

Launch of the Mozambique Equity Watch

REPORT



September 27 2010
Maputo, Mozambique



Ministry of Health, Government of Mozambique

with
**Regional Network For Equity In Health In
East and Southern Africa (EQUINET)**



**During the World Health Organisation skills workshop on
Equity and social determinants of Health**



Table of contents

1.	Background	2
2.	Presentations	3
2.1	Official launch, Minister of Health Mozambique	3
2.2	EQUINET overview of the Equity Watch at regional level	4
2.3	An overview of the Mozambique Equity Watch.....	5
2.4	Discussion.....	6
3.	Discussions on follow up	7
3.1	Actions to be taken by the Ministry of Health	7
3.2	Dialogue with other stakeholders and partners.....	8
3.3	Areas of follow up investigation and research.....	8
3.4	Discussion.....	9
4.	Closing.....	9
	APPENDIX 1: Progress markers in the equity watch	10
	APPENDIX 2: Summary of equity watch indicators in Mozambique	11

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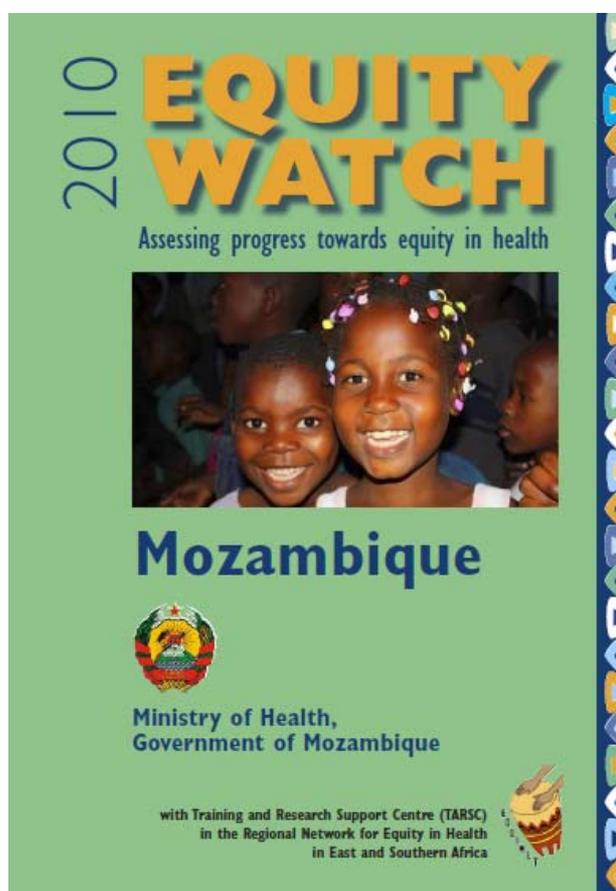
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1. Background

An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analysing, reporting and reviewing evidence on equity in health. Equity Watch work is being implemented in countries in East and Southern Africa in line with national and regional policy commitments. In February 2010 the Regional Health Ministers Conference of the ECSA Health Community resolved that countries “Report on evidence on health equity and progress in addressing inequalities in health”. Using available secondary data, the Equity Watch is implemented by country personnel with support and input from EQUINET (TARSC). The aim is to assess the status and trends in a range of priority areas of health equity and to check progress on measures that promote health equity against commitments and goals. The equity watch presents evidence within four major areas: equity in health, household access to the resources for health, equitable health systems and global justice.

The Mozambique Equity Watch report was completed in September 2010. It explores the dimensions of inequality that need to be addressed for the improvements in economic performance to translate into the eradication of poverty and sustained and widest improvements in human development. It focuses on the social determinants of health and the features of the health system that have been shown to make a difference in reducing social inequalities, including in health. It asks the question: what progress are we making? The report examines the positive results achieved so far, the current levels and the prevailing constraints, in the context of the overall national response to equity. It presents recommendations based on an analysis of information available.

On September 27 2010, the Ministry of Health of Mozambique, in co-operation with partners, launched the Mozambique Equity Watch report. The launch was held during a one week World Health Organisation AFRO training course building capacities in health equity and the social determinants of health. The launch was held in co-operation with EQUINET, represented through Training and Research Support Centre (TARSC). The launch was organised by the Directorate of Planning and Cooperation in the Ministry of Health (Dr G Machatine), presided over by the Minister of Health Hon Dr Paulo Ivo Garrido and attended by the Dr Jorge Tomo, Permanent Secretary of Ministry of Health, together with the Directorate of Planning and Cooperation, Directorate of Human Resources and the Directorate of Administration and Finance, by the National Institute of Health, the Ministry of Women and Social Action, various technical institutions, including Catholic University of Mozambique, the University of Free State,



the National Institute of Statistics; other partners of the Mozambique Sector Wide Programme (SWAP) in health, including, Dr. Gerritsen, Marco , Netherlands Embassy and focal point for the donor community, international agencies; Dr. Benzerroug Resident Representative of World Health Organization (WHO) and Dr Benjamin Nganda WHO AFRO and other WHO representatives; Dr Emanuele Capabianco, Chief of Health and Nutrition UNICEF and other UNICEF representatives and . Participants of the WHO and Ministry of Health Training Course on Equity analysis also attended the launch.

2. Presentations

2.1 Official launch, Minister of Health Mozambique

The Hon. Minister of Health of Mozambique, Dr Paulo Ivo Garrido, noted with satisfaction that the Ministry of Health presents the first Equity Watch report which maps progress in advancing towards equity in health along various markers of equity in health, household access to the resources for health, redistributive health systems and a just return from the global economy. It uses a mix of quantitative, policy and qualitative information to provide an understanding of where progress has been made and where our challenges lie in improving equity in health.

He noted that Mozambique has a constitutional and policy commitment to ensure that all its people have universal access to health care and are not impoverished by ill health. With social differences in the population across regions, social groups, age, gender, different levels of wealth, and so on, achieving this calls for attention to equity, and a distribution of resources that responds to health need, and that raises the widest opportunities to be healthy for all.

While the country has a high level of historical poverty and under-development, it has also had a decade of macro-economic progress, raising new opportunities for progressively realizing this goal.

“It shows that what we do in the health system matters in closing social gaps in our society. Ensuring that Primary Health Care reaches and involves all groups is key”.

He noted that while Mozambique has made progress in closing differences between rural and urban areas, there was still work to be done to ensure that being poor, having lower levels of education or the zone one lives in do not create barriers to health or attendance at health care services. He encouraged discussion on the measures needed to widen universal coverage. One issue he noted is that this needs closer work with communities. It also needs action from sectors dealing with safe water and sanitation, education, access to food. The report also shows that Mozambique is affected by the global environment. Thus, he pointed out, the links between government and civil society and international partnerships are important to reach those who are more vulnerable, isolated and disadvantaged.

The Minister recognised the input from EQUINET and WHO and hoped the partnership would continue, noting that Ministry of Health would want to repeat the Equity Watch in 2012 to



Minister of Health of Mozambique Dr Garrido

see what progress has been made, and include the inputs from other sectors of government and from civil society.

Finally the Minister reaffirmed the commitment of the Government of Mozambique to health equity, observing that it was not enough to have health workers and services to achieve this, but that equity raises issues of social justice. He noted that even a rich society will not be stable without social justice. It is the responsibility of government to ensure that life has dignity, and to put into practice health as a human right, and not simply a 'good' that can be bought or sold. This is operationalised through ensuring equity, and making sure that each step taken integrates progress towards equity.

2.2 EQUINET overview of the Equity Watch at regional level

Dr Rene Loewenson, Director TARSC and cluster lead for the Equity Watch work in EQUINET introduced the Equity Watch work in the region. In 2009, the United Nations in a Policy Note observed that *'It will be difficult, and in some cases not possible, to achieve the health Millennium Development Goals (MDGs) without reducing health inequalities'*. She showed evidence on this in the region, indicating the relative position of Mozambique. For example, the table below indicating the changes in the under 5 year mortality rate show that even where overall mortality is falling this is sometimes together with an increase in inequality, unless there are deliberate efforts to reach currently disadvantaged people:

Country	% change in <5MR	Rate ratio year 1	Rate ratio year2	Change in rate ratio
Kenya, 2003; 2008-9	-34.7	1.64	1.40	Decrease
Malawi 2000;2004	-28.6	1.49	1.64	Increase
Mozambique 1997;2003	-22.7	1.92	1.81	Decrease
Tanzania 1999;2004-5	-21.9	1.18	1.47	Increase
Namibia 2000;2006	-21.9	2.13	3.13	Increase
Zambia 2001; 2007	-22.7	2.08	1.12	Decrease

Source : Demographic and Health Surveys

She provided evidence, using the MDG health goals in the region, that some dimension of health inequality is geographical, and calls for strategies like equity in the allocation of health resources across districts. This is the case for example in uptake of treatment for acute respiratory infection in children under 5 years of age.

However for other data, such as access to qualified health personnel for delivery at childbirth, the inequalities in health are also wide by social factors, like wealth and mothers education. This calls for strategies that reach vulnerable community groups and households, even when they live in wealthier areas or districts with higher average coverage. Interventions need to address the social and living conditions that undermine health or uptake of services in these vulnerable households.

Based on this evidence, and building on prior commitments made at regional level, in 2010 the Health Ministers in the ECSA Health Community in Resolution: ECSA/HMC50/R9: Tracking Progress towards the MDGS urged member states to report on evidence on health equity and on progress in addressing inequalities in health and called for strengthened capacities and measures to monitor and report on progress in addressing inequalities in health.

The Equity Watch was initiated as a regional process by EQUINET in 2008, following the regional equity analysis, and aims to

- ❑ Map and assess trends in inequalities in health, social determinants of health and health care
- ❑ Present evidence on causes of and responses to inequalities in health
- ❑ Monitor progress on actions taken to improve health equity, particularly against commitments
- ❑ Share evidence for dialogue to draw perspective, evidence, experiences and views on options, practices for strengthening health equity.
- ❑ Point to areas for deeper research
- ❑ Provide and shares evidence for regional compilation and exchange.

After pilot work in 2008, and in co-operation with country teams and the ECSA Health Community, measures, called progress markers, were identified for this. These were based on their availability in existing evidence. This is now being applied in five pilot countries (Zimbabwe, Mozambique, Uganda, Zambia, Kenya) as a first stage for wider application and as an input to planning in those countries. It is also proposed that a regional equity watch will be implemented in 2011/2012. Regional equity indicators were also incorporated in July 2010 into the ECSA monitoring and evaluation framework. She commended the Ministry of Health leadership and co-operation that had produced the Mozambique Equity Watch 2010 and observed that it would contribute not only to national dialogue but also to these regional processes. She also recognised the valuable training provided by WHO on health equity and the WHO Country office support to Ministry of Health in the work on health equity.

2.3 An overview of the Mozambique Equity Watch

Dr Gertrudes Machatine, Director of planning and Cooperation presented the main results of Equity Watch in Mozambique.

She outlined the framework of the Equity Watch, along various markers of equity in health, household access to the resources for health, redistributive health systems and a just return from the global economy. It shows past levels (1980–2005), current levels (most current data publicly available) and comments on the level of progress towards health equity with a coloured bar indicating whether the situation is:

Green= Improving

Yellow = Static, mixed or uncertain

Red = Worsening

The relationship to the average in the east and southern African region is also shown

The report presents evidence that show progress in a range of areas:

- The inclusion of rights to health in the constitution and laws
- The improvement in infant and child mortality rates
- The narrowing of urban - rural differences in health indicators, such as in the under 5 year mortality rate
- The improvement in immunisation coverage
- Closing gender differentials in access to education
- Improvements in the availability of health workers and in provision of incentives for health worker retention
- Increased per capita funding for health within the context of a publicly funded national health system
- A reduction in levels of debt, and negotiation of bilateral and multilateral agreements to support national health goals.

She noted that Mozambique has amongst the lowest levels of inequalities in wealth in the east and southern Africa region, and that while the Human Development Index has improved, the health components have not improved as much as other areas, and there continue to be inequalities in health and agriculture. The significant differences in chronic undernutrition point, she noted, to the need to orient agricultural and food policies to address this.

There are some other areas that raise concern, for example:

- While Mozambique has prioritised HIV prevention and care, there is an increase in prevalence in young people in Maputo urban area;
- The transition from primary to secondary school has shown slower progress;
- User charges do present barriers to access to health care in the poorest households, and charges vary across services;
- The level of domestic financing for health needs to be protected even while external funding increases;

Dr Machatine also noted a wide gap in access to safe water and sanitation against desired levels, and the unequal distribution across regions and social group. She noted that this is a critical health determinant that needs greater attention. She also drew attention to the need for greater focus in programmes on supporting community participation. While support for this exists in policy, she observed that it needs to be formalised, capacitated and resourced.



Dr Machatine Ministry of Health discussing the Equity watch work

2.4 Discussion

In opening the discussion to those present, the Minister observed that the challenge was now on how to make the most effective use of the evidence gathered and analysed in the report. He urged those present not to lose the historical opportunity to address the issues raised. He observed that the issues would be followed up in the work on the National Health Accounts, the Multi-sectoral Plan for reduction of Malnutrition and other programmes where Ministry works with other sectors to address the social determinants of health.

The WHO Country Representative commended the initiative. He noted that the report confirmed the need to address cost barriers to access to care, and to further address the need for evidence on the distribution of essential inputs to health, like medicines, by level of care. He urged for the production of a summary in Portuguese and English (the full report is available in both languages) and to take the lessons learned into the future poverty reduction strategy process as well as to more immediate actions that can be taken.

The focal point for external partners, Netherlands Embassy, observed that global level inequalities were profound and that it should not only be countries with scarcity of resources that take equity seriously. He indicated that partners would use the report in

their planning, in line with policies of the Ministries of health, and urged for the indicators assessed to be integrated within the strategic framework for the sector.

3. Discussions on follow up

After the presentations and comments participants were organized in three groups to discuss and propose measures for the follow up action on the report:

1. On the actions to be taken by the Ministry of Health
2. On taking forward the dialogue with other stakeholders and partners on the report
3. On areas of follow up investigation and research



Group discussions on follow up

The groups reported in their proposals in the plenary, as outlined below:

3.1 Actions to be taken by the Ministry of Health

For the current 2010 Equity Watch the group recommended that resource allocation/ financing and community involvement be two priority areas of focus:

- The evidence should be used to improve the allocation and management of resources in relation to health needs. In planning and management greater attention can also be given to methods for improving the access to care, including issues of transport, access routes and distribution of medicines. The group recommended that a connection be made between the equity analysis and the process and results of the National Health Account (NHA)s reports and forthcoming exercise to better understand the financial factors affecting the equity in health services, and to identify options for promoting equity.
- The group endorsed the proposal that greater attention be given to involvement of civil society and communities and that practical measures be further developed on strengthening this in all provinces.

In relation to the 2012 Equity Watch the group proposed that a group be set up now to keep a 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.

3.2 Dialogue with other stakeholders and partners

The group recommended that within two years the report should have been disseminated to all levels of the health system, with summaries produced for different target groups:

- Parliamentarians: to debate the problems in Parliament;
- Civil Society: to enhance their understanding and involvement in actions;
- International Partners: to share information and decisions making in terms of allocation of resource;

(UNICEF offered to work with Ministry of Health and EQUINET to produce materials/summaries to the study for dissemination).

The report should be disseminated and used in the SWAP process to discuss how equity can be better addressed. The results should also be presented in the Health Partners group to identify partners interested in being involved and addressing issues of health equity raised.

Focus should be given to increasing the involvement of civil society and ensuring greater exercise of citizenship in health.

The dissemination of the report should be accompanied by a dialogue and discussion to identify areas of consensus on actions; and to define priority areas for short, medium and long term action. This process will also feed into the areas of inequality for inclusion in the 2012 Equity Watch. Finally the group recommended that the National Commission on the Social Determinants of Health be established as a forum to promote equity and suggested that Dr. Pascoal Mocumbi, who was a commissioner on the global Commission on the Social Determinants of Health could advise on the process for this.

3.3 Areas of follow up investigation and research

The group identified a number of areas of follow up research flowing from the Equity Watch report:

The first was to get a better understanding of the distribution and determinants of the inequalities in health, ie

- of gender inequalities
- of factors causing high rates of malnutrition eg in Cabo Delgado, in order to develop interventions to overcome them
- disaggregated information (district region, urban, rural) on causes of mortality
- how wealth and urban- rural residence interact in inequalities (eg how do poor people in urban areas differ between the same wealth group in rural areas)

Part of this is to better understand areas of promising practice, eg

- what determinants contribute to the low rate of malnutrition in Maputo in order to replicate in other provinces

- What factors are encouraging exclusive breastfeeding and other positive feeding practices of low-income groups and how can these be promoted in high-income groups.

Secondly the group proposed doing deeper research within and across districts, starting with two pilot districts, to assess and understand the barriers to coverage of health services, from provision through access and cultural or other acceptability barriers, to the functioning of the system itself.

Some areas of intervention or operations research were identified, including

- evaluating how interventions impact on the equitable distribution of health workers in terms of both numbers and quality, by province and by district
- understanding what affects the involvement or exclusion of groups from programmes, such as involvement of men in sexual and reproductive health programmes
- surveying the distribution and availability of medicines by level of health service

The group noted the value in making better use of existing information before gathering new data and improving partnerships with research institutions, such as by making databases more available to research institutions.

Finally, an important area of assessment will be to track and report on progress on actions taken to rectify the problems identified in the 2010 Equity Watch Report.

3.4 Discussion

There was consensus across the groups on priority areas such as financing and resource allocation, community involvement, on widening dissemination, linking to existing strategic planning forums and exercises, and setting up a wider group to track the implementation of the 2010 Equity Watch proposals and identify areas for the 2012 Equity Watch.

In the discussion on the group reports it was noted that added to training in analysis, people also need training in dissemination approaches so that work done is widely disseminated and used. Where-ever possible studies implemented should be more widely disseminated.

Dr Loewenson pointed to the EQUINET newsletter as a dissemination channel for studies and other information within the region as it provides monthly updates on new studies on different dimensions of health equity in east and southern Africa. She invited delegates to contribute to it.

4. Closing

The Director of Planning and Cooperation in the Ministry of Health, Dr Machatine, thanked all the delegates and partners for their input, and noted that the discussions would be captured for follow up. Special appreciation was addressed to Dr Rene for the support she provided during the elaboration of Mozambique Equity Watch. Dr Machatine then closed the launch meeting.

APPENDIX 1: Progress markers in the equity watch

Advancing equity in health

1. Formal recognition and social expression of equity and universal rights to health
2. Achieving universal access to prevention of vertical transmission, condoms and antiretroviral treatment,
3. Eliminating differentials in access to immunisation, in contraceptive prevalence, in antenatal care and in deliveries by skilled personnel
4. Eliminating differentials in maternal mortality, child (neonatal, infant, <5) mortality, and stunting
5. Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in ESA)

Household access to the national resources for health

6. Achieving the Millennium Development Goal of reducing by half the number of people living on \$1 per day by 2015
7. Achieving and closing gender differentials in attainment of universal primary and secondary education
8. Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
9. Increasing the ratio of wages to Gross Domestic Product;
10. Abolishing user fees from health systems, backed by measures to resource services
11. Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems;
12. Overcoming the barriers disadvantaged groups face in accessing and using services.

Resourcing redistributive health systems

13. Achieving the Abuja commitment of 15% government spending on health
14. Achieving the WHO target of \$60 per capita public sector health sector expenditure;
15. Increasing progressive tax funding to health; reducing the share of out-of-pocket financing in health;
16. Harmonising the various health financing schemes into one framework for universal coverage;
17. Establishing and ensuring a clear set of comprehensive health care entitlements for the population;
18. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on primary health care;
19. Implementing a mix of financial and non-financial incentives agreed with health workers organisations
20. Formally recognising in law and policy and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system.

A more just return for ESA countries from the global economy

21. Reducing debt as a burden on health - Debt cancellation negotiated, with debt relief allocated to health and social sectors, and control of debt stress;
22. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;
23. No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws;
24. Health officials in trade negotiations and clauses for protection of health in agreements;
25. Bilateral and multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration.

APPENDIX 2: Summary of Progress on equity watch indicators in Mozambique

This report of the Mozambique Equity Watch has been produced by the Ministry of Health Mozambique working with EQUINET through Training and Research Support Centre. The summary table below shows the progress markers that were assessed, the trends, with green for improving progress, red for worsening trends and yellow for uncertain or mixed trends. The report provides the evidence on these trends and proposes areas for action.

PROGRESS MARKER	TREND
EQUITY IN HEALTH	
Formal recognition of equity and health rights	Green
Halving the number of people living on US\$1 per day	Yellow
Reducing the gini coefficient of inequality	Yellow
Eliminating differentials in child, infant and maternal mortality rates and undernutrition	Green
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries	Yellow
Universal access to prevention of mother to child transmission, antiretroviral therapy and condoms	Yellow
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH	
Closing gender differentials in access to education	Green
Halving the proportion of people with no safe drinking water and sanitation	Red
Increased ratio of wages to gross domestic product	Green
Provide adequate health workers and drugs at primary, district levels	Yellow
Abolish user fees	Yellow
Overcoming barriers to access and use of services	Yellow
REDISTRIBUTIVE HEALTH SYSTEMS	
Achieving the Abuja commitment	Yellow
Achieving US\$60 per capita funding for health	Green
Improve tax funding and reduce out of pocket spending to health	Yellow
Harmonize health financing into a framework for universal coverage	Green
Establish and ensure clear health care entitlements	Yellow
Allocate at least 50% public funding to districts and 25% to primary health care	Green
Implement non-financial incentives for health workers	Red
Formal recognition of and support for mechanisms for public participation in health systems	Red
A JUST RETURN FROM THE GLOBAL ECONOMY	
Reducing the debt burden	Green
Allocate resources to agriculture and women smallholder farmers	Yellow
Ensure health goals in World Trade Organization (TRIPS, GATS) agreements	Green
Health officials included in trade negotiations	Yellow
Bilateral and multilateral agreements to fund health worker training	Green