

Health equity from the African perspective

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A recent draft of the report by the United Nations Development Program (UNDP), the Economic Commission for Africa (UNECA) and the African Development Bank (AfDB) suggests that most African countries will not be able to achieve the MDGs as scheduled. According to the report, sub-Saharan Africa will not be able to realize meaningful poverty alleviation despite the creditable record of relatively high economic growth rate over the last decade. The report attributes the shortfall of progress towards the realization of the poverty alleviation project to the compound problems of unsustainable development, design of the poverty reduction framework and increasing population (1).

The Committee of Experts of the 5th Joint Annual Meeting of the African Union Conferences of Ministers of Economy and Finance and the ECA Conference of Ministers of Finance, Planning and Economic Development—at their meeting in Addis Ababa in March 2012 to assess the progress made in achieving the MDGs in Africa—observed that promising trends are noticeable in education and gender parity (goals 2 and 3), infant mortality (goal 4), fight against HIV/AIDS (goal 5) and global partnerships for development and access to technologies (goal 8). However, the committee concluded, Africa needs to fast track progress to achieve poverty reduction by reducing unemployment, maintaining quality education, improving child and maternal health, ensuring environmental sustainability and increasing access to basic services (water, sanitation and essential drugs). Reducing inequity in access to social services remains a critical challenge for Africa and these inequities largely explain the continent's slow progress in attaining the health dimension of the MDGs (2).

Poverty reduction is the MDG goal most crucial to health equity. Anyangwe et.al characterize poverty as both the cause and the consequence of ill health. As they put it simply, “the low income of the poor cannot provide for adequate quantities of nutritious food and this low intake in turn leads to weakened, malnourished bodies incapable of adequate mental and physical productivity and incapable of fighting off disease”(3).

When one considers health equity in the African setting, it becomes very evident that Target 7C of the Millennium Development Goal related to water and sanitation has not been given the emphasis that it deserves. In rural setting,

one may have the best health facility with all the essential drugs and the most competent health personnel, but without adequate and sustainable access to potable drinking water and good sanitation the delivery of quality and equitable health care to the community will remain a mirage. Communicable and water-borne diseases will prevail, preventive measures will be difficult to implement and health personnel will abandon their posts because of their personal needs for clean water. In the implementation of the WHO recommended SAFE strategy for Trachoma Control, success in eyelid surgery and mass distribution of the potent antibiotic, Azithromycin, will not be sufficient to prevent and control the blinding disease without clean water for face washing and related environmental sanitation components.

Over the years, I have closely observed that villages that had been provided with adequate water supply had healthier children, happier community, dramatic drop in the incidence of infectious and communicable diseases with resultant overall improvement of their socio-economic status. The transformation is noticeable even from casual observation without sophisticated measurements. There is no doubt that the provision of water and sanitation contributes significantly to health equity. Unfortunately, in rural sub-Saharan Africa very limited resources are available for improving water supply and sanitation. It is unfortunate that only very few public-private partnerships are actively involved in this sector. In its recent report—titled “Off-track, Off-target”—the international charity organization, Water-Aid, pointed out that most countries in sub-Saharan Africa may fail to meet the MDG pledge of reducing by half the proportion of people without sanitation by 2015. Furthermore, only 20 countries in the region were reportedly on track to meet the MDG water target by 2015. The report highlights that diseases caused by unsafe water and poor sanitation cause more child deaths than AIDS, malaria and measles combined. Water-Aid calls on all governments across the world to do more to tackle the water and sanitation crisis (4).

It is against such background of rather challenging and pessimistic progress reports on the attainment of MDG targets that I will address health equity from the African perspective.

The concept of equity, as applied to health, has been the subject of heated discussions and debates for quite some

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time and has been defined in different ways. For the purpose of measurement and operationalization, Braven and Gushin define equity in health “as the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage. Inequities in health put group of people who are already socially disadvantaged at further disadvantage” (5).

The issue of the social and economic determinants of health (SEDH) has attracted global attention for some time. To that effect, the World Health Organization established a Commission on the Social Determinants of Health (CSDH) in 2005. The Commission submitted its report, titled “Closing the Gap in a Generation” in 2008 (6).

In their review of the literature on the social determinants of health, Eshetu and Woldesenbet point out that the WHO Commission report on the subject does not reflect the broader underlying health inequality factors in the world’s poorest countries such as Africa. Harmful traditional and cultural practices, the lack of good governance and accountability, weak economic performance, political instability, armed conflicts, etc. are conspicuously missing in the literature on this topic, factors that are particularly important from the African perspective. The authors of the review conclude that there is a need for the Africanization of the social determinants of health in order to build on the work of the WHO Commission to strengthen the global effort to achieve a better health for all the world’s poorest countries (7). In fact, when one examines the issue closely, its significance goes beyond its Africanization only. Among other things, it has to be country-specific. In Uganda, for instance, socio-economic factors, conflicts and displacement as well as poor health delivery were identified as causes of health inequity (8); while in South Africa, in addition to socio-economic status, race, eligibility for insurance and urban/rural divide were found to be formidable barriers to access health care (9). Generally speaking, inequity of health care in disadvantaged populations is a result of differences in accessing and utilizing health services according to gender, income, rural/urban residence and ethnicity.

Dr Loewensen, a founding member and coordinator of the Regional Network for Equity in Health in Southern Africa (EQUINET), identified poverty as the major contributor to health inequity, whose burden has been greater among women than men at the household level. She singled out the AIDS pandemic as a contributor to health care inequity and the overall decline of health in Africa. In her words: “HIV is placing great demand, great stress on services and resources, on households reducing social cohesion and polarizing access”. She further noted the inability of health systems to retain trained health personnel as adversely affecting the delivery of health services in an equitable manner. The

phrase “global conveyor belt of health personnel” that Dr. Loewensen coined aptly describes the exodus of workers from health services in rural areas to urban public and private services and from poor countries in the African region to wealthier Europe and North America (10).

Other factors compounding the problem of health care inequities in Africa include natural and man-made disasters such as drought and armed conflicts, conditions placing additional burden on already limited resources allocated to health care. As a case in point of natural disaster, the Horn of Africa recently experienced drought-caused famine and a similar threat is looming over countries in the Sahel region of West Africa.

To promote the equitable distribution of health services, under-resourced countries have welcomed mobilizing additional resources through public-private partnerships as a means of financing public health programs. As a result, many such partnerships—involving UN agencies, philanthropic foundations, civil society organizations and pharmaceutical companies—have mushroomed over the years. Have these partnerships succeeded in addressing and bridging the inequity gaps in health care systems in Africa? Have there been negative fallouts from these partnerships? These are questions I wish to address briefly next.

WHO defines public-private partnership as the “means to bring together a set of actors for the common goal of improving the health of a population through mutually agreed roles and principles?” (11). I would like to underline the important phrase, “mutually agreed roles and principles”. I believe it is the responsibility of African ministries of health to negotiate the best deal for such partnerships. There are several important issues to consider by national governments before signing these partnership agreements. How will the collaboration impact on the general health care delivery system and the strengthening of related programs? Will the partnership undermine the stability of the health workforce? Are the targets well defined and aimed at improving health equity? Will there be transparency and accountability on both sides of the partnership?

Allow me to take the Polio Eradication Initiative as a typical example of a global initiative. This initiative is a product of a public-private partnership bringing together the collaboration of national governments with UN Agencies—notably, WHO and UNICEF—Rotary International and the Bill and Melinda Gates Foundation. It would not be overstating the fact to say that the Initiative has received the blessing of all nations and governments globally. The eradication strategies have well designed and measurable indicators to judge whether or not the program is on track in each participant country and the program managers in each country have successfully identified underserved groups of the population in hard to reach inaccessible areas through

surveillance activities and mass vaccination campaigns. The coverage of routine vaccination is continuously monitored down to the sub-district level. The movement pattern of mobile migrant population has been mapped out. The eradication program has reliable information on the distribution of health care facilities and staff allocation. At the continental and regional levels, useful lessons have been learned from the program on the challenges facing countries affected by political conflicts and the disruption of health services like Somalia, Chad and the Democratic Republic of Congo. These are readily available data that are very useful to countries for health planning and intervention purposes. The initiative, therefore, offers an opportunity to explore the African perspective of health equity, because the eradication of polio can be slowed and indeed hampered if there are gross inequities in health care delivery.

I am not in any way suggesting that the programs of these global initiatives have been totally successful. The polio virus is still circulating in Africa and routine vaccination coverage is not at the optimal level in many African countries. The message I want to pass is that such useful global partnerships should be integrated into the national health program for improving the delivery of equity health care and should not be taken as initiatives addressing a single communicable disease or a single program. The investments should be geared to strengthening general national health care systems and exploited accordingly. The same strategy should also apply to the many very well funded initiatives that are operational in the HIV/AIDS sector. However, it should be noted that maximizing the gains from public-private partnership can be successful only when the national health delivery system at all levels is well organized and focused on an innovative and comprehensive agenda.

Since public-private partnerships are expected to play a big role in bridging the gap in health equity, I would like to comment on some of the shortcomings of these global initiatives. Asante and Zwi characterize public-private partnership as a double-edged sword that can promote or undermine fairness in global health care (12). There are serious reservations about the disease-specific nature of public-private health initiatives without their incorporation into the general health care system to which I have alluded to earlier. Undeniably many of these partnerships programs are donor driven where the funding agencies dictate the terms. As Laurie Garrett put it, "most funds come with strings attached and must be spent according to donors' priorities, politics and values" (13). These global initiatives with generous funding entice workers away from established posts in the public health services such as hospitals and primary health care services. There are complaints about the limited transparency and the lack of accountability for failed projects in some of these partnerships. There are also claims that a significant percentage of donated funds never reach clinics and hospitals at the end of the line. Therefore, unless newly generated partnership projects

are carefully regulated and integrated into the national health care system they can destabilize basic national health care services.

Given the great deal interest and concern generated on the issue of health equity in the African Union and African health ministries, what is the position of these institutions on the progress made towards health MDGs and health equity? The Third Session of the African Union Conference of Ministers of Health held in 2007 on "Strengthening of Health Systems for Equity and Development in Africa" endorsed the Africa Health Strategy (2007 – 2015) and reaffirmed that investment in health impacts poverty reduction, economic development and the advancement of women's rights and equality. It also set universal access to equitable health service as the rallying point of the response to all health challenges. The strategies proposed different approaches for "addressing avoidable diseases, disability and death in Africa and for strengthening health system to equity and development." The roles of the stakeholders including member states, the Africa Union, regional economic communities and international and national civil society organizations are clearly defined. It is a meticulously prepared comprehensive document worth reading by all individuals and institutions interested in public health in Africa (14).

After studying the proposals contained in the Africa Health Strategy, one is compelled to ask how much of the recommendations have been translated into action? Two years after the adoption of the African Health Strategy, the report from the Fourth Session of the African Union Conference of Ministers of Health on "Health Financing in Africa" stated: "Governments in Africa are constrained in their capacity to finance health as evidenced by the low levels of public-sector health spending in most Africa countries" (15). It is quite evident that without adequate financial commitment African countries can neither implement the African Health Strategy nor achieve the health MDGs. In relation to health financing, we should recall the famous 2001 Abuja Declaration where member States of the African Union pledged to allocate 15% of their national budgets to health (16). In 2006, "The Africa Public Health Alliance 15% Campaign" was launched as the "15% Now! Campaign" led by the Nobel Peace Prize Laureate, Archbishop Desmond Tutu, as honorary chair and patron of the movement. The campaign pleads with African Heads of State and Governments "not to revise, drop or further delay" the implementation of the Abuja commitment. Unfortunately, many countries have not made progress expected towards achieving the "Abuja target". In fact, after nine years since the Abuja declaration only six out of fifty-three AU members have met the 15% pledge (17).

At this juncture, I wish to raise some questions connected with the goals and recommendations of the African Health Strategy for achieving health equity in sub-

Saharan Africa. Has the African Union and Ministries of Health seriously engaged in global health initiatives to promote their integration into the national health system and to fund core programs and human resource requirements? Do national plans assure social protection for the vulnerable and families from long term debt traps of catastrophic illness and injury? Have countries developed good systems of surveillance for both diseases and vectors and high level of vigilance for outbreaks? Are the logistics and supply systems good enough to ensure the availability of required supplies at health facilities? Has the African Union facilitated a common African position on the migration of health professionals? These are major issues covered by the Africa Health Strategy.

In 2008, the Economic Commission for Africa produced a report on "Mainstreaming health equity into the development agenda in Africa". The report was based on an analysis of the demographic and health survey data of ten African countries. The document identified the lack of access to health care, where rural-urban disparities were very obvious, as the main constraint on health inequity. In all countries, women from the poorest quintile were less likely to use basic services. The report reaffirmed that equity was emerging as an urgent policy priority in health sector reforms in many African countries where reducing inequity in health was found to be integral to success in reaching the target of the three health-related MDGs and the other MDGs with health as an important component. The report concluded that health inequity should, therefore, be mainstreamed across all sectors, departments and tiers of government and the broader development agenda of African countries. The study also recommended the need to develop targets and indicators to monitor progress towards equity in health. (18).

In conclusion, I would like to summarize the issues that I think are important if we are to bring about health equity in Africa, particularly in sub-Saharan Africa.

- First and foremost, African countries should break the vicious cycle of poverty and ill-health. I am quite aware that this is easier said than done. Nevertheless, maximal efforts should be exerted by African governments to bring about accelerated socio-economic development and growth to reduce the disproportionate burden of poverty in sub-Saharan Africa.
- African Countries should mobilize adequate budget allocation to the health sector, at least to the level of the 2001 Abuja Declaration of 15% of national budgets. I sincerely hope they will take to heart Archbishop Desmond Tutu's appeal for "15% Now". External assistance should be used to build and strengthen the overall health system. Innovative approaches should be employed to bring in more flexible resources for health system such the Health MDG Performance Fund (MDG PF), which provides financing without earmarking for underfinanced

priorities in the health sector. In the case of Ethiopia, the evidence attests to the significant contributions of the pooled fund obtained from Development partners through MDG-PF and managed by the Ministry of Health towards the improvements of health delivery systems in the country (19).

- The capacity of health systems should be strengthened to provide effective and equitable quality health care services, including appropriate infrastructure, essential drugs and equipment and adequate skilled and motivated manpower. Special attention should be given to people who are marginalized and underserved, such as those with physical disabilities, epilepsy and mental illnesses. Since the majority of the Africa population is rural, primary health care services and Preventive Health activities should be re-activated, upgraded and expanded. I cannot emphasize more the importance of the primary health care approach to bridge the gap in health equity at the grass roots level in Africa.
 - Health system and health care facilities should have appropriately designed and stable structures with the right staff allocations. Frequent turnover of personnel should be minimized. The human resource crisis should be addressed methodically. As Kaseje put it, the human resource issue was both a quantitative (appropriate numbers) and qualitative (appropriate skill, mix and motivation) issue" (20). Countries have to take resolute action to train and retain African health workers. Other innovative approaches, such as the Ethiopian initiative of deploying trained Health Extension Workers at the community level, as part of the country's strategic plan for strengthening the health system, should be considered by others as a good lesson learned (21).
 - In sub-Saharan countries, since the majority of the poor cannot afford to pay for health care, they either avoid seeking timely care or wait until they are serious ill, which leads to unnecessary morbidity and mortality. It is, therefore, necessary for governments to explore appropriate methods of social protection in the form of health insurance system or the abolishment of users' fee. The development of community health insurance (CHI) has not been very successful in sub-Saharan Africa, because of operational difficulties. Allegri et. al. suggest that policy makers should overcome the barriers through adequate legislation, equitable enrolment, substantial investment and reduced overhead cost (22).
 - Sub-Saharan African countries should urgently address the water, sanitation and hygiene crisis, because there cannot be health equity without equity in access to safe drinking water and improved sanitation. I fully support the recommendation of WaterAid to that effect:
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“national governments should exert strong leadership on water and sanitation, ensuring relevant institutions are fit for the purpose and the required staff and skill are in place at all levels” (23). This issue has often worried me. Which government body should carry the mandate for the provision of potable drinking water and improved sanitation for rural populations in sub-Saharan Africa? Is it the Ministry of Water Resources or the Ministry of Health? The allocation of responsibilities remains to be a grey area. I believe this is a very crucial issue because health equity and equity in the provision of drinking water are very much interdependent. I have often wished that the Ministry of Health would play a stronger catalytic role in water and sanitation because of the important contribution it makes to health equity.

- Accurate data are necessary to evaluate health interventions aimed at reducing health inequities. In sub-Saharan Africa, monitoring of intervention programs and global targets such as the Millennium Development Goals are not easy due to the lack of key information. Census data in most countries are outdated. There is, therefore, a need to invest in demographic surveillance systems which is best fitted for longitudinal follow-up of households, an approach critical for measurement of the possible correlations between social and economic status and health outcomes (24).
- Governance and accountability are issues that are raised frequently in the health system of Sub-Saharan countries. There is therefore a dire need for transparency and accountability in the use of domestic and externally generated resources allocated for health.
- Finally, while preparing for this lecture and reviewing the literature on MDG and health equity, I have come to realize that the challenges facing Africa (sub-Sahara in particular) in meeting MDG goals and closing the gaps of health inequity have been clearly identified by the African Union, the United Nation Economic Commission for Africa and individual countries themselves. The African Union has developed the Africa Health Strategy and other health policy frameworks which contain all the ingredients of what actions should be taken and by whom. What is called for in Africa is a strong political will and commitment with health equity as one of its top priorities.

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