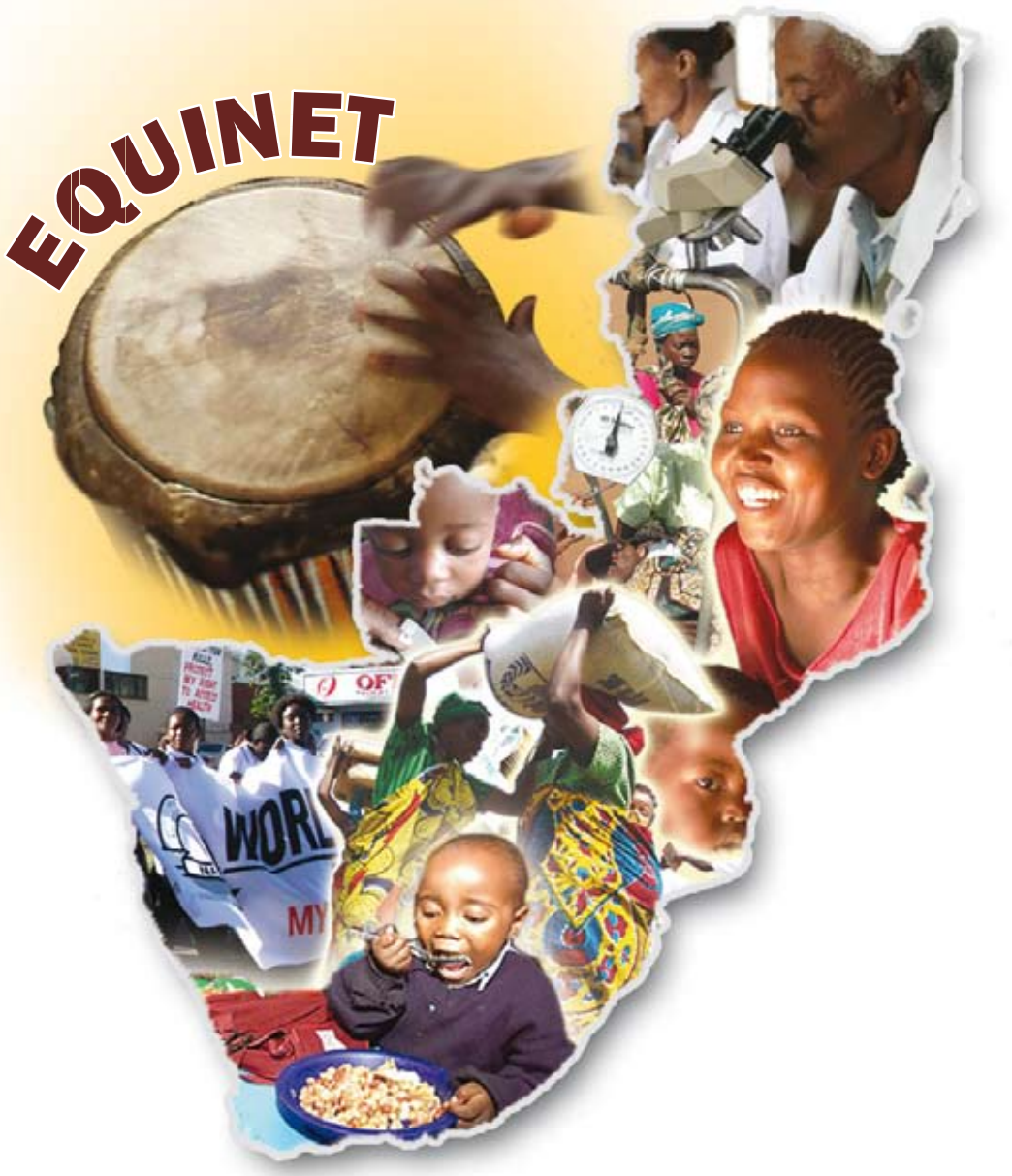
Regional network for equity in health in east and southern Africa (EQUINET)

Reclaiming the Resources for Health

Building Universal People Centred Health Systems in East and Southern Africa



CONFERENCE REPORT

Third EQUINET Regional Conference on Equity in Health in East and Southern Africa

Speke Conference Center, Munyonyo, Uganda

September 23-25, 2009

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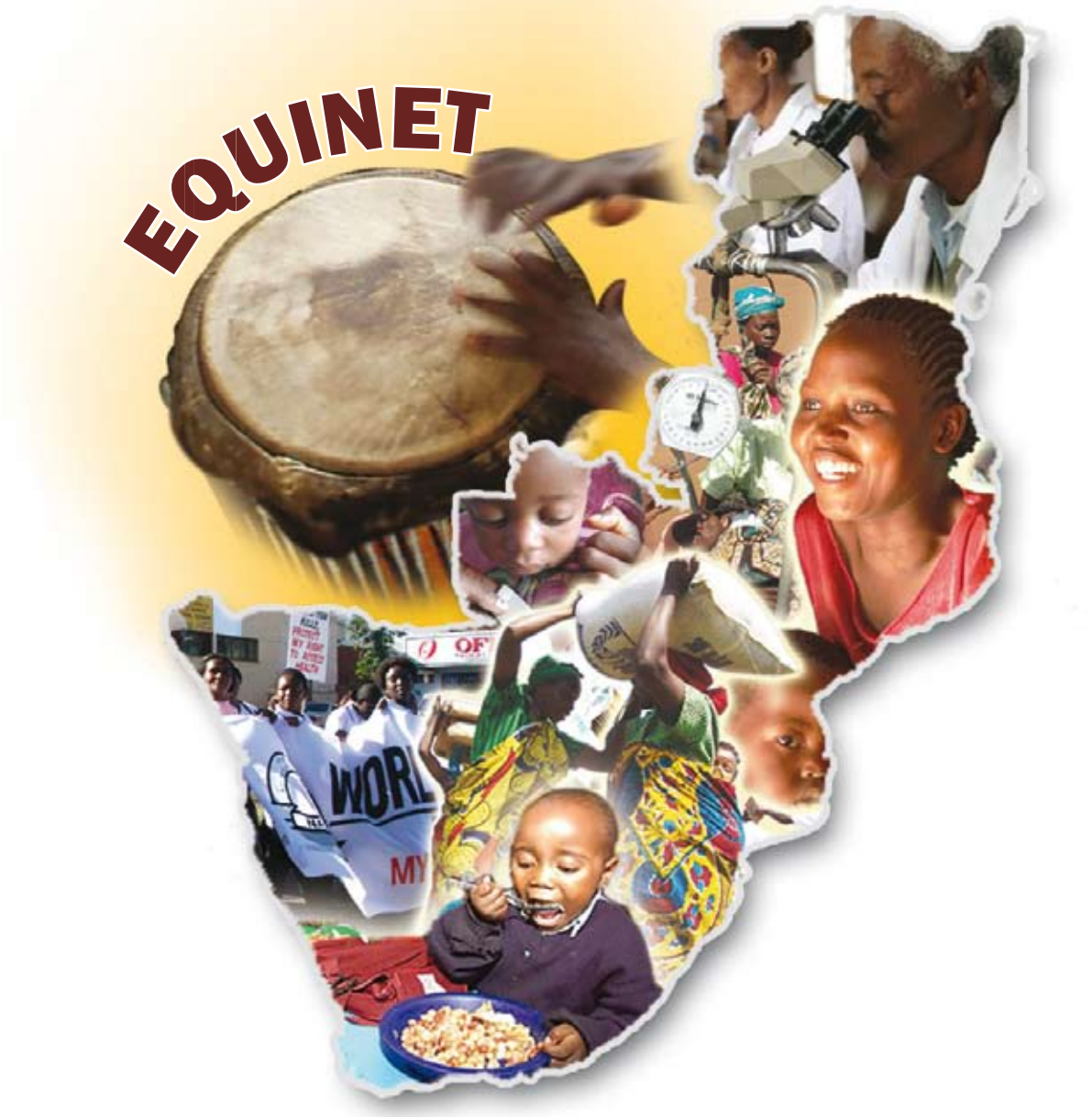

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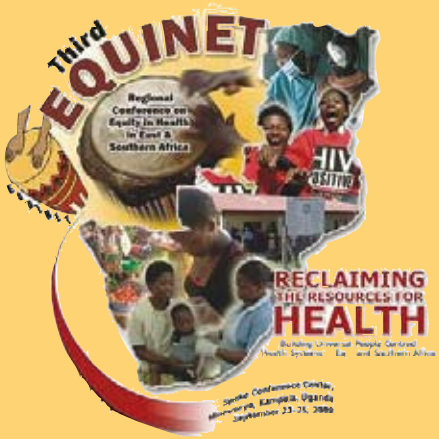


Reclaiming the resources for health

The Third EQUINET Regional Conference on Equity in Health in East and Southern Africa

Munyonyo, Kampala
UGANDA
23–25 September
2009

RESOLUTIONS FOR ACTION

Over 200 government officials, parliamentarians, civil society members, health workers, researchers, academics and policy makers, as well as personnel from United Nations, international and non-governmental organisations from East and Southern Africa and internationally met at the Third EQUINET Regional Conference on Equity in Health in East and Southern Africa, held 23–25 September 2009 in Munyonyo, Kampala.

Delegates recognized the significant, growing, avoidable and unjust inequalities in health and health resources in our countries, our region and our world. Like the WHO Commission on the Social Determinants of Health, we are aware that this social injustice is killing people on a grand scale.

We note that while we have the resources for health within our region, many of these, for example, our health workers, flow out of Africa and our remaining resources rarely reach the people with greatest health needs. Inequality blocks access to economic opportunities for those who need them most.

We stand for equity and social justice in health.
Unless we address inequalities in health and in the resources for health we will not achieve the policy goals set in the 1999 SADC Protocol on Health, in the resolutions of the Ministers of the East, Central and Southern African Health Community or the United Nations Millennium Development Goals in Africa.

It is imperative that we act to improve health equity and to reclaim the resources for health.

We know that we can only advance health equity when we:

- **integrate** health in national policies and goals,
- **advocate**, plan for and monitor equity in health as our political and social goal,
- **stengthen** our public health sector and redistribute resources to those with highest need, and
- **value**, support and adequately resource the role of communities and health workers.

So we call on all of us in the region as well as our international partners to intensify efforts to achieve the following four goals:

Build Strengthen Advance

1 Advance equity in health as a political and social goal and in all policies:

- Ensure that we always include the **universal right to health** in our constitutions and our laws;
- Strengthen **community awareness** and capacity to claim these entitlements;
- Promote and **protect health in all policies**, including those encompassing education, safe water and sanitation, food sovereignty, energy and technology – social determinants of health;
- Expose the health implications of trade and intellectual property regimes and of new technologies to strengthen our **power to negotiate for resources** to protect health in the context of corporate control of resources;

2 Build universal, redistributive and people-centred health systems:

- Establish clear, comprehensive, integrated health care entitlements to secure **universal coverage**;
- Strengthen, resource and prioritise **primary health care** and inter-sectoral action for health;
- Generate and share evidence and implement options to **close gaps in access to key services** for priority health conditions, including for maternal, family and child health, for mental health and for improved nutrition;
- Mobilise the evidence, advocacy and political support to **meet and go beyond the 2001 Abuja commitment of 15 per cent government spending on health**, excluding external funding, and to **increase per capita spending** on health, supported by debt cancellation;
- Meet the 'people's Abuja' of at least **25 per cent of government spending in health allocated to the primary care and community level** of the health system;
- Harmonise health financing schemes into one framework for **universal coverage**, reduce out of pocket payments, provide for cross subsidies and pool resources from progressive tax funding and prepayment schemes;
- **Remove user fees** through a sustainable, planned strategy that strengthens the health system;
- Provide decent working conditions to **recruit and retain health workers** and make **vital and essential drugs and supplies available** at primary and district levels of health systems;
- Promote **constructive engagement** between health workers, trade unions and governments to negotiate, resource, implement and monitor country-driven strategies to retain health workers;
- Allocate health resources equitably and effectively by **strengthening public sector systems** and capacities, including in financial management;
- **Monitor through civil society and parliament** how funds are used and how services are provided;
- Regulate the private-for-profit sector effectively so it complements public sector provision and does not impact negatively on health equity;
- Identify, expose and **overcome any barriers** that disadvantaged and vulnerable communities face in accessing and using health and essential services;
- With AIDS one of many disease burdens, support **rights-based, holistic, integrated and primary health care approaches** to prevention, treatment and care for HIV and AIDS and remove any social or economic barriers to access and uptake of services to close disparities in access, including for children, commercial sex workers and other vulnerable groups. Provide health care workers with HIV and AIDS prevention and treatment;
- Strengthen local safety nets and recognize and train traditional healers, community health workers, peer support networks and non-medical health promoters to **link communities and services**;

Monitor Recognize

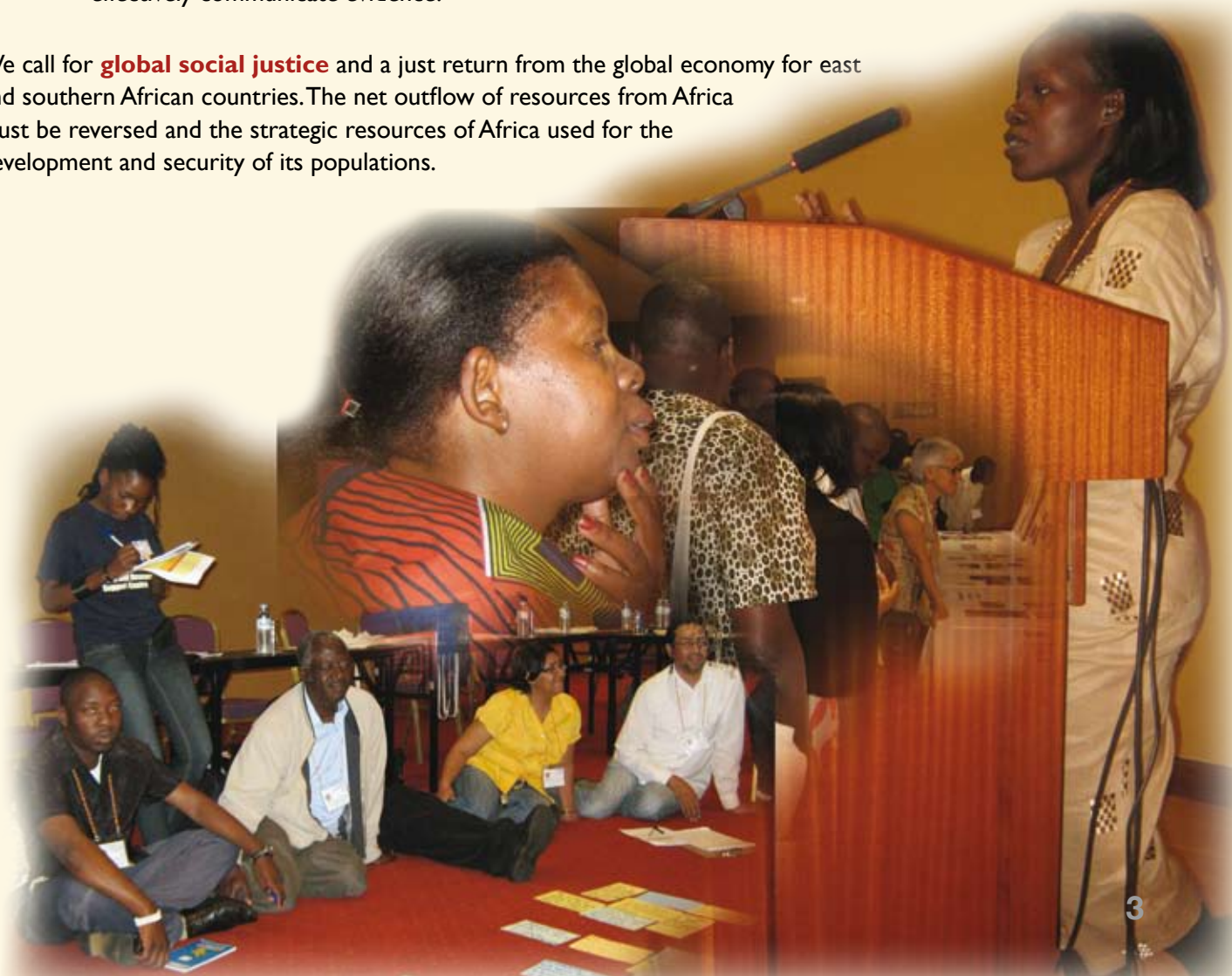
3 Recognize and support the central role of people, leadership and alliances:

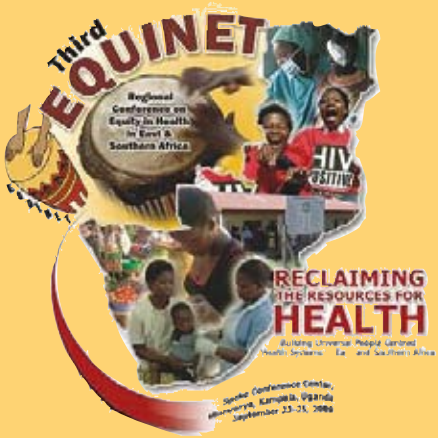
- Recognize the central role of **informed, empowered communities and health workers** in health systems and ensure laws, budgets, programmes and processes provide for this;
- Demand **strategic and capable leaders and managers** who consult, engage with and harness the range of constituencies and resources needed to advance health equity;
- Develop communication, engagement, capacities and networking to **strengthen alliances** between government, civil society, health workers, parliament and researchers to advance health equity;

4 Monitor progress and expose gaps in advancing health equity:

- Implement a country and regional level **Equity Watch** that builds alliances, analyses health disparities and progress in addressing them, monitors health equity and complements deeper district and household level assessments, using different forms of evidence, including from community level photography, to stimulate action;
- Invest in **research on health equity**, including: on new challenges, such as how climate change and globalisation affect health; on operational issues, such as how systems function without user fees; and to inform policy development, such as how the private-for-profit sector and commercialisation affect health equity;
- Build capacities to **involve stakeholders from the earliest stages of research** and to effectively communicate evidence.

We call for **global social justice** and a just return from the global economy for east and southern African countries. The net outflow of resources from Africa must be reversed and the strategic resources of Africa used for the development and security of its populations.



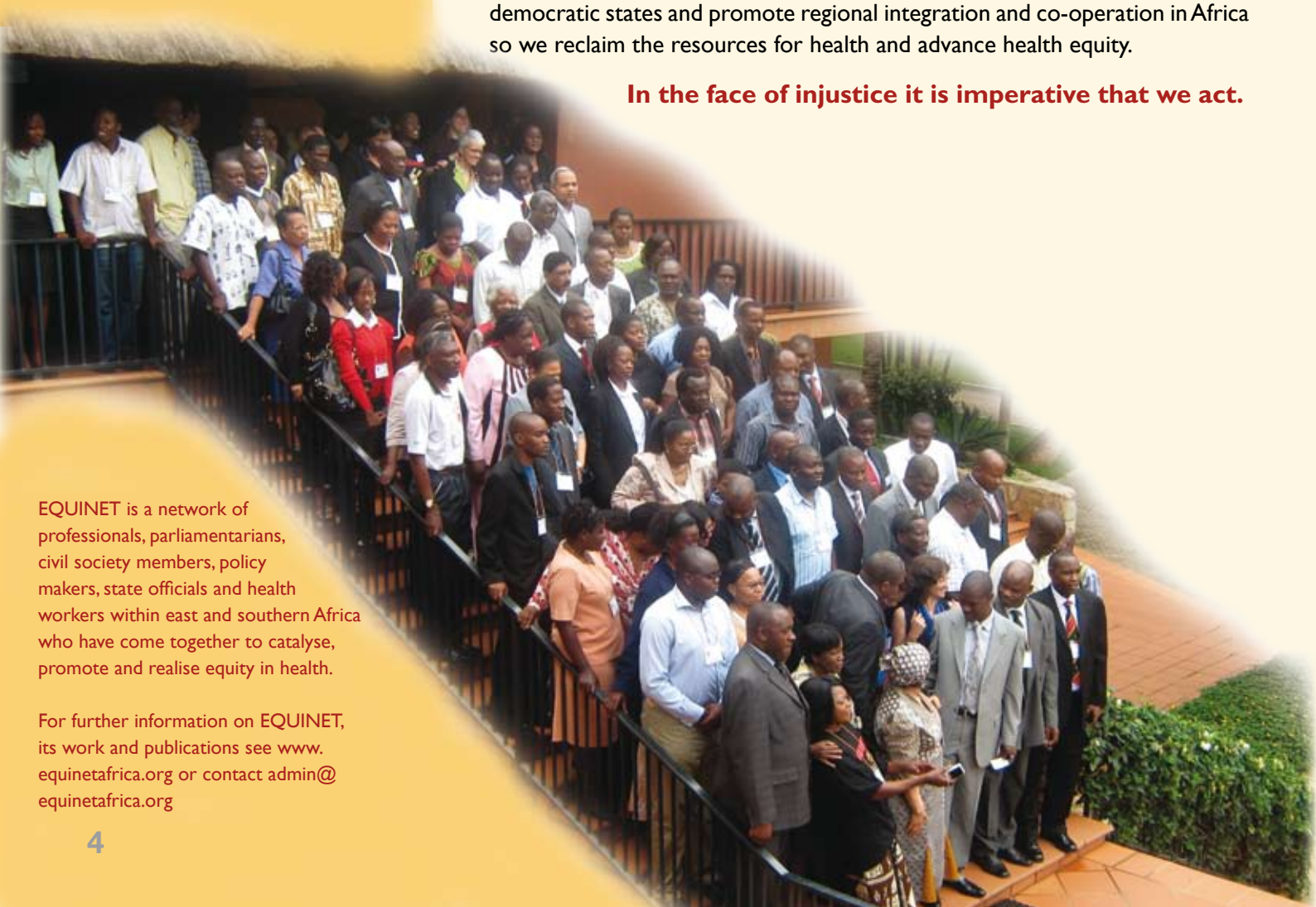


We call on our international partners to engage with us to achieve:

- The **global commitment** to and resourcing of the universal rights to health in the International Convention on Economic and Social Rights, the Convention on the Rights of Children and the Convention on the Elimination of Discrimination against Women;
- G8 targets of **universal access** to prevention, treatment and care for HIV and AIDS and the United Nations Millennium Development Goals;
- Debt cancellation, with the resources released channelled to **human development**;
- Economic **justice, fair trade and democracy** in the governance of global financial institutions;
- Bilateral and **multilateral agreements** that recognize and redress the resource outflows that affect African health and health systems, particularly from health worker migration.
- Genuine **partnerships** and external funding aligned to **national priorities**, that are developed through participatory and informed consultation with the people.

We will take these commitments forward in all our various organisations and forums. The conference set out our programme of work and action. EQUINET, as a consortium of institutions from the region, is committed to taking action to advance health equity. We will research and share evidence and good practice and advocate and monitor equity and social justice, including through the Equity Watch. EQUINET is committed to building inter-governmental, parliamentary, civil society, health worker and academic forums in east and southern Africa. We aim to strengthen our values-based leadership, develop democratic states and promote regional integration and co-operation in Africa so we reclaim the resources for health and advance health equity.

In the face of injustice it is imperative that we act.



EQUINET is a network of professionals, parliamentarians, civil society members, policy makers, state officials and health workers within east and southern Africa who have come together to catalyse, promote and realise equity in health.

For further information on EQUINET, its work and publications see www.equinetafrica.org or contact admin@equinetafrica.org

1. Background

The Regional Network for 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. EQUINET is a consortium network, bringing together academic, government, non-state research centres, civil society and parliament institutions from east and southern Africa on the basis of common values and a shared programme of work, in co-operation / interaction with regional policy institutions (Southern African Development Community and the East Central and Southern Africa Health Community).

EQUINET has since 1998 fostered a forum for dialogue, learning, sharing of information and experience and critical analysis. While the work has generated evidence within areas of high policy focus (like health worker migration or retention), cross disciplinary work has also provided opportunities to draw attention to areas that merit greater policy attention, such as the protection of health in trade agreements. To systematise and consolidate this diverse body of work, the EQUINET Steering Committee produced in 2007 a consolidation of its work across the network - the book *Reclaiming the Resources for Health* 1.

Every four years, a regional conference is held, providing an opportunity for communication, co-ordination, exchange of knowledge and policy visibility.

The third EQUINET regional conference was held in September 2009 and brought together parliamentarians, professionals, civil society members, policy makers, state officials, health workers and international agency personnel. It provided an opportunity to exchange across areas of work on different dimensions of health equity in east and southern Africa. The conference was held at Speke Conference Centre, Munyonyo, Kampala, Uganda September 23rd–25th 2009. The EQUINET steering committee was the conference Scientific Committee, and it was organised by Training and Research Support Centre (TARSC), working in cooperation with a local organising committee involving HEPS Uganda, Makerere University and Ministry of Health Uganda. It was supported by institutional participants from the region and by SIDA (Sweden), IDRC (Canada), Cordaid, Kellogg, and APHRC.

The conference theme, **'Reclaiming the Resources for Health: Building Universal People Centred Health Systems in East and Southern Africa'** was chosen to share experience and evidence on alternatives through which:

- *poor people claim a fairer share of national resources to improve their health;*
- *a larger share of global and national resources are invested in redistributive health systems, to overcome the impoverishing effects of ill health; and*
- *countries in east and southern Africa (ESA) claim and obtain a more just return from the global economy, to increase the resources for health.*

EQUINET provides forums for dialogue, analysis and exchange *M Chigama, EQUINET 2009*

[1] EQUINET Steering Committee *(2007) Reclaiming The Resources For Health: A Regional Analysis Of Equity In Health In East And Southern Africa.* EQUINET: Weaver press, Fountain Publishers and Jacana media Harare, Uganda and Johannesburg.

The sessions covered areas of

- Globalisation and womens health
- Trade, technology and health
- Claiming rights to health
- Social empowerment in health systems
- Participatory, Primary Health Care (PHC) approaches to health priorities
- Equitable health services
- Access to health care: addressing barriers in vulnerable groups
- Fairly resourcing health systems
- Valuing and retaining health workers
- Capital flows in the health sector
- Equity in health services responses to AIDS
- Building parliamentary alliances and people's power in health
- Policy engagement for health equity
- "Eye on Equity" approaches to keeping a watch on equity

The final day exchanged information on country networks and experiences, reviewed proposals for the future of the network, and proposed and adopted the resolutions from the conference. Pre- and post- conference workshops were held on participatory methods in PHC, health literacy, writing skills, policy analysis, fair financing, health literacy, BANG – the next technological challenge to Africa's health and well-being. These are separately reported.

The conference included an "Eye on Equity" photographic exhibit from community photographers showing participatory action research on different aspects of PHC in seven countries.

This report, compiled by TARSC summarises the proceedings, discussions and resolutions of the conference.

The programme is shown in *Appendix 1* and the delegate list in *Appendix 2*.

Eye on Equity Exhibit *D Baatjies, EQUINET 2009*

2. Opening Plenary: Reclaiming the resources for health: Building universal, people centred health systems in east and Southern Africa

Welcome remarks

Dr Francis Runumi Acting Director, Ministry of Health, Government of Uganda welcomed delegates. He noted that the conference was an opportunity for strengthening networking in the region and welcomed participation in the conference of Hon parliamentarians from the region through the Alliance of Parliamentary Committees on Health in East and Southern Africa (SEAPACOH), World Health Organisation (WHO), UNICEF, civil society, academics and health workers from the region. He acknowledged financial support from SIDA (Sweden), IDRC (Canada), Cordaid, Kellogg, African Population Health Research Centre and organisational support from the EQUINET Steering Committee, from Training and Research Support Centre and from institutions in Uganda including HEPS Uganda, Ministry of Health, PPD ARO and others.

East, Central and Southern African Health Community: Fostering regional cooperation for better health

Dr Helen Lugina, Manager of the Human Resources for Health and Acting Director of the East Central and Southern African Health Community (ECSA-HC) expressed appreciation to EQUINET and pledged continued commitment to the collaboration with EQUINET and other stakeholders in the region for the common goal of improving the quality of health care to meet the Millennium Development Goals (MDGs).

> *"Ladies and Gentlemen, the theme of the conference could not have been any better and in indeed it is very timely as we examine our efforts towards meeting the MDGs and as we all know, time is not our side. We need to think differently and act differently. This conference is very important and I believe the discussions and deliberations will be fruitful and allow us to do just what the theme says: Reclaiming the Resources for Health: Building People Centred Health Systems in ESA. I am also hoping that some of the deliberations and recommendations of the conference will be presented to high level forums, especially for policy discussion."*

Helen Lugina, Acting Exec Director ECSA-HC *D Baatjies EQUINET 2009*

The ECSA-HC was established in 1974 to foster and strengthen regional cooperation and capacity to address the health needs of the member states. The organisation recognises health as a human right and promotes health through advocacy, capacity building, brokerage, coordination, inter-sectoral collaboration and harmonisation of health polices and programmes. Its Conference of Health Ministers meets annually to review policies and strategies and to define regional health priorities. Conference resolutions are taken forward by the secretariat and partners, with advice and input from permanent secretaries of the ministries of health of member states, such as through the Directors' Joint Consultative Committee comprising permanent secretaries, directors of health services, deans of medical schools and other health institutions.

The activities of the ECSA health community are organised under seven technical programmes, including for: family and reproductive health, food and nutrition security, health systems and services development, HIV and AIDS and infectious diseases, human resources for health and capacity building, that also supports the work of the East Central and Southern Africa College of Nursing (ECSACON) and the College of Surgeons of East Central and Southern Africa (COSECSA); for research, information, and advocacy and for monitoring and evaluation.

She highlighted the importance of regional exchange and networking in advancing health equity. To take forward resolutions set by the health ministers, ECSA-HC taps into regional and international expertise to promote exchange of experience and good practice, to identify priorities and to provide technical support and to build capacities within member states.

Networking and support for exchange and dialogue provides an important forum for making and reviewing progress on regional and international health targets including MDGs. Dr Lugina noted that in this, EQUINET has had a longstanding partnership with ECSA-HC:

> *"We have a long collaborative relationship with EQUINET where we have especially worked on the issues of retention of health workers, as an effort to ascertain equitable access to quality health care. Through technical expertise from EQUINET and other partners, issues on increasing access to health care and health financing mechanisms have been discussed and common positions taken, for example, on reaching the Abuja target."*

She wished everyone a good conference and thanked EQUINET, those who participated in making this conference a success, and the Government of the Republic of Uganda.

Following these opening remarks a film was shown produced by the "Eye on Equity" Team of community photographers from the region and TARSC, showing photographic images from the region and messages from EQUINET related to the conference theme. The images presented the realities across the different countries of the ESA region, from its southern most tip in South Africa to its boundaries in Uganda and Kenya. The images showed the health challenges, but also the diverse economic, social and institutional resources within the region to respond to these challenges.

Dr Runumi congratulated the producers for the moving content of the images, and particularly for showing the critical role of social organisation in producing a positive change for health. He welcomed the guest of honour, Hon James Kakooza, the Ugandan Minister of State for Primary Health Care.

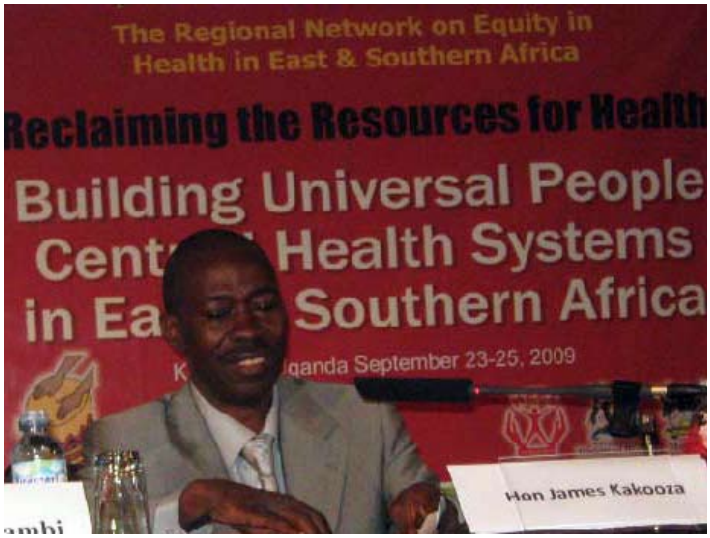
Official opening

Hon James Kakooza, Minister of State for Primary Health Care, Uganda officially opened the Conference. He welcomed delegates to Uganda and expressed his satisfaction at the agenda of the conference and the expertise present to address this agenda. He pointed to the strong policy and constitutional underpinning to health in Uganda, with economic growth, a reduction in conflict in the Great Lakes region, and an impressive decline in HIV prevalence meaning that Uganda is well placed to make significant advances on its policy goals of health equity.

> *"So it is an issue of national concern that Uganda continues to experience differences in health that are avoidable, and thus unfair. For example, urban areas and higher income, more educated groups have better health outcomes than rural, lower income, less educated groups on a range of health indicators, such as low birth weight and child mortality. The social differences that lead to lower rates of literacy or lower enrolment in education in poorer groups and more remote communities are not only affecting health outcomes but also access to health services. Yet health care services are extremely important for preventing and managing the ill health that further impoverishes these groups. Equitable health systems must thus be a top priority not only for Uganda, but for our entire global community."*

He noted that EQUINET's work has documented such inequalities in all countries of the region and at global level. The theme of the conference — "Reclaiming the resources for health" — sets the focus not only on the problem, but on the actions to address it, and particularly what health systems can do. He pointed to promising practices in Uganda that merit more attention to assess their impact on closing inequalities in health, such as the establishment of a Minimum Health Care Package, the increasing funding since 1997 of district and primary health care services, the lifting of user fees, or the establishment of the Village Health Team programme in Uganda.

> *"As the WHO Commission on the Social Determinants of Health pointed out, improved health is not simply a matter of better health services, but depends on*



Hon James Kakooza, Minister of State for Primary Health Care, Uganda EQUINET *I Zulu, Eye on Equity 2009*

other sectors seeing the value in reducing inequalities and improving health. It is thus a major challenge for all of us to make health everyone's business. We need in future work on health equity to point to and monitor the policies and programmes that other sectors can implement to close gaps in health, so that the living and working conditions and incomes of vulnerable groups improve as the economy grows."

He observed that improving equity called for measures to enhance domestic health financing, to retain health workers, to invest in Primary Health Care and to address the social barriers to vulnerable communities using services. He noted EQUINET's proposal to set up an equity watch in the region to monitor and share information on progress in health equity, and urged the ECSA Health Community to include such measures in its regular report on and exchange of good practice when the Ministers meet.

Expressing optimism that the presence in the conference of diverse delegates from all sectors and from countries in and beyond the region would strengthen and inform the networking of public sector interests in the region to take these issues forward, Hon Kakooza officially opened the conference.

Globalisation and women's health in sub-Saharan Africa

Dr Sarah Wamala, Director General, Swedish National Institute of Public Health welcomed the opportunity to be at the conference, noting that Uganda was her birthplace and her association with institutions in the region, including EQUINET. She outlined gender dimensions of globalisation and health. While there have been areas of progress, such as in the increased participation by women in parliaments in sub-Saharan Africa (see *Table 1*), there remained a question of how the benefits of globalisation were reaching ordinary people, especially women, in sub-Saharan Africa.

Table 1: Percentage of woman parliamentarians in government, 1990–2006

	1990	1998	2006
World	12,4%	11,4%	16,6%
Sub-Saharan Africa	7,2%	9,0%	16,2%

She observed that women are the motor for development, particularly in sub-Saharan Africa, but are also vulnerable to shifting patterns in global markets, such as in relation to food security. While global influences are bringing some benefits for some urban communities, there is little transfer of benefits to rural areas, leading to levels of urbanisation that place significant stress on systems. Dr Wamala pointed to the need, therefore, to take monitoring of global measures to local levels, where the impact on health is observed. She called for more empirical research on the impact of economic globalisation on women's health and for a public health perspective in foreign aid. She outlined as an example work to assess how globalisation is affecting women's health in sub-Saharan Africa with a focus on household food security. This work would be further presented at the conference.

Reclaiming the resources for health: Advancing health equity in east and southern Africa

Dr Rene Loewenson, Director of Training and Research Support Centre (TARSC) and coordinator of a Regional Network for Equity in Health in East and Southern Africa (EQUINET) thanked the many partners noted earlier by Dr Runumi for their support to the conference and the Uganda institutions. She noted the role of all members of the EQUINET Steering Committee in leading the processes in the conference and EQUINET's work on equity and social justice in health.

She outlined EQUINET's background and purpose. Her presentation addressed three major areas:

- why we need to take inequity seriously;
- why reclaiming the resources for health is central to the response to inequity, and
- the opportunities for and challenges to action.

"Social injustice is killing people on a grand scale."

Citing the above words of the WHO Commission on the Social Determinants of Health, she presented evidence on the dimensions of inequalities in health and access to health care globally and in the region, noting the increase in such inequality at national and global level.

"Evidence shows that even where there is economic growth, rising relative inequality appears to be putting a brake on poverty reduction. Current rates of growth would not produce a sufficient rate of reduction in poverty to meet MDGs unless there was also a reduction in income or asset inequality. In Kenya, for example, if inequality remained the same (0.43) growth rates 2009–2012 would need to average 12% to meet 2015 targets of poverty reduction to 28%."

Analysis of equity in the region indicates the social and economic policies that underlie and influence these outcomes. Achieving health equity is not just about increasing wealth, but about how that wealth is distributed. We need to break the vicious cycle of inequality, poverty and ill health by addressing firstly the social determinants of health, such as transport, food and housing, and by ensuring that households are protected from the financial costs of ill health. Yet there are a number of ways in which resources for these social determinants of health are flowing out of the poor communities with high health need, such as through trends in food production and marketing, in pricing and access to medicines, in the distribution of and charges by health services, or the costs to health systems and communities of out-migration of health workers.

She observed that addressing these trends is a matter of policy choice.

> *"We have for some time known from United Nations data that saving several million lives annually by bringing safe water and sanitation to all would cost $10 billion a year. This money has never been found. Yet in October 2008, in one week, the US government provided a bail out package to the banks of $250 billion, 25 times this amount."*

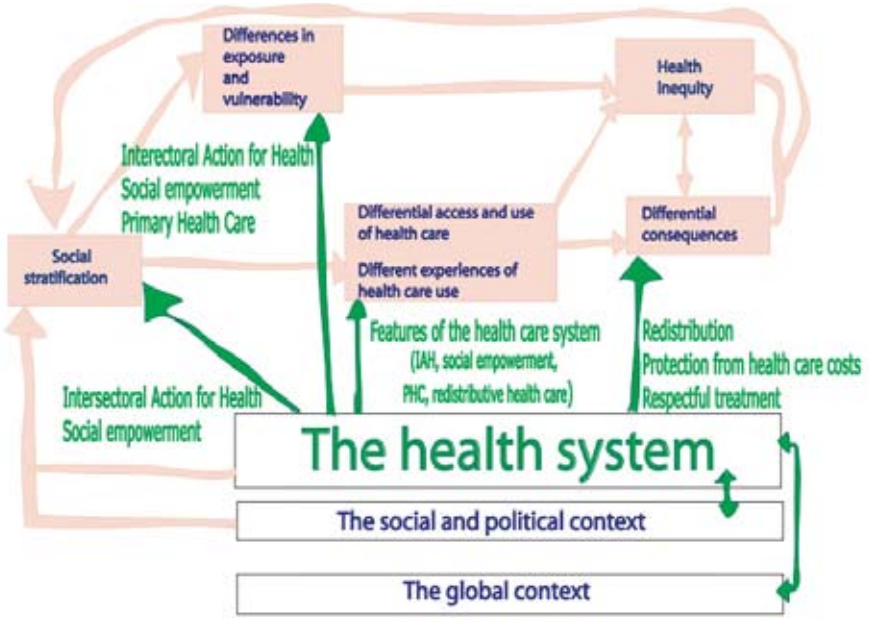
There is evidence of policy choices being made to respond to these conditions, such as in the increase in global flows of funds for health; in the commitments to achieve universal coverage of health care, and diverse social and institutional resources within the region are being mobilised for health.

> *"Despite limits to the evidence and complexity in the context, our analysis suggests that it is possible to act and that action is imperative in the face of injustice. Our challenge is to strengthen our networking across actors and institutions to move perspective, evidence, and analysis into strategic alliances, effective engagement, policy and action. We are excited to be part of this process and hope the conference nourishes it."*

Dr Runumi commented that such evidence needs to reach decision-makers, and that we need to work across stakeholders to deal with the issues raised. We have the capacities to identify and implement the measures needed to address inequalities in health. It calls for the different stakeholders to work together and to share experience and knowledge.

In the discussion on the opening presentations, delegates raised further issues for attention, including the role of climate change and its effects on health and the loss of health workers. These issues were noted, and future sessions of the conference would take them up.

Health systems as a social determinant of health equity



Source: Gilson, Doherty, Loewenson and Francis 2008

3. Plenary: Equity in health and health systems

Nicole Valentine, World Health Organization welcomed everyone to the session, which examined the challenges to equity in health and opportunities for building equitable, universal health systems.

Reclaiming the economic resources for health

Rangarirai Machemedze, Southern and Eastern African Trade Information and Negotiations Institute (SEATINI), citing the 2008 *World Health Report*, noted that globalisation measures are putting the social cohesion of many countries under stress, and that health systems are clearly not performing as well as they could or should. The per capita Gross Domestic Product (GDP) in sub-Saharan Africa fell in most years from 1980–1994, limiting the resources to expand access to health care or transform health systems. For sub-Saharan Africa, the 1980s and 1990s were a time of managing shrinking government budgets and disinvestment.

> *"Under-resourcing and fragmentation of health services has accelerated the development of the commercialised health care and public sector health care delivery has been commercialised, through informal payments and cost-recovery systems, shifting the cost of services to users in an attempt to compensate for the chronic under-funding of the public health sector and the fiscal stringency of structural adjustment."*

Trade liberalisation is often presented to African leaders as necessary to bring foreign capital and technology to remedy 'supply-side' constraints on Africa's production, and to enable Africa to compete in global export markets. In reality, these returns have not been realised, and social conditions and health systems have declined rather than improved.

Neo-liberal economic policies have resulted in systematic outflow of resources from Africa in the form of debt repayment; falling terms of trade; capital and financial market outflows; export of natural resources and of skilled personnel. These outflows deplete the national resources for health. International agreements on trade, aid, foreign direct investment (FDI) thus have a direct bearing on health. For example, trade measures that liberalise agriculture may reduce revenue for countries from tariff reductions, and affect production patterns and markets in ways that affect food security and nutrition. The Trade Related Aspects of Intellectual Property Agreement (TRIPs) impacts on access to medicine, or farmers' rights to plant particular varieties and thus food production. The General Agreement on Trade and Services (GATS) opens the way for widening privatisation and commercialisation of health services.

Many of the policies and measures needed to reclaim resources for health lie outside the health sector, such as improving disclosure of financial flows; cancelling debt payments; domestic reinvestment of pension, insurance and other institutional funds; control of capital flight; applying trade incentives that develop and protect infant industries; ensuring that investments do not lead to natural resource depletion; taxing currency transfers; and ensuring that trade agreements specifically protect population health. These measures call for health-promoting policies from other sections of government. The current recession and climate, food, energy, financial crises at global level are a wake up call that change is also needed at global level, in global policy and in the global financial and trade architecture that sets these policies as well as in the regulatory frameworks on trade, FDI, aid at domestic level, if we are to plug the holes through which the resources for health flow away from communities with high health need.

Household food security, Western Kenya *S Juma EQUINET 2009*

Lessons and challenges for building health systems that promote equity in health

Prof Lucy Gilson, University of Cape Town/ London School of Hygiene and Tropical Medicine presented evidence from the EQUINET regional equity analysis and the health systems knowledge network in the WHO Commission on the Social Determinants of Health that indicates that the public sector plays a primary role in improving health equity and should be strengthened to achieve this function. Addressing the wider determinants of health calls for leadership, processes and mechanisms that leverage inter-sectoral action (IAH), as well as organisational arrangements and practices that facilitate social empowerment. Ministers of Health and senior health officials need to develop high-level political support for this, especially from Ministry of Finance and political leaders and to institutionalise measures for it such as through accountability mechanisms, dedicated budgets or performance incentives.

We also need to address differentials in access and the financial consequences of ill-health through health care financing and provision arrangements that aim at universal coverage and re-distribute welfare. Central to this is revitalising and resourcing primary health care.

> *"Health systems in ESA have significantly improved health when they have increased public spending on health, provided comprehensive primary health care oriented approaches, provided public leadership to involve other sectors in health, redistributed resources towards primary care and district services to major health problems, and invested in the central role of people in health systems."*

Evidence shows that primary level spending benefits poor households, but economic reforms have reduced public funding and undermined comprehensive PHC. In contrast, positive impacts have been achieved through identifying and costing a comprehensive essential health package and linking funding, partnerships to achieving this. Further, regulation of private health providers and commercial practices harmful to health have had positive impact on health. Both need to be secured by an established platform of health rights and obligations by constitution, law and treaty.

> *"Tackling health inequity is not just about making appropriate policy choices. We need to act politically to re-frame the value basis, relationships and management of health systems through coalitions of support for policy change, policy implementation to address health inequity and working with public managers to lead sustained institutional change. The EQUINET regional equity analysis argues that when health systems organise around social action and empowerment, they create powerful constituencies to protect public interests in health."*

For international agencies to support national measures that promote equitable health systems, funding flows to these areas of health systems need to be enhanced and directed in ways that work with and respect national decision-making and institutions. While technical analysis can point to equitable features of health systems, political action is key to challenging powerful actors, institutional constraints and socio-cultural norms that act as brakes on health system development, as well as to stimulating, rewarding and strengthening the groups, processes and mechanisms that support virtuous changes.

Struggling for the basics: A perspective from the community in rural Democratic Republic of Congo

Amuda Baba, Pan African Institute of Community Health (IPASC), DRC presented a snapshot of health in the area he works, in Bembeyi, a rural community in north eastern Democratic Republic of Congo (DRC). He showed images taken in community photography.

Crossing the river, DRC *A Baba EQUINET 2009*

People in Bembeyi practice agriculture for daily survival, and supply Bunia town with fresh vegetables, sugar cane, sweet potatoes, beans, cassava leaves, bananas.

> *"But malnutrition is a problem, especially for children, as are water-borne diseases such as typhoid fever, malaria, especially for pregnant women and children. Community members have very limited knowledge about diseases and local health services have poor infrastructure and do not provide outreach. Some patients prefer to go to traditional practitioners and access is worse during the rainy season."*

To overcome barriers of flooding rivers, in 2007 the local people made a wooden bridge. In December 2008, after a participatory process linked with EQUINET where the community diagnosed their barriers to health care, the local people are building a stone and cement bridge, supported by resources from UNDP. Barriers remain, as bicycles are the people's only means of transport to services, and ambulances cannot cross until the second bridge is complete. And even those who get to services still face a lack of adequate drugs, equipment and personnel at the local health centre.

> *"Most of all, we can't wait for people to fall ill. We must prevent disease as a priority, especially from the poor environments people live in."*

A health workers perspective from Zambia

Idah Zulu, Matero Health Centre, Lusaka gave a perspective from a health worker wthin the health system, also supported by community photography. She raised many challenges for health workers at health centre and community level, including poor socio-economic conditions, increasing disease burdens, over-stretched health services, frequent changes of health policy, a critical shortage of health workers, and dissatisfied community members.

In response to some of these challenges, her Health Centre has undertaken activities such as contact-tracing of cholera patients, lobbying for better water and sanitation, testing water sources and disinfecting toilets and stagnant water pools. Health workers have engaged with community volunteers to support health work; retired and off-duty staff have been involved.

> *"We have improved the communication flow on health centre management with communities using participatory processes. For frontline health workers, improved relationships with our communities are vital to provide services in resource-limited settings, and participatory methods help us achieve this."*

In the discussion that followed, Amuda described the baseline and follow up study that assessed levels and changes in health knowledge and health service use, after the interventions from the participatory work. Local knowledge and change was seen to be key. Delegates noted that health workers experience stress from adapting to frequent health policy changes such as implementation of user fees and then their removal, promotion, abandonment of and then promotion again of community health workers. We need to remember our past to rebuild our future, and to use what we already know.

Meanwhile at global level, participants noted that Africa is not perceived to be a viable market, affecting technology availability. This has affected production of and access to pharmaceuticals and anti-retrovirals (ARVs). Even where technologies are brought in, this often displaces instead of supporting domestic markets. Managing this takes policy leadership, but global or international agreements may be signed without clear aalysis of their impact. For example, some ESA countries recently signed the Economic Partnership Agreement (EPA) with the European Union, despite evidence of potential problems of shortfalls in the relevant infrastructure for implementing it. Participants suggested that pressure is put on negotiators or leaders at these forums, and people need to equally put pressure to put the interests of countries first, and that parliaments should debate and agree to agreements before they are signed.

Communication between health worker and community during outreach
I Zulu, Zambia 2009

4. Parallel sessions I: Rights to health, globalisation, equity in health services and social empowerment

After the plenary four parallel workshops were held to further explore the issues raised in the plenary sessions. These are reported here. The abstract book on the EQUINET website at http://www.equinetafrica.org/bibl/docs/EQ%20Conf%20Sep09%20abstract%20bk.pdf provides details on the individual papers presented so this report provides a summary of the discussions and issues raised in each session.

4.1 Claiming rights to health

The session was convened by Nomafrench Mbombo, University of the Western Cape and Leslie London, University of Cape Town

Leslie London, School of Public Health and Family Medicine, University of Cape Town noted that globalisation opens opportunities to use and realise international benchmarks for human rights to improve regulation and governance as a basis for health systems improvements. Some have argued that a human rights paradigm provides a *'foundation for challenging globalisation's effects'* and a means to actively claim social and economic entitlements across all cultures and settings, and to codify them in national and international laws. Ratification alone is not predictive of health equity and strong civil society action is need to reinforce legal measures. Analysis of practice among east and southern African parliamentarians found that rights are rarely used in their processes and that parliamentarians were often unaware of health rights. States have more policy latitude than they admit, if supported by social movements they use the space.

Prima Kazoora, HEPS Uganda presented work on realisation of maternal health rights in Pallisa and Budaka districts Uganda. Work in Pallisa and Budaka districts aimed to increase awareness and knowledge on maternal health rights and responsibilities, promote community participation and men's involvement in women's health, and strengthen civil society advocacy for improved implementation of maternal health policies. Building a response to rights violations, they provided an independent channel for expectant mothers to complain and get redress. Despite this, problems persisted. For example, communities are still reluctant to voice their complaints despite frequent stock-outs of drugs and supplies.

Rosette Mutambi, HEPS Uganda described work to establish an effective health consumer feedback mechanism, called *'Operation Excellence'*, to provide an unbiased channel through which community members can voice their concerns and effectively participate in decisions that affect their health, through dialogue with health workers at health facility level. She outlined how the claims and complaints process was set up and supported, through Health Complaints Commissions made up of district health stakeholders. The issues (such as stock-outs, illegal fees) are fed back to national level through advocacy, mass media, health bulletins, websites and conferences. She described how communities are now bringing claims from local issues, ranging from building a bridge to enable access to services to a national enabling law to address health rights violations. HEPS is consolidating this through a report on health rights observation in Uganda.

Jacky Thomas, Leslie London and Nicole Fick, Health and Human Rights Programme, University of Cape Town, Nomafrench Mbombo, University of the Western Cape; Damaris Fritz, Cape Metropole Health Forum; and Glynis Rhodes, Women on Farms Project described a civil society network to realise the right to health in South Africa. Despite health rights being enshrined in the South African Constitution, major health inequalities persist. The Learning Network explored strategies and developed training materials and tool-kits, parliamentary briefs and pamphlets to inform parliamentarians and communities in protecting, promoting and fulfilling the right to health. The Learning Network gave civil society access to research and documentation, support for advocacy, and helped community health committees get a better sense of their role. This enabled communities to engage government on service delivery and infrastructure. A Women's Circle helped people develop confidence in voicing issues and acting on their rights, sharing of knowledge and experience.

The delegates proposed that in follow up EQUINET build a community of best practice in promoting dialogue between health workers and communities that recognise the rights of both and that advocate policies that protect health workers health and labour rights and the rights of patients.

People should claim rights at all levels, from local to global. Community and civil society roles in realising the right to health should be made clear and brought in wherever rights are at stake,

including in the negotiation of government treaties and agreements.

Future work in EQUINET could

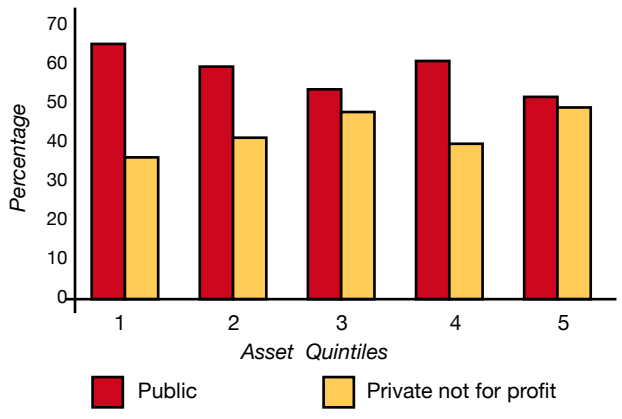
- engage around how to measure empowerment;
- explore a model of creating synergy between stakeholders around the right to health, drawing on examples within the region and involving all parts of the health sector, including health professionals; and
- explore the rights of overlooked vulnerable groups, such as of the elderly.

4.2 Equitable health services

This session was convened by Prof Lucy Gilson, University of Cape Town.

Elizabeth Ekirapa-Kiracho, School of Public Health, Makerere University, Uganda explained that in Uganda, physical access to health facilities has increased from 49% in 1999 to 72% in 2005, but disparities in access to care persist. An analytic cross-sectional study at ten public and ten private-not-for profit (PNFP) health facilities in eastern and western Uganda, with a sample of 1,446 patients showed significant differences in use of public and private not for profit facilities, with poorer groups more likely to use public facilities. The quality of communication by health workers was generally poor, but worse in public facilities, calling for assessments to improve this aspect at all services. Given the importance of communication in health service uptake important to overcome this barrier, especially for patients in the lowest socioeconomic groups.

Utilisation of public and private facilities by wealth quintile



Denis Kibira, HEPS Uganda reported that since 2006 HEPS has been monitoring medicine access in Uganda, and under the Country Working Group (CWG), has conducted quarterly monitoring of a basket of 40 essential medicines on availability, price and affordability. The surveys, conducted in four regions and three sectors per region showed that availability of medicine was lowest in the public sector and in rural areas, yet this is where most disadvantaged people seek treatment. Poor funding for medicines and challenges experienced in the supply-chain affect availability. Free medicine policies in the public sector are undermined by constant stock-outs, while medicines in the private and mission sector were found to be unaffordable for the lowest paid government worker. Access to medicines in Uganda is still a major challenge: 'Free care' policies in the public sector must be made effective through increased funding to medicines, improved procurement and supply chain capacities, and increased transparency and accountability. A medicine pricing mechanism should also be implemented for medicines in the private sector to increase affordability.

Ronnie Graham, SightSavers International, East, Central and Southern Africa Regional Office referred to the *Vision 2020: The Right to Sight,* a global initiative for the elimination of avoidable blindness. With few ophthalmologists, several countries started training cataract surgeons in the 1980s, and many more are needed in rural areas. Research shows the low density of cataract surgeons and that surgeons reached maximum productivity after five years. Productivity levels in mission and private hospitals were 2–3 times higher than in public hospitals. Those with three or more support staff were twice as productive, while improved access to equipment tripled productivity. They project that it is feasible to implement 500 surgeries per year, double the current level, supported by harmonised training curricula, investment in surgical services, and supported by a strengthening of health systems to ensure that patients with cataracts seek support and are referred in good time. This implies an end to vertical eye disease control programmes operating in a parallel way, outside the health system.

Alfred Agwanda, Population Studies and Research Institute, University of Nairobi explained that for poor people, non-availability of family planning (FP) and reproductive health (RH) services is strongly correlated with economic burdens and inequalities in income and in economic opportunities. While Kenya has one of the strongest FP programs in sub-Saharan Africa, inequalities in access to FP persist, with almost

double the unmet need among the poorest groups compared to the wealthiest group and wide regional disparities. There are frequent stock-outs of contraceptives, and accessing FP is costly in terms of time and transport. Uptake of FP services by poor people is limited by misconceptions, inaccurate information (about methods, costs and side effects of contraception), poor communication by health workers, by issues of confidentiality, male opposition or exclusion, and other sociocultural and religious barriers. FP/RH are weakly supported by political and government leaders, and with development partners there is need to provide compelling evidence to overcome inequalities in support and use of these services.

Nicole Valentine, WHO said that resolutions from the World Health Assembly on the Social Determinants of Health and Primary Health Care highlighted the need for inter-sectoral action and health-in-all policies. Health mobilisation needs to be driven by the values of equity, solidarity, social justice and participation, with particular emphasis on addressing health inequalities, people-centred care, better public policies and stronger leadership. Primary health care can be strengthened through reforms on universal coverage, service delivery, leadership and public policy. Health should be seen as a primary factor for enjoying and participating fully in what life has to offer, not an isolated goal. Across government, all sectors thus have a role in acting on the social determinants of health and strategies need to be based on information and co-operation, backed by involvement of communities.

Source: WHO 2009

The delegates proposed that in follow up:

- The focus on strengthening public primary health care-oriented systems should include pharmaceuticals, appropriately-trained mid-level health workers and on empowering communities, particularly around local action for health.
- We need to gather and use information, working with community groups to hold the system accountable for its goals;
- We need capable, strategic leaders who can enable inter-sectoral action and ensure sustained policy implementation; and
- External funders should support primary health care, especially in the public sector, given its role in poorest communities.

4.3 Globalisation and women's health in east Africa

This session was convened by Rene Loewenson, TARSC and Sarah Wamala, National Institute of Public Health Sweden. Sarah introduced the programme of work carried out under Karolinska Institute and TARSC Tanzania to explore the link between globalisation and womens health and nutritional outcomes in east Africa, focusing on the pathways of women's occupational roles. Field studies were implemented in three countries, Tanzania, Uganda and Kenya, on different dimensions of the issue.

John Kanyamurwa, Mass Communication department, Makerere University,Uganda explained that globalisation was introduced in Uganda with promises of improved incomes and food security for farmers. However, a study of women smallholder farmers in coffee and in food production in rural Uganda found that while coffee producers, in the export sector, had higher access to fertilisers, seedlings and credit and higher incomes, they also had less livestock, were more dependent on food purchases and had poorer diets than food producers, and were more likely to use higher cost private sector health services. There was no significant difference in health care seeking, access to medicines, or use of antenatal care between coffee and food producers. The income benefits coffee producers obtained from liberalised markets did not translate into better nutritional, dietary or health outcomes.

Peter Kamuzora, University of Dar Es Salaam/ TARSC Tanzania, explained that Export Processing Zones (EPZs) were created in liberalisation policies in the 1990s. A study was carried out of 190 women in EPZ firms, and 187 in non-EPZ firms, both firms in the textile sector. The researchers

found that compared with non-EPZ companies, in EPZs, female workers were younger, with low job security, short terms contracts and less benefits. Non-EPZ firm workers had higher levels of job security and benefits. Although EPZ workers earned more, they had less time available for personal and domestic issues due to long working hours. EPZ workers had no health care, food or child care provided by the employer, while the Non-EPZ workers did. None had access occupational health services. Diets at both workplaces were similar, dominated by cereals, oils and fats, sweets, and legumes, nuts and seeds. Although EPZs have created new employment opportunities, their wage, time and welfare features are worse, suggesting that workers and their families are meeting the costs of concessions given to EPZ employers.

Mary Amuyunzu-Nyamongo, African Institute for Health and Development, Kenya was not present at the time of the session. Her study explored the consequences of globalisation-led reforms on women's caring and health roles, and the impacts on household health and food security in poor urban Kenya. Her study, presented in the abstract book, found that the commercialisation of health made access more difficult for women to balance healthcare and household needs.

In the discussion it was noted that there has been limited research on globalisation and health, given the difficulty in following the pathways between global-level factors and local outcomes, and that protocols and skills need to be developed for this work. The role of the health sector in intervening in poor health outcomes was noted, but it was also observed that this is weakened when health services are themselves liberalised and commercialised.

Rene Loewenson, TARSC summarised the increasing time and resource burdens for women, with negative consequences for their own and their families' health and nutrition. These trends call for improved monitoring of gender and socio-economic trends at household and community level.

The delegates proposed that in follow up a process be put in place to set a research agenda on globalisation and health, with evidence on shifts in social determinants of health and commercialisation of services serving as sufficient warning of poor health outcomes. Research on this area also needs to be stimulated by investments in research capabilities, collective both qualitative and quantitative evidence.

4.4 Social empowerment in health systems

This session was convened by Itai Rusike, Community Working Group on Health, and Fortunate Machingura, TARSC.

Paul Akankwasa, HEPS-Uganda described a participatory approach used in tackling maternal health in Kamwenge in Uganda, where only 19% of deliveries are supervised, lower than the national average. Health workers, community members, community and district leaders, expectant mothers and male spouses identified barriers to uptake of maternal health services. These included shortages of staff, health care and surgery resources, and of staff accommodation. At community level bad roads, traditional and cultural beliefs discouraged women from delivering in hospitals. Communication between health workers, fathers and expectant mothers was poor and there was competition between traditional birth attendants and health workers. Community leaders and health workers trained and sensitised on maternal health rights led a campaign in their target areas, including information dissemination and public dialogue on radio. As a result of the intervention, attendance of antenatal and delivery services increased and communication improved between women and their partners. Male participation remained low however, as did communication between mothers and health workers in some services.

Dr Vincent Mubangizi, Kamwenge District Local Government, Uganda spoke about the use of child health cards (CHCs) as a home-based health record containing vital information. A study conducted at Itojo hospital assessed whether CHCs were completed correctly, whether children attending the hospital brought their card with them, and whether health workers consulted the card during the consultation. Only 10% of children attending curative services had a CHC, although health workers asked to see the card. Recordings on the card were explained to caretakers in just under half (49%) of cases and most cards were incomplete. At immunisation clinics health workers usually (89%) asked for the card, but in curative services, this was rare. Cards were not correctly filled because of health workers poor technical skills, lack of refresher courses on the cards, lack of adequate support supervision, and work overload. While important for involving families in child health, the cards were thus underused in curative services, incomplete or incorrectly completed, and underused in early detection of child health problems.

Sam Mulyanga, Family Care International, Kenya explained that in Kenya, government is rolling out a community strategy and management skills training for Committees and Boards involving communities in health service planning. A structured follow-up after the intervention found that there was increased clarity about committee and board roles and responsibilities, lines of authority and accountability mechanisms in those involved, that members started using the formal guidelines and procedures to direct activities and proceedings, and that there was clearer communication between these mechanisms and district health managers. The training also led to improved financial oversight of revenues and expenditures, increased use of facility service data in management decisions, and increased engagement in fundraising.

Clara Mbwili-Muleya, Lusaka District Health Team, Zambia described a participatory action research activity undertaken in Lusaka in 2006 with EQUINET to strengthen community and health worker involvement in planning, budgeting, resource allocation and activity implementation. Health worker and community members at health centre level used participatory methods to identify needs, systems barriers and actions to improve planning processes. The process built a 'common language' and information exchange between health workers and community members, and increased community members' confidence in approaching health workers on needs, plans and resources. Community members became involved in resource allocation, and there was an increased understanding of the resource constraints, with community members' knowledge of how funds were allocated increasing from 25% to 63% of those interviewed in a baseline and follow-up survey. These processes are now being scaled up through horizontal capacity building, mentorship and as part of routine duties.

Therese Boulle, an Independent researcher, South Africa described the functioning of Community Health Committees (CHCs) in Nelson Mandela Bay, South Africa. There are 52 health facilities in Nelson Mandela Bay; 24 of which have CHCs, eight require revitalisation and 20 facilities do not have CHCs. Even where CHCs existed, they lacked representative legitimacy and were composed of health volunteers whose allegiance was to health workers, and whose own interests were represented in the CHCs. Staff and supervisors were satisfied that CHCs were in place, even though the community was left out. She described a programme of work to strengthen community structures, build civil society at community level and strengthen the role of the communities in the CHCs, using participatory methodologies.

Gabriela Glattstein-Young, University of Cape Town reviewed the functioning of the 72 CHCs in the Cape Metropolitan Area in South Africa, and found that only three were well-functioning (more than 10 active members, regular meetings, ongoing involvement at health facilities). There was gate-keeping by facility managers and a lack of consensus on CHC roles and functions. Structural barriers (such as communication) were rigid and complex, the CHCs were not representative of the community and CHC members were not visible, although they did ensure service delivery to a certain standard and monitor clinic statistics. Inter-sectoral action also existed with police and volunteers in trauma victims unit, affiliation with wards councillors and municipalities, hospital boards, homeless shelters, community housing projects, schools and youth.

In the discussion that followed delegates proposed that there be greater support and capacity input to sustain programmes beyond project life spans. Community-based organisations need to collectively plan and collaborate on issues of volunteerism particularly on incentives so that they do not kill the spirit of volunteerism, and supported and strengthened active mechanisms for community participation. Some delegates felt that there is a gender bias in participation mechanisms that needs to be overcome by finding persuasive methods to increase the participation of both men and women in programmes. Health Committees should be recognised as they play an important role in health systems.

5. Plenary 3: Fairly resourcing health systems

Sam Okuonzi, Africa Centre for Global Health and Social Transformation welcomed delegates to the plenary session on fairly resourcing health systems both in terms of financing health systems, allocating resources, including AIDS treatment resources and in relation to health workers.

Reclaiming public domestic funding for health care

Di McIntyre, Health Economics Unity, University of Cape Town gave an overview of recent EQUINET sponsored research on health financing, focussing on user fee removal, progress on Abuja target, and the growth of health insurance. She said the next phase of work will focus on the importance of reclaiming domestic resources for financing health systems.

> *"To support universal health systems, financing mechanisms must provide financial protection (pre-payment and maximum pooling of resources and risks) and enable the use of needed services. Equitable health care financing systems mean that people should contribute according to ability-to-pay (progressive contribution mechanisms) and benefit according to need. Countries need a system of cross subsidies from wealthy to poor and healthy to ill in one large pool so that cross-subsidies can happen."*

Meanwhile, private-for-profit provision of health is being promoted. While this is argued to contribute to coverage, it has been found to attract a higher share of personnel, to exclude poor groups, and to lead to higher spending in poor people who do use these services, thus to have negative consequences for health equity. Out-of-pocket payments (OOP) for health services can drag people below the poverty line, and there is evidence that user fees are impoverishing people in Africa. Conversely, Uganda, Zambia and other countries have showed that user fees can be removed but that this must be accompanied by increased allocations from health budgets to respond to the increased utilisation that occurs, particularly in the poorest districts. This needs careful planning in terms of increased supply of drugs and staff.

This places focus on domestic financing for health. Most east and southern African countries have a heavy reliance on donor funding and need to improve domestic funding. To fund systems equitably calls for prepayment through compulsory insurance or tax funding. Di noted that in 2001 African Heads of State committed to spending 15% of national budgets on health. There has been some progress in Zambia, Malawi and Namibia. Zambia has increased its health budget from 8% of government spending in 1997 to 18% in 2003, and Namibia from 10% in 1997 to 14% in 2003. Some budget shares have fallen, however, such as in South Africa where the health sector spending as a share of total government spending went from 17% in 1997 to 9% in 2003, or in Kenya with only 5% of the national budget going to health. Meeting the Abuja commitment calls for public and parliamentary pressure, but also debt cancellation as debt is constraining governments' ability to increase funding.

Community based health insurance schemes (CBHI) have been introduced in rural and urban areas of some countries, but there are concerns about the coverage, flat contribution rates and sustainability of these schemes. Private health insurance, currently found in South Africa, Zimbabwe and Namibia is becoming more common in other countries. There are concerns about equity and sustainability of these schemes. Many countries in east and southern Africa have discussed and developed policies to introduce social health insurance (SHI), but few have yet put these into full implementation. This is an issue that needs greater attention, to identify and address the obstacles. She pointed to a set of priorities for reclaiming public domestic funds for health, including advocating for a fair share of tax revenue for health, backed by debt cancellation, and exploring insurance options, particularly mandatory, single-pool funds.

Retaining health workers in east and southern African health systems: Lessons from a regional programme

Scholastika Ndatinda Iipinge, University of Namibia outlined the EQUINET-ECSA-HC programme on retaining health workers in the region. Health ministers in the region have adopted a common position on ethical recruitment of health workers and on promoting retention through incentives.

> *"Losing health workers from our health systems has direct and knock-on costs, including loss of institutional memory, of morale for remaining workers and increased workloads. Communities are forced to seek care at higher levels or have unmanaged disease burdens. Retention signals that health workers are valued and is cheaper*

than replacement. It is an equity issue, to ensure there are health workers in areas of the greatest need, to attract and retain skilled personnel in under-served areas."

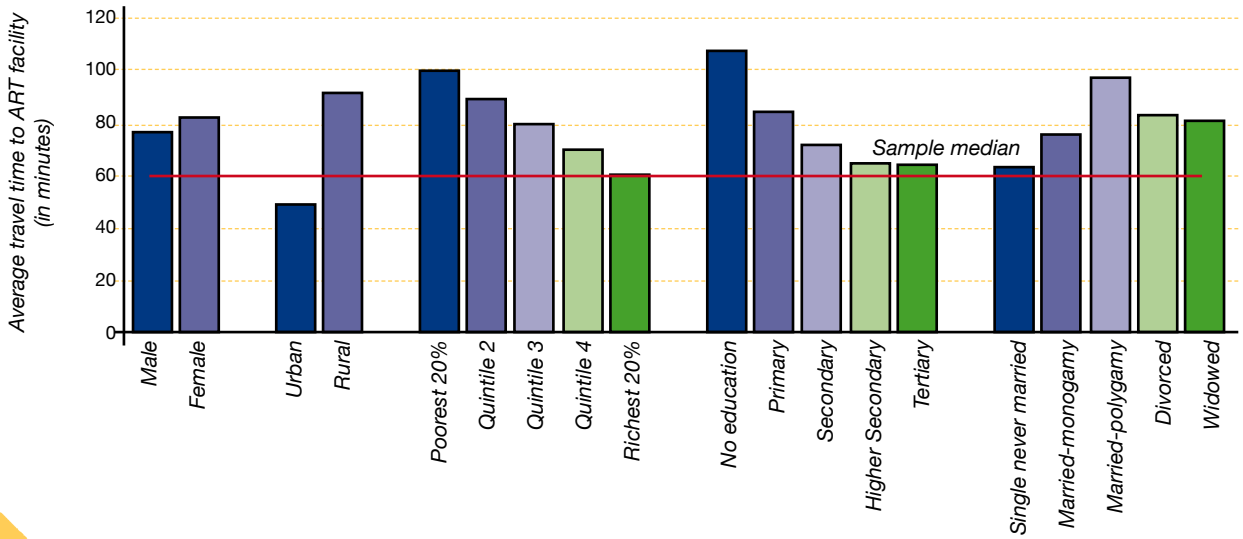
Qualitative and quantitative research in Kenya, Swaziland, Tanzania, Uganda, and Zimbabwe has established the context for, and trends in, the recruitment and retention of health workers. It also identified existing policies, strategies and interventions in place to retain health workers and how these were introduced and resourced to assess their sustainability. Many financial incentives are being applied in east and southern Africa, including salary top-ups and adjustments, allowances, dual practice especially for doctors, per diems and sitting allowances. Non-financial incentives have been more limited in scope and often only applied to doctors and nurses. They include training and career paths, social needs (housing, transport, childcare), working conditions and health care. They are supported by strategic planning and information systems that facilitate appraisal and supportive supervision. Implementation of these incentives has been found to be inconsistent with limited monitoring and evaluation of their impact. Evidence from country-level studies indicates that they do however play a role in workers being attracted to or retained in services and in addressing some of the 'push' factors leading to health worker migration. She argued that retention strategies need to be planned and implemented, costed and monitored across the health sector, with stakeholder input. She proposed that specific training is needed to manage incentives. Policies should aim to build cohesive and functional health teams, with a set of core retention strategies applied and regularly reviewed across all countries in the region. Documenting and exchanging this experience will guide future strategies.

Equity in accessing AIDS treatment resources: Experiences from Malawi

Hastings Banda, REACH Trust Malawi said that ante-retroviral therapy (ART) in Malawi started with patients initially paying a small amount, but were later made available free in a few places, and then more widely as demand increased. ART provision was thus not set up according to need, and some areas remain under-served. A study conducted in five of 28 districts of the country found that women were more likely to access AIDS care, and that more adults accessed care than children. Men on ART had a higher risk than women of defaulting from treatment. He proposed therefore that when looking at ART provision, it is important to look both at the level of mobilisation of resources, but also who is being reached by those resources and with what uptake.

The discussion on the papers was referred to the parallel workshops that followed on each of the themes.

Time to an ART Facility, Malawi H Banda et al 2009



H Banda et al 2009

6. Parallel sessions II: Fair financing, health workers, and equitable, primary health care oriented responses to AIDS

After the plenary four parallel workshops were held to further explore the issues raised in the plenary sessions. These are reported here. The abstract book provides details on the individual papers presented so this report provides a summary of the discussions and issues raised in each session.

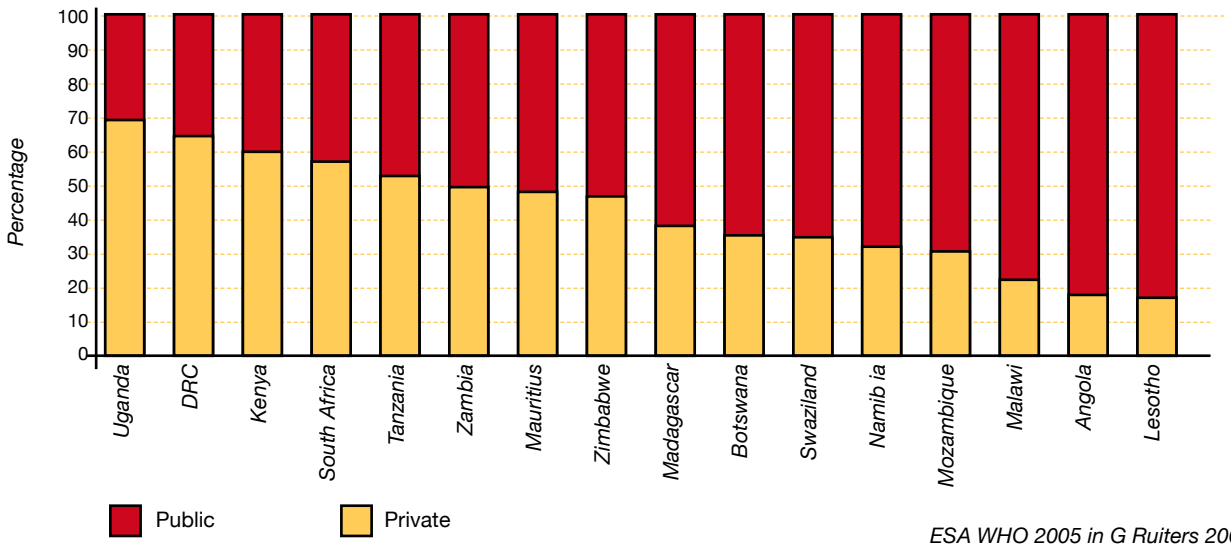
6.1 Fairly resourcing health systems

Prof Di McIntyre and Prof Lucy Gilson, University of Cape Town convened this session, using facilitated dialogue on poster presentations.

Antony Opwora, KEMRI/ Welcome Trust Programme explained that after the Kenyan government reduced user fees in 2004, direct funding for facilities was piloted in Coast Province. A survey of 30 health centres and dispensaries was undertaken to assess how well this was working. Funds were transferred directly into facility accounts, covering recurrent expenses excluding drugs operations and health workers. Health Facility Committees (HFCs) prepare a work plan of expenditure, approved by district management. and communities are empowered to monitor funds, as accounts are displayed on public notice boards. The survey found that procedures were well-established, that HFCs met regularly, produced and implemented work plans, and followed accounting procedures. The funds were often used for outreach activities, patient referrals, staff incentives, improved supplies and a safer and cleaner working environment. It was perceived to have improved staff morale, facility utilisation and quality of care. However there was inadequate training for HFC members, especially in financial management and a lack of relevant guidelines at facility level. Communities had low awareness of the scheme and could not identify HFC members. Further, the policy of removing user fees was not adhered to. However, small increases in funding at the periphery can have a positive impact on quality of care and utilisation. It needs to be supported by training of HFCs and by a simple and clear manual for HFC members. Policies, such as on user fees should be clarified and adhered to.

Charlotte Zikusooka, HealthNet Consult, Uganda reported that attaining equity in health financing is an objective of Uganda's Health Sector Strategic Plan II, but not regularly assessed or monitored. Health Services at government health facilities are free at point of care since 2001 to enable universal access to the national minimum package. As the health sector is significantly under-funded, the quality and scope of services provided are below that promised in the minimum package, and this, together with poor physical access leads to use of formal and informal private health care providers and a persistence in out-of-pocket payments. External funds are often targeted at vertical or disease-specific programmes, and social health insurance, while discussed, has not

Public-private expenditures on health in ESA countries, 2005



ESA WHO 2005 in G Ruiters 2009

been introduced due to institutional weaknesses and stakeholder resistance. Uganda thus has very limited pooled resources and cross-subsidisation, with negative implications for equity.

Prof Greg Ruiters, Institute of Social and Economic Research, Rhodes University observed that in 2005 sub-Saharan African countries US$16.7 billion is spent on health, 60% of which is from out-of-pocket expenditure. In 2005, UNCTAD reported that private health was the fifth most promoted sector in Africa, after tourism, hotels, energy, and computer services. He argued that the myth of large commercial flows and FDI creates false expectations and debilitates public sector initiatives. In fact only Mauritius, South Africa, Botswana and Namibia are growth points for capital, and most new FDI in health is in the pharmaceutical sector.

The concentration of this private sector in health is indicated by the fact that only 1% of Africans have private health insurance, and 82% of these are South Africans. Poor and rural populations in Africa often rely more heavily on informal private sector providers, including those trading unregulated drugs and fake and counterfeit drugs. Private-for-profit health care has an almost exclusive focus on curative services. He argued for defense of the public sector in health, noting that commercialisation of health services is not a preferred option in high income countries, where public health services dominate.

Yoswa M Dambisya, University of Limpopo, South Africa described the capital flows in the South African health sector where, despite increased funding for health between 1995 and 2007 to both public and private services, access to health care has remained inequitable across the public and private health services. The public sector caters for over 80% of the population, pools about 45% of the funds for health, while the private sector pools together more than 55% of funds for health but regularly caters for less than 20% of the population.

Participants called for examination of the politics and contexts for private-for-profit health sector expansion, and the entry points for commercialisation of health services, such as private-public partnerships; out contracting. They felt that the right to health and the approaches and benefits packages to achieving this need to be protected by the state and used to assess the performance of any sector and providing services. In the discussion it was also noted that if financing of services is transparent, communities will know what has been allocated and disbursed. Community-level monitoring of financing and use of resources is key to creating demand for equity in health financing.

Delegates thus proposed that efficiency needs to remain on the agenda to deal with waste, duplication and corruption in public resources, to achieve more with current resources. As follow up work

- We need to encourage governments to meet the 15% contribution to health, and strengthen the public sector and remove bottlenecks to absorbing additional resources.
- While encouraging removal of user fees, we need to produce guidance on supporting steps and resources (including from external funders) and monitor the impact.
- Civil society should monitor the use of public funds and service provision.
- More evidence is needed on the benefits and costs to equity of the private-for-profit sector, keeping clearly the difference between the not-for-profit, private-for-profit, and the informal private sector.

6.2 Equity in health services responses to AIDS

The session was convened by Hastings Banda, REACH Trust, Malawi

Buyana Kareem, Cavendish University, Uganda described a study on the sexual reproductive health (SRH) challenges faced by HIV+ pregnant women, conducted at health centres in Kampala city in 2008 with 120 female out-patients and ten health personnel. The study found a perception that the primary objective of identifying HIV infection in women is to prevent transmission to infants rather than for the benefit of the women themselves. Local health workers lack specific training in HIV and AIDS during pregnancy and knowledge about the available clinical services is low. Patients have fears about history-taking during routine counselling, about toxicity of ART, and of directive, judgmental and non-confidential abortion counselling. There is a scarcity of screening services for cervical cancer and sexually transmitted infections; of effective nutrition counselling, care and support and of information on measures for managing HIV in pregnancy. Women fear disclosure-related violence from spouses and coercive sex during pregnancy. He proposed that SRH policies need to go beyond clinical guidelines to make social and economic assessment central to the design of interventions.

Judith Daire, University of Cape Town reported on the lack of progress in maternal and child

health (MCH) in Malawi, despite policies and programmes. Mortality and morbidity rates have remained high, and key services are heavily dependent on external funding. She suggested that a top-down policy development process does not include implementers is poorly translated into operations at district level. District level managers do not use local data from the health information system for planning, monitoring and evaluation and thus do not evaluate programmes. She proposed that evidence based management be built at district level to promote ownership and commitment to services, to build capacity for evaluation of progress and as means for implementers to inform national policies.

Janis Huntington, University of Alberta, Canada explained that in Uganda healers were often more accessible than healthcare workers, and were therefore a potential means to increasing ART coverage. A study of 219 healers found that 67% of healers had a high knowledge score on ART, particularly male healers, birth attendants, those aged 18–35 and those with secondary or higher level of education. Just over three quarters (79%) of healers were very willing to collaborate with services. She proposed that it may thus be possible to involve some healers, such as younger healers, in ART programmes to help increase programme coverage.

Hastings Banda of REACH Trust said that despite access to health in Malawi being free at the point of service delivery, poor, rural residents benefit less, despite their high burden of disease. Studies have shown that poor people wait longer, receive fewer drugs and pay more in comparison with non-poor. Research has found that rural people travel a longer distance, take longer and incur higher costs to get to ART compared to urban areas. Real costs of access to ART services is higher for poor people, particularly the poorest rural populations. ART scale-up in Malawi favours higher income urban populations. He proposed increasing the number of ART clinics operating in rural areas, such as through mobile clinics.

Richard Hasunira, HEPS Uganda noted debate on whether the international response to HIV and AIDS is weakening primary care or distorting health systems. Field research in Uganda, Argentina, Brazil, Dominican Republic, Zambia, and Zimbabwe found positive impacts on health systems from AIDS funding, including increased health financing, training, recruitment and payment of medical personnel, as well as inclusion in AIDS programmes of treatment for other diseases, such as TB, malaria and diarrhoea. Safe water programs for PLWHAs have benefited whole communities, and social mobilisation systems to respond to HIV has been used to distribute insecticide-treated mosquito nets, anti-malarial medicines and family planning. However, HIV and AIDS programmes have also been found to create pressure and increased workloads for health personnel, whose numbers have not increased proportional to the demand. Infrastructure is stretched and facility capacity has not increased proportionally. There is report of parallel services for HIV and AIDS, with staff attrition to these services due to the pull of better pay. He argued that on balance we need to better organise and fund health systems as a whole, while also increasing the momentum of AIDS service scale-up.

Grace Bongololo, REACH Trust Malawi reported that anecdotal evidence shows that about 5–10% of all those currently accessing services in Malawi are health workers. Research has found that most (61%) of health workers (HCWs) indicated that it is difficult for a HCW to go for testing, although 73% reported to have ever tested for HIV. Self testing was found to be common, as was sending an anonymous blood sample. There were no special ART programs for HCWs and most HCWs on ART devised their own way of collecting ARV drugs. Distance and quality of service were the most common factors cited on HCW choice of where to access ART, most delaying ART until they were ill. There was a very low utilisation of post-exposure prophylaxis due to lack of awareness, unavailability, and fear of the HIV test. Occupational exposure was raised by lack or shortage of protective materials especially gloves, heavy duty aprons, soap for hand washing and goggles. HCWs face challenges to access HIV and AIDS services, even where services are available at their own workplaces and they devise strategies to use counselling, testing and ART in secret. Establishing special HIV and AIDS services for HCWs may help to improve HCW access, although this would partly depend on the openness between HCWs.

Delegates in the discussion noted the need to monitor and review implementation of policies in countries through policy monitoring alliances, comprising of NGOs, government and international bodies, with close-to-community support groups. They proposed building on a range of alternatives to health care workers in the community to help in supervising ARV treatment under the direction of professional health care workers.

Delegates proposed that HIV and AIDS funding and programming should strengthen a holistic health care system, rather than building parallel programmes that disrupt systems. It was proposed that follow up work

- Assess and include response to needs and costs borne by poor people in accessing treatment, such as reducing transport costs by scaling up mobile clinics and widening community health workers roles;
- Examine options for targeting VCT and ARV access in specific groups, such as health care workers, and poor, rural, and male groups.

6.3 Participatory, Primary Health Care approaches to public health priorities

The session was convened by Barbara Kaim and Rene Loewenson, TARSC. It explored work in the region in different settings largely using participatory approaches that aimed to build PHC oriented responses to key public health problems, particularly AIDS. Much of the work has been done in the participatory action research (PRA) network in EQUINET.

Awino Mary Aoko, Rachuonyo Health Equity, Kenya outlined how in Rachuonyo, a resource-limited area, inadequate health facilities and staff, fear of social rejection and cultural practices increase the spread of HIV. Hence only 13% of eligible people access treatment. Participatory approaches have been used to strengthen links between health workers and women living with HIV for improved PHC. The Kasipul Division HIV Clients Network Against Defaulter Rates (KADHICNADER), a local network of people living with HIV, was started as a result of the diagnosis of poor coverage of services in PRA work in 2007. The network has mobilised five member groups into community meetings taking up issues in health care provision and in the community to empower PLWHIV to manage disclosure issues and treatment with ART. It has also facilitated support by community members of the health services to make best use of available resources.

Caleb Othieno, University of Nairobi described how efforts to treat those infected with HIV and AIDS and to reduce new infection rates are hampered by behavioural factors, including alcohol abuse. This is not addressed in the Kenya National HIV/AIDS Strategic Plan (KNASP) 2005/6–2009/10. A PRA study was undertaken to improve the management and adherence to ARV treatment among PLWHIV who concurrently abuse alcohol. Clinic staff poorly identified alcohol- related problems and did not have a formal alcohol screening. He reported on the work done on psycho-education and to discuss the adverse effects of alcohol on treatment and developed skills in early identification of alcohol related problems in PLWHIVA using a simple screening instrument. This was followed up with community support, and attempts to create ways for PLWHIVA to engage in economic activities and thereby reduce the need for alcohol. While the latter efforts were successful within the time-frame of the research, the other activities were implemented. The post intervention assessment found reduced rates of harmful alcohol use and increased compliance, and improved communication between health workers and community members. The service constraints were still apparent: the lack of public treatment facilities such as rehabilitation centres in the community and of national guidelines on the treatment of alcohol-related disorders.

Mulumba Moses, HEPS Uganda described a PRA process that sought to identify the barriers to delivery, coverage and uptake of prevention of mother-to-child transmission (PMTCT) services at primary health care and community level. It also aimed to generate improved demand for and use of PMTCT in Kamwenge sub-county in Kamwenge district and Mulagi sub-county in Kiboga district in Uganda. The dialogue across communities and health workers PRA improved shared understanding of each others' barriers. Both groups perceived barriers in the inadequacy of health workers and drugs to support demand, and the many societal challenges that inhibit women's access to services, particularly lack of male support. They planned actions on prioritised barriers, and implemented a range of actions, including media, sensitisation and training of local leaders.

Amanda Jones, University of Alberta,Canada described a peer education programme targeting school students' understanding of sexual health. Many young people in Uganda lack sexual health information, and most rely on the media as their primary source of information, as well as schools and friends. Less than 2% of youth surveyed rely on health professionals. She reported a study of Ugandan secondary school student sources of sexual health information to establish the most appropriate strategy for conducting peer education among Ugandan secondary school students as a means of sexual health promotion. A peer education intervention was designed with student input, and the changes in knowledge and practice assessed after its implementation. The programme increased student confidence and teacher support, the latter contributing to their sustainability.

Caleb Thole, Global Hope Mobilisation described a community empowerment process among pregnant women in Lilongwe-district, enabling their uptake of HIV testing and counselling, and encouraging use of antenatal care services and uptake of Nevirapine before delivery. Information exchange and counselling backed by support to referral processes led to increased pre- and post-VCT counselling testing and uptake of Nevirapine. Most women (60%) returned for post-test counselling. The main risk factor found for lack of uptake of Nevirapine for HIV+ women was found to be home delivery and lack of knowledge on their HIV status, as well as cultural beliefs, limited resources, poor transport infrastructure and a shortage of health workers.

Wilson Damien Asibu, Country Minders for Peoples Development (CMPD), Malawi explained how PRA approaches were used in Monkey Bay, where a high HIV prevalence rate of 21% (national average = 12.2%) is resulting in large number of orphans and vulnerable children. There is inadequate support for vulnerable children in Monkey Bay, and many female children resort to commercial sex work or other risk behaviours. Inadequate care and support to vulnerable children was attributed to a lack of adequate resources, poor coordination of available resources and weak links between formal institutions and community organisations. The community was not adequately involved in designing, planning and implementing interventions. Based on a shared diagnosis of problems, actions were taken to establish a community health forum, to raise awareness and support re-admission to schools for single female mothers who had dropped out due to early pregnancies, and to community farming activities. Village child protection groups were formed to protect vulnerable children from exploitation, abuse and violence. An assessment after the actions found improved shared understanding, communication and cooperation between local organisations and community members of the health needs and coping strategies of vulnerable children in Monkey Bay, and increased uptake on children of health services.

Dumisani Masuku, Holistic Child Support Initiative, Zimbabwe explained that in Victoria Falls in Zimbabwe, Primary Health Care (PHC) services were not meeting the health needs of children. There was a lack of child participation in identifying health needs and inadequate collaboration between PHC service providers, community and AIDS Service Organisations. PRA processes were used to address these issues, involving children in the process with service providers and community members. Creating a supportive and enabling environment for the participation of children improved communication between health workers, community members and children on the delivery of health services and encouraged a shared approach to looking beyond providing ad hoc material support to children to set up long term safety nets for children within community social systems.

In discussion, delegates identified common features of the participatory processes that were effective in promoting community involvement in health or enhancing community voice. These processes can bring visibility to community issues ad bridge the gap between the community and the health system. Such processes can address social barriers to uptake of services and need enabling environments for communities to solve problems and articulate needs. At the same time they demand investment in PHC as these supply-side barriers are not easily dealt with through PRA processes.

This calls for resource strengthening of PHC. It gives emphasis to the demand that at least 25% of government spending in health should be allocated to PHC, over and above the Abuja commitment of 15% government spending on health. The delegates called on governments to meet the this demand they called the ‘People’s Abuja’.

Children in PRA activities Victoria Falls *D Masuku EQUINET 2009*

6.4 Valuing and retaining health workers

The session was convened by Scholastika Iipinge, University of Namibia and Yoswa Dambisya University of Limpopo and chaired by Helen Lugina, ECSA-HC. It reviewed work on health worker retention and migration, some of the studies having been done through the EQUINET-ECSA-HC programme on health worker retention.

Dr Kate Mandeville, University College London said that in Malawi pre-service training of health workers has increased considerably under the Emergency Human Resources Plan and enrolment at the national medical school has increased from 15 students in 1992 to 312 in 2008, with plans for 600 by 2010. However, many qualified health workers continue to leave the public sector to work or train abroad. Therefore a study was undertaken to explore the association between the background of current students and their post-qualification plans. Most students came from rural areas (81.5%) and most had private education (38%), mission education (23%) or went to boarding school (27%). The immediate plans of most doctors were to stay, practice, teach, research or pursue further training in Malawi, although some planned to pursue further training or practice elsewhere. Others were undecided. The main reported incentives to stay were career path development and salary. With about a third of current medical students planning to leave Malawi in the future, the current increase in pre-service training in Malawi needs to be complemented by measures to attract and retain graduates into the public sector.

Charles Dulo, Mustang Management Consultants, Kenya described a study undertaken in Kenya with International Organisation on Migration and EQUNET to identify the impact of the migration of health workers on health services in Kenya, examining impacts on resource generation, stewardship and service provision, and looking at doctors and nurses only. Migration is a problem in Kenya: The desire in health workers to leave current positions was high, and more than half (53%) of those interviewed said they would leave the country if they could. The pull factors were higher income, better career prospects and improved training opportunities. The impact on service delivery cannot accurately be measured but it was found that gaps in staffing increased workloads for remaining staff, compromised service delivery, and weakened training and in-service supervision by more experienced personnel. It was difficult to quantify these costs to the system, but a rough assessment using available data found that training costs alone of nurses who had out-migrated were not matched by the estimated remittance inflows of these same workers.

Deogratius Mbilinyi, National Institute of Medical Research,Tanzania found in their study of seven districts in Tanzania that non-financial incentives could be improved by providing extra payments, such as hardship allowances, proactively increasing the health budget in hard-to-staff districts over time, providing training opportunities for health workers, facilitating the acquisition of staff loans and ensuring more timely salary increments and promotions for health workers working in disadvantaged rural districts. These incentives are however difficult to implement due to shortage of funds, and weak monitoring and evaluation means that problems are not quickly identified and dealt with. This meant that health workers often had to rely on their own resources, and 40% reported attending training based on their personal initiatives. Most (70%) respondents felt that available non-financial incentives are not adequate to motivate them and increase productivity. And while there were mixed responses on the adequacy of feedback mechanisms, other factors such as lack of funds, equipment and transport were preventing feedback mechanisms from being a sufficient incentive.

Moses Chimbari, University of Botswana assessed the impact of incentives instituted by the Zimbabwe government to retain Critical Health Professionals (CHPs). The study focussed on CHPs at urban and rural settings in Mashonaland West, Matebeleland South and Masvingo, and Harare and Bulawayo. Numerous incentives were applied in 2006–2008, but were undermined by an unfavourable macro-economic environment. The Zimbabwe Health Services Board (ZHSB) strategic plan for 2005–2010 provided a framework for monitoring and evaluating the incentives programme, but struggled to sustain incentives in the prevailing macro-economic environment. The gap between policy and practice was thus found to be due to a lack of capacity to implement the retention package. Bonding staff as a means of retention was found to be unpopular and to promote staff desertion without contractual notice periods being given. The researchers proposed that retention strategies target all staff categories and be extended to staff in training institutions. They proposed that retention packages prioritise non-financial incentives that are not directly eroded by inflation. There should be clear career paths for staff and management courses incorporated in the training curriculum of health

professionals. They also proposed that the ZHSB be afforded more autonomy. As follow up research they proposed documenting the number of CHPs leaving the country and the countries they go to.

Ijeoma Okoronkwo, Department of Nursing Sciences, University of Nigeria reported that in Nigeria, health workers are forced to seek alternative sources of income due to poor working conditions, even though various incentives were provided by management. A cross-sectional study in a federal tertiary institution in Enugu, Nigeria, reviewed 87 doctors and 152 nurses. The study revealed that a unified salary structure (unconditional rewards) affected job performance negatively and health worker job dissatisfaction was caused by jobs not offering opportunities for independent thought, personal growth or self-fulfilment. Political differences, tribalism and favouritism during promotions also negatively affected job performance. Incentives did not match cost-of-living increases and half (55%) of respondents preferred to leave the organisation if offered a comparable job elsewhere. The researchers proposed that better incentives would include fair and adequate salaries, health worker participation in decision-making, recognition of personal responsibilities, adequate opportunities for professional growth and career development, and provision of adequate tools for work.

Dr Lincoln Khasakhala, Africa Mental Health Foundation (AMHF), Kenya reported on research to review incentives applying in Kenya. Facilities offered a number of financial incentives to staff, such as paid leave, overtime pay, housing, car loans at lower negotiated market rates and transport, entertainment, hardship, responsibility, special duty and uniform allowances. Non-financial incentives included housing, post-graduate and continuing medical education, life insurance, personal loans and reduced working hours. However it also found very variable application of the incentives. Many workers in public sector and district services are junior cadres who do not qualify for many of the incentives. Limited medical supplies, poor supervision and non-implementation of incentives was found, especially in rural services in low income areas where resources are more limited. The researchers recommended that government set specific policies to retain health workers in rural areas, in lower-income districts and at lower levels of the health system and ensure application of policies across all services.

Judith Daire, University of Cape Town explored gaps in maternal and child health policy implementation in government and private health facilities in Malawi. Government and external funders are addressing health worker shortages, such as through salary top-ups and increasing enrolment in training institutions. Yet health workers leave the government sector as they lack rewards, supportive supervision and have poor working conditions. Some strategies for dealing with shortages were found in the research to further deplete the health systems workforce and compromise quality and equity. For example, task-shifting has resulted in unqualified staff performing critical clinical procedures, without training and supervision. The study recommends that apart from taking urgent corrective action on salaries and increasing training capacity of health professional workers, strategic decisions must be made in three areas: training, deployment, and retention of health workers. Retention strategies should include effective human resources management systems and styles, improved work environments and resources and incentives should also be applied to non-health professional workers who support health workers in delivering health care.

Participants pointed out in the discussion the need to improve training institutions and courses on management and administration across the region. Retention incentives need to address a broad cadre of health workers, not just doctors and nurses and task shifting strategies need to be supported by training and supervision. In follow up, delegates observed that evidence concerning the causes of health worker migration (rural-urban, government private and south-north) should be presented to health unions, and there should be constructive engagement between health activists and trade unions to address issues of retention of health workers with government.

Further:

- Policy makers should be involved in all processes of research so that they own and adopt recommendations from the studies. This process requires researchers to have skills and capacity for communicating with policy makers;
- Advocacy should be scaled up to raise the profile of health worker concerns;
- Country level retention strategies should be country- and evidence-driven, involving all stakeholders, including those from international level and civil society; and
- Ministries of Health should actively engage with trainee health workers in order to promote employment within the public sector.

7. Building alliances and people's power in health

Dr Francis Omaswa of the African Centre for Global Health and Social Transformation (ACHEST) chaired the session. Dr Omaswa thanked EQUINET for hosting such a conference and briefly introduced ACHEST, an initiative promoted by a network of African and international leaders in health and development who have gained first-hand experience in planning and implementing health and development programs in Africa and at international level. It is an independent Think Tank and Network. He outlined learning from work on the support to the stewardship function of health systems, to better understand the roles, challenges, resources and inputs to enhance effectiveness. He noted that effective stewardship and governance of country health systems is fundamental to achieving national, regional and global health goals. He observed the need for strong country-level institutions from within and outside government to build and strengthen technical capacities and real time information resources for health system leadership and stewardship, especially by ministries of health, and to mobilise the resources for this. He called for improved networking of institutions within the region towards this, an area that ACHEST would be taking up in future work. He welcomed the speakers from participatory work, civil society and parliaments for their insights on leadership, alliances and peoples power in heath.

Experiences and lessons on empowerment from participatory methods

Barbara Kaim, Training and Research Support Centre presented collective work and learning of the regional learning network (pra4equity) working with participatory methods in health, noting the input from many organisations to the input. From two stories of engagement with health systems, one from a disempowered woman and one from an organised community, she pointed to the role of social power in health outcomes.

> *"Equity is really about power. It's not about distributing rights or empowering, but about creating conditions for people to come out and claim their rights and exercise their power. EQUINET has recognised this, saying that equity in health means having the power to influence decisions over how resources for health are shared and allocated."*

She presented the learning from twenty participatory action research studies in nine countries within EQUINET, exploring different aspects of community interactions with health workers, and PHC oriented responses to AIDS, using the spiral model of participation, reflection and action (shown below). She outlined learning from this work, including that communities understand and prioritise the structural causes of ill health and social determinants of health to a greater degree than health workers, given their importance in health. Communities don't raise ill health issues that they don't think services will respond to and health services themselves act as a social determinant of health and health care uptake by the way they relate to people.

> *"Health systems do not link well across sectors and narrowly perceive community roles. While they have high legitimacy, they have weak capabilities for social roles, apply top down planning and weakly address barriers and facilitators to health service uptake and adherence, leading to resource inefficiencies."*

The PRA processes produced changes by closing communication and perception gaps between communities and health workers. They improved co-operation and co-ordination across agencies, actors, sectors and enhanced uptake of local resources for health and to some extent the resource inflows for promotion, prevention and care. One of the biggest challenges has been to institutionalise these processes. Formal recognition and support of participatory planning mechanisms is weak, health workers have limited skills and few incentives to facilitate participation, especially when PHC resources are limited. While this calls for capacities for health leadership and mechanisms for accountability, sustaining this work also requires political support, partnerships and alliances.

THE SPIRAL MODEL

Building alliances and people's power in health

Itai Rusike, Community Working Group on Health, Zimbabwe commented that civil society is often associated with protest actions, especially when authorities don't respond to issues, but that civil society comes together and acts in different ways around values and fundamental rights to health so that people can get greater control over the resources for health, including health services. He argued that these roles and the mechanisms to involve civil society in health systems need to be recognised and supported.

There is evidence from research that social empowerment for health has led to improved allocation of resources to health centre level, improved quality of health care as perceived by both providers and users of services, resource mobilisation at local level and enhanced community capabilities for health. However there is still much work to be done in facilitating wider public participation in budget processes, promotion of the 'expert patient' concept, and global relations that promote equity and public interests and public interest over commercial interest. He gave numerous examples of how Community Working Group on Health and other civil society organisations are taking up such issues.

> *"People need to be organised to use and defend health services, and health systems need to be organised around social participation and empowerment to create powerful constituencies to protect public interests in health."*

He noted the recognition of community roles in Primary Heath Care programmes. When structural adjustment programmes were introduced in a top-down manner, however, with the position that 'there was no alternative', citizen-state relations were damaged, with narrowing space for civil society, and with loss of control and social confidence in health. This has led to token recognition of communities in many settings, with their roles not adequately resourced. Loss of dialogue and burdens on health workers have led to a range of barriers in health systems: such as people's fear of health workers and resentment or suspicion between communities and health workers. He suggested that addressing this calls for strengthened state–civil society alliances in health. At the same time this should be based on equity values and fundamental rights to health, in national policies and in international and regional agreements.

Experiences and lessons from parliamentary roles and alliances in health

Hon Blessing Chebundo, Association of Parliamentary Committees on Health in East and Southern Africa (SEAPACOH) explained the role of parliament in enabling accessibility and public participation in policies and budgets for health, through parliament roles in legislation, oversight and budgets. This role can be better tapped if supported by capacity building and specialisation so that members of parliament (MPs) become more effective.

He gave a number of examples of successful action in the region. For instance the Kenya parliamentary health committee, working with technical assistance from APHRC, analysed and positively influenced the 2004 Population Bill. The Zambian committee with support from CHESSORE inputted to the 2002–4 National AIDS Policy and the South Africa National Assembly health committee, with Health Systems Trust support promoted a formula for the equitable allocation of health funds to provincial governments. In Zimbabwe the committee, working closely with TARSC, CWGH, and Ministry of Health has also promoted integration of equity in the resource allocation process and in the annual budget formulation, while the Malawi health committee collaborated with MHEN to prioritise health and HIV and AIDS in the budget.

He explained the origins and role of SEAPACOH to bring together parliamentary committees on health from east and southern African parliaments, with the involvement of both regional and national organisations. The network creates an opportunity for strong and co-ordinated advocacy, for review of health laws and for exchange of evidence, knowledge and practice.

> *"Self-driven, consistent collaboration, communication and networking amongst committees of health in ESA are critical to achieving health equity. Regional networking has added advantage which is not available at national level."*

He raised a number of challenges, such as regular changes in national committee membership due to their political, elected nature, parliamentarians not always having technical knowledge on health, limited resources or capacities affecting the role of national committee clerks or officers in acting as 'bridging gaps', and a lack of appreciation and support by presiding officers in some parliaments of the role of parliamentary committees. He proposed that such resource constraints can be addressed if collaboration is built between national civil society, professionals and academics and parliamentary committees on health.

8. Parallel workshops III: Policy engagement; trade, technology and health; access to health care and the Equity Watch

After the plenary four parallel workshops were held to further explore issues raised in the different plenary sessions of the conference. These are reported here. The abstract book on the EQUINET website provides details on the individual papers presented so this report provides a summary of the discussions and issues raised in each session.

8.1 Policy engagement for health equity

This session was convened by Lucy Gilson, University of Cape Town.

Uta Lehmann, University of the Western Cape, South Africa described their study exploring the implementation of new national community health worker (CHW) policy in one rural sub-district in South Africa. They found that many CHWs in district were mature women with little education but lots of experience, but were excluded from receiving stipends on grounds of qualifications. The new policy resulted in reduced numbers of CHWs and consequently reduced coverage. Communities participated neither in the CHW selection nor the coordination of the programme. The local health promotion manager had little information to understand the content and scope of the policy, no assigned role in the policy process and was undermined by resistance from colleagues. She understood the different roles of other implementers, established a monthly feedback/continuing education meeting with all CHWs in sub-district and formed alliances with facility managers, CHWs and researchers. But key policy elements, such as community participation, skills development and infrastructure support were lost in the implementation process. She noted the need to improve information and communication flows; ensure middle managers have authority and competence to drive policy implementation; and design policy processes sensitive to local contexts and flexible enough to allow for local adaptation.

Joseph Munsanje, Country Director of Sightsavers International, Zambia outlined a national eye Co-ordination structure set up in Zambia to support 120,000 Zambians who are blind and 3,118,212 who are visually impaired. Beyond setting up training for mid-level eye care personnel, and recognition of ophthalmic personnel by the public service commission, a new eye care policy is under debate. The process towards this indicated the importance of identifying allies and opponents and of bringing a credible evidence-base and political voice to the issues. He noted that it is important to reach for the easiest changes first, and then use evidence on the impact of these changes to motivate further change.

Joanne Stevens, Google, USA described South Africa's attempts to address health worker migration, through financial incentives, hospital revitalisation programmes, a comprehensive HRH plan, a number of bilateral agreements on health worker migration, and mandatory community service. However, research showed that young doctors have no knowledge of the HRH plan, are frustrated about the response to AIDS and see the department of health as coercive and unapproachable. In contrast, community service increased doctor loyalty to patients and opened their eyes. They were largely satisfied with infrastructure, equipment, remuneration and allowances, but less satisfied with remediable problems such as processes (procurement, referral, outreach, hiring, payment), relationships (fellow staff, senior medical personnel, management and administration), and grassroots problems not always obvious to the department of health. Young doctors reported that they feel unheard and say there is no way to escalate concerns, so many resort to neglecting duties as a form of 'psychological exit'. She proposed that young doctors need to be encouraged to voice their concerns and be educated about channels for voice at local, provincial and national level. Protection for whistle-blowers needs to be legislated and direct communication prioritised, using communication technologies such as corporate email address, guidelines on responsibilities and expectations and online help forums and ideas boards.

Wilson Okaka, Kyambongo University, Uganda outlined elements of an effective communications strategy and noted that experience shows that health communication is more effective in a stable social, economic, legal and political environment, and when it uses credible role models, messages and media. However this is often blocked by lack of awareness and information, poor co-ordination of stakeholders, misconceptions and myths, conflicting and distorted messages. He observed that the absence of a comprehensive health communications strategy, along with financial

constraints and unsynchronised messages undermines policy implementation.

Jacob Ongala Owiti, Rachunyo Health Equity, Kenya observed that while policies are being developed in Kenya, these are not translating to improved health or health care, especially among rural and slum dwellers. He reported on a review of existing health policies from the two ministries of health, backed by interviews with directors on state and non state institutions in the health sector. The evidence suggested a top-down approach in policy advocacy and development that creates a gap in implementation of programmes that promote health equity. In contrast, he argued that participatory programmes have created empowering environments for communities to act on their own health, and called for integration of participation in health strategic planning in ways that engage communities. However he also suggested that where processes are top-down, communities themselves need to build alliances to reclaim their role and influence.

Participants observed that communication and information are tools of power. Information may be withheld so that certain people can retain power. In contrast participatory methods share information and understanding. Appreciation of policies means that civil society needs to find ways of translating policies into meaningful forms for such processes. Participants observed that parliamentarians can play an important role in bridging processes on the ground with those at national or even global level. It was however noted that policies are sometimes fragmented, confusing and conflicting. This leads to resistance amongst key actors, and the implementers cannot always see the benefits. This itself calls for a shift in management styles to support policy implementation, to build more flexible, listening managers able to consult and more realistic implementation plans. Delegates identified that:

- Leaders should continue advocating for policies after they have been adopted by creating supportive environments for implementation, through information to stakeholders and follow up of successful implementation.
- Parliamentarians and civil society are targets for work to improve communication strategies, capacities and alliances to engage from local to global level.
- The role of managers in health systems should be recognised for them to be able to support participatory processes for development and implementation of policies.

8.2 Trade, technology and health

Rangarirai Machemedze, Southern and East African Trade Information and Negotiations Institute (SEATINI) convened the session, building on the introduction given in the second plenary on issues and challenges on trade, technology and health.

Mugambi Laibuta, Health Rights Advocacy Forum, Kenya presented evidence on how substandard and counterfeit medicines in markets were leading to health complications, drug resistance and mortality. He estimated that sale of counterfeit medicines in Kenya is high, harmful to people and channels money into criminal networks. The *Anti-Counterfeit Act 2008* was consequently enacted to prohibit trade in counterfeit goods after pressure from the Kenya Association of Manufacturers. However, the definitions of counterfeit and generic medicines in the act are ambiguous and it has some conflict with other laws providing for compulsory licensing. This ambiguity and non-demarcation between essential and non-essential goods in the law can lead to barriers to access to medicines. He thus noted that new laws should not limit the flexibilities provided for in the TRIPS agreement.

Patrick Mubangizi, Health Action International, Africa described the work of the African Civil Society Coalition on the Inter-Governmental Working Group on Public Health, Innovation and Intellectual Property (IGWG) to monitor implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property (GSPA). The strategy has eight main elements, including promoting and prioritising research and development (R&D) needs, enhancing innovative capacity, technology transfer, management of intellectual property, improving delivery and access, ensuring sustainable financing mechanisms, and establishing monitoring and reporting systems. There are issues to address, such as whether to limit the strategy to selected diseases, how to prioritise R&D in traditional medicines, whether to support open databases and compound libraries, whether 'other' incentives for innovation are alternatives to IP, how to encourage or promote technology transfer and how to develop sustainable financing. There is now some consensus on promotion of product development in developing countries, on improving capacities for health innovation and on promoting technology transfer. The GSPA (WHA 61.21) must not be perceived as 'just another Resolution of WHA but its implementation is crucial in the attainment of the human right to health. HAI Africa and IQsensato have developed a tool to monitor the implementation of the GSPA, and have piloted it in Uganda, Kenya, Ghana,

Zimbabwe and Rwanda to complement WHO and government monitoring efforts.

Kathy Jo Wetter, ETC Group, Canada introduced new technologies affecting health in the form of information technology (bits); nanotechnology; neuro and biotechnology and synthetic biology (manipulation of genes). She noted that nanotechnology is increasingly being used by a few forward-looking companies to make old drugs more effective. However the environmental and health risks of these new technologies are not known. Synthetic Biology and genetic engineering are creating 'designer organisms' from synthetic DNA that can be used for a range of functions, including for fuel, food and medicines. The drugs produced, such as synthetic artemisinin used in antimalarials, replace petroleum-based products or the artemisinin sourced naturally from farmers in East Africa. If synthetic Artemisia comes on the market, production and manufacturing will shift away from areas where the natural form is sourced, with negative consequences for African countries. The fact that these technologies are under private corporate control means that decisions on their development are driven largely by corporate rather than social interests.

21st Century Bang =
(control of bits, atoms, neurons, genes)

Information Technology - controls & manipulates data in the form of **Bits**

Nanotechnology - controls matter through manipulation of **Atoms**

Cognitive Neuroscience - controls brains and minds through the manipulation of **Neurons**

Biotechnology + Synthetic Biology - controls life through manipulation of **Genes**

etc group

Participants raised that corporate concentration and control of new technologies (especially nano-scale technologies and synthetic biology) will have serious impacts on livelihoods and health of people, especially in commodity dependent countries. There is thus an urgent need for education of communities and policy makers to understand the implications of emerging and converging technologies, intellectual property and control of resources. Existing gains in trade and technology laws and policies need to be monitored and protected. New intellectual property regimes (including Kenya's newly enacted anti-counterfeit law and the anticounterfeiting legislation being formulated in Uganda) should in no way restrict flexibilities already won in the TRIPS agreement, providing for access to essential medicines, including generic medicines. It was recognised that trade, technology and health remains a key area of work in EQUINET to develop capacities, information flow, policy awareness, monitoring and advocacy.

8.3 Access to health care: Addressing barriers in vulnerable groups

Mwajumah Masaigana and Fortunate Machingura, TARSC convened this session.

Kingsley Chikaphupha, REACH Trust Malawi reported on the high level of HIV in commercial sex workers (CSWs) in Malawi (70% in the 2006 Malawi Behaviour Surveillance survey) with girls as young as 12 years of age joining the sex industry. CSWs are recognised in policy as high risk group and a priority for access to antiretroviral treatment (ART) but are not included in the design, implementation or evaluation of policies and programmes affecting them. He described their PRA research implemented with EQUINET to explore and address barriers to coverage and uptake of HIV prevention and treatment services among CSWs in Lilongwe, Malawi. The process identified challenges of poor communication with health workers, poor clinical examination practices in health workers, over-dosing of medication by private clinics, CSW shyness and experience of stigma and abuse, including from health workers. The shortage of drugs at clinics further demotivated CSW uptake of services, while health workers observed that CSWs do not bring partners for STI treatment, do not adhere to treatment and checkup schedules, undermining their own recovery and with risks of resistance to treatment. The participatory process led to a range of interventions to address communication and adherence barriers, designed with and involving CSWs, with positive impacts measures on knowledge, service uptake and communication perceived by both CSWs and health workers.

Ivan Masembe, Hope Restoration Community Foundation, Malawi described their study exploring stigma, perceptions and local understandings of medical, care and treatment for people with disabilities (PWDs). The team observed in the region studied a lack of provision for specialised wheel chair carriers in rural centres, of hearing aids, and of specialised toilets for disabled people. Only 15% of PWD respondents reported that they were able to satisfactorily access medical services both at home and in health centres, with money for this from wealthier relatives or families. PWDs reported barriers in access to medical services due to stigma, poverty, and lack of policy driving systems changes. The demand for support with scarce resources overwhelms the few available organisations providing support. They proposed support for counselling and training to home based care providers and professional service providers on

disability management, and that guidelines be put in place on the management of PWDs at health centres, clinics, schools and other public places. They also proposed that government subsidise equipment for PWDs, like wheelchairs and hearing aids.

Anne A. Khasakhala, Population Studies and Research Institute, University of Nairobi, Kenya explained the numerous approaches tried to stop female genital mutilation/ cutting (FGM/C), particularly those encouraging community initiatives and government legislation. Despite this, the practice is still common in districts in Kenya, and prevalence may be even higher than reported in surveys, given that data was only collected for those over 15 years of age. Stigma, lack of community support and low prioritisation in district development has been a barrier to approaches to stop the practice. She described a Value-Centred approach that is based on the premise that when people are given information that enables them to make informed choice, they practice it for their own and their families benefit, eventually cascading to the rest of the community. With this approach, an initial cluster, or group of influence within the community, was created. This group became champions through public declaration that they would not allow their daughters to be circumcised and instead used the seclusion for the week to impact information regarding their sexuality and reproductive health after which they graduated in a public ceremony. She noted that this appeared to have more promise as an approach.

In the discussion delegates observed that effectively addressing the needs of such vulnerable social groups calls for greater investment in PHC, through rights-based approaches and with resources specifically directed to improve uptake in these groups. Community interventions are key , through processes that build action on local experience and perceptions, to increase access and uptake of health services. Value-centred approaches should shape the way primary health care is implemented in any setup.

8.4 'Eye on Equity': Approaches to keeping a watch on equity

Rene Loewenson, TARSC convened the session. She introduced evidence in the EQUINET

regional analysis that identifies that health equity is advanced when:

- health is central to and integrated within national goals;
- health equity is advocated and monitored as a political, social and policy goal;
- there is wide understanding of and efforts towards redistributive health systems; and
- peoples roles are recognised, valued and supported.

She introduced the proposal and work to date to implement an Equity Watch in EQUINET, outlining its purpose to track, make evident and engage on priority dimensions of health equity and particularly the interventions that promote health equity. It thus organises evidence on health equity and measures for improving it, and monitors progress on actions taken to improve health equity, particularly against commitments made. The programme shares evidence and views on options, practices for strengthening health equity, and points to areas for deeper research. It also provides and shares evidence for regional compilation and exchange. Equinet has identified six markers of advancing equity in health, seven markers of improving household access to the national resources for health, eight markers of resourcing redistributive health systems, and six markers of a more just return from the global economy. The Equity Watch process involves setting up the analysis, forming a stakeholder group involving government, parliament and civil society to review and dialogue on the work, and the technical analysis. She presented examples of how the evidence is organised and presented, using the pilot Zimbabwe Equity Watch and the work in Uganda.

Mulumba Moses, HEPS Uganda described the Equity Watch undertaken in Uganda. He presented the context of economic growth without sustained improvements in the human development index (HDI) and health equity; and of governments goals of economic growth and transformation, good governance, poverty reduction and improved quality of life of poor people. The Equity Watch has pointed to areas of progress in this context, such as in the strong constitutional and policy provisions for health equity, but also the gaps, such as in the low and unequal coverage and uptake of maternal health services. From existing

evidence, education seems to be one driver of inequality, as well as the continued level of out-of-pocket spending, despite stopping user fees. He noted that the Uganda Health Equity Network will discuss the report, and it will also be peer reviewed by government, parliament, health professionals and civil society, before it is finalised and taken forward for advocacy.

Eliyah Zulu, African Population Health Research Centre noted the increasing level of decentralisation of decision making, resource allocation and administration in health systems, and thus the need for robust information and technical capacity for monitoring progress at district level. Yet, facility-based data often underestimates community health issues as not all health issues reach facilities. There is an acute shortage of data at district level to monitor health systems. Some community based studies follow-up people living in geographically defined areas in either full districts or a sizable portion of districts, allowing for collection of comprehensive and time trend information and helping to identify groups that are persistently in bad conditions and those transitioning in and out of poverty. He gave examples of such data. This has been helpful in supporting health planning. For example, the Tanzania Essential Health Interventions Project (TEHIP) model enabled district health managers to optimise allocation of resources in accordance with burden of disease, using community and clinic health data. To improve monitoring, it is necessary to find innovative ways for triangulation with other data systems.

Rene initiated discussion on the design and parameters in the watch and in the interest and process for taking it forward. In discussion, participants said it was necessary to differentiate between indicators for measurement of social differentials, performance against benchmarks and against targets so that the basis for assessment of inequity is made clear. They noted that the decisions on how to organise the evidence needs to take into account what evidence exists and that it needs to reach and make sense to people outside the academic circle and policy makers. The indicators need to be universal and specific to the needs of a country, and we also need to track and show progress with all the work done in equity across the region.

The delegates discussed other forms of evidence to demonstrate inequity. In particular focus was given to the work that had been done to train for and implement a programme of community photography integrated within the programme of work on participatory action research for people centred health systems. The session participants agreed after reviewing the exhibit that it was a powerful complementary tool for the Equity Watch, if used as part of a process of social change around health that builds voice and power to community level, as it had in the work presented, and not as an isolated photography process. The pictures gave profile to issues that had less profile, like gender, and made participants want to act on the health issues shown. It was agreed that photography can strengthen our watch on equity, projecting both contrast and change.

> *"From the other sources of evidence I imagined reality. From the photos I saw the reality."*
>
> *Session participant*

8.5 A dialogue on research methods and evidence on private capital flows in the health sector

Greg Ruiters from the Institute for Social and Economic Research, Rhodes University convened and led the session. He gave a brief background account of the desk studies undertaken in South Africa, Zimbabwe and Tanzania, which examined the capital flows in the private medical insurance industries in South Africa and Zimbabwe and the pharmaceutical industry in Tanzania. The dialogue explored the methods and evidence needed to monitor private capital flows. Capital flows appear in many forms, including transfer of shares from public medical and drug facilities to private companies, acquisition of laboratories, clinics, pharmacies, drug production, procurement and distribution infrastructure and other medical services. Much growth in the private sector has been facilitated either by deliberate incentives or signals, or inaction from the state. Brief reports were presented on work being done in Tanzania (by Robert Mhamba) and Zimbabwe by Shepherd Shamu) on capital flows in the pharmaceutical sector and in medical aid societies respectively.

Delegates discussed the trends. They commented on the need to regulate the private-for-profit industry in the health sector in order to minimise the negative impacts of unregulated capital flows, and to put in place mechanisms to engage and influence private actors and monitor capital flows. Ministries of health need to create a dedicated desk to manage and monitor developments in the private sector in health, and we need to analyse and enforce competition laws and control of monopolies.

9. Plenary: Country alliances and regional networking

Rosette Mutambi, Director of HEPS Uganda and Philemon Ngomu, Co-ordinator of the Southern African Network of Nurses and Midwives chaired the session.

Kenya Health Equity Network (KHEN)

Charles Dulo, chair of KHEN outlined how KHEN was initiated in October 2008 to raise visibility of health equity issues in Kenya among policymakers and the public including mental health neglect, access to essential medicines, to healthcare in urban poor communities, and on equity in the Millennium Development Goals. The network has held monthly meetings since January 2009, elected network leaders, and is developing a constitution, communication strategy, fundraising plan and initial activities and priority health equity issues that the network can focus on. APHRC is the acting Secretariat for KHEN. While monthly meetings are met with enthusiastic participation and KHEN is now represented on the EQUINET Steering Committee (SC), it still faces challenges including lack of funding, competing priorities, and lack of organising or institutional capacity. He reported that KHEN will be registered and will establish institutional structures and will work with EQUINET on a Kenya Health Equity Watch. He noted the need for EQUINET capacity building support.

Malawi Health Equity Network (MHEN)

Saiti Chikwapulo, Malawi Health Equity Network (MHEN) reported that MHEN is a non-profit making alliance of civil society organisations established in 2000 to promote equity and quality health care services for all Malawians. The network has undertaken community work on equitable access to essential health, HIV and AIDS services, analysed the national budget, undertaken policy research on health financing and access to health care, run campaigns on access to medicines, research on essential medicines availability and pricing, medicines for malaria, and in collaboration with TARSC, implemented health literacy in four districts. Challenges in access to health care include distance to services, inadequate financing, drugs, health workers and equipment, and the impacts of AIDS on services. MHEN has developed a knowledge base and experiences, shared resources and expertise, and offered a platform for action at national and local levels and regionally. Her argued that successful and effective alliances needed networking and exchange visits to promote learning and links.

Networking on health equity in Zimbabwe

Tafadzwa Chigariro, Community Working Group on Health (CWGH) described networking in Zimbabwe through CWGH, TARSC and Parliament of Zimbabwe. He gave an example of the work in the networking on health resource allocation policies at district level, strengthened and shared evidence for equity oriented resource allocation, and supported capacities for MPs, local government, health centre committees and communities to promote and monitor equity oriented resource allocation. The team have conducted community meetings on health priorities, health providers and resource allocation, and discussion with the parliamentary committee on health on the budget implications. He noted that collaboration enriches work at local and national levels, but must but must be based on a clear understanding of the needs and aspirations of the different players, while putting communities at the centre of action.

Uganda Health Equity Network (UHEN)

Mulumba Moses, HEPS Uganda said that they were inspired by country networking examples in Zimbabwe and Malawi and created UHEN in Uganda to overcome isolation, share interests, and combine efforts on common work. EQUINET supported a 2007 national process to bring together 35 organisations to define equity issues and develop themes such as health and trade, health rights, fair financing and gender. Under these themes the network identified specific organisations to take work forward as theme leaders. HEPS is currently the secretariat. UHEN pools resources, builds solidarity, exchange with other country networks, and is building a community level network similar to the CWGH in Zimbabwe. UHEN has a mailing list through EQUINET as a networking tool, and a steering committee. In February UHEN and TARSC in EQUINET held a writing skills workshop and with *African Journal of Health Sciences* has a special of journal issue based in the output from the national meeting and writing skills workshop. Funds have been raised to take activities forward, including monitoring and reporting on health rights. Work

has also been done with EQUINET on a health equity watch.

EQUINET's organisation and mission into the future

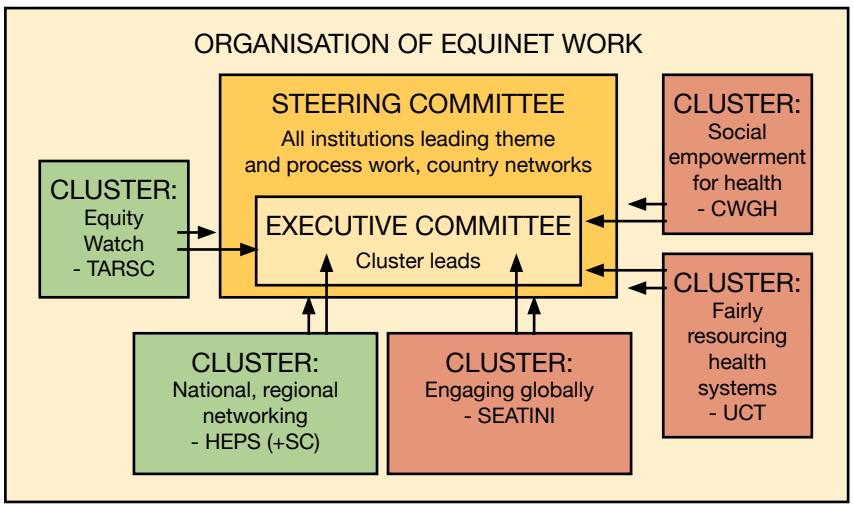
Itai Rusike for the EQUINET Steering Committee described EQUINET as a network of professionals, civil society members, policy makers, state officials in east and southern Africa that aims to advance and support health equity and social justice through sharing information and experience, research, building critical analysis and skills, and networking and building strategic alliances. He outlined the history of the network since its formation after the Kasane meeting in 1997, and the progression of areas of focus from conceptualising equity, to realising shared values of equity and social justice in health, to turning values into action through work on specific areas of health action, co-operating with SADC. With many areas of work developing, work from 2001–2004 aimed to sharpen the message, widen the constituencies and consolidate the network, leading up to the second conference in 2004 on Reclaiming the State. In 2005 EQUINET and the ECSA-HC established a formal co-operation and SEAPACOH was launched. The work from 2005–2009 focused on building health systems that deliver on values of equity and justice in health, with the consolidation of analysis in 2007 in the form of Reclaiming the resources for Health. In 2009 EQUINET distributed its 100th newsletter and is hosting its 3rd regional conference with the theme Reclaiming the resources for health. The evidence in our regional the analysis pointed to three major ways in which reclaiming the resources for health could strengthen health equity:

- for poor people to claim a greater share of national resources to improve their health;
- for a more just return for east and southern African countries from the global economy; and
- for a larger share of global and national resources to be invested in redistributive health systems to overcome the impoverishing effects of ill health.

This has led to five major work areas planned for 2010–2015, as follows, with the way EQUINET will organise to achieve this shown in the diagram below:

1. strengthening social empowerment in primary health care and health;
2. fairly resourcing national health systems;
3. engaging on global economic and social policies on priorities, policies and needs for health equity within east and southern Africa;
4. implementing a health equity watch at district, country and regional level; and
5. strengthening national and regional responses to advancing health equity.

Delegates indicated that the presentations were inspiring and that they were keen to develop similar networking and engagement. Delegates from Zambia reported that work linking stakeholders reduced duplication of efforts, and through partnership enhanced achievement. A delegate from Nigeria was impressed by what is happening in the ESA region and in the consortium of institutions working together on health equity and expressed the desire to explore ways to extend this networking to Nigeria and west Africa. EQUINET was called on to continue the work in the directions planned, including the support to country level processes.



10. Resolutions

The draft resolutions were presented by Aillet Mukono of the EQUINET SC and discussed by the delegates with inputs made and recorded.

The final version of the resolutions adopted by delegates are shown on page 1.

Delegates agreed to take the commitments forward in various organisations and forums. EQUINET, as a consortium of institutions from the region, indicated its commitment to taking the actions forward to advance health equity through research, sharing evidence and good practice and to advocate and monitor equity and social justice, including through the Equity Watch.

Conference delegates *EQUINET 2009*

11. Closing plenary

Prof David Serwadda, Dean of Public Health, Makerere University chaired the session and gave a summary of what he had heard of the discussions and debates at the conference, commending the organisers, speakers, participants and local hosts for their contribution. He introduced Rene to give remarks on the next steps.

Taking up the resolutions

Rene Loewenson, for the EQUINET Steering Committee explained that the resolutions would guide EQUINET's work and positions in the coming years and would be taken forward into other platforms and processes to advance equity in health and in health systems. She commented on how the conference had displayed a wealth of self-confident and wise experience and informed action at community and national level, and commitment from regional institutions to support this.

These are resources within the region that are critical to overcoming inequity, and it was a privilege to have gathered at the conference and to feel this sense of community of purpose and practice. She felt that this would carry all of us forward with renewed energy.

She noted that we also need to make changes at the global level so that what we do in our communities, countries and region is not undermined by what is happening at global level. This was a bigger challenge, and one that EQUINET would try to address more strongly in the coming period, based on the evidence and experience from within the region.

She thanked everyone who played an important role in this conference with commitment, passion, values and intellect. She particularly thanked colleagues from the steering committee, TARSC, the local organising committee (HEPS, Makerere University and Ministry of Health) Global Event Management, the organisations who had funded the conference (SIDA, IDRC, Cordaid, Kellogg, APHRC) and supported EQUINET, and the delegates and their institutions from local to international level.

> *"The conference was a rich exchange and now we need to take it forward through action. We have always known that action is imperative in face of injustice. The conference has showed us that we have the evidence and the capacity for action. It has renewed our energy and made us feel that action is not only imperative, but also possible. Whether at global level or in the most remote community, when we act to advance equity we are not acting alone."*

A short film was shown, drawing on photographs taken during the conference by the community photographers in the "Eye on Equity" team and edited by Thandiwe Loewenson. It gave a feel of the active engagement and interactions of the conference.

Reflections from the meeting

Damaris Fritz, Metro Health Care Forum, South Africa called on delegates to follow up on the issues raised, especially budgets and expenditures for health, given that so few countries in our region are meeting commitments made at Abuja. *"As civil society we need to monitor to make sure this is met."*

Ephraim Mafalo President of SANNAM expressed delight at the opportunity to interact with participants, and to listen, learn, and share information meaningful to their network. He urged all to stop working in silos, and continue interacting with each other and in EQUINET. *"Advancing equity in health demands regional integration and cooperation."*

Hon Munji Habeenzu, Chairperson Parliament committee on Health, Zambia said the conference was an eye-opener, and had closed the gap between policy makers, civil society and health workers. *"Push your governments to act on this information to achieve equity, otherwise the conference will be like a woman who has made a wonderful menu and hides it under her bed until it rots and then throws it away! Please work with us to take this forward!"*

Connie Walywaro, Young Peoples Forum Kenya said the conference was a great experience and that they would focus on building and consolidating partnerships to push for economic policies that protected health and for 15% of budgets to be set aside for health.

Prof Serwadda thanked the organisers for the invitation to close the meeting. He said that equity was at the forefront of the Makerere University School of Public Health mission statement and its ongoing research. The conference, attended by a wide cross-section of people had brought forward a range of issues on health systems, resourcing health systems, and building alliances, which are all major considerations for equity.

> *"In light of WHO report on health, which emphasises PHC, the resources for healthcare have significantly increased. However most of this funding is external and governments are still not reaching the Abuja target…There are many challenges, despite increased funding. The delivery of heath care is complicated and complex; equity requires a political commitment, and we must work together, at different levels of society to make in-roads."*

He called on our networks to speak the language of policy makers, and of those in other sectors, and to improve human capacity and keep health workers in the region. He urged communities to lead action based on their experiences, to speak out on what works for them and make sure this is implemented.

Prof Serwadda encouraged the conference convenors to circulate the proceedings of the meeting widely and to disseminate it in the media, so people know what EQUINET and the resources of the region offer. He wished everyone a safe trip back and declared the conference closed.

Making a point in a conference session
D Baatjies EQUINET 2009

Conference Delegates *D Baatjies EQUINET 2009*

Appendix 1: Delegate list

LAST NAME	FIRST NAME	COUNTRY	ORGANISATION
Adjei	George	Ghana	National Catholic Health Services, Ghana
Agiresaasi	Apophia	Uganda	Parliament of Uganda
Agwanda	Alfred	Kenya	Population Studies Research Institute, University Of Nairobi
Akankwasa	Paul	Uganda	HEPS- Uganda
Aliyo	Bestason	Uganda	Uganda Health Equity Network HEPS-Uganda
Amuli Jiwe	Jean-Pierre	DRC	Association Nationale des Infirmiers(eres)
Amunyunzu-Nyamongo	Mary	Kenya	African Institute for Health and Development
Asibu	Wilson Damien	Malawi	Country Minders for Peoples Development
Awases	Magda	Namibia	World Health Organisation (WHO) AFRO
Awino	Mary	Kenya	Rachuonyo Health Equity
Awor	Linnet Agnes	Uganda	Network of Uganda Researchers and Research Users
Baatjies	Dorothea	South Africa	HOSPERSA
Baba	Amuda	D R Congo	IPASC
Banda	Alpha	Zambia	Centre for Infectious Diseases Research in Zambia (CIDRZ)
Banda	Hastings	Malawi	REACH Trust
Baryomunsi	Chris	Uganda	Parliament of Uganda
Basilio	Matilde Francisco	Mozambique	ANEMO
Bongololo	Grace	Malawi	Research for Equity and Community Health Trust
Boulle	Therese	South Africa	
Buyana	Kareem	Uganda	Cavendish University Uganda
Byarugaba	Alex	Uganda	Parliament of Uganda
Bulayi	Geoffrey	Uganda	Uganda National Association of Private Hospitals
Chebundo	Blessing	Zimbabwe	Parliament of Zimbabwe, SEAPACOH
Chibilika	Davidson	Zambia	Lusaka District Health Management Team
Chiboleka	Catherine Daka	Zambia	Zambia Union of Nurses Organisation
Chigama	Maria	Zimbabwe	Holistic Child Support Initiative
Chigariro	Tafadzwa	Zimbabwe	Community Working Group on Health
Chikaphupha	Kingsley Rex	Malawi	Research for Equity and Community Health Trust
Chikwapulo	Saiti	Malawi	Malawi Health Equity Network
Chimbari	Moses	Botswana	Harry Oppenheimer Okavango Research Centre, University of Botswana
Chipenzi	Ambrose	Zimbabwe	ZimPATH /VVOB- Zimbabwe
Chitah	Mukosha Bona	Zambia	Economics Department, University of Zambia
Choruma	Doreen Rose	Zimbabwe	Zimbabwe Nurses Association
Chuma	Jane	Kenya	KEMRI-Wellcome Trust Research Programme
Daire	Judith	South Africa	University of Cape Town
Dambisya	Yoswa	South Africa	University of Limpopo/EQUINET
Dhlomo	Senele	Zimbabwe	Training and Research Support Centre
Dubuya	Kiven Tutani	Zimbabwe	Nyadire Teachers' College Zimbabwe
Dulo	Charles	Kenya	Mustang Management Consultants
Ekirapa- Kiracho	Elizabeth	Uganda	Makerere University School of Public Health

Erasmus	Ermin	South Africa	Centre for Health Policy, Wits University
Fick	Nicolé	South Africa	University of Cape Town, School of Public Health and Family Medicine
Fritz	Damaris	South Africa	Metro Health Care Forum
Gilson	Lucy	South Africa	University of Cape Town/ London School Hygiene and Tropical Medicine
Glattstein-Young	Gabriela Simone	South Africa	University of Cape Town Learning Network
Gleeson	Nana	Botswana	BONELA
Gooding	Kate	UK	Sightsavers International
Gordon	Christina	Namibia	Namibia Nursing Association
Graham	Ronald	Kenya	Sight savers International, East, Central And Southern Africa
Hansina	Christian	Namibia	Parliament of Namibia
Hasunira	Richard	Uganda	Uganda Health Equity Network HEPS-Uganda
Hofnie-//Hoëbes	Käthe	Namibia	University of Namibia
Hoaran	Marie-Antoinette	Seychelles	Nurses Association of Seychelles
Huntington	Janis	Canada	University of Alberta
Iipinge	Scholastika	Namibia	University of Namibia
Imasiku	Monde Christine	Zambia	Lusaka District Health Management Team
Irumba	Nathan	Uganda	SEATINI
Jones	Amanda Clarisse	Canada	University of Alberta
Juma	Samson Ouma	Kenya	Victory Fellowship Centre
Kabanda	David	Uganda	Makerere University, Faculty of Law
Kabasiime	Joseline	Uganda	HEPS-Uganda
Kagaba	Cissy	Uganda	Anti Corruption Coalition Uganda
Kaim	Barbara	Zimbabwe	Training and Research Support Centre
Kaiyama	Eliya George	Namibia	Parliament of Namibia
Kamuzora	Peter	Tanzania	Institute of Development Studies, University of Dar Es Salaam
Kane	Molly	Canada	ETC Group-Action Group on Erosion, Technology and Concentration
Kanyamurwa	John Mary	Uganda	Makerere University
Kanike	Emmanual	Malawi	Youth Net And Counselling
Kateeba	John	Uganda	Global South Institute – Uganda Christian University
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Wamani	Samson	Uganda	Abayudaya Congregation, Health Department
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Zlatunich	Nichole	USA	Partners in Population & Development Africa Regional Office (PPD ARO)

Appendix 2: Programme

SEPTEMBER 22 2009				
1700-1900	Registration			
SEPTEMBER 23 2009				
REGISTRATION: VICTORIA BALLROOM FOYER				
0830-0930	Registration. Music and images from the region			
0830-0930	COFFEE/TEA			
P1 OPENING PLENARY: RECLAIMING THE RESOURCES FOR HEALTH: BUILDING UNIVERSAL PEOPLE CENTRED HEALTH SYSTEMS IN EAST AND SOUTHERN AFRICA VICTORIA BALLROOM				
0940-1230	Welcome and opening remarks: *Helen Lugina, East Central and Southern Africa Health community* Keynote speakers: *Minister of Health, Uganda,* *Dr Sarah Wamala director General, Swedish National Institute of Public Health* EQUINET steering committee paper: *Rene Loewenson, Training and Research Support Centre, Zimbabwe, EQUINET Steering committee* Music and images from the region			
1230-1345	LUNCH			
P2 EQUITY IN HEALTH AND HEALTH SYSTEMS : VICTORIA BALLROOM				
1345-1515	Reclaiming the economic resources for health: *Rangarirai Machemedze, SEATINI, Zimbabwe* Lessons and challenges for building health systems that promote equity in health: *Lucy Gilson, University of Cape Town, South Africa* View from the community (DRC) and health workers (Zambia): *Amuda Baba, IPASC, Democratic Republic of Congo (DRC)* Discussion			
1515-1530	COFFEE/TEA			
PARALLEL SESSIONS				
1530-1730	Pa1 **Claiming rights to health** Victoria Ballroom	Pa2 **Equitable health services** Regal Hall	Pa3 **Globalisation and womens health in East Africa** Meera Hall	Pa4 **Social empowerment in health systems** Majestic Hall
DAY ENDS, PHOTO EXHIBIT, SOCIAL TIME				
SEPTEMBER 24 2009				
0830-0930	Photo exhibit: Meet the photographers			
P3 PLENARY: FAIRLY RESOURCING HEALTH SYSTEMS: VICTORIA BALLROOM				
0900-1030	Reclaiming financial resources for public sector health services: *Di McIntyre, Health Economics Unit, University of Cape Town, South Africa* Retaining health workers in east and southern African health systems: Lessons from a Regional programme: *Scholastika Iipinge, School of Nursing, University of Namibia, Namibia* Equity in accessing AIDS treatment resources: experiences from Malawi: *Ireen Makwiza, REACH Trust, Malawi* Discussion			
1030-1100	COFFEE/TEA			

SEPTEMBER 24 2009				
PARALLEL SESSIONS				
1100-1300	Pa5 **Fairly Resourcing Health Systems** Victoria Ballroom	Pa6 **Equity in health services responses to AIDS** Regal Hall	Pa7 **Participatory, PHC approaches to public health priorities** Meera Hall	Pa8 **Valuing and retaining health workers** Majestic Hall
1300-1400	LUNCH			
P4 PLENARY: BUILDING ALLIANCES AND PEOPLE'S POWER IN HEALTH: VICTORIA BALLROOM				
1400-1515	Experiences and Lessons on empowerment from Participatory methods: *Rene Loewenson, Barbara Kaim TARSC Zimbabwe; Selemani Mbuyita IHI Tanzania* Health civil society experiences in building peoples power for health: lessons learned: *Itai Rusike, Community Working Group on Health, Zimbabwe* Experiences and lessons from parliamentary roles and alliances in health: *Hon Blessing Chebundo, Alliance of Parliamentary Committees on Health in East and Southern Africa (SEAPACOH)* Discussion			
1515-1530	COFFEE/TEA			
PARALLEL SESSIONS				
1530-1730	Pa9 **Claiming rights to health** Victoria Ballroom	Pa10 **Trade, technology and health** NB: 1530-1720 Regal Hall	Pa11 **Access to health care: addressing barriers in vulnerable groups** Meera Hall	Pa12 **"Eye on Equity" approaches to keeping a watch on equity** Majestic Hall
1720-1800	Pa10 **Private capital flows in the health sector** Regal Hall			
1845	LAKESIDE DINNER			
SEPTEMBER 25 2009				
0830-0900	Exhibits, exchanges Rapporteurs drafting session			
P5 COUNTRY ALLIANCES AND REGIONAL NETWORKING: VICTORIA BALLROOM				
0900-1100	Experiences of networking to advance health equity at country level EQUINETs organisation and mission into the future: *EQUINET Steering Committee* Presentation of the draft resolutions from the conference: *EQUINET Steering Committee* Discussion			
0830-0930	COFFEE/TEA			
P6 CLOSING PLENARY: VICTORIA BALLROOM				
1130-1245	Taking up the resolutions: *EQUINET Steering Committee* Closing remarks: *Uganda local organising committee* Closing and images of the conference, images of ESA, music: *Conference delegates*			
1245	LUNCH			

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity-motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity-oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

Conference Scientific Committee: EQUINET Steering Committee,
Conference organisers: Training and Research Support Centre, with
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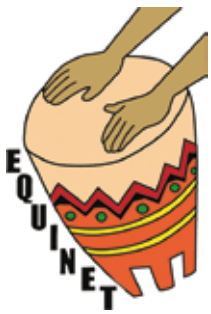

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