Economic
Commission
for Africa

Policy Brief

Mainstreaming health equity into the development agenda in Africa

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Policy goal

To influence the adoption by ECA Member States of policies and strategies that address inequities in health and the mainstreaming of such policies into their MDGs-based poverty reduction strategies or national development plans. Mainstreaming is understood in this Policy Brief to mean the systematic integration of health equity concerns into the analyses, formulation and monitoring of policies, programmes and projects, with the overall objective of promoting equitable access to health services and in health outcomes.

Background

Health inequalities are a reality in Africa as in other regions of the world. These inequalities are in part due to socio-economic differences, policy choices that countries make as the behavioural choices of individuals. Increasingly, inequities in access to and utilization of health care are being seen as a major impediment to the achievement of the Millennium Development Goals (MDGs) in Africa insofar as they contribute significantly to inequities in health outcomes.

All African countries are signatories to the World Health Organization Alma-Ata Declaration of 1978, in which they committed themselves to achieve health for all by the year 2000. Towards the end of the twentieth century, it was recognized that achieving health for all was still a major challenge. As a consequence, new global commitments were made in the "World Health Declaration" of the World Health Assembly of 1998. Member States re-affirmed in this Declaration, the need to give effect to the "health-for-all policy for the twenty-first century" through relevant regional and national policies aimed at reducing social and economic inequities in improving the health of the whole population. At the regional level, African governments have repeatedly underscored the importance of reducing health inequities by improving access to health for all. The most recent affirmation of their commitment was made at the 3rd Ordinary Session of the African Union Conference of Ministers of Health held in April 2007 in Johannesburg, South Africa under the theme "Strengthening of Health Systems for Equity and Development". In their final declaration, the Ministers renewed their commitment to strengthen health systems for equitable health outcomes and specifically to develop social protection systems, particularly for the poor and vulnerable groups in society, aimed at promoting greater access to health-care services and protecting families from the financial hardship associated with catastrophic health emergencies.

Despite these commitments, many African governments are still grappling with the challenge of developing health policies and health-care systems that can assure equitable access to adequate health care for all. Translating the commitments to reality requires not only effective policies and strategies that address these inequities, but also information on the inequities in a manner accessible to policy makers. This policy brief aims to contribute to the available information on health equity in Africa by addressing the following questions:

- What are health inequities and why do they matter?
- What is the evidence of health inequities in selected African countries?

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- What have countries been doing to address health inequities?

- What should countries do to effectively mainstream health equity into the development agenda?

What are health inequities and why do they matter?

Health inequities are avoidable, unfair and unjust inequalities in access to and utilization of health services between regions and population subgroups within a country. Inequity in health does not refer to all health disparities, but specifically to those health disparities that are unfair because they are associated with underlying socio-economic circumstances, such as wealth or geography, that systematically put some groups of people at a disadvantage with respect to health opportunities. There are three forms of access that are important for equitable access to and utilization of health services. These are: geographic access, which relates to physical availability of health services; economic access, which relates to the affordability of health services by people; and cultural access, which relates to acceptability and respect that can be affected by language barriers, cultural beliefs/norms and attitudes of health personnel.

Inequities in accessing health care matter because they have serious implications for human development. Firstly, they, to the extent that they are socially determined, violate the basic precepts of social justice for everyone to have equal opportunity to be healthy. The Universal Declaration of Human Rights recognizes access to health as a human right and emphasizes the importance for governments and development actors to guarantee access to basic health for all. Secondly, health inequities can impede the achievement of the Millennium Development Goals (MDGs), insofar as the health MDGs targets cannot be fully achieved if large segments of the population do not have access to health. Thirdly, inequities in access to health care are bad for economic growth, poverty reduction and overall development. Extreme health inequities can lead to intergenerational deprivation or limitation of access to health care and other livelihood assets such as education, resulting in limited opportunities for breaking out of poverty.

What is the evidence of health inequities in selected African countries?

The Economic Commission for Africa (ECA) recently undertook a study to identify the main sources of inequities in access to and utilization of health care in ten African countries, including Cameroon, Chad, Egypt, Ethiopia, Ghana, Kenya, Malawi, Morocco, Senegal and Zambia. The study was based on the analysis of demographic and health survey (DHS) data. Most of the variables investigated in the study relate to women because maternal and child health indicators predominate in this dataset. In addition to bivariate analysis of the data, concentration indices were calculated to identify income-related sources of health inequity. The findings reveal striking evidence of inequities in access to and utilization of health care due to income differences and the rural-urban divide. In all the study countries, women from the poorest quintiles were less likely than those in better-off quintiles to use basic health services such as prenatal care, modern contraceptives, delivery assistance by a health professional and immunization. Similarly, the rural population group was less likely to access health-care services than the urban population. Inequities were most extreme for delivery assistance. The health indicator with the most equitable service in terms of income and the rural-urban divide was immunization.

Over two DHS time periods, the results reveal that the countries under study have progressed at different rates in closing the inequity gap. Egypt and Morocco have made significant progress in closing health inequities caused by wealth and rural-urban divide. There was marginal progress in bridging health inequities caused by wealth differences in Cameroon, Ghana, Malawi and Senegal. These findings heighten the need for countries to take urgent action to address health inequities and their root causes.

What have countries been doing to address health inequities?

A review of the national health plans of the studied countries indicates that they all refer to equity in one form or another. Some plans clearly articulate their health equity objectives and the relevant strategies that will be deployed for their achievement. However, the targets of the health goals generally need to be improved so that they emphasize both equity in geographical and financial access. It is also important for the equity objectives to be translated into real actionable programmes.

A number of the countries have institutional frameworks that support the integration of equity objectives into health sector plans and provide for the monitoring of progress achieved. These are mostly in the form of parliamentary committees on health and the health-care sector. Malawi, for example, has set up the equity and access subgroup, which allows the government, donors and civil society organizations to monitor progress and advances towards health equity. In response to a questionnaire that was completed by officers in the Ministries of Health of the study countries, all countries except Chad, indicated the contributory role played by NGOs, especially faith-based organizations, in promoting health equity, especially in rural or remote areas. In Malawi, the Christian Health Association of Malawi provides over 40 per cent of the health care in the country, mainly in the rural areas. In Ghana, the deliberate location of service delivery sites in disadvantaged communities in the northern regions of the country by the Christian Health Association of Ghana has helped improve access to health care. In Kenya, faith-based health service providers are mainly providing health services to marginalized areas where government presence is very thin. In Zambia, the Churches Health Association of Zambia, the umbrella body of faith-based health organizations, provides 50 per cent of rural health care services in the country. However, respondents generally felt that there was need for a clear framework to guide the support of faith-based organizations in promoting health equity.

Some countries have taken a variety of equity-oriented measures, including basic or essential health packages; expansion of health services to remote areas; expansion and integration of community health services; targeted fee exemptions at public facilities; free health services; expansion of national health insurance; promotion of community-based health insurance; financial decentralization; and a more inclusive resource allocation formula to address regional disparities. These innovations have brought about improvements in health equity in some countries more than others. Morocco in particular has introduced a community-based “maison du citoyen”, a government-sponsored centre tasked with addressing social exclusion in all its aspects, including health inequities. This is a significant contributing factor to the progress shown by Morocco. In Egypt, the government has been striving to expand social health insurance coverage from 47 per cent (in 2003) of the population to universal coverage by 2012.

The quantum of resources allocated to the health sector in all countries studied is rather low. The two countries that report the greatest positive equity impacts on all the studied health variables and over time – Egypt and Morocco – also report the highest public expenditure allocation per capita to health. None of the countries studied have reached the Abuja Declaration commitment of allocating 15 per cent of total government expenditure to health.

A review of the selected countries’ national development plans or PRSPs indicates that they all make reference to health equity and acknowledge the importance of addressing the issue. However, only a few of them have developed specific health equity strategies. Most of the plans outline strategies that are aimed at universal coverage for health services and not specifically at health equity. It is important for health equity to be clearly mainstreamed into the national development plan or PRSP, because it provides the overall strategic direction to ensure that development is more inclusive and it can establish the multi-sectoral linkages required to address health inequities and strengthen the case for increased health resources.

What should countries do to effectively mainstream health equity into the development agenda?

The evidence of health inequities in the selected study countries is striking and indicates the need for African governments to strategically mainstream health equity into their development plans. Based on the evidence, the study recommends a programme of action at three levels: sectoral, national and regional.

Mainstreaming health equity into the health sector

- Deeper integration of health equity into national health plans to ensure that sectoral strategies prioritize health equity; more work is needed to identify equity-oriented goals, targets and priority strategies that address health inequities perculiar to the country;
- Strengthening of the institutional framework that can support greater integration of health equity into health sector plans;
- Strengthening of the role of NGOs and faith-based organizations in promoting access to health through the development of clear supportive frameworks to guide their work in promoting health equity;
- Scaling up of measures that improve geographical access, such as expansion of basic or essential health packages;

expansion of health services to rural and remote areas; and expansion and integration of community health services to promote access to health services;

- Scaling up of measures that improve financial access, such as expansion of national health insurance and promotion of community-based health insurance to improve utilization of health services by the poor;
- Emphasis on health equity in resource allocation decisions within the health sector; and development or enhancement of resource allocation formulas that take due account of equity objectives in the allocation of all resources, including financial and human resources, equipment and drugs;
- Increasing the efficiency of public expenditure to improve the health of the whole population and produce equitable outcomes;
- Addressing the challenge of shortage of health personnel through strategies that aim to intensify training and retention and sustain the productivity of health workers;
- Emphasizing health equity objectives in the monitoring and evaluation of health, as national average data can conceal major inequities in access suffered by disadvantaged groups; in this regard, it is important to collect disaggregated data for use in monitoring and evaluation of health equity outcomes..

Mainstreaming health equity into the broader national development agenda

- Deeper integration of health equity into national development and poverty reduction strategies; relevant sectors such as water and sanitation, education, housing, agriculture, transport and social welfare, should securely mainstream health equity into their sectoral policies to assist in improving geographical and financial access to health care; this can be successfully achieved through integration of health equity into the overarching framework for national development;
- Deeper reflection of health equity objectives in national resource allocation decisions;
- Improve geographical distribution of health services, personnel and infrastructure, especially in rural areas;
- Strengthening of participatory decision making so that the issue of health equity can be addressed in a democratic process.

Mainstreaming health equity into regional processes

- Assistance from regional institutions to help countries mainstream health equity into their national development strategies by mobilizing the necessary resources for addressing health inequities;
- Promoting policy dialogue and providing Member States with guidelines that they can use to mainstream health equity into development;
- Support from regional or subregional organizations to help Member States in several other areas: building capacity to generate and use disaggregated data for monitoring health equity; providing support for strategies aimed at improving human resource capacity in health; and development of effective inter-country mechanisms of sharing best practices or experiences on policies, strategies, data and other resources for mainstreaming health equity.

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