



African Population and
Health Research Center



Regional Workshop on Reducing Inequalities in Reproductive, Maternal, Newborn and Child Health in sub-Saharan Africa: Use of Data and Evidence for Action and Accountability

**September 10-11, 2019
Ole Sereni Hotel, Nairobi.**

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Executive Summary

On September 10-11, 2019, Countdown to 2030 (CD2030) and the African Population and Health Research Center (APHRC) organized a workshop to share findings of regional and country analyses of Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) inequalities; assess the current place of equity in country RMNCAH strategies, plans, monitoring frameworks and reviews; and agree on how evidence on RMNCAH inequalities can better be incorporated into these strategic and tracking structures. The workshop was held in Nairobi, Kenya, and organized in partnership with WHO, the Inter-Parliamentarian Union, and UNICEF. It was attended by 45 participants from 11 countries, including parliamentarians, civil society representatives, researchers and academicians, and Ministry of Health officials.

Results of analyses of wealth-related inequalities, inequalities between urban (poor) and rural populations, and sub-national inequities in RMNCAH coverage were presented and discussed. The studies concluded that, although the poorest groups had made significant progress, they still had lower RMNCAH coverage than the wealthiest ones. In addition, mortality and coverage inequities by place of residence had significantly reduced in Africa, with rural areas experiencing faster progress than urban ones in mortality reduction and increase in coverage. The analyses also showed that there were significant persistent inequalities between sub-national units in many countries.

Participants pinpointed obstacles to better use of equity data for action and accountability as inadequate access to the data, poor communication of existing data, and low understanding of the data. They identified the most neglected inequalities in their countries as wealth-related and sub-national differences as a result of cultural and religious diversity, neglect of the urban poor, poor governance, corruption, shortage of finances, and inequality in the distribution of resources.

A desk review of the inclusion of equity data in-country national plans and its use for accountability in RMNCAH revealed huge disparities between policies and actual action and monitoring. In general, there was only limited evidence of efforts in government documents or digital platforms to track if people were left behind, or even if they were being reached at all, five years into the launch of the Sustainable Development Goals (SDGs). A panel discussion highlighted best practices in the use of data and evidence for action and accountability, and there were also deliberations on roles of the different constituencies in improving and strengthening the use of data. The meeting concluded that dialogue between various constituents and collaborative relationships was essential for enhancing the use of data for advocacy and action.

Background

There has been substantial progress in the reduction of maternal and under-five child deaths, which declined by 44% and 58%, respectively, between 1990 and 2015. Despite this advancement, there has been growing concern about significant gaps and inequities in some countries that still have a notable impact on health outcomes for women, children, and adolescents. For instance, while there has been a general increase in coverage of interventions, the quality of services is wanting. Besides, significant disparities exist between the poor and wealthy, between those living in urban and rural areas, and between regions at the subnational level. The effect of these inequalities is that some populations are being left behind as the world moves towards the SDGs.

Countdown to 2030 (CD2030) is a global initiative that aims to promote increased coverage of and access to RMNCAH services for all people, ensuring that disadvantaged groups are not left behind. It focusses on low- and middle-income countries (which account for 90% of all child deaths and 95% of all maternal deaths), including 41 countries in Africa. Accountability is at the heart of CD2030: it

aims to strengthen the generation of critical data that is needed to monitor the progress of health interventions for women, children, and adolescents and inform decision-making on policy, programming, and financing for RMNCAH.

In sub-Saharan Africa, CD2030's efforts are led by the APHRC through two regional initiatives (one in West Africa and the other in East and Southern Africa). These initiatives bring together research and public health institutions, ministries of health, and civil society actors to strengthen the evidence in support of RMNCAH and nutrition programs. Since 2017, CD2030 and APHRC, in collaboration with the WHO and UNICEF, have been working with analysts and academics from 41 countries in SSA to generate evidence on inequalities in RMNCAH and nutrition and to disseminate the evidence to relevant audiences in selected countries.

On September 10-11, 2019, CD2030 and APHRC organized a workshop to share findings of regional and country RMNCAH inequality analyses; assess the current place of equity in country RMNCAH strategies, plans, monitoring frameworks and reviews; and agree on how evidence on RMNCAH inequalities can better be incorporated into these strategic and tracking structures. The workshop was organized in partnership with WHO, the Inter-Parliamentarian Union, and UNICEF and attended by 45 participants from 11 countries, including parliamentarians, civil society representatives, researchers and academicians, and officials of Ministries of Health. This is a report of the proceedings and outcomes of that meeting.

Introductory remarks by organizing partners

The African Population and Health Research Center (APHRC) works in about 30 countries across sub-Saharan Africa, supporting the generation of evidence, building capacity for generation of evidence, and ensuring that the evidence gets into the hands of policymakers. As CD2030 regional lead, APHRC has been providing technical support to help countries build evidence for improving RMNCAH. The workshop marks the culmination of two years of hard work in the first phase of the initiative and the beginning of the next stage. – *Catherine Kyobutungi, Executive Director, APHRC.*

The World Health Organization has a new 'triple billion' program that aims to see one billion more people benefitting from Universal Health Coverage; one billion more people better protected from health emergencies, and one billion more people enjoying better health and well-being. This work aligns with the SDGs and the Global Strategy for Women's, Children's and Adolescent Health, which emphasizes the importance of helping children to survive and thrive on building communities. It is essential to generate and use data to ensure equity so that no one is left behind. – *Kate Strong, WHO*

UNICEF is keen on identifying inequities in RMNCAH and building capacities to reduce them. Extending services to children in the most marginalized communities save more lives for every dollar spent. This entails gathering evidence on inequity and ensuring that the evidence is put to use where decisions are made. – *Maria Muniz, Regional Office, UNICEF*

Participation of parliamentarians in CD2030 is essential for driving the allocation of funds to ensure that services go where the need is greatest and that health services reach all. The Inter-Parliamentary Union supports national governments with capacity building in this area. Unfortunately, the benefits of development are not always shared with women, children, and adolescents. The use of evidence will help to inform policies to ensure that health services reach these groups. – *Miriam Sangiorgio, IPU*

The Global Strategy 2016 lays an excellent emphasis on equity and recognizes the fact that different partners have a role to play in reaching UHC. The Partnership for Maternal, Neonatal and Child Health

(PMNCH) is a global health alliance that works through partners, including civil society, to support the Global Strategy, and to get budgets and accountability for RMNCH. – **Kadi Toure, PMNCH**

CD2030 is about using data, evidence, and analysis, and moving it from policy and knowledge translation to action to bridge the gap between research and programs, and people's health. The initiative began in 2003 to provide evidence for advocacy and accountability on child survival and maternal health, later expanding to incorporate newborn survival, reproductive health, health systems, and adolescent health with a focus on equity and coverage in low- and middle- income countries. It is a multi-stakeholder collaboration between academic institutions, UN agencies, PMNCH, civil society, and parliamentarians. The main outputs are global reports, country statistical profiles, scientific publications, analytical advances, and country case studies.

In 2020, CD2030 will shift focus from global activities to regional and country activities, supporting ministries of health in 15 African countries to strengthen their capacities for monitoring progress in RMNCAH. It is aligned to the SDGs, which have a strong focus on equity, with an estimated 239 indicators related to health, plus focus on UHC. It also reflects the goal of the Global Strategy for Women's, Children's and Adolescent Health 2016-2030 to move forward together, leaving no woman, child, or adolescent behind. – **Ties Boerma CD2030**

Definition of terms:

- **Equity** is the absence of avoidable, unfair or remediable differences among groups of people.
- **Health equity**, according to WHO, is fair opportunity for everyone to obtain their full potential.
- **Health inequalities** are caused by remediable or controllable factors or by factors that are beyond human influence.
- **Accountability** is the process of monitoring, review, remedial action and monitoring again. It is at the heart of CD2030.
- **Monitoring for equity** requires collection of disaggregated data and analysis by dimensions of inequality. It includes reviews of progress and performance towards health equity targets.
- **Action** means change and implementation of policies to reduce inequalities in the opportunities and resources needed to be as healthy as possible.

RMNCAH Inequalities

Most participants felt that health inequalities are decreasing, but they needed details about current health inequalities and whether these are changing. Many said they knew which groups were most disadvantaged and how significant the gaps were between the top and bottom regions. Significant obstacles to better use of equity data for action and accountability were identified as inadequate access to the data, poor communication of existing data, and low understanding of the data.

Evidence: Results of equity analyses in Africa

1) Findings on Wealth-Related Inequalities

- *Dessaiegn Melesse, University of Manitoba*

Wealth is an essential dimension of inequalities. It determines access to health services. The study sought to explore disparities in the levels and trends of RMNCAH coverage indicators according to wealth quintiles. Measurement was done on differences, variations, and gaps in health status, exposure to risk factors, and access to and use of health services to several stratifiers, including wealth, ethnicity, gender, education, and age. Data were obtained from 127 DHS and MICS surveys from 36 countries in Africa.

Key results and conclusions:

- Narrowing the gap in RMNCAH coverage by wealth contributes to progress in national coverage
- Though the poorest groups made significant progress, they still had lower RMNCAH coverage than the wealthiest groups
- Rwanda and Malawi made substantial progress in improving coverage and narrowing the gap by wealth
- South Africa narrowed the gap by wealth but made little progress in RMNCAH coverage
- Ethiopia made good progress in coverage but none in closing the gap by wealth
- Countries that did not make progress in coverage or closing the gap by wealth were mostly in Central and West Africa

2) Inequalities between urban (poor) and rural populations

- *Agbessi Amaouzou, John Hopkins University*

Urbanization has been increasing, with more than half the world's population living in urban areas – 46% in West Africa and 32% in East and Southern Africa in 1990. While urban areas offer advantages such as employment, housing, access to education, health care, and social status, urban growth can generate significant socio-economic and health inequalities, posing a threat to the most vulnerable populations, such as the poor. According to UN-Habitat, most urban dwellers in Africa live in conditions that can be quantified as slums.

The study looked at gaps in child mortality by place of residence, trends in under-five mortality rates by place of residence, and the under-five mortality gap between capital centers, other urban areas, and rural areas.

Key results and conclusions:

- Mortality and coverage inequities by place of residence have significantly reduced in Africa. Rural areas have experienced faster progress than urban ones in mortality reduction and increase in coverage.
- Capital cities are losing their primacy in child mortality reduction and RMNCAH coverage over rural and other urban areas, especially in ESA.
- There is a large urban health gap between the richest and poorest groups in most African countries.
- The poorest in urban areas have no advantage over the rural population.

Questions and comments:

- The urban poor in Ethiopia is almost on the same level as the urban rich because it is less urbanized than other countries; only 20% of the population is urbanized.

- The rapid rate of urbanization is associated with increasing urban poor. The percentage of the urban population in slums is strongly associated with mortality levels in urban areas. Contributory factors need to be looked into.

3) Sub-national inequities in RMNCH coverage: Levels and Trends in SSA – Cheikh M Faye, APHRC

During the Millennium Development Goals era, most countries in sub-Saharan Africa made significant efforts towards achieving national goals in health interventions. For instance, there were 12.7m under-five deaths in 1990, compared with 5 million in 2015. But the progress was hiding some equity gaps, particularly at the sub-national level, where health interventions did not reach all targeted populations.

Now, in the context of the SDGs and UHC, the evidence is needed to understand in-country inequalities. Analyzing data on levels, trends, and determinants of sub-national disparities is essential for decision-making on the allocation of resources and design of interventions to ensure that some regions do not lag.

The study focused on country administrative divisions such as states, regions, provinces, districts, and counties. Data from the most recent (2000-2010 and 2011-2017) DHS and MICS surveys from 39 countries were analyzed. Measurement was done using the sub-national gap in coverage.

Key results and conclusions:

- There are significant persistent inequalities between sub-national units in many countries.
- There is a definite trend towards the reduction of sub-national inequalities as 19 out of 34 countries reduced inequality.
- The capital cities in most countries had much higher coverage than other regions.
- Significant efforts are needed to bring down sub-national inequalities and reach everyone with quality RMNCAH services.
- High national coverage can only be reached by closing the coverage gap between capital cities and other regions.

Questions and comments:

- There are capital cities that are not the best performing regions in some countries like Uganda, where Teso and Acholi Districts performed better than Kampala.
- The data from the surveys and methodology used need to be presented in a simple way for easy understanding by policymakers.
- Investment needs to be made into exploring explanations or corresponding data for sub-national inequalities, such as infrastructure and health workforce.

Country Equity Profiles

Inequality Assessment Using Disaggregated Data in South Africa

– Candy Day, Health Systems Trust

Although South Africa appears to have high coverage of RMNCAH services, health outcomes are still poor, the reason being lack of quality services. The Health Systems Trust is supporting the National Department of Health with data collection to see what factors are feeding those outcomes, and how to improve them. One of the essential products is the District Health Barometer (DHB), an annual publication that uses data from various sources to show long-term trends in disease burden and health services and to synthesize complex data into messages about equity. Another product is the South Africa Health Review.

In RMNCAH, the DHB uses data from the Vital Registration System, Rapid Mortality Surveillance, DHS, HIV, Nutrition and other surveys, as well as routine national indicator data from the District Health Information System, patient registers, laboratory data, confidential inquiries around maternal deaths and child health audits. Indicators track child health and nutrition, maternal and neonatal health, and women's health.

For a fair comparison, the DHB looks at the geographical area, population size, density and structures; health service levels; socio-economic quintiles; and context-relevant issues such as HIV prevalence. League graphs are produced showing couple year protection rates, detailed tables displaying district performance compared with the province and country, and trends for every indicator. The data has now been taken down to sub-national level.

Health Profiles allow districts to look at their performance and focus initiatives to address disparities. The districts are ranked using a basket of RMNCAH indicators to raise awareness about relative return, and of working with them to identify areas of focus.

In 2013, the South Africa Index of Multiple Deprivation was developed with indicators from four domains – income and material deprivation, employment deprivation, education deprivation, and living environment deprivation. Each district is ranked according to deprivation level and categorized into a social-economic quintile. Detailed reviews and surveys are used to collect the data, and consistent effort made to work with Treasury to resource-deprived districts. Overall, the data shows that there has been a decline in the share of the burden of disease per district due to communicable, maternal, perinatal and nutritional causes of death.

Mentimeter Interactive Poll for Country Teams

Country situation and trends and how to communicate data on equalities

Participants identified the most neglected inequalities in their countries as wealth-related and sub-national differences. Reasons for the disparities include cultural and religious diversity, neglect of the urban poor, lack of accountability, poor governance, corruption, shortage of finances, inequality in distribution of resources at the sub-national level, and lack of sustainability of social interventions. However in Malawi, the gap is decreasing because of availability of supplies and equipment. In Uganda, the government has prioritized investment in rural areas and health systems strengthening, so that people get services despite their wealth status or where they live. In Tanzania, the cost-sharing model has contributed to inequality: an exemption policy states that poor people are supposed to access services for free, but they are still asked to pay. As a result those who have insurance are getting services, but those who are exempt are not. South Africa has seen a considerable increase in roll-out of services, but quality is wanting so mortality rates are still high.

Most participants were of the opinion that inequalities in their countries had reduced due to increased investment in health and development of rural areas; economic empowerment of women and increase in the number of girls in schools; subsidized and free health services; increased political commitment by government and better governance; and deployment of Community Health Workers.

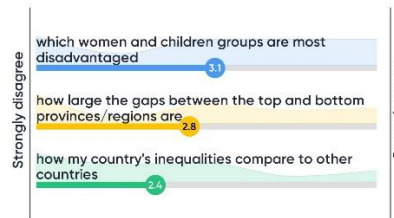
To effectively communicate information on inequities, participants suggested the use of dashboards, scorecards, and infographics, community accountability forums, advocacy workshops, and media campaigns, complementing data with community voices and testimonials, packaging information appropriately for the various target groups; and strategic engagement of parliaments.

Mentimeter Poll Results:

How much do we need to know about health inequalities?



Concerning my country's health inequalities I know



Obstacles for better use of data on equity for action and accountability:



Which constituency is most hungry for health equity data (research, government, parliament, civil society, media, private sector etc.)



WHO SRMNAH Policy Survey 2019

The WHO SRMNAH Policy Survey is carried out every two years to assist countries in tracking progress in meeting the objectives of the Global Strategy on Women's, Children's and Adolescent Health, and the SDGs. Survey results contribute towards populating a database and document repository that can be used by all countries for creation and updating of regional and state profiles. The 2019 Survey was completed using an online tool, with 42 out of 47 countries participating. Of these, 83 percent have national policies or legislation on free access to health services by children under 5, while 40% have national policies or laws on free access for older children aged 5-9. Immunization, child visits for growth monitoring, and insecticide-treated nets are often free, but sick child and outpatient care are not free. Thus, the standard and accessible services are free, but the ones that need improvement for child survival are not. The leading causes of death in Under 5 children – pneumonia and diarrhea – are addressed by Integrated Management of Childhood Illnesses (IMCI); 98% of countries have national policies on IMCI. Still, infectious diseases remain the leading cause of death among children aged one to 11 months.

Reproductive health policies can be used to enhance programs and planning or to deny access to a specific population. Disaggregation of data should be used positively. For instance, data disaggregated by particular population groups can be used to inform contraceptive action.

The next steps include validation of policies and guidelines submitted by countries for the survey and analysis of reports – regional reports, global reports, and special topics. Policy documents and data will be available on the WHO MCA data portal, and those who would like to view them will be given access.

The availability of policies and guidelines correlates to disease burdens and trends. In future, the data will only be updated for countries that submit it.

Practices: desk review of use of equity data: synthesis of initial findings

CD2030 carried out a desk review on the inclusion of equity data in-country national plans and the use of this data for accountability in RMNCAH. The study looked at four dimensions: integration of equity in national health strategic plans, and specifically plans for women's, children's and adolescent health; indicators and disaggregation of equity data in M&E plans; use of equity data in situation analyses for determination of priorities; and use of equity data in annual reports to review progress of national strategies.

Documents reviewed were from WHO repositories, including health systems planning and monitoring reports, health information systems multi-country assessment (SCORE), and the Global RMNCAH+N policy survey. Information was also obtained from ministry of health websites, regional and country repositories and Google searches.

Equity in national strategies and plans

The central goals of equity in national strategy should be UHC and universal access to quality essential services, with focus on geographic areas and subpopulations that are lagging. The review revealed significant gaps in the strategies concerning reducing inequalities. In-depth analysis using Equiframe framework revealed further weaknesses. The study is centered on inclusive policy content to ensure equitable universal access to health care. It ranks policies as high-level, moderate or low based on a range of core concepts, coverage of specific groups and a human rights approach to health.

Most policies reviewed were ranked moderate, but there were gaps in implementation and monitoring. Specifically, the Kenya Health Sector Strategic and Investment Plan (KHSSP) scores 93% on coverage and 40% on quality. It provides indicators for tracking several health outcomes and has good indicators for RMNCAH outcomes. Previous research identified geographical and gender differences in health outcomes, and although these are only mentioned in the current strategic plan, there is no clear action plan to address them.

The Malawi Health Sector Strategic Plan II scores 93% on coverage and 20% on quality. The plan uses a human rights approach to health and equity and emphasizes equitable access to quality health services through an essential health package. Though the package articulates specific interventions targeting women and children, only 35% of facilities were aware of or were implementing them. Communication of the service should, therefore, have been prioritized in the current strategy, but it is not.

In general, equity concepts are generally well covered in national health strategies. However, there is a need to explain and articulate clear policy actions to inform implementation. While macro-tracking on RMNCAH services is consistent, some aspects of inequalities at implementation level are not represented in M&E plans. In addition, reference to evidence use in some policies is not matched by clear actions to address identified challenges.

Equity in M&E plans

Several countries, such as Tanzania and Malawi, have indicator tables with disaggregation that captures dimensions of inequality. Some countries have indicators of equity, and several also include social determinants of health. Others, however, only mention the importance of disaggregation but have no specifics in M&E plans.

Equity data use in situation analyses

Most countries refer to equity issues as an essential part of situation analyses, and some, such as Nigeria and Mozambique, have RMNCAH plans with sub-national analyses to prioritize districts. Ethiopia's National Health Sector Plan 2015/16-2019/20 includes a particular chapter on equity analyses with data on inequalities for contraceptive use, mortality, and deliveries. Most other situation analyses, however, are very brief and use virtually no data to address inequality concerns.

Equity data use in annual reviews and reporting

Some countries, like Kenya, Uganda, and Tanzania, have comprehensive mid-term reviews with equity analyses and even some trend analyses. Others, such as Malawi and South Africa, have multiple publications with extensive equity analyses. Zimbabwe has EQUINET reviews of progress towards reducing inequity, detailed analyses of surveys, and other data such as determinants, as well as summary reviews. Often, though, annual reviews are not published or available to the public. Besides, analyses of equity indicators in national M&E plans are generally non-existent.

Conclusion

There were huge disparities between policies and actual action and monitoring. In general, there was only limited evidence of efforts in government documents or digital platforms to track if people were being left behind, or even if they were being reached at all, five years into the launch of the SDGs. In several countries, however, special initiatives by civil society and researchers were used to monitor health inequalities, sometimes with connections to parliament.

Feedback by the country team on desk reviews

The country teams gave comments on the desk reviews, including other available documents, strengths, and weaknesses of use of equity data and evidence in their countries, and made commitments to monitor progress so that no one is left behind.

Tanzania

Additional documents: National Family Planning Costed Implementation Strategy 2019; One Plan II MTR 2015-2020 (Draft Report August 2019); Draft National Policy 2019; Service Availability and Readiness Assessment

Strengths: Allocation of resources at sub-national level through Comprehensive Council Health Plans; deployment of clinic outreaches based on data from areas with limited access to health services; under Big Results Now program, use of data to improve underperforming areas and results-based financing to strengthen well-performing facilities.

Weaknesses: Lack of capacity to use data for decision-making, especially at sub-national level; resource constraints to implement change based on data findings; there is no connection between data collected and the decision-making process; the country has a costed health plan based on data, but there are no resources to implement what the data recommends, hence a disconnect

Zimbabwe

Strategies should run concurrently for ease of comparison and analysis

Additional Documents: Adolescent Sexual and Reproductive Health Strategy 2016-2020

Strengths: Equitable distribution of resources; evidence-based advocacy; classification of the population by need

Weaknesses: incomplete or inaccurate data; the data does not reflect the quality of services being provided

South Africa

The government has been deliberate about improving infrastructure in rural areas and increasing coverage of health services.

Strengths: Regular monitoring of the PMTCT program, National Health Laboratory Services and researches to pinpoint high disease burden areas for prioritization; regular reporting to the auditor-general for accountability; social grants as incentives for birth registration; strong civil society that keeps watch on government programs; increasing use of real-time digital data to provide responsive, targeted services; working with partners to close identified gaps; intense scale-up of HIV treatment based on data; use of feedback and information to increase uptake of services through programs like Mum Connect.

Weaknesses: Monitoring tends to be reactive to negative incidents; limited use of conventional information systems; 'vulnerable populations' mentioned in documents, but no data is collected on them; challenge in quantifying migrants for planning.

Ethiopia

Additional documents: Health Sector Transformation Plan II MTR; National Health Strategy; National Nutrition Policy; situation analysis and M&E plans

Strengths: Equity is captured in health strategy documents

Uganda

Strengths: The National Planning Authority certifies ministries whose budgets respond to equity considerations in national plans; parliament only approves budgets of ministries certified by the NPA; the Equal Opportunities Commission ensures every ministry plans, allocates resources and implements policy based on a set of equity-sensitive indicators; two strategic shifts on equity in the Sharpened Plan for Uganda; advocacy groups use data to lobby government

Weaknesses: there is a clash between the political priorities of the government and what the data says the need is

Ghana

Strengths: Budget allocation is guided by national level equity data stratified by region, gender and wealth; long traditional of reporting statics from all the regions that are used for budgeting; integration of data builds efficiency; equity data is used in allocation of health staff

Weaknesses: gaps in systematic disaggregated sub-district level data; data collected is mostly 'topical'

Malawi

Documents used in the review are outdated.

Additional Documents: Malawi Growth and Development Strategy; National Community Health Strategy; Adolescent Girls and Young Women Strategy 2017-2020; Human Resources for Health Strategy

Strengths: Equity data is useful in Malawi's resource-limited environment; HIV, Family Planning, and HRH programs have valuable equity data.

Weaknesses: equity data does not capture the quality of interventions; it should be accompanied by qualitative data

Mozambique

Additional Documents: Ministry of Health Gender Strategy; HIV Strategic Acceleration Plan; Government Strategic Plan 2015-2019

Strength: The government is committed to including equity data in strategic documents and M&E plans

Weaknesses: publication of data on equity is not timely; loss of data; non-experts do not easily understand equity data

Zambia

Additional Documents: National Development Plan; Human Resources Strategic Plan; National Supply Chain Strategy; Adolescent Strategic Plan

Nigeria

Additional Documents: Health Sector Strategic Plan 2018-2022; National Strategic Health Development M&E Plan 2018-2022; National Health Act; Basic Health Care Provision Fund; Nigeria Economic Recovery and Growth Plan (log on to www.health.gov.ng for all plans)

Strengths: Equity concerns are included in the strategic plans, including access to health care for the weak and poor; the Child Health Plan has a clear M&E plan and indicators; RMNCH plan looks at equity concerns; the Basic Health Care Provision Fund was set up in response to the strategic plans

Weaknesses: equity data is not stratified to rural-urban or sub-regional considerations; allocation of resources is not needs-based, but instead programming is based on hype.

Participants were asked to send all additional documents to Correta for inclusion in the review.

Parliamentary effort to strengthen equity

Uganda's Equal Opportunities Committee in parliament ensures all ministries have equity considerations in their plans, and Ghana has a ministry in charge of Gender, Children, and Social Protection. Zambia has a parliamentary committee that looks into youth, gender, mother, and child and health issues. The committee receives submissions on budget allocations from the Ministry of Health, civil society, and public health institutions. In Malawi, parliament tracks budget allocations by the Ministry of Health. South Africa has a parliamentary committee that focuses on women's health and gender violence. Besides, the Women's Caucus in parliament provides oversight to the Ministry of Women, which sits in the president's office.

Comment: M&E is mostly viewed negatively, like auditing. Instead, it should be defined as Monitoring and Learning. Besides, countries have limited capacity for M&E, leading to poor quality data.

Panel Discussion: Best practices in the use of data and evidence for action and accountability

Panelists: Catherine Kyobutungi, APHRC; Dan Peterson, Danida; Esther Nasike, Director for Advocacy in Uganda; Susan Kihika, Member of Parliament, Kenya; Quantu Nuama, Member of Parliament, Ghana; Tinu Taylor, MOH Nigeria; Kate Strong, WHO

Moderator: Kadi Toure, PMNCH

What are some of the best practices in using data for advocacy and accountability in your country?

Civil society in Uganda plays a role both in raising awareness about issues and generating data to inform advocacy. In addition to statistics provided by the MOH or the national bureau of statistics, civil society brings in community-generated data, enabling community members to contribute to development. Community voices put a face to the data, and members of parliament relating to that.

In addition, having a strong, well organized civil society platform is important for active engagement with other stakeholders. Another best practice is working with researchers to unpack the numbers and put meaning to them to ensure that the data is consumable for the different levels. Civil society facilitates friendly engagement between citizens and duty bearers on allocation of revenue for services. Based on the discussions, an action plan is drawn up and commitments made by both the community leaders and the local leaders. If allocation of funds needs to be done at national level, civil society advocates for that. – **Esther Nasike, Uganda**

Parliament is usually not able to get independent data and information to properly oversight the executive, hence the need for collaboration with civil society. – **Quantu Nuama, Ghana**

The use of data is crucial to inform policy change. Over time there has been a disconnect between researchers, policymakers and parliamentarians, leading to poor implementation and poor results. Still, the Nigerian government has a lot of experience in working with civil society in directing budgeting of resources and drawing attention to gaps and how to close them. When there is collaboration, everyone feels a sense of ownership and belonging. – **Tinu Taylor, Nigeria**

Tanzania's star-rating of facilities, which is based on the evaluation of quality and coverage of services, encourages facilities to improve their services. Another successful initiative is the Public Health Care Facility Financing, where funds go directly to the facilities to manage, which has encouraged ownership and accountability. The question of equity can be addressed through such functioning mechanisms, with the right capacity and incentives. It is also important for researchers to understand what politicians and policymakers want to achieve and find a balance to avoid a disconnect. – **Dan Peterson, Tanzania**

Budgeting for a working health care system needs to be informed by the valid data. But data is often not presented in user-friendly packaging. Kenya is investing in policy analysts to help parliamentarians unpack data so that they can articulate the issues, advocate for them and pass budgets. Disaggregation of data by counties has helped to target problematic areas. – **Susan Kihika, Kenya**

Researchers must realize that it is not their passion for the work that matters, but how the research fits into the big world out there. Evidence use does not start and end with the project; it is about relationships with the users, a process that continues way beyond the project. APHRC peddles expertise, not evidence, pairing experts with users so that the research is useful and relevant. It is also essential for researchers to learn new skills about how the world works, such as the budget cycle and what committees are essential. A presentation made to a budget committee is not the same as that formed at a conference; the evidence must be relevant to the audience. Neither should researchers assume that their work is useful for everyone.

However, the demands of expertise can be substantial. An organization can decide to divide the available budget to fund policy engagement activities for each project or use the funds to support a limited number of issues. In the absence of core support, a long-term strategy is needed with the end game in mind and a plan of how to get there. – **Catherine Kyobutungi, APHRC**

Evidence and data must be relevant to the country context, actors, and users. It requires forming relationships with the various players and being there to provide the data that is needed. Barriers to sharing data include potential errors and irrelevance: sharing the right data at the right time and place is essential. A lot of learning happens when data is shared. Making it available on platforms that

display the information, with maps and relevant analysis, helps to provide digestible information. –
Kate Strong, WHO

Questions and comments:

- The role of MPs in data collection includes being respondents to provide information on the issue. Together with other policy actors, they are involved in looking at the data and ensuring its relevance and usefulness, refining study questions, gauging the depth of engagement, interrogating preliminary results, validating the final findings, and making recommendations on what is practical and relevant. Their role is also to make sure that the data is converted to budget and that it meets the needs of the people.
- Use of qualitative and quantitative data – evidence is evidence in the hands of the right person, depending on who is working on it and what they want to get out of it. It is evident if it is understandable and usable for the intended consumer. Every little piece of the puzzle changes the situation, leading to learning and new directions. Some researchers deal with data, and others use evidence. Partnerships are essential for leveraging on each other's strengths, rather than trying to build the same capacity across the data generation chain.
- Intervention research is needed to evaluate the improvement of services as a result of programs such as the Health Facility Fund in Tanzania, but there is limited capacity to do this.
- To promote the use of routine data, governments should take ownership of data collection and not leave it up to donors and civil society. The data also needs to be focused, not too wide. A framework of data use needs to be in place, including laws, policies, and mechanisms for it to be shared and channeled for purpose. The more your data is used, the better it becomes. The assessment shows that there is capacity for data generation, but not for analysis and application.
- An essential use of evidence by civil society organizations is highlighting gaps between evidence and practice, and inequities in the system.

Q: What are the roles of your different constituencies in improving and strengthening the use of data?

Researchers should be intentional about disseminating data and evidence and creating relationships that help to move this data.

Government strategic plans should inform how equity data can be put into use, and civil society should keep the government accountable for this. The role of government should be to bring down inequality through need-centered interventions and to ensure quality in delivering services.

WHO produces several products for monitoring and learning, such as the equity monitor, score package of tools for M&E, and a health portal, which are freely accessible? But country perspectives and content are also crucial for local context. Impactful displays of data analysis are needed to make it more relevant for thriving and transforming communities.

The role of civil society is to highlight gaps between evidence and policy, to advocate for the closure of these gaps, and to make data user-friendly for targeted audiences. The role of parliament is to make sure that budgets that are passed will help to leave no one behind; to analyze and synthesize data needed to bridge identified gaps and to give oversight to the executive on use of evidence to address inequalities.

Way Forward - Promoting Evidence Use for UHC

Parliamentarians should make sure that researchers ask the right question to gather relevant data. The approved budget should be based on data; parliament should provide oversight in ensuring that approved budget is used for the intended purpose; demand feedback from technocrats on use of data; spot checks to see whether data given is matching that provided by civil society; and demand agreement on use of evidence-driven data. Parliamentarians should push for implementation of the Abuja Declaration and demand domestication of global protocols and declarations into national law after they are signed. They can also use zones of autonomy to demand compliance at regional and continental levels. The MPs will lobby backbenchers to force the hand of the executive, and will not approve the national budget if the 15% for health prescribed in the Abuja Declaration is not taken into account. But this has to be a collective decision across the region, with the support of the IPU. In addition, the IPU is developing a resolution on UHC that countries will be expected to adopt and implement.

Researchers should maximize the use of existing data by translating it and having regular forums to share and formalize arrangements for its use. They should build capacity of routine data producers so that they can become users; diversify tools and channels for sharing data; communicate better what the data is showing, and incorporate equity considerations during analysis, using layered analysis to bring out information that may not be apparent in a single data source. They should build the capacities of various players in the data value chain. The researchers can guide prioritization of national research agendas, become custodians of those priorities, and improve sharing of data among themselves. They can do more to build respect and trust with the MOH and other partners, learn and understand the political-economic environment, strive to understand the needs of various data users and provide tools for stakeholders to identify their problems and the solutions. It is essential to work out how to deal with politicization of data. Researchers should improve how they communicate results so that they are not seen as a challenge but as an opportunity for improvement.

The government needs to improve collection of routine data – decide what kind of data is wanted, build capacity at facility level to collect and use data, and encourage parliamentarians to ask questions about it. There must also be coordination of data demands from various agencies so that the collection is too scattered. There needs are common ground for discussion between the multiple constituents so that all are working in sync to improve health care. Review forums where all constituents are present should be organized, led by government.

Civil Society should organize itself better for effective engagement with other stakeholders. They should review government documents and discuss them on a shared platform. Building capacity of communities to engage with their representatives is important so that their voices can be heard. They should produce independent analyses to inform action, focusing on evidence from the community. Civil society should work with researchers to simplify evidence and package it in a format palatable to different constituencies. They should work with media so that the information is shared effectively, document best practices, and share them with government for scaling up. They should produce a barometer on accountability and transparency on equity data, push governments to centralize M&E frameworks and advocate for more disaggregated data by sub-national level. They should bring stakeholders together to review progress on use of data and centralized M&E frameworks.

Platforms are available for both dialogue and dissemination at the country level. Annual reviews and technical working groups are excellent forums for engagement at country level, but participants should be knowledgeable enough to be effective. A committee should be created to push for domestication of international protocols through the attorney-general, while MPs need to educate the populace on available avenues for interacting with parliament.

In the next phase of CD2030, it will be important to have forums to engage countries to ensure that data is used to reduce inequalities. CD2030 will work more with public health institutions to strengthen the analysis and communication of data, as well as with civil society, media, and parliament. Since there are many actors, platforms will be created where all parties come together to discuss and share.

The last word

Collaborative relationships are important, where everyone plays a complementary role. A lot still needs to be done to ensure that data and evidence, and their use, are presented and communicated in ways that are widely understood. We need to look beyond the numbers to the context of the data.

- WHO

Partnership plays an important role in enhancing use of data for advocacy and action. PMNCH will play a bigger role in building linkages between the different constituents, partners and countries for more effectiveness. – **PMNCH**

CD2030 has organized several workshops to bring constituents together and get them to discuss their challenges in analyzing and using data. Hopefully data and equity will become key to the way partners work. We must keep an eye on the ultimate goal – leaving no one behind. In the next round, CD2030 will work closely with selected countries to assess data for program reviews and provide technical capacity. – **CD2030**

The equity story – we have done well, but we can do better. The next phase will be informed by lots of elements. Communication will be shared on how to move forward. But what we learnt here can already be used in many other ways. Let us be the change we want to see. – **APHRC**