

The Challenge of Achieving Health Equity in Africa



A nurse holds a young girl who came with her mother to an AIDS screening clinic. (IDRC Photo: G. Toomey)

2004-04-07

Maureen Johnson

What does equity in health and health care mean? Equality? A basic minimum standard of service? A system of entitlements?

Global health professionals have struggled with a definition for some time. Dr Rene Loewenson, a Zimbabwean epidemiologist, recently brought to Canada a Southern African view: equity in health implies addressing differences in health status that are unnecessary, avoidable, and unfair, she says. This also means understanding and influencing, not only the way society allocates health resources, but the power relations involved.

Director of the [Training and Research Support Centre \(TARSC\)](#) in Zimbabwe, Dr Loewenson is also a founding member and coordinator of the [Regional Network for Equity in Health in Southern Africa \(EQUINET\)](#). Launched in 1997, this network of institutions is supported by Canada's International Development Research Centre (IDRC) and a number of other organizations. [See related sidebar: [The Making of an Equity Network](#)]

Defining equity

EQUINET spent a "fair amount of time" in 1998 trying to define what equity means, says Dr Loewenson. The consensus definition arrived at has driven its work ever since. "The first thing that springs out of that definition is that equity is a socially defined parameter that involves social values," she says, "... so if it's considered to be unfair that rural people and urban people should have differences in mortality, then that is inequitable. If it's considered to be unfair that women and men should have different access to health services, then that too is inequitable."

In addition to redistributing health resources, equity includes the redistribution of societal resources — of social and economic resources — to those with greatest need, as well as equity in political power, she adds. “We consider that strengthening peoples' power to direct resources to their health needs is part of the equity framework and that you can have inequitable distributions of power and access to decision-making that are as important as inequitable distributions of health workers or of drugs and so on... So our work is also looking at that area. And we consider all of that to be part of an equity agenda.”

Spreading the net

EQUINET is placed geographically within the [Southern African Development Community \(SADC\)](#), but some of its work has relevance elsewhere. Recently, there have been meetings with East African parliamentarians, and work on health personnel has led to interactions with organizations in Canada and the United Kingdom. As Dr Loewenson points out, “... we believe that to advance health equity agendas, we need to have more than a one-on-one national approach: we need to have a regional engagement in the international community.”

It's tragic, she says, that since EQUINET-type networking began around 1990, there has not been a huge advance in health equity. In fact, “if anything, the underlying processes have moved us in the other direction in many respects.”

Most countries in the region went through liberation struggles during the last 40 years, she says, and from the 1960s to the 1980s the region led globally in many areas of social improvement — gains in life expectancy, nutrition, access to water and sanitation, adult literacy and primary school enrolment, as well as declines in mortality rates. There was a development agenda in the region, with social policy objectives fundamental to many governments.

Nation-building after colonial rule meant a strong focus on “inclusion” and reducing social differences, particularly in health and other areas, Dr Loewenson explains. Yet by 2002, Southern Africa had the world's highest HIV prevalence rates, the biggest burden of HIV, and resurging tuberculosis. In the last couple of years, a severe famine has also overlaid chronic food and security issues. The quality and coverage of essential health care services has declined, as has life expectancy in many countries.

There is absolutely no question that the AIDS pandemic has been one of the most profound contributors to inequality and to overall declines, she says. “HIV is placing great demand, great stress on services, and stress on households... reducing social cohesion and polarizing access.”

The poverty factor

The burden has been greatest at the household level, particularly in the poorest households and in the services that are provided to them, she points out.

Across the region there is a huge variability in income. Poverty also has a gender dimension: women are worse off than men in many countries. And, says Dr Loewenson, because the top level of the “non-poor” population is increasingly disappearing from the statistical base — they might live in the region, she explains, but their corporations and wealth are increasingly “globalized” — statistics are measuring an overall poorer population.

Poorer households, she says, have less insurance coverage and generally less access to pooled funding. In the last decade there has been a shift to payment for health services. The poor also don't have access to radios, television, and networks that provide information enabling them to make cost-effective decisions about health care spending. They are thus seriously affected by declines in tax-funded public services. Primary health care and district services have improved public health in Southern Africa, but there are still significant gaps in the delivery and, in some cases, declines. Research shows, for example, that in some SADC countries, fewer than 40% of births are attended by a trained birth assistant.

Government budgets have shrunk due to external debt payments, declining terms of global trade, reduced employment security, and lowered incomes, Dr Loewenson explains. The fall in public budget resources makes health sectors more dependent on external resources at the very time that official development assistance flows have declined.

The public-private divide is also generating inequality, with inadequate service coverage in the public sector and over-servicing in the private sector. "In the richest sections of the private sector, people are given medical tests and treated in First World style while some in the same country cannot even obtain a vaccine," she says.

Moreover, when public resources are scarce, the richest districts attract and use more resources. This is the case in South Africa where wealthier districts get four times more resources from public budgets than the poorest districts, she says. However, the widest differences are North-South. Net resource outflow due to trade imbalances, debt, and falling investment — in addition to falling incomes in Southern Africa — have meant that North-South resource imbalances have grown. This has produced a number of additional pressures.

The global conveyor belt

Among these pressures is what Dr Loewenson calls the "global conveyor belt of health personnel." Workers are going from the poorer public sectors, such as rural areas, to the urban public and private sectors, and from poorer countries in the region to wealthier ones — from Africa to Canada, the UK, and Australia, she says. "Research that we've done on health personnel shows an absolutely phenomenal loss in our region," she points out. Of 1200 physicians trained in Zimbabwe in the 1990s, for instance, only 360 remain.

These resource imbalances mean that new technologies, information, and treatments such as anti-retroviral therapy for HIV/AIDS do not reach poor communities. It is estimated that in South Africa, about 500 000 people need anti-retrovirals; in Malawi, 300 000; in Zimbabwe, about 400 000; yet fewer than 20 000 actually have access. "The technology is there, but it's just not reaching the people," she explains.

Trade, investment, and financing are also undermining the ability to distribute societal resources toward health. "Health professionals now have to be very familiar with trade agreements," says Dr Loewenson. "We all became economists in the 1980s because we had to interface with the World Bank. We're now becoming trade specialists and lawyers because we know we have to interface with the World Trade Organization."

She points to a range of global trade issues — international agreements that are limiting governments' ability to promote and safeguard public health — that are undermining the ability to do "what we know works. Not only do we have weakened states, but we now have trade agreements that are saying 'Whatever level of capacity you have left, you can't apply it any more, because we will tell you what to do through the trade system'," says Loewenson.

She lists challenges to the fundamental principles of equity in trade systems: tariffs and policies that weaken food sovereignty and market access; patenting systems that undermine drug access; international capture of indigenous knowledge systems and biodiversity; and commitments that limit government authority to regulate and cross-subsidize services such as water supplies and health.

Political intervention

EQUINET is trying to intervene at the policy level, she says, but also at the level that influences the policies. This includes supporting communities to participate more effectively in health systems and in influencing those systems, and support to governments in implementing equity commitments through their health personnel and resource allocation systems. The network is also bringing together those inside and outside the health sector to ensure that trade agreements do promote public health interests. And it is building regional networks to share evidence, information, capacities, and institutional resources.

In addition, the network supports a Southern African regional framework on health issues, such as the development of regional patenting systems and the bulk procurement of essential drugs. And it seeks to strengthen negotiating skills so that those involved can “dig in their heels” and refuse to make trade commitments that will compromise public health.

EQUINET provides information support through a regular [newsletter](#), briefings, and a Web site that will soon include a searchable database of equity materials in the region, she says.

Maureen Johnson is an Ottawa-based writer and editor.

For more information:

Dr Rene Loewenson, Training and Research Support Centre (TARSC), 47 Van Praagh Avenue, Milton Park, Harare, Zimbabwe; Phone: (263-4) 705-108; Fax: (263-4) 737-220; Email: admin@tarsc.org or admin@equinetafrica.org

Dr Christina Zarowsky, Team Leader, Governance, Equity, and Health (GEH) Program Initiative, IDRC, PO Box 8500, Ottawa, Ontario, Canada K1G 3H9; Phone: (613) 236-6163; Email: czarowsky@idrc.ca

Sidebar

The Making of an Equity Network

Influencing the national and regional policies of the 14 member states of the Southern African Development Community (SADC) to ensure equity in health is no small task. Where even to start?

For the Regional Network for Equity in Health in Southern Africa (EQUINET), information sharing was the first step. Funded by Southern African institutions, by the International Development Research Centre (IDRC), the Rockefeller Foundation, Oxfam GB, and the United Kingdom's Department of International Development, EQUINET's main role is to provide information, evidence, resources, capacity, mentoring, policy analysis, and networking support to equity in health work in the region. EQUINET is also helping to consolidate the energy and commitment to equity into a "coherent united platform," says coordinator Dr Rene Loewenson. Its work is feeding into policy dialogue, research work, program design, information dissemination, advocacy, and monitoring around health equity issues.

A response to structural adjustment programs

Dr Loewenson, who is also director of the Training and Research Support Centre (TARSC) in Zimbabwe, worked for a decade at the University of Zimbabwe's community health department and for five years on workers' health and public health issues with Zimbabwe's Congress of Trades Unions (ZCTU). She points out that although the current phase of EQUINET started after the Southern African meeting on equity in health in 1997 at Kasane, Botswana, networking had begun much earlier — in 1989-90 — in response to structural adjustment programs that were being introduced in Africa.

"We started a network for research and advocacy on equity in health in Zimbabwe in 1990 with the University of Zimbabwe and the Zimbabwe Congress of Trades Unions," she points out. "We linked up with colleagues in Mozambique, Zambia, Nigeria, and Uganda. This was supported by IDRC, so I think IDRC has a record of having a relationship with the oldest network on equity in health globally."

Dr Loewenson, who at the time was involved in occupational health work and participatory research with unions and with rural and urban communities in Zimbabwe, focusing on primary health care, says that the initial network went into limbo for a while. Then, in 1997, a strong commitment to equity in health voiced at the Kasane meeting by a cross-section of Southern Africans, from the presidential and prime ministerial level to community health activists and researchers, revitalized the network.

The workshop had generated a huge amount of energy, and some of the participants wanted to ensure that the policy commitment bore results. "So six of us from institutions in the region — from Botswana, South Africa, Zimbabwe, Zambia, and Tanzania — who were either at or who had heard about the meeting got together afterwards. We formed this network... to try to take this policy commitment to equity forward, operationalizing and supporting it, and holding accountable those expressing equity-oriented policies."

A growing network

That group, which became EQUINET, has grown today to a steering committee of 15 representatives from research, governmental, and nongovernmental organizations (NGOs), as well as from civil society. It has had formal collaborative status with SADC since 1999. The network is currently doing both theme work and core work coordinated by 12 major institutions, 11 of which are in the region. The twelfth, in the United Kingdom, is handling the Web work.

EQUINET's current thrust is to build the capacity of institutions in Southern Africa, to involve stakeholders in policy dialogue and advocacy, and to develop a regional resource base for health equity. Collaborators include researchers, policymakers, community health boards, and NGOs.

The members of the EQUINET steering committee are Lucy Gilson, Centre for Health Policy, South Africa; Rene Loewenson, TARSC, Zimbabwe; Leslie London, University of Cape Town (UCT), South Africa; Gertrude Machatini, Ministry of Health, Mozambique; Firoze Manji, Fhamu UK; Di McIntyre, UCT, South Africa; Gabriel Mwaluko, Tanzania Essential Strategies Against AIDS; Adamson Muula, Malawi Health Equity Network; Abisha Nyanguwo, SATTUC, Botswana; T.J. Ngulube, Chessore Zambia; Antoinette Ntuli, Health Systems Trust, South Africa; G. Ruiters / P. Bond, Municipal Services Project, South Africa; Godfrey Woelk, University of Zimbabwe. Representatives of SADC, IDRC, and other cooperating partners are also invited to steering committee meetings.