SDH Research to Policy to Practice Tanzania

International Conference Social Determinants of Health, Intersectoriality and Social Equity in Latin America

FIOCRUZ, November 17th, 2015.

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Outline

1. General Context and Policy Framework
1. IHI: SDH Research for Action
1. Research to Policy and Practice
1. Implementation Challenges
1. Summary

General Context
and
Policy Framework

IFAKARA HEALT research

Tanzania's social and economic development is challenged by sharp inequalities -

- **Between and within urban centers and rural areas**
- **Among different socio-economic groups.**

Aggravated by:

- **unequal access** to essential **public services** and **employment** opportunities
- The **gender imbalance** of labour and structural and social norms, as well as **unequal power relations**

Informal employment is on the rise -

- **Women** are mostly concentrated in casual, low-skilled, poorly renumerated & irregular forms of employment
- **Vast majority of working poor** who work informally earn their living in the informal economy where:
  - risks are high, average earnings are low
  - have **no social security coverage** to protect against short term risks or life-time contingencies
  - cannot afford private insurance, have **little access to social insurance**

Many programmes and plans are in place but have not yield favorable results, it's a long journey to achieve Tanzania's Aspiration

THE UNITED REPUBLIC OF TANZANIA

THE TANZANIA DEVELOPMENT VISION 2025

1999

Tanzanian Government launched Tanzanian Development Vision 2025 and healthcare has been one of the primary focuses

The United Republic of Tanzania
Ministry of Health and Social Welfare

Health Sector Strategic Plan
July 2009 – June 2015

HSSP

Mkukuta

2000 - 2013

Various Healthcare-centric programmes were developed over the years aiming to achieve TDV 2025's goal

This will further widen the regional development gaps...

2000 – 2013

The Healthcare sector is not doing well among the peers...

2013

Current results 50% of HSSP III's plans are NOT on-track

MTR 2013

TdV25!

2014 onwards

Long way to catch up to catalyse the effort in achieving the aspired productive & healthy Tanzanian population by 2025

2014 onwards

Without Healthy population, Tanzania will NOT achieve its aspiration

Without a healthy population, Tanzania risks NOT achieving TDV2025's Aspirations...

USD 272.6 million[1] Losses to GDP

420,000 total mortality

USD 431 million[2] Spent on Treatment

Without a healthy population, Tanzania risks NOT achieving TDV2025's aspirations…

USD 272.6 mn[1] losses to GDP

420,000 total mortality

A portion of **USD 431 mn**[2] spent on treatment could be used for development purposes…

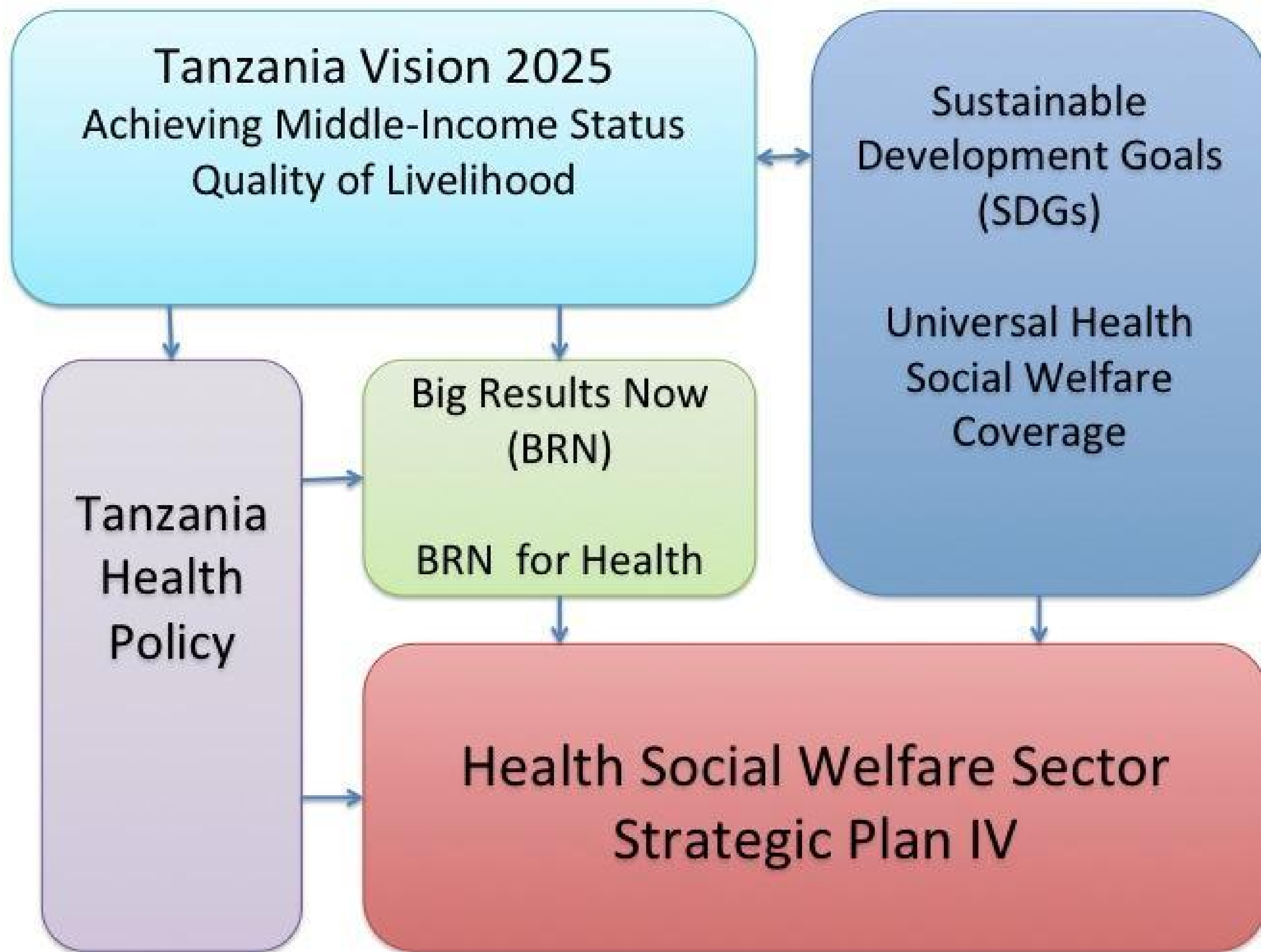
Notes:

(1) Based on WSP's studies on average annual lost due to premature deaths, productivity losses due whilst sick or assessing healthcare and loss in national income due to burden of chronic diseases. The 5 key diseases encompassed Diarrhea, LRI, infectious diseases, NTD, Malaria, Diabetes, Cardio & circulatory diseases, etc.

(2) MoF's 2013/14 Budget allocation based on annual average exchange rate at TSH 1618 per dollar

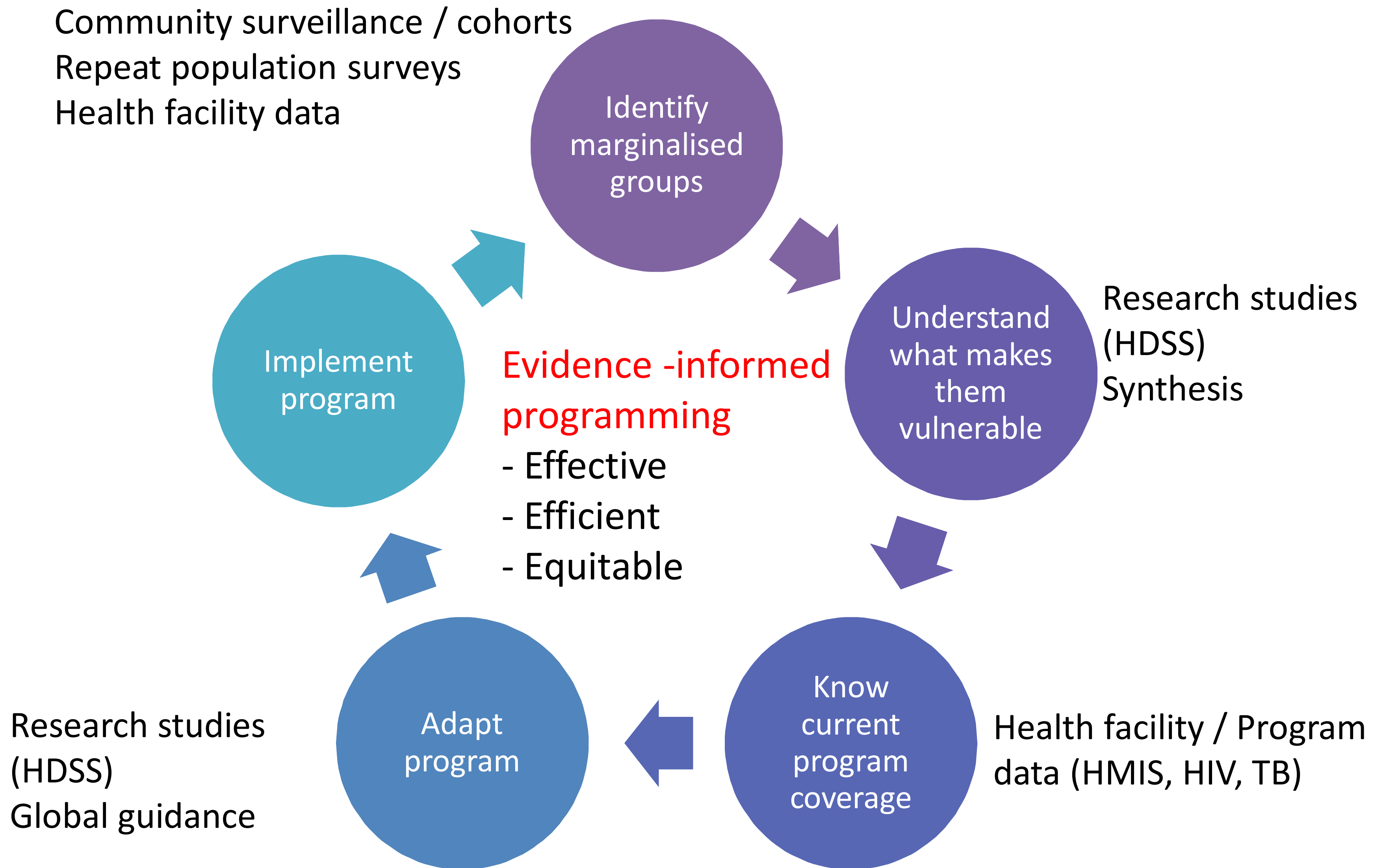
Sources:

WSP, WHO,IHME, GBD 2010, MoHSW Midterm review, MoF, team analysis

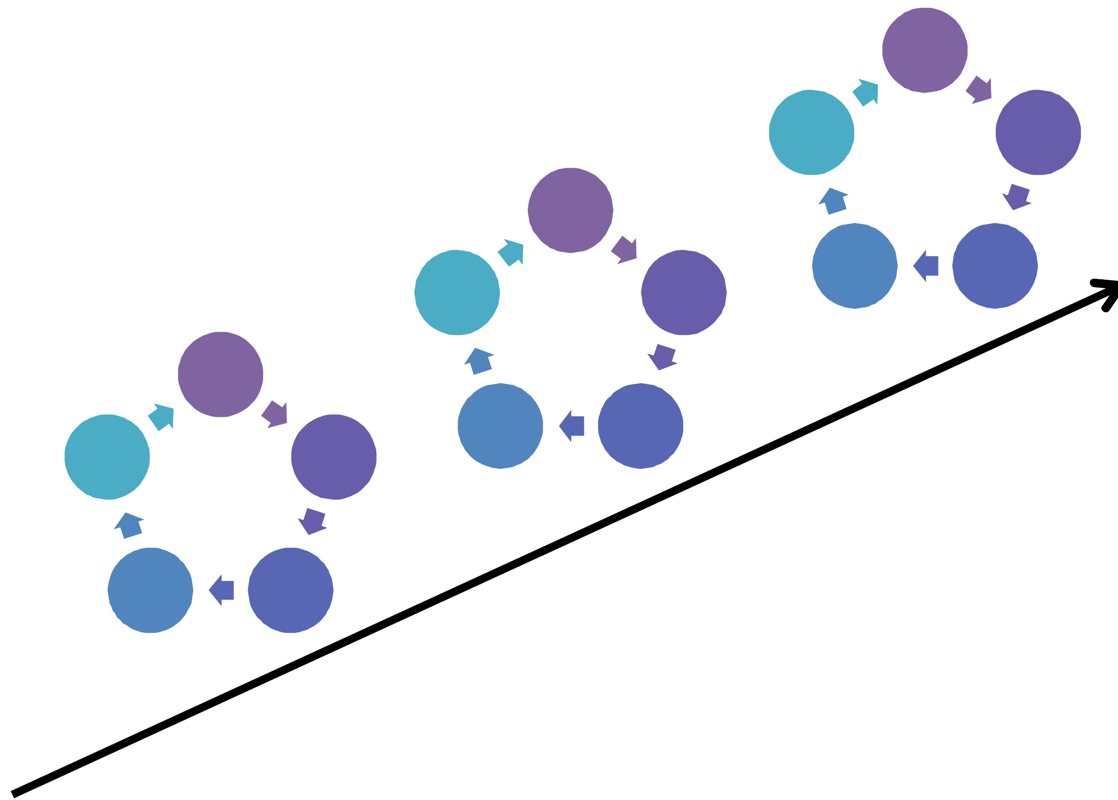

Tanzania Vision 2025
Achieving Middle-Income Status
Quality of Livelihood
Sustainable
Development Goals
(SDGs)
Universal Health
Social Welfare
Coverage
Tanzania
Health
Policy
Big Results Now
(BRN)
BRN for Health
Health Social Welfare Sector
Strategic Plan IV

Ifakara Health Institute
SDH Research for Action

IHI: Evidence-informed policy and planning..



.. is an iterative process



Improve:
- **Survival**
- **Health**
- **Wellbeing**

in an equitable way

SAVVY + HDSS Districts

HDSS: 400,000 population, since 1994

SAVVY 800,000 population, since 2013

National population & health surveys

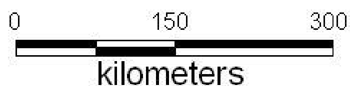
Muleba
Musoma Rural
Magu HDSS
Geita
Arusha
Moshi Rural
Kahama
Babati
Kasulu
Kondoa
Korogwe HDSS
Tanga
Kigoma Urban
Uyui
Singida Rural
Bagamoyo
Kilosa
Kinondoni
Ilala
Temeke
Iringa Urban
Kilombero
Rufiji
Rufiji HDSS
Sumbawanga Rural
Ifakara HDSS
Ulanga
Mbozi
Ruangwa
Mtwara Urban
Songea Urban

23 SAVVY Districts
+4 HDSS Districts

0 150 300
kilometers

N

Ifakara Health Institute / April 2010



Some examples of research on SDH

1. Bed-net social marketing increased child survival through increased ownership and equity in ownership (Schellenberg Lancet 2001; Nathan Trop Med Int Health 2004)

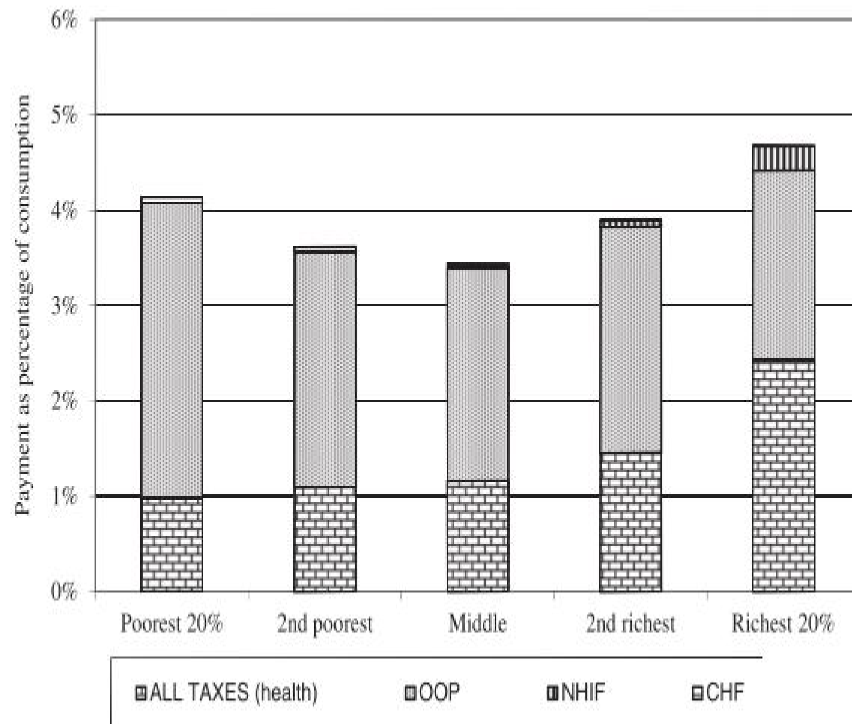
2. Heterosexual anal sex new driver of HIV: gender power, modernity, economic, pleasure (Mtenga Sex Transm Inf 2015)

3. Women's savings groups increase women's likelihood for (transactional) extramarital sex, because they need to pay back loans (Mtenga et al, forthcoming)

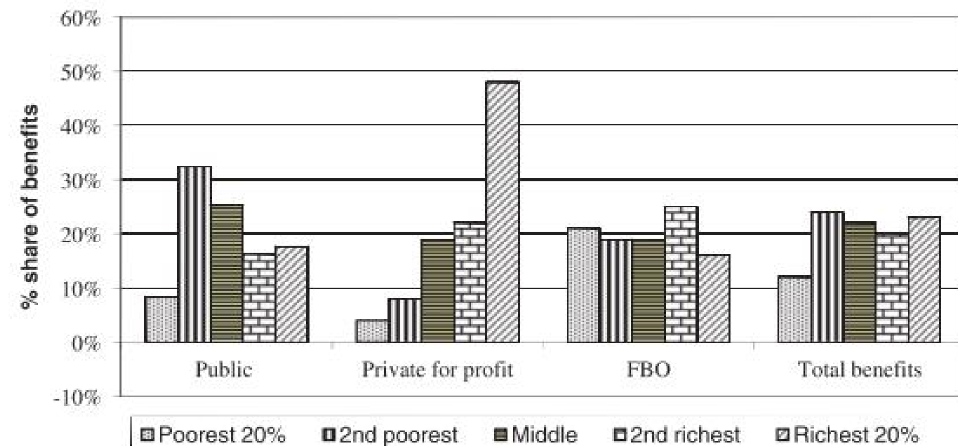
4. Traditional cultural schema delay timely health seeking by diabetes patients (Metta et al, BMC Pub Health 2015)

Equity in Health care financing & benefits

Relative burden of health financing by wealth quintile



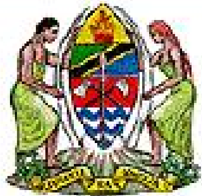
Health benefits distribution from use of public, private and faith based clinics, by wealth quintile



Who pays and who benefits from health care? An assessment of equity in health care financing and benefit distribution in Tanzania

Gemini Mtei,[1*] Suzan Makawia,[1] Mariam Ally,[2] August Kuwawenaruwa,[1] Filip Meheus[3,4] and Josephine Borghi[1,5]

Health Policy and Planning 2012;27:123–134



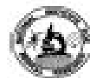
MIDTERM ANALYTICAL REVIEW OF PERFORMANCE OF THE HEALTH SECTOR STRATEGIC PLAN III 2009-2015

September 2013

Ministry of Health and Social Welfare
United Republic of Tanzania

in collaboration with

Ifakara Health Institute
National Institute of Medical Research (NIMR)
World Health Organization



Mboera *et al*. Midterm review of national health plans: an example from the United Republic of Tanzania. Bull WHO 2015;93:271-278

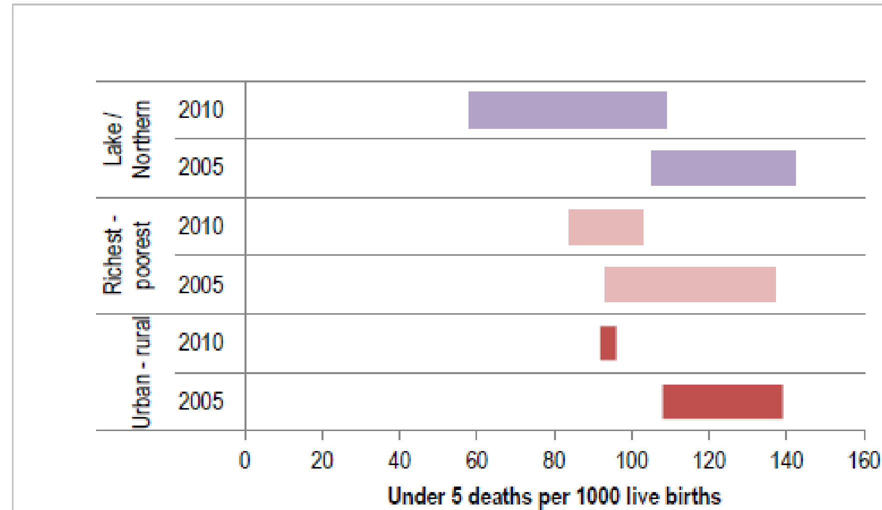
Progress and equity

HSSP III indicators

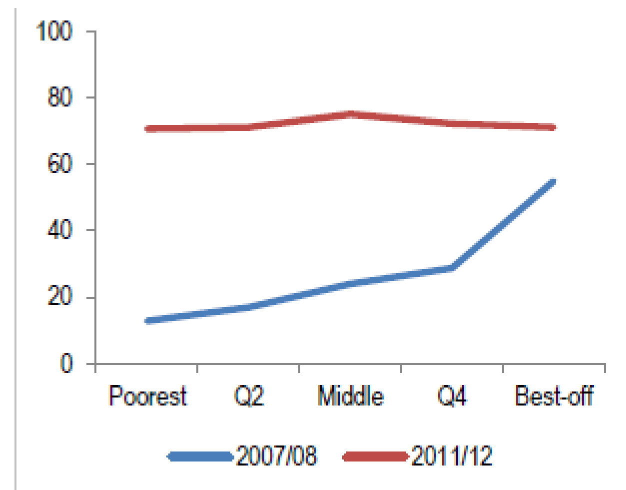
	Overall progress	Achievement	Target 2015	Equity	Compare (rank)
HEALTH STATUS					
Life expectancy (years)		61 (F) /58 (M) (2011)	62/59		
Under-5 mortality rate		81/1,000 (2006-10)	54		1
Neonatal mortality rate		26/1,000 (2006-10)	19		1
Infant mortality rate		51/1,000 (2006-10)	-		1
Child stunting rate		35% (2011)	22%	G R W	3
Child underweight rate		14% (2011)	14%		5
Maternal mortality ratio		454/100,000 (2004-10)	156	G	2
Total fertility rate		5.4 (2008-10)	5.1	G R W	4
Adolescent fertility rate		44% (2010)	39%	G R W	5
HIV prevalence among young people		2.0% (2011/2)	-	G	
HIV prevalence, pregnant women (15-24)					
TB notification rate		75% (2011) 52% (2012)	70%		
Leprosy cases diagnosed and treated					
Cholera incidence rate		343 cases	0		
Cholera case fatality rate		4.1%	<1%		
Malaria prevalence among OPD (lab)	-	33% (under 5) (2012)	-		
Parasitemia prevalence (children)		9.2% (2012)	5%		
COVERAGE OF INTERVENTIONS					
Measles immunization coverage		100% (2012)	85%		1
DTP-Hb 3 immunization coverage		95% (2012)	85%		4
Vit A coverage (2 doses)		60% (2010)	-	G W	7
TT2 immunization coverage		88% (2011)	90%		

(G=gender, R = place of residence (urban-rural, region) and W=wealth quintile).

Equity



Gaps in child mortality between poorest and best-off quintiles and between urban and rural children have reduced



The big equity gap in 2007/08 in the use of ITN was completely closed by 2011/12

Current analysis plans

Triangulate information on õ

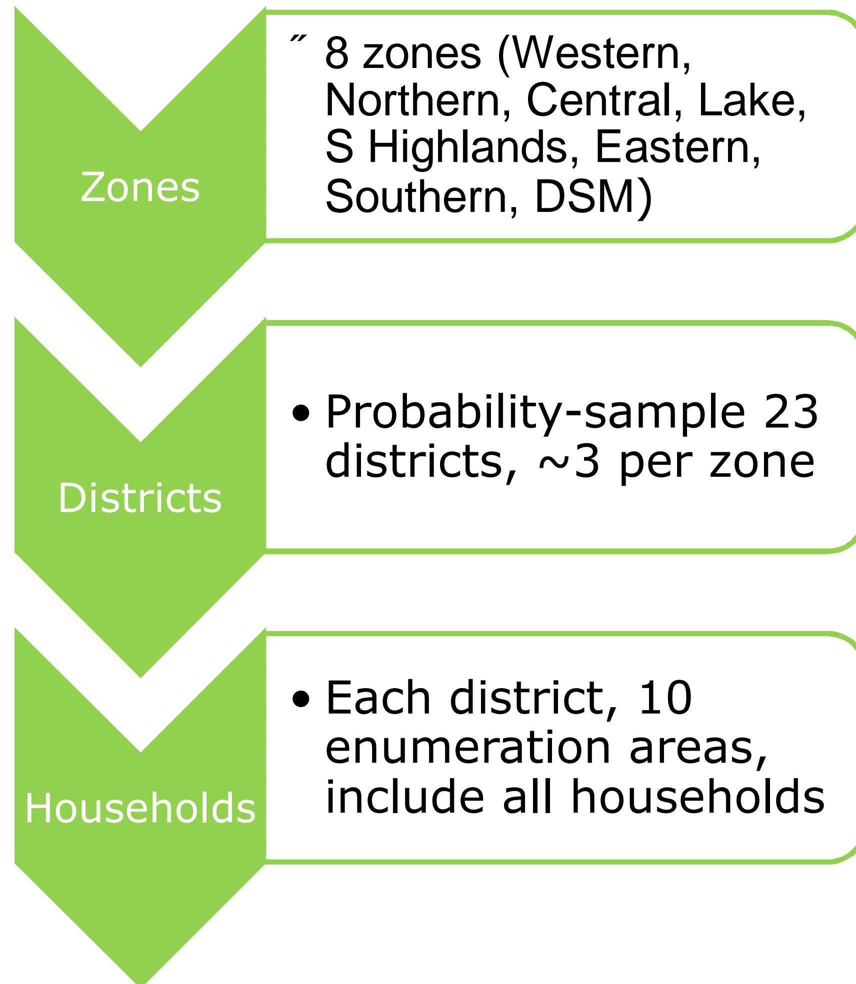
- **Burden of disease** (THMIS, DHS, national prevalence survey for TB, STEPS survey for NCD)
- **Service availability and readiness** (SARA)
- **Service utilization** (FBIS)
- **Mortality** (SAVVY, DSS)

õ .**through an equity lens, i.e. break down by geography, age, sex, occupation / education, etc**

Å ..try to understand differences through analysis of research project information

Focus: HIV, maternal and newborn, TB, malaria, NCD,

SAVVY Sample



Sample design

- Nationally representative, 2-stage sample
- Can stratify by
  - DSM, other urban, total urban, rural
  - zone
- 650,000 population

HDSS – beyond SAVVY

CORE

- Individual level data on migration→ estimation of person-time at risk
- Individual data on marital status, pregnancy, relationship to other hh members

HDSS – beyond mortality & fertility

- Estimate **disease burden** for non-lethal diseases
- Estimate behavioural, social, structural drivers for **demographic** trends
- Measure **what** health program **impact** is (mortality and disease incidence)
- Understand **why** there is program impact
- Measure **unintended** effects of programs
- Platform to test **novel** health interventions

SAVVY & HDSS – what & how

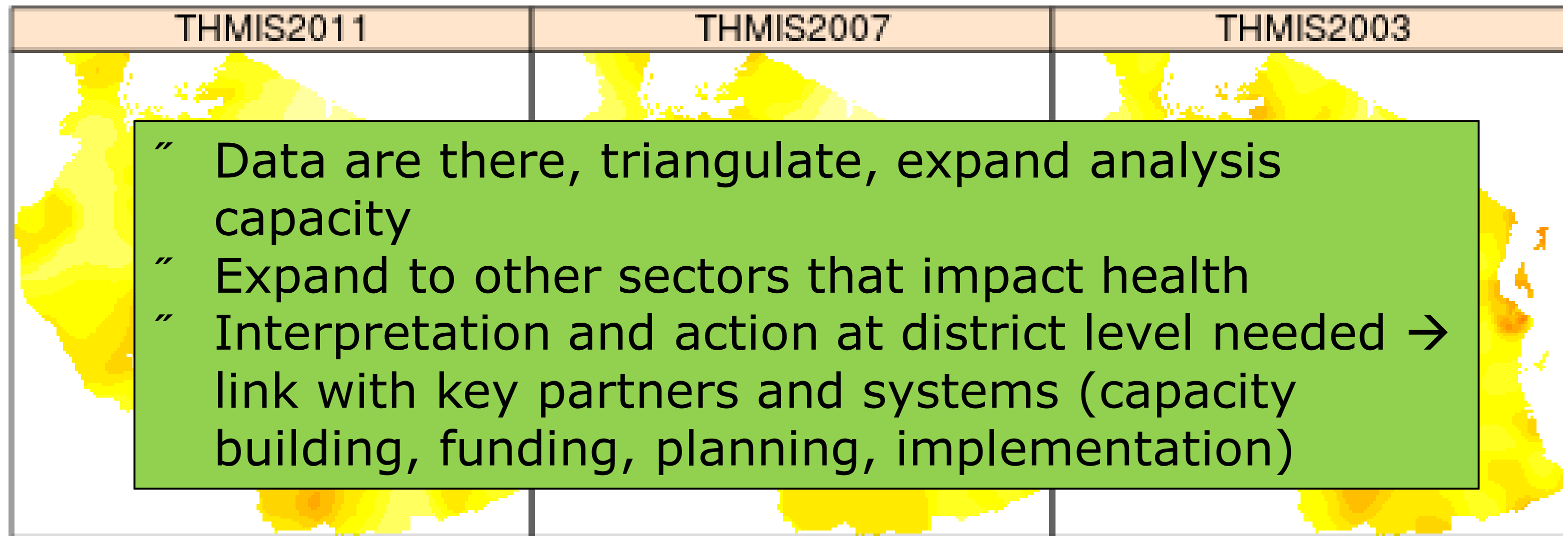
SAVVY & HDSS

- Census by age, sex, occupation, education
- Prospective births, deaths, birth outcomes
- Cause of death by Verbal Autopsy

DSS

- Household visit every 6 months
- Social determinants, health behaviour, health seeking, health status, family dynamics

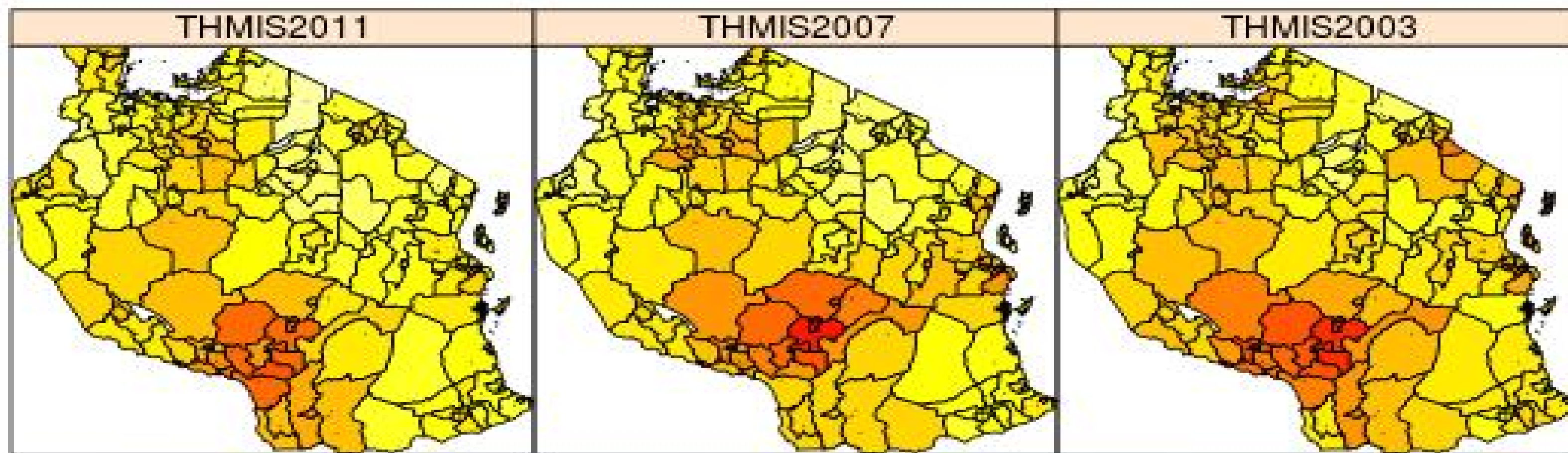
HIV Prevalence surface

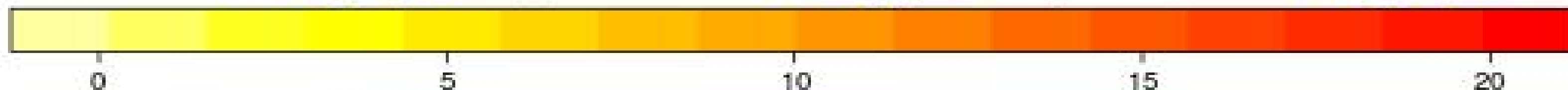


- Data are there, triangulate, expand analysis capacity
- Expand to other sectors that impact health
- Interpretation and action at district level needed → link with key partners and systems (capacity building, funding, planning, implementation)

%

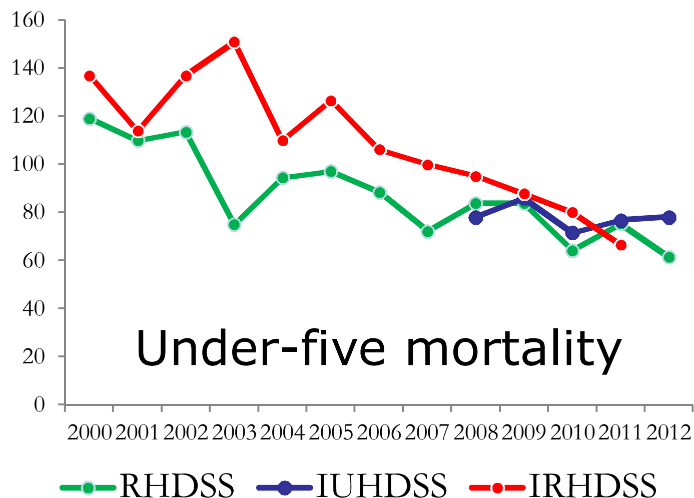
District Prevalence

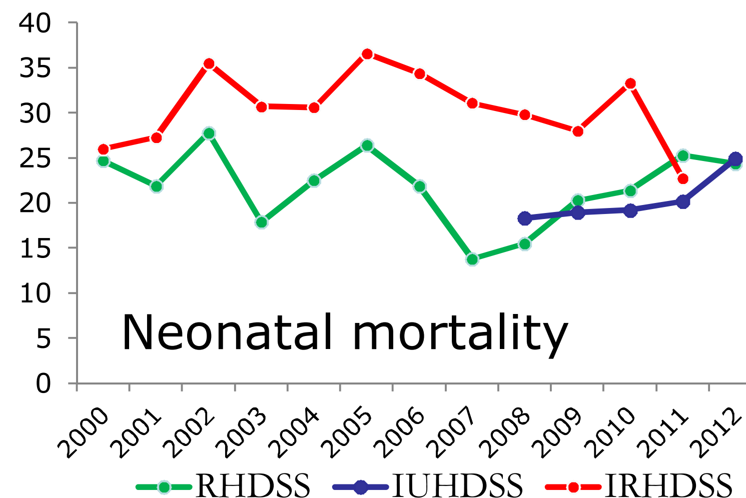


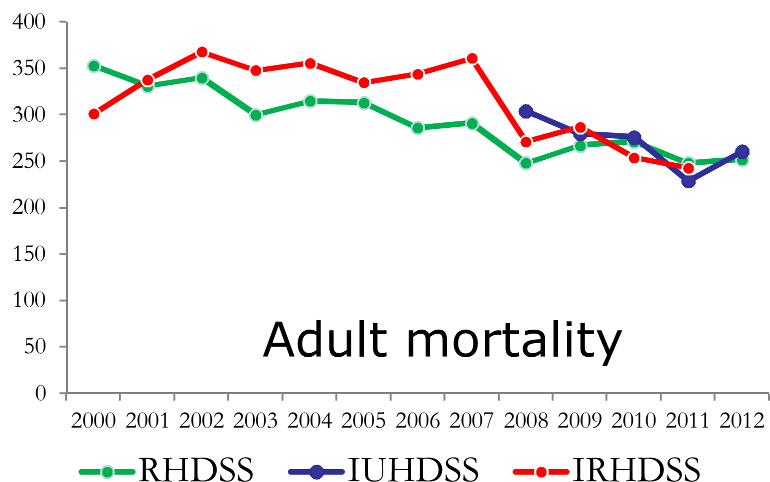


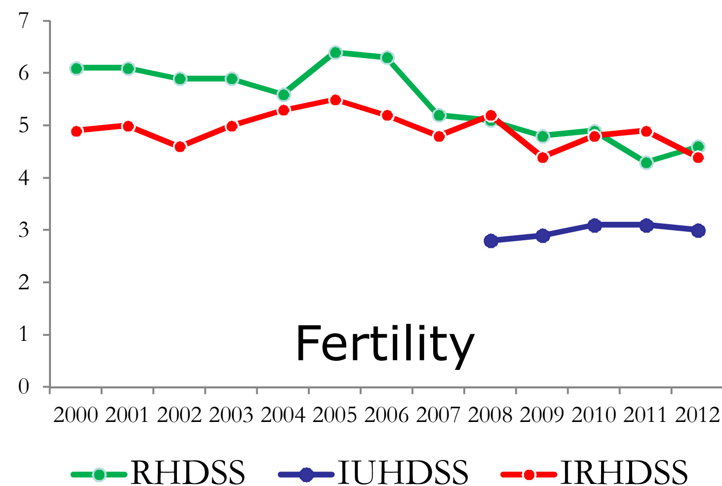
%

Demographic trends (Ifa. & Ruf. HDSS)









RHDSS = Rufiji; IUHDSS = Ifakara Urban ; IRHDSS = Ifakara Rural

Most factors determining health are outside the health system

Deepen conceptualisation: Explore broader and **contextualized drivers** of health inequities

Promote **interdisciplinary programme research – adapt and innovate**

Co-production of knowledge – interdisciplinary teams and analysis for better policy

Prioritise **community participatory research and empowerment** to explore the **underlying causes** of health inequalities

Inform Policies/ Programmes/ Planning/ Budgeting at national and **local government level**

Promote public debate -> informed citizens

->What are the context specific policy imperatives necessary to reduce inequities?

A focus on conceptualisation and contextualisation of SDH research…

"an absence of critical thinking and analysis, pulling together various determinants; need to build capacities towards defining the research question that is context specific."

"talk to each other.. share and learn from each other" => promote interdisciplinary & participatory research => lend an SDH inequity perspective to findings

THINK BIG
"consider the changing dynamics …demography, migration, urbanisation, effects of globalisation"

Promote public discourse -> informed citizens

IHI in EQUINET

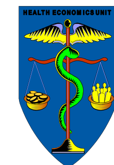
- **is a consortium network of professionals, civil society members, policy makers, state officials in east and southern Africa that aims to advance and support health equity and social justice through research, analysis, networking and dialogue**

″ Formed in 1998, linked to SADC, extended to East Africa in 2003

″ Covering 16 countries in ESA

Visit www.equinetafrica.org

Southern and Eastern African Trade Information and Negotiations Initiative


SEAPACOH

CEHURD
social justice in health

IFAKARA HEALTH INSTITUTE
research | training | services

2008 EQUITY WATCH

health

2010 OBSERVATÓRIO DA EQUIDADE

Avaliação do progresso da equidade na saùde

Moçambique

2011 EQUITY WATCH

Assessing progress towards equity in health

Zambia

2011 EQUITY WATCH

Assessing progress towards equity in health

Uganda

2011 EQUITY WATCH

Assessing progress towards equity in health

Zimbabwe

2012 EQUITY WATCH

Assessing progress towards equity in health

Tanzania

Ministry of Health and Social Welfare

Ifakara Health Institute

REGIONAL

2012 EQUITY WATCH

Assessing progress towards equity in health

East and Southern Africa

EQUINET
Regional Network for Equity in Health in East and Southern Africa

2011 EQUITY WATCH

Assessing progress towards equity in health

Kenya

EQUITY WATCH

- Gathers and organises evidence on **25 progress markers of contexts**; equity in health/ health care, equity in social determinants of health, redistributive health systems; global issues
- To **promote dialogue** on the findings, & stimulates debate on **implications for policies and actions** and for more regular monitoring;
- To **identify key equity concerns** in the region
- To **exchange country evidence** at regional level on **common trends and promising practices**.

The 2012 Regional EW found

1. More constitutional recognition of rights, but weak mechanisms and social literacy for meaningful participation
2. Rising within area inequalities, urban social inequality
3. Progress in gender differentials in primary school, but very poor progress in early childhood education
4. Low progress in water and sanitation, womens access to resources for food sovereignty
5. And moreÅ

PROGRESS MARKER in Watch report from	Zimbabwe 2008	Zimbabwe 2011	Mozam-bique 2010	Zambia 2011	Kenya 2012	Uganda 2011
EQUITY IN HEALTH						
Formal recognition of equity and health rights						
Halving the number of people living on US$1 per day						
Reducing the gini coefficient of inequality						
Eliminating differentials in child, infant and maternal mortality and under-nutrition						
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries						
Universal access to prevention of vertical transmission, antiretroviral therapy and condoms						
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH						
Closing gender differentials in access to education						
Halving the proportion of people with no safe drinking water and sanitation						
Increased ratio of wages to GDP						
Provide adequate health workers and drugs at primary, district levels						
Abolish user fees						
Overcoming barriers to access and use of services						
REDISTRIBUTIVE HEALTH SYSTEMS						
Achieving the Abuja commitment						
Achieving US$60 / capita funding for health						
Improve tax funding and reduce out of pocket spending to health						
Harmonize health financing into a framework for universal coverage						
Establish and ensure clear health care entitlements						
Allocate at least 50% public funding to districts and 25% to primary health care						
Implement non-financial incentives for health workers						
Formal recognition of and support for mechanisms for public participation in health systems						
A JUST RETURN FROM THE GLOBAL ECONOMY						
Reducing the debt burden						
Allocate resources to agriculture and women smallholder farmers						
Ensure health goals in World Trade Organization (TRIPS, GATS) agreements						
Health officials included in trade negotiations						
Bilateral and multilateral agreements to fund health worker training						

Future Directions of IHI Research: Urban Spaces, SDH observatory, UHC, Regional networks, South-South learning

- 2012 Census - Dar es Salaam 10% of total population; 5.6% annual growth

- **Youths: 47% of Tanzania's population** <15 yrs
  - Unemployment & Employment in the informal market

- **Cities are divided** (social/economical/political)
- 'Urban Bias' Vs 'Urban Penalty' → disaggregated and accurate data on urban health

- **Inequity and Inequality in Urban Spaces** --> access to services, physical environment, social fabric, livelihood

- **Governance systems for social equality**

61 % urban SSA population in slums

Research to Policy and Practice

Research alone is of limited value in influencing policies

"SDH is challenging the status quo...can research have a role?"

Call for integration of Health in All Policies across sectors and priority public health conditions

Many unresolved questions -

- **How** does evidence-informed policy and practice **change happen**?
- **How, or when**, intersectoral action contribute to addressing social determinants of health and improving health equity?
- **How to strategize** on ways forward for establishing a Health in All Policies across sectors?
- How to **incorporate** a Health in All Policies agenda at **planning and budgeting** at **Local Government Level?**

Implementation .. relationships with oth sectors

Information

Coordination

Cooperation

Integration

Health in All Policies

Information

Coordination

Cooperation

Integration

Compatibility and accesibility

Autonomy loss , resources share and grade of formality

Interdependency and budget integrate

Better understanding of how policy is made, financed and implemented with specific attention to national circumstances is urgently needed

- A great deal of attention has been paid to the contents of policies
- A great deal of effort internationally has been expended in examining best practices

Several factors critical in shaping the extent to whi~~ch research is used to influence~~ policies: addressing health inequities requires-

- Credible **evidence**
- Influential leader/ **champion**
- **Strategic alliances & coalitions**-between health and other "SDH" stakeholders, research & advocacy groups
- **Informed citizens** and public debate
- An awareness of **political priorities vs. needs**

  =>SDH Research is not only valuable in itself but as a driver of wider social change.

  =>Long and challenging process

Policies that work best

- ***Start simple but may become complicated over time*** - easily understood by all concerned; e.g. SA Child Support Grant; Swaziland Neighbourhood Care
- ***Make modest demands on institutions*** -involving just one line ministry e.g. Primary Education Development Programme, Tanzania; Child Support Grant, South Africa
- ***Command popular support*** -a policy that is nationally-owned will be much easier to implement, finance and monitor

the most important factor that influences good outcomes is sound administrative capacity; and good, transparent, well-resourced and working governance institutions

Implementation Challenges

Limited capacity to implement complex social policies at national and local government level

- **Weak/ fragile** institutions
- **Over-stretched** human resources
- A multiplicity of **uncoordinated initiatives** at LGA level:

Coordination and Scale

CBOs and NGOs in Tanzania provide much-needed services …They are:

- **Serendipitously located and structured**
- **Uncoordinated**
- **Not linked to health, education and welfare services**
- **Of unknown quality and effectiveness**

Government oversight and commitment is critical -

- Achieve **scale** and universal coverage
- Reach **Consensus**
- **Coordinate** responses
- Ensure **effective use of resources**
- Ensure **sustainability**

Some key points

- SDH / equity data informs policies at national level, but do these policies get effectively implemented?
- Need to better understand the drivers of policy change/ implementation
- Need to deepen the role of implementation and participatory research in linking research to national and local policy dialogue.
- Influence policies as and when …………
- An emphasis on partnerships, integration of inputs from various disciplines -> co-production
- A focus on interpretation and action at district level

- ***The core requirement:***

to do the basics well

- ***The core question***:

what specific policies, mechanisms and accountabilities can be put in place to promote the wellbeing of the majority in a manner that recognizes rights and entitlements, can go to scale and is lasting…redistribution!

SUMMARY

- The emphasis is to **do the simple things well and at scale**, providing for the majority in need: **less for more rather than more for less**.
- The emphasis is on **national ownership and leadership,** building upon and strengthening existing institutional capacity.

More reading

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