EQUINET

Regional network for Equity in Health in east and southern Africa
www.equinetafrica.org

Despite the strong social values and policy commitments to ensure health for all east and southern Africa, there are wide, avoidable social inequalities in health and its determinants, and in access to health care. Founded in 1998, the Regional Network on Equity in Health in east and southern Africa (EQUINET) is a network of professionals, civil society members, policy makers, state officials and others within the region who have come together as an equity catalyst, to promote and realise shared values of equity and social justice in health. This brief introduces EQUINET, our organisation, work and the lessons we have learned in the struggle for equity and social justice in health.

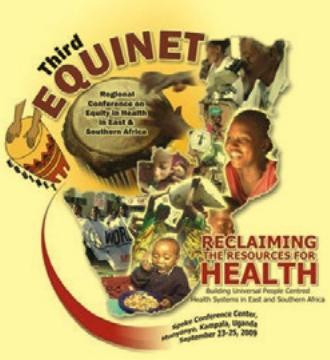
Our vision and mission

EQUINET networks people to overcome isolation, give voice and promote exchange and co-operation using bottom-up approaches built on shared values. We have come together in a spirit of self determination and collective self reliance working through existing institutions in east and southern Africa, and with regional organizations, including regional intergovernmental forums, parliament forums, professional networks, regional union bodies and health civil society forums.

We understand that change is brought about by the interaction of diverse policy, technical, social and political actors, and by evidence on both problems and options to address them. EQUINET supports rigorous, relevant research, and fosters forums for collective analysis, dialogue, learning, sharing of information and experience and learning from action. We do this to build knowledge and perspectives, shape effective strategies, strengthen our voice nationally, regionally and globally and our strategic alliances to influence policy, politics and practice towards equity and justice in health.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In east and southern Africa, these typically relate to disparities by race, residence, socio-economic status, gender, age and region. EQUINET promotes policies and interventions that allocate resources for health in relation to health need (vertical equity). We seek to understand and engage on the distribution of social and economic resources for equity oriented interventions to improve health. We also seek to understand and inform the power and agency people (and social groups) exercise to make and use choices over health inputs to realise their health rights and improve health and wellbeing.

We have built knowledge on different dimensions of health equity through supporting, mentoring and implementing policy, legal and equity analyses, literature and data review, field research studies and participatory action research (PAR).



By early 2016, EQUINET had

- convened 150 meeting and training workshops in the region;
- held three regional conferences; and
- published 107 externally reviewed discussion papers, 20 PAR papers, 8 country equity analyses, three regional equity analyses, 40 policy briefs and a range of training materials.

We have participated in regional senior official and ministerial conferences, including through a formal memorandum of association with the East Central and Southern African Health Community (ECSA HC).

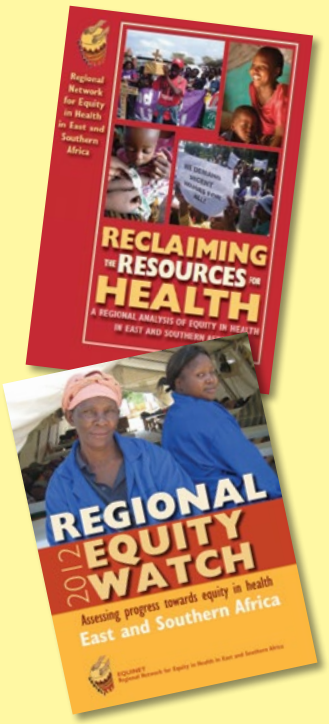
We seek to raise the profile of perspectives from and work undertaken within the region. All of our publications are available open access and online at http://www.equinetafrica.org/content/equinet-publications, Our website has a searchable database of publications on health equity in the region. We disseminate and share information through our monthly EQUINET newsletter, which by mid-2016 had reached its 183rd issue.

We have an affirmative and problem solving agenda, engage with diverse communities on options to enhance equity and share the evidence in our publications and in posters, videos, community photography exhibits, radio programmes, scientific presentations and inputs to strategic forums.

Twenty years of advancing health equity

Post independent east and southern Africa has had a longstanding policy commitment to equity in health. A Southern Africa regional meeting in 1997 on 'Equity in Health—Policies for Survival in Southern Africa' in Botswana raised the need to translate this commitment into analysis, policy and practice. EQUINET was formed in 1998 to inform and support the newly formed Southern African Development Community (SADC) Health sector to do this.

In our first years, we clarified how equity was understood in the region and the policies and practices that turn values into action. The SADC Health Minister's meeting in 2001 recognised EQUINET work and co-operation in this area. In 2001 to 2004 we widened and consolidated the network, focusing on 'reclaiming the state' and public sector leadership in health, given the challenges to equity from a decade of structural adjustment policies in the region. By 2005 EQUINET had, in response to demand, spread to east and southern Africa, and had established a formal co-operation with the ECSA Health Community (HC). We widened our work and institutions to inform, support and engage with different dimensions of the systems that deliver on equity in health and with the constituencies that influence them. Hence, for example, we raised equity issues in prevention and treatment of HIV and AIDS, and played a catalytic role in the launch of the Southern and East African Association of Parliamentary Committees on Health (SEAPACOH).



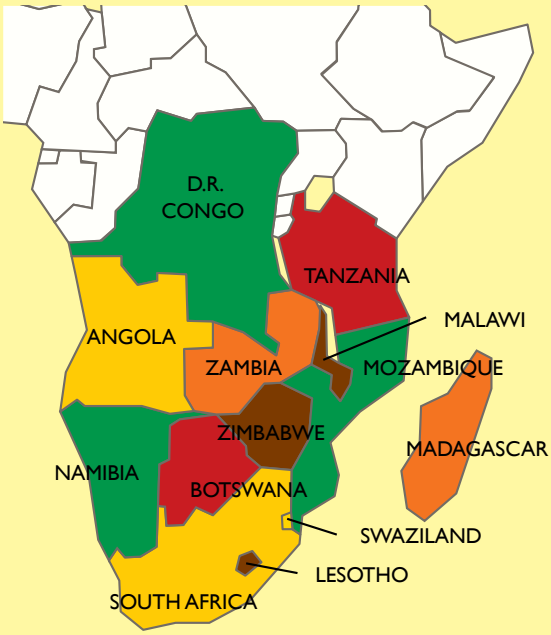
Our work highlighted the economic, food security, living and working environment, education, health system and social literacy and power issues that determine the distribution of health in our region and the global forces that influence this. We consolidated our analysis of these determinants and options to address them in our 2007 regional analysis on 'Reclaiming the Resources for Health'. Since 2010 we have explored and proposed options where we can improve health equity. We recognize that this demands a sustained process of building and consolidating the perspectives, policy and practical levers, institutions and constituencies for progress- and of defending against reversals- over a long term. Our longevity enables this longer term focus, while we also forecast and engage with emerging challenges.

From a small network in southern Africa, we now cover 16 countries in east and southern Africa, with institutions and people from across the region involved in EQUINET training, research, policy dialogue and information activities, and significantly more globally using our resources. We have brought regional perspective and evidence to global level, including as a co-lead in the World Health Organisation Commission on social determinants of health knowledge network hub on health systems, and with global civil society (such as Peoples Health Movement) and technical organisations.

How we are governed and organized

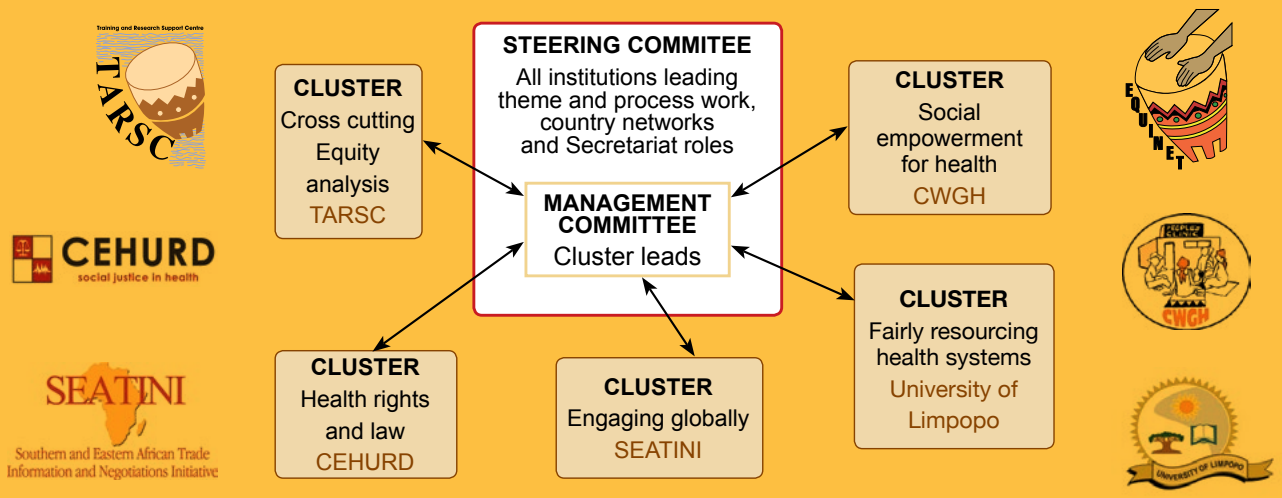
EQUINET is a consortium network of institutions registered in different countries in the region, with its secretariat at TARSC, a non-profit organization registered in Zimbabwe. The network constitution sets out its vision, principles, composition, structures, governance and procedures.

The network is governed by a **steering committee** of institutions leading key areas of work from within and beyond east and southern Africa. The steering committee includes academic, government, civil society, parliament and non-profit institutions that co-ordinate different **theme, process and country** activities in the network and the secretariat. The steering committee provides overall policy co-ordination and direction of the network, including strategic review and evaluation, and hosts the regional conference. It communicates online and meets in person at least once in strategic plan periods, for strategic planning and review. The secretariat is the point of contact for and manages external communications to/for the network.



In 2009, as the work expanded, the steering committee devolved and organised its processes through **cluster leads**. These co-ordinate and manage the five clusters of work within which the different theme and process work is organised, communicate regularly with the theme and process leads within their areas, and make up a **management committee that meets** annually and communicates regularly to plan, manage, oversee and report on the work of the network. The five clusters of EQUINET work are:

1. **Cross cutting equity analysis**, integrating work in other clusters, the pra4equity network on PAR and the newsletter, together with theme work on the equity watch and district health systems, co-ordinated by Training and Research Support Centre (TARSC).
2. **Health rights and the law,** integrating work of the learning network on heath rights, theme work on law and constitutional rights in health, and work in national networks, co-ordinated by Centre for Health Human Rights in Development (CEHURD).
3. **Fairly resourcing health systems**, integrating theme work on health financing and health workers, co-ordinated by University of Limpopo.
4. **Social empowerment for health**, integrating theme work on health centre committees, and with parliamentarians and civil society co-ordinated by Community Working Group on Health (CWGH).
5. **Global engagement**, including work on trade and health and health diplomacy co-ordinated by the Southern and Eastern African Trade, Information and Negotiations Institute (SEATINI).



Our work, learning and its impact

EQUINET work has over the past decades focused on advancing health equity in the region.

In its current phase, EQUINET is focusing on its main strategic agendas (turning values into action; reclaiming the state and resources for health), while deepening the engagement with and uptake of evidence at local, country, regional and global level, through approaches that directly involve key actors.

From a resource based that was limited to the contributions of the six founding members, the network has over the years mobilized about US$6 million directly from a range of funders, including Rockefeller, Swedish International Development Aid, International Development Research Centre Canada, Cordaid, Dag Hammerskold, DfID, Medico, Open Society Foundation, Canadian Institutes of Health Research, GTZ Germany, WHO, WEMOS Netherlands, Southern African Health Trust and ECSA-HC. Many others have contributed grants directly to consortium institutions. We are constantly seeking to strengthen the network's effectiveness and sustainability.

Within these broad goals, our cluster and theme work, has supported various areas of change.

In the **cross cutting cluster on equity analysis**, co-ordinated by TARSC working with national technical and government partners, and in co-operation with the ECSA Health Community, we have built capacities for equity analysis in 9 ESA countries, published country Equity Watch reports in 6 countries and at regional level, reporting progress over the last two decades in 25 progress markers of health equity. The findings have been discussed with policy, parliament and civil society actors at country and regional level, and used in a range of teaching and research programmes. The evidence has been used in various national processes, such as in policy dialogue on equity in universal health coverage in Zimbabwe, or on equity in resource allocation and on social determinants of health equity in Mozambique. It has informed regional Health Ministers' resolutions and, including through a joint analysis with UNICEF, has been used in advocacy for a stronger equity focus in the post 2015 agenda.

One of the findings was the growth in urban poverty and inequality, and the limited evidence on *within* area inequalities in health. We are thus now exploring the distribution of and responses to urban inequalities in health in ESA countries. A review of the literature in an annotated bibliography on urban health equity found fragmented evidence of different and often disconnected facets of urban risk, health and care. There is limited direct voice of those affected, and limited report of features of urbanisation that promote wellbeing. We are thus exploring urban health equity further using a holistic, transdisciplinary and participatory lens.

Following a situation assessment of social determinants of health (SDH) equity in Tete province, Mozambique, we are implementing work to review the extent to which international guidance on health responsibilities of the extractive sectors are contained in domestic regulation in ESA countries. Further, from discussions on the Equity watch reports, we are also now implementing work co-ordinated by Ifakara Health Institute (IHI) and with health ministries from several countries on the development, costing, role and impact of 'essential health benefits' in equitable health systems. IHI is also working on urban health and SDH.

Participatory action research (PAR) has since 2005 been a cross cutting process, applied in diverse areas of work within a pra4equity learning network that now extends beyond ESA countries to other regions. Co-ordinated by TARSC and involving many network institutions, we have held six regional and several national training and review workshops, with mentoring and further skills development on areas such as 'photovoice', building facilitation capacities in over 200 people across the region.

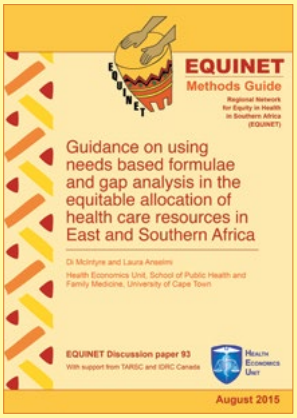
PAR has been used to build analysis, action, new knowledge and changes in local health systems in relation to health worker-community interactions, environments for health, food sovereignty, public health PHC responses to HIV and maternal health services post Ebola. We have produced a methods toolkit. numerous publications on this work, that help to explain the use of PAR in practice, a PAR Methods Reader in English and Spanish jointly with WHO, and we co-ordinate a PAR cluster within a thematic working group Health Systems Global.

The PAR has shown that health systems have high legitimacy to address social determinants of health, but do not always effectively do this, and often do not reward or build capacities for social roles in health. This has negative consequences for services and communities. In contrast, the PAR processes have mobilised greater mutual understanding and communication and 'people-centred' changes in local systems, although sometimes meeting resistance from authorities and health workers, who saw it as 'giving up power'. With the many global factors affecting our health and health systems, our learning network enables us to build meta-analysis and regional review and we have developed a proposal for a web platform to bring together people with common experience across countries to implement PAR online.

The **cluster of work on health rights and the law**, co-ordinated by CEHURD, has over the past decade with University of Cape Town and the learning network on health and human rights explored and identified best practice in using human rights to advance health issues, including to operationalise the right to health as stated in national constitutions and in international treaties and agreements. The cluster is producing various resources, such as regional toolkit on health rights to support civil society activists, applying the learning from the work. It also facilitates exchanges between civil society activists in the region and globally, such as in the Peoples Health Movement. The learning network has implemented work on using health centre committees as a vehicle for achieving health rights, reported later, and has used a rights lens to analyse and make input on new national laws and policies. A CEHURD review in east Africa of public health laws using a rights framework and a review of inclusion of the right to health and health care in the constitutions of 16 ESA countries is now being followed by country case studies to audit and communicate on how these rights are being implemented, and how advocates of health rights have subjected constitutional provisions to court interpretation. The work indicates the these legal provisions are important but vary greatly in presence and use within the region, with gaps in constitutional rights to health in many countries and relatively old public health laws. The lack of effective awareness and use of existing legal provisions indicates that participatory methods and health personnel training can enhance uptake. EQUINET also aims to review public health law revisions within the region.

The work on health rights has been applied in various processes. It has informed inputs to constitutional, legal and policy review in several ESA countries. In South Africa, for example, UCT used a rights lens to support civil society submissions on new laws and policies, including on the National Health Insurance proposal. In Uganda, CEHURD, in liaison with the UN Special Rapporteur on the Right to Health and supported by a coalition of 40 civil society organisations, filed a constitutional case on maternal deaths arising from deficits in provision of essential maternal health commodities in government health facilities. CEHURD has worked with the Ministry of Health to develop a manual on health and human rights for health professionals. Globally, CEHURD and the pra4equity network participated in an international consortium on how a right to health approach would affect the post 2015 MDGs, with participatory consultations on community understanding of the right to health in Uganda, Zimbabwe and South Africa that fed into follow up proposals on global development goals and learning on social power in health.

Work on **fairly resourcing health systems**,
integrates theme work on health financing and health workers, co-ordinated by University of Limpopo. University of Cape Town Health Economics Unit (UCT HEU) and country teams in Zambia, Mozambique, Zimbabwe, Uganda, Kenya, South Africa have identified equity- oriented issues in and options for domestic resource mobilisation, resource allocation and in financing for universal health coverage (UHC), and provided a guidance resource for integrating equity in resource allocation. The work has shown pro-poor pro-equity benefit of spending at primary care level, and provided options for strengthening mandatory pre-payment to reduce catastrophic spending, especially through tax funded public sector health services. The regional work has been taken forward within the Global Network for Health Equity, with UNICEF in exploring catastrophic expenditures and in regional policy and international scientific forums. It has informed various country programmes on health financing, including in Zimbabwe, Mozambique, Namibia and South Africa. The theme work has raised attention on equity concerns in commercialisation of health systems, and pointed to areas for improved regulation of the private sector in health. A co-operation with the Municipal Services Project has produced new information, discussion papers and a book with the Institute of Social and Economic Research on capital flows in the health sector in east and southern Africa and a book on Alternatives to Privatisation.

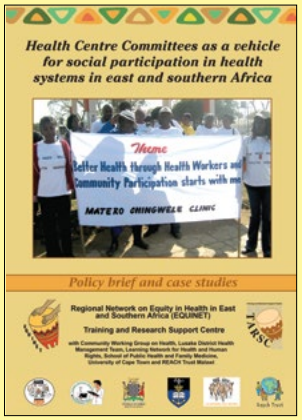


University of Limpopo, working with ECSA HC, University of Namibia and country partners has in ten ESA countries over 5 years built evidence and learning on health worker retention and migration, that has informed pro-equity resolutions at the regional health Ministers in ECSA HC, radio debate in Channel Africa, WHO technical committee staffing norms and standards for the Africa region, and has contributed to the 3rd Global Forum on HRH report and country health worker strategies. The regional work has been used in engagement on the Code on International Recruitment of Health Workers, in the Steering Committee and policy of the Health Workforce Advocacy Initiative, with NORAD and other partners in a consultation on access to skilled health workers for improved maternal and child survival and in the ECSA HC Human Resources Alliance for Africa (HRAA). The lead of this work in EQUINET was appointed in 2015 as Director General of the ECSA HC. With the significant body of evidence and policy advances, EQUINET is supporting and informing implementation of the learning, including of the WHO Code and of measures for health worker retention, and particularly of skilled health workers in primary care.

The **cluster on social empowerment for health**,
integrates theme work on health literacy and health centre committees, and with parliamentarians and civil society, and is co-ordinated by CWGH. Within countries work has been done with TARSC and country civil society partners to develop materials for and implement health literacy programmes in Zimbabwe, Zambia, Malawi, Botswana and Uganda. In Zambia, Lusaka District Health Office health literacy work was adopted at national level, after it was found to have reduced epidemic diseases and to have improved service performance.

Further CWGH with TARSC, UCT and Lusaka district health management team is implementing work to strengthen the role of health centre committees (HCCs) as a vehicle for social participation in health. Materials have been developed for HCC training, with the Zimbabwe materials now recommended for use nationally by government. A repository of HCC training materials is being compiled for use in the region. Guidelines have been developed on the election, composition and role of HCCs, and several regional meetings have been held to discuss the HCC role within the wider context of social power and people centred health systems, and with UCT as a vehicle for advancing health rights.

The regional meetings have identified shared regional learning on the important role HCCs can play in building an informed community through health literacy and in bringing community voice to 'the table' for health planning and budgeting on the views of different social groups and the situation in the community in relation to health risks and violations of health rights. Working with HCCs and exchanging across areas and countries the work has shown that HCCs can play a key role in advancing primary health care, through facilitating social action and partnerships and through dialogue with different actors, including local authorities. In Zambia, the Lusaka District Health Team and Ministry of Health is using outcome mapping as a tool in the national health programme to assess achievement of health and participation goals in their work with HCCs.



The Association of Parliamentary Committees on health in East and Southern Africa, now extended to Africa continentally in NEAPACOH, has held meetings annually on health, initially with EQUINET support and after 2009 with support from PPD ARO. The meetings have been used to review and take up issues in national parliaments, such as on holding the executive to account in meeting the 2001 Abuja commitment on 15% government budgets allocated to health, with positive impact in some countries.

The regional context has raised issues for **the cluster on global engagement**, including on trade and health and health diplomacy in relation to health issues in World Trade Organisation agreements and under debate at the World Health Assembly. The cluster co-ordinated by SEATINI has advanced this, with information and policy briefs, twelve papers in the global GHD-network monitor, and in training and preparatory workshops with senior officials and diplomats, parliament, civil society and other constituencies on global health. As research and information lead within the ECSA HC Initiative on Global Health Diplomacy, EQUINET has provided policy, information and training inputs in the ECSA HC senior official and Ministerial meetings, and with the Africa group of health diplomats in Geneva. Research co-ordinated by TARSC and Carleton University generated evidence and learning on African engagement in global health, including on the implementation of the WHO Code led by U Limpopo, on local production of essential medicines led by SEATINI, on the involvement of African actors in global health governance on performance-based-financing, led by University of Sheffield and on the relationship of the health commitments in BRICS to those expressed in regional policies. The papers have been published in a 2015 issue of Journal of Health Diplomacy on Africa co-edited with EQUINET, reviewed at a regional meeting and used in training and policy forums of the ECSA Health Community to identify shared learning and areas of follow up work.

From the work we have learned of the need to support early, consistent, multiactor co-operation at country level on issues being taken to global level, to strengthen communication within the region and between capitals and embassies, and to link global processes with African policies and frameworks for health system strengthening (HSS). We are now taking this forward, together with new work on food sovereignty and HSS, and strengthening exchange of learning and experience south-south with other regions.

Across these various areas of work and interactions, network institutions have engaged in work in almost all of the 16 ESA countries on different aspects of health equity, involving or collaborating with more than 50 universities, research institutions, state and civil society institutions; and interacting with SADC task forces, with the ECSA HC, WHO, Peoples Health Movement, Copasah, Health Systems Global, UNICEF, and many others. EQUINET was cited in the WHO World Health Report 2008 as a promising practice in regional networks. A 2009 evaluation cites the credible information and consistent values based interaction from institutions in the network as contributing to the uptake and impact of its work.

Lessons learned

This brief outlines our diverse theme and process work, its use in a range of processes from global policy engagement to local community action and specific areas of learning.

We have the resources in the region to close unacceptable differences in health. The diversity of disciplines and actors in EQUINET has enabled a breadth of understanding and engagement on health, within and beyond the health sector, including to support the universal and participatory national public sector health systems needed for comprehensive PHC and health equity.

The consistent links we have built with national and regional institutional platforms and partners have embedded our research within policy, strategic and activist agendas the region. We have increasingly engaged and involved policy, technical, implementation, civil society and community actors in building evidence, analysis and knowledge for change, and share evidence in a range of open access, printed and other media. We are constantly seeking to improve methods and nourish capacities, learning from teamwork with district, national and regional actors and from south-south interactions.

In a complex policy environment with strong global influences, our regional communities and interaction are key to shaping and implementing self- determined responses. EQUINET provides a consistent regional platform based on institutions within the region for diverse disciplines, actors, institutions and work to come together, to raise the profile of health equity, to inform and advance options to build health equity and to nourish and support the leadership and capacities to take these options forward.

Follow up resources and contact

The resources referred to in this brief on the network and its publications and work can be found on the EQUINET website, (www.equinetafrica.org) together with links to the secretariat, cluster lead institutions and other resources. This brief is available electronically online to facilitate direct hyperlinks to documents.

Please visit the website for the resources it has: To search, read and download our publications, including externally peer reviewed discussion papers, training materials, policy briefs, books, videos and community photography. A searchable annotated bibliography on health in the website has about 3000 publications on or from the region, searchable by theme, key word or country. You can read the EQUINET newsletter online, or contact the secretariat at the email below to be subscribed to it. The newsletter provides information about new publications, resources, meetings, conferences, research grants and training relevant to health equity.

For further information on EQUINET

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Photos: p2 Community meeting, Kenya, S Juma 2009; EQUINET Conference, Uganda, TARSC 2009; p4 Nutrition community situation analysis, DPS Tete 2011; p5 Social mapping in PAR, Lusaka, A Zulu 2012; Meeting on maternal; health rights, CEHURD, 2009; p6 Chipata health literacy team, Zambia, LDHMT 2011.
DTP: Blue Apple Projects

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