What's the Available Evidence?

Canadian Coalition for Global Health Research
Dossier Series
Strengthening Health Systems in sub-Saharan Africa

Dossier #2: Equity in Health System Development

Dossier Includes:
- Issues & Challenges
- African Case Studies
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Introduction:

The Alma Ata declaration of Health for All in 1978 was underpinned by an explicit commitment to equity in both health and health care. In the years since, equitable access and resource distribution in health systems around the world continue to be a challenge. Yet, equitable health systems are a pre-requisite to achieving the Millennium Development Goals. For the purpose of this dossier, equity in health implies addressing differences in access to health care and health status that are unnecessary, avoidable, and unfair.

CIDA Questions:

The following questions have guided the development of the dossier.

1. What strategies are effective in increasing equity in health systems?

2. What evidence is available regarding the impact of front-line health workers (community health workers and auxiliary or mid-level health workers, distinguished from health professionals such as doctors or nurses) on equitable access to services and on health outcomes? What more do we need to know?

In response to key questions posed by CIDA, the CCGHR compiled this Dossier Series to present current knowledge and evidence in health system strengthening. The dossiers do not necessarily represent the views of CIDA. They provide a basis for further discussion and provide materials and resources for further exploration. *First Launched: March 2006*

Issues & Challenges

- *Axis of inequity*: many axes exist across which health care access and health status can vary at levels that can be considered unnecessary, avoidable and unfair. These include income level (poverty), urban/rural location, gender, race or ethnicity, and other minority status. Often these axes of inequity can be laid on top of each other for multiple levels of marginalization (for example gender and race can interact with poverty so that within the poor, women in general and minority women in particular have poorer health status). These axes can have complex effects on health seeking behaviour, access to services, ability to adhere to treatment and other determinants of health status, all of which need to be understood in order to make health systems more equitable.

- *HIV/AIDS*: The HIV pandemic has been shown to intensify existing axes of inequality in societies so that those on the disadvantaged end of many axes are more likely to be infected and affected by HIV and less able to withstand the economic impact of attendant personal or family illness.

- *Reasons for inequitable access*: causes are multiple but include chronic under-resourcing of health systems, lack of strategic leadership, attrition of health personnel, and high prevalence of poverty.

- *Human resources for health*: Human resource policies and strategies are critical determinants of equitable health systems, particularly as they effect issues of distribution and retention of workers where they are needed.

- *Intentionality*: if those designing programs or interventions do not explicitly consider how coverage can be maximized for disadvantaged groups, for example through specific objectives or criteria, they cannot be assured that their plans will have a positive equity impact.

- *Health financing*: different financing options within health systems can have widely divergent health equity effects. User fees for services can decrease access to services by the poor without adequate exemptions. On the other hand, there is more positive evidence for community health insurance (except for the poorest, for whom pre-payment schemes may remain inaccessible).

- *Community participation*: empowering community members, and particular the poor, to play a role in the design and operation or management of health systems at local levels can improve the equity within the system.

- *Responsiveness*: The poor or other disadvantaged groups do not necessarily choose to use the public systems for health services even where it is free or very low cost. The level of responsiveness of the health system to people's expectations is important. Responsiveness has two main elements including respect for persons (dignity, autonomy, confidentiality) and client orientation (prompt attention, choice, quality, and access to social support networks). Assessing the perceptions of clients and community members, including the most disadvantaged groups, is useful to identify areas where equity could be improved in health systems.

- *Evidence*: work is needed at country level to understand the social, economic, and political determinants of health and the interventions that can effectively mitigate these. Other important areas where more research is needed include the ways in which affordable and appropriate technologies can help address equity issues, how health equity can be protected from market failures and the challenges associated with globalization; and mechanisms for pro-poor financing of health systems.

African Case Studies

Monitoring Equity in Health and Health Care in Developing Countries
The Development of Zambia's Health Equity Gauge

"An Equity Gauge is an approach to promoting equity which includes monitoring of key indicators, coupled with advocacy and community participation to ensure that information is acted upon." [Reference : Global Equity Gauge Alliance Report August 2000] http://www.gega.org.za/download/equity_rep.pdf

The Equity Gauge initially began as a national project in South Africa to help measure improvement in health as well as whether health and health care is provided in a fair and equitable manner. The project partnered South African legislators with the Health Systems Trust and was funded by the Henry J. Kaiser Family Foundation (USA) and the Rockefeller Foundation. In 2000, twelve new Equity Gauges joined (Chile, Ecuador, Peru, Burkina Faso, Kenya, Zambia, Zimbabwe, Bangladesh, China, Thailand, India, and Cape Town City Equity Gauge).

In Zambia, the development of an Equity Gauge has the purpose of working at district, provincial and national levels, to monitor health and health service delivery across social strata including: gender, socio-economic status, religion, geographical location, provinces and districts. Specifically, the Gauge aims to advocate for, as well as to monitor the policies on and provision of health services in Zambia as well as equity in health. The ultimate aim of which is to ensure that issues of equity in health and health service delivery are considered and taken into account both at the policy, planning and implementation levels.

In the years since it's creation, the Zambian Equity Gauge has successfully developed quantitative and qualitative methods for capturing community perceptions of unmet health needs and quality of health services. McCoy et al. 2003 captured the story:

> "Following public dissemination of the Zambia Gauge's assessment of health equity in four districts (Chama, Lusaka, Choma, Chingola), health-sector decision-makers withdrew a proposal to raise user-fees, and a fascinating saga has subsequently unfolded. Based on the publicity engendered by the Zambia Gauge's work, the Health Committee of the Zambian Parliament called for ending user-fees altogether. This move, however, met resistance from health workers in urban areas, who saw the user-fees as the only feasible means of maintaining services. The Gauge has responded with renewed efforts, involving drama, dance, songs, and poems, to make officials aware of people's perspectives on health equity. This story continues—a top official in one district was so moved by the people's testimony captured by the Gauge that he has committed to instituting measures to increase health workers' sensitivities to people's concerns. The Portfolio Committee on Health sees the dramas as a mechanism to strengthen advocacy for health equity within the legislature, since it provides a form of public feedback on priorities and creates political pressure for response."

[McCoy D, Bambas L, Acurio D, Baya B, Bhuiya A, Chowdhury AMR, Grisurapong S, Liu Y, Ngom P, Ngulube TJ, Ntuli A, Sander D, Vega J, Shukla A, Braveman PA. 2003. Global Equity Gauge Alliance: Reflections on Early Experiences. J Health Popul Nutr 21(3):273-287]

Health Equity for System Strengthening
CHESSORE, Zambia

The Centre for Health Science and Social Research (CHESSORE) is working to make the concept of community participation for attaining health equity in the Zambian health system operational and relevant. CHESSORE does not simply conduct research, but mobilizes and brings together key stakeholders at the district and national levels. This is meant to improve the understanding of health equity as well as bring about interest in community participation in health and the needed government policy.

CHESSORE worked on monitoring and evaluation of the Zambia health reforms from 1994 to 1999. During this time CHESSORE sampled 16 districts and assessed 76 health facilities (government, mission and mine company ones) for impact and equity of benefit from reforms. Feedback sessions were held with health staff with all the 16 DHMT stations as well as with the Central Board of Health officials after each provincial tour of the study phase.

This work, and other work by CHESSORE, has been very useful in planning and implementation as well as feedback to the donor community. This engagement with the health system and its key stakeholder also educated CHESSORE to understand and identify key issues of relevance for research, with a view to feeding back into policy and implementation.

In order to create an appropriate knowledge translation framework, CHESSORE focused its research efforts at the interface between the community and the health system in 4 districts, purposively selected to represent an equity profile of Zambian districts, in order to ensure relevance of findings.

The major findings from the studies by CHESSORE have been brought to the attention of all stakeholders. The findings include:

i) the Zambian health reforms have meant different things to stakeholders at different levels in the health system;
ii) the intended outcomes from implementing the concept of community participation as applied were nullified by an ‘excessive’ use of power and reliance on use of this power over the less powerful stakeholders;
iii) a purposeful approach was needed to redress the power imbalances between stakeholders for meaningful community participation to achieve better governance, equity and health.

In order to address these finding and the identified bottleneck in participation and governance, CHESSORE is now embarking on an “empowerment approach” applied research programme to equip both the community members and their health workers with the necessary capacity and skill for meaningful and effective community participation in the Zambian health system.

Stakeholders have included: Ministry of Health (Zambia), Ministry of Education (Zambia), Ministry of Finance and Economic Development (Zambia), The Zambian parliament, United States Agency for International Development (USAID - under contract with BASIC, Zambia), WHO (Geneva and AFRO – Health System Reform, ITN advocacy and RBM), the African Academy of Sciences, Danish International Development Agency

(DANIDA), The Rockefeller Foundation, The Health Reforms Implementation Team (HRIT), The Central Board of Health (Zambia), The National Malaria Control Centre (Zambia), The Southern African Malaria Control (SAMC), EQUINET, and The Department for International Development (DFID-Central Africa).

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Director, CHESSORE

Highlights from Key References

Equity in Health Systems – General References

1. ***Davidson Gwatkin, Abbas Bhuiya, Cesar G Victora: Making Health Systems more Equitable. The Lancet 2004;364: 1273-80***

   Health systems can be made more equitable by:
   - improving health financing systems
   - revising national health system objectives that are more relevant to the conditions of the poor (including women, men and children);
   - applying the lessons learned from several innovative efforts to reach the poor more effectively (than traditional approaches)
   - empowering poor potential clients of health systems to play a more central role in the design and operations of systems

2. ***Evans T., M. Whitehead, F. Diderichsen, A. Bhuiya, & M. Wirth (Eds.). 2001. Challenging inequities in health: From ethics to action. New York: Oxford University Press.***

   - This book provides perspectives on the scale and nature of health inequities in 13 countries and assessments of relevant policy developments and their implications. It explores the ways that health status is affected by gender, broader social determinants and globalization.

3. ***INDEPTH Network. 2005. Measuring Health Equity in Small Areas: Findings from Demographic Surveillance Systems. Ashgate Press, Hants, England; Burlington VT, USA .*** [Further information from: http:www.ashgate.com].

   - This publication results from collective exploratory research efforts in the area of health equity. Ten member sites of the INDEPTH network participated in this project, including teams from Tanzania, Ghana, South Africa and The Gambia. The studies examine how assets, consumption expenditure, gender, education, occupation, social connectivity and other socio-economic status proxies relate to mortality and service use in various population subgroups.

4. ***People's Health Movement, Medact, GEGA. 2005. Global Health Watch, 2005-2006. Zed Books, London.*** Available at: http://www.ghwatch.org/

   - This publication announces itself as "an alternative world health report", and is a collaborative effort of several non-government organizations (NGOs): The People's Health Movement; Medact (London, UK), and the Global Health Equity Guage (based in Durban, S. Africa). The *Watch* is fundamentally about health inequities, and sets out *"an explicitly political understanding of the current state of health around the world".*

Gender, Access and ART

5. ***Bongololo, G., I. Makwiza, L. Nyirenda, B. Nhlema, S. Theobald. Using research to promote gender and equity in the provision of anti-retroviral therapy in***

Malawi. Paper presented to Forum 9, Global Forum for Health Research, Mumbai, September 12-16th, 2005.

Gender and health equity related to ART are shaped by a number of factors:

- Gender interacts with poverty to shape access to resources and decision making trajectories about accessing and adhering to ART (as well as other decisions related to health care and preventative strategies);
- The experience of stigma is influenced by gender and poverty and affects health seeking behaviour and ability to adhere to treatment;
- Providing ART free is an extremely important step in facilitating access by different groups (eg women, low-income, rural). In Malawi, the free provision of ART has enabled access rates to begin to reflect prevalence rates (more women than men are living with HIV in Malawi);
- Even where the actual ART treatment is free, opportunity costs (related to transport and displacement activities and foregone income) and problems with accessing enough food are experienced, especially by women and rural communities;
- Staff shortages and long waiting times constitute additional barriers to ART access and adherence and are particularly challenging in the light of over-stretched and under resourced Malawian heath systems;
- Looking at gender equity in ART provision means not only considering who is accessing ART, but also what are the implications of ART provision on the health system as a whole. Looking at ways to use ART to strengthen the health system requires integration and collaboration with other health service delivery packages within and beyond the public sector.

6. ***Equinet and Health Systems Trust. 2005. Equity in the distribution of health personnel in southern Africa: Report of regional meeting, 18-20 August 2005, Johannesburg.*** **Accessible at:** http://www.equinetafrica.org/pubs.php

   - Human resource policies and outcomes are critical determinants of equitable health systems. In particular, valuing and retaining health workers at levels in the health system where they are needed contributes to more equitable distribution and improved access. (for more on Human Health Resources see Dossier #1)

7. ***Loewenson, and D. McCoy. 2004. Access to antiretroviral treatment in Africa. British Medical Journal 328:241-242***

   - Inequitable access stems from chronic under-resourcing of health systems, the underdevelopment of strategic public health leadership, the attrition of health personnel, and the high prevalence of poverty.

   - Equity in access to treatment (ART) is improved when criteria for selecting patients explicitly targets low income groups, particular sub-groups of the population whose professions promote services to poor people (health workers, teachers), or involve the community in decisions about selecting patients

Health Financing and Governance

8. ***Impacts of participation and governance on equity in health systems: Report of a Research review meeting of the GovERN network. Report by CHESSOR/TARSC, June 2003.*** (available: http://www.equinetafrica.org/bibl/docs/REP052003gov.pdf)

    - Governance within the health system has direct implications for equity. This study on community health committees in Zambia and Zimbabwe (health centre committees and district health boards) found that a community participation and empowerment program is a mechanism to increase the capacity of communities to particiante in the governance of health – thus potentially improving equity within the system.

9. ***Jakab M, Krishnan C. Review of the strengths and weaknesses of community financing. In: Preker A, Carrin G, (eds). Health financing for poor people: resource mobilization and risk sharing. Washington, DC, World Bank, 2004***

    This review of community health insurance (CHI) schemes concluded that:
    - CHI systems mobilize significant resources for healthcare;
    - CHI schemes systematically reduce the out-of-pocket share of members, while increasing utilization of health services;
    - These schemes effectively reach large numbers of low-income populations, even though there are indications that the poorest, and those who are socially excluded, are not automatically reached by these initiatives. There have been programs effective at reaching the poorest such as conditional cash transfer developed in Latin America (eg PROGRESA)

10. ***Sen, G., George, A., Ostlin, P. 2002. Engendering international health – A Review of Research and Policy (Chapter 1). In: Engendering international health – The Challenge of Equity. Sen, G., George, A., Ostlin, P. (Eds). The MIT Press, Cambridge, Massachusetts.***

    - Health insurance schemes and public funding are a means to ensure adequate health equity funding. However, health equity requires not only sensitizing senior policy makers but require that attention be extended to other sectors outside of health as well (education, credit).

11. ***McCoy D, Sanders D, Baum F, Naravan T, Legge D. 2004. Pushing the international health research agenda towards equity and effectiveness. The Lancet 364: 1630-31***

    - This discussion piece identifies a number of gaps in current knowledge related to health equity in health systems including how to protect health equity and how to design and finance of systems and basic services to ensure to access to good quality care and other health inputs (eg. water and adequate nutrition).

Other Resources

1. **The Network for Equity in Health in Southern Africa (Equinet):**
   Initiated in 1997, Equinet is dedicated to influencing both national and regional policies of the countries of the Southern Africa Development Community (SADC). It does so by networking professionals, civil society and policy makers to promote policies for equity in health, undertaking research, initiating conferences and workshops, conducting internet-based discussions, and providing inputs at the SADC forums. An extensive body of reports is available through its website.

   Website: www.equinetafrica.org

2. **GEGA: The Global Equity Gauge Alliance:**
   This alliance supports teams (called "Equity Gauges") in 11 countries, engaged in monitoring health inequalities and promoting equity within and between societies. African teams include: the African Population Health Research Council (Kenya); University of Western Cape (South Africa); University of Ouagadougou (Burkina Faso). Also included are political bodies such as the Parliamentary Committee on Health (South Africa) and the Urban Slums Development Project (Nairobi, Kenya).

   Website: http://www.gega.org.za/

3. **INDEPTH Network: An International Network of field sites with continuous Demographic Evaluation of Populations and Their Health in developing countries**
   INDEPTH aims to harness the collective potential of the world's community-based longitudinal demographic surveillance initiatives in resource constrained countries to provide a better, empirical understanding of health and social issues, and to apply this understanding to alleviate the most severe health and social challenges. INDEPTH has 26 sites in Africa, in the countries of Burkina Faso, Gambia, Ghana, Guinea Bissau, Senegal, Ethiopia, Kenya, Tanzania, Uganda, Malawi, Mozambique, and South Africa.

   Website:http://www.indepth-network.org/

4. **Malawi Health Equity Network (MHEN)**

   The MHEN was formed in 2000 as a grouping of individuals and organizations working to promote equity in health in Malawi. In October 2004 the Malawi Health Equity Network held a meeting in co-operation with EQUINET to discuss health equity issues in Malawi and priorities for future work. The meeting resolved to prioritise future work on fair access to treatment for AIDS, advocacy on traditional medicines and social health insurance. It was proposed that joint work be carried out between MHEN and the Malawi Parliamentary Portfolio Committee on Health, with support from EQUINET to review current health legislation. (Coordinator: Dr Adamson Muula, and can be contacted at College of Medicine in Blantyre; 08 838067 / a_muula@yahoo.com)

5. Tanzania National network on Equity in Health (EQUINETA)

A Tanzania National Meeting on Equity in Health held in Dar es Salaam, 26 February 2004 hosted by TANESA, CEHPRAD and the Tanzania Public Health Association with support from EQUINET formed a Tanzania National network on Equity in Health (EQUINETA) as a country network in the EQUINET Southern African regional network.

EQUINETA held its first national meeting on 26th of March 2004 in Dar es Salaam on HIV/AIDS Treatment access through Strengthening Health Systems with participation from and support of EQUINET.

For the February 2004 meeting report:
http://www.tgpsh.or.tz/modules/news/fileupload/store/2005-4-18-1-45-49_meeting_report__country_meeting-tanzanian_network_on_equity_in_health.pdf