taken for granted. They need active regional and national follow up to realise them in practice and need to be constantly protected against erosion.

## Embedding principles of universalism and equity

This regional *Equity Watch* presents evidence to justify and add urgency to policy commitments to equity. While 'growth with inequality' has roots in global processes, in the East and Southern African region, it compounds historical inequalities, leading to unacceptable depths of deprivation for some communities and unacceptably wide and avoidable gaps in survival, health, social and service outcomes within and across our communities and countries. This is stark evidence that the distributional impact of policies and measures must be made more explicit and that both universalism and equity must made more central in policies and goals, including in global development goals, after 2015.

The report also presents evidence of interventions and policies that are closing the gaps. Within identified priorities, promising practice within the region points to areas for greater and sustained investment, within and beyond the health sector.

Countries and global actors should explicitly seek to close these unacceptable gaps because they can. Whatever its determinants, the major dimensions of inequity in health are socially produced. They are an outcome of the values, choices and decisions made within political, social and economic sectors and institutions, at local, national, regional and global level. They can be socially resolved.

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# Measuring progress in health equity

What is measured counts. The decision to track and report on progress in equity in health made by the EQUINET steering committee in 2008 and the East, Central and Southern African Regional Health Ministers in 2010, was based on a premise that to advance health equity, inequalities need to be made visible and discussed in planning and in social dialogue. Equity analysis thus feeds into health policy or strategy review processes, as was underway in Zimbabwe in 2009, after the 2008 *Equity Watch*, or in Kenya in 2011, during production of the 2011 Kenya *Equity Watch*.

In April 2012 when we reviewed the evidence we made it clear that we are not simply monitoring problems, we are monitoring progress and the lessons learned for future action. The involvement of state, technical institutions, civil society, parliament and a range of sectors is important in raising and using evidence.

The experience of the work to date highlights opportunities and challenges and raises issues for future equity monitoring:

## On evidence for tracking equity

We chose the progress markers used from 2008 to 2012 to reflect the conceptual understanding of health equity and its determinants. They cover areas where policy commitments have been made or areas identified from prior evidence as having an impact on health equity. They present the disaggregation of parameters reported in other policy processes, such as the Millennium Development Goals.

*'Coping with HIV, the loss of my partner and poverty', Kasipul, Kenya*

© Jacob Ongala, 2009

The social disaggregations largely relate to those found in demographic and health surveys (region, wealth, mother's education, gender). The analysis confirms that disaggregations by area (geographical region/ rural-urban residence) and by socio-economic indicators (wealth, mother's education, gender) appear to both be necessary, given the changing relative weight of these different social factors in health outcomes and the different responses needed.

While the available evidence in countries covers many of these disaggregations, there are gaps raised in the report. Particularly important gaps appear to be the following:

- Socially disaggregated data on maternal mortality and non-communicable diseases is not generally available. This could be addressed by including measurement of maternal mortality, as done, for example in the DRC, and of non-communicable diseases in future demographic and health surveys.
- Household surveys are not able to generate district-level disaggregations so that evidence is available to the level of provinces or regions and by social group. However, information on specific groups, such as poor, urban households or newly resettled households, calls for evidence within districts. Additional data collection is needed from census, routine information systems and specific surveys such as the demographic surveillance sites to collect evidence to district level.
- Health expenditures are often not disaggregated in annual reporting by level of the health system, including community, primary, secondary and higher levels. As noted in the report, this is essential to track trends in allocating resources to primary and community levels that benefit lower-income groups more and to assess associations between allocations and health outcomes.

The progress markers in the *Equity Watch* are not exhaustive and may be added to. In dialogue on the different country *Equity Watch* reports, it was suggested that future analyses include evidence on shares of formal and informal employment and unemployment, and on the distribution and use of household energy sources. In the health sector, proposals were made to include stock-outs of tracer drugs at primary and secondary level facilities. It was suggested that evidence on tax revenue for health be disaggregated to show the different sources, including payroll, wealth, VAT and other earmarked tax contributions to the health sector. An EQUINET commissioned gender analysis of health equity in East and Southern Africa highlighted, for example, the need to track and address gender differentials in participation in decision-making and in access to resources for health within households (MacPherson *et al*., 2012).

Different sectors (education, labour, agriculture) organise evidence differently. Geographical disaggregations may not overlap and social disaggregations may be different. This complicates links across data sets. However, multiple sources of evidence create a more holistic picture of the different dimensions of equity. As was raised in the national meeting of the Zimbabwe *Equity Watch*, analysis of health equity and its determinants is an inter-sectoral activity with implications for a range of sectors. Coordinating the compilation and analysis of evidence across sectors helps to better understand the wider distributional impact of policies, the multiple dimensions of disadvantage experienced by some households and the cross-sectoral impact of policies aimed at addressing social inequalities in health.

Community evidence helps to understand barriers or experiences of services that affect uptake and equity. In Zimbabwe, the 2008/9 *Equity Watch* stimulated community-based research on primary health care that highlighted areas for investment and, in the 2011 *Equity Watch,* institutional and survey evidence was combined with evidence from community sentinel site monitoring to better understand the trends and how communities see and experience them.

## Some limitations in using data from many sources

In the regional analysis there are limitations relating to the evidence that need to be kept in mind in interpreting the findings:

- While efforts were made to use data sets that had comparable information across all 16 countries in the region, the data sets across countries were not always complete or uniform. United Nations or multi-country data sets sometimes varied from country-level data, noted in the report.
- Making comparisons across time is affected by changes in the definitions of parameters, which are noted wherever this was made clear.
- Publicly reported data is not always current. Demographic and health surveys are implemented every five years and, unless a multiple indicator cluster survey (MICs) is also implemented, there may be a long time lag in accessing relevant disaggregated household information. This suggests that more detailed *Equity Watch* reports covering changes in household level indicators may only be possible every five years, even while routine and administrative data can provide information for some progress markers annually.
- Wealth quintile data in the demographic and health and multiple indicator cluster surveys is an index based on a selection of assets that varies from country to country. Wealth differentials in water and sanitation are not available as these two indicators are used in setting the wealth index.
- Because the level and distribution of wealth differs from one country to another, wealth index scores do not indicate absolute wealth differences across countries. The wealthiest 20 per cent of households in one country do not necessarily correspond to the wealthiest 20 per cent of households in another country. Despite this, the wealth index quintiles provide a reasonable measure of gradients and thus comparison of the relative differences between countries. Some countries – Botswana and South Africa – do not provide wealth disaggregations.
- Comparisons using ranges and rate ratios – such as highest to lowest quintiles – provide useful summary information on absolute gaps but may miss an understanding of the gradients or of anomalous patterns.

*Notwithstanding all these 'caveats' on the data, WHO AFRO (2010) pertinently note in relation to the limitations in available evidence that:*

> *'The best strategies for ameliorating inequities in social determinants of health are those that reflect local knowledge, innovation and a community's readiness for change, not just "expert" knowledge regarding the best way to create change. One of the most important trends in public health is the inclusion of those who experience health inequities in all aspects of work… ensure that they have the opportunity to fully participate once at the table. A great deal of work suggests, for example, that within various ethnic and racial groups there are significant differences in perspectives and experiences depending on class gradations, occupational category and gender. The challenge is incorporating this broad range of perspectives' (WHO AFRO, 2010: 207).*

## On using the evidence

Whatever the limitations, reporting and using the data helps to improve it. For example, in Zambia, discussing findings of immunisation coverage rates of over 100 per cent in some districts pointed to service issues that lead to people using services outside their catchment area.

The data has best use when it is linked with a policy and planning process, such as the national health strategy; when it involves a wide range of national stakeholders; when the findings are reviewed with sectors relevant to social determinants, with parliament and civil society, as was done in Zimbabwe; and when used in policy platforms such as in the SwAP process and the health partners' meetings in Mozambique.

The *Equity Watch* is currently linked to departments responsible for planning or for health information. In Mozambique it was proposed that a National Commission on the Social Determinants of Health be established to promote equity across sectors. Similarly, in Zambia, it was suggested that a strong group galvanize concerted action from across key sectors affecting health (housing, water, sanitation, food, employment), convened by the Ministry of Health and involving local government, civil society and other stakeholders in health.

*Community meeting with the District Commissioner in Bagamoyo, Tanzania*

© Selemani Ally Joe, 2009

In review meetings, stakeholders called for annual or biannual updates of the *Equity Watch*. Mozambique proposed that:

> '…a group be set up to keep track of the progress and feed into the gathering of evidence for assessing progress. The process should include technical institutions and civil society and involve politicians, governors and district administrators.'

In Zambia, they proposed that:

> 'The Ministry of Health should look for money to continue with the *Equity Watch* project on a regular basis to update evidence and track progress.'

Zimbabwe repeated the *Equity Watch* after three years to give time for policy implementation and for a new round of household surveys. In a national stakeholder review meeting in Zimbabwe, delegates used the evidence to discuss how equity and social determinants could be integrated within a framework for universal health coverage and suggested that the future *Equity Watch* be 'steered' by a multi-sectoral group, implemented periodically using household data and more regularly including annual indicators from routine monitoring systems.

In 2008, the United Nations Economic Commission for Africa noted:

> ' Urgent action is necessary to minimise inequity… This requires that concern for health equity be made routine and commonplace (mainstreamed) across all sectors, departments and tiers of government and in the broader development agenda of African countries' (UN ECA, 2008: xiv).

They observed that while countries make health equity a priority concern and their national health plans make reference to equity in their objectives, these largely focus on improving physical (geographical) access to health. They noted that few countries set targets for equity or monitor them (UNECA, 2008).

The UNECA call for urgency has even greater relevance at the global level, where reporting on Millennium Development Goal targets is largely not disaggregated, where targets for equity are not set or monitored and where the inequalities across countries globally dwarf many of those within the region.

There is now a growing experience of monitoring and tracking equity within countries and at regional level in East and Southern Africa. While there are many challenges, there are also growing processes within the state, civil society and communities to make the social, economic and geographical dimensions of health equity visible, linking this analysis to policy dialogue, to planning and to social activism. This is work in progress, embedded within the social activism for and policy dialogue on building universal systems, fair economic and social development and democratic participation in the region.

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## Acronyms and abbreviations

| | |
|---|---|
| ACHPR | African Commission on Human and Peoples' Rights |
| ANC | Antenatal care |
| ARI | Acute respiratory infection |
| ART | Ante-retroviral Therapy |
| AU | African Union |
| CHWs | Community Health Workers |
| CMH | Commission of Macroeconomics and Health |
| CEHURD | Centre for Health, Human Rights and Development |
| CSDH | Commission on the Social Determinants of Health |
| DRC | Democratic Republic of Congo |
| DHS | Demographic and health survey |
| EC | European Community |
| ESA | East and Southern Africa |
| EAC | East African Community |
| EPAs | Economic partnership agreements |
| EQUINET | Regional Network for Equity in Health in Eastern and Southern Africa |
| EU | European Union |
| ECSA HC | East Central and Southern Africa Health Community |
| GDP | Gross domestic product |
| GFATM | Global Fund for AIDS, TB and Malaria |
| GHIs | Global health initiatives |
| GoK | Government of Kenya |
| GoMoz | Government of Mozambique |
| GoU | Government of Uganda |
| HIPC | Highly indebted poor countries |
| HIV/AIDS | Human immune virus/ Acquired immune deficiency syndrome |
| HRIS | Human resource information system |
| HRM | Human resource management |
| HSS | Health systems strengthening |
| HSSF | Health Sector Service Fund |
| HSSP II | Health sector strategic plan II |
| IMR | Infant mortality rate |
| ICESR | International Covenant on Economic and Social Rights |
| ITN | Insecticide Treated Bednets |
| IPRs | Intellectual property rights |
| IMF | International Monetary Fund |
| IT | Information technology |
| MICS | Multiple indicator cluster survey |
| MMR | Maternal mortality rate |
| MDG | Millennium Development Goal |
| MDRI | Multilateral debt relief initiative |
| MISAU | Ministério de Saúde |
| MoF | Ministry of Finance |
| MoFNP | Ministry of Finance and National Planning |
| MoFPED | Ministry of Finance, Planning and Economic Development |
| MoH | Ministry of Health |
| MoHCW | Ministry of Health and Child Welfare |
| MoMS | Ministry of Medical Services |
| MoPHS | Ministry of Public Health and Sanitation |
| NAC | National Aids Council |
| NGO | Non-government organisations |
| NHA | National health accounts |
| OOP | Out of pocket |
| OPD | Out patient department |
| PHC | Primary health care |
| PPP | Purchasing power parity |
| SEAPOCH | Southern and East African Parliamentary Alliance of Committees of Health |
| SWAp | Sector Wide Approach |
| SADC | Southern African Development Community |
| SEATINI | Southern and Eastern African Trade, Information and Negotiations Institute |
| Tanzania | United Republic of Tanzania |
| TARSC | Training and Research Support Centre |
| TRIPS | Trade-related aspects of intellectual property rights |
| TB | Tuberculosis |
| UBOS | Uganda Bureau of Statistics |
| UNDP | United Nation Development Programme |
| UNICEF | United Nation Children's' Fund |
| US$ | United States dollars |
| USAID | United States Agencies for International Development |
| UN | United Nations |
| U5MR | Under five year mortality rate |
| UNAIDS | The Joint United Nations Programme on HIV/AIDS |
| VAT | Value added tax |
| WTO | World Trade Organisation |
| WHO | World Health Organisation |

# Statistical appendix

## Section 2: Equity in health outcomes in East and Southern Africa

**Table A2.1: Population data for East and Southern African countries, 1989–2009**

| Country | Population | | | | | | |
|---|---|---|---|---|---|---|---|
| | Total (000s) | Under 15 yrs (%) | Annual growth rate (%) | | Living in urban areas (%) | | |
| | 2009 | 2009 | 1989–1999 | 1999–2009 | 1990 | 2000 | 2009 |
| Angola | 18 498 | 45 | 2.9 | 2.9 | 37 | 49 | 58 |
| Botswana | 1 950 | 33 | 2.5 | 1.4 | 42 | 53 | 60 |
| DRC | 66 020 | 47 | 3.3 | 2.9 | n.a | n.a | 35 |
| Kenya | 39 802 | 43 | 3.0 | 2.6 | 18 | 20 | 22 |
| Lesotho | 2 067 | 39 | 1.6 | 1.1 | 14 | 20 | 26 |
| Madagascar | 19 625 | 43 | 3.0 | 2.8 | 24 | 27 | 30 |
| Malawi | 15 263 | 46 | 2.3 | 2.9 | 12 | 15 | 19 |
| Mauritius | 1 288 | 23 | 1.2 | 0.9 | n.a | n.a | 42 |
| Mozambique | 22 894 | 44 | 2.8 | 2.5 | 21 | 31 | 38 |
| Namibia | 2 171 | 37 | 2.7 | 2.0 | 28 | 32 | 37 |
| South Africa | 50 110 | 31 | 2.1 | 1.3 | 52 | 57 | 61 |
| Swaziland | 1 185 | 39 | 2.4 | 1.1 | 23 | 23 | 25 |
| Uganda | 32 710 | 49 | 3.3 | 3.2 | 11 | 12 | 13 |
| Tanzania | 43 739 | 45 | 3.0 | 2.7 | 19 | 22 | 26 |
| Zambia | 12 935 | 46 | 2.8 | 2.4 | 39 | 35 | 36 |
| Zimbabwe | 12 523 | 40 | 2.0 | 0.1 | 29 | 34 | 38 |
| African region | 824 401 | 42 | 2.7 | 2.5 | 29 | 34 | 38 |
| Income group (global) | | | | | | | |
| Low income | 844 667 | 39 | 2.5 | 2.2 | 23 | 26 | 29 |
| High Income | 1 083 915 | 18 | 0.7 | 0.7 | 73 | 76 | 77 |
| Global | 6 816 573 | 29 | 1.5 | 1.2 | 43 | 47 | 50 |

n.a = not available

Source: WHO, 2011

**Table A2.2: Fertility and life expectancy East and Southern African countries, 1990–2009**

| | Total fertility rate (per woman) | | | Adolescent fertility rate/1000 girls 15–19 yrs | Life expectancy at birth (years) | | |
|---|---|---|---|---|---|---|---|
| | 1990 | 2000 | 2009 | 2000–2008 | 1990 | 2000 | 2009 |
| Angola | 7.2 | 6.8 | 5.6 | 165 | 42 | 46 | 52 |
| Botswana | 4.7 | 3.4 | 2.8 | 51 | 66 | 51 | 61 |
| DRC | 7.1 | 6.9 | 5.9 | 127 | 48 | 47 | 49 |
| Kenya | 6.0 | 5.0 | 4.9 | 103 | 61 | 54 | 60 |
| Lesotho | 4.9 | 4.1 | 3.3 | 98 | 60 | 47 | 48 |
| Madagascar | 6.3 | 5.6 | 4.6 | 148 | 52 | 59 | 65 |
| Malawi | 7.0 | 6.2 | 5.5 | 178 | 48 | 43 | 47 |
| Mauritius | 2.2 | 2.0 | 1.8 | 35 | 69 | 71 | 73 |
| Mozambique | 6.2 | 5.7 | 5.0 | 185 | 48 | 48 | 49 |
| Namibia | 5.2 | 4.0 | 3.3 | 74 | 60 | 53 | 57 |
| South Africa | 3.7 | 2.9 | 2.5 | 54 | 63 | 56 | 54 |
| Swaziland | 5.7 | 4.2 | 3.5 | 111 | 61 | 48 | 49 |
| Uganda | 7.1 | 6.8 | 6.3 | 159 | 48 | 47 | 52 |
| United Republic of Tanzania | 6.2 | 5.7 | 5.5 | 139 | 53 | 51 | 55 |
| Zambia | 6.5 | 6.2 | 5.7 | 151 | 46 | 42 | 48 |
| Zimbabwe | 5.2 | 3.9 | 3.4 | 101 | 61 | 45 | 49 |
| African region | 6.2 | 5.4 | 4.9 | 117 | 51 | 50 | 54 |
| Income group | | | | | | | |
| Low income | 5.4 | 4.5 | 3.9 | 115 | 52 | 54 | 57 |
| High Income | 1.8 | 1.7 | 1.7 | 21 | 76 | 78 | 80 |
| Global | 3.3 | 2.7 | 2.5 | 48 | 64 | 66 | 68 |

Source: WHO, 2011

**Table A2.3: Child mortality in East and Southern African, 1990-2009**

| Country | Life expectancy at birth (years) | | | Neonatal mortality rate (per 1000 live births) | | | MDG 4 Infant mortality rate (per 1000 live births) | | | MDG 4 Under-5 mortality rate (per 1000 live births) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1990 | 2000 | 2009 | 1990 | 2000 | 2009 | 1990 | 2000 | 2009 | 1990 | 2000 | 2009 |
| Angola | 42 | 46 | 52 | 53 | 48 | 42 | 153 | 126 | 98 | 258 | 212 | 161 |
| Botswana | 66 | 51 | 61 | 23 | 32 | 22 | 46 | 66 | 43 | 60 | 99 | 57 |
| DRC * | 48 | 47 | 49 | 51 | 51 | 40 | 126 | 126 | 95 | 199 | 199 | 155 |
| Kenya * | 61 | 54 | 60 | 25 | 27 | 33 | 59 | 71 | 59 | 91 | 105 | 84 |
| Lesotho | 60 | 47 | 48 | 35 | 42 | 33 | 74 | 86 | 61 | 93 | 124 | 84 |
| Madagascar* | 52 | 59 | 65 | 43 | 34 | 24 | 103 | 70 | 54 | 178 | 111 | 82 |
| Malawi * | 48 | 43 | 47 | 49 | 46 | 34 | 136 | 112 | 69 | 240 | 202 | 110 |
| Mauritius | 69 | 71 | 73 | 15 | 12 | 9 | 21 | 16 | 13 | 23 | 18 | 15 |
| Mozambique | 48 | 48 | 49 | 53 | 47 | 41 | 155 | 123 | 96 | 232 | 183 | 142 |
| Namibia * | 60 | 53 | 57 | 35 | 22 | 26 | 62 | 40 | 49 | 92 | 60 | 69 |
| South Africa | 63 | 56 | 54 | 19 | 22 | 19 | 48 | 54 | 43 | 62 | 77 | 62 |
| Swaziland | 61 | 48 | 49 | 24 | 26 | 20 | 67 | 71 | 52 | 92 | 105 | 73 |
| Uganda * | 48 | 47 | 52 | 49 | 35 | 31 | 106 | 89 | 84 | 187 | 157 | 143 |
| Tanzania * | 53 | 51 | 55 | 40 | 45 | 28 | 99 | 107 | 60 | 153 | 161 | 92 |
| Zambia * | 46 | 42 | 48 | 40 | 33 | 36 | 98 | 94 | 82 | 178 | 168 | 137 |
| Zimbabwe * | 61 | 45 | 49 | 30 | 27 | 21 | 56 | 60 | 49 | 85 | 90 | 69 |
| Africa | 51 | 50 | 54 | 44 | 41 | 36 | 109 | 98 | 80 | 179 | 159 | 127 |
| Income group globally | | | | | | | | | | | | |
| Low income | 52 | 54 | 57 | 47 | 42 | 36 | 108 | 91 | 75 | 170 | 142 | 117 |
| High income | 76 | 78 | 80 | 6 | 4 | 4 | 10 | 7 | 6 | 12 | 8 | 7 |
| Global | 64 | 66 | 68 | 33 | 29 | 24 | 62 | 54 | 42 | 89 | 77 | 60 |

* DHS data used for closest year as at http://www.statcompiler.com/ Source: WHO, 2011

### Table A2.4: Child nutrition, East and Southern Africa, 1990-2010

| | % Infants exclusively breastfed for 1st 6 mths * | % Children aged <5 years <2SD on weight for age (underweight) (DHS data; births in 5 years before survey) | | | | % Children aged <5 years** | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Stunted | MDG 1 Underweight | | Overweight |
| | 2000 –2010 | Year <2005 | % | Year >2006 | % | 2000 –2009 | 1990 –1999 | 2000 –2009 | 2000 –2009 |
| Angola | 11 | n.a. | n.a. | n.a. | n.a. | 50.8 | 37.0 | 27.5 | 5.3 |
| Botswana | n.a. | n.a. | n.a. | n.a. | n.a. | 29.1 | 15.1 | 10.7 | 10.4 |
| DRC | 37 | n.a. | n.a. | 2007 | 30.1 | 45.8 | 30.7 | 28.2 | 6.8 |
| Kenya | 32 | 2003 | 19.8 | 2009 | 20.4 | 35.2 | 17.6 | 16.4 | 5.0 |
| Lesotho | 54 | 2004 | 19.4 | n.a. | n.a. | 45.2 | 13.8 | 16.6 | 6.8 |
| Madagascar | 51 | 2004 | 41.4 | n.a. | n.a. | 49.2 | 35.5 | n.a. | n.a. |
| Malawi | 57 | 2004 | 22.1 | n.a. | n.a. | 53.2 | 26.3 | 15.5 | 11.3 |
| Mauritius | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 13.0 | n.a. | n.a. |
| Mozambique | 37 | 2003 | 23.8 | n.a. | n.a. | 47.0 | 28.1 | 21.2 | 6.3 |
| Namibia | 24 | 2000 | 23.1 | 2007 | 21.0 | 29.6 | 21.5 | 17.5 | 4.6 |
| South Africa | 8 | n.a. | n.a. | n.a. | n.a. | 10.1 | n.a. | n.a. | n.a. |
| Swaziland | 32 | n.a. | 2007 | 6.6 | 29.5 | _ | 6.1 | 11.4 | n.a. |
| Uganda | 60 | 2000 | 22.5 | 2006 | 20.2 | 38.7 | 21.5 | 16.4 | 4.9 |
| Tanzania | 50 | 2005 | 21.6 | 2010 | 20.6 | 44.4 | 25.3 | 16.7 | 4.9 |
| Zambia | 61 | 2002 | 28.2 | 2007 | 19.1 | 45.8 | 19.6 | 14.9 | 8.4 |
| Zimbabwe (i) | 25 | 1999 | 13.0 | 2009 | 12.0 | 35.8 | 11.5 | 14.0 | 9.1 |

n.a. = not available; (i) Zimbabwe breastfeeding and household data from Zimstat, UNICEF 2009 WHO data based on global data bank on infant and young child feeding [online database]. Geneva, World Health Organization, 2010 (www.who.int/nutrition/databases/infantfeeding and global database on child growth and malnutrition [online database]. Geneva, World Health Organization, 2010 (www.who.int/nutgrowthdb/database/en). Prevalence estimates are based on WHO standards (<2 SD)

Source: WHO, 2011

## Table A2.5: HIV and AIDS data East and Southern Africa, 1990 -2008

| | Prevalence of HIV among adults aged 15–49 years (%) | | | AIDS related mortality in <5 yr olds due to AIDS | | % deaths /100 000 | % ARV coverage in people with advanced HIV | | PMTCT coverage in HIV positive pregnant women | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2005 | 2009 (i) | | 2009 (ii) | | 2008 | 2009 (iii) | | 2009 (iv) | |
| Angola | 3.7 | 2.0 | [1.6–2.4] | 62 | [42–89] | 2 | 24 | [19–32] | 19 | [12–36] |
| Botswana | 24.1 | 24.8 | [23.8–25.8] | 296 | [116–702] | 17 | 83 | [77– >95] | >95 | [74– >95] |
| DRC | 3.2 | n.a. | [1.2–1.6] | n.a. | [40–60] | 1 | n.a. | [14–21] | n.a. | [4–11] |
| Kenya | 6.1 | 6.3 | [5.8–6.5] | 201 | [154–249] | 9 | 48 | [42–55] | 73 | [50– >95] |
| Lesotho | 23.2 | 23.6 | [22.3–25.2] | 680 | [495–893] | 31 | 48 | [43–54] | 64 | [48– >95] |
| Madagascar | 0.5 | 0.2 | [0.2–0.3] | 8.6 | [7.2–10] | 0 | 2 | [2–3] | n.a. | [1–5] |
| Malawi | 14.1 | 11.0 | [10.0–12.1] | 337 | [250–436] | 13 | 46 | [40–53] | 58 | [40– >95] |
| Mauritius | 0.6 | 1.0 | [0.7–1.3] | 28 | [18–41] | 0 | 22 | [17–30] | n.a. | [33– >95] |
| Mozambique | 16.1 | 11.5 | [10.6–12.2] | 325 | [248–400] | 10 | 30 | [26–34] | 70 | [51– >95] |
| Namibia | 19.6 | 13.1 | [11.1–15.5] | 306 | [116–516] | 20 | 76 | [62–92] | 88 | [61– >95] |
| South Africa | 18.8 | 17.8 | [17.2–18.3] | 627 | [511–775] | 35 | 37 | [35–39] | 88 | [66– >95] |
| Swaziland | 33.4 | 25.9 | [24.9–27.0] | 594 | [385–845] | 30 | 59 | [53–66] | 88 | [68– >95] |
| Uganda | 6.5 | 6.5 | [5.9–6.9] | 196 | [150–245] | 6 | 39 | [33–46] | 53 | [37– >95] |
| Tanzania | 6.7 | 5.6 | [5.3–6.1] | 196 | [158–241] | 6 | 30 | [27–34] | 70 | [48– >95] |
| Zambia | 17.0 | 13.5 | [12.8–14.1] | 351 | [228–467] | 12 | 64 | [56–75] | 69 | [50– >95] |
| Zimbabwe | 20.1 | 14.3 | [13.4–15.4] | 661 | [556–776] | 25 | 34 | [30–38] | 56 | [41– >95] |
| African region | n.a. | 4.7 | [4.5–5.0] | 177 | [151–205] | 5 | 37 | [34–40] | 54 | [41–84] |
| Global | n.a. | 0.8 | [0.7–0.8] | 33 | [28–39] | 2 | 36 | [33–39] | 53 | [40–79] |

n.a. = not available; (i) Based on 2010 report on the global AIDS epidemic; UNAIDS, WHO, 2010: ww.unaids.org/globalreport/Global_report.htm (ii) Mortality data, Geneva, WHO, 2010: www.who.int/healthinfo/statistics/mortality/en/; (iii) WHO, UNAIDS, UNICEF, 2010; WHO issued new criteria for treatment initiation in 2010 so coverage figures not comparable with earlier years; (iv) Regional and income level aggregates based on data for all low and middle-income countries if available. Point estimates published only for countries with a generalised epidemic. Income-group aggregates based on the 2007 World Bank list of economies in WHO, UNAIDS, UNICEF, 2010; Source: WHO, 2011; UNAIDS, 2006

## Table A2.6 Immunisation coverage, East and Southern Africa, 1990–2009

| | Immunisation coverage among one-year-olds (%) | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Measles (MDG4) | | | DTP3 | | | HepB3 | | Hib3 | |
| | 1990 | 2000 | 2009 | 1990 | 2000 | 2009 | 2000 | 2009 | 2000 | 2009 |
| Angola | 38 | 41 | 77 | 24 | 31 | 73 | n.a. | 73 | n.a. | 73 |
| Botswana | 87 | 91 | 94 | 92 | 97 | 96 | 86 | 93 | n.a. | n.a. |
| DRC | 38 | 46 | 76 | 35 | 40 | 77 | n.a. | 77 | n.a. | 77 |
| Kenya | 78 | 78 | 74 | 84 | 82 | 75 | n.a. | 75 | n.a. | 75 |
| Lesotho | 80 | 74 | 85 | 82 | 83 | 83 | n.a. | 83 | n.a. | 83 |
| Madagascar | 47 | 55 | 64 | 46 | 57 | 78 | n.a. | 78 | n.a. | 78 |
| Malawi | 81 | 73 | 92 | 87 | 75 | 93 | n.a. | 93 | n.a. | 93 |
| Mauritius | 76 | 84 | 99 | 85 | 88 | 99 | 88 | 99 | n.a. | 99 |
| Mozambique | 59 | 71 | 77 | 46 | 70 | 76 | n.a. | 72 | n.a. | 74 |
| Namibia | n.a. | 69 | 76 | … | 79 | 83 | n.a. | n.a. | n.a. | n.a. |
| South Africa | 79 | 72 | 62 | 72 | 73 | 69 | 71 | 67 | 71 | 67 |
| Swaziland | 85 | 92 | 95 | 89 | 87 | 95 | 82 | 95 | n.a. | 95 |
| Uganda | 52 | 57 | 68 | 45 | 52 | 64 | n.a. | 64 | n.a. | 64 |
| Tanzania | 80 | 78 | 91 | 78 | 79 | 85 | n.a. | 85 | n.a. | 85 |
| Zambia | 90 | 85 | 85 | 91 | 85 | 81 | n.a. | 80 | n.a. | 81 |
| Zimbabwe | 87 | 75 | 76 | 88 | 79 | 73 | 78 | 73 | n.a. | 73 |
| African Region | 57 | 56 | 69 | 57 | 55 | 71 | n.a. | 70 | n.a. | 62 |
| Global | 73 | 71 | 82 | 75 | 74 | 82 | n.a. | 70 | n.a. | n.a. |

n.a. = not available; Measles = measles-containing vaccine (MCV); DTP3 = 3 doses of diphtheria-tetanus-pertussis vaccine; HepB3 = 3 doses of hepatitis B vaccine; Hib3 = 3 doses of Haemophilus influenzae type B vaccine. WHO/UNICEF estimates of national immunization coverage [online database]. Geneva, WHO, 2010 based on data available up to 2 July 2010 (www.who.int/immunization_monitoring/routine/immunization_coverage/en/index4.html).Source: WHO, 2011

**Table A2.7 Reproductive health indicators, Millennium Development Goal 5, East and Southern Africa, 2000–2010**

| | MDG 5 Contraceptive prevalence ii (%) 2000–2010 | MDG 5 Unmet need for family planning ii (%) 2000–2009 | MDG 5 Antenatal care coverage (%) At least 2000–2010 | | MDG 5 Births attended by skilled health personnel i (%) 2000–2010 |
|---|---|---|---|---|---|
| | | | 1 visit | 4 visits | |
| Angola | 6.2 | n.a. | 68 | 47 | 49 |
| Botswana | 44.4 | n.a. | 94 | 73 | 95** |
| DRC | 20.6 | 24.4 | 87 | 47 | 74** |
| Kenya | 45.5 | 25.6 | 92 | 47 | 44** |
| Lesotho | 47.0 | 31 | 92 | 70 | 62 |
| Madagascar | 39.9 | 18.9 | 86 | 49 | 44** |
| Malawi | 41.0 | 27.6 | 92 | 57 | 54 |
| Mauritius | 75.8 | 3.5 | n.a. | n.a. | 100* |
| Mozambique | 16.5 | 18.4 | 92 | 53 | 55 |
| Namibia | 55.1 | 20.6 | 95 | 70 | 81 |
| South Africa | 59.9 | 13.8 | 92 | 56 | 91 |
| Swaziland | 50.6 | 24.0 | 85 | 79 | 74** |
| Uganda | 23.7 | 40.6 | 94 | 48 | 42** |
| Tanzania | 34.4 | 21.8 | 96 | 62 | 51** |
| Zambia | 40.8 | 26.5 | 94 | 60 | 47 |
| Zimbabwe | 60.2 | 12.8 | 93 | 71 | 60 |
| Africa | 24.4 | 24.8 | 74 | 44 | 48 |
| Global | 62.7 | 11.2 | 80 | 53 | 66 |

n.a. = not available; i WHO global database on maternal health indicators, 2011 update. Geneva, WHO (www.who.int/gho); only include antenatal care visits provided by skilled provider (doctor, nurse and midwife) ii World contraceptive use 2010 (2011) UN DESA, Population Division, (POP/DB/CP/Rev2010).
* Institutional births. ** Includes deliveries by cadres of health workers other than doctors, nurses and midwives.; Source: WHO, 2011

## Section 3: Household access to the social determinants of health

**Table A3.1: Adult literacy, primary school enrolment,East and Southern Africa, 1990-2010**

| Member state | Adult literacy rate (%) | | MDG 2: Net primary school enrolment rate (%) | | | | Primary school enrolment gender parity index | |
|---|---|---|---|---|---|---|---|---|
| | | | Male | | Female | | | |
| | 1990–1999 | 2000–2008 | 1990–1999 | 2000–2010 | 1990–1999 | 2000–2010 | 1990–1999 | 2000–2010 |
| Angola | n.a. | 70 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| Botswana | 69 | 83 | 80 | 86 | 83 | 88 | 1.04 | 1.02 |
| DRC | n.a. | 67 | 33 | n.a. | 32 | n.a. | 0.97 | n.a. |
| Kenya | n.a. | 87 | 62 | 82 | 63 | 83 | 1.02 | 1.01 |
| Lesotho | n.a. | 90 | 54 | 71 | 61 | 74 | 1.13 | 1.04 |
| Madagascar | n.a. | 71 | 66 | 98 | 66 | 99 | 1.00 | 1.01 |
| Malawi | 64 | 73 | 99 | 88 | 97 | 93 | 0.98 | 1.06 |
| Mauritius | 80 | 88 | 90 | 93 | 91 | 95 | 1.01 | 1.02 |
| Mozambique | 39 | 54 | 58 | 84 | 46 | 80 | 0.79 | 0.95 |
| Namibia | 76 | 88 | 85 | 87 | 91 | 91 | 1.07 | 1.05 |
| South Africa | 82 | 89 | 91 | 87 | 93 | 88 | 1.02 | 1.01 |
| Swaziland | n.a. | 87 | 69 | 82 | 71 | 84 | 1.03 | 1.02 |
| Uganda | 56 | 75 | n.a. | 96 | n.a. | 99 | n.a. | 1.03 |
| Tanzania | n.a. | 73 | 48 | 96 | 50 | 97 | 1.04 | 1.01 |
| Zambia | 68 | 71 | 71 | 90 | 68 | 92 | 0.96 | 1.02 |
| Zimbabwe | 84 | 91 | 83 | 89 | 83 | 91 | 1.00 | 1.02 |
| Africa | 51 | 63 | 61 | 81 | 54 | 77 | 0.89 | 0.95 |

n.a. = not available; Source: UNESCO Institute for Statistics data centre, 2010, Montreal, UIS http://stats. uis.unesco.org

**Table A3.2: Agricultural production, East and Southern Africa, 1990-2010**

| | Value added/worker in agriculture in 2000 US$ | | | | % government budget allocated to agriculture (*) | | | |
|---|---|---|---|---|---|---|---|---|
| | 1996 | 2000 | 2005 | 2009 | 1995 | 2000/2 | 2005/6 | 2007-10 |
| Angola | 100 | 116 | 200 | 313 | n.a. | n.a. | n.a. | n.a. |
| Botswana | 681 | 531 | 459 | 597 | n.a. | 4.4 | 3.8 | 3.7 |
| DRC | 217 | 177 | 161 | 168 | n.a. | 0.8 | 1.8 | n.a. |
| Kenya | 338 | 337 | 361 | 334 | n.a. | 5.0 | 6.6 | 4.8 |
| Lesotho | 207 | 256 | 185 | 207 | n.a. | 4.1 | 2.9 | n.a. |
| Madagascar | 200 | 197 | 181 | 192 | n.a. | 8.0 | 8.0 | n.a. |
| Malawi | 130 | 151 | 133 | 162 | n.a. | 8.7 | 11.0 | 12.2 |
| Mauritius | 4064 | 4431 | 4719 | 5556 | n.a. | 2.7 | 2.9 | n.a. |
| Mozambique * | 125 | 125 | 161 | 220 | n.a. | 5.3 | 3.3 | n.a. |
| Namibia | 1604 | 1732 | 1950 | 1638 | n.a. | 6.0 | 5.5 | n.a. |
| South Africa | 2377 | 2664 | 3160 | 3641 | n.a. | n.a. | n.a. | n.a. |
| Swaziland | 920 | 1018 | 1106 | 1176 | n.a. | 4.0 | 5.0 | n.a. |
| Uganda * | 202 | 201 | 215 | 203 | 1.6 | 4.2 | 3.0 | n.a. |
| Tanzania | 224 | 235 | 267 | 283 | n.a. | 4.5 | 5.5 | n.a. |
| Zambia * | 235 | 234 | 227 | 216 | 2.0 | 4.0 | 5.7 | 6.8 |
| Zimbabwe * | 279 | 322 | 212 | 141 | 4.0 | 2.0 | 7.7 | 3.4 |

n.a. = not available; *= country Equity Watch reports, Fan et al., 2009
Figure given is for year closest to year shown in header
Source: World Bank, 2011

## Section 4: Economic opportunities and challenges for health

**Table A4.1: Economic indicators, East and Southern Africa, 2000–2009**

| | Population (millions) | | | GDP (current US$million) | | | GDP per capita (US$000s) | | | GDP growth (annual %) | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2005 | 2009 | 2000 | 2005 | 2008 | 2000 | 2005 | 2009 | 2000 | 2005 | 2008 |
| Angola | 13.8 | 15.9 | 18.5 | 9,1 | 28,0 | 83.3 | 0.7 | 1,8 | 4,1 | 3.0 | 14.7 | 14.8 |
| Botswana | 1.8 | 1.8 | 1.9 | 5,2 | 9,4 | 12.9 | 2,9 | 5,2 | 6,1 | 7.6 | 3.8 | -1.0 |
| DRC | 50.1 | 57.5 | 66.0 | 4,3 | 7.0 | 11.6 | 0.09 | 0.1 | 0.1 | -6.9 | 6.6 | 6.2 |
| Kenya | 30.7 | 34.3 | 39.8 | 12,7 | 18,0 | 34.5 | 0.4 | 0.5 | 0.7 | 0.6 | 2.8 | 3.6 |
| Lesotho | 1.8 | 1.8 | 21. | 0.9 | 1,5 | 1.6 | 0.5 | 0.8 | 0.8 | 1.3 | 1.2 | 3.9 |
| Madagascar | 16.2 | 18.6 | 19.6 | 3,9 | 5,0 | 9.0 | 0.2 | 0.3 | 0.4 | 4.8 | 4.6 | 6.9 |
| Malawi | 11.5 | 12.9 | 15.3 | 1,7 | 21 | 4.3 | 0.22 | 0.2 | 0.3 | 1.6 | 2.6 | 9.7 |
| Mauritius | 1.2 | 1.2 | 1.3 | 4,5 | 6,4 | 8.7 | 3,7 | 5,4 | 6.7 | 4.0 | 4.5 | 5.3 |
| Mozambique | 17.9 | 19.8 | 22.9 | 3,8 | 6,6 | 9.7 | 0.2 | 0.3 | 0.4 | 1.9 | 7.7 | 6.5 |
| Namibia | 1.9 | 2.0 | 2.2 | 3,4 | 6,1 | 8.6 | 1,8 | 3,1 | 4.3 | 3.5 | 3.5 | 2.7 |
| South Africa | 44.0 | 45.2 | 50.1 | 132,9 | 240,2 | 276.8 | 3,0 | 5,3 | 5.8 | 4.2 | 4.9 | 3.1 |
| Swaziland | 1.9 | 1.1 | 1.2 | 1,4 | 2,7 | 2.6 | 0.7 | 2,5 | 2.5 | 2.0 | 1.8 | 2.5 |
| Tanzania | 34.8 | 38.3 | 32.7 | 9,1 | 12,1 | 20.5 | 0.2 | 0.3 | 0.5 | 5.1 | 7.0 | 7.5 |
| Uganda | 24.3 | 28.8 | 43.7 | 5,9 | 8,7 | 14.5 | 0.2 | 0.3 | 0.5 | 5.6 | 5.6 | 9.5 |
| Zambia | 10.7 | 11.7 | 12.9 | 3,2 | 7,3 | 14.3 | 0.3 | 0.6 | 1.0 | 3.6 | 5.1 | 6.0 |
| Zimbabwe | 12.6 | 13.0 | 12.5 | 7,4 | 3,4 | n.a. | 0.6 | 0.3 | 0.5 | -7.9 | -7.1 | n.a. |

n.a. = not available
Source: World Bank, 2006, 2011

## Table A4.2: Poverty levels, East and Southern Africa, 1990-2010

| Countries | GDP/capita US$000s | | % change | % population on <$1/ day | | % of population below national poverty line (iv) | |
|---|---|---|---|---|---|---|---|
| | 2003 | 2009 | 1990-2009 | 1990-2003 | 1990-2010 (ii) | | |
| Angola | 919 | 4081 | 344.1 | n.a. | 54.3 | n.a | n.a |
| Botswana | 4366 | 6064 | 38.9 | 23.5 | 28.0 | 30.6 | 2003 |
| DRC | 105 | 160 | 52.4 | n.a. | 59.2 | 71.3 | 2006 |
| Kenya | 459 | 738 | 60.8 | 22.8 | 19.7 | 45.9 | 2005 |
| Lesotho | 592 | 764 | 29.1 | 36.4 | 43.4 | 56.6 | 2003 |
| Madagascar | 311 | 438 | 40.8 | 61.0 | 67.8 | 68.7 | 2005 |
| Malawi | 143 | 310 | 116.8 | 41.7 | 73.9 | 52.4 | 2004 |
| Mauritius | 4288 | 6735 | 57.1 | n.a. | n.a. | n.a. | n.a |
| Mozambique | 251 | 428 | 70.5 | 37.9 | 68.2 | n.a | n.a |
| Namibia | 2252 | 4267 | 89.5 | 34.9 | 60.0 | 38.0 | 2003 |
| South Africa | 3626 | 5786 | 59.6 | 10.7 | 17.4 | 23.0 | 2006 |
| Swaziland | 1722 | 2533 | 47.1 | n.a. | 62.9 | 69.2 | 2001 |
| Tanzania | 279 | 503 | 80.3 | 19.9 | n.a. | 33.4 | 2007 |
| Uganda | 233 | 490 | 110.3 | n.a. | 28.7 | 24.5 | 2009 |
| Zambia | 384 | 990 | 157.8 | 63.7 | 64.3 | 59.3 | 2006 |
| Zimbabwe | 615 | 449 | -27.0 | 56.1 | n.a. | 72.0 | 2003 |

n.a. = not available; (i) UNDP, 2005, 2010. (ii) UN Stats, 1990 – 2010 (iv) World Bank, 2010, citing national poverty surveys. Various poverty measures used so national poverty lines are not comparable. Equity Watch reports Zambia, 2011, Mozambique, 2010, use % population on <$1 a day; n.a. = not available; Source: World Bank, 2009

## Table A4.3: GDP, employment and earnings, East and Southern Africa, 2008

| | GDP / capita US$ | % of population 15–64 yrs employed | | % total employment that is vulnerable | % total employment earning <$1.25/day | % children 5–14yrs working |
|---|---|---|---|---|---|---|
| | 2009 | 1991 | 2008 | 2000–2008* | 2000–2008* | 1999–2007* |
| South Africa | 5,786 | 39.4 | 41.1 | 2.7 | 44.4 | n.a. |
| Namibia | 4,267 | 45.4 | 42.9 | 21.1 | n.a. | 13 |
| Botswana | 6,064 | 46.7 | 46.0 | 11.7 | n.a. | n.a. |
| Lesotho | 764 | 48.3 | 54.1 | n.a. | 61.0 | 23 |
| Zambia | 990 | 57.0 | 61.2 | 79.3 | 76.6 | 12 |
| Zimbabwe | 449 | 70.1 | 64.9 | 61.9 | n.a. | 13 |
| DRC | 160 | 67.8 | 66.7 | n.a. | 69.6 | 32 |
| Malawi | 310 | 71.7 | 72.1 | n.a. | 79.8 | 26 |
| Kenya | 738 | 73.4 | 73.0 | n.a. | 22.9 | 26 |
| Angola | 4,081 | 76.5 | 76.4 | n.a. | 59.9 | 24 |
| Mozambique | 428 | 79.9 | 77.9 | n.a. | 81.2 | 22 |
| Tanzania | 503 | 87.4 | 78.0 | 87.7 | 90.0 | 36 |
| Uganda | 490 | 81.8 | 83.0 | 85.2 | 55.7 | 36 |
| Madagascar | 438 | 79.3 | 83.3 | 82.2 | 76.7 | 32 |

n.a. = not available; *Data refer to the most recent year available during the period specified.
Source: UNDP, 2011

### Table A5.1: Health worker numbers and densities, East and Southern Africa, 2000–2010

| Country | Physicians midwifery personnel | | Nursing and personnel | | Dentistry personnel | | Pharmaceutical personnel | | Environment & public health workers | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Density /10,000 people | Number | Density /10,000 people | Number | Density /10,000 people | Number | Density /10,000 people | Number | Density /10,000 people |
| Angola | 1,165 | 0.8 | 18,485 | 13.5 | 222 | 0.2 | 919 | 0.7 | n.a. | n.a. |
| Botswana | 591 | 3.4 | 5,006 | 28.4 | 38 | 0.2 | 333 | 1.9 | 172 | 1.0 |
| DRC | 5,827 | 1.1 | 28,789 | 5.3 | 159 | <0.05 | 1,200 | 0.2 | n.a. | n.a. |
| Kenya | 4,506 | 1.4 | 37,113 | 11.8 | 1,340 | 0.4 | 3,094 | 1.0 | 6,496 | 2.0 |
| Lesotho | 89 | 0.5 | 1,123 | 6.2 | 16 | 0.1 | 62 | 0.3 | 55 | 0.3 |
| Madagascar | 3,150 | 1.6 | 5,661 | 3.2 | 57 | <0.05 | 175 | 0.1 | 130 | 0.1 |
| Malawi | 257 | 0.2 | 3,896 | 2.8 | 211 | 0.2 | 293 | 0.2 | 318 | 0.2 |
| Mauritius | 1,303 | 10.6 | 4,604 | 37.3 | 233 | 1.9 | 1,428 | 11.6 | 238 | 1.9 |
| Mozambique | 548 | 0.3 | 6,214 | 3.1 | 159 | 0.1 | 817 | 0.4 | 564 | 0.3 |
| Namibia | 774 | 3.7 | 5,750 | 27.8 | 90 | 0.4 | 376 | 1.8 | 198 | 1.0 |
| South Africa | 34,829 | 7.7 | 184,459 | 40.8 | 5,995 | 1.3 | 12,521 | 2.8 | 2,529 | 0.6 |
| Swaziland | 171 | 1.6 | 6,828 | 63.0 | 32 | 0.3 | 70 | 0.6 | 110 | 1.0 |
| Uganda | 3,361 | 1.2 | 37,625 | 13.1 | 440 | 0.2 | 762 | 0.3 | 1,042 | 0.4 |
| Tanzania | 300 | 0.1 | 9,440 | 2.4 | 230 | 0.1 | 81 | <0.05 | 1,831 | 0.5 |
| Zambia | 649 | 0.6 | 8,369 | 7.1 | 56 | 0.1 | 108 | 0.1 | 803 | 0.7 |
| Zimbabwe | 2,086 | 1.6 | 9,357 | 7.2 | 310 | 0.2 | 883 | 0.7 | 1,803 | 1.4 |
| Africa | | 2.3 | | 10.9 | | 0.3 | | 0.8 | | 0.4 |
| Global | | 14.0 | | 29.7 | | 3.0 | | 4.1 | | n.a. |

n.a. = not available
Source: WHO, 2011

### Table A5.2: Health expenditure, East and Southern Africa, 2000-2008

| Country | Per capita total expenditure on health US$ average exchange rate | | Per capita expenditure on health (PPP int. $) | | Per capita govt expenditure on health US$ average exchange rate | | Per capita govt expenditure on health (PPP int. $) | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2000 | 2008 | 2000 | 2008 | 2000 | 2008 | 2000 | 2005 | 2008 | 2009 |
| Angola | 15 | 148 | 54 | 183 | 12 | 126 | 43 | 53 | 155 | 281 |
| Botswana | 155 | 530 | 401 | 1 053 | 96 | 414 | 250 | 669 | 823 | 1072 |
| DRC | 11 | 13 | 9 | 23 | <1 | 7 | <1 | 3 | 13 | 16 |
| Kenya | 17 | 33 | 47 | 66 | 8 | 12 | 21 | 23 | 24 | 23 |
| Lesotho | 28 | 60 | 68 | 119 | 14 | 38 | 35 | 41 | 76 | 91 |
| Madagascar | 9 | 22 | 29 | 46 | 6 | 15 | 20 | 22 | 33 | 27 |
| Malawi | 9 | 18 | 36 | 49 | 4 | 11 | 17 | 37 | 30 | 29 |
| Mauritius | 145 | 402 | 299 | 681 | 76 | 140 | 156 | 223 | 237 | 259 |
| Mozambique | 14 | 21 | 26 | 39 | 10 | 15 | 19 | 29 | 29 | 41 |
| Namibia | 131 | 284 | 248 | 440 | 90 | 155 | 171 | 193 | 240 | 256 |
| South Africa | 251 | 459 | 552 | 843 | 101 | 182 | 223 | 285 | 334 | 346 |
| Swaziland | 78 | 141 | 199 | 287 | 46 | 86 | 117 | 220 | 175 | 198 |
| Uganda | 15 | 44 | 45 | 112 | 4 | 8 | 12 | 20 | 20 | 50 |
| Tanzania | 10 | 22 | 28 | 57 | 4 | 16 | 12 | 19 | 41 | 22 |
| Zambia | 18 | 68 | 49 | 80 | 9 | 42 | 25 | 43 | 49 | 52 |
| Zimbabwe * | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 10 | n.a. | 36 |
| Africa | 34 | 83 | 87 | 146 | 15 | 41 | 38 | n.a. | 71 | n.a. |
| Global | 484 | 854 | 566 | 899 | 280 | 517 | 320 | n.a. | 524 | n.a. |

n.a. = not available; **TARSC, MoHCW, 2011; Source: WHO, 2011

**Table A5.3: Sources of total health expenditure, East and Southern Africa, 2000-2008**

| Country | Total expenditure on health as % of GDP | | General government expenditure | | Private expenditure | | External resources | |
|---|---|---|---|---|---|---|---|---|
| | % total Health expenditure that is | | | | | | | |
| | 2000 | 2008 | 2000 | 2008 | 2000 | 2008 | 2000 | 2008 |
| Angola | 2.4 | 3.3 | 79.2 | 85.0 | 20.8 | 15.0 | 3.6 | 3.0 |
| Botswana | 4.7 | 7.6 | 62.2 | 78.2 | 37.8 | 21.8 | 0.5 | 4.2 |
| DRC | 4.2 | 7.3 | 3.5 | 54.2 | 96.5 | 45.8 | 3.2 | 18.8 |
| Kenya | 4.2 | 4.2 | 45.3 | 36.3 | 54.7 | 63.7 | 8.8 | 26.8 |
| Lesotho | 6.7 | 7.6 | 50.9 | 63.3 | 49.1 | 36.7 | 3.1 | 19.3 |
| Madagascar | 3.7 | 4.4 | 66.5 | 70.2 | 33.5 | 29.8 | 20.1 | 16.1 |
| Malawi | 6.0 | 9.1 | 46.3 | 60.6 | 53.7 | 39.4 | 27.1 | 88.9 |
| Mauritius | 3.8 | 5.5 | 52.0 | 34.8 | 48.0 | 65.2 | 1.4 | 2.0 |
| Mozambique | 5.9 | 4.7 | 71.9 | 75.2 | 28.1 | 24.8 | 26.4 | 80.8 |
| Namibia | 6.1 | 6.9 | 68.9 | 54.6 | 31.1 | 45.4 | 3.8 | 21.4 |
| South Africa | 8.5 | 8.2 | 40.5 | 39.7 | 59.5 | 60.3 | 0.3 | 1.2 |
| Swaziland | 5.7 | 5.8 | 58.6 | 60.8 | 41.4 | 39.2 | 5.5 | 11.1 |
| Uganda | 6.6 | 8.4 | 26.8 | 17.4 | 73.2 | 82.6 | 28.3 | 27.9 |
| Tanzania | 3.8 | 4.5 | 43.4 | 72.3 | 56.6 | 27.7 | 27.8 | 59.5 |
| Zambia | 5.7 | 5.9 | 51.3 | 62.0 | 48.7 | 38.0 | 17.8 | 38.4 |
| Zimbabwe | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. |
| African region | 5.5 | 6.0 | 43.7 | 49.8 | 56.3 | 50.2 | 6.6 | 9.5 |
| Income group | | | | | | | | |
| Low income | 4.6 | 5.4 | 37.1 | 40.5 | 62.9 | 59.5 | 11.0 | 16.4 |
| High income | 10.0 | 11.1 | 59.3 | 62.2 | 40.4 | 36.4 | 0 | 0 |
| Global | 8.3 | 8.5 | 56.4 | 60.5 | 43.5 | 38.4 | 0.3 | 0.3 |

n.a. = not available
Source: WHO, 2011

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# 2012 REGIONAL EQUITY WATCH
## East and Southern Africa

Drawing on a diversity of evidence and experience, including country Equity Watch reports, the Regional Equity Watch 2012 reports on progress towards health equity in East and Southern Africa, using 'progress markers' identified by the EQUINET regional stakeholders.

By making the distribution of benefits and burdens of current policies and trends visible, it highlights areas for public and policy attention and points out opportunities for action, drawing on promising practice from the region.

Aggregate progress in health in the region masks persistent and sometimes widening social inequalities in health and access to services within and between countries of the region and globally. Priorities are presented for closing avoidable gaps across groups through investments in:

- *Social determinants* – smallholder food production, early child and secondary education, employment, primary health care and safe water;
- *Redistributive health systems* – particularly at primary and community level;
- *Social participation, political support and public leadership in health*.

Economies in the region are growing, but with increasing poverty and inequality, through pathways within countries and driven by global economic trends. Significant health gains could be made if equity is more centrally, explicitly addressed in development policies, including in the Millennium Development Goals post 2015.

*'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?'*

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

ISBN: 978-0-7974-5051-6
EQUINET, 2012 www.equinetafrica.org