Taking forward the Equity Watch in east and southern Africa

Regional methods workshop REPORT

November 30 – December 2 2009
Cape Town , South Africa

Regional Network For Equity In Health In East and Southern Africa (EQUINET)
through
Training and Research Support Centre
with Healthnet Consult

in co-operation with the
East, Central and Southern Africa Health Community

with support from University of Cape Town, Health Economics Unit
SIDA Sweden, IDRC Canada

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Delegates to the workshop EQUINET 2009

Cite as: Training and Research Support Centre, Healthnet Consult, EQUINET (2009) Taking forward the Equity Watch in east and southern Africa *Report of a regional Methods Workshop, 30 November – 2 December 2009, Cape Town South Africa* EQUINET: Harare.

1. Background and objectives

In 2007, EQUINET produced an analysis of health equity in the 16 countries of east and southern Africa covered by EQUINET that

1. Mapped, outlined and analysed determinants of the major dimensions of and trends in equity in health and health care in the region;
2. Discussed the economic and policy context for these trends, from country to global level;
3. Examined key policies and measures for closing inequalities in health, generally and particularly by the health systems of the region, and the opportunities and challenges for implementing these responses.

The full book can be downloaded at
http://www.equinetafrica.org/bibl/docs/EQUINET%20Reclaiming%20the%20Resources%20for%20Health%20in%20ESA.pdf

The analysis proposed that health equity is advanced when:

i. Health is integrated within and occupies a central position in national, regional and global goals, as a fundamental right and a development goal; and that is operationalised in practice. This means that all policies, particularly economic and trade policies, protect and promote health.

ii. Equity is given profile and monitored in health and health sector advocacy and strategic reviews at country, regional level and in international partnerships:

iii. There is a wider understanding of, advocacy for and effort to operationalise fair resourcing of health systems through progressive public tax and social health insurance financing with resources allocated in line with health needs.

iv. The role of people – communities and health workers- is recognized, valued, supported and programmed in equitable health systems.

The regional equity analysis sourced evidence from a range of sources, including published studies on and from the region, reviews of current evidence, data drawn from government, intergovernmental sources, policy documents, as well as grey literature, interviews, testimonials and community level evidence gathered through participatory processes. This provided an indication of

- What parameters are being more consistently used within the region to describe the current situation and trends in the four major dimensions of health equity outlined above
- What quantitative evidence may be feasible to collect consistently across countries within the region

In the regional equity analysis the EQUINET steering committee noted that while knowledge and evidence are important for advancing health equity, there is need to give visibility to this evidence to motivate policy attention and reinforce good practice. This is especially important for policy measures that are identified from prior research and practice to improve health equity.

Based on this the EQUINET steering committee has proposed to take forward the production of an **Equity Watch** at country and regional level to gather evidence on, analyse and promote dialogue on equity in the context of country and regional opportunities and challenges. The country analysis follows a standard regional framework, adding further information as relevant to that country. The country analysis is implemented by national institutions with support from TARSC and the EQUINET steering committee, and the regional analysis is compiled by TARSC.

1.1 Objectives

The Regional methods workshop was held to gather potential lead institutions of country teams and resource personnel to build on existing work done on the equity watch to date to develop the design and plan implementation of the equity watch work at country level in participating countries and at regional level. The workshop aimed to

1. review and agree on the purpose, intended targets, process and outcomes of an equity watch at country and regional level
2. discuss the questions about equity to be addressed, and the dimensions of equity to be included
3. review and agree on the parameters, indicators, targets / progress markers; stratifiers for the analysis and organization of the analysis to address these questions/ dimensions
4. review types, quality and sources of evidence for the analysis
5. discuss and set the next steps and roles for the work at country and regional level, including mentoring and regional review.

The meeting was organised by Training and Research Support Centre (TARSC) WHO (AFRO), EQUINET, ECSA-HC and SADC with financial support by SIDA Sweden, IDRC Canada and WHO, and hosted at the Health Economics Unit, University of Cape Town. The delegate list is shown in Appendix 1 and the programme in Appendix 2. This report has been prepared by R Loewenson, TARSC.

2. Opening session

Dr Di McIntyre welcomed delegates to the UCT Health Economics Unit where the meeting was being hosted. She introduced the two colleagues from UCT HEU who would be joining in the meeting and gave an introduction to the unit and its facilities. Dr Rene Loewenson thanked UCT HEU, Di and Latiefa Adams for the support for the meeting and also welcomed delegates, noting the wide ranging and diverse experience gathered at the meeting. She outlined the objectives of the meeting (noted earlier). Delegates introduced themselves, their institutions and the work they are doing related to health equity.

Sibusiso Sibandze from the East Central and Southern Africa Health Community (ECSA-HC) noted the role of ECSA in relation to the policy processes spearheaded by the Ministers in the region, with the Regional Health Ministers Conference taking place twice yearly, and the director generals, research institutions and heads of ministries also meeting annually. He drew attention to prior resolutions passed on equity and effectiveness in health in these forums as a sign of the commitment to equity in the region. Despite this gaps remain in key areas, such as in the implementation of the Abuja commitment. This means that the equity watch comes at an important time and provides an opportunity to discuss and resolve challenges to health equity, drawing on evidence. He communicated ECSA support and welcomed delegates to the methods workshop. He encouraged the delegates to discuss and identify the way forward for the Equity Watch. Finally he noted that the ECSA-HC monitoring and evaluation programme was happy to be involved in the workshop and work.

The delegates reviewed and adopted the programme.

3. Motivations for, purpose of and targets for the Equity Watch

3.1 Motivations for raising the profile of evidence on equity

Through a participatory activity, delegates explored the motivations for raising the profile of evidence on health equity, as well as the reasons for not wanting to raise such evidence. This was responded to from the lens of political, policy, technical and civil society actors. The perceived motivations and sources of resistance were discussed for the implications for the work.

Motivations for the watch were identified as:

- *Political:* to check progress in meeting international commitments and in improving the welfare of the population, especially the poorest groups. Equity is a positive political message and signals social solidarity. It feeds into a pro-poor political and electoral agenda.
- *Policy:* to motivate the allocation of budget resources, and provide evidence to highlight priority areas for policy attention; improve the targeting of interventions to those with greatest need; enable delivery on global goals by focusing on equity
- *Technical:* Gives direction and evidence to programmes aimed at achieving health and social goals and MDGs
- *Civil society:* Desire to ensure that poverty and social, MDG goals are addressed and for fair access to health, health care, and to close geographical and social differences in health and access to health care

At international level there is an emerging understanding that needs to be consolidated that reaching the MDGs will not be possible unless equity is addressed, that current programmes to address the MDGs are not adequately reaching poor groups, and that the current scale up to the MDGs could increase inequality unless there are deliberate efforts to reach poor people.

It is important therefore to demonstrate the value of the watch to addressing these motivations and issues, to have an affirmative message of the pivotal importance of closing equity gaps in overall goals, to show where addressing equity will enable this and communicate positive social values, and to give credible evidence to guide the allocation of resources towards this.

This puts the watch in an affirmative rather than a critical framework, as a tool for achieving social goals. It offers the opportunity to raise the demand to address health equity as a means to achieving national goals, but also needs to give profile to promising practice to address health equity.

This framework may assist to address some areas of fears or resistance to a watch. These were raised as being due to:

- Lack of political support and sensitivity of some issues (eg ethnicity) (technical)
- Possibilities for it to be projected negatively as gaps that are signs of failure to deliver, as a signal of weaknesses in governance, and be used in political opposition (political, policy, civil)

- Demands for reallocation of resources being resisted by wealthy groups (political)
- Competing policy pressures (political).

It also needs to be done in a manner, through a process that addresses concerns for

- Lack of capacity, data or resources to implement the process and increased workload (policy, technical, civil)
- Exclusion from policy decision making (technical), and
- Limited space for civil society engagement (civil society)

It was raised that an inclusive process, that involves key groups at the onset and that generates wider public support for equity goals is necessary to overcome some of these potential sources of resistance.

3.2 Purpose for and experience of the equity watch to date

Rene (Loewenson) introduced the thinking and work in EQUINET to date on the Equity Watch. She discussed the current significant focus of evidence on inequity and its causes. She gave some examples from the region of evidence on inequalities in health and access to health care and the determinants of this. However, she also noted the need to gather evidence on equity and the progress towards it. She defined equity in health in line with the EQUINET definition below:

- Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair
- Equity in health implies directing more resources for health to those with greater health need
- Equity in health means having the power to influence decisions over how resources for health are shared and allocated (EQUINET 2008)

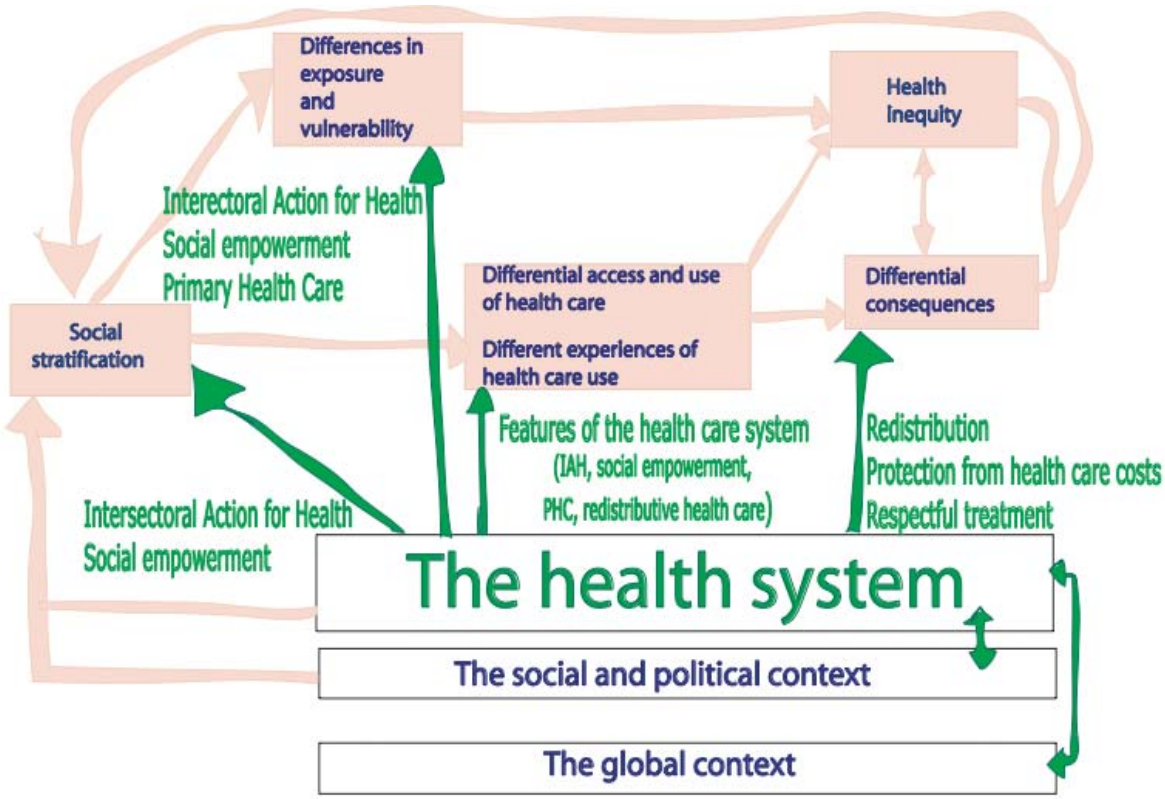
The question that thus needs to be asked is “How far are we applying our existing knowledge on health equity?”

For example knowledge on the equity enhancing dimensions of health systems has been systematically organised through the knowledge network for the Commission on the Social Determinants of Health in which a number of equity enhancing features of health systems were identified (See Figure overleaf).

The issue thus is not simply one of measuring inequity, but of assessing the extent to which we are delivering on these equity enhancing features. She highlighted some of those identified from the literature, ie:

1: Improving access to the social determinants of health (eg safe water, education in female children and other gender equity issues)
2: Setting benefits entitlements and a framework for universal coverage
3: Mobilising resources adequately and fairly, through tax and insurance funding, eliminating user charges;
3: Allocating resources fairly, especially to primary care and district health systems and across social groups and regions
4: Recognising and investing in the central role of people and social action in health systems
5: Negotiating and aligning international, global resources and policies to address

Figure: Equity enhancing features of health systems



Source: Gilson, Doherty, Loewenson and Francis 2008

Yet many of these features are still weakly implemented, or monitored. There are many policy messages that promote health equity in east and southern Africa at regional and country level, such as:

"Health must constitute a central pillar of any coherent vision of African Development"

WHO African regional report, 2006

"We commit to spending 15% of government spending on health"

Heads of state, Africa, Abuja 2001

The production of an Equity Watch informs and tracks the implementation of these policy intentions. It seeks to gather perspectives, evidence and experiences to strengthen the strategic review of, dialogue and networking on equity in health. It aims to assess current status and trends on a range of priority areas of health equity, to share experience and evidence on options for addressing these priorities. She noted that it builds on other efforts to measure equity, including the equity audits, equity gauges, health equity focused impact assessments, gender equity analysis and equity analyses being implemented by WHO and UNICEF.

An equity watch provides evidence to

- ❑ Track, makes visible and support engagement by key national (and regional) institutions (government, parliament, health worker, civil society) on priority dimensions of equity in health and in health systems;
- ❑ Organise and give visibility to evidence on health equity, and to proposals for the measures to improve health equity, as an input to strategic planning and action;
- ❑ Promote dialogue on evidence, experience and perspectives on health equity, and on the priorities and options for action to strengthen health equity to inform and motivate programmes and actions;
- ❑ Monitor progress on actions taken to improve health equity, particularly against commitments made and goals set;
- ❑ Point to areas for deeper research; and
- ❑ Share and compile evidence at regional level, and exchange across countries, including on promising practices.

It is implemented through a process that aims to raise awareness, build accountability and strengthen networking to support health equity. The Equity Watch thus seeks

- *as a product,* to inform strategic planning and advocacy, and
- *as a process,* to strengthen networking of and exchange between key stakeholders on health equity work.

The analysis of inequality can be done through:

- Measuring social and economic differentials (income or asset quintiles, poverty maps)
- Comparing absolute or relative differences between groups (gap, gradient); against reference group (average, best, target) and between areas, and over time.
- Implementing decompositions, associating inequalities in causes with inequalities in outcomes;
- Comparing coverage gaps across groups, interventions, and measuring benefit incidence, impacts of different programmes.

Analysis links to accountability and action through linking:

- Inequalities in health status, access to health care, and care-seeking, knowledge, or opportunities to be healthy (eg differentials in maternal and child mortality, deliveries by skilled health workers)
- Comparing outcomes against benchmarks – and differentials in their attainment- (eg reducing out of pocket funding to health; health worker norms)
- Comparing outcomes against targets set in policy commitments at global, regional or national level; (such as the Abuja commitment of 15% government funding to health; or the MDG commitments).

Drawing on this and the evidence in the regional analysis for equity in health in ESA, the Equity Watch developed to date includes

- 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.

In briefly presenting and discussing these and the experiences of implementing the equity watch in Zimbabwe and Uganda, she noted that the watch draws not only on survey data to address these markers of progress towards health equity, but also on the views and perceptions of communities, health workers and those in leadership.

3.3 Enhancing the production and use of evidence on equity through an Equity Watch

Delegates discussed in working groups the target groups and measures to enhance the production and use of evidence on health equity. The plenary report back and discussion was chaired by Sibusiso Sibandze ECSA HC.

In terms of encouraging *production of evidence on health equity,* the group observed that the types of evidence are mixed, quantitative, qualitative, numerical, verbal and photographic. To this end the producers are mixed, including technical, community and policy groups. This means that in addition to measures to improve the quality of data collected it is also important to be inclusive of the sources of evidence and to package the evidence in ways and languages that are accessible to these different actors. It was suggested that the equity watch includes a stakeholder analysis process to:

- Identify key policy and strategic planning processes to engage with;
- Identify key policy and social forums to engage in; and
- Identify key stakeholders to be involved.

This should apply at both national and regional level, and used to identify alliances and processes to institutionalise the equity watch at both levels. Tools for this will be provided in the guidance to the watch.

In terms of the evidence itself the group identified the need for standardised clear measures that are comparable across countries and settings, and that are stable across time to allow for development of time trends. It was noted that beyond the specific evidence there is need to develop the 'second generation' tools of time trend analysis, modelling, projection and scenario planning, to facilitate uptake for policy and strategic planning. Tools are also needed to analyse and present qualitative evidence so that it has profile in the work, including the perceptions and views of community, parliament, health workers and others.

The sources of evidence need to be credible, and the target groups for gathering evidence include government administrative data, household surveys, formal reports, parliament inquiries, civil society assessments, surveillance and other such quantitative and qualitative sources. It was raised that the watch needs to use existing data as a first priority to make more effective use of this for equity analysis. The group suggested that there be a core set of parameters that are common across all countries, complemented in each country by a context specific set of parameters that may be unique to that country.

There was some debate on the use of the term 'progress marker' or 'indicator'. The latter is better known and used. However it also often connotes a variable that is measured and quantified[1]. It doesn't send a clear signal that the watch intends to monitor and encourage *progress,* which is core to its purpose. The term 'progress marker' was selected by the EQUINET steering committee to send this signal and to make clear the inclusion of many types of evidence. The terminology will be revised and finalised after consultation, noting these issues.

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[1] An indicator is commonly referred to in various definitions as a measurable variable or "a number or ratio (a value on a scale of measurement) derived from a series of observed facts". A more rigorous definition is given by the International Institute for Sustainable Development (IISD):

Finally delegates endorsed the EQUINET plan for the process of producing an equity watch, through analysis of available secondary data, with some reanalysis of available datasets, followed in a second stage by more specific and focused collection and analysis of primary data on areas identified as priority. In both steps the producers need to make clear shortfalls, (in terms of definition, bias, accuracy) in the data and methods behind the analysis.

To enhance *use of evidence on health equity,* delegates proposed that the evidence must feed into existing processes and forums where decision making is taking place. Those raised in the discussion included the Medium Term Expenditure Framework (MTEF) processes, national development plans, national health strategic plans, and the Millennium Development Goal (MDG) reporting, forums on the National Health strategic plan; parliamentary processes on the budget; and national processes on resource allocation. These should be identified in the initial set up of the watch and the evidence needs to be used as planned to advocate, track and monitor key policy goals within these processes. The evidence should feed into existing networks and forums as relevant to countries. The aim should be to institutionalise processes and measures use of evidence on equity in policy, planning and practice. The group noted the need for pilot district work to pilot methods and approaches for district level equity analysis within countries and suggested that this be done initially in one or two countries as a pilot on methods and approach before wider roll out.

Discussions on the design of the watch R Loewenson 2009

Finally the groups recommended that countries set up a steering group to guide and advise the process at national level, and a regional working group to support and strategise on the process at regional level. This regional working group would make links with the regional policy forums and with the UN agencies engaging on health equity (WHO, UNICEF, UNDP and others).

Towards this, a core group of government, technical, civil society and parliament was proposed to steer the process in each country, who would need to identify and liaise with the wider institutions to engage with, such as Ministry of Finance, civil society, health workers, the UN agencies, especially WHO and UNICEF, other technical personnel and media. It was proposed that core terms of reference for this group be proposed as a draft by EQUINET and modified in each country based on context.

4. Monitoring dimensions of health equity

Chaired by Bonah Chitah, UNZA Zambia, the meeting explored experiences and options for monitoring health equity. Prior to the meeting a series of resource materials were distributed on this, including the WHO CSDH Commission report Chapter 16 capturing evidence and proposals for monitoring, research and training; the UNICEF guide on monitoring equity in the Millennium Development Goals; World Bank materials on the measurement and analysis of inequality in the health sector, the EQUINET Regional equity analysis and Zimbabwe equity watch amongst others. The presentations thus added to these resources to introduce discussion on the processes and parameters for the Equity Watch.

4.1 Monitoring health equity in the MDGs

Abdelmajid Tibouti outlined the concerns on how the interventions to attain the MDGs are reaching the poorest groups. There is a major push for scale up of interventions to reach the targets set to 2015, but a recent UN report from a UN ECOSOC review meeting recognized that the MDGs are not achievable unless poor people benefit from the process. In fact, he observed that unless the current scale up gives specific attention to reach to the poorest, there is evidence from research that inequalities may increase in rapid scale up processes, as the better educated, higher income groups and urban based access the benefits of intervention more rapidly. This is particularly exacerbated in the context of wider global trends that weaken programme reach to poor communities.

He indicated that this appreciation had led to a call for inclusion in the monitoring of the MDGs a disaggregated analysis of the monitoring of differentials in effective coverage, particularly coverage in poor groups or those disadvantaged on other parameters, such as gender or geographical location. This means making better use of the evidence available from the Demographic and Health Survey and other household surveys to analyse equity dimensions of the interventions for and progress towards achievement of the MDGs. He also noted the formation of a new Scientific Reference Group in WHO on research on equity; and the monitoring of equity taking place in the countdown on the MDG on maternal mortality in 68 countries. These initiatives are also important points of synergy with the work on the watch for linkages and cross reference on approaches.

Finally he welcomed the work at country and regional level on the equity watch. He noted that there is synergy between the work in UNICEF to make the case for and monitor equity in health, and the work in the region through EQUINET on the equity watch and welcomed the links made in the process of taking this forward.

In the discussion Dr Loewenson updated delegates on the communication links made with WHO AFRO both in producing the regional analysis and on the follow up work on the equity watch, and acknowledged the important work of WHO underway in building capacities for equity analysis. Dr Pascaol gave a brief overview of this capacity building within the overall process of follow up of the World Health Assembly resolutions on the social determinants of heath. Delegates noted that these initiatives were all important and they create reinforcing push for enhancing a focus on equity. They also noted that they each have somewhat different scope, but also have synergies that can be strengthened through communication and exchange across them. For example in Mozambique the Ministry of Health Team is working on the equity watch in close partnership with WHO, thus building the synergy.

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4.2 Equity Dimensions of fair financing

Dr Charlotte Zikusooka, of Healthnet Consult, outlined key dimensions of equity in health financing. Fair financing is based on a basic set of principles, namely: *financial protection* (no one in need of health services should be denied access due to inability to pay and that households' livelihoods should not be threatened by the costs of health care); *progressive financing* (contributions should be distributed according to ability-to-pay, and that those with greater ability-to-pay should contribute a higher proportion of their income than those with lower incomes); and *cross-subsidies* (from the healthy to the ill and from the wealthy to the poor) in the overall health system should be promoted. Fair financing is necessary to achieve *universal coverage***,** where health systems seek to ensure that all citizens have access to adequate health care at an affordable cost, and where there is both income cross-subsidies (from the rich to the poor) and risk cross-subsidies (from the healthy to the ill) in the overall health system.

For this people should contribute to the funding of health services according to their ability to pay and benefit from health services according to their need for care.

She highlighted parameters in the Equity Watch that track progress on fair financing (see later discussion on the progress markers in Section 4.3)

At a September 2009 regional meeting on fair financing, in a review of these parameters a number of issues were raised for further consideration. It was noted, for example, that the Abuja target is good at showing government commitment but doesn't necessarily show equity, which needs further evidence to show whether money is going to primary or tertiary care. It is important to see how the 15% is allocated, such as to young people, women, or elderly people. We need to monitor what percentage of the health budget goes to primary care, and how much goes to drugs and human resources. The meeting also noted that we need to have a balance between input and output measurement. Beyond input indicators, we need measures of the distribution of benefits from resources (e.g. benefits from using services across SES, gender, ethnic groups, rural-urban areas and so on). The equity watch should go beyond documenting progress through descriptive evidence on fair financing and provide insights into what needs to be done to move implementation forward.

4.3 Process and progress markers for monitoring equity

Rene (TARSC) introduced the background work to the current meting in terms of the production of the regional equity analysis, the review by the EQUINET steering committee of learning from the analysis and the decade of research and evidence on areas for progress in health equity, and the application of two pilot activities in Zimbabwe and Uganda to test the watch in practice.

The process for an equity watch thus seeks to achieve both product and process outcomes noted above. It is a technical process of gathering and analysing evidence, and a social and institutional process for using this to strengthen networking, interaction and dialogue on taking forward measures to enhance health equity. Broadly to date the process has involved:

- Identifying the lead policy and technical institution for the work;
- Setting up a steering group of stakeholders from civil society, state, parliament, research and academic institutions who will peer review and discuss the work;
- Meeting of the country team to review the framework for the analysis, sources of evidence, stakeholders, work roles, steps and time frames for the work.
- Technical work to gather and analyse evidence within the framework of the Equity Watch, adding additional evidence and parameters as relevant for the country;
- Production of a draft report, with input from EQUINET and peer review nationally (by at least civil society, state and parliament) and regionally through EQUINET, to prepare a final draft report;
- Meeting with national institutions on the report to review the evidence, identifying priority areas for policy, strategic planning and advocacy, and areas for follow up action, research and analysis.

This is followed through with relevant dissemination, engagement, follow up and updating of the work, including of research on areas identified as knowledge gaps.

She noted that a core set of parameters in the 2007 regional equity analysis were selected for their representation of the four major dimensions of advancing health equity against which progress needs to be tracked, that is:

- **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
- **SIX** markers of a more just return from the global economy.

Together, and they need to be read as a combined set, they provide evidence

- of inequalities in health status, access to health care, and care-seeking, knowledge, or opportunities to be healthy;
- against benchmarks – and differentials in their attainment- of affirmative processes, investments and policy decisions that contribute to health equity outcomes; and
- against targets set in policy commitments at global, regional or national levels.

These markers are disaggregated by the key equity stratifiers: wealth, age, sex, educational attainment, urban versus rural residence and region. Stratifying by ethnicity was raised as one dimension, but this was also noted to be very country specific and may be politically divisive or sensitive.

Three further questions are also addressed:

i. What factors in the context affect these trends and differentials;
ii. What are the promising practices that are useful for wider exchange, and
iii. What knowledge or evidence gaps are there? She presented the selected progress markers (See Section 4.4 below), noting that the choice was guided by:
    - Their relevance across countries and at regional level;
    - Their relevance to vulnerable groups;
    - Their consistent availability and quality in existing data sources across countries;
    - The need to balance comprehensiveness with depth, and to keep the core watch accessible to a wide range of people;

The analysis of the evidence on these progress markers thus presents:

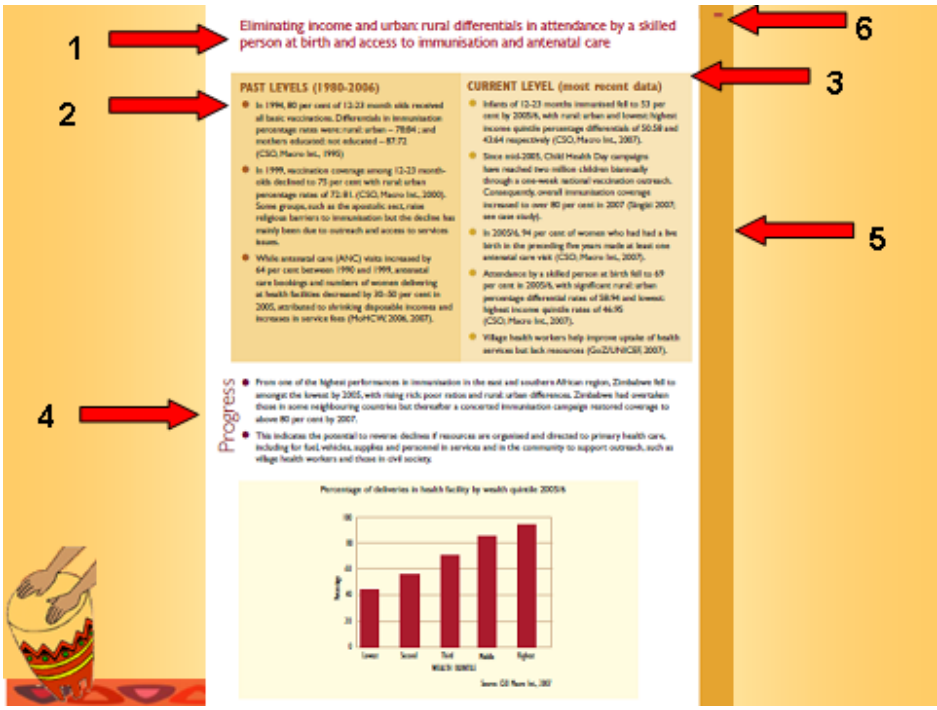
- The current situation in terms of overall and absolute and relative inequalities (range, rate ratio; rate difference)
- Trends across time and differentials between areas
- Gaps against benchmarks or targets

She pointed to the type of stratifiers for the analysis, such as wealth; education; area; gender or age, and the opportunities for using these in decomposition of the evidence, ie exploring the factors generating inequalities, or in analysis of the differential impacts of programmes or policies. In addition to quantitative evidence, some parameters call for content through verbal or image evidence, as well as case studies that give more insight into determinants and impacts.

This is followed through with relevant dissemination, engagement, follow up and updating of the work, including of research on areas identified as knowledge gaps.

She gave an example of how the evidence has been summarised from detailed technical reports into a more accessible format (shown adjacent) where for each progress marker (1) the watch provides

- Past levels, including differentials (2)
- Most recent data including social differentials (3)
- A comment on the progress and any trends, gaps, specific groups or challenges, together with relevant charts (4)
- A red, yellow or green bar indicating negative, static/mixed or positive trends in the indicator and differentials (5)
- A positive or negative sign indicating how the performance in the country compares with the region (6).



Source: Loewenson and Mastoya (2008)

4.4 Proposals for progress markers in the equity watch

Delegates reviewed and discussed in working groups the proposals for the core set of parameters in the watch, which can be expanded on from country and regional level. These were reviewed in several rounds in the meeting, through initial working group sessions, plenary feedback and discussion, review of drafts and final adoption. Reaching agreement on the core parameters was acknowledged to be a critical purpose of the meeting and was thus given ample time for development and review in both working group and plenary sessions. The country level parameters as revised are shown below and the regional level analysis framework will be developed by TARSC and EQUINET steering committee for wider peer review.

The list of progress markers finalised after the discussions are shown overleaf. The notes in italics are not part of the progress markers but are additional explanatory information on the progress markers as raised by delegates.

Advancing equity in health

1. Formal recognition and social expression of equity and universal rights to health
   Covering constitution, law, policy, and evidence on application

2. Achieving universal access to prevention of vertical transmission, condoms and antiretroviral treatment,
   Noting UN goal on this for 2010;the need to include HIV prevalence trends and differentials across all indicators

3. Eliminating differentials in access to immunisation, in contraceptive prevalence, in antenatal care and in deliveries by skilled personnel
   Stratifying by all stratifiers (see information below) and giving rate ratios, coverage gaps, and possible co-coverage gaps. Cover also other interventions that relate to priority public health burdens, including treatment for acute respiratory infections, malaria prevention and treatment and oral rehydration for diarrhoea.

4. Eliminating differentials in maternal mortality, child (neonatal, infant, <5) mortality, and stunting
   Stratifying by all stratifiers (see information below) and giving rate ratios,and linking to health coverage differentials, (eg through concentration curves)

5. Reducing the Gini coefficient to at least 0.4 (the lowest current coefficient in ESA)

Household access to the national resources for health

6. Achieving the Millennium Development Goal of reducing by half the number of people living on $1 per day by 2015
   To check both $1 and $1.25 as targets, disaggregate by stratifiers, and note the definitions and evidence from other poverty assessments.

7. Achieving and closing gender differentials in attainment of universal primary and secondary education
   Capturing enrolment, dropout, transition rates and differentials from all stratifiers

8. Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
   Cover evidence on availability, access, functioning, safety of water (ie beyond infrastructure availability)

9. Increasing the ratio of wages to Gross Domestic Product;
   From national economic data, showing time trends, disaggregated by sector

10. Abolishing user fees from health systems, backed by measures to resource services
    Disaggregated by levels of care, providers and other stratifiers, with special focus on primary care level, profiling evidence on formal and informal charges, exploring implications for referral system, and making links to other indicators of health services coverage (access and effective)

11. Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems;

Using WHO and regional health worker norms, and vital and essential drug norms set in essential drug programmes, and noting differentials by service level, region, and other stratifiers

12. Overcoming the barriers disadvantaged groups face in accessing and using services.
    Unpacking barriers through a matrix of financial and non financial barriers and demand and supply side barriers and actions taken to address them and linking to evidence on health/ health service outcomes

Resourcing redistributive health systems

13. Achieving the Abuja commitment of 15% government spending on health
    Noting Abuja refers to government funds and separating donor from government funds

14. Achieving the WHO target of $60 per capita public sector health sector expenditure;
    Separately showing both PPP$ and local exchange rates, and showing public sector and total health expenditure as a comparison

15. Increasing progressive tax funding to health; reducing the share of out-of-pocket financing in health;
    Differentiating progressive and regressive tax funding, examining and making clear unintended negative health effects of taxes, including some progressive taxes, and including analysis of shares to and trends in health insurance, differentiating community, voluntary and mandatory insurance, as well as public and OOP

16. Harmonising the various health financing schemes into one framework for universal coverage;
    Noting the need to include external funding and global health initiatives in this analysis

17. Establishing and ensuring a clear set of comprehensive health care entitlements for the population;
    Covering the provisions for comprehensive (not disease specific) services, including essential health packages at different levels, and using the term entitlements to go beyond standards to their delivery and covering through surveys or case studies the extent to which they are known and being engaged on by communities.

18. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on primary health care;
    Disaggregating by service type and the critical commodities for those services, by spending on prevention and curative services, and by other stratifiers

19. Implementing a mix of financial and non-financial incentives agreed with health workers organisations

20. Formally recognising in law and policy and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system.

A more just return for ESA countries from the global economy

21. Reducing debt as a burden on health - Debt cancellation negotiated, with debt relief allocated to health and social sectors, and control of debt stress;
    Including public, commercial and private debt as collected at national level

22. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;
    Exploring indicator budget lines to smallholder agriculture and gender disaggregations

23. No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws;
24. Health officials in trade negotiations and clauses for protection of health in agreements;
    Actual presence in consultations and / or delegations

25. Bilateral and multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration.
    Giving priority to approaches that cover the whole sector

Where different sources are available, delegates recommended that preference be given to national level, census or household survey data, using data sources repeated over time to assess trends and for data that provides disaggregation by area, income, gender or other differentials. All indicators would be for the most recent year, with at least two additional data points over the past decade to indicate time trend. Where there are conflicts in evidence it was agreed that where differences are insignificant, national official data be used; while for larger differences the issue needs to be referred to the national steering and review process, with both sets of data and sources cited, after which both may be cited or the evidence identified as most valid cited.

It was proposed that data disaggregations include the following stratifiers where relevant and possible:

- wealth (asset quintile),
- urban versus rural residence (intra-area differentials)
- age,
- sex,
- educational attainment, (especially mothers)
- geographical region (to lowest possible level)
- ethnicity (noting country specificities and sensitivities)

Other potential stratifiers include occupation, employment status, birth order, and geographic regions defined by factors such as climate or remoteness.

5. Analysis of equity in the equity watch

Jane Chuma chaired a session where Mr Charles Dulo of Mustang Management Consultants presented a study supported by IOM, EQUINET and the Kenya Working Group on

5.1 Sources of data and evidence

Rene (TARSC) outlined that the analysis uses sources of secondary evidence at national level in the first phase: These include published policy and official reports, official data, demographic and health surveys, national surveys and reports by government, academic and non government/ civil society surveys and sources. International data sources include WHO, UNDP, World Bank, UNAIDS data bases. Country sources include legal documents (Constitution and laws); relevant policies and strategic plans; census; national household survey reports; Demographic and Health Surveys (DHS); poverty assessment surveys, and indicator monitoring surveys (MICS) and administrative statistics. In addition there are burden of disease surveys, health facility and service coverage surveys, sentinel surveys, health accounts and various health, finance and other sector reports. Some population groups may be excluded from surveys or vital registration, such as refugee populations or displaced people; orphans, foster children, street children; hospitalized and institutionalized individuals. Their situation may be captured in ad hoc surveys, and case study evidence as well as other grey literature. She indicated that the watch should seek to triangulate evidence, cite and reference sources and include peer review to improve data quality. Inconsistencies in data need to be explored in terms of differences in definition, scope or validity.

She commented that the first phase of the equity watch work draws on available secondary data and complex further analysis of existing data sources may be done on areas identified as priority, through a second stage of work. She pointed to the important of information that provides evidence on context,

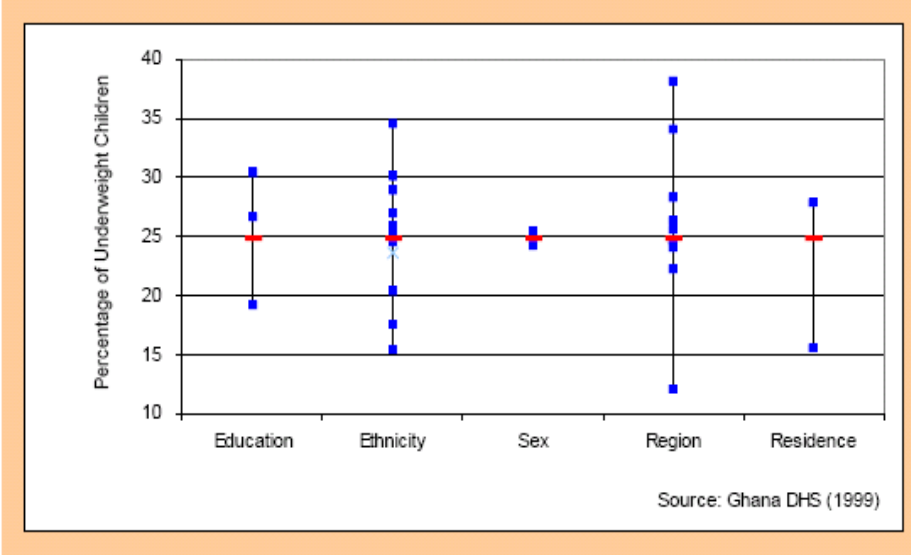
5.2 Use and analysis of existing population household survey data

Abdelmajid (UNICEF) presented the use of population-based surveys for equity analysis and monitoring. He noted the growing availability and frequency of population-based surveys, with DHS and MICS being carried out in the vast majority of low and middle-income countries. The living standards monitoring surveys are also amenable to health equity analysis although they have a greater focus on price and income data. There is also the World Health Survey and national surveys, especially on health care seeking behaviour and health expenditures.

He focused his attention on analysis of the magnitude and pattern of inequity; inequities related to resource allocation and service deployment; and the reasons for inequities. The choice of indicator is critical because the degree of inequality revealed can vary greatly depending upon the indicator chosen. The careful selection of multiple indicators will yield a more complete picture of health inequity, with a need to consider the extent to which the indicator is likely to be meaningful to the public and policy-makers and the cost of data collection, quality issues, availability for monitoring at appropriate time intervals and cultural appropriateness.

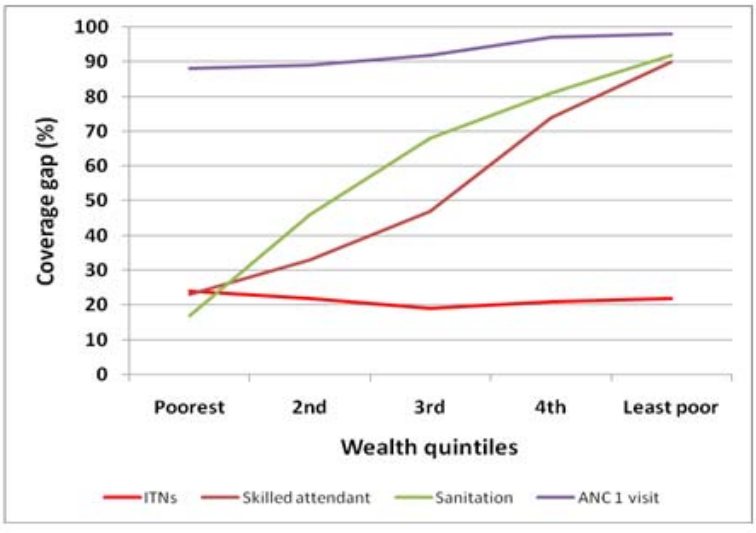
For example, child health indicators selected by the 68 countdown countries include: underfive mortality; infant mortality; neonatal mortality, underweight (%); stunting (%); wasting (%); contraceptive prevalence (all married women); skilled attendant at delivery; antenatal care (1+ or 4+ visits); early initiation of breastfeeding; postnatal visit for baby; DPT3 vaccine; measles vaccine; oral rehydration; care-seeking for pneumonia, insecticide treated net coverage; and Vitamin A supplementation.

Equity analysis and monitoring requires dividing a population into groups according to social advantage. He presented commonly used stratifiers as: Wealth (quintiles of wealth- country specific); sex (sex of child); educational attainment (mother's highest level of education); ethnicity (country specific); residence (urban and rural); region (country specific) and the poverty line (above or below national poverty line). He presented examples as shown in the figure below, to show comparison of an indicator across different stratifiers.

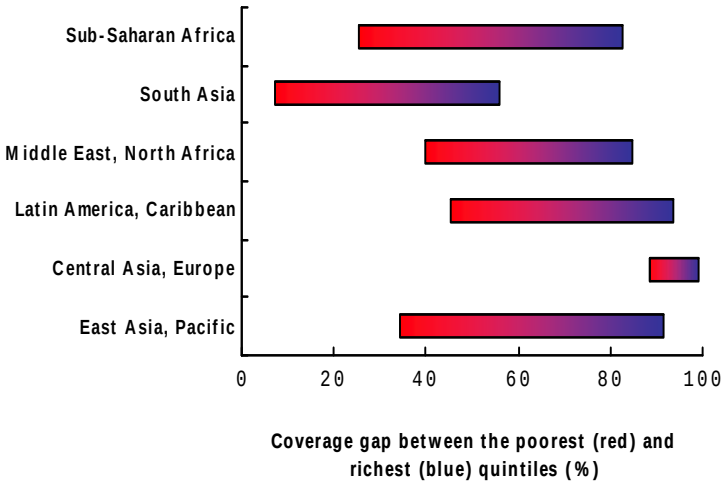


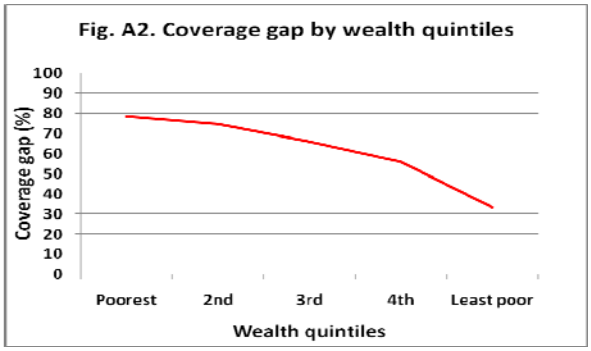
Proportion of underweight children by different social stratifiers, Ghana

Monitoring coverage is done in terms of coverage indicators, coverage gap and co-coverage, as exemplified in the charts below. Co –coverage combines the data from a number of areas of coverage into one indicator.



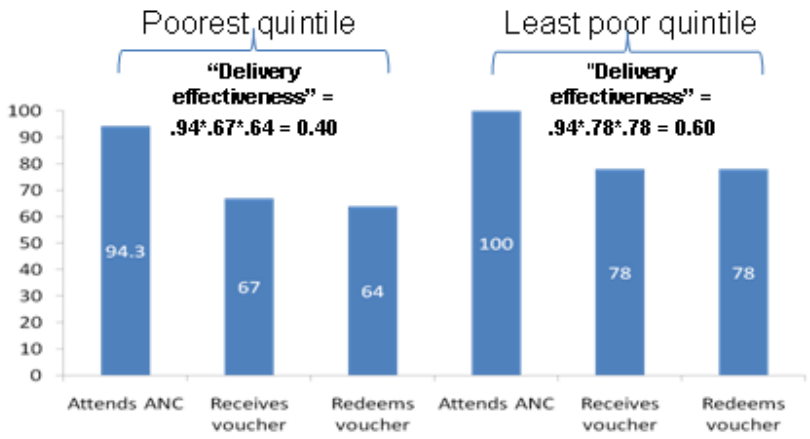
Coverage rates of selected interventions by wealth quintile, Ghana





Equity gaps in skilled delivery care Source: Gwatkin et al, 2007

He noted that such analysis can be used to identify inequities related to resource allocation and service deployment, to delivery strategies or to the way services are organized. For example, analysis of bed net use by women can be deepened through examining coverage rates for attending ANC, rates of receiving a voucher and of redeeming the voucher for a net in a shop. Understanding the voucher process points to where inequalities in final outcome (net use in target group) can arise because of failures in any one step. While inequalities in individual areas may not be large, the cumulative effect can be large, as he showed with the example below:



Access to insecticide-treated nets in Tanzania Source: As presented by A Tibouti

He concluded by noting that the increase in availability of population based surveys provide an unprecedented opportunity to analyze and monitor health equity. Tracking MDGs and other national health goals with an equity lens is this both necessary and feasible with available data. Cross-tabulation of indicators and stratifiers and visualization of findings can provide powerful arguments for advocacy and programming. Stratification by wealth, ethnicity, educational level of the mother, sex, region, and urban – rural residence yield statistically significant differences across a wide range of health indicators. Analysis needs to be mindful of limitations, including in survey data, quantitative analysis and the exclusion of certain population groups.

5.3 Benefit incidence analysis

Charlotte (HNC) outlined the methods for and purpose of benefit incidence analysis (BIA). It provides a means to assess the links in the chain between government spending and the outcomes that the government wishes to influence. It focuses on the extent to which government expenditure on services improves the lives of different groups of the population and that estimates the impact of government spending and measures the distributional incidence of benefits for different groups of interest.

She outlined the steps to compute it as:

i. Determine the public spending – that is obtain/calculate the unit subsidy/spending of providing a particular service. Unit subsidy is calculated on the basis of actual expenditure of Govt; most recent BIA studies have confined themselves to recurrent expenditure of Govt.
ii. If there is cost recovery, it should be netted out of Govt spending
iii. The unit subsidy is "imputed" to households or individuals. Thus, BIA measures the distribution of Govt spending across the population. Assigning unit subsidy to individuals/households
iv. Aggregate individual or households into sub-groups of the population in order to compare how spending is distributed across such groups.
v. The Individual asset score is converted to the benefit incidence by dividing the Value of the asset variable (the unweighted mean of asset variable) by the unweighted standard deviation of asset variable.

The information needed to do BIA is thus: Government spending on specific set of services; public utilization and socio-economic characteristics of the population using the service. She showed the calculation of an example from Uganda of the benefit incidence of antiretroviral treatment by wealth quintile, shown in the table below:

Quintiles	**Total number of people**	**Total annual monetary benefit (USD)**	**Annual monetary benefit per person (USD)**
Q1	59	38,499.85	652.54
Q2	30	18,329.76	610.99
Q3	55	28,664.72	521.18
Q4	88	43,480.11	494.09
Q5	168	88,599.63	527.38

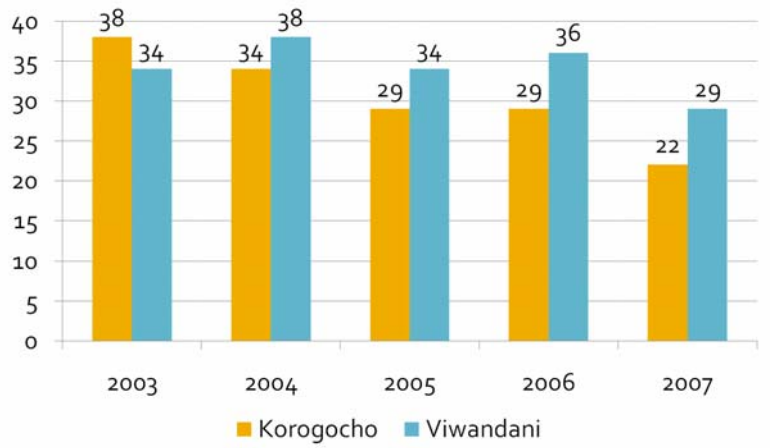
Source: As presented by C Zikusooka

5.4 Use and analysis of existing community level surveys

Eliya Zulu of the African Institute for Development Policy Research discussed the motivations and methods for equity monitoring at district level. Decision making and resource allocation in the health system and overall administration is increasingly becoming decentralized. Districts need to have robust information systems and technical capacity for monitoring progress and performance in meeting health targets and reducing inequities in health outcomes. Evidence shows that more progress is made in alleviating poverty and improving health outcomes by focusing on the marginalized, underserved, and disadvantaged populations since their health conditions drive national and district level health indicators. He noted that there is, however, an acute shortage of data at district level to monitor health systems and performance.

He presented the option of longitudinal demographic and health systems (HDSS) in the INDEPTH Network, which coordinates activities of over 38 sites in Africa, Asia, and Oceania. These are community based studies that follow-up people living in geographically defined areas for long periods of time. I some cases, the geographical areas cover entire districts or a combination of districts, while in others they are sizable portions of districts. Data is collected through interviews and updates done in all households at regular intervals (some do every 3, 4, 6, or 12 months). They collect basic demographic, health and socioeconomic data, such as births, deaths, migration, vaccination, morbidity, health seeking behavior, economic conditions and schooling. Of the African countries with HDSS, the following have more than one site: Kenya, Uganda, Tanzania, Burkina Faso, Ghana, Senegal, and South Africa. The following countries have one DHSS each: Mozambique, Ethiopia, Malawi, Guinea Bissau and Gambia.

The DHSS sites provide comprehensive data that would allow monitoring of equity and assessing impact of programs over time. The key advantage of the longitudinal data systems are that beyond basic mapping of inequalities, they help understand issues of causation and identification of groups that are persistently in bad conditions or those able to transition out of poverty and poor health situations. The HDSS systems are also very valuable for evaluating the impact of health interventions and programs at community level, and the effect of poverty on health outcomes. He demonstrated data from the site run by the African Population and Health Research centre in urban Nairobi, such as that shown in the figure below.



Trends in full child vaccination in Nairobi slums Source NUDHSS 2003-7

He noted that this type of evidence is useful to address inequity in allocation of health resources at district level, such as was done in the Tanzania Essential Health Interventions Project (TEHIP), which played a big role in improving quality of care and reducing child mortality by, among other things, enabling district health managers to optimize allocation of resources in accordance with burden of disease profiles, which were generated using a combination of community based and clinic based health data. Having several HDSS sites in Tanzania also helped to extrapolate profiles from the HDSS sites to the national level.

As a concern he observed that the sites are localised, the data collection time and resource consuming, and use of data from most HDSS is restricted and not uin the public domain. He noted that the best way to access such data is to enter into

partnerships with the institutions that run the HDSS sites. He also noted that there may be convergence of interest in partnership as the sites would welcome EQUINET's efforts to add value to their work by taking the key progress indicators to policy makers and other potential end-users of the data.

6. Reporting and engaging on the equity watch

The presentation of the watch in a summary form for wider use by different groups was endorsed. Delegates discussed (in small grounds and then in plenary) the format for presentation of the equity watch using the pilot Zimbabwe Equity Watch as the case example (can be found at http://www.equinetafrica.org/bibl/docs/zim%20equity%20watch%20v2.pdf)

In general the format used in the Zimbabwe pilot was supported. Features that were seen as positive were

i. The attractive and user friendly format, and accessible layout of evidence
ii. The accessible size of the document, the font, use of colour
iii. The colour coding of the bar on progress
iv. The mix of media- text, graphs and images
v. The introduction provided
vi. The clear presentation of the EQUINET context

Features that were seen as needing to be addressed in future versions were

i. The need for clear national identify of the country watch on the front, such as with a national map in colours
ii. Not using the strong yellow colouring on the pages on the programme markers to avoid confusion with the colour bars
iii. To make the plus and minus signs relating to the regional levels clearer
iv. Making sure the graphs are clearly on the evidence of the parameter on the page

The participants made the following further suggestions:

i. There should be a table at the end of the report (back cover page) summarising all the indicators for the reader to quickly look at the whole picture and which areas there is progress
ii. There should be a summary at the end of the report that also highlights proposals and priorities for action.
iii. Unfamiliar technical terms used should be clarified.

Following this, and chaired by Charles Dulo, chair of the Kenya Heath Equity Network, the options for engaging on the watch were reviewed. A range of processes were presented, as background to country discussions on the country specific government, civil society and parliament processes that could be pursued.

6.1 Engaging on equity through civil society

Itai Rusike, Executive Director of the Community Working Group on Health, indicated that civil society had a role in the production and use of the analysis. He noted that health civil society was actively engaged in health equity in many of the initial countries and thus could play a valuable role in advocacy on the evidence. For this civil society should have a collective understanding of the motivations for and purpose of monitoring equity, and should be involved in the discussion of the evidence on health equity and the national and regional links and sharing of experiences and learning from the watch.

He proposed that teams use existing networks and alliances for advocacy and engagement at country level and regional level. Examples of these included community input in the budget process (the 'Peoples Abuja'), lobbies of Parliament and Health and Finance ministries on areas of health spending and the Abuja 15% commitment, budget monitoring and tracking. He proposed that the analysis be put in a summary and more popular formats and local languages for community uptake, and be included as content in the Regional Health Literacy programme in EQUINET and in the training of health workers.

Civil society faced challenges however in taking up issues of equity and social justice, including the limited space for civil society engagement, their vulnerability to economic crisis, and problems of governance. While they have a major role to play in engaging on equity, he pointed out that they too are affected by the inequality associated with unfair globalization.

6.2 Engaging on equity through parliaments

Hon. Habeenzu Munji, Chair of the committee on health of the National Assembly of Zambia welcomed the idea of being brought into such fora, where Members of Parliament can get information that they would use in their daily work. He noted that equity was an important issue for parliamentarians interested in the "welfare" of people. He noted that for parliamentarians like him, who are accountable to the people living in rural areas who seem to be neglected and are living in poor conditions, the evidence in the watch is important.

He noted that Parliaments play a significant role in ensuring that appropriate policies are in place to govern the implementation of services. They hold the Executive accountable at various levels. This offers processes of legalization, budget review, oversight and debate through which to raise issues in the watch. It is therefore important to ensure that Parliamentarians have adequate information about the wide range of health issues.

He emphasised the importance of parliamentarians in monitoring what happens at the grass-roots. He gave examples of people in his constituency where schools are too far and the modes of transport are poor. He noted that in this case, he (as a member of Parliament) becomes "the voice" of the people in his constituency.

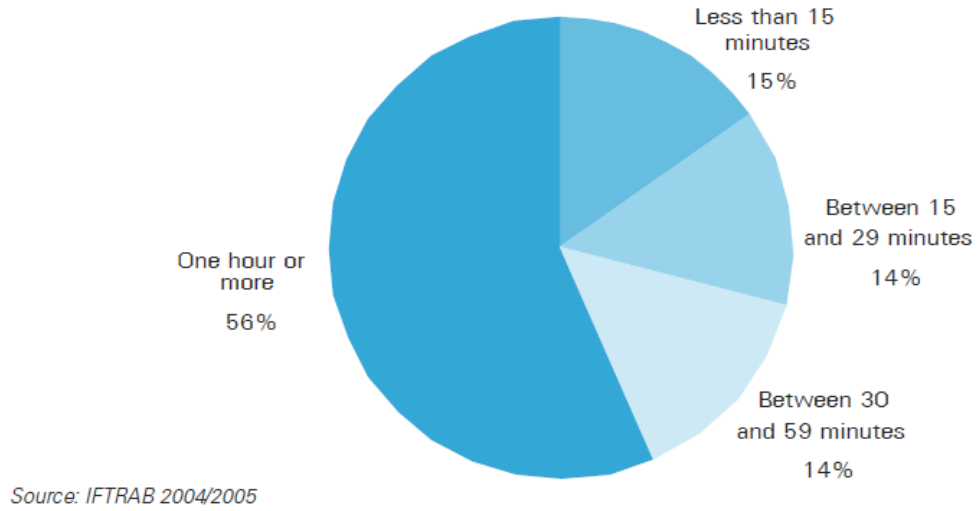
Parliamentarians are rarely doctors, economists, lawyers, etc, and yet they are expected to understand and guide all things pertaining to these areas in the country. The alliances built through the equity watch process are thus important to bring information to members of parliament so they are able to review policies and monitor implementation. He indicated that this information needs to be made available in a form that makes the key issues clear, both through the content and format.

6.3 Engaging on equity through government

Gertrudes Machatine Director for Planning and Cooperation in the Ministry of Health in Mozambique presented their experience on the equity watch work.

She noted that Mozambique made great improvements in the health of its population after peace was established, with significant reductions in infant, child and maternal mortality. There is still concern however as the levels of child and maternal mortality are higher than other countries in the region and the pace of the decline over time is

less than the rate expected for achieving the MDGs. In terms of health services, improvements in coverage are constrained by limited capacity, lack of a sufficient large health workforce, and a shortage of financial resources over the short to medium term. Since 1993, the use of health services have increased (23%), but access to basic health services is estimated to be at 50% of the population. (See Figure below)



Source: IFTRAB 2004/2005

Access to heath facilities: time taken by households to reach the nearest health facility

The health sector in Mozambique is heavily dependent on external funding, even though the national allocation of resources is progressing towards the Abuja target of 15% of government expenditure on health. Yet national resources are inadequate for the country's huge needs. For example, the country needs another 20,000 health workers by 2015 to maintain its progress towards the MDGs. Meeting this challenge calls for longer term, predictable funding from international sources. The country has made progress on this, with its partners in terms of increasing alignment, with a code of conduct signed in 2005, and a memorandum of understanding, updated in 2008, which commits common funding partners to provide sector budget support, using government systems, through a single budget, more predictable financing and a single monitoring and evaluation framework.

She pointed to this national sector wide framework as the framework within which equity analysis is situated. It provides the basis for performance based monitoring for the health sector and the annual joint review process undertaken by the Ministry and partners, including non government organisations. Key HIV and AIDS indicators have been included in this framework, for example. A General Budget Support performance assessment framework includes 42 key indicators which are reviewed twice a year by the Government and the Programme Aid Partners, including Civil Society. Joint review is also made of progress made in the implementation of the Poverty Reduction Strategy (PARPA II). The Medium Term Expenditure Framework, the mechanism through which budget allocation takes place, is key in any resource allocation process.

Equity issues remain of concern. She noted that their links with EQUINET were motivated by the need to generate strong evidence of disparities of the health sector, and based on this evidence, to mobilize more resources in the health sector in response to health needs.

Her presentation indicated that for Mozambique the equity analysis and watch work is thus centred within the framework of the budget and Medium Term Expenditure Framework process, as a means of giving government leadership to the wider actors involved in health.

The discussion on the presentations highlighted the potential for the watch to inform these processes of government, parliament and civil society. For this it would be important to include people from these groups within the steering group early in the process.

7. Country and regional work on the equity watch and next steps

Delegates worked within country teams (Kenya, Zimbabwe, Mozambique, Zambia and Uganda, with a technical group on financing in South Africa) to discuss taking forward their work on the equity watch, taking the discussions and recommendations made at the workshop into account, and drawing on a template of steps proposed from prior work in EQUINET. The country teams discussed a process that would include all elements of the watch, including the analysis of fair financing.
The included

i. Identifying the lead technical institution (s) and researchers
ii. Identifying institutions for the steering group in government, technical institutions, parliament and civil society
iii. Identifying the strategic planning and policy processes that would be a target for the watch work.
iv. Meeting as the steering group to set up the terms of reference, protocol, framework of progress markers, establish sources for data collection and roles for the equity watch
v. Setting up the workplan and budget with key milestones for peer review agreed with TARSC and HNC.

Countries briefed the plenary on their proposals on taking the watch forward, mainly linked to national health advisory, national health strategic planning or budget/ medium term expenditure frameworks.

It was agreed that countries would finalise identification of their lead institutions and identify proposed members for the steering group in December, and would have set up and met with the steering group by end January to set up the protocol and plans for the country work and communicate these to EQUINET. While this was generally noted, some countries (Mozambique, Zimbabwe and Uganda) are already in the middle of processes and thus will tailor the process in 2010 to the stage they are at.

Plans will be sent to TARSC in January to share across teams, and to trigger budget support required for the work, as well as to set up MOUs between EQUINET and the lead institutions (for those that do not already have them). It was agreed that time frames would generally set the work during 2010, with completion and report of the technical work by early 2011, unless already more advanced than this.

A group of institutions working at regional level (EQUINET/TARSC; ECSA, UNICEF, AFIDEP) discussed also the regional work and processes.

Rene (TARSC) briefed the plenary on the **proposed work at regional level**, both in EQUINET and from the wider group discussion. At regional level:

i. EQUINET with ECSA-HC and partners will take forward the proposal to set up a regional reference group for the equity watch, building on the EQUINET steering committee, and strengthen the linkages with SADC, WHO AFRO, UNICEF and other regional institutions.
ii. EQUINET with ECSA-HC will bring the proposed watch work to policy dialogue at the next Regional Health Ministers meeting in 2010.
iii. EQUINET through TARSC and HNC will support country teams with guidance materials, draft terms of reference, mentoring and technical peer review of and edit and publications support for the analysis. An updated guidance document will be prepared in December 09/January 2010 to guide country work on the watch.
iv. EQUINET through TARSC and HNC and with support from SIDA (in 2009) and IDRC Canada will provide seed funding for the watch work covering the first phase of secondary data analysis and will work with countries to develop funding proposals to deepen the work and implement follow up research.
v. EQUINET will build and support a learning network in the region on the equity watch. Through TARSC the network will co-ordinate and share information on the equity watch across the implementing country teams. A moderated members mailing list 'eqwatch@equinetafrica.org' has been set up for this and communications on readings, progress, capacity support and reports will be shared across the countries. Support will also be given to some exchange visits across countries for mentoring support or to share experience.
vi. EQUINET through TARSC with the EQUINET steering committee, HNC, and with input from the regional reference group will set the framework for and produce an updated regional equity analysis in 2011, building on the existing analysis produced and drawing on the country reports.

8. Closing

Rene and Charlotte for EQUINET thanked delegates for their work and team interaction in the meeting and for setting the design of the equity watch on a firm platform. They expressed great thanks to Latiefa Adams and the colleagues at UCT HEU for hosting the meeting and assisting with the organisation, and delegates warmly applauded the kind hospitality they had received. They also thanked SIDA Sweden and IDRC Canada for their support of the meeting.

Abdelmajid for UNICEF expressed his thanks, and noted the particular importance of the country led work on monitoring health equity. He indicated that EQUINETs work in building country led work and capacities in a regional network on monitoring progress towards health equity was important and unique. That it was an evidence-driven process was also an important feature of the work and the meeting had shown the serious focus on this. He urged the institutions involved to build strong links with the global institutions, and indicated UNICEF's support for the work, within the overall spectrum of efforts in addressing equity within the scale up to the MDGs.

Rene recognised the important collaboration that EQUINET has with the intergovernmental forums in ECSA-HC and SADC, and noted that they would engage these as they take forward the work to ensure that the watch is affirmatively rooted in the region. She wished delegates safe travel and a healthy new year and renewed energy for their efforts towards equity in health in 2010.

APPENDIX 1: MEETING DELEGATE ADDRESS LIST

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APPENDIX 2: Meeting Agenda

DAY ONE – MONDAY 30TH NOVEMBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE	
9-930am	Registration Opening and Introductions	Registration and administration. Welcome and objectives Delegate introduction Adoption of the agenda	S Sibandze, ECSA R Loewenson EQUINET, Delegates	
PURPOSE, TARGETS AND INTENDED OUTCOMES OF THE EQUITY WATCH				
9.30-10.15am	Motivations for monitoring equity in ESA	Participatory activity to explore motivations for raising (and not raising) the profile of evidence on equity from different lenses; Discussion of contexts, opportunities and challenges	Delegates	
10.15am	**TEA**			
10.30-11.30am	Background: Purpose and experience of the Equity Watch to date	Presentation Questions and issues raised Discussion: *What do we want to "watch" to advance health equity?*	R Loewenson	
11.30-1215pm	Working groups on aims, targets for evidence on health equity	Two working groups Gp 1: What should we aim for, with which target groups, and implemented by who if we want to enhance the *PRODUCTION* (gathering, analysis, reporting) of evidence on health equity? Gp **2:** What should we aim for, with which target groups, and implemented by who if we want to enhance the *USE* (for policies, programmes, actions) of evidence on health equity?	Delegates	
1215pm	Plenary report	Plenary feedback and discussion	S Sibandze	
13.00	**LUNCH**			
MONITORING DIMENSIONS OF EQUITY				
14.00-15.15pm	Proposals for monitoring dimensions of health equity	• Monitoring health equity in the MDGs (20 min) • Equity dimensions of fair financing (20 min) • Proposed progress markers for the equity watch (20 min) Discussion (15 min)	Chair: B Chitah A Tibouti C Zikusooka R Loewenson	
15.15-15.30pm	Individual review of proposed dimensions	Input to proposed progress markers: • What current markers are priorities? • What markers that are priorities are excluded? • What progress markers should be further elaborated to deepen the analysis?	Delegates	
15.30pm	**TEA**			
15.45-16.45pm	Working groups to review proposed dimensions	• Gp 1: What progress markers, benchmarks/ targets; indicators, and analysis on household health and the socio-economic determinants of health are available, relevant AND useful? • Gp 2: What progress markers, benchmarks/ targets; indicators, and analysis on health systems are available, relevant AND useful? • Gp 3: What progress markers, benchmarks/ targets; indicators, and analysis on global justice for health are available, relevant AND useful?	Delegates	
16.45	Report back	Plenary feedback and discussion	E Zulu Chairing	
17.30pm	**END OF DAY**			

DAY TWO – TUESDAY 1st DECEMBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE	
RECAP OF DAY ONE				
9.00-930am	Recap of purpose, targets, outcomes, and dimensions of health equity identified on Day 1	Summary review Discussion	R Loewenson Delegates	
INDICATORS, STRATIFIERS, AND ANALYSIS				
930-1045am	Analysing health equity using available data	Sources for gathering, measuring or analyzing key variables - Secondary data sources, community and qualitative evidence (15 min) - Using existing HIS and household data (DHSD/ MICS) (20 min) - Using existing community level data (sentinel sites, survey) (20 min) Discussion (20 min)	Chair:J Chuma R Loewenson A Tibouti E Zulu	
10.45am	**TEA**			
1115-1245pm	Working groups: analysing and presenting health equity evidence	Sources and types of evidence and analysis for Gp 1: sources and types of evidence, stratifiers and analysis of health and the social determinants of health Gp 2: sources and types of evidence, stratifiers and analysis on health systems and access to health care Gp 3: sources and types of evidence, stratifiers and analysis on health financing	Delegates Facilitators: E Zulu A Banda C Zikusooka	
12.45	**LUNCH**			
1400-1445pm	Plenary report back	Plenary feedback and discussion on sources and analysis of evidence Discussion of data quality and using evidence from qualitative sources	C Zikusooka Chairing	
ENGAGING WITH THE EVIDENCE				
1445-1600	Presenting trends, areas for policy attention	Proposal from Equity Watch work to date (10 min) Discussants on reporting formats and processes to engage on the findings: With civil society (15 min) With parliaments (15 min) In national health planning processes (15min) Discussion and recommendations (30 min)	R Loewenson Delegates I Rusike Hon Munji G Machatine	
16.00	**TEA**			
16.15pm	Proposed process and steps for implementing the analysis	Recap of proposed steps (10 min) Process and steps in countries: Delegates in country teams - Kenya, Mozambique, Uganda, Zimbabwe, Zambia	R Loewenson Delegates	
17.30pm	**END OF DAY**			

DAY THREE – WEDNESDAY 2ND DECEMBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE	
RECAP OF DAY TWO				
9.00-930am	Recap of proposals for indicators, analysis and reporting identified on Day 2	Summary review Discussion	R Loewenson Delegates	
NEXT STEPS				
930-10.30	Plenary feedback from countries	Feedback from countries on proposed steps, roles and time frames	Chair: M Moses Delegates	
10.30	**TEA**			
11.00-1200	Areas for mentoring, capacity support, regional review	Participatory exercise to identify supporting areas for development of methods and guidance; mentoring, capacity inputs, national activities and regional exchanges and review Discussion	Delegates	
12.00-1245	Next steps and workplans at country and regional level	Facilitated plenary discussion - Country level work and analysis - Regional analysis, processes and forums - Links with other regions	R Loewenson Delegates	
1245-1300	Closing of the formal meeting	Closing remarks		
13.00pm	**LUNCH**			
13.30-1530pm	Finalising workplans and grant outlines with individual country teams	Work with country teams from Kenya, Mozambique, Uganda, Zimbabwe, Zambia to finalise draft plans, roles and budgets for the follow up work	Country teams R Loewenson	

High energy in the team- ready to take the next steps! Photo EQUINET 2009