

A comparative study of the knowledge and attitudes of intern doctors at rural and urban hospitals regarding the migration of health workers

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. The capacity building activities in EQUINET are integrated within the existing areas of work of the network or build cross cutting skills demanded across themes by institutions in the network. The papers and reports produced in these training activities are products that are used to support or target mentoring. This report has been produced within the student grant programme and is disseminated in this context. It is not a formal EQUINET discussion or policy paper.

Executive summary

The reasons for migration of health workers have been extensively studied in some countries, but not in Uganda (Dambiysa, 2004). When the international community embarked on the eradication of malaria, in 1955, Africa was not among the beneficiaries because it lacked adequately trained personnel. Today more than ever before, the migration of health workers especially from developing to developed countries is of great concern. According to the population census carried out by the Ministry of Finance and Economic Planning in 2002, there are 2,919 Medical Doctors in Uganda. Of these, 1,349 are working in and around Kampala city. There is a lot of research going on in Uganda especially to try and look into the persistent poor health indicators. But there is not much research about migration of health workers. This problem is growing steadily and destroying the heart of our health care delivery system. Worse still, the ones here have not been spared from HIV and AIDS and many others are seeking a better life and a more rewarding work environment by leaving for richer countries.

The study was aimed at comparing information on the knowledge and attitudes of intern doctors at two urban hospitals and three rural hospitals regarding international migration. This was a comparative, descriptive cross sectional survey using qualitative and quantitative designs. The sample size was 55 intern doctors. In addition, key informant interviews were conducted with government human resource management and hospital personnel from public and private hospitals.

The survey results indicated that 88% of the urban respondents are aware of opportunities to practice and study abroad as compared to 77% of the rural respondents.

The search for better pay is the most significant push factor; the least significant being the need to improve Uganda's economy. The most significant retention factor is feeling indebted to the government and family who sponsor their education; and the least significant is patriotism. The respondents in rural hospitals are more likely to be influenced by their family background in their decision making regarding migration. The respondents from both settings think that the workload and working conditions will affect their eventual specialty and location of practice. A minority of intern doctors in both settings (31.8% rural, 36.4% urban) think that the government should make bonding a condition for training especially for the government sponsored students.

The key informant interviews suggested that migration is not prioritised as a problem by government, and while improved investments for health worker pay and conditions were recognised as needed, the financial resources for this was a limiting factor.

1. Background

The movement of people from one place to another has shaped and will continue to shape society. In 2000, almost 175 million people (2.9% of the world's population) were living outside their countries of birth for one year or longer. These numbers have doubled since 1965 and the migration of health workers has followed a similar trend. As expected most of the migration is to developed countries. Moreover, 65% of all economically active migrants who have moved to developed nations are highly skilled. When the international community embarked on the eradication of malaria in 1955, Africa was not among the beneficiaries because it lacked adequately trained personnel. Today more than ever before, the migration of health workers especially from developing to developed countries is of great concern. This is due to the prevalence of HIV and AIDS in these areas, re-emerging infections like tuberculosis, and health concerns due to famine and civil wars. At present, Africa still lacks such personnel and yet it must deal with multiple disease-control efforts.

The reasons for migration of health workers have been studied in some countries, but not in Uganda, specifically among intern doctors. Since health human resource is critical to the delivery and promotion of quality health care in Uganda, we sought to evaluate, through a comparative cross-sectional survey, the knowledge and attitudes of intern doctors at Mulago hospital and three rural hospitals regarding migration to other countries. International migration describes the movements of health workers who temporarily or permanently settle abroad. The proposed causes of medical migration are grouped into two categories:

- the “push factors” in the sending or donor countries; and
- the other group consists of the “pull factors” in the recipient countries.

Human resources for health remain inadequate and the recruitment ban by the Ugandan government in the past few years has led to a decline in the availability of human resources for the health sector. The trained health workers are inadequate in number and inappropriately distributed. Whereas more than 80% of the population is found in the rural areas, the distribution of trained health workers favours the urban areas (Ministry of Health, 2001).

The Ministry of Health carried out a study on the inventory of human resources for health in the public facilities in 1999 and found out that only 34% of the established positions were filled by qualified staff. The rest were either filled by untrained nursing aides or remained vacant. Current human resource management practices aggravate the situation; the wages are inadequate and irregular (ibid).

Negative attitudes to health workers in some districts by leaders and managers erode staff morale and compromise the quality of health care that they provide to the population (ibid).

Poor remuneration is a feature of many health systems in Africa. This is especially so because most health workers in African countries work for the government and poor remuneration of civil workers helps to reduce public spending. The salaries are low and unrealistic and the living conditions are not up to the required standards. Most health workers desire a good working environment and would like their skills to be utilised to their best technical and professional ability for example early promotion. In order to

advance in their careers, to find greener pastures and to be able to specialise in fields not offered back home, many health workers migrate to the recipient countries in Europe and North America. Many health workers also migrate to avoid political governance and administrative bureaucracy issues, and in response to perceived shortfalls in supplies to ensure observation of universal precautions to prevent transmission of communicable diseases. It is generally perceived that countries in the Western world are suffering from increased demand and low production of health workers to satisfy the demand. Hence these countries are seen to offer better, adequate and fair retirement security and pensions for health workers. (Diallo, 2004)

About 40% of the Ugandan population is below the poverty line, so incomes are too low to make the private sector a profitable venture in most areas. Thus, the scope for private medical practice is also limited (Dovlo and Nyonator, 1999; Muula, 2005; Alkire and Chen). Health for all, through Primary Health Care, proclaimed many years ago at the Alma-Ata conference-1978, will remain a major objective for years to come. This strategy demands human resources (WHO Regional Office for Brazzaville, 2003). Unfortunately, health workers have not received the attention they deserve, hence the persisting significant gaps between ongoing reforms in the health sector and the management of human resource for health (ibid). In all countries of the world, health resources constitute the most valuable asset because, in addition to their economic impact, they enhance the value of all other resources by converting them into socially useful products (ibid). African public health systems suffer from significant “brain drain” of its health professionals and knowledge as health workers migrate to wealthier countries such as Australia, Canada, USA and the United Kingdom (Muula, 2005).

Africa is a net exporter of health workers. Loss of health workers to migration undermines a nation’s ability to respond to disease epidemics and pandemics e.g. HIV and AIDS. The already fragile health systems are being robbed of skilled staff when they are most needed (UNAIDS, 2003). Migration losses combine with losses due to AIDS. According to a recent study by Dambiya (2004), about 30% of the 1986 graduates from Makerere University Medical School had died twenty years of graduation. This high rate of death of young doctors highlights the impact of HIV and AIDS. Moreover, 30% of the surviving doctors had migrated.

Health professionals have always been mobile. Leading specialist physicians have long been able to find posts anywhere. What is new is that there is a global market for health workers at all levels; including just-qualified health workers (Cambridge, 2004). In contrast, at the front line of human survival, we see overburdened and over stressed health workers, few in number and without the support they so badly need, losing the fight against HIV and AIDS. Many are collapsing under the strain, many are dying of AIDS and above all, many are seeking a better life and a more rewarding work environment by leaving for richer countries (ibid).

Today, more health workers are needed because the changing human ecology nurtured new pathogens, while globalisation enabled familiar ones to threaten to spread in pandemic proportions (Cambridge, 2004). The trust that the public has in scientists, experts and professionals, e.g. Chief Medical Officers, is highly valued and should not be put at risk (World Bank Development Research Group, 2002). The performance of Health centres ultimately depends on the knowledge, skills, motivation and utilisation of the people responsible for the delivery of health services (WHO, 2002). To meet the requirements of priority health interventions as recommended by the World Health

Organisation many developing countries would require a several-fold increase in health personnel (World Bank, 2004).

In Africa, the situation is concerning. In Burkina Faso, the average number of physicians per 100,000 people was 3.4 in the 1990s compared with 303 for 9 industrial countries. Zambia's dilemma is even greater. The already low number of physicians, about 8.3 per 100,000 people in the 1960s, declined to 6.9 in the 1990s (ibid). An estimated 61% of the Ghanaian doctors trained between 1985 and 1994 left the country. More than 600 South African doctors are registered in New Zealand (ibid). The UK in 2001 approved 22,462 work permits for nurses from developing countries. So, poor / developing countries have to offer internationally competitive wages and benefits in order to retain internationally marketable staff (ibid). There are increased rates of absenteeism which reflect disenchantment with working conditions. Studies of health professionals in Ghana, India, Mozambique, Tanzania and Uganda show that the health workforce, nurses and doctors in particular, feel overworked and under appreciated (Stillwell B, Diallo K, Zurn P, Adams O and Poz DM, 2004). The dilemma lies in how to balance personal autonomy, right to economic prosperity, right to personal professional development and the expectations of the public in relation to adequate public health care services in the developing nations (ibid). A survey of health-care workers in five African countries who intended to leave their home country demonstrates that although the relative importance of factors affecting migration varies from person to person, there are common patterns within countries. In Cameroon, for example, a lack of promotion opportunities, poor living conditions and a desire to gain experience ranked above poor wages as reasons why health care professionals choose to migrate. By contrast, in Uganda and Zimbabwe, wages were the most important factor (ibid).

2. Objectives

The study was aimed at comparing information on the knowledge and attitudes of doctors at two urban hospitals and three rural hospitals regarding international migration, specifically to:

- assess knowledge and attitudes of intern doctors regarding international migration of health workers and opportunities for it;
- compare the effect of working in a rural and urban setting on push and pull factors;
- assess the intention of intern doctors to migrate to other countries; and
- assess the monetary and non-monetary factors that impact on retention of doctors in rural and urban public hospitals.

3. Methods

The study was conducted at the following hospitals:

- Mulago Hospital; Uganda's largest, national referral, a teaching and research hospital;
- Mbale Regional Referral Hospital; a government aided hospital and it serves the districts in the Eastern region
- St. Raphael of St. Francis Hospital-Nsambya; a private hospital run by the Catholic Church;

- Mbarara Regional Referral Hospital; a government aided teaching hospital for Mbarara University of Science and Technology. It serves the districts in the Western region; and
- St. Mary's Hospital-Lacor; a non-profit charitable institution belonging to the Gulu Catholic Diocese. It serves the districts in the Northern Region. They were chosen for regional balance.

This was a comparative, descriptive cross sectional survey, using in-depth key informant interview and questionnaire based on qualitative and quantitative designs. To ensure that the set objectives were achieved, the questionnaire was designed with both open- and close-ended questions that yielded balanced views which were not limited by the research team.

The survey population consisted of both female and male intern doctors at Mulago hospital, St. Raphael of St. Francis Hospital-Nsambya, St. Mary's Hospital-Lacor, Mbarara and Mbale Regional Referral Hospitals.

We carried out convenient sampling of all intern doctors who had given verbal consent at five major hospitals: two in urban area and three in rural areas for regional balance. We had a total of 55 respondents plus one key informant.

The survey included all interns employed by the hospitals, male and female as long as their verbal consent was given. The key informant was the acting commissioner for human resources at the Ministry of Health, Uganda.

Financial incentives include salary and allowances from the government:

- transport
- housing
- child education
- electricity
- community support.

Non-financial incentives include the following:

- training and career related path related measures including bonding and training loans;
- availability of postgraduate programmes;
- availability of modern equipment;
- the government's input to stop emigration;
- ongoing research;
- working conditions and hours;
- mentors; and
- human resource and personnel management systems.

Data collection was done using a pre-tested questionnaire. The questions were explained carefully to the respondents who did not understand them. Qualitative data was collected through key informant interviews with the acting commissioner for Human Resources Development at the Ministry of Health and reviewing research papers from the Human Resources for Health (HRH) symposium that took place in April 2006 in Kampala. The key informant was asked several interview questions to assess the opinion of the Government on the human resources for health crisis.

To ensure that appropriate data was obtained, the questionnaire was pre-tested using fifth year medical students at Makerere University to increase validity. All intern doctors present at the time of data collection and who gave verbal consent were included. During the interviews, questions were adequately explained to the respondents to avoid getting vague answers. All the questionnaires were given serial numbers to avoid loss and confusion. Open ended questions were asked during the key informant interview.

Data was analysed using SPSS 12.0 for Windows, Microsoft Office Excel 2003 and was tabulated and put in graphs. The qualitative data was summarised manually; similar opinions were grouped together.

Permission to carry out the research was first obtained from the Faculty of Medicine, Makerere University. We sought permission from the administrators of the different hospitals. Verbal consent was obtained from the respondents before they were given questionnaires. Confidentiality was also strictly observed by de-identification of the questionnaire.

We had problems of compliance with intern doctors; many claim to be too busy to fill in questionnaires. This affected the amount of data collected and hence, we decided to consider a second urban hospital, Nsambya.

4. Findings

The findings include responses from the key informant interview and the questionnaire. There were 55 respondents in total, 33 urban and 22 rural. We also interviewed a senior management official in the Human Resource section of the Ministry of Health and two personnel, one at a public hospital and one at a private hospital.

4.1. Knowledge and views of intern doctors on health worker migration

The urban respondents replies indicated that of the terms relating to migration of health workers, 'bonding' is the least understood (57.6%), while the most understood term is 'health worker migration' (94%). Other terms were well understood. For the rural respondents the most understood terms were 'brain drain', 'donor country' and 'recipient' (67.9%) while the least understood terms were 'remuneration' and 'bonding' (46%). Other terms were well understood.

For the urban interns, 48.5% think that our local curricula meet global requirements for health workers, while 75.8% think that the local curricula meet the Ugandan requirements for health workers. Rural interns had a slightly higher rate of opinion that the local curricula meet global requirements for health workers (54.6%) and a much lower perception that the local curricula meet the Ugandan requirements for health workers (59.1%)

As shown in *Figures 1a* and *1b*, urban respondents were more aware of opportunities to practice and study abroad. This suggests a greater likelihood of these doctors practicing in urban areas to migrate than their rural counterparts, although awareness is high in both groups.

Figure 1a: Awareness of opportunities to practice abroad - urban respondents

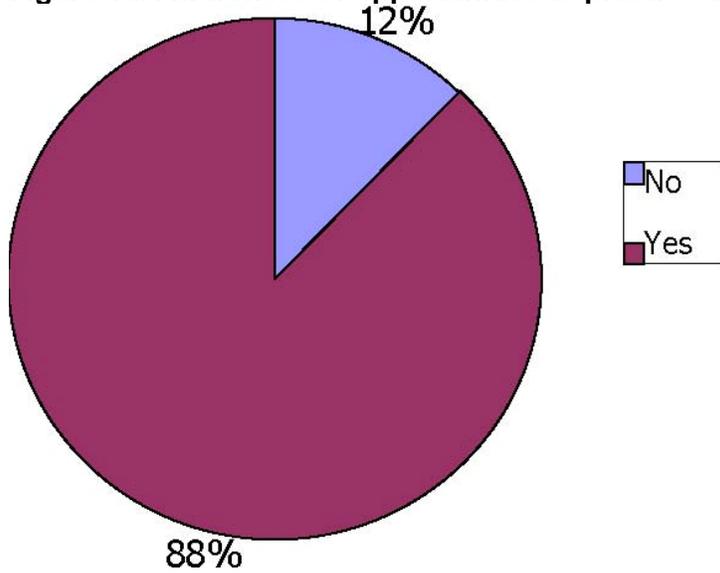
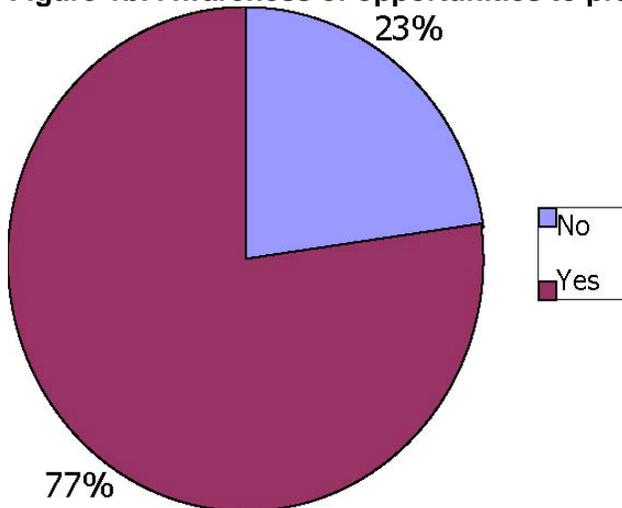
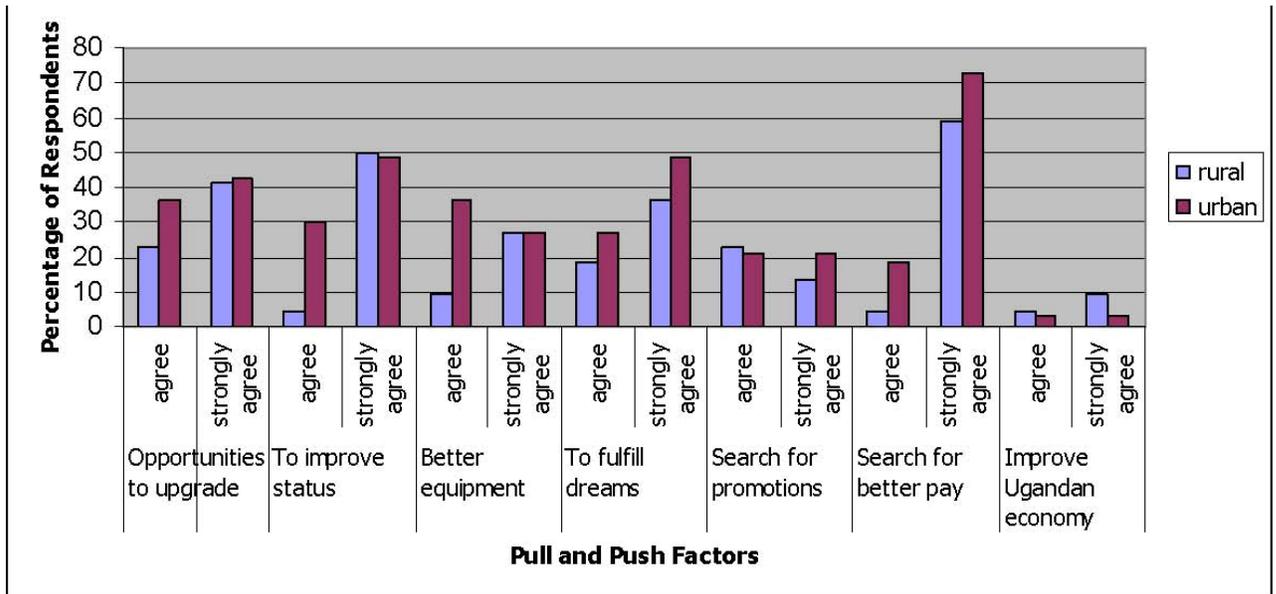


Figure 1b: Awareness of opportunities to practice abroad - rural respondents



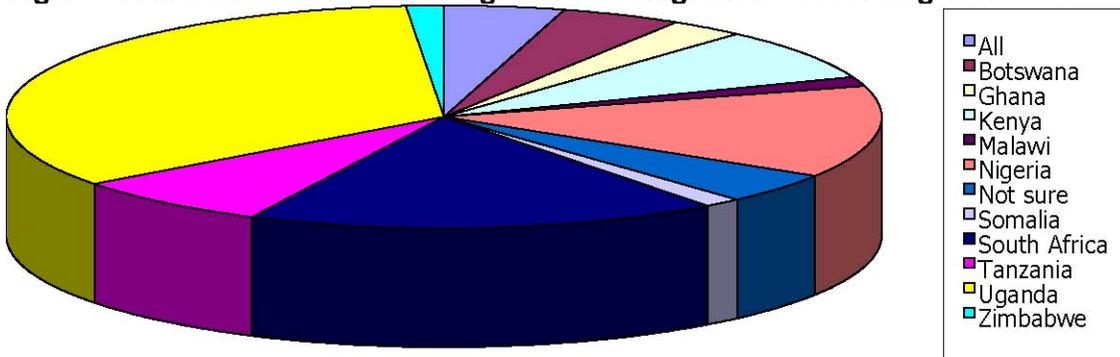
As shown in *Figure 2*, the strongest cause of migration was reported to be poor remuneration in Uganda, followed closely by need to achieve goals and status and less significantly, poor equipment. There was little difference between urban and rural interns in this.

Figure 2: Reported causes of migration of health workers



It was generally believed by the interns that Uganda, South Africa, Nigeria and Tanzania have the highest rates of health worker migration to Western countries (*Figure 3*). The interns thus saw Uganda as a country with particularly high levels of health worker migration.

Figure 3: African countries with high rates of migration - according to interns



4.2. Attitudes of intern doctors on international migration

The rural respondent replies indicated that 22.7% prefer to practice in rural settings in future and 36.4% want to practice in urban settings. The larger share (40.9%) want to practice in both settings. While 59.1% are satisfied with what they are doing as interns, (40.9%) are not satisfied with their work.

In the urban areas, 12.1% want to practice in rural settings in future and 60.6% prefer to continue working in urban settings, while only 27.3% want to practice in both settings. A

half (51.5%) are not satisfied with their work as intern doctors, while 48.5% are satisfied. Rural interns are thus less likely to seek urban employment and more satisfied with their work than urban interns. The reasons given for choosing to work in urban settings included:

- exposure to career and social development opportunities;
- better facilities;
- accessibility to other services; and
- there are less ignorant patients.

The reasons given for preferring to work in rural settings are:

- gaining hands on experience;
- feeling indebted to community members; and
- desire to decrease the workload there.

In terms of their decisions on practice, 82.7% of rural interns and 50% of urban interns believe that family background has an effect on one's decision on where to practice. Further, 86.4% of rural interns and 84.8% of urban interns believe that working environment and workload of intern doctors has an effect on one's decision on where to practice. A third of rural interns (36.4%) and 27.3% of urban interns felt that their internship hospital is equipped well enough to facilitate their service delivery, the majority of both groups not being satisfied with these conditions.

For the rural interns, 72.7% felt accountable to their community as a health worker, while 27.3% did not. A large share (87.3%) feel that there is a need to curb the increased migration of health workers. In urban areas a higher share felt accountable to their community (84.9%) but only 66.7% feel that there is a need to curb the increased migration of health workers, a lower share than for rural interns.

Of interns in rural hospitals, 77.3% would consider rendering their services to people outside of Uganda to help poorer nations and for better remuneration. Of those in urban hospitals, 69.7% would consider rendering their services to people outside of Uganda for better remuneration, standards of living exposure and adventure. The reported motivations of urban interns are thus more self oriented while those of rural interns are more service oriented.

Following the ban on recruitment being lifted by the government, the government is recruiting more doctors according to the Health Sector Strategic Plan (HSSP) II. This has been implemented in only a few areas because of financial constraints. The government is also in the process of banning dual employment (operating in both government hospitals and private clinics). This will ensure that doctors spend more time in hospitals than they have been doing. According to the intern doctors, however, enrolment levels remain only. It may be that the doctors are not sensitised about the health worker enrollment (*See Figure 4*).

Figure 4: Intern views on Health worker enrolment at internship hospitals



4.3 Factors impacting on retention of doctors in rural and urban public hospitals

The factors cited by the interns that would influence their decisions to stay in practice in Uganda included:

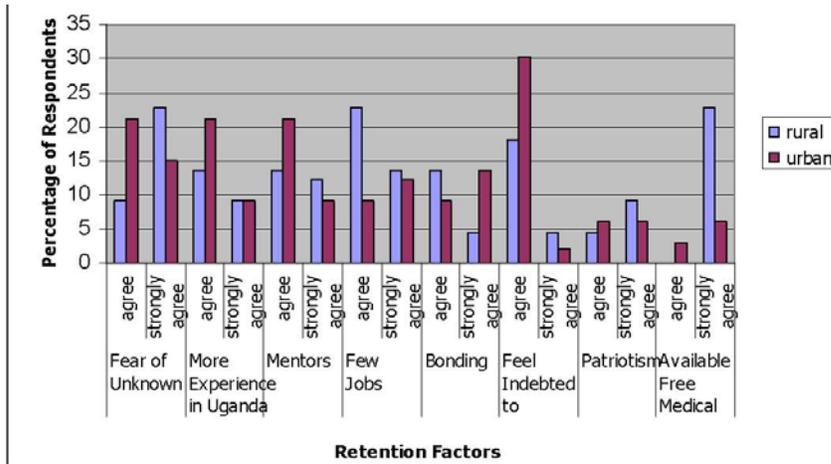
- bonding;
- mentoring;
- patriotism;
- fear of the unknown;
- feeling indebted to sponsors (government and family);
- fear of the unknown;
- hands on experience in Uganda and availability of free medical care; and
- housing and other amenities.

Bonding refers to working for some years before being registered to practice by the Uganda Medical Council as a doctor. Of the urban respondents, 36.4% think that the government should make bonding a condition for training especially for the government sponsored students, since it offers assured employment, hands on experience and is a way of giving back to the government and community. However the larger share of the interns (65.6%) believe that education is a right and think that the government should address the actual causes of migration. Of the rural respondents, 31.8% think that the government should make bonding a condition for training especially for the government sponsored students while 68.2% differ.

In general, the respondents believe that medical doctors have rights like any other professionals and that bonding would affect the number of people studying medicine. The hospitals are not well equipped to facilitate their service delivery and they think that if this is worked on, it can be a strong retention factor. They have poor laboratory facilities, most are non functional, and lack basic supplies like gloves, drugs, stationery and beds. There is a lot of improvising and there is bureaucracy in service delivery. Nsambya hospital, for example, is reported to be well equipped to facilitate service

delivery. There are efficient support and senior staff, the hospital is organised and most procedures are performed. Lacor hospital is also reported to be well equipped to facilitate service delivery. It has functional laboratories with modern equipment, teamwork and all procedures are done. These are, however, privately owned hospitals.

Figure 5: Factors involved in retention of health workers



According to key informant interview, government has considered mentoring as a non-monetary retention factor, but believe it should be done at the hospital level. Support supervision is also encouraged because it has enabled the hardship areas to retain doctors. The interns largely feel that the government has not done enough to curb the migration of health workers and believe that more work needs to be done in regard to improving remuneration and working conditions (see Figure 6).

Figure 6: Government's input to curb migration



Suggestions to the government by urban respondents to curb the increased migration of health workers were primarily to increase the remuneration of health workers (75.8%), but other suggestions included prioritising health care; improving working conditions; and improving health care facilities. Even more rural respondents suggested increasing remuneration of health workers (86.4%), and added improving working conditions;

implementing fair health worker distribution policies; and encouraging career development and improving health care facilities.

Those who feel that there is need to curb the increased migration of health workers suggest that this is necessary to avoid brain drain; to increase the doctor: patient ratio; and to boost the understaffed disciplines especially since the disease burden is high.

Key informant interview indicated that government, through Ministry of Health, has in the 2004/2005 financial year, secured a small salary rise of about US\$ 50,000 (\$30) to US\$ 100,000 (\$60) and is lobbying for a higher salary rise. The ministry has also secured a 'hardship allowance', on top of the salary, for people working in difficult areas like war-torn zones (northern Uganda) and hard to reach areas like Kalangala (an island on lake Victoria). This is about 30% of the salary.

Most of this comes from donors. The government is committed to contributing more money to health but this is not yet available. The government has also made an effort to build good houses doctors in such areas. Scholarships for in-service training are also available for post graduate courses for priority areas. Bonding for three years has been introduced to 'encourage' doctors to stay in hardship areas. An extra allowance for Senior House Officers (SHOs) for the extra work is in the offing because they work on top of studying.

5. Discussion

5.1. Push and pull factors influencing retention and migration

The respondents practicing in the urban hospitals understand the terms relating to migration of health workers better and are more aware of opportunities to practice and study abroad than the rural respondents (compare *Figures 4 and 5*) than those in the rural hospitals. This greater awareness suggests a greater likelihood to migrate to Western countries than their counterparts in the rural hospitals. A large share in both areas think that the curricula meet the international requirements for health workers hence both groups of interns believe that they can work anywhere in the world. The search for better pay is the most significant push factor; the least significant being the need to improve Uganda's economy. The most significant retention factor is feeling indebted to the sponsors; the least significant being patriotism.

Surprisingly, urban respondents feel more accountable to the community as health workers than their rural counterparts and attribute it to feeling indebted to the community members and the respect they are given, while others believe that there is a great disease burden and it is their duty. The respondents in rural hospitals are more likely to be influenced by their family background in their decision making regarding migration and this is mainly due to the degree of exposure in a family, wanting to be close or far from the family and one's need to improve or maintain family status or standards. Only a third believed it to be a personal decision.

The respondents from both settings think that the workload and working conditions will affect where and what they will eventually choose to practice and say they will be looking for better work places with good working environments, adequate facilities, less work, better pay, a comfortable standard of living and an appreciation of their services . Some

felt that working for long hours and with limited resources was a learning experience. Others reported that it has given them an insight on what they enjoy and some would like to change disciplines, while others felt that internal migration would not change things as conditions were similar across the country. Most respondents in both settings would consider rendering their services to people outside of Uganda and if given the opportunity, would migrate. Intern doctors in both settings think that the government should not make bonding a condition for training for government sponsored students.

5.2. Policy responses

The government is aware of the need to improve remuneration but faces financial constraints to do this. The government is not aware of the actual figures of medical migrants but is currently conducting a study on migration of health workers. Government and hospital management both see that conditions at the hospital impact on retention but note that it is not always the urban hospitals with the better facilities. Some rural hospitals like Lacor in the north have very good facilities because of donor input. The government plans to but has not yet put into operation mentoring systems for new health professionals.

6. Conclusions and recommendations

Likelihood of international migration is high for respondents in both rural and urban areas, if opportunities exist. Working in the rural area appears to be a bonding factor because it exposes the health workers to the magnitude of the disease burden in Uganda. However poor remuneration appears to be the most potent push factor. Interns in both settings were able to identify factors that would encourage them to stay in Uganda, and in rural service, such as pay, working conditions, and career prospects. Uganda cannot compete with developed countries in terms of monetary incentives suggesting that much emphasis be put on making local working conditions better.

While this situation calls for investments, under conditions of scarce resources there is a challenge in the lack of documented evidence of rate of out-migration of health workers from Uganda.

The Ugandan health sector is trying to deal with the “Human Resources for Health Crisis” and made the recommendations at the Human Resources for Health Symposium in Kampala, April 2006 to introduce a new system of performance appraisal and result oriented management with fair reward and recognition (Sezi, 2006). It was also proposed that there be mentoring sessions where doctors share lessons and experience with each other and brainstorm about their motivators and dissatisfiers (Kanyesigye, 2006). Organising in-service training of doctors especially those in supervisory posts was recommended to instill human resource management skills where all doctors feel that they are a part of the system (Sezi, 2006).

The recommendations called for better management of payrolls by linking and computerising health human resource data to ensure that those who depart do not continue to receive salaries. This would ensure that all the positions in the health management structure are filled in order to reduce on the workload (Sezi, 2006). The number of doctors on the government payroll should then be distributed according to the need, to overcome the current inequity where about half of the medical doctors in

Uganda work in Kampala. This would ensure that the health workers in some areas (upcountry) are not overworked into losing morale (Sezi, 2006; Kyobutungi and Amandua, 2006).

While some actions are underway, there appears to be a communication gap between government and health workers, with disgruntled health workers believing that government is not doing enough to make the situation conducive for their service delivery. Signals of support, like mentoring, are almost nonexistent in the Ugandan public sector health system and only seems to be available in privately owned hospitals.

Since human resource for health is critical for health care delivery, we recommend that the Ministry of Health conduct research on and strengthen communication with health workers to obtain and provide information to inform and regularly update policy in this area.

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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.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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