Report from the seminar

‘EQUITY IN HEALTH—POLICIES FOR SURVIVAL IN SOUTHERN AFRICA’

Kasane, Botswana, 13–16 March 1997

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INTRODUCTION

In March 1997, a seminar on 'Equity in Health—Policies for Survival in Southern Africa', organised by the Dag Hammarskjöld Foundation and the National Institute of Development Research and Documentation, University of Botswana, was held in Kasane, northern Botswana. At this seminar, 34 participants ranging from politicians, policy makers and academics to health practitioners and NGO activists engaged in wide-ranging discussions on equity in health and health care. The participants came from eight different Southern African countries and Sweden, all participating in their personal capacity.

This report from the Kasane seminar begins with a short section on the background to the Seminar, explaining how it was conceived and organised. In the next section, summaries of the papers specifically prepared for the seminar are presented, followed by a summary of the plenary discussions divided into cross-cutting themes. The report ends with appendices which include a list of participants (Appendix 1), the Seminar programme (Appendix 2), information on the organising institutions (Appendix 3) and the Agenda for Action document (Appendix 4).

BACKGROUND

RATIONALE

Several factors motivated the Seminar:

The critical health situation: Southern Africa is facing several serious health challenges. Many health indicators are among the worst in the world and diseases such as lower respiratory infections, diarrhoeal diseases, malaria, measles and tuberculosis continue to be dominant causes of morbidity and mortality. Recently, the HIV/AIDS epidemic in the region has emerged as one of the most serious in the world and its impact is expected to worsen the health status of the region significantly. In addition to the suffering it causes to individuals and families, the epidemic will have major impacts on society and prospects for development for several generations to come. There is thus an urgent need to put health and health care at the top of the development agenda.

Increasing inequity: There are clear indications of growing inequities in health and health care, both within and between countries in the region as well as in the global context. These often seem to be ignored and are persistently downplayed as countries implement policy changes that affect health. Equity in health must be a priority and new, improved policies to reduce inequities must be conceived and implemented.

Regional perspectives: Although there are variations in socio-economic development in the region, there are many commonalities in the way health problems manifest themselves, calling for a regional approach to intervention. There are needs and opportunities for countries to share experiences in terms of policy strategies and their implementation. Moreover, many problems are regional in nature, such as the brain drain of professionals and the spread of infectious diseases.

There are several health initiatives in Southern Africa at both national and regional levels. Some of these are being pursued by external bilateral and multilateral actors—the World Bank and WHO, for example, are guiding health sector reform in a number of countries. In the light of these developments there appears to be a need for joint scrutiny, on a regional basis, of policy options and alternatives.

AIMS

The Seminar had as its general aim to provide a forum for open, frank and innovative discussions on equity in health and health care by concerned individuals from the Southern African region. More specifically, the Seminar aimed to promote in-depth analysis and critical examination of aspects of the present health situation; to promote and develop alternative thinking of relevance to policy-making in this area; and to identify and explore opportunities for regional cooperation. A concrete goal, and outcome, of the Seminar was the formulation of a Southern African Agenda on Equity in Health.

In order to attract a broad range of participants and to identify the issues of greatest relevance to concerned people in the region, the organisers conducted several rounds of consultations in the Southern African region. Discussions with more than 100 people from various disciplines and countries took place, laying the ground for the structure and thrust of the Seminar.

ORGANISERS

Consultations in the region led to a decision to hold the Seminar in Botswana, with the Dag Hammarskjöld Foundation, Uppsala, Sweden, and the National Institute of Development Research and Documentation, University of Botswana as joint organisers, assisted by a regional steering committee, which would itself be backed by a local organising committee in Botswana (see List of Participants, Appendix 1 for the composition of the committees and Appendix 3 for further information on the organising institutions).

SUMMARIES

The Seminar was divided into two parts. In the first part, presentations of papers and plenary discussions took place in order to map out the main issues and stimulate further thinking. In the second part, participants together identified five major topics as particularly relevant (the concept of equity in health; decentralisation; intersectoral collaboration; HIV/AIDS; and training and research), with working groups focusing on each topic. The work of these groups was discussed in plenum and eventually led to the formulation of the Agenda for Action.

In the following section some of the main point of the papers that were presented are summarised.

Summaries of Paper Presentations

OPENING ADDRESS OF THE SEMINAR
Mr Festus Mogae

The opening address was introduced by Professor Thomas Tlou, Vice-Chancellor of the University of Botswana, and delivered by The Honourable Festus Mogae, Vice-President of Botswana at the time of the Seminar and currently President of the Republic. In his charismatic speech Mr Mogae declared his commitment to equity in health, emphasised the importance of discussing these issues regionally, and encouraged the seminar participants to find innovative ways of solving some of the pressing health problems of Southern Africa.

The seminar on Equity in Health in Southern Africa provides an opportunity to take stock of where the region stands with regard to equity in health and health care, but, even more importantly, it provides a forum for discussing and recommending a future direction in this area. The meeting will provide an opportunity to deliberate on concrete and realistic measures that can be effected to achieve the goal of equity.

The Southern African region is facing serious health problems. For instance, maternal mortality in the region is among the highest in the world. The 1994 WHO estimates

place four of the countries in the region among the top five countries with a HIV prevalence rate higher than 12 per cent among the adult population. These poor health indicators are avoidable and unjustifiable.

Most countries in the region experience geographical disparities in health, in particular between urban and rural areas. Related to this problem are the inequities in health indicators between different socio-economic groups. In most cases, the groups with less favourable health indicators tend also to be disadvantaged in terms of other development indicators; the same holds true for disparities between men and women. None of these inequities should be allowed to continue. Given the connection between development and health, the challenge is not just inequity in health, but how to reorient development strategies towards a more people-centred focus. Health policy in any country is depending on the overall development strategies, and the underlying causes of inequalities within and between countries must therefore be tackled.

One of the major challenges facing most governments in the region is the sustainability of health expenditures. There is now a strong body of opinion in support of cost-sharing in health care delivery systems through, among others things, user fees and charges. Although this appears to be a solution towards sustaining health financing, there are still unanswered questions. Are these user charges affordable? Are they appropriate? What should be the government and private sector mix in the provision and financing of health care? These questions need urgent answers. The region has an obligation to its people, an obligation to sponsor policies that will promote equity in health and health care for the better health of people in Southern Africa.

WHEN WILL SUB-SAHARAN AFRICAN COUNTRIES HAVE EQUITABLE HEALTH SYSTEMS?
Dr Olikoye Ransome-Kuti

Following Mr Mogae's opening speech, Dr Olikoye Ransome-Kuti, paediatrician and former Minister of Health in Nigeria and presently Chair of the 'Better Health in Africa Expert Panel' presented his paper, 'When will Sub-Saharan African Countries have Equitable Health Systems?' The presentation provoked lively discussion.

Primary health care is the most appropriate, cost-effective health care system to ensure an equitable distribution of health resources, and a level of health for all citizens that allows them socially and economically productive lives. While primary health care projects have been developed in Africa, none has grown to become a national system with integrated and comprehensive services. Rather, focus has been on vertical programmes to reduce deaths caused by diseases that could be prevented or cured using simple means. The challenge is to strive for disease eradication programmes which will, at the same time, promote the development or the reforms of national health systems.

More common health problems now co-exist with AIDS, calling for new strategies to combat them. Problems in health systems, corruption and inequities, if not resolved, will hamper progress in reducing the burden of premature death and disability, and frustrate efforts to respond to new or reappearing major health challenges such as AIDS, malaria and tuberculosis.

Ultimately, the structure and function of a national health system must be decided within the country itself so that the services are equitably distributed between the rural and urban areas. Apart from national commitment, reforming the health sector demands the participation of all stakeholders in the process. National policies must create the framework within which the donors, the private health sector, non-governmental organisations and the civil society work and are coordinated by the government. It must mean the phasing out of all projects outside of this framework, for example, the vertical programmes.

A number of components are essential for such a national health system: a national essential drug system based on the use of generic drugs; appropriate training of health personnel; reallocation of resources toward primary health care rather than expensive tertiary level care; and the decentralisation of health services. The behaviour of donors in the practice and funding of health development in Africa must change. The disruption of government programmes, the fragmentation of Ministries of Health and the usurpation of national policies caused by donor driven activities must be transformed to a system where donors support the Ministry of Health with financial assistance channelled through a common system—a 'basket'.

POLICIES FOR HEALTH AND DEVELOPMENT

Dr Rene Loewenson

Dr Rene Loewenson, Director of the Training and Research Support Centre (TARSC) in Harare, a health-oriented institution working at the interface between civil society, academia and policy-making, outlined in her paper the connections between non-health sector factors and health. Her challenging presentation stimulated extensive discussions with the result that many of the most crucial points of concern were raised already on the first day of the seminar. In particular, her sections on health as a right and on the connection between macro-economic policies and health received much interest.

Poverty is without doubt the most significant cause of ill-health and underdevelopment. Over the past 15 years the world has seen spectacular economic advancement for some countries, particularly China, India, other Asian countries and the OECD countries, while for others, particularly in Sub-Saharan Africa and Latin America, there has been an unprecedented decline. Half or more of the people in the Southern African Development Community (SADC) countries live constantly in poverty. It has persisted even under conditions of GDP growth, signalling a further challenge of widening disparities in wealth and economic opportunity. Sluggish growth should not draw attention from the fact that resources exist to provide basic primary health care to the people of the region, even in its poorest countries. Remaining or widening economic inequality have, however, undermined the distribution of these resources towards the health and development of the poorest. This makes the structure and quality of growth as critical a development issue as its quantity.

Globalisation and liberalisation pose a further challenge, presenting opportunities for 'boom or bust'. While some countries have been able to use these opportunities to compete, globalisation under 'liberalised' markets has generally benefited only the industrialised and strong economies and has marginalised the weak. Adapting to global change in a manner that tackles the major problems of poverty and inequality demands the space and power to explore and choose within a range of policy options. While this places a responsibility on governments to build appropriate institutional vehicles and relations with their people in order to secure sovereignty and choice, decision-making is centralised in many SADC countries and key economic institutions are neither transparent nor well understood.

Health and development policies need to consider the constitutional right to health: that health, as part of human development, is an essential objective of economic policy; that investing in health, as part of investment in human capability, is an essential contributor to economic growth and development; and that health improvements are a function of participatory democracy.

Recent concerns over efficiency and the financial management of health care have shifted the focus away from equity in health and health care as an objective to which a range of resources should be applied. For ordinary citizens, development implies improvements in housing, food, employment (both job security and income), health

and schools. While aggregate GDP growth has been equated with improvements in these areas, this is generally only the case when it reduces poverty and improves public services. Where social policies have directed public and community resources towards these areas of human development, remarkable social progress has been made despite low and even declining national incomes.

Many economies of the SADC region make relatively low investments in human development, and rely on low wages, low skill systems and the exploitation of natural resources (in mining and agriculture) in order to compete in the global market, often at significant social cost. In contrast, economies that have made investments in people (skills, research, social development, culture) have obtained a more sustained path to growth. Such efforts include the redistribution of assets (land reform, incomes, credit), widening of labour intensive production and secure employment, and investments in health, education and social security.

Such policies require strong state initiative to mobilise and organise the resources for change, matched by strong community initiatives to use these resources productively. Building participatory democracy requires the reform of public institutions to enhance transparency and accountability, from the local to United Nations level. It calls for mechanisms to strengthen the bargaining power of low income countries, such as the regional cooperation and integration envisaged in SADC. It implies building more participatory forms of democracy at national level, in which community social organisation and state interventions are complementary. The WHO/UNESCO Conference on Primary health care in Alma Ata 1978 made it clear that health is an outcome of informed control over and choice of the factors that influence well-being, and that technical interventions can only complement informed action by individuals and communities. The health sector has in the past and can in the future play an important catalytic role in effecting the sort of multisectoral and community-based action needed to restore people's faith in their own ability to bring about change.

POLICIES FOR HEALTH SECTOR DEVELOPMENT: WHERE DOES EQUITY FEATURE?
Professor Max Price

Professor Max Price, Dean of the Medical School at the University of Witwatersrand, South Africa and former Director of the university's Centre for Health Policy presented a paper examining the challenges and opportunities for the health sectors in Southern African countries. In particular, Professor Price managed to problematise and widen the discussion of the public/private mix in the financing and delivery of health services, arguing that there may be useful alternatives that are neither all public, nor all private.

The structure of health care provision is similar in most countries of the Southern African region, based on a commitment to largely nationalised health services and public funding and provision of health care. In most countries, however, there also exists a private health sector, which differs widely in scope and shape from country to country.

To a greater or lesser degree the health sectors of all the countries of the region are facing serious problems: the levels of government funding for health services have declined, mainly as a direct result of monetarist policies to reduce social spending; there is a serious professional braindrain; the morale and motivation of public health workers is at a low ebb; and patients often have a poor view of the health services.

Policies for health sector development must tackle these serious problems, which could partly be done through increasing the number of health facilities; increasing the number and improving the skills of health workers; improving drug availability; improving referral systems; increasing quality and outreach services, preventive and promotive care; increasing accountability of health services; and reducing inequality of access to good-

quality care. In addition, increased funding for health services must be obtained, and allocative efficiency (the selection of the most cost-effective health care interventions) and technical efficiency (the efficient management of health services) must be improved.

Health financing has come to occupy the centre stage of health sector policy debates and is an area where concerns for equity might come into conflict with other goals. In the Southern African region, public health services are both publicly funded and publicly provided. Similarly, privately funded health services are privately provided. Thus many possibilities of a public/private mix remain insufficiently explored. For example, services could be delivered by a private doctor, but be financed publicly. The debate on privatisation and equity is often confused because of a failure to specify which dimensions of the public/private mix are being addressed. Inequality of access in the private sector is therefore not *per se* a feature of the private provision of medical care, but rather a result of their dependence on private sources of finance.

Public funding, derived from taxes, deficit financing and donor aid, are likely to remain the core and major part of public sector health services in most countries in the region. However, in countries with a narrow tax base or a macro-economic policy hostile to increased social spending, there is no option other than attempting to increase private or quasi-public sources of funding.

It is essential that countries undertake a careful analysis of what options for a public/private mix are available and what their implications are for equity. In order to attract additional private financing to improve the public health care system, and thus health care provision for the poorest, it may be necessary to introduce policies that might seem to be inequitable such as multiple tiers of care. In this example, well-off patients would be attracted to the public system, paying, for example, for choice of doctor, queue jumping, or private wards but thereby cross-subsidising the poorer patients. In poor countries facing increasing inequality, the commitment to total equality in access to health care may thus need to be revisited. While the policy of equal care for equal need is an important goal, poor countries should pursue a policy of Rawlsian distributive justice which holds that, as a first goal, the well-being of the poorest should increase, but only as a secondary goal, that the degree of inequality should be reduced.

A crucial role of government is to regulate the private health sector in order to reduce inequity. For example, regulations are needed to control the tendency of private insurers to 'cream skim', that is, to select the low-risk, low-cost members of society and to dump the high-risk, high-cost patients on the public sector.

THE ROLE OF NGOs AS AN AGENT FOR CHANGE
Ms Barbara Klugman

NGOs evidently play a crucial role in the struggle for increased equity in health. In her paper, Ms Barbara Klugman, Director of 'Women's Health Project', a policy-oriented NGO connected to the Centre for Health Policy at University of Witwatersrand, South Africa, provided analyses how NGOs can play important roles in various policy processes. In addition to the more theoretical discussion, she illustrated her arguments through her personal experiences from the national policy process to achieve a cervical screening programme in South Africa and the international policy process for injecting a gender and rights perspective into the Cairo and Beijing UN conference documents. In the discussions following her presentation it was clear that there is a great potential for NGOs in the region to strengthen each other through informal networking, joint strategising and the establishment of more formal ways of collaboration.

The view that NGO participation is essential to good policy-making and implementation is widely accepted and has been institutionalised in international agreements. The

recognition of the importance of NGOs does not, however, always extend to national acceptance of NGO influence in policy and implementation, nor to the existence of NGOs able to play this role effectively. It is therefore important to consider the conditions under which NGOs can influence policy in the direction of equity; the skills required by NGOs in order to play this role; the strategies required for securing influence in the policy process; the legitimacy of NGOs; and challenges as well as opportunities facing NGOs concerned with health and equity in Southern Africa.

In particular, two factors determine the power of policy-oriented NGOs: whether they have won recognition from their constituencies and whether there is a general recognition of their skills. Although some might argue that policy-oriented NGOs acquire legitimacy through their accountability to communities or mass movements, in reality, they are winning legitimacy in their own right. A policy-oriented NGO's legitimacy seldom reside in being a representative organisation; rather this legitimacy is a result of the organisations commitment to ensure that the experiences and concerns of disadvantaged constituencies influence the policy agenda, process and outcome.

Several factors facilitate NGO involvement in the policy terrain: For example, NGOs can take advantage of the lack of research and strategic resources within the formal policy framework. By having access to information, skills and analyses which other parties lack, they can secure recognition and exert influence. A strategy of having members involved in delegations and formal decision-making fora can sometimes be an important means of gaining status and influence.

Skills required for policy activism include strategic competence and a deep understanding of the strengths, weaknesses and various roles of the actors in the policy process. Skills also involve the ability to involve those who have been most disadvantaged by past policies; facilitation skills to win trust among a range of stakeholders; and, imagination in order to identify appropriate actions. In addition, NGOs need to be able to collaborate with each other in alliances; produce or access relevant information and research; and develop their capacity for effective advocacy of their policies, including lobbying and gaining access to the media.

Factors that might constrain Southern African NGOs from collaborating effectively towards equity in health include the different political and economic contexts across countries in the region and the fact that most Southern African countries have a political environment not amenable to participation in the policy-making process by either NGOs or other stakeholders. As a result, policy-oriented NGOs constantly need to push for space. Also significant are differences in organisational cultures and in how NGOs perceive their roles; a strong dependency on donors for funding; and the lack of institutionalised fora in the region for NGO collaboration and participation. It would therefore be useful if SADC, when developing its new health sector, could provide a forum where NGOs can both lobby and lend support in developing appropriate regional policies.

Factors that facilitate NGOs working for equity in health in the region include the potential sharing of resources and experiences across boundaries and a growing trend towards democratisation. Mass-based organisations and NGOs increasingly explore the meaning of citizenship and how to create and entrench open government and a culture of human rights.

POPULATION AND EQUITY IN HEALTH
Dr Marvellous Mhloyi

Dr Marvellous Mhloyi, demographer and Director of the Department of Sociology at the University of Zimbabwe, presented her paper 'Population and Equity in Health' with an aim to provide a general understanding of the demographic aspects of disparities in health, both within and between countries.

Equity, health and economic growth are clearly connected to demographic factors such as fertility, mortality, and migration. High population growth undermines productive investment and consequently economic growth. However, increasing access to secure income, rather than high national economic growth *per se*, is linked to improvements in health and education which in turn drive fertility declines. Most populations of Southern Africa are still growing at fairly high levels, although with some significant declines in Botswana, South Africa and Zimbabwe. The marked fertility declines are to a large degree results of development in education, the improved status of women, and urbanisation—although, some of the gains in education are being eroded by economic reforms. However, in contrast to this 'development-driven' fertility decline, there is also a 'crisis-driven' fertility transition taking place in the region, due to the economic crisis, droughts, and diseases such as HIV/AIDS. Thus, the current demographic scenario in Southern Africa is characterised by marked fertility decline due both to development and the lack of it.

Policy formulation and implementation in the region is dominated by the view that economic growth is the basis for poverty alleviation and the meeting of social needs. Powerful international institutions, such as the World Bank, often seem to assume an implicit trade-off, rather than complementarity, between economic growth and improving social sectors. Yet, experience shows that unless health and consequently mortality rates are at acceptable levels, human welfare will not be achieved, which will in turn ultimately affect fertility levels as well as macro-economic performance. Equity in health is thus an important principle both from a demographic as well as an economic point of view. Moreover, fertility is kept at high levels because women are faced with inequities such as not having easy access to credit facilities and being less likely to attend school than males. Having many children for economic security and as insurance against crisis places an inequitable burden of risk on women as maternal mortality rates are high in many Southern African countries.

An additional population-related factor influencing health in the region is the high level of migration, both internal and international, which facilitate the spread of diseases.

TRAINING AND RESEARCH FOR SURVIVAL
Dr David Sebina

In order to stimulate discussions on the role of training and research to increase equity in health, Dr David Sebina, former Permanent Secretary at the Ministry of Health in Botswana and at the time of the Seminar working as consultant for the WHO in Namibia, presented his paper 'Training and Research for Survival'. In his presentation, Dr Sebina drew on ideas and experiences from earlier initiatives with the aim to stimulate a new effort to set up a regional Southern African school of public health.

All the countries of Southern Africa have drawn up policies on human resource development, planning, employment and utilisation to address personnel requirements for community-based health delivery systems. However, critical shortages of public health professionals remain a major constraint on achieving equity in health and health care in Southern Africa. The unmet needs in public health training in the region have led to a severe shortage of public health professionals with the necessary skills to plan, manage, implement, monitor and evaluate the health system of the region.

There is need for long-term capacity building and institutional support for a regional facility for training and research in public health. Such a facility in the form of a fully fledged Southern Africa School of Public Health would not only undertake teaching and research, but provide a service in public health. The school would be a centre of excellence for teaching, discovery, application and integration. It would participate in health policy formulation, analysis and implementation; address the human resources development constraints of the region; respond to the essential public health functions and needs; and address the determinants of health and important health problems among the member countries.

The idea of a regional school of public health for Southern Africa is not new. In 1985, the University of Tulane, USA, carried out a feasibility study and recommended that a public health school rather than a department within a medical school be established. The proposed facility was to be accorded a full faculty status and a budget of its own. It was to be multi-disciplinary offering degree courses in the desired and relevant areas.

Several options for a management structure are possible: (a) It could be established within the African Capacity Building Foundation based in Harare, which includes African governments and bilateral donors as members; (b) a separate facility for public health training and research could be initiated by SADC, multilateral and bilateral agencies; (c) it could come under a SADC initiative of the Human Resources Development Sector and/or the new Health Sector in collaboration with other partners.

New opportunities exist for partnership, collaboration and alliances in public health training and research where the SADC could take a lead role involving public health schools, other renowned schools of public health overseas, private foundations and multilateral and bilateral partners. A facility with such backing could advance the goal of equity in health and health care in the region through the application of science and appropriate technology.

There are risks and uncertainties concerning regional training and collaboration. These include macro-economic performance and vulnerability; fragile political systems; weak managerial capacities; brain drain; donor fatigue, political will and commitment; availability of space and legal protocols. All these factors deserve consideration to minimise potential conflicts among regional partners.

Summaries of Country Case Studies

In preparation of the seminar, participants from four countries were asked to prepare case study presentations on the equity in health situation in their respective countries. The purpose was to share examples of both accomplishments and problems, as well as to provide a pool of examples that could be referred to and which could be used to concretise discussions during the seminar. Countries were selected with an aim to achieve substantial diversity: Botswana was chosen as an example of a country which has not undergone economic structural adjustment programmes imposed by external agencies; Zimbabwe as a country which has been deeply affected by structural adjustment; Mozambique as a country which has suffered immensely by war and economic sanctions; and finally, Sweden as an equity-oriented country which, despite the vast differences in many regards to Southern African countries, may have relevant experiences, both positive and negative, to share.

EQUITY IN HEALTH: THE BOTSWANA EXPERIENCE

Edward T. Maganu and Mbulawa Mugabe

The Botswana experience of equity in health was presented by Dr Edward Maganu, former Permanent Secretary at the Ministry of Health in Botswana and presently Regional TB Adviser at the WHO Liaison office in Pretoria, together with Dr Mbulawa Mugabe, research fellow at the National Institute of Development Research and Documentation, University of Botswana.

Classified among the least developed countries in the world at independence in 1966, Botswana faced the major challenge of providing basic health and social services to a predominantly rural population dispersed over a vast area. The strategy adopted which was articulated in Government Paper No 1 and 2 of 1972/73 entitled Accelerated Rural Development (ARD) was the establishment of a basic social infrastructure to include health. ARD was premised on the recognition that health is a product of total development and therefore activities in other areas such as education, water, employment, income and food were equally accelerated as part of the improvement of health.

Because of the lack of basic social services at independence, equity in health and health care in ARD was conceived of primarily as a matter of making such services accessible to all citizens. Accessibility was defined in physical terms; the aim was to ensure that every citizen was within 15 km of a fixed health facility. By the 1990s, it was estimated that 85-90 per cent of the population was within 15 km and 70 per cent within 8 km of a fixed health facility. However, coverage is much higher in the eastern corridor of the country where most of the population lives and poorer in the western part of the country where about 15 per cent of the population is scattered across a vast area and living in isolated settlements. As a strategy for strengthening equity in access to health services, these were decentralised through the primary health care system (PHC), with services delivered through a network of clinics, health posts and mobile clinics backed up by a national referral system. These PHC facilities are run by the local authorities (districts/towns/city councils) and financed by the government. In recent years, the annual development budget of the Ministry of Health has ranged between 2 per cent and 5 per cent of the total annual government development budget. This does not include health allocations to local authorities for the delivery of basic health care services. The education sector gets on average 20 per cent of the annual development budget.

Varying levels of development in the different districts of Botswana contributes to inequity and disparities in health indicators. For instance, in 1991 the average national infant mortality rate was 45/1000 with a district variation between 32/1000 and 85/1000; in 1996 the average national undernutrition rate was 13 per cent with a district variation between 8.4 per cent and 19.3 per cent; immunisation coverage for BCG in 1994 showed a national average of 92.3 per cent with a district variation of between 88.6 and 96.3. Measles immunisation coverage in the same year averaged 71.3 per cent with a district variation of between 60.7 per cent and 83.5 per cent. Geographical or district variations are the clearest, while data on other dimensions of inequities in health and health care such as social class and gender are lacking in Botswana.

Constraints to equity in access in Botswana include small scattered communities, long distances and poor roads, especially in the western part of the country. Research shows that the delivery of health care services becomes progressively more expensive as one moves from the east to the western part of the country, largely covered by the Kalahari desert. The same applies to infrastructure development. Among the new ideas under consideration for contributing to greater equity in health in Botswana are cost recovery in the form of user fees and pre-paid schemes as a means of increasing resources in the health sector. Consideration is also being given to the promotion of a private-for-fee sector. One of the greatest challenges is to overcome the lack of a defined minimum package of essential health care services that can be guaranteed to all groups in society.

EQUITY IN HEALTH: THE MOZAMBIQUE EXPERIENCE
Dr Pascoal Mocumbi

Dr Pascoal Mocumbi, Prime Minister of Mozambique, a medical doctor by profession with former positions as Minister of Foreign Affairs as well as Minister of Health, presented the case study from Mozambique, describing the innovative work that has been undertaken to operationalise the goal of increasing equity in health. The development and use of indicators to monitor progress and allocate resources raised much interest among the participants.

Equity in health care provision was perceived as a major concern of the health sector in Mozambique at independence in 1975, at which time the inequities inherited from colonial rule were evident in all sectors: health care provision, access to education, water, roads and other basic infrastructures. Attempts to address these inequities were halted by the devastating 16-year civil war that destroyed economic and social infrastructure and in particular primary health care facilities, schools and communication networks. All this had a severe impact on the health of the population and aggravated inequalities even further.

Since 1992, Mozambique has been engaged in a process of defining and redefining indicators that would assess equity in health and health sector development in the post-war era. This exercise is informed by a conceptual framework that considers two types of equity: horizontal equity—where people under the same conditions should have the same benefits such as access to health care and education; and vertical equity—where people under different conditions should have different benefits so that, for example, the poorer are accorded more benefits, the vulnerable (women and children) are given priority in health care provision, and low income earners pay less tax.

The first step in defining indicators for equity was to establish a suitable double-purpose indicator for assessing equity of health sector development processes which could also act as an operational tool for planning resource allocation. Indicators relate to a range of activities, each being given a relevant weighting in terms of time spent and the corresponding approximate cost. A service unit indicator would be the sum of activities carried out in a specific field, multiplied by a factor related to the performed activity and its costs. Once the number of service units in each district is determined and the population and the number of existing health workers are known, two other indicators may be calculated: the ratio of service units to local population and the ratio of service units to health staff. The former measures the population's access to health care, while the latter measures the health workers' productivity. The ratio of service units to local population would be the more relevant for assessing equity in access.

Equity measurements at the provincial level is done through the Inequity Index. In calculating this index, two groups of districts are used, one of favoured districts and the other of disadvantaged districts, altogether accounting for 25 per cent of the province population. The mean ratio of service units to local population in the two groups of districts are calculated, and the coefficient between these mean ratios constitutes the Inequity Index for the province. The lower the Inequity Index is, the better the equity in health care provision of the province. Its position on the index should be compared with that of previous years to monitor equity trends over time.

Equity in health care provision is achieved through an ever-improving resource allocation mechanism. In a normal operational planning exercise, it is important that both the ratio of service units to local population and the ratio of service units to staff are used as indicators. This conceptual framework for assessing equity could assist in the allocation of scarce resources to reduce inequities in health and health care.

EQUITY IN HEALTH— A SNAPSHOT OF DECADES OF STRUGGLE IN SWEDEN

Professor Göran Sterky

Professor Göran Sterky, founder of the Department of International Health Care Research at Karolinska Institutet, Stockholm, presented an overview of the Swedish experience in the struggle for equity in health. Professor Sterky, who started working with the Dag Hammarskjöld Foundation on health issues already in 1973, noted that despite Sweden's success in reaching almost complete equity in access, inequities in the state of health still remain between different groups.

The health status of the Swedish population is good, as measured by any available indicator. However, inequalities in health remain despite many efforts—although these inequalities are small by international standards.

The health care system is an integral part of the Swedish welfare state which has been made politically sustainable through a system of social policies where cash benefits and service provision are tailored to satisfy not only the basic needs of the population but also the higher expectations of the middle classes. The readiness of the middle classes to pay taxes and support policies based on a high level of taxation is sustained because they themselves benefit from the system.

Social rights are guaranteed to all citizens and there is a welfare system covering, for example, health services, parental leave, insurance schemes for compensation of income loss due to sickness, prevention of and compensation for occupational injury, advisory and counselling services, disability allowances, and extensive subsidy programmes for housing costs, medical drugs and the use of health services. To a large extent, Swedish health and social policies are based on intersectoral collaboration.

The health care system is publicly managed under 26 county councils. The financing of the system is done mainly through proportional income taxes levied on the population, but also through grants from the central government and the social insurance system, together with flat-rate payments from patients at the point of service delivery. Since 1970 all patients have paid a uniform patient fee for each visit to a physician—a major aspect of equity. A general employment scheme makes it impossible for doctors to earn extra money from running private services on the side.

As part of the general welfare system, health services have been developed in line with the societal objective that all residents should have access to health services related to every need and that these services should be of high quality rather than just being basic. Health care during pregnancy and delivery is free, as are health services for pre-school and school children. All social classes utilise these services and the system could perhaps be said to exemplify the concept of 'something for all and more for those in need'.

However, in spite of equity in access and utilisation, health outcomes are still unequal. The 1982 Health and Medical Act stated that health care should aim at levelling out inequalities caused by differences in age, sex, income and education. Thus, during the 1980s the elderly and chronically ill were given preferential treatment. Nevertheless, inequities remain. It has been estimated that a reduction of total mortality for the whole population to a level which is now experienced by higher-income groups, would mean that mortality would need to be reduced by as much as 20-30 per cent.

The 1990s have so far posed serious challenges to the existing welfare system and to the possibilities of improving, or at least maintaining, the high degree of equity in health. In essence, Sweden is undergoing a process of structural adjustment which is in several regards similar to that of many developing countries. Public spending is being reduced, with the aim of balancing the budget and reducing the external debt burden. As a result welfare schemes and health services are being cut back. Many health workers have lost

their jobs which has led to higher unemployment rates and decreased capacity within the health care system. Those remaining are becoming overburdened, which causes tension and ill-health. In fact, the welfare and health care situation is one of the hottest issues in the public debate today.

It is difficult to distinguish the effects of the various elements of health care reform. At present there seems to be no clear answer as to what the optimal balance between equity, quality, efficiency and cost-containment would look like.

EQUITY IN HEALTH: THE ZIMBABWEAN EXPERIENCE
Ms Gift Mwanyisa

Ms Gift Mwanyisa, Chief Evaluation Officer at Family Health International, Harare, presented a country case study from Zimbabwe, examining the post-independence efforts to increase equity in health and the difficulties faced in recent years.

Inequities characterised the health care delivery system of colonial Zimbabwe. The majority of Zimbabweans were denied access to basic health care. Most health facilities and personnel were concentrated in the urban areas. The rural areas, where 75 per cent of the population lived, relied on health services provided exclusively by religious mission facilities. Access to health care was determined by race, geographical location and socio-economic status. The effects of these disparities were mirrored in various health and health care indicators.

At independence, the government quickly moved to address these inequities in health and health care. Equity considerations were central to the government strategy of transforming the health care system to accord every citizen access to health and health care. This approach was clearly articulated in a government policy document entitled Planning for Equity. The new policy thrust sought to redirect resources in order to provide comprehensive primary health care to the majority of the population. This focus was accompanied by substantial investment in the social sector through the expansion of basic infrastructure in health, education, water and other basic provisions, investment which transformed health and health care indicators during the 1980s. By 1988, antenatal care coverage was approximately 90 per cent with 80 per cent of the women giving birth in institutions (90 per cent in urban areas and 60 per cent in rural areas). Infant mortality rate had declined from 140/1000 to 73/1000. Access to services expanded significantly and, by 1994, 80 per cent of rural women lived within 8 km of a health facility.

The downturn in the economy in the 1990s, aggravated by a prolonged drought, forced the government to accept the Economic Structural Adjustment Programme (ESAP). This programme severely compromised the pursuit of equity strategies in health care delivery and other aspects of the social sector. The impact of this has been the erosion of the major equity gains in health and health care achieved throughout the 1980s. The government was forced to reintroduce user fees in the health sector as part of the ESAP cost-recovery programme, resulting among other things in a decline in access to and utilisation of health care services. The impact of ESAP on equity in health and health care needs closer monitoring to ensure that the programme does not further erode the equity gains Zimbabwe has made.

Summaries of Plenary Discussions

The following section summarises discussions that took place in connection with the presentation of the different papers and is divided into four cross-cutting themes. Each theme thus reflects viewpoints and debates from various discussions held during the whole seminar. Much of the discussion that took place during the seminar is also reflected in the Agenda for Action (Appendix 4).

EQUITY IN HEALTH

Should health be regarded as a right? What are the potential risks and benefits of promoting health as a constitutional right? What is the definition of equity and what does equity in health really mean? Discussions on the tricky issues of the concepts of equity, rights and equity in health came to the fore throughout the seminar. Most participants argued that health should be regarded as a constitutional right, and the principle of equity always requiring an equal response to equal needs. Some participants argued, however, that in countries with poor resources a Rawlsian view of distributive justice would be more appropriate, meaning that as a first goal policies should lead to increasing the well-being of the poor, while only as a secondary goal the degree of inequality should be reduced. Some participants stressed that the individual rights agenda needed to be recast into a social rights agenda, turning away from the usual human rights debate, which, it was pointed out, could result in increasing inequities as privileged people would be better able to claim their rights. It was argued by some that this was exactly the kind of risk that positioning health as a constitutional right might incur. The latter position was challenged, however, by those maintaining that health as a constitutional right would necessarily have an equity orientation, justifying the curtailing of individual rights in favour of the protection of public health.

Furthermore, it was proposed that equity should be seen not only as an instrumental value but as a goal in its own right, including not only aspects of equity in access to health services and other factors promoting health, but also equity in utilisation of such services and health outcome—the actual state of health. Equity in health would in this respect necessarily involve the need for procedural justice in addition to the more narrow view of equity as largely a question of distributive justice.

Some expressed concerns arguing that rights must be practically achievable in order to be useful; otherwise they would run the risk of being neglected or not taken seriously. In this connection, it was argued that the right to complete health and the right to equal health were both goals that could probably never be achieved and that the right to equal *access* to health services would be the only right that could actually be implemented.

Several participants pointed out that equity must be regarded as a process—a dynamic goal that has to be constantly fought for as conditions change. Another aspect that many participants raised was the need to place equity in health in a larger context of overall equity in society. In the struggle to reach equity in health, one would necessarily have to struggle for equity in most other areas of society as well.

HEALTH AND THE HEALTH SECTOR

During the seminar, discussions constantly moved between issues specifically concerning the health sector and broader issues of health and development. Due to the broad mix of participants, the common tendency of only focusing on the health sector, and even more narrowly on medical care, was at least partly avoided.

There was broad consensus that the state of the health sector is poor in most countries of the region. The health sector seems powerless in comparison with many other sectors

of society. Yet, health needs to be put at the top of the agenda. In most countries, the health sector is plagued by dissatisfaction and lack of motivation among its workers, which together with client/patient dissatisfaction become a vicious circle. Due to decreased social spending, the financing of the sector has been severely curtailed and finding new ways of management and financing seems critical.

The issues of decentralisation and health sector reform were extensively debated. In many African countries health sector reform is presented as a panacea both by the Ministry of Health and external actors such as the World Bank and WHO. Although there was some disagreement on how successful such reforms had actually been where implemented in the region, there was broad agreement that decentralisation and community participation are important means to improve the system. Many participants warned, however, against regarding health sector reform as a universal cure and pointed out that reforms needed to be carefully crafted to suit each country's particular situation.

Participants agreed that given the ultimate goal of improving health for all, innovative thinking and thoughtful allocation of resources to the areas where most gains can be made is needed. Responding to this, Max Price, in his paper 'Health sector development—where does equity feature', presented an overview of various alternatives to the widely debated perspective of either totally public or completely private provisioning and financing of health services—thus triggering discussions on the 'public-private mix'. The paper argued that as long as one's objectives are clear, it should be possible to find new alternatives, involving the quasi-public and the private sectors, that would contribute to improved health as well as increased equity. Some participants argued that the important point was to make the public service more cost-effective without worsening the imbalances between the poor and the well-off. Based on this reasoning it was proposed that efficiency should be defined in terms of the promotion of equity. Many participants noted the apparent conflict between equity and the strive for efficiency, although several noted that there would not have to be an inherent conflict between the two.

Many stressed the need for intersectoral collaboration and it was pointed out that national improvements in water and sanitation and mass immunisation undertaken by the state, rather than direct medical intervention, had been the most instrumental factors in reducing the burden of disease in Europe. The challenge was to introduce equity in health as an objective into other sectors. In this context it was recognised that one weakness on the government side is that Ministries of Health are generally weak, and often have a rapid turnover of both Ministers and staff.

In plenary discussions, decentralisation and the challenge to improve intersectoral collaboration were singled out as particularly important issues to be discussed further in small groups (see the Agenda for Action for the final outcome of these discussions).

PARTICIPATION

The need to place equity in health in a context of participatory democracy was repeatedly emphasised during discussions. In addition to being an important goal in its own right, participation was also seen as indispensable in the struggle for equity in health. Participants agreed on the important role that NGOs, grassroots and people's movements, traditional healers and all the different stakeholders could, and should, play in policy-making.

Barbara Klugman highlighted in her paper 'The role of NGOs as an agent for change' how NGOs can successfully influence the policy-making process. Depending on the overall policy context, rights and policy-oriented NGOs may either be able to use existing political space or otherwise use their strength and skills to claim such space. To be

successful, they need, most importantly, to be able to strategise in innovative ways. Their power, ultimately, lies in being recognised by their constituencies and in the successful utilisation of their skills.

It was noted that although it has become fashionable for governments to express their recognition of NGOs and the need for participation as crucial for development, the reality is somewhat different. There is a clear tendency for governments to favour development and service-oriented NGOs while opposing rights and policy-oriented organisations which they regard as threats to their power base. Participants encouraged Southern African policy-oriented NGOs to enhance collaboration within the region and called on governments and SADC to adopt policies to facilitate participation by NGOs.

Stemming from the presentation by Barbara Klugman, participants also discussed the legitimacy of NGOs and their role *vis-à-vis* their constituencies. Klugman pointed out that in order to meet the goal of equity, NGOs 'must develop strategies to involve those who have been most disadvantaged by past policies, and who have the most to gain by policy change, so that the policy intentions reflect their goal'. However, she stressed, it would be incorrect to claim that policy-oriented NGOs acquire their legitimacy by being accountable to communities or mass movements. Rather, they gain their legitimacy in their own right, through their expertise and skills, and because of the goals they are pursuing.

Several participants emphasised the need to regard health as a function of participatory democracy, both at the international and the local level. At the international level, it was proposed that the Southern African region should build much stronger, participatory forms of regional cooperation, using health and human development as key levers for removing obstacles to integration. At the national and local levels, participatory democracy would involve all stakeholders in the policy-formulating process, and, as expressed in René Loewenson's paper 'Policies for Health', 'a return to the experience of inclusive, community-oriented approaches, such as community-oriented drought relief and supplementary feeding programmes and the comprehensive outreach of free primary health care'. In order to find ways to achieve equity in health, a clearer understanding of the power relations and the social interests and forces that influence policies would have to be developed.

It was observed that there is a potential within the region to accelerate the development of the health sector provided there is vigour and maximum determination. Broad consultations and participatory approaches involving all stakeholders could greatly help in this process.

THE ROLE OF EXTERNAL ACTORS AND INSTITUTIONS

One of the most important cross-cutting discussions focused on the role of external institutions and their influence on policies in the Southern African region. Many participants strongly maintained that these institutions—the World Bank, the IMF, the Africa Development Bank as well as multilateral health-oriented organisations such as WHO, UNICEF and UNDP—often cause or exacerbate problems. The ideological and financial power of these institutions often prevent indigenous, locally based policy initiatives from developing.

It was pointed out that the structural adjustment programmes imposed by the IMF and the World Bank in combination with unfavourable international trade agreements and other forces of globalisation are seriously undermining the possibilities of most Southern African nations developing their social sectors and following their own, culturally appropriate, models of development.

Although there were differences in the degree of criticism of these multilateral institutions, all participants agreed on the need to develop Southern African-based alternatives and on the potential power of Southern African states to develop joint policies and positions. It was recognised that, all too often, politicians or government officials lack the confidence to challenge external institutions, partly as a result of lack of skills and expertise. In this connection, it was noted that there is a major need to develop the capacity for critical analysis and scrutiny of the ideologies of these institutions. Some participants pointed out that often such capacity might be found among policy-oriented NGOs, thus providing further reasons for taking NGOs seriously, and including them in the policy-making process.

CONCLUSION

The Seminar strongly emphasised the urgent need to tackle inequities in health and to strengthen Southern African collaboration on these matters. Despite the diverse backgrounds of the participants, there was a clear consensus on the importance of critically questioning current trends, both those imposed by external actors as well as countries' own policies. The formulation of an 'Agenda for Action' was thus the group's modest attempt to provide a joint, endogenous Southern African proposal for how to improve the situation. There was also a recognition that health, as seen in its broadest intersectoral context, must gain in status and be put at the top of the development agenda. Regional collaboration through the formation of formal and informal networks, joint projects and other links are crucial in this endeavour.

The opportunity to discuss, in a free and frank atmosphere, issues of health and equity with participants from a variety of backgrounds was much appreciated. It was suggested that these kinds of fora be organised regularly so as to enable open debate and input to the policy process by all stakeholders. One suggestion would be to set up such a forum in connection with the SADC ministerial meetings, perhaps organised and financed by the newly established SADC health sector.

It is time to start implementing and operationalising the proposals put forward in the Seminar. The Agenda for Action, which has been widely distributed both within and outside the Southern African region, outlines a number of action items that could be taken up. While many of these items could be tackled by single countries, organisations or individuals, other items require collaboration and networking. One concrete and very promising example of a regional follow-up activity to the Seminar is the formation of a 'Regional Network on Equity in Health in Southern Africa' (EQUINET). The network was initiated by the Training and Research Support Centre in Harare with the aim to conduct relevant research and to influence the policy-making process in the region.*

Challenged by the grim state of health in the region, participants in the seminar showed great spirits, a deep commitment and a strong will to formulate their own, Southern African solutions. The challenges are huge, but as the seminar showed, there is an enormous potential to work constructively towards the ultimate goal of equity in health.

* As a first activity, an annotated bibliography on equity in health related literature relevant to the region has been compiled. The network is currently embarking on new equity-oriented research projects with an aim to involve stakeholder groups and ultimately influence policy-making. The bibliography and other material will be possible to order or download from the EQUINET web-site (details about the web-site and other information can be obtained at tarsc@icon.co.zw). The bibliography can also be downloaded from the Dag Hammarskjöld Foundation web-site (www.dhf.uu.se).

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APPENDIX 2: SEMINAR PROGRAMME

WEDNESDAY, 12 MARCH	afternoon	Checking in at the Mowana Safari Lodge; welcome drink
	18:30	Reception given by the Minister of Health of the Government of Botswana
	20:00	Dinner
	8:30	Gathering at the seminar room
	9:00	**Opening statement** *His Excellency, the Vice-President of the Republic of Botswana Festus Mogae* Session chaired by the Vice-Chancellor of the University of Botswana, Professor Thomas Tlou
	9:30	Coffee or tea
	10:00	**Introduction to the seminar, expectations and brief introduction of the participants** *Marvellous Mhloyi*
	11:30	Health, Health Sector and Development *Olikoye Ransome-Kuti*
		Questions and clarification
	12:30	Lunch
	14:00	**Policies for Health and Development** *René Loewenson*
		Reflections **Discussion**
	15:30	Coffee or tea
	16:00–17:30	**Population and Health in the Southern African Region** *Marvellous Mhloyi*
		Reflections **Discussion**
	19.30	Dinner

FRIDAY, 14 MARCH	**9:00**	**Country case studies of equity and health** • Botswana: *Mbulawa Mugabe, Edward T. Maganu* • Zimbabwe: *Gift Mwanysia* • Moçambique: *Pascoal Mocumbi* • Sweden: *Göran Sterky* • Zambia: *Patricia Ndele*
	12:30	Lunch
	13:30	**Policies for Health Sector Development—Where does equity feature?** *Max Price*
		Reflections **Discussion**
	15:45	End of session
	16:00	**Boat ride**
	19:30	Dinner
Saturday, 15 March	**9:00**	**The Role of NGOs as an Agent for Change** *Barbara Klugman*
		Reflections **Discussion**
	10:30	Coffee or tea
	11:00	**Training and Research for Survival** *David Sebina*
		Reflections **Discussion**
	12:30	Lunch
	14:00–19:00	**Group work**
	19:30	Dinner
SUNDAY, 16 MARCH	**8:00**	**Presentation of Draft Southern African Agenda for Equity in Health** **General discussion**
	10:00	Coffee or tea
	10:15	**Discussion on follow-up**
	11.30	**Closing session** *Hon. C.J. Buthale, Minister of Health, Botswana*
	12:00	Lunch
	13:00	Departure from the hotel
	14.00	Departure from Kasane Airport
	17.15	Departure from Victoria Falls Airport

APPENDIX 3: ORGANISING INSTITUTIONS

THE DAG HAMMARSKJÖLD FOUNDATION

The purpose of the Dag Hammarskjöld Foundation is to organise seminars, conferences and courses on the political, social, economic, legal, cultural and environmental issues facing the Third World. Activities have developed from training courses in the strict sense into comprehensive seminar projects at the interface between research and policy. In particular, the Foundation has concentrated on issues relevant to alternative development strategies in such areas as, e.g. rural development, health, environment, education, science and technology, international monetary policy, information and communication, and participation. In these efforts, the Foundation works closely with governments in developing countries, civil society organisations, researchers and research institution, as well as the United Nations and other inter-governmental organisations.

In the field of health, activities started as early as 1973 with a seminar on 'The Dilemma of Quality, Quantity and Cost in African Child Care' in Addis Ababa, which was followed in 1977 by a seminar on 'Another Development in Health' strongly emphasising the importance of preventive measures and primary health care in improving the health of the populations of the Third World. This seminar had a significant impact on the Alma Ata Conference on Primary Health Care, organised by WHO and UNICEF the following year. In 1985 and 1992, the Foundation arranged seminars on the crucially important subject of pharmaceuticals in an effort to promote cheap, essential and useful drugs in place of expensive, dangerous and useless ones. Recently, the Foundation has also taken up the issue of reform of the global health cooperation system, in particular the need for the reform of WHO. In all these health oriented activities, the Foundation has worked closely with Professor Göran Sterky, who was also influential in the planning of the Kasane seminar.

THE NATIONAL INSTITUTE OF DEVELOPMENT RESEARCH AND DOCUMENTATION (NIR)

The National Institute of Development Research and Documentation, popularly known as NIR, was created in 1975 as a documentation centre of the University of Botswana. Shortly after, it grew into a research Institute with the Environmental Research Unit as its first subunit. The Educational Research Unit, the Health and Nutrition Research Unit, and the Rural Development Research Unit were created subsequently. In 1993 the Institute launched a Gender Research initiative for promoting and coordinating gender studies and research at the University and in the country at large.

The University of Botswana statute of 1982 set out the following objectives for the Institute: promote, coordinate and conduct research on issues of socio-economic, environmental, and cultural development affecting Botswana; develop the national research capacity within Botswana; and document, publish and disseminate the results of such research.

The Health and Nutrition Research Unit provides a focal point for analysis, evaluation, research and study of health status and health services in Botswana. The Unit's research thrust is on health services and health status evaluation; health transition research; health and social policy analysis and reproductive health research. The Health and Nutrition Research Unit is also involved in collaborative research activities with teaching departments of the University and at national level with the Ministry of Health and with some development agencies. The Unit also participates in health research and policy development and analysis fora at the national level.

APPENDIX 4

An Agenda for Action

Priority Issues for a Southern African Agenda as Identified by the Seminar 'Equity in Health—Policies for Survival in Southern Africa'

Kasane, Botswana, 13-16 March, 1997

The Dag Hammarskjöld Foundation, Sweden
The National Institute of Development Research and Documentation, University of Botswana

I . INTRODUCTION

BACKGROUND

The seminar on *Equity in Health—Policies for Survival in Southern Africa* was jointly organised by the National Institute of Development Research and Documentation of the University of Botswana and the Dag Hammarskjöld Foundation, Uppsala, Sweden from the 13 to 16 March, 1997, at Kasane in northern Botswana.

The seminar brought together 34 participants from eight Southern African countries, drawn from various disciplines and organisations. It included a range of people, such as politicians, policy makers, health and development practitioners, academics and NGO activists. This provided for broad and comprehensive discussions. All participants were invited in their personal capacities.*

The overall objective of the seminar was to identify and discuss critical issues of Equity in Health in Southern Africa and to explore and propose possible joint solutions and actions.

The seminar was opened by the Vice-President of the Republic of Botswana, Hon. Festus Mogae and closed by the Minister of Health of the Republic of Botswana, Hon. C.J. Butale.

THE IMPORTANCE OF EQUITY IN HEALTH

Based on the presentations and discussions in the seminar, it was concluded that Equity in Health involves addressing inequalities in opportunities for achieving health, including factors beyond the health sector such as access to productive resources, incomes, employment, water, shelter, food etc. Equity in Health further involves addressing the inequalities in the provision of and access to health promotion and health care, and the manner in which the health care system complements household capacities and shortfalls in meeting health needs. In this context, Equity in Health should be central to health and development efforts.

Despite international initiatives to place Equity in Health on top of the development agenda, disparities in health status persist, both within and between countries in the Southern African region, as well as at the global level. Although equity concerns have been central in development policies in the region, together with policies that emphasise sustainable human resource development, they have lost prominence to issues of macroeconomic stability, fiscal policy and efficiency, often under the influence of external actors.

In preparing for the seminar, six of the participants were requested to write papers on selected topics related to Equity in Health. In addition, four country case studies were prepared. This material formed the basis for the seminar discussions in which the participants acknowledged the need to formulate an endogenous, Southern African agenda for action that places equity as a priority in health and development policies.

The proposed agenda is a reflection of the nature and spirit of the discussions that took place in Kasane. The document begins by delineating key concepts used at the seminar

* This agenda for action reflects the discussions held at the seminar and particularly the group work reports. While there was broad agreement on the main issues discussed some participants did not necessarily agree with all suggestions made. A list of the participants is provided in Appendix 1 of this report.

and by presenting an overview of some major issues in relation to Equity in Health in Southern Africa. This is followed by a presentation of five areas where group discussions took place: equity in health, intersectoral collaboration and coordination, decentralisation, aspects of HIV/AIDS, and public health training and research. Each of these areas are arranged with subsections headed 'Critical issues', 'Areas for regional support for National Action' and 'Areas for Regional Joint Action'.

II. DEFINITION OF KEY CONCEPTS USED BY THE SEMINAR

EQUITY

The seminar noted that the concept of equity has a number of dimensions and interpretations, and that follow-up work should aim towards conceptual clarity and a clear operational definition. It was agreed that equity does not mean equality. Participants observed that equity is a dynamic concept that signifies equivalency and comparability and should be conceived as a process. A distinction was made between 'vertical equity' (or providing different inputs according to different needs) and 'horizontal' equity (or equal treatment for equals). It was recognised that a priority focus needs to be placed on vertical equity. The participants distinguished between different aspects of equity in relation to health: equity in opportunities relating to the political, social, economic, and environmental conditions affecting individuals and communities; equity in access and provision relating to health services and inputs; and equity in outcomes relating to the state of health that results from opportunities and access. Equity in Health as used in this document includes all these aspects.

HEALTH

The seminar adopted the WHO definition that health should be seen not merely as the absence of disease or infirmity, but as a state of complete mental, social and physical well-being. It was observed that there is a need to move away from a limited biomedical disease concept towards a comprehensive, holistic developmental concept of well being. Health care is an aspect of health, relating to interventions aimed at promoting better health.

Medical care is an even smaller component of health, concerned with biomedical interventions. Conventional approaches to health generally overemphasise the biomedical interventions (often curative) and their outcome as determinants of health. The need to focus on other determinants of health (political, social, economic, environmental, cultural) and how these should be tackled to promote health and prevent ill health were underscored.

RIGHTS

The seminar agreed on the basic principle that all people should have a constitutional right to equitable access and provision of health care and health promoting services. However, different opinions were expressed whether equity in opportunity and outcome should also be considered as rights. Some observed that such rights would be practically unattainable. Others believed that the expression of such rights was important to drive redistributive policies and programmes. All agreed that equity in health, involving opportunity, access, provision and outcomes, is a goal that the region should strive for.

III. EQUITY IN HEALTH

CRITICAL ISSUES

The unequal global and national economic order, which in turn lead to inequitable distribution of resources and disparities in health status, was mentioned as the most important factor limiting equity in opportunity. There was concern that current macro-economic policies are intensifying such inequalities, leading to economic and social poverty that undermine future opportunities for health. The under-developed and weak frameworks for participatory democracy further inhibits access to opportunities and services, particularly of women, aged, children and economically marginalised groups.

Equity in access and provision is limited by a scarcity of public resources, infrastructures and services, technical and allocative inefficiencies and inequitable coverage of services, including the lack of safe, affordable and efficient health inputs such as medicinal drugs. Furthermore, the inequitable access to essential health promoting services such as safe water supply, sanitation and nutrition were identified as major limiting factors. Other factors included pollution, environmental destruction, income constraints and inadequate health financing systems. Legal and social barriers also exist, such as those affecting the supply of and access to reproductive health services.

ACTION ITEMS

Areas of Regional Support for National Action

- Examine current development models to enhance and further develop people-centred approaches, building on sustainable human resource development and ensuring that determinants of health such as education, employment, clean water, sanitation, food security and clean environments are developmental priorities.
- Review and compare outcomes of policies and practices with regard to different groups in order to monitor and assess progress towards equity, and develop resource allocation planning tools that locate equity as a desirable goal.
- Review the legal constraints to access by vulnerable groups and put into place empowering provisions.
- Develop training, research and monitoring mechanisms designed to promote equity.

Areas for Regional Joint Action

- Initiate research to develop regional indicators of equity in order to facilitate the monitoring of Equity in Health both within and between countries in Southern Africa.
- Develop a disaster preparedness capacity at the national level, and the sharing of experiences and coordination at regional level.

IV. INTERSECTORAL COLLABORATION AND COORDINATION

The seminar agreed that intersectoral collaboration and coordination are important in addressing the challenges of Equity in Health. Because the major determinants of health lie outside the health sector, collaboration and coordination with other sectors are fundamental. The seminar also emphasised the challenge of sensitising decision-makers in other sectors to make health and equity part of their primary concerns.

CRITICAL ISSUES

The development of alternative human-centred development models must be based on effective intersectoral collaboration and the understanding of the complex interrelationships between issues that have traditionally been compartmentalised into separate sectors. However, approaches to intersectoral collaboration have differed between countries in the region with no obvious successful model to follow. The seminar noted that current trends towards the decentralisation of the health sector provide opportunities for integration of health and other social services, particularly at the local level where government sectors, private business and NGOs can be encouraged to interact and work together meaningfully.

Successful interdisciplinary work and effective intersectoral collaboration require communication across disciplines and should be emphasised at all training institutions in Southern Africa. The role of education/training and the supportive roles they can play in fostering intersectoral collaboration should be strengthened.

In most Southern African countries, external organisations active in the health and development fields are not often well coordinated. This may result in duplication of efforts and sometimes contradictory programmes and actions. In times of financial constraints and cut-backs in the social sector, efficient use of scarce resources is particularly important. Through effective intersectoral collaboration and coordination it should be possible to find ways of sharing resources.

ACTION ITEMS

Areas for Regional Support for National Action

- Establish intersectoral coordinating mechanisms around health issues at all levels.
- Initiate research to analyse successes and failures of intersectoral collaboration initiatives and their effect on Equity in Health and strengthen interdisciplinary approaches in existing institutions.
- Acknowledge the important role of traditional health systems and include these in intersectoral collaboration. Question uncritical adoption of modern technologies that mystify issues and disempower people.

Areas for Regional Joint Action

- Establish institutional mechanisms for the involvement of civil society and the private sector at national and regional decision-making levels, particularly with regard to universities and NGOs.
- Strengthen the objectives and approaches of SADC sectors which have a bearing on health, so that health concerns are articulated and prioritised.
- Support the establishment of the new health sector within SADC and ensure that it takes a broad, intersectoral approach to health.
- Once the SADC health sector is operational, invite Ministers from other sectors than health to attend the Health Ministers' sectoral meetings.

- Strengthen the NGO presence within SADC with a view to improving the capacity to promote issues of Equity in Health and formalise the right of NGOs to access SADC information and participate in SADC events.
- Request governments to ensure that bilateral and multilateral aid agencies as well as international organisations and NGOs providing health services do so within the framework of government policy and programme objectives whether at regional, national or local levels.

V. DECENTRALISATION

Participants recognised that decentralisation of the health sector as well as other sectors of government is a critical tool for increased Equity in Health. It is also a necessary (but not a sufficient) prerequisite for community participation in decision-making and can also contribute to improved efficiency in the use of resources. Decentralisation has a wider aim to promote participatory democracy. However, the seminar pointed out that if decentralisation is not accompanied by specific equity measures it may result in the transfer of costs to more vulnerable groups and an increase in inequity. It was also noted that, often due to technical and managerial problems and resource constraints, attempts towards decentralisation in the region have generally not been successful.

CRITICAL ISSUES

For effective decentralisation to take place, Ministries of Health can not be expected to decentralise alone: however, they could play the lead role to push the process forward. It is vital that resources, knowledge and information should not be concentrated only at central Ministries of Health but disseminated to lower levels. In particular, it is important to provide incentives to personnel to remain at the local level.

When discussing decentralisation, there is a tendency for economic aspects to be neglected. The seminar recognised that decentralisation without a decentralised budget is meaningless. Often budgeting and its control and personnel management (including hiring and firing) continue to be concentrated at the central level in many countries. Where user fees have been introduced, revenue collected still remains at central level and not available for use at the level where the fees are collected.

There should be a shift in the allocation of resources according to needs in order to address the issue of equity. Decentralisation models such as contracting NGO/private providers should be studied and at the local level the role of community health workers and traditional health care providers should be integrated in the decentralisation process.

ACTION ITEMS
Areas for Regional Support for National Action

- Explicitly state the objective of increased equity as a top priority in all decentralisation efforts.
- Find ways to shift the allocation of resources, which are currently in favour of curative services, towards preventive and promotive health services benefiting the majority of populations, particularly the impoverished and under-privileged.
- Involve a broad section of stakeholders in the decentralisation process at the country level.
- Provide adequate training in public health and health management for district level health workers and local health managers.

- Explore and study the merits of various health financing models that have been tried in various countries. Conduct research on appropriate and effective means of regulating the private sector.
- Support analyses of the conditions for decentralisation reforms based on the particular social, economic, political and cultural situation of each country.

Areas for Regional Joint Action

- Involve national and regional research institutions in joint research programmes with an aim to analyse current decentralisation reforms in the region and to formulate appropriate policies for decentralisation.
- Improve the circulation and exchange of information between the Ministries of Health and relevant institutions (training institutions, NGOs, private sector) in Southern Africa, e.g. by setting up electronic bulletin boards and databases.

VI. HIV/AIDS AS A REGIONAL PROBLEM

The HIV/AIDS pandemic is a public health concern with grave implications on the whole of society. It has serious consequences on equity in that it affects certain groups disproportionately in terms of risk, prevalence, access to care and support, and social and economic implications.

Participants recognised the need to ensure that interventions and actions do not lead to widening social and economic inequities, and that they address factors such as economic insecurity, poor working and social conditions, and gender inequality, which all promote and sustain high risk behaviours.

The HIV/AIDS epidemic is by its very nature a cross-border phenomena and must therefore be tackled from a regional perspective.In light of this, the Kasane seminar supported the development and implementation of comprehensive Southern African joint policies and actions, recognising that several programmes on HIV/AIDS have been outlined in regional fora such as the EU/SADC Conference on Regional Approaches to HIV/AIDS in Southern Africa (Lilongwe, Malawi, December 4-6, 1996).

CRITICAL ISSUES

In relation to such initiatives, participants emphasised the importance of assessing the implications of regional integration for the spread of HIV/AIDS. For instance, how does improvement in regional communications relate to HIV/AIDS? How do increased trade among SADC countries and cross-border movement of labour impact on the spread of the epidemic? The way forward, the seminar concluded, is not to discourage regional integration, but to assess its implications on the HIV epidemic and develop innovative mechanisms to minimise the spread of the disease. Furthermore, the impact of economic crisis and structural adjustment programmes on the spread of HIV was recognised.

In addition, some of the participants highlighted equity aspects of Home-Based Care (HBC), an issue they felt had been somewhat neglected. With a rapidly spreading epidemic and limited health care resources HBC is becoming increasingly important. In order to promote equitable quality of care and to reduce inequitable burdens on those providing the care (mostly women), regional collaboration to document positive and negative experiences and to develop improved models of HBC is needed. Participants

meant that for HBC to be an acceptable alternative, home-based care providers must be given substantial support, both in terms of resources and skills. The formal health care and social sectors, practitioners of traditional medicine and the private sector should play important roles in the support of equitable HBC systems.

ACTION ITEMS

Areas for Regional Support for National Action

- Strengthen, support and improve the coordination of organisations and programmes concerned with HIV/AIDS in Southern Africa.
- Document best practice in home-based care and develop systems for support to home based care providers (through training, provision of resources, assistance by health personnel etc.).
- Initiate research in traditional medicines, explore traditional therapies and work in collaboration with traditional healers.

Areas for Regional Joint Action

- Initiate efforts to assess implications of regional integration for the spread of HIV/AIDS.
- Examine the need for research on the relationship between macro-economic policies, economic recession and the spread of HIV.
- Examine the need for further analysis on equity aspects of Home Based Care in the context of HIV/AIDS.

VII. TRAINING AND RESEARCH

The Central role of Public Health Training and Research to improve Equity in Health in the region was underscored by the seminar. The development of a regional critical mass in Public Health skills and research is an indispensable way to achieve sustainable Equity in Health and improved health status. Improved Public Health Training and Research would also be important components of a strategy to reduce regional public health brain-drain and would in addition reduce the expenses for overseas training.

CRITICAL ISSUES

An increase in the number of people trained in public health is an essential and urgent requirement for the promotion of equitable health systems in the region to meet future challenges. Increased access to public health training for people from countries without such facilities is also required.

No country or initiative within the region has the breadth and depth to meet the full range of competencies required for a comprehensive public health training. There are, however, a range of institutions with capacity in some of the fields which can complement each other. There are also urgent needs for training at several levels. These include as the first priority, the building of a critical mass of academics able to sustain such training in order to achieve the second priority—the training of health system managers at clinic, district, and higher levels.

Recognising the limited existing capacity, and the need to build on existing resources, an incremental approach is proposed. At present it is not advisable to establish a new institution for public health training and research, but rather to build on and enhance existing institutions which have the appropriate competence in the region.

Many of the proposed actions, be it national or regional, put forward by the seminar demand capacity in multidisciplinary research. At present there are few such teams in the region to undertake the necessary research.

ACTION ITEMS

Areas for Regional Support for National Action

- Focus training on the building of a critical mass of Public Health academics from various disciplines who can later sustain the training of health system practitioners, researchers and managers.
- Involve the health sector, NGOs and the private sector in the development of Public Health curricula for Southern Africa.
- Support efforts that ensure gender balance in Public Health training and research.

Areas for Regional Joint Action

- Develop measures and incentives to curb regional brain-drain of Public Health trained personnel.
- Undertake an assessment of needs and resources in relation to public health training and research in Southern Africa.
- Identify existing public health training facilities in the region. Share information about curricula and the structure of training between institutions engaged in public health training and research.
- Develop systems of collaboration where lecturers and researchers are invited to teach and pursue research at each others institutions. Develop means of sharing of resources.
- Develop a system of public health training that enables students to take modules that are offered at other universities in the region. Ensure that students from countries without their own public health training facilities are guaranteed a certain number of places in existing regional institutions.
- Gradually expand the system to include accreditation at different levels, from certificates, diplomas, masters degrees and PhD training to specialist training. Develop a system of monitoring to allow in-service training and distance learning.
- Ensure, through SADC, the coordination of all regional initiatives in the area of public health training to avoid duplication.
- Ensure, through SADC, that interested donors are invited to support the initiative through 'basket funding'.

Immediate Proposals

- Commission a position paper on collaboration efforts for regional public health training and research for submission to SADC based on the above action items as terms of reference.
- Mobilise funding from external donors for the preparation of the position paper.

VIII. THE WAY FORWARD

The proposed agenda on Equity in Health for Southern Africa is a modest contribution to a process of addressing health inequities in the region. The seminar does not claim to have raised and discussed all the possible strategies for dealing with Equity in Health in Southern Africa. For this reason, it was resolved that this process should be carried forward to facilitate wider regional debate and action by various stakeholders. More specifically, the participants agreed on the following:

- The constitution of a working group to follow up on the recommendations of the seminar and present this agenda for endorsement by the Ministers of Health in SADC. It was agreed that this group should include the organisers of the seminar.
- The promotion of regional networking to enable the participants of the seminar and other interested individuals to continue their involvement in the process by, for example, advising the SADC Health Ministers, making input at SADC meetings, as well as meeting regularly to debate the issues and find means to initiate action in line with the agenda.
- To circulate the Agenda for Action on Equity in Health to Regional networks including NGOs, Public Health/Medical Schools of Health Sciences in the region, Ministries of Health, Bilateral and Multilateral Agencies.
- To forward the Agenda to the SADC Secretariat to make the necessary arrangements to have it discussed at upcoming SADC Summits.
- To commission one paper on the regional approach to public health training and research, and to examine the need for a paper on equity aspects of Home Based Care (HBC) in the context of HIV/AIDS. The National Institute of Development Research and Documentation (NIR) and the Dag Hammarskjöld Foundation were mandated to follow up on these recommendations.