Influencing Policy Reforms
For the Achievement of Health Equity;

Introduction

Health inequity between and within countries is emerging as a major developmental concern. Individuals and communities are demanding and expecting more equitable health care and better opportunities for health. Also the global community as reflected in the Millennium Development Goals and their concern with poverty, gender equity and maternal health is placing social justice highly on the agenda of development. As a result, health inequity as a serious development challenge is starting to find its rightful place.

The recognition of health disparities is indeed not new, yet the framing of these disparities and their underpinnings are witnessing major paradigm shifts. The paradigm shifts crystallized the differences between inequities and inequalities and moved the health equity framework beyond the direct proximate determinants with its focus on behavioral and biomedical underpinnings to incorporate structural root causes of health inequities operating on the national and even global levels. Such root causes go beyond the health system monopoly of the solution and include key aspects of governance, policies, politics and international relations.

These developments pushed to the forefront the understanding that the: “unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programs, unfair economic arrangements, and bad politics.” (CSDH, 2008; p1). These developments framed health equity as a social success and also called into question the definition of actors in the health field, and their respective roles and responsibilities. In other words, there is currently a call for serious health policy reforms in which health equity is considered an integral and key dimension of not merely the health sector policies, but of all social policies.

The Arab region has not adequately responded to these developments and has yet to engage in the needed policy reforms prioritizing health equity and placing it in all policies. Indeed a review study by members of the Social Research Center (SRC) (Salem 2009, Rashad 2010) of health policy documents published on the worldwide web revealed that only six countries in the region; namely Oman, Sudan, Jordan, Qatar, United Arab Emirates and Morocco, provided a clear statement on their strategic health plans based on equity-oriented policies. Furthermore, while the rhetoric of health equity is recognized by some ministries of
health in the region, adoption of the social determinants framework in the strategic planning for health policies have not yet been fully mainstreamed.

**SRC Activities on Health Equity and Social Determinants of Health**

The social Research Center have identified a number of constraints contributing to the Arab region’s slow response and impeding the needed reforms and has been working, over the last few years, in partnership with The World Health Organization and many regional and national actors, to support a movement from health policies to policies for health equity.

Drawing on its long experience in social research and capacity building, the activities of SRC targeted a number of fronts:

- Advocating for reform through the provision of evidence on the persistence of patterned inequalities despite the appreciable progress achieved on the health front in terms of averages, as well as bringing out the unfairness of these inequalities through the application of a social model approach sensitive to the structural root causes.

- Supporting the movement from research and knowledge into policies and actions. This involves proposing and supporting mainstreaming health equity in the implementation of social policies and initiatives.

- Contributing to the development of a critical mass and cadre of policy makers, social and biomedical scientists, service providers and active personnel with the ability to understand the nature of health equity concerns and its causes as well as the ethical underpinnings and practicality of action on these fronts.

**Health inequities in the Arab region**

The analysis of a large number of national and sub-national surveys documented that despite general improvements on the health front, pervasive intra-country socio-economic disparities persist. Moreover, in some Arab countries, the improvements in health were not accompanied by narrowing such disparities.

For example, in five Arab countries (Algeria, Egypt, Morocco, Tunisia and Yemen). The children in the poorest wealth quintile experience more than twice the chance of dying before age 5 compared to those from the wealthiest quintile. Disparities were also documented across a good number of health indicators (infant and child mortality, child nutrition, acute respiratory infections, maternal health, vaccination, antenatal

These disparities were not exclusively found in economically disadvantaged countries in the Arab region. In Gulf countries, Rashad (2010) using data from Family Health surveys (FHS) showed that health disparities by wealth and educational attainment were substantially large in many health and health services indicators. She revealed that despite the substantial gains in child health, the relative risks of infant and under-five mortality between the lowest and highest educational attainments in the Gulf countries exceeded 1.5 and were as high as 2.5 for IMR and 2.25 for under-five mortality rate in Kuwait. Educational disparities in health were also observed in maternal and reproductive health where uneducated women were more likely to experience risky pregnancies, not using contraceptive or antenatal care. Wealth disparities also showed significant health inequities. The poorest quintile of the population was four times more likely to experience depression compared to the wealthiest quintiles. Furthermore, Rashad (2010) revealed the persistence of social gradient across wealth quintiles in accessibility to health services and the respondents’ subjective assessment of health services in the Gulf countries.

In addition to the common social dimensions as health classifiers, SRC introduced nontraditional groupings to emphasize the importance of unveiling the underlying forces of change. For example, Khadr (2010) proposed a new strategy to classify Cairo neighborhoods according to their physical deprivation. Using this classification, she produced concrete evidence on how structural forces of neighborhood’s deprivation play a significant and separate influence on many aspect of health.

Another example of non-traditional grouping is provided in which study Sheneity (2009) investigating the relationship between health and women empowerment revealed that classification of women based on their financial autonomy can capture significant health disparities.

Health information systems and health observatory with an equity lens are considered the basic policy requirement that allow the monitoring and evaluation of equity as well as assessing the impact of the various policies and interventions. An important contribution of the SRC for the production of the evidence based knowledge on health equity was a collaborative research effort between WHO Regional Office and SRC to develop a regional repository of data and existing knowledge on health equity in the region with the aim to support improved policies for health. The first stage of this effort aimed at providing a model for this repository through which health inequities for key health impact indicators across the common stratifiers, are documented and linked to health system factors, including health system inputs, process and output. Egypt
was used as a case study. Zaky (2009) using this matrix revealed that the high level of infant mortality in Upper Egypt (52 death per 1000 live births) is almost double that of the Urban governorates (26 per 1000 live births). He further showed that this high level of IMR can be traced to the disadvantageous status of Upper Egypt on the health system input, process and output fronts. Upper Egypt was characterized with the least number of nurses, physicians and hospital beds per capita, the lowest total health expenditure as % GDP and per capita, and the lowest rates of antenatal care visits, modern contraceptive use, EPI coverage and education and the highest poverty rates.

**Mainstreaming Health Equity in Social Policies**

Illustrating the potential impact of social policies on health was an area of concern at SRC. This effort was addressed through two different approaches. The first approach documented and analyzed successful equity oriented health policies identifying their main points of strength. Research at SRC included a review of successful international and regional equity oriented health policy models (Rashad and Khadr (forthcoming); Khadr et al (forthcoming), Salem 2008). On the international arena, the examples of Cuba, Costa Rica, Sweden, Jordan and Sudan were analyzed in details bringing out the importance of the stewardship role of ministry of health, intersectoral collaboration, investment in early child development, partnership with civil society and the involvement of all sectors and actors at different levels.

The second approach emphasized the production of empirical evidence on the potential, feasibility and practicality of social actions in achieving health equity. Over the last four years, SRC has launched a program entitled “Social policies for empowerment and health equity” that aimed to evaluate the health impact of different models of social policies and intervention. Two field studies have been conducted under this program evaluating two different social interventions. The first study focused on evaluating the health impact of a Conditional Cash Transfer Pilot Program (CCT) in a small urban community, Ain Es-Sira. The Ain Es-Sira Conditional Cash Transfer Pilot Program (CCT) is a social policy program implemented by the Ministry of Social Solidarity (MoSS) and is designed as a pro-women cash transfer intervention, focusing specifically on aiding women’s well-being. The reason women are put at the centre of the social policy design is the unequal burden of poverty that they, married or not, carry in the context of Egypt’s urban and rural settings. The field study involved conducting a baseline survey of the living conditions of the families enrolled in the program with a particular focus on mother and child health. Data from the baseline as well as the monthly monitoring tool of those families are currently under analysis to assess the impact of the program on the process indicators of health.
The other field study was an evaluation of the comprehensive development model adopted in the upgrading of Zeinhum slum (Khadr and Bulbul 2010). By 1999, Zeinhum was an example of squatter structure and precarious residential area. Socially, its inhabitants were characterized by high levels of social and economic deprivation. Poverty was a common feature in the area with the average income mounting to LE272 (less than $50) per month. Illiteracy was widespread among Zeinhum’s residents with a 31% illiteracy level (compared to 24% in Cairo governorate) and only 2.5% of residents had university education. More than one fifth of the heads of the households were unemployed, with the majority of employed heads working in service (domestic or public) outside Zeinhum. Polluted environment whether inside the residential units or surrounding them contributed to the widespread of infectious diseases particularly among children and led to an infant mortality rate that exceeded twice the national figure of Egypt. Insecurity, pollution and economic and social stress contributed to the wide spread of disruptive family relations and high prevalence of violence and delinquency among children. By 1999, a development initiative pioneered by the Egyptian Red Crescent (ERC) targeted the root causes of the health problems and poverty in Zeinhum through the adoption of an integrated and comprehensive community development approach with particular emphasis on the individuals and the welfare of the families. This approach emphasized building of trust and opening channels of communication and interaction among different partners and stakeholders involved in the development process and Zeinhum residents. It gave substantial weight to the development of the human and social capital among Zeinhum residents and provided them with sufficient opportunities and resources to voice their needs and worries and to participate in addressing and discussing their neighborhood issues and problems. In other words, this approach emphasized the importance of individuals’ and families’ role as active agents of change in their neighborhood. This emphasis was reflected in a myriad of urban planning, social and economic activities that were provided to Zeinhum. The urban planning was directed to secure a healthy and proper environment for the families while the social activities aimed to build the residents social and human capital as well as secure full engagement of the community in the upgrading process and its sustainability. The field study revealed significant improvement in the residents’ socioeconomic status. Illiteracy rate declined from 31% to 14.5% and those enrolled in higher education increased from 2.5% to more than 8%. Furthermore, 40% of the residents reported an increase in their income compared to its level before the upgrading efforts. More than 50% of the residents felt more secure in the neighborhood compared to the pre upgrading period. On the health front, the study showed the significant impact of the changing social and landscape of neighborhood on the Health. About 72% of the respondents in the survey indicated that the incidence of some common diseases in Zeinhum has significantly declined after the upgrading effort. Furthermore, while the majority of residents reported no changes in their families’ health, about 17% reported improvement in the health of their chronically ill
members (19% of those who were living in precarious accommodation and 16% of those who were living in proper accommodation). Reasons for such change were mainly attributed to the improved environment.

Alliances and Capacity Building Activities

One of the major tasks currently undertaken by SRC is building alliances and partnership with regional and international parties for the promotion and the advocacy of health equity and the social determinants of health framework. These alliances covered a large number of workshops and meetings in collaboration with WHO regional Office (EMRO) and the International Union for Scientific Studies of Population (IUSSP). In addition SRC has strong collaborative ties with faculty of health sciences at the American University in Beirut. This resulted in an edited book on public health in the Arab region and a formation of a regional network on public health.

Furthermore, the concerns for health equity have created an urgent need to support the development of a new cadre of health researchers and policy makers who are able to mainstream social determinants of health and health equity in social policies.

- Recently The Social Research center has received a grant from Hewlett Foundation to develop and launch two rounds of a three week workshop during the period 2011-2013. The workshop aims to encourage more informed knowledge on health inequity issues and concerns, promotes effective policy and priority setting approaches and explores successful interventions in the area of social determinants of health.

The road to the achievement of Health Equity and for the needed reforms in policies for health is still a long way ahead. The current policy brief provides examples of three tracks of work needed to speed up policy reforms for health equity.
References:


- Rashad, Hoda. 2010. “Social Determinants of Health and Their Policy Implications” paper presented in 7th (GCC) Primary Health Care Conference organized by Ministry of Health in Bahrainin coordination with the Executive Board of the Health Ministers council for Gulf cooperation council states and with the support of Eastern Mediterranean Regional Office (EMRO). 3-5 May 2010.


