



Regional Network
for Equity in Health
in East and
Southern Africa



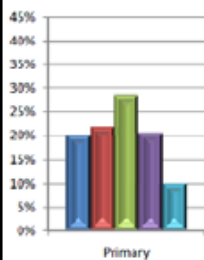
In association with the East Central and Southern Africa (ECSA) Health Community, Zambia, Zimbabwe, Kenya, Uganda and Mozambique Equity Watch teams and IDRC Canada



Report of the session on “Bringing evidence on equity to health policy in Africa: Experiences of the Equity Watch”

Wednesday 25 April
1530-1700 Room 2.61/2.62

Convened by EQUINET, in association with the ECSA Health Community and IDRC Canada, this session presented evidence and experience from work carried out in 2010-2012 in five countries and at regional level in East and Southern Africa to assess progress in key areas of equity in health outcomes, in social determinants of health and in redistributive health systems. The session reviewed the learning from the work, particularly in relation to monitoring policy commitments to equity in health, and discuss the opportunities and the challenges for institutionalising and using equity analysis within health policy and planning. This report summarises the presentations and issues raised at the session.

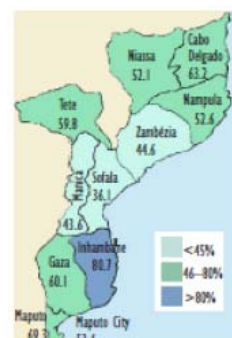


Rene Loewenson, Training and Research Support Centre and co-ordinator of the Equity Watch Cluster in EQUINET introduced the session and the work on the Equity Watch and co-moderated the session with Sharmila Mhatre, Director of the IDRC Governance Equity and Health Systems programme.

Rene outlined the nature of EQUINET as a network of professionals, civil society members, policy makers, state officials in east and southern Africa that aims to advance and support health equity and social justice through sharing information and experience; implementing research; building critical analysis and skills; networking and building strategic alliances (www.equinet africa.org). The EQUINET steering committee drew in 2007 on its regional equity analysis to propose 25 progress markers that are relevant and possible to track trends in health inequalities and in progress made in addressing them, framed as an ‘Equity Watch’. In follow up, and in support of the February 2010, ECSA Regional Health Ministers Conference (RHMC) resolution to track and report on evidence on health equity and progress in addressing inequalities in health, technical institutions working with Ministries of Health and EQUINET in five countries have now implemented a country Equity Watch (Mozambique, Zambia, Zimbabwe, Uganda and Kenya), Tanzania has initiated the process and other countries are implementing or initiating equity analysis, while EQUINET has used the progress markers in the Equity Watch (EW) to carry out a second regional equity analysis in ESA. The Forum session sought to review the learning from the EW work on equity in health and health systems; and on integrating and institutionalising equity analysis into policy, planning and health system processes.

Sibusiso Sibandze, ECSA Health Community introduced the policy context on equity in the ECSA Health Community and the networking across countries and stakeholders.

Sibusiso presented how ECSA works as a centre of learning and excellence; a technical resource organization, an information hub and strong voice and policy advocate in health, facilitating collaborative, joint and cross border actions and acting as an intermediary between member states and other regional and international health organisations. Since 1999, the health Ministers in ECSA have sought to address equity issues and in 2010,



the Ministers reaffirmed their commitment to addressing equity issues by passing a resolution (ECSA/HMC50/R9) that urges member states “to report on evidence on health equity and progress in addressing inequalities in health” and the secretariat “to strengthen capacities and measures to monitor and report on progress in addressing inequalities in health. In follow up to this ECSA HC has been collaborating with EQUINET in the development and implementation of the equity watch work and in building capacities for equity analysis, and has included equity in the indicators within its annual monitoring and reporting framework.

In the following hour there was a round table moderated discussion of the major findings, use for policy and challenges of equity monitoring in each country and at regional level. The discussion took input from panellists below from the country Equity Watch teams and opened to delegate discussion on the issues indicated. The key points are briefly captured below.

Why is equity analysis important for strategic planning? What was learned from the Equity Watch? How has it affected understanding of equity in health and health systems?

Bona Chitah University of Zambia, (working with Ministry of Health Zambia) raised the importance for health equity of addressing the distribution of benefits from economic growth and of a redistributive health system. The Zambia EW has shown evidence of overall improvement and a closing of the rural- urban gap in poverty, in gender parity in education and in environmental health, linked to public investments in education and agriculture and abolition of primary school fees. At the same time some urban indicators have worsened such as access to safe water and sanitation. Wealth related disparities however remain high and this raises challenges for the health sector, itself facing disparities in the distribution of resources like existing health workers. Positive measures were found in the Zambia EW, such as the improvement in health care financing, the distribution of public resources between the primary level and the hospital sub-sector and in the abolition of user fees. He noted that progressive measures that address inequalities like fee abolition should be widened and backed by adoption and resourcing of the essential benefits, particularly at primary care level, and by revenue streams like social health insurance that increase pooled health financing and by measures that address within area wealth related inequalities in access to services. These are longer term processes and the EW and equity analysis need to be institutionalized and systematically and continuously implemented, with tracking of resource support for and the implementation of access policies in primary health care.

Jane Chuma KEMRI Wellcome Trust working with Kenya Health Equity network and Ministry of Public Health and Sanitation Kenya pointed to the opportunity of the increasing policy profile being given to equity internationally and within Kenya, and the inclusion of comprehensive clauses on the right to health in the new Kenya constitution. The first phase in Kenya concentrated on consolidating existing knowledge in a single document to provide a ‘one stop shop’ for equity that includes indicators beyond the health sector. This was very time consuming but has provided an important synthesis of available evidence that points to where future work and policy attention is needed. She raised that the Kenya EW, only recently completed, has highlighted key issues with implications for policy, such as the need for programmes to ensure that communities are aware of and can claim their rights to health in the constitution; the need for better understanding of the distribution of and factors influencing maternal mortality and for attention to improved domestic financing to implement redistributive policies.

Responding to questions in this part of the programme, Charlotte Zikusooka Healthnet Consult (who led on the Uganda EW working with TARSC, HEPs and Ministry of Health Uganda) responded to questions from the floor on the challenges for equity analysis raised in Uganda by the decentralization of the health system. She noted the need for within district and small area analysis. The findings in the Uganda EW, such as the rise in catastrophic expenditure even following the abolition of fees or the inequalities in distribution of health personnel, point to the need for additional studies to assess the causes of inequity, the benefit incidence from services, the reasons for differential uptake and service performance and to evaluate interventions to address the inequities. At the same time she and other presenters noted the time, resource and capacity

investments needed to carry out equity analysis, at national level in the EW and to implement such studies. This needs to be invested in if equity analysis is to be institutionalized.

What challenges do countries face in implementing equity analysis? What opportunities exist for linking equity analysis to processes within the health system?

Moises Mazivila and Laura Anselmi, Ministry of Health Mozambique outlined the key findings from the Mozambique EW, noting the improved economic context for health equity and improved availability of and aggregate funding for services but inequalities in health and access to health services by province; and the widening within area wealth and social differences in health and access to services. Mozambique has taken forward work to work to revise the criteria for the allocation of financial resources in the health sector. They noted that this is an information intensive exercise that faces challenges of a scarcity of district level data and reference norms and that demands interaction with a number of institutions. Integrating equity into resource allocation calls for other measures to be taken: To increase overall health funding, to ensure efficiency and capacity to absorb funds and to harmonise with other government priorities and tools and with external funding flows. Allocations to provinces also need to be complemented by analysis within districts to understand the drivers of social and economic inequalities in uptake of health resources within areas. They noted in the discussion that this goes beyond a technical exercise. It calls for consensus among relevant stakeholders, stronger capacities for need based planning and improved coordination with external funders.

What recommendations do you have from the work for institutionalizing equity analysis across different sectors of government and with other actors?

Gibson Mhlanga, Ministry of Health and Child Welfare Zimbabwe noted that Zimbabwe has now implemented two rounds of EW work (with TARSC) and that this has provided opportunities to explore trends and discuss how the analysis of equity can be institutionalised. In his presentation he pointed to the findings of the comparison across the two rounds in terms of positive and negative trends, noting that these findings had now been taken to a national intersectoral stakeholder discussion on priority areas raised. Stakeholders had identified areas for policy follow up. For the health sector this included giving high focus on primary care services and the tracking of resources to and benefit incidence at this level, as well as work to update and cost the essential health entitlement and to identify and assess the financing incidence of new domestic revenue flows such as earmarked taxes linked to growth areas, sin taxes and VAT. For the other sectors issues were raised of strengthening the health benefits in economic recovery, such as through investment in medicine production; strengthened port health, review of Public Health law; and through interventions to improve water, sanitation and food security.

In the discussion on the presentations, moderated by Sharmila, delegates raised the intersectoral nature of the policy issues that health equity analysis points to, whether with finance and planning ministries or with other sectors responsible for social determinants. This raises both challenge and opportunity for how Ministries of health not only manage the dialogue with the non state actors in the health sector, but also lever the involvement of other sectors in ways that are relevant to their own policy and budget processes. At the same time participants in the discussion also noted that community and public support is essential for addressing issues raised. This opened the issue of how evidence on equity is communicated and used to build the institutional relations needed to lever progress.

Rene Loewenson gave a concluding PechaKucha (20 images in 20 seconds each) that flagged the key messages and continuing debates in taking equity monitoring and analysis from research to institutional practice in health and health systems.

The session raised that building evidence, analysis and policy on health equity demands strategic evidence, reflection and dialogue – in the ESA region there is active work in progress strengthened by consistent support for equity in policy and long term regional networks for exchange and support.

It is clear that much evidence exists- making effective and persuasive use of it demands time, capacities and resources, and dialogue across a range of actors. The EW reports are not just monitoring problems but monitoring progress, and they show evidence that unfair inequalities can be modified by policy and that closing the gap is feasible. They also have limits and need to be backed by more specific work, such as on the distribution of benefit from resources for health within districts, and how interventions and services are affecting this.

Many of the structural determinants found lie outside the health sector, raising attention to dimensions of economic growth paths that raise inequity, and the unplanned urbanisation, employment, farming, and other economic trends that limit the distribution of the benefits from economic growth.

The experience in implementing the EW points to the role of evidence on health equity as a lever for dialogue with other sectors whose policies, activities and budgets need to integrate these health outcomes as a measure of their performance, such as water, food production, trade, education and so on. This cannot be adhoc, is time consuming and calls for investment in these processes and in putting evidence in forms that are relevant to these sectors.

At the same time the EW evidence shows that the health system can make a difference and points to areas for policy discussion across programmes and institutions *within* the health sector. For example the EW reports have highlighted the need for more active measures to ensure and track that resources reach the primary care and community level of health systems, as well as specific areas of significant inequality, such as in access to reproductive and maternal health services. Making progress on health equity is not simply a technical matter: public participation and support is critical for policy adoption and health workers are critical for policy implementation, but both are areas that need more investment in health systems.

The country experiences highlight that evidence on equity and its policy implications 'comes alive' when linked to policy, strategy, evaluation, resource allocation and other processes that link to practice.

This is not only relevant at local or national level: In global processes such as the MDGs, aggregate goals and measures are not enough. The monitoring and evaluation framework for accountability should include equity focused indicators and collect disaggregated data on progress, and equity should be included in any future development goals.

