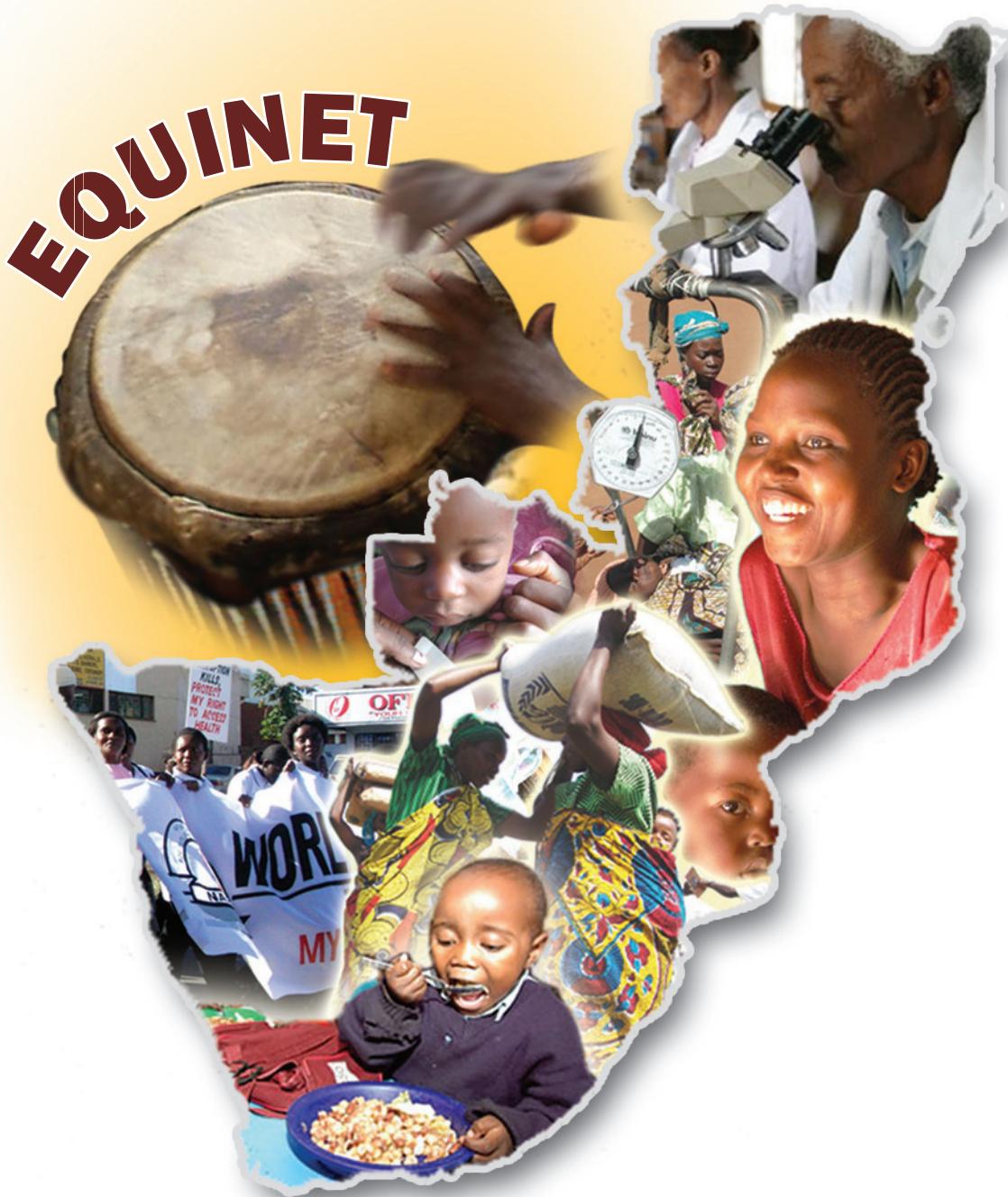Regional network for equity in health in east and southern Africa (EQUINET)

Reclaiming the Resources for Health

Building Universal People Centred Health Systems in East and Southern Africa

EQUINET

Abstract Book

Third EQUINET Regional Conference on Equity in Health
in East and Southern Africa
Speke Conference Center, Munyonyo, Uganda
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**Regional network for equity in health
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Reclaiming the Resources for Health: Building Universal People Centred Health Systems in East and Southern Africa

EQUINET Regional Conference on Equity in Health in East and Southern Africa
Speke Conference Center, Munyonyo, Uganda
September 23-25, 2009

The EQUINET Steering Committee welcomes you to the Third EQUINET Regional Conference on Equity in Health in east and southern Africa at Munyonyo, Uganda September 23rd -25th 2009.

The Regional Network for Equity in Health in East and Southern Africa (EQUINET) is a network of institutions within east and southern Africa- involving university, state, civil society, parliament and other institutions- that have sought to support the regional community in its commitment to secure equity in health. We are happy to come together with colleagues from state, civil society and non-state organisations, parliaments, regional and international organisations from within and beyond the region to share our collective experiences, knowledge, work and views, to explore the challenges we face in addressing inequalities in health and access to health care, and to support the development and implementation of policy choices that will strengthen health equity.

We have chosen the conference theme 'Reclaiming the Resources for Health: Building Universal People Centred Health Systems in east and southern Africa to raise, debate and give visibility to the alternatives we have for advancing people's health based on values of fairness and justice, particularly through policies and actions through which

- poor people claim a fairer share of national resources to improve their health;

- ESA countries claim a more just return from the global economy, to increase the resources for health; and

- a larger share of global and national resources are invested in redistributive health systems, to overcome the impoverishing effects of ill health.

We hope that the conference will provide you with an opportunity to review evidence; to share information on policy, programme and health systems options; and to strengthen networking and interactions towards goals of improved health and social justice. We hope that the conference will energise and inform your work, and that you will identify key areas to be followed through by EQUINET and others in future research, policy and programme design to advance health equity.

PROGRAMME OUTLINE

SEPTEMBER 22 2009	
1700-1900	Registration

SEPTEMBER 23 2009	
REGISTRATION VICTORIA BALLROOM FOYER	
0830-0930	Registration
	Music and images from the region
0830-0930	COFFEE/TEA
P1 OPENING PLENARY: RECLAIMING THE RESOURCES FOR HEALTH: BUILDING UNIVERSAL PEOPLE CENTRED HEALTH SYSTEMS IN EAST AND SOUTHERN AFRICA VICTORIA BALLROOM	
0940-1230	Welcome and opening remarks Keynote speakers EQUINET steering committee paper Music and images from the region
1230-1345	LUNCH
P2 EQUITY IN HEALTH AND HEALTH SYSTEMS VICTORIA BALLROOM	
1345-1515	Reclaiming the economic resources for health Lessons and challenges for building health systems that promote equity in health View from the community (DRC) and health workers (Zambia) Discussion
1515-1530	COFFEE/TEA

PARALLEL SESSIONS				
1530-1730	Pa1 **Claiming rights to health** Victoria Ballroom	Pa2 **Equitable health services** Regal Hall	Pa3 **Globalisation and womens health in East Africa** Meera Hall	Pa4 **Social empowerment in health systems** Majestic Hall

DAY ENDS, PHOTO EXHIBIT, SOCIAL TIME

SEPTEMBER 24 2009	
0830-0930	Photo exhibit: Meet the photographers
P3 PLENARY: FAIRLY RESOURCING HEALTH SYSTEMS VICTORIA BALLROOM	
0900-1030	Reclaiming financial resources for public sector health services Retaining health workers in east and southern African health systems: Lessons from a Regional programme Equity in accessing AIDS treatment resources: experiences from Malawi Discussion
1030-1100	COFFEE/TEA

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

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P1: Opening Plenary:
Reclaiming the Resources for Health:
Building Universal People Centred Health Systems
in East and Southern Africa

Wednesday 23 September 2009 0940-1230

Victoria Ballroom

P1.1: Opening remarks:

Helen Lugina, East Central and Southern Africa Health community

P1.2: Opening speech

Minister of Health, Uganda

P1.3: Opening paper

Globalisation and women's health: issues for health equity in east and southern Africa

Dr Sarah Wamala director General, Swedish National Institute of Public Health

Globalisation is an outcome of long-term processes including trade, communication technologies, population movements, and the establishment of global institutions. These processes have shaped the modern world. Some scholars argue that globalisation has made the world better while others argue that benefits of globalisation have been played out in an unequal pattern between regions of the world. In September 2000 concerns about poverty and commitments to key areas of social and economic development were consolidated in the Millennium Development Goals (MDGs). Evidence based on the monitoring of the MDGs demonstrates that Africa is performing poorly and is a nett 'loser' from globalisation. Literature also demonstrates that globalisation's negative health effects have not been gender-neutral. Women have experienced some of the gravest negative consequences in relation to health and caring burdens.

Women are vulnerable to shifting patterns in global markets in relation to food crisis since women have primary responsibility for food for their households. In fact, women are responsible for 80% of food production in Africa, including the most labour-intensive work related to agriculture. The evidence suggests the changes wrought by globalisation in the agricultural sector are widening gender inequalities, and negatively impacting on women's and child health. Globalisation has reduced the national space for policies and strategies to promote health or tackle inequalities in health. Thus the MDGs Goal 8 (Develop a global partnership for development) offers a unique opportunity to utilise foreign aid effectively. One of the main concerns for strategies that aim at reducing poverty is the need to incorporate perspectives of how benefits and losses from globalisation are distributed between women and men and how these impact differentially on women's and child health. Empirical research with case studies addressing the link between globalisation and women's health is needed and necessary. Additionally strategies that tap on the benefits of globalisation to enhance women's living conditions and health would be beneficial.

P1.4: 'Reclaiming the resources for Health'

Rene Loewenson, Training and Research Support Centre, Zimbabwe, EQUINET Steering committee

For and with the EQUINET Steering committee

We have the knowledge, ability and experience to overcome persistent inequities in health in east and southern Africa (ESA). Yet inequalities in health persist in the region and are widening globally, not only in health, or in the resources for health, but also in the opportunities for current and future health. An examination of these inequalities show that they arise in the different living, working and social conditions across communities. These

conditions themselves track back to underlying economic and political conditions that deplete the resources for health, within the region generally and moreso within the most disadvantaged communities. As a result, even where aggregate growth has occurred, it has been associated with falling human development and increased poverty. In many ESA countries, widening national inequalities in wealth block poor households from the benefits of growth, while pathways that fuel global inequalities mean that substantial resources flow outwards from Africa, depleting the gains from the production processes and investments that should be generating the resources for health.

Globally, the deprivation and health burdens found in ESA point to a level of shortfall in realising global social norms and commitments made at the United Nations that call with urgency for a more human-centred form of globalisation and a more just return to African people from the global economy. For communities and countries in Africa, there are challenges and opportunities in engaging globally to advance such changes, while also using the domestic and regional policy space to break vicious cycles of diminishing returns; to address outflows; to develop the food, water, education, employment, health care and other resources and opportunities needed for health; and to ensure a distribution of these resources for wider and more sustained economic and social gain. The conference will explore this, including emergent new challenges, in greater depth.

Prioritising people's health adds momentum and forces attention to shaping global, regional and national policies that promote health, as witnessed by the responses to the activism around AIDS, but health as a universal goal needs to be given even greater impetus to promote

equity. While the right to health is recognised globally and 'health equity' has been a stated commitment regionally, both have been deeply undermined in recent decades, and need to be reasserted, socially and politically. This places challenges on health systems and professionals to provide the leadership, norms and values, evidence and options to support this, including by building health systems that themselves reclaim and fairly organise the resources for health. Within ESA, despite a recent history of reversals under structural adjustment, resource scarcities and selective and commercialised approaches, there is policy and capacity support for and experience of the comprehensive, primary health care oriented, people-centred and publicly led health systems that have been found to provide such leadership and to improve health equity. This gives an important basis for work in the region, to affirm and advance such systems and to identify and address the weaknesses that undermine them and their reach. The presentation points to work that will be discussed in more depth at the conference, including in how health systems protect and promote public health and facilitate action across sectors; in options for mobilising and allocating additional resources needed without burdening poor households; in valuing and organising health workers and the capabilities to support effective universal coverage and comprehensive primary health care; and in supporting empowered, social action for health. Health as a goal, the key dimensions of action on health equity, and the progress made towards achieving them (or not) need to be agreed on, watched and engaged on at all levels, for a robust participatory democracy within countries to inform an affirmative and self-determined engagement within the global political economy.

P2: Plenary: Equity in health and health systems

Wednesday 23 September 2009 1345-1515

Victoria Ballroom

P2.1: Reclaiming the economic resources for health

Rangarirai Machemedze, SEATINI, Zimbabwe

Aulline Mabika, Percy Makombe, Riaz Tayob, Patrick Bond, Mickey Chopra, Mark Tomlinson, George Dor, Greg Ruiters, Rene Loewenson

The globalisation process has brought with it challenges of enormous proportions especially to Africa. The continent has, over a period of two to three decades, suffered a massive outflow of economic resources for health due to a number of global economic activities. This paper highlights some of the vehicles through which resources are vacuumed out of the region, including debt servicing and repayment, falling terms of trade and trade liberalisation, among others. Emerging global issues, and the use of African land and biological resources to address the resource demands of high income countries, also have serious implications for health, but are hardly on the African health policy radar.

These include bio-fuels production, new, often unregulated technologies, genetically modified foods and climate change. Weak control over the resources for health within the region has left African countries confronted by numerous challenges to health. These include social determinants such as poor food security and nutrition and poor access to safe water. The situation also poses challenges to health care, including inadequate , under-resourced services, weak local production of health and medical supplies, the transfer of health service provision from governments and local authorities into the hands of the private sector and a growth of poorly regulated private providers, many in the informal sector.

Many of the policies and measures that address this situation lie outside the health sector. Yet with serious implications for health, the health sector is called on to mitigate growing problems in this wider terrain. The paper argues that this calls for a strong leadership for a proactive, rights-driven protection of population health, based on the core principles of public health. Countries, including health sectors and health civil society should ensure health in all policies through this.

The paper will use as an example the role of the World Trade Organisation and the international trade agreements that commit governments to extensive market liberalisation, and the impact on government authorities to protect and regulate public health. It will explore the underlying interests and principles that present in these trade agreements, and the manner in which bilateral agreements and corporate practice have added potentials for reversals of gains for health achieved by African countries at multilateral forums.

Apart from the vigilance needed to protect public health against these trends, the paper argues for measures that need to be introduced to reclaim economic resources for health in Africa, ranging from the protection of intellectual property and biodiversity, the investment, incentive, revenue and tariff measures to protect and encourage domestic industries. Finally it argues, with examples, that the health sector can contribute public health leadership to strategies that reclaim the economic resources for health.

P2.2: Lessons and challenges for building health systems that promote equity in health

Lucy Gilson, University of Cape Town, South Africa

Jane Doherty, Ireen Makwiza, Sally Theobald, Leslie London, Greg Ruiters, Nomafrench Mbombo, Gabriel Mwaluko, Victoria Frances, Rene Loewenson

This paper will provide an overview of southern and eastern African experience in building equitable health systems, over the last decades. It will draw on the regional equity analysis produced by EQUINET and the work of the network, as well as the work of the Knowledge Network on Health Systems of the Commission on the Social Determinants of Health, in which EQUINET was involved. Using material from these sources, it will:

- outline key features of health system develop-

ment in southern and eastern Africa over the last decades
- highlight positive experiences from the region of health system action that promotes health equity
- identify the key, critical challenges that have been faced in the region in addressing inequity through health systems
- outline features of health systems that are particularly important in promoting health equity
- provide lessons for the action needed to strengthen health systems and promote health equity.

P2.3: Struggling for the basics: A perspective from the community and from health workers

Amuda Baba, IPASC, Democratic Republic of Congo (DRC)

Idah Zulu Lishandu, Lusaka District Management Team (DHMT), Ministry of Health Zambia

The presentation will draw on images and experiences from DRC and Zambia to present the struggles that communities and health workers face in accessing and delivering essential health interventions and services.

A perspective from the community (DRC):

The presentation focuses on a rural community in Bembeyi 10 to 12 km east of Bunia town in eastern DRC. The local population practises agriculture for their daily survival and supply Bunia town with fresh food. Yet the people experience malnutrition, as well as water borne diseases, typhoid fever and malaria, particularly in children under 5 years and in pregnant women. People have had very limited knowledge about diseases and HIV. Local health services do not provide any outreach activity. Although many of these problems could be prevented and treated locally, the health centre in the community often lacks the needed drugs and equipment to do this. When this happens cases have to be referred to other health centres or to the general referral hospital in Bunia, and some people go to the traditional medicine practitioners around Bembeyi village if they can't afford the hospital services. Patients then travel for about two hours by foot or by bicycle to Bunia, crossing two rivers on the way. These are small in the dry season, but dangerous and not possible to cross during the rains. To overcome this barrier, community members in 2007 made a local bridge using wood for bicycles and motorcycles to pass. Then in December 2008, after work with

participatory methods in health, they initiated a project to build durable bridges using cement and stones for cars to reach the area, especially the ambulance from the general referral hospital. With funding support from UNDP and involvement of the local community the bridge construction is underway. In the meantime, people push their relatives on bicycles to a part of the river where the ambulance can stop. For this community, the biggest barrier to health is in their poor environment, and their barrier to health care lies in having adequate drugs, equipment and personnel at their own health centre.

A health workers perspective (Zambia):

As health workers we see (and live in many of) the social and economic conditions that contribute to the disease outbreaks in our community. For example we can see how the cholera epidemic arises due to causes such as inadequate water and sanitary facilities; high poverty levels and poor living conditions in high density areas. We also see how these preventable causes are a burden on our health services. As health workers we are involved in health promotion around these conditions, such as through door to door health education, follow up and contact tracing of cholera patients, swabbing of toilets for possible contamination and water sampling. The presentation will highlight the challenges we experience at the level of a health centre in providing services for those who, including inadequate health workers, equipment, supplies, and how this affects our relationships with our community members. There is alot of innovation going on at health centres to overcome these challenges. For example health workers who are off duty work on "part-time" basis to fill shortages, people find creative ways of dealing with non functioning equipment, like using heaters to dry x-ray films as the dryers are not functioning. To improve relationships with our communities, who may not appreciate the difficulties we face, we involve them through the neighbourhood health committees with whom we hold meetings to discuss services and to involve community members in the health promotion with clients at the health centre and in the community. We recognise the need to improve our communication with communities, such as through participatory methods. Yet, we health workers, like communities, often feel that policy makers are not listening to our voices.

Pa1: Parallel Session: Claiming rights to health

Wednesday 23 September 2009 1530-1730

Victoria Ballroom

Convenors: Nomafreanch Mbombo, University of the Western Cape;
Leslie London, University of Cape Town

Pa1.1: Globalisation and inequity: Are human rights a solution?

Leslie London, School of Public Health, University of Cape Town, South Africa

H Schneider, N Mbombo, J Thomas

The consequences of globalisation continue to pose major obstacles to the realisation of the Millennium Development Goals and to efforts to address the problems of world poverty. This is manifested in increasing health inequalities within and between countries, reflecting increasingly uneven economic development under neoliberal economic policies. In particular, globalisation has been severely criticised for its disempowering of nation-state sovereignty and the constraints placed by globalisation on the capacity of governments to regulate in the interest of their citizens. Yet globalisation has also ushered in an unprecedented attention to human rights concerns around the world and to issues of good governance. However, the human rights paradigm is predicated on holding governments accountable to deliver on their human rights obligations. This poses a critical contradiction. How are governments to regulate with a view to promoting citizens' rights to health when global trade policies, for example, seek to restrict governments' ability to act independently of the global market? In the context of this contradiction, a set of critical questions are posed to explore whether a human rights approach can help to buttress governments against the powerful forces of globalisation, and, if so, how.

The paper explores this in relation to health and health services using data drawn from a survey of parliamentarians in southern and eastern Africa and a policy analysis of state ambivalence towards HIV control in South Africa. The former analysis will be used to explore how parliamentarians view the right to health and its relationship to affording spaces for engagement with civil society in the context of global commitments. The latter analysis illustrates how the terrain of HIV became a testing ground for contestation of power between the state and civil society in which international forces were operative on both 'sides' of the conflict. Two concepts appear useful in explaining how these contradictions may be best understood and challenged. Firstly, states may not simply be disempowered, but rather have agency in deliberately avoiding their responsibilities (so-called 'cunning' states). Secondly, disjunctures in power between the executive and legislature may offer opportunities for policy interventions that advance a health equity agenda.

Pa1.2: On the road to realisation of the right to health by mothers in Pallisa and Budaka districts, Uganda

Prima Kazoora, HEPS Uganda

The Community Empowerment and participation on Maternal Health in Pallisa and Budaka districts was a health rights promoting community initiative that aimed at contributing to the reduction of maternal mortality ratio by improving the health of expectant mothers in the project area. This sensitisation and empowerment based sixteen month project was implemented in seven sub counties of Kamuge, Butebo, Bulangira, Gogonyo and Pallisa Town Council in Pallisa district and Kamonkoli and Budaka rural in Budaka district. The project aimed to increase awareness and knowledge of maternal health rights and responsibilities by expectant mothers and their partners as well as promote community participation and involvement of men in the affairs of mothers.

The project used identified grass root community leaders as trainers and change agents on maternal health rights and responsibilities in their respective parishes. 84 men were among the 210 community leaders that were selected and trained as community trainers. These men mobilised other men to attend community meetings and passed on the benefits of their involvement in maternal health issues. These trainers used easy to read, picture based training materials to generate discussion among community members on health rights and responsibilities in relation to access to maternal health services. 180 health workers were trained on the rights based approach to service delivery.

The outcomes of this intervention included increased maternal health awareness in the seven sub counties with community leaders acting as ambassadors in mobilising and sensitising mothers and their partners to increasingly demand for services as well as practicing their health responsibilities. This is reflected in the end of project evaluation report that showed an increase in number of pregnant women accessing health services. The communities were also able to identify the most violated health rights in the communities and demand increased health services for the most vulnerable expectant mothers. These were highlighted during the lobby meetings held between the community leaders and the subcounty and district leaders.

Communities gain confidence when given health information and are able to demand for their rights. Community leaders become health resource persons in their areas and participate in other health programs like

sanitation, child days and in health unit management meetings to present their views. However, the communities are still reluctant to voice their complaints due to lack of an enabling environment for people to demand their health rights. There is no support and protection of health consumers under the Ugandan law. Changing peoples attitudes is a process and it cannot be done within a short time like one and half years.

Pa1.3: Building an effective health consumer feedback mechanism

Rosette Christine Mutambi, Coalition for Health Promotion (HEPS) Uganda

Robert Peters and Richard Mugisha

Realising that violations of health rights were not properly addressed in Uganda, in 2006 HEPS Uganda designed a health consumer feedback methodology code named Operation Excellence that has been piloted in three districts in Uganda – Kampala, Pallisa and Lira. Operation excellence provides a platform through which health consumers voice their complaints and/or suggest improvements to the health services they are rendered by health providers at facility level and to policy makers at district and national levels. A presentation of this methodology and results from the three pilots and achievements so far will be made, together with audio/visual recordings of what health consumers and stakeholders say about Operation Excellence.

Pilot health facilities collaborated with HEPS Uganda. Information on Operation Excellence was disseminated to both community and health facility. For one week each quarter HEPS set up a mobile office at the pilot and collected complaints and compliments from health consumers, using questionnaires in both English and local language, with volunteer assistance for consumers not able to read and write. Feedback boxes were strategically placed for respondents to return filled questionnaires. All information was entered into the Operation Excellence database and analysed. Findings were discussed with health facility management and community representatives and a way forward agreed. HEPS worked with the local community on follow up and used the findings for national level advocacy.

The method led to an acceptance of suggestion box method for feedback in the facilities, consumer reports of reduced use of rude language by health workers, and an increase in the number of pregnant women attending antenatal services. Positive health worker behavioural change was realised and a strong collaboration with the health facility administrators, some health workers, District Directors of Health Services and Uganda Human Rights Commission. Communities have now demanded representation on such key policy making structures. Through the OE health consumers gained confidence and became activate participants in the design and improvement of health services. When health providers and policy-makers know that they are dealing with confident consumers who know their rights and responsibilities and where to complain they (former) are more likely to be accountable.

Pa1.4: Operationalising the right to health through a learning network

Jackie Thomas, School of Public Health and Family Medicine, University of Cape Town, South Africa

Nicole Fick, Leslie London, Maria Stutafford, Anthea Emmanuel, Nomafrench Mbombo, Mala Makan

Despite health rights being enshrined in the South African Constitution, major health inequalities persist. Some have criticised human rights approaches for being focused on individuals, which may aggravate health inequities. However, there are other ways to understand human rights, which emphasise the importance of community actions as essential for achieving health. However, there is little research in this area to inform best practice. Previous EQUINET work identified the critical role of Civil Society agency in realising rights and developed a conceptual model of the role of human rights approaches in promoting health equity. In 2006, this model was tested in research with three civil society groupings working on health related demands in the Western Cape. One of the key recommendations of that study was to develop a civil society learning network (LN) to realise the right to health through mobilising the agency needed, individually and collectively, to overcome factors driving health inequalities. Secondly, a LN can help to explore what kinds of strategies are most effective and the role that health care providers play in either facilitating or acting as obstacles to such agency. The Learning Network was then established in 2007 to provide support for six civil society and two university groups in the Western Cape, South Africa, to explore collaboratively the use of human rights approaches to advance health objectives. This submission relates the experiences and lessons learnt by the members of this action Learning Network.

Evidence was gathered through group discussions, interviews and initial observations of member organisations involved in the Learning Network. Initial findings showed that organisations recognise that civil society gives voice to vulnerable groups. A learning network provides the opportunity for the co-production of knowledge through designing and developing participatory methods and approaches. CSO networking with like-minded organisations and departments across sectors is critical to realising rights. CSO members lack clear understandings of what a human right implies, and therefore, what a human rights approach could bring to their work; therefore, a firm knowledge base is needed within civil society organisations around human rights and rights-based approaches to health. Collective agency enables vulnerable people to take action to access the right to health. The authors suggest that adopting a human rights approach enables organisations to work together across economic, civil and other political divides around a common agenda. Human rights approaches provide additional opportunities for mobilising resources, both human and financial from outside of the health sector.

Pa2: Parallel Session: Equitable health services

Wednesday 23 September 2009 1530-1730

Regal Hall

Convenor: Lucy Gilson, University of Cape Town

Pa2.1: Poverty and Strategies for Health Equity in Mozambique

Victor Muchanga, Chemonics International, Mozambique

Patricio Murgueytio

Since its independence in 1975, and especially in the post-war period, a working hypothesis in the design of poverty reduction strategies in Mozambique has been that an expanded and improved network of health services would contribute to poverty reduction, especially among vulnerable populations. This paper examines the relationship between health, poverty and vulnerability. We argue that good health is an important determinant of overall development. Poverty conditions in Mozambique, however, contribute to unequal access to and utilisation of quality health services. Such inequitable patterns of health care distribution coupled with a weak performance of the health system hinder the nation's opportunities to attain higher levels of human capital and development.

We analysed the relationships between key indicators of population well-being, differentials in access to and delivery of health services, and their implications to poverty reduction. Available data show that, although some progress has been achieved in recent years, significant inequalities exist in access to and quality of public health services, along with uneven resource allocation among different geographic sub-regions and across income levels. There are large gaps in access to health services between poorest and richest income quintiles, as measured, for example, by distance and availability of transport to health posts. Inadequate access leads to significant morbidity and mortality differentials across income levels and urban/rural groups. Urban areas exhibit favorable budget allocation and concentration of health facilities and other resources, despite smaller population size and lesser disease burden. Public hospitals in Maputo City, for example, show significant "leakage" towards the better-off. These findings suggest that health investments may be failing to express "pro-poor" policy statements and orientations.

Based on this brief analysis and on a comparative review of health care in Africa and other less developed countries, the authors suggest several health system strengthening interventions. In addition to seeking greater resource mobilisation for health care from domestic and foreign sources, Mozambique should consider health need or "capacity to benefit" criteria to revisit resource allocation decisions. A less hierarchical approach to leadership and management, as well client-focused "strategic purchasing" strategies may contribute to developing effective performance incentives, maximising "value for money," and improving accountability practices, particularly at decentralised levels of government. Health management training should reflect these new perspectives. The public health sector and non-governmental providers may benefit from these innovations. Only a value-oriented, better performing health system will effectively contribute to improved human capital and poverty alleviation efforts in Mozambique.

Pa2.2: Disparities in access to quality health care in Uganda

Elizabeth Ekirapa- Kiracho, School of Public Health, Makerere University, Uganda

Susanne Kiwanuka, Olico Okui, George Pariyo, David Bishai

Concern has been raised about the quality of care in developing countries such as Uganda. There is therefore a need to assess the quality of care, and inequities in quality of care across different socioeconomic groups, so that action can be taken to address the gaps. This study assessed the quality of out-patient care provided by public and Private not for Profit Facilities (PNFP) and the quality of outpatient care provided to patients of different socioeconomic status.

An analytic cross-sectional study was carried out in ten public and ten private health facilities in Eastern and Western Uganda. Observations of 1446 patient provider interactions in the out-patients' clinics of the facilities were done. Thereafter exit interviews were also done with the 1446 observed patients. The presence of structural components of the facilities were ascertained using observation checklists. Principal Components Analysis and raw scores were used to construct the indices that were used to assess different components of quality, as well as the socio-economic status of the patients. Regression analysis was used to asses the relationship between quality of care, ownership of the facilities and socio-economic status. Ethical approval for the study was sought from the relevant institutions in Uganda.

The majority of health workers had low scores on assessment of their general performance and the quality of their communication. Regression analysis showed no statistical difference in their general performance and in the quality of communication to patients of different socio-economic status. However there was a difference

in the availability of essential drugs and supplies with the public facilities more likely to have essential drugs and supplies than the Private not for Profit Facilities (C.I – 2.87 -.29; P>0.019 (drugs); C.I -3.2 -.377; P > 0.01 (supplies)). Although no major disparities were seen in the measured components of quality of care, the general performance of the health workers and the quality of their communication was poor. Public facilities were better stocked with essential supplies and drugs than the PNFP facilities. Since PNFP facilities provide care to a substantial proportion of the population, steps should be taken to revaluate the adequacy of subsidies provided by the government to PNFP facilities. Regular assessments aimed at improving the quality of services provided at PNFP and public facilities should also be undertaken.

Pa2.3: Determinants of health care utilisation in Uganda

Solome Kiribakka Bakeera, Department of Policy and Planning, Makerere University School of Public Health, Uganda

Sarah Wamala, Sandro Galea, Andrew Ellias, Stefan Peterson, George B Pariyo

Healthcare utilisation has particular relevance as a public health and development issue. Unlike material and human capital, there is little empirical evidence on the utility of social resources in overcoming barriers to healthcare utilisation in a developing country context. Social resources are a feature of social capital and refer to the diverse resources embedded in social networks. Several studies in Uganda that have investigated patterns of healthcare utilisation have not investigated the role of social resources. We sought to assess the relevance of social resources in overcoming barriers to healthcare utilisation. This work aimed to explore community perceptions among three different wealth categories on factors influencing healthcare utilisation in Eastern Uganda.

We used a qualitative study design using Focus Group Discussions (FGD) to conduct the study. Community meetings were initially held to identify FGD participants in the different wealth categories, ('least poor', 'poor' and 'poorest') using poverty ranking based on ownership of assets and income sources. Nine FGDs from three homogenous wealth categories were conducted. The FGDs were analysed using content analysis revealing common barriers as well as facilitating factors for healthcare service utilisation by wealth categories. The Health Access Livelihood Framework was used to examine and interpret the findings.

Barriers to healthcare utilisation exist for all the wealth categories along three different axes including: the health seeking process; health services delivery; and the ownership of livelihood assets. Income source, transport ownership, and health literacy were reported as centrally useful in overcoming some barriers to healthcare utilisation for the 'least poor' and 'poor' wealth categories. The 'poorest' wealth category reported

no difficulties utilising free public health services. Conversely, there are perceptions that public health facilities were perceived to offer low quality care with chronic gaps such as shortages of essential supplies. This study suggests that in addition to income, physical resources and free public health services, social resources were perceived as important in overcoming some of the existing barriers. However, there was variability in the usefulness of social networks among wealth categories. For instance the 'least poor category' reported the most useful networks. The patterning of social resources could explain or contribute to the persisting inequities in health care utilisation. More in depth research is needed to describe the types of social ties and how these are important in overcoming the existing utilisation barriers.

Pa2.4: Access to family planning services among the poor: What are the options?

Alfred Agwanda, Population Studies and Research Institute, University of Nairobi, Kenya

Wasunna Owino, Collete Obunga, Beatrice Okundi

The HPI (2007) analytical study of DHS data drawn from 47 countries has drawn attention to the continued inequalities in Family planning service utilisation within a number of developing countries. In Kenya, progress in reducing inequalities in FP use between the poorest and wealthiest groups has continued to increase over time. Inequalities in access to family planning services are critically linked to a number of barriers. Campbell et al. (2006) outlined a number of barriers from the perspective of the client in low resource settings. These include geography and method choice; financial costs; status of women; medical, provider bias, side effects, misinformation and fear. Most of these factors closely associated with different dimensions of poverty. For example, even if services for the poor were readily available, misinformation may affect the women's interest in seeking family planning methods and services. Gribble et. al., (2007) suggests that the effectiveness of policies designed to improve access among the poor must also address this wider range of barriers that undermine utilisation of services. This paper presents the part of an ongoing research on barriers to family planning among the poor and the strategies for improving access to family planning services among the poor in Kenya. It examines historical policy perspectives and the extent to which the poor were taken into account in the provision of family planning services. The service provision environment affected by a number of contextual factors led to low prioritisation of family planning in both national and international policy agenda. The weakening prioritisation of family planning however undermined access to contraceptive services the poor. The second part of the paper presents the results of rapid assessment of the barriers to services among the poor from the results of focus group discussions held by women and men in selected areas where the poor live in both urban and rural parts of the country with low contraceptive use

uptake. Although barriers to family planning largely remain similar, factors such as misinformation, fear of side effects, hidden costs of services and continued male dominance continue to affect the poor women's interest in seeking family planning services. The last part of the paper discusses policy options that need to be addressed to increase access to Family Planning among the poor. It concludes that in order to improve access among the poor, policy strategies must also address a wider range of barriers that undermine utilisation of services.

Pa2.5: Using cataract surgeons and PHC approaches to improve coverage and quality of eye health services

Ronnie Graham, Sightsavers International, East, Central and Southern Africa Regional Office, Kenya

Nancy Thuo, Kate Gooding

In most parts of Africa cataract is the leading preventable cause of blindness. Since the 1980s East Africa has pioneered the development of a new cadre of health workers called cataract surgeons – mid-level eye health workers who receive an additional 12-18 months training in cataract surgery, in an effort to improve the coverage, quality and sustainability of eye health services in selected countries in East Africa, particularly Kenya and Tanzania. In 2006, Sightsavers International commissioned a study to ascertain the effectiveness of this cadre as a cost-effective alternate to ophthalmologists for whom training and deployment options were scarce. The study was aimed at influencing a change in health policy to set up training programmes for cataract surgeons and deploy them to areas with greatest need. At the same time, Sight Savers International, revitalised the integration of Primary Eye Care (PEC) into Primary Health Care in an effort to strengthen health systems and ensure that a comprehensive approach to eye health was put in place. This approach sought to build the capacities of primary health care workers by training them to deal with five basic eye health issues: common eye problems; minor trauma; Vitamin A Deficiency; community eye health awareness; diagnose and refer everything else, particularly cataract.

The study revealed that cataract surgeons had made 'a major contribution' to the prevention of cataract blindness in the region, contributing up to 40% of total cataract surgeries in Tanzania alone. The evidence showed the need to harmonise regional training curriculae, utilise unit costing for economy of scale, upgrade skills of existing cataract surgeons, enhance supervision, improve detection and referral pathways, and enhance health worker productivity from 250 to 500 cataract surgeries per year. The PEC approach demonstrated that the health system as a whole benefits from developing services at the most appropriate level, dealing with simple eye problems at the community level whilst developing a referral

mechanism which encourages health seeking behaviour. A combination of strengthening primary detection, treatment and referral with a strengthening of surgical capacity at the secondary, district level proved to be an effective and sustainable solution to the expansion of eye health services in underserved areas. Developing surgical services at the district level with an effective referral mechanism from the primary level provides a paradigm shift in how eye services are delivered in many countries in Eastern Africa. Cataract surgeons are an appropriate and practical tactical response to improve eye health and reduce avoidable blindness in East Africa where there is an alarming shortage of fully trained ophthalmologists, mitigate the effects of health worker migration, and increase health equity through improved coverage and access.

Pa2.6: Monitoring medicine prices and affordability

Denis Kibira, HEPS Uganda

HEPS Uganda carries out quarterly monitoring of 40 key medicines availability and price in health facilities in four regions in Uganda under a Country Working Group that includes Ministry of Health and World Health Organisation. Existing evidence has highlighted large gaps and inconsistency in the availability of medicines in all sectors, as well as a wide variation in prices which render essential medicines unaffordable to the poor and most vulnerable people. This study draws national picture on the level of availability and affordability of essential medicines in the public, mission and private sectors and making a comparison between urban and rural. In the surveys carried out in 2008, availability of essential medicines was lowest in public sector at 63%, in mission was 71% and 79% in private sector. Availability was lower in rural compared to urban facilities. This finding is similar to findings in the National Pharmaceutical Assessment Health Facility Survey of 2008 where availability of essential medicines was in 68% of public facilities. The first line antimalarial Artemether/Lumefantrine was available in 75% of public facilities, compared to only 28% of private sector. Pediatric formulations were poorly available. Suspension cotrimoxazole was in only 29% of public facilities. Whereas medicines are free in public sector, availability was found to be poor in the private and mission sectors and medicines to be unaffordable to the lowest-paid government worker. For Artemether/Lumefantrine, private facility prices were more than ten times higher than the international reference prices. Prices at both mission and private facilities were found to be three times more than the international reference prices. This disproportionately affects the third of Ugandans that live on less than a dollar a day. With poor people dependent on public services and to make 'free care' policies effective, measures should be implemented through increased funding, improved procurement capacities and increased transparency to enhance availability of essential medicines at public facilities and in rural areas. Pricing mechanisms should be implemented for medicines in the private sector to increase access on that sector.

Pa3: Parallel Session:
Globalisation and women's health in East Africa

Wednesday 23 September 2009 1530-1730

Meera Hall

Convenor: R Loewenson, TARSC; S Wamala, SNIPH

Pa3.1: Nutrition and health care in urban women in Kenya

Mary Amuyunzu-Nyamongo, African Institute for Health and Development, Kenya

Rene Loewenson, Sarah Wamala, Dennis Marube

The study was conducted in June/July 2008 by the AIHD in collaboration with Karolinska Institute and TARSC and funded by SIDA-SAREC. The study aimed to explore the consequences of globalisation-led reforms on women's caring and health promoting roles, burdens and capabilities, and the impacts on household health and food security in poor urban Kenya. A woman's health is defined as her total well-being, not determined solely by biological factors and reproduction, but also by the effects of poverty, nutrition, stress, workload and conditions, etc. Although women typically live longer than men they also report worse health status and a higher prevalence of morbidity. An interviewer-based questionnaire was administered to 450 mothers of children under-5 years in Kaptembwo informal settlement in Nakuru district and the data were processed using CSpro and analysed using SPSS. The results indicate that 78.5% of women who had been ill four weeks prior to the survey failed to seek healthcare while 82.8% failed to buy medicine, mainly due to lack of funds. About half (52.2%) reported that their children under-5 had fever in the previous two weeks. For about 59% healthcare was sought from health facilities while medicine was purchased from shops/kiosks for 37.2%. Mothers were responsible for healthcare during ill-health (90.7%). About half (52.5%) of the mothers reported that their children's ill-health forced them to miss work while 16.3% said they could not concentrate at work. This was also true for household chores which were adversely affected as they focused on the sick children. In terms of nutrition, 62.2% of the households reported that a member had gone to bed hungry due to lack of food in the previous four weeks due to lack of resources to purchase food. Although the amount of money required to feed household members differed, 53.2% of the women reported that they used between Ksh. 2001 – 4000 on food monthly. This was beyond their ability - 62.2% of the women were not engaged in any income generating activity.

In conclusion, one effect of globalisation is the commercialisation of health which makes access more difficult for the poor. Similarly, proper nutrition is impacted by the ability of the women to earn an income to be able to purchase food. Women are more vulnerable to and disproportionately affected by the global health threats like poverty as seventy per cent of the world's poor are women. Poor access to food affects household nutrition especially when the women have to balance between healthcare and their household needs.

Pa3.2: Globalisation and health inequalities in women farmers in Uganda

John Kanyamurwa, Makerere University, Uganda

Joe D. Bahenu, Rose Baryamutuma, Sarah Wamala, Rene Loewenson

This abstract is based on an ongoing research project on globalisation and women's health in sub saharan Africa, part of the three case studies in East Africa funded by SAREC and supported/co-ordinated by Karolinska/TARSC programme. Although globalisation measures were expected to restructure, revitalise agricultural production, increase farmers' incomes, ensure better food security and improved health outcomes, data from rural Uganda portrays gross health inequities for smallholder female headed households engaged in coffee and food production. The study aimed at examining whether there were differences in socio-economic control over the resources for food security between smallholder female-headed coffee and female-headed food producing households as well as the differences in women's personal and household food security, nutrition and health outcomes between these households. Cluster sampling technique was used to divide the sampled area in rural western Uganda into clusters targeting smallholder female headed households engaged in coffee and food production from which 381 subjects were randomly selected using snowball sampling. The final sample of respondents was randomly selected using simple random sampling from a list compiled by researchers. Data was cleaned, analysed using the Statistical Package for Social Scientists (SPSS). Frequencies were obtained and cross tabulations done to establish statistical relationships, with chi-square tests used to establish the levels of significance between and among variables.

Contrary to the expected benefits from globalisation, the study established that education level for both categories was still lower than the MDG targets,

majority of the respondents having only attained primary education. Equally so, better employment opportunities associated with the globalisation process and improved health were yet to be accessed as envisaged. However there were differences in personal and household incomes for coffee and food producers with those of coffee producers reportedly higher. Nonetheless, while coffee producers have higher incomes, better housing and better sanitation, and being more dependent on remittances, they have poorer reported food security, have significantly worse diets than food producers and less control over decisions regarding health.

It would seem that coffee producers have higher levels of income and assets but that this does not necessarily translate into better nutritional, dietary and health outcomes than the poorer group of food producers. With state withdrawal from providing social services and those of health in particular, the two respondent categories appear to have equally suffered dire health inequities but with food producers coming off worse despite the reported personal and household food security and nutrition.

Pa3.3: The effects of women's employment in export processing zones on household food security and dietary patterns in urban Tanzania

Peter Kamuzora, University of Dar Es Salaam/ Training and Research Support Centre, Tanzania

Rene Loewenson, Sarah Wamala

Reorganisation of production worldwide by Transnational Corporations coupled with liberalisation of national economies in developing countries has led to establishment of Export Processing Zone (EPZ) manufacturing activities in urban areas. EPZs are viewed as part of a strategy for national liberalisation programmes to open up and integrate their economies directly into the global economy. During the 1990s the Government of Tanzania adopted liberalisation policies leading to the creation of the EPZs in urban areas. This created new employment opportunities which attracted migrants to the urban areas, accelerating urbanisation. EPZs are reported to prefer to employ women because they have better manual dexterity and are more adaptable to monotonous operations.

This paper reports the findings of a study, which was conducted in two textile firms (EPZ and non-EPZ firms) to find out how employment of women in EPZ activities affects women's health and nutrition and the food security and dietary patterns of their households in the urban areas in Tanzania. The study was conducted in collaboration with Karolinska Institute and TARSC and funded by SIDA-SAREC. We used a questionnaire to collect responses from the randomly selected 190 women in the EPZ firm and 187 women from the non-

EPZ firm. The findings indicated that EPZ employment has several implications for women's health and nutrition. EPZ working conditions were unfavourable: the majority of workers were employed on contract basis, which does not legally bind the employer to provide basic benefits such as health care and other terminal benefits. Although EPZ workers relatively earned better wages, more than half of the workforce earned low incomes, and payment of wages was irregular. The majority of workers were not unionised, implying poor protection of their interests and rights. The one-shift structure in the working day in the EPZ firm gave workers less time than in the non-EPZ firm to either engage in informal activities to supplement their low incomes or to do domestic work, including taking care of household affairs. Welfare provision for workers was minimal in the EPZ firm, with no health care, food and child care facilities for workers. Although workers in both EPZ and non-EPZ firms perceived their work to be affecting their health and identified dust as the cardinal occupational hazard (causing chest tightness), neither firm organised any occupational health service for their workers. In both firms, respondents indicated cereals, dark green leafy vegetables and fruit to be their major diet. Foods high in protein, such as meat, eggs, fish and milk rarely featured in their meals.

We conclude that although EPZs have created new employment opportunities, EPZ production activities have wage, time and welfare features that are negative for women's health, more so than in non-EPZ firms. While the reported health outcomes, diets and health service access was equally poor in both EPZ and non-EPZ firms, the higher presence of these negative features in EPZ firms suggests that workers and their families are meeting the costs of concessions given to EPZ employers.

Pa4: Parallel Session: Social empowerment in health systems

Wednesday 23 September 2009 1530-1730

Majestic Hall

Convenors: Itai Rusike, Community Working Group on Health; Fortunate Machingura, TARSC

Pa4.1: Promoting maternal health using participatory approaches in Uganda

Aaron Muhinda, HEPS Uganda

Mutumba Abrahams, Joyce Mugarura

The participatory action research aimed to facilitate the community to identify and analyse barriers to use of maternal health services; work with the community to prioritise, identify and implement actions for overcoming one or more barriers to use of maternal services; promote cordial and mutually respectful relationships between health workers and expectant mothers in the sub-county. This project was implemented between May 2007 and November 2007 as part of multicounty programme in EQUINET exploring different dimensions of participatory approaches to people centred health systems in east and southern Africa. 40 participants drawn from community and health services in Kamwenge Sub County, Uganda were facilitated to, identify barriers to use of maternal health services, and to prioritise, act and follow up on one of the barriers identified. A community work plan was implemented to address the identified problems and the changes resulting from the programme on key areas assessed through a baseline and follow up questionnaire.

The PRA meetings identified a number of problems:

- Understaffing in health facilities with low morale and stress among health workers leading to rudeness with to clients.

- Poor roads and distant health facilities reducing access to services, compounded by poor appreciation of the need to deliver in health services, including in husbands and relatives.

- Poverty, social roles, relationships and knowledge gaps, with mothers burdened by multiple roles and male partners not giving expectant mothers the support expected.

Actions were planned to address identified priorities, to raise awareness in the community about the importance of expectant mothers to deliver in health facilities, to address the negative attitude of health workers; and to increase support from the male partners to expectant mothers, including community training and awareness campaigns on maternal health rights; suggestion boxes and dialogue at health facilities in and around the sub-county. The review found that awareness and willingness among people to support maternal health care in the district rose and relationships between the community and health workers had improved. Improved uptake of antenatal and maternal care services was also found in health centre statistics. PRA methodologies in programming of maternal health services is key to the improvement of maternal health situation in Uganda. PRA is an effective way to gather information, plan and act on challenges facing communities at grass root level. Many community members are keen to participate in health programmes, even on a volunteer basis. It is important to involve decision makers and community leaders in activities, as they have authority and their messages are taken seriously, so sustainability of the project is also ensured. Community workers need skills in managing expectations from community members to maintain community motivation to support and participate in the project. It's important to understand the social values and history of the target area, to avoid any negative history and values.

Pa4.2: Assessment of completeness and use of child health card in Itojo hospital, Ntungamo district, Uganda

Vincent Mubangizi, Kamwenge District Local Government, Uganda

Child health cards help health workers and caretakers follow up child health issues, inherently promoting child health. The factors affecting the completeness of the card in Itojo were not known. No study had seen done before on the completeness and use of child health cards in Ntungamo district, Uganda. The main objective of the study was to assess the completeness and use of child health card in Itojo hospital. This was a descriptive cross-sectional study. The study population was children 0-60 months and their caretakers. Using stratified sampling 390 children and their caretakers attending curative services and immunisation clinics were studied. Key informants were interviewed. Data was analysed using the Epi Info version 3.4.1. Only 40% of mothers had attended antenatal clinic four or more times during pregnancy.   About 82% of the children's immunisations status was up to date. Sixty percent of the children had a child health card. Only 10.3% of children attending curative services had a card while visiting the hospital. The section on dates when vitamin A and de-worming was given was the most incomplete part of the card. There was low use of card by health workers.

Most child health cards were either incomplete or incorrectly completed. There was low use of cards by children attending curative health services. Health workers were not utilising the information on cards, which makes early detection of deviation from normal impossible. This will make the cost of care expense and the poorest section of the community will be the most affected. The health system should strengthen the community participation, advocate and promote the use of card by the caretakers/mothers and health workers.

Pa4.3: Strengthening health facility management committees in Kenya

Angela Mutunga, Family Care International, Kenya

Samson Mulyanga, Kathleen McFarland, Ellen Brazier

In 2008, Family Care International (FCI), Kenya, in collaboration with the Ministry of Health (MoH), implemented a unique initiative in Yatta District in Kenya aimed at strengthening the role of community members in health service delivery management. The objective was to improve the quality of maternity care by enhancing community participation in and contributions to the management of facilities. FCI Kenya's initial work with health facility management committees (HFMC) was carried out with the MOH in Homabay District in 2006. Through previous work in Homabay and neighbouring Migori District, FCI Kenya found that, while these committees have been established to provide certain oversight and support functions, in practice, such committees receive little orientation or preparation for carrying out their designated roles and responsibilities. Based on lessons learned and tools developed through this initial work, FCI Kenya developed a Management Training Guide that focused on the specific roles and responsibilities of HFMCs as outlined in official MOH guidelines. The Training Guide is designed to sensitise committee members about key maternal health issues and equip them with the skills needed for fulfilling their management functions.

Using this Management Training Guide, 51 members from six committees were trained in 2008. At the start of the training, each committee worked together to complete a self-assessment exercise focused on various management areas. Throughout the training, each committee also developed an action plan outlining how they would work to better fulfil their overall roles and responsibilities. Follow-up visits were conducted in December 2008 to evaluate progress in implementing action plans, and to administer the self-assessment exercise again to gauge their current management status and identify areas where they have improved. All six committees made significant progress and key outcomes included: increased knowledge and role in management of health facilities, increased recognition of organisational mission and values, demonstrated initiative in reviewing service delivery data and demanding accountability of health facility resources, increased efforts towards resource mobilisation,

active engagement in sensitising communities about safe motherhood, and improved working relationship between the committees and staff. This initiative yielded important outcomes and results, particularly with regard to developing management assessment and training materials that are tailored to the roles and functions of HFMCs in Kenya. Evaluation results showed that the training and capacity-building activities did much to address community participation in managing health facilities.

Pa4.4: Consolidating partnership processes in Zambia

Clara Mbwili, Lusaka District Health Team, Zambia

Moses Lungu, Irene Kabuba, Idah Zulu Lishandu, Rene Loewenson

This paper presents work and outcomes from two study projects done within the capacity building programme on participatory research and action for people centred health systems in EQUINET. The 2006 initial work aimed at strengthening community and health centre partnership and accountability in planning, budgeting and implementation of health activities using Participatory Reflection and Action methodology in two Zambian districts, one urban, Lusaka and one rural, Chama. The follow up work done in Lusaka and extended to two new health centres, aimed at consolidating the participatory approaches and action research to further enhance the community voice in planning, budgeting and implementation processes. It also aimed to build the capacity of the 2006 group to facilitate scale up of participatory processes to other health centres and to learn how to institutionalise the approaches used. The target groups were health workers and community members involved in health activities at the selected health centres. For both projects, intervention studies were designed using an iterative spiral model of participation, reflection and action carried out by the target groups. Experiences, issues and areas for change were obtained through focus group discussions and use of participatory tools during combined workshops of health workers and communities, followed by an implementation phase of the activities planned during the workshop. Regular review meetings were held to reflect on activities and outputs achieved, followed by identified further necessary action. A pre- and post-intervention questionnaire was administered to participants to assess change.

The 2006 project showed that the participatory, reflection and action methodology is replicable in other Zambian health centres under district health management teams be they in rural or urban settings like Chama and Lusaka. The methodology can also improve communication and interaction between community members and health providers in attaining a people-centred health system in resource-limited settings such as Zambia. The follow up work

demonstrated that using participatory approaches can demystify and remove suspicions surrounding the district and health centre planning process, increase community involvement in planning and budget processes, strengthen dialogue and resolve issues in the interface between communities and health workers. Lessons from the action research study further suggested that participatory processes take time to have impact, and for processes to be institutionalised continuous mentoring and resource support is needed in the early stages, whilst integration within routine work and support by authorities with orientation of new health workers is essential for sustainability.

Pa4.5: The gap between policy and practice: Community Health Committees in Nelson Mandela Bay

Therese Boulle, Independent Researcher, South Africa

As part of South Africa's commitment to comprehensive primary health care, it has recognised that formal structures for community participation are an essential component of the health system. In terms of the operationalisation of this approach, Community Health Committees (CHCs) or Clinic Committees, outlined as statutory bodies in the National Health Act, 61 of 2003, serve to facilitate such participation. Given the policy framework, CHCs ought to be supported by the Department of Health to become effective structures for community participation. However, those that exist within the Nelson Mandela Bay Municipality (NMBM), within the Eastern Cape Province, South Africa are perceived by the Municipal Health Directorate not to be functioning effectively. This research aimed to investigate the factors related to the functioning of CHCs in NMBM. It intended to elicit information on factors which promote and inhibit effective CHC functioning. Focus groups and in-depth interviews were used to collect the data and the transcriptions were analysed so as to identify recurring themes and key suggestions made by respondents.

The findings indicated that CHCs are not functioning as per their original intention. The membership composition of the CHCs was found to be a major factor inhibiting effective functioning. CHCs appear mostly to be composed of health volunteers who are in receipt of a stipend, and serve as an extension of the services of the health facilities. There was little evidence of the membership composition including local government councillor and health facility staff participation as required by legislation. The study highlighted other inhibiting factors which could broadly be categorised as a lack of institutional arrangements, co-ordination and support for CHCs; an absence of operational guidelines; and a lack of resources for CHCs' effective functioning. The current context too was considered to limit effective functioning. In relation to the context, two conditions were identified to be of particular importance: the poor socio-economic conditions within

NMBM; and secondly a perceived change in the political terrain which is considered not to sufficiently encourage and support community volunteerism. These factors collectively contribute towards the regularly reported perception of CHC members that they are not being afforded recognition for the contribution they make. Recommendations were made which it was hoped would assist the Eastern Cape Department of Health to provide future support for CHCs, both in the NMBM and in other parts of the Eastern Cape Province.

Pa4.6: Community health committees as a vehicle for participation in advancing the right to health in South Africa

Gabriela Glattstein-Young, University of Cape Town, South Africa

Leslie London

Since the Alma Alta declaration on Primary Health Care (PHC) which advocated the right and duty of people to plan and implement their own health care, several governments have taken legislative and executive measures to include community participation in the delivery of health services. Case studies, observations and empirical evidence suggest that community participation can assist the progressive realisation of the right to health; nevertheless, many authors agree that community participation as envisioned by Alma Ata is largely absent from health systems. In South Africa, primary health care presented the guiding principles for health system transformation focusing on the vast health inequities inherited from apartheid. Formal structures for participation in health took the shape of community health committees (CHCs) which were anticipated, in part, to address health inequities of the past through partnerships with health facilities for greater community involvement in health promotion and to ensure that community health needs are met. However, South African studies have highlighted the fact that many CHCs are functioning poorly or ineffectively, if at all (Boulle et al., 2008; NMMU, 2006). Furthermore, preliminary data collected as part of a larger project on the right to health, indicated that numerous health committee members felt that their inputs were neither valued nor considered in the planning and provision of health services to underscore a serious deficit of community representation.

The present study employs a mixed methods research design in order to explore the relationship between participation and the right to health within the context of CHCs in the Western Cape and to identify best practice for participation in health through CHCs. Rifkin et al's pentagonal model for community participation (1988) has been applied as a semi-quantitative measure with members of CHCs and health providers. Qualitative research methods were subsequently employed to investigate outcomes from the pentagonal model in greater depth. This study provides in-depth case

studies illustrating the nature of the relationship between CHCs and their corresponding health facilities in three different communities and the factors influencing these relationships (with particular focus on the use and understanding of human rights). The selected cases are used to highlight barriers impeding effective community participation, provide insights into mechanisms to overcome these barriers and assist to clarify the relationship between participation and the right to health. By way of a human rights approach, the findings from this study have the potential to serve as a basis for dialogue between CHCs and the Department of Health in supporting arguments for the right to participation as a critical component for communities to realise their right to health. In doing so, human rights approaches can help to build people-oriented health systems responsive to the needs of the most vulnerable in society.

P3: Plenary: Fairly resourcing health systems

Thursday 24 September 2009 0900-1030

Victoria Ballroom

P3.1: Reclaiming financial resources for public sector health services

Di McIntyre, Health Economics Unit, University of Cape Town, South Africa

Lucy Gilson

This paper will provide an overview of key findings of recent research undertaken as part of the EQUINET Fair Financing theme and will also look forward to future research on key health care financing issues facing ESA countries. These research issues will be integrated within a core focus on how to improve financial resourcing for public sector health services in pursuit of health system equity.

The paper highlights the following issues:

- the progress in fee removal in a growing number of ESA countries and the critical importance of increasing public funding of health services and other policy interventions to support the implementation of fee removal;
- the limited progress in pursuing the Abuja target in many ESA countries, the associated difficulties Ministries of Health have in motivating for an increasing share of existing government funds which may adversely affect other social sectors (i.e. to argue for an increasing percentage share of the budget), the possible need for other targets which focus on urging governments to devote an increasing share of total economic resources to public funding of health services and the need for adopting effective policy processes in engagements between Ministries of Health and Finance;
- the growing interest in introducing or expanding health insurance, the equity problems associated with the current emphasis on private voluntary health insurance (whether commercial or community-based) in terms of fragmenting health funding pools and reducing the potential for cross-subsidies in the overall health system and the potential for mandatory health insurance strategies, if appropriately

designed, to contribute to improved domestic funding of public sector services;
- the need to ensure that global health initiatives do not detract from or undermine the domestic funding of public health services; and
- the challenges associated with increasing commercialisation of health services in drawing limited resources available for health care into services that only serve the needs of a minority of the population.

P3.2: Retaining health workers in east and southern African health systems: Lessons from a regional programme

Scholastika Iipinge, School of Nursing, University of Namibia, Namibia

Yoswa M Dambisya, Helen Lugina, Rene Loewenson

In Sub Saharan Africa there is a gap of 4.5 million health workers to meet the minimum WHO standards of health worker density. This compromises health service contribution to health equity. Many countries in east and southern Africa lack policies that demonstrate the value given to health workers and retention strategies for health workers; and lack information and evidence on the impact of any incentives applied. Ministers in east and southern Africa (ESA) have made policy commitments to value and retain health workers at regional level and EQUINET in co-operation with ECSA-HC have implemented a programme to explore the experiences of implementing incentives for retention of health workers in ESA.

This work explored demands for and experiences in applying non-financial incentives for health worker retention in ESA countries, and identify policy options arising. It is based on a synthesis of findings from five country studies using secondary data and cross section surveys, cross country analysis, national review and a follow up regional review meeting of the results.

The driving forces for health workers movement across the five countries include poor working conditions, heavy workloads; lack of supportive supervision, lack/insufficient recognition, low salaries and or low remuneration packages fail to attract and retain staff. While a range of non-financial incentives are provided across countries, those valued by workers across most countries include: career paths; stimulating training and encouraging deployment through investment in services (including "centers of excellence"); providing housing mortgages / loans; rewarding performance and securing health worker health and access to health care. Delegates to a regional review meeting proposed that these be considered as core retention strategies, applied across all countries, even while further locally relevant strategies are considered. A number of factors enhance or impeded the effectiveness of incentives, and will be presented. Many countries have now developed policies for health worker retention but implementation was found to be variable and the studies identified shortfalls in moving from policy to practice. This includes sustainable financing for retention incentives, and the management and information systems and capacities to plan and implement them. The regional review meeting suggested that capacities and systems need to be strengthened for governance and performance management of incentives, backed by guidelines for planning, financing, implementation, monitoring and evaluation of incentives. Documentation of best practices would support this but is still weak in all the countries, especially with regard to monitoring and evaluation of the non-financial impacts.

Non financial incentives can have positive impacts on retention of health workers. Retention packages should preferably be sector wide, based on needs assessment and inter-sectoral and stakeholder input; be costed and supported by a monitoring system and an institutional capacity to manage incentives. For sustainability, governments must increase budgets for health to meet the Abuja commitment of 15% government spending on health, and encourage donors to pool funds into sector wide incentive schemes. Designing incentives depends on country specific contexts, although some common features will prevail. This places high demand on the strategic health worker management capacities and information systems in ESA countries.

P3.3: Equity in access and treatment outcomes in resources AIDS treatment in Malawi: Lessons learned

Ireen Makwiza, REACH Trust, Malawi

Erik Schouten, Bertha Simwaka, John Arberle-Grasse, Talumba Chilipaine-Banda

In Malawi, HIV prevalence among adults (15-49 years) is estimated at 14 percent. Though the number of people accessing ART is rapidly expanding, the goal of ART provision is to reach only 50% of the population becoming eligible every year. The Ministry of Health recognise the importance of equity in the national ART scale up as highlighted in the World Health Organisation's Alma Ata declaration. Equity is defined as comprising elements of an assessment of vulnerability, in terms of HIV infection and access to care and treatment or ability to cope with the impact of the illness. Equity monitoring is crucial in ensuring that the disadvantaged and vulnerable populations are accessing treatment. EQUINET/WHO/REACH Trust have identified monitoring equity in access and health systems issues as an informative and integral part of ART programme expansion and initiated a programme of work in southern Africa. The key dimensions identified for monitoring included areas of equity, justice and accountability and ensuring that provision of ART strengthens health systems for efficient and sustainable provision of ART and other health services. The study aimed at conducting an equity assessment to analyse who is accessing treatment by age and gender, to compare if ART access is in line with HIV prevalence trends and to assess the effect of gender and age on the patient's treatment outcomes in Malawi. Data analysis used existing routine ART registers and focus was on all ART patients who initiated treatment in 2006 in the 5 districts of Malawi. Data was collected on the following variables; age, gender, area of location and also patient's treatment outcomes.

Results show that 10800 patients were enrolled on treatment in the 5 districts studied in 2006. Treatment access compared with HIV prevalence by gender shows proportionately more females accessing treatment than males. A comparative analysis of the age-sex distribution with HIV prevalence showed proportionately more young men than women in the age group of 15-19 years on treatment, although HIV prevalence in the 15-19 age group is higher in women than men. In the 30-39 year age group there were more women on

treatment than men, yet HIV prevalence in this age group is higher in men as compared to women. Disparities in treatment outcomes by gender and age shows that significantly more men on ART are at risk of dying compared to women (P=0.003),and that men are 1.15 times more likely to default on treatment as compared with women (P = 0.078).

In general, there are gender and age differentials in access to treatment: men are accessing treatment less compared to women and age specific differences in access to ART that do not match prevalence occur amongst the 15-19 age group for women and 30-39 age group for men. In order to increase equity in treatment scale up, it is imperative to target women in

the 15-19 age group and men in the 30-39 age group for counselling and testing. Furthermore, the treatment outcomes by gender suggests that there is need to understand the health seeking behaviour patterns amongst men in order to establish the confounding factors for the higher death rate and default rate in men as compared to women. The study highlights the importance of equity monitoring in identifying the extent to which services are accessible and meet needs of different population groups. Programme managers and policy-makers need to actively identify equity challenges in ART scale up programmes and creatively develop solutions to promote equitable access.

Pa5: Parallel Session: Fairly resourcing health systems

Thursday 24 September 2009 1100-1300

Victoria Ballroom

Convenors: Di McIntyre, Lucy Gilson, UCT South Africa

Pa5.1: Assessment of health care financing in Uganda: Equity issues

Charlotte Zikusooka, HealthNet Consultants, Uganda

Patrick Tutembe, Mark Tumwine

In Uganda, the attainment of equity in health financing is one of the desired objectives of the Health Sector Strategic Plan II. This paper documents the key equity-related issues associated with Uganda's current health care financing mechanisms. Information for this paper is based on extensive review of existing literature and government documents. In addition, we obtained information through key informant interviews. Lastly, we rely on our extensive knowledge and experience obtained previously on health financing-related research we have conducted (including: public expenditure reviews, review of the proposed national health insurance, etc). Uganda's health sector remains significantly under-funded, relying heavily on private sources of financing, especially out-of-pocket spending.

Public spending on health (i.e. government and donor funding) is far below the Abuja target of 15% of total government expenditure. There is a heavy reliance on external funds. Contributions through tax funding are progressive, and hence equitable, but they are relatively small. Without social health insurance and with very limited private health insurance, Uganda has very limited pooled resources, hence minimal cross subsidisation.

Social health insurance has been designed and debated for a long period of time, but is not yet implemented, mainly due to resistance from stakeholders, but also because the structures and experience required for its implementation are not yet in place. The manner in which SHI is implemented has the potential for creating a two-tier system in access to services, which may have negative equity implications especially for the poor and the unemployed. Overall, the key equity issues for Uganda's health financing are: (1) very limited pre-paid mechanisms, (2) regressive financing mechanisms (especially out-of-pocket spending) and thus limited financial protection, (3) limited cross subsidisations and (4) fragmentation within and between financing mechanisms.

Pa5.2: Towards universal access: From targeted exemptions to user from removal in Zambia

Felix Masiye, Economics Department, University of Zambia, Zambia

Bona M Chitah

Zambia as with most developing countries was beset with the enigma of additional resource mobilisation for health care financing arising out of the worsening economic conditions of the 1980s. Following the structural adjustment reforms that targted reduced social sector expenditures among other aspetcts, user feees were introduced in the Zambian health system in the very early 90s. Furthermore some Community Based Financing 'Initiatives' were also introduced. However, following a critical assessment of the poverty context and the assoication of poverty and health, the Government, did during the early part of 2006 abolish user fees in public insitutions in all rural facilities. The removal act was intended to be scaled up to effect the urban areas as well as higher levels of the health system i.e.the hospital sub-sector.

Prospective data following the abolishing of fees was collected from a sample of 22 districts over a 12 motnh period between 2006 and 2007. Historial data was collected for the two years preceding the elimination of user fees. The data was collected from all facilities that included the district hospitals and health centres. Qualitative data was collected through FGDs in two of the districts. These included the community members as well as health workers. Data analysis was done using SPSS, STATA and Excel spreadsheets. Key variables included in the data collection were: Utilisation or facility visits, Drugs/medicines, human resource contact time, quality perceptions. Demonstrable effects were strongly evident in the following: Increased utilisation of about 55%. Increased staff – patient contact time, high level of drug stock – outs and more frequent opening of 'drug – kits in the health facilities. Perceptions were rather mixed with communities being content with the measures, although slightly negative about the frequency of drug stock-outs. The health workers were negative with respect to the addded work load and the associated moral hazard.

Government provided additional resource support to 'compensate' districts with the assistance of DFID for revenue loss in order to avoid disruptions to quality of care.

Pa5.3: Introducing direct funding for rural health facilities

Anthony Opwora, KEMRI/Wellcome Trust Programme, Kenya

Catherine Goodman, Margaret Kabare, Sassy Molyneux

Following evidence that user fees present a barrier to accessing health services, especially for poor and vulnerable people, there has been increasing pressure for their reduction or abolition. In 2004, Kenya reduced fees substantially and widened exemption criteria. However, there have been concerns that these lower fees limit the money available to health facilities for daily expenditures. Moreover, many facilities failed to implement the new policy as they felt the fee revenues were essential, meaning that the expected equity benefits of fee reduction were not achieved. In response, an innovative system of direct facility funding (DFF) was piloted in Coast Province starting in 2005. Funds are transferred directly into the facility's bank account, and managed by the Health Facility Committee (HFC). The pilot was funded by DANIDA. Nationwide scale up is now planned with a mix of government and donor resources. We evaluated DFF implementation in two pilot districts in 2007-8. Quantitative data collection at 30 randomly selected public health centres and dispensaries included a structured interview with the in-charge, record reviews, and exit interviews with ten patients per facility. In-depth interviews were also conducted with the in-charge, and other members of the HFC at twelve purposively selected facilities, and with district staff and other stakeholders. As baseline data were not available, we focused quantitative measures on process outcomes, and used qualitative methods to explore perceived impact on utilisation and quality of care.

Overall, DFF procedures were well established: HFCs met regularly, workplans were produced, money was accessed, and accounting procedures were broadly followed. DFF made an important contribution to facility income, accounting for 47% in health centres and 62% in dispensaries, although it only represented a small fraction of the total running costs of these facilities (2% and 13% respectively). DFF was perceived to have a highly positive impact through funding support staff; outreach activities for immunisation and antenatal care; building renovations; patient referrals; and increasing the activity of HFCs. Together these factors were perceived by health managers and facility staff to have improved health worker motivation and quality of care. A safer and more attractive working environment, and expanded outreach activities, were felt to have increased utilisation significantly. A number of problems were identified. Despite the increased funds, overcharging of user fees remained common, and understanding of DFF among the broader community was very limited. HFC training was reportedly inadequate, and no DFF documentation was available at facility level, leading to confusion. Finally, relationships between HFCs and health workers were sometimes characterized by mistrust and

resentment. Direct funding offers an opportunity to compensate health facilities for loss of user fee revenue where these are removed or reduced. However, to reap these benefits fully, the user fee policy must be clear and displayed at all health facilities, adherence to the policy should be made a key part of DFF training, and continued receipt of DFF money should be conditional on user fees adherence. Successful nationwide scale-up will also require improved training and documentation, and greater emphasis on community engagement.

Pa5.4: Privatisation of health care in east and southern Africa

Greg Ruiters, Institute of Social and Economic Research, Rhodes University, South Africa

Proponents of private for-profit sector expansion in health care have argued that the private sector is cost effective, provides quality care, is able to complement government in expanding coverage and relieves pressure on public funding. The private sector has, however, had a mixed record in health systems in the region, with reports of poor quality care, limited reach beyond higher-income groups, barriers to access due to user charges and fragmentation of risk pools. Despite these problems there is evidence that the privatisation of health care services is expanding and new pressures for liberalised trade in health care services are being exercised through global and bilateral trade agreements.

This paper raises questions about the form and intensity of private capital flows in the health sector in ESA and how these are affecting the state's ability to ensure equitable health care. The paper is based on a review of data and secondary literature and the ongoing research work of a research project, entitled 'Capital Flows in Health in Eastern and Southern Africa'.

The paper considers present and past private capital flows to the health sector. It identifies key entry points for capital, identifies the key arguments used to justify privatisation, and provides a mapping of impacts of these flows on health systems and access to health care. The paper argues that the extent of the private sector is grossly exaggerated, yet state policies and international donor agencies remain geared to the chimera of private sector-led solutions.

Pa5.5: Capital flows in the South African health sector (1995-2007): Implications for equitable access to health care

Yoswa M Dambisya, Department of Pharmacy, University of Limpopo, South Africa

Sehlapelo Irene Modipa

Since 1994 South Africa has undergone many reforms towards increasing access of health care for previously

disadvantaged groups. This paper sought to describe and assess the way in which public and private capital flows have affected access to health services in South Africa between 1995 and 2007. We carried out a literature review on capital flows in the health sector, gathering secondary data on the capital flows, and their effects on access to health services in South Africa between 1995 and 2007. We explored the composition of the health system, sources of financing, financial intermediaries, access to and utilisation of health services, and policy and legislative reforms with impact on health service delivery.

The South African health system is made up of a public sector which caters for the majority (>80%) of the population, and a private sector that pools together more than 55% of funds for health but regularly caters for less than 20% of the population. Public sector funding is from general taxation, with provincial departments of health as financial intermediaries, while the private sector funds are largely from government departments, private companies and individuals through medical aid schemes. Further, a significant proportion of the population incur out-of-pocket health costs, and for many this is catastrophic expenditure. There has been an increase in health expenditure in both sectors. For instance, public health sector expenditure rose from R32.9 billion in 1998/99 to R38.9 billion in 2005/06; and per capita public sector expenditure on health rose from R670 in 1998 to R1232 in 2006; the respective private sector per capita figures were R3099 and R6767. Increased public sector expenditure has resulted in more facilities constructed, and upgrading or expansion of existing ones, and there has been a net increase in utilisation of public sector health services in 2006. Public sector services have become more accessible and affordable, with fewer people in need of health care finding the cost of health care prohibitive, but geographical accessibility remains a barrier. Racial inequalities in access to health services persist, with Whites and Indians more likely to have medical aid cover and utilise private health services than Africans and Coloureds, fewer of whom are covered by medical aid and therefore utilise mainly public health services. The population with medical aid cover, and presumed to have reliable access to private health care, however, remained virtually unchanged between 1995 and 2007. There was increased funding for health between 1995 and 2007, with increased access to public health care, but there remains inequitable access to private health services in South Africa.

Pa5.6: Expired medicines and their disposal: An ignored healthcare cost

Freddy Kituku, College of Health Sciences, Makerere University, Uganda

Norbert Anyama, Paul Kutyabami, Richard O Adome, Robert B D Otto, Ashraf K Buwembo

Joint Medical Stores (JMS), a joint venture of Uganda Catholic and Protestant Medical Bureaux (UCPMB) has

promoted universal health care by improving supply of medicines and medical supplies to church based health units and by providing pharmaceutical training for their health workers. However, anecdotal evidence suggests that expiry of medicines in Uganda is frequent and creates another cost to their storage and disposal. We studied the extent to which medicines expiry and disposal is a problem in hospitals accredited to the UCPMB.

This was a cross-sectional, descriptive, hospital-based study. Pre-tested self administered questionnaires were sent to a universal sample of 42 hospitals accredited to UCPMB. Based on the distribution of facilities that responded to this questionnaire, six hospitals were selected by maximum variation sampling and visited by the survey team to undertake key informant interviews and make observations of the pharmacy, medicines store and of related procedures for handling of medicines. An equity analyses was done to compare centrally located hospitals (<100km from Kampala city) and hospitals on the countryside. Twenty nine out of 42 hospitals accredited to UCPMB participated in study. Up to 22 hospitals had medicines expiring in previous six months, 15 of these located in the countryside. Using six tracer medicines, this study found that health units frequently experience drug expiries in their stores. More rural hospitals had expired tracer medicines than those nearer Kampala city. However, the estimated average cost of expired medicines was higher among the centrally located hospitals than those on the countryside. These expiries were attributed to poor handling of donated medicines, poor record keeping, unreliable (lack of) forecasting, unpredictable prescribing practices, shortage of staff trained in pharmaceutical issues, all resulting from poor medicines stores management and push system of drug supply. Fewer personnel in rural hospital pharmacies were trained in pharmaceutical issues compared to those centrally located hospitals, and rural hospitals had lower numbers personnel in pharmacy compared to the centrally located hospitals. Rural (countryside) hospitals also lower shares of nurses having undergone in-service training; and having guidelines on handling donated medicines than central hospitals, and lower rates of disposal of expired medicines in the last 2 years. Disposal methods included incineration at the unit, use of the sewer, burying the expired medicine in pit dug in the ground, burning the medicines in open area inaccessible to public or non disposal at all. Hospitals in the countryside had poorer records of expiries and the means to manage drugs than centrally located hospitals. Hospital staff involved in drug management cycle should undergo periodic re-tooling in pharmaceutical courses tailored for their understanding and immediate tasks.

Pa6: Parallel Session:
Equity in health services responses to AIDS

Thursday 24 September 2009 1100-1300

Regal Hall

Convenor: Ireen Namakhoma, REACH Trust, Malawi

Pa6.1: Coupling nation-wide approaches and women-specific responses to sexual reproductive health rights in the time of HIV/AIDS: A gender analysis

Buyana Kareem, Cavendish University, Uganda

Although governments across Sub-Saharan Africa have made considerable efforts to refurbish the performance of sexual reproductive health services, through policy approaches that strengthen essential ante-natal and obstetric care, revitalise family planning, promote the reproductive health rights of adolescent girls, and violence against women; there still inadequate understanding on the progress made by government health agencies in matching the peculiar needs and rights of HIV positive pregnant women with the accessible sexual reproductive health services. This paper is a preliminary attempt to respond to this knowledge gap by presenting findings from a qualitative study on access to care, treatment and sexual reproductive health rights and needs of HIV positive pregnant women in Kampala, Uganda's capital and largest city. The study revealed that knowledge about sexual reproductive health rights (SRHR) for HIV positive pregnant women is still moderate; and health workers are yet to receive any specialised training in care and treatment of HIV positive pregnant women. Similarly, knowledge about access to care and treatment for HIV positive pregnant women in urban areas is partial. Additionally, although there is evidence of government commitment to protection and promotion of HIV positive pregnant women's SRHR, the image at the local level is contradictory. For these reasons, the paper concludes with suggestions on how to ensure that the available sexual reproductive health services are matched with the peculiar needs and rights of HIV positive pregnant women.

Pa6.2: PMTCT in policy context: policy analysis, lessons and strategies for addressing gaps

Judith Daire, University of Cape Town, South Africa

The progress of improving maternal and child health is not making progress as it should despite existing Maternal and Child Health (MCH) policies and programmes since independence in Malawi. Maternal and child mortality rates still remain high to this date. One of the contributing factors is HIV/AIDS which is both direct and indirect cause of mortality and morbidity. This abstract is part of a study for a PhD thesis on Malawi's maternal and child health policies: analysis, lessons and strategies for addressing gaps. The aim of the study was to analyse HIV/AIDS policies in Malawi, in order to identify lessons, gaps and strategies for addressing gaps in PMTC programme.

The study employed a qualitative approach and triangulated evaluation, case study and ground theory research designs. Data was collected through official document review, questionnaires and key informant interviews. Data from each data source was analysed separately through content analysis. Findings from each data collection method were triangulated to validate the results and field visits were also conducted to observe MCH services in health facilities. PMTCT services are heavily dependent on international donors who provide both financial and technical assistance in Malawi and there are no mechanisms yet for mobilising resources locally to sustain expanding PMTCT programmes. PMTCT programmes are implemented using the existing staff, infrastructure and equipment. There are problems of persistent inadequate human resources; medical supplies and drugs; and inadequate and poor infrastructure that are constraining achievement of health outcomes in the health system as a whole. The same problems affecting the health system in Malawi also affect PMTCT services in terms of availability, accessibility and quality of PMTC services.   On the other hand HIV policies are formulated by government official through various technical working groups. This has made the policy development process to be dominated by to-down approach which does not include implementers. Further to that, HIV/AIDS national policies are not translated to operational policies at implementation level i.e. district hospitals, which makes managers and staff not to be committed. Furthermore, district level management is not evidence based/result

based i.e. district level managers do not use local data from HMIS for planning, monitoring and evaluation.

Technical and financial support from development partners have facilitated the progress in PMTCT Programmes. In addition to continued international funding, Malawi needs to establish mechanisms for sustaining the expanding response to PMTCT. In addition, strengthening the health system capacity as a whole by addressing problems of inadequate human resources; inadequate medical supplies and equipment; and inadequate and poor infrastructure will also improve PMTC services. Further to that, MOH should emphasize translation of national policies to operational policies and result/evidence based management at district level to promote ownership and commitment to services. Additionally, there is need for an established system for implementers to inform national policies. Finally, improving accessibility and quality of health and MCH services in general both at policy development and implementation level will also improve PMTCT services.

Pa6.3: Can healers help increase ART coverage in Uganda

Janis Huntington, University of Alberta, Canada

Walter Kipp, Rubaale Tom, Banura Lillian

In Uganda, despite increasing access to HAART, treatment reaches only 40% of those who need it. This gap between HAART coverage and the number requiring treatment is unequal between urban and rural, largely due to a shortage of available health human resources in villages. In order to meet the goal of equitable access to HAART, it will be necessary to engage non-conventional health workers like traditional healers (THs). They are present in most communities, have been shown to successfully aide in other aspects of HIV care, and have been utilised to provide treatment for other diseases. The purpose of this study is to assess the feasibility of including THs in HAART programs in western Uganda by identifying factors which predict willingness and capacity to participate and collaborate with the formal health sector.

Data was collected in two districts in 2008. THs, recruited using a list of THs registered in a healers association with subsequent snowball sampling, were randomly chosen to either participate in one of four group discussions, or complete questionnaires (219 completed). Two group discussions with patients were also held, and participants were selected from pre-existing post-test counseling groups. In-depth interviews with six health care workers (HCW) were held. Sixty-five percent of THs in the study were female, 44% were identified as solely herbalists, 38% were over the age of 60, and 43% had not completed at least primary education. Survey responses were used to create index scores to quantify each TH's knowledge/attitude towards HIV/AIDS, previous collaboration with formal health care, and willingness to collaborate to provide HAART. 67% had a high knowledge score,

49% had a high positive attitude score, 21% had a high previous collaboration score, and 79% had a high willingness to collaborate score. Age, type of healer, and education level were significant factors in the odds of having high scores. Qualitative data was used to identify barriers to collaboration and potential avenues for THs to be involved in HAART. All parties agreed extensive training would be necessary. HCWs and THs both expressed desire to work together, despite factors currently inhibiting this process. THs were thought to be important for rural sensitization programs, and there could be potential for them to work successfully with HAART programs to monitor treatment. THs are an important human resource in western Uganda, and there is great potential to involve them in increasing the coverage of HAART.

Pa6.4: Barriers to Antiretroviral therapy in Malawi: An assessment of socio-economic inequalities

Talumba Chilipaine-Banda, presented by Hastings Banda Research for Equity and Community Health Trust, Malawi

Eyob Zere, Erik Schouten, Bertha Simwaka, Ireen Namakhoma

Despite access to health services being free at the point of service delivery, evidence suggest that the poor in Malawi wait longer, receive fewer drugs and pay more in comparison with the non-poor. These conditions are worse for people living in rural and geographically remote areas. For a country heavily affected by HIV/AIDS, the situation would be worse for patients on Antiretroviral Therapy (ART) whereby costs, long distances and long waiting times are highlighted as some of the barriers to treatment adherence. This study interviewed ART patients using a structured questionnaire. Data was collected in two districts in Malawi namely, Lilongwe and Rumphi. A total of 947 ART patients were interviewed in almost all public sites providing ART in these two districts. Information was collected on patient's demographic and household characteristics as well as asset ownership. The Principal Component Analysis (PCA) was used to obtain asset indices and wealth quintiles among patients on ART. The analysis was done using STATA SE 10.1.

Based on the wealth quintiles, there were wide differences in barriers to access between the two extreme wealth quintiles- the poorest 20% and the richest 20%. The poorest 20% travel a longer distance to get to a health facility as compared to the richest 20%. Furthermore, the poorest 20% incur higher transport costs and on average take longer time travelling to the facility as compared to the richest 20%. The poorest 20% from rural areas travel long distances, incur higher transport costs and take longer to get to the facility as compared to the poorest 20% in urban areas. The results indicate that the current ARV treatment is inequitable. It is therefore imperative that the government should devise new treatment mechanisms

that would enable the poor and other vulnerable groups access treatment at minimal cost. The government would, for example, need to increase the number of clinics that operate in rural areas or use mobile clinics.

Pa6.5: Equity and access to HIV/AIDS treatment in a post-conflict situation and free ART in Côte d'Ivoire

Tenguel Sosthène N'guessan, Swiss Center of Scientific Research, University of Cocody, Côte d'Ivoire

Cléopâtre Kablan, F. Séri Dedy, Brama Kone, Guéladio Cisse, Marcel Tanner

The capacity of care and support structures to ensure equitable access to care and treatment for people living with HIV/AIDS (PLWHA) was analysed in a context of free antiretroviral (ART) treatment in Bouake (a city in Côte d'Ivoire) during a post-conflict period. The data collection combined quantitative and qualitative approaches. We conducted 133 structured interviews with patients, six focus groups discussion with male and female groups of patients and sixteen in depth interviews with patients, health personnel and NGOs' leaders from November to December 2008. For structured interviews, we interviewed men and women randomly on the study site, after obtaining their informed consent. For the focus group discussion agreement was obtained from NGO leaders and members were informed on the principles of people anonymity and data privacy. The results show that 80% of people going to care and support centres have people low incomes. Despite the fact that ART was free, few patients succeeded in covering the costs of treating opportunistic infections. Sixty per cent (60%) of PLWHA often walk 15 km to reach care centres for their treatment. This is because care and support centres are located far in urban areas. In addition there is a lack of technical assessment for therapeutic treatment. Faced with this, mechanisms to reduce inequalities in access to care and treatment are developed by managers and technical staff of centres. This consists of establishing a partnership between the care centre and a private pharmacy which supplying medicine. Centres also provide PLWHA with financial support to implement income-generating activities. Ninety per cent (90%) of PLWHA do not know what equity means because of lack of information and their level of education. For health staff, equity refers to justice and ethics in patient care and treatment. The study finally shows that in a post-conflict situation, the lack of means and governmental institutional support restricts patients' access to care and treatment. This study shows that inequalities of access are linked to lack of care and poor distribution of existing centres. In addition, patients lack financial means to cope with other infections and the government commitment is weak. In such context, support for PLWHA requires coordinating actions among the public care sector and community actors.

Pa6.6: The AIDS response and health systems: From success to health care for all

Richard Hasunira, HEPS Uganda

Prima Kazoora, Aaron Muhinda, Rosette Mutambi, Beatrice Were

This abstract presents evidence on the impact of the scale-up of HIV/AIDS services on broader health systems in Uganda. The study aimed to find out how the response to HIV/AIDS affected different aspects of health care; the lessons learned from scale-up of HIV/AIDS services; and identify priorities for improving prevention of parent-to-child transmission (PMTCT) services. We interviewed key informants from Uganda AIDS Commission, Health Sector Development Partners Group, the Ministry of Health, Joint Clinical Research Centre, Pallisa AIDS Project, The AIDS Support Organisation (TASO), and Family Health International (FHI). Other respondents included three health care consumers and two PHA groups (Uganda Young Positives, and Together Against AIDS Positives Association). The research team also reviewed Uganda's Second Health Sector Strategic Plan (HSSPII), the PMTCT policy and internet resources, and proceedings of meetings convened by civil society organisations and the Health Policy Advisory Committee.

We found that HIV/AIDS claims the biggest share of health financing of any single disease in Uganda. The increased inflow of funds from foreign donors for HIV/AIDS has resulted in broader improvements to public health, but significant additional funding is needed to meet health care needs. HIV/AIDS programmes have improved community mobilisation, e.g. TB and village health teams and there are limited successful examples of integrating HIV/AIDS care into primary health care services. The epidemic has placed increased workload and strain on medical personnel – whose numbers have not increased proportionally to the demand – and on infrastructure. Personnel working in HIV/AIDS are better paid, and their facilities better equipped, a situation that has led to further attrition in other health services. An increase in funding has not led to the efficient delivery of services and commodities. There continue to be many reports of late deliveries, wrong deliveries, and stock-outs. The availability of huge amounts of money, without adequate resources to strengthen accountability and good governance, has fueled leakage of funds and corruption and the demand for treatment continues to outstrip supply because infection rates have stopped falling and reports indicate they may have started rising again. Investments in HIV services have paid off. The impact of HIV/AIDS service scale-up has been visible and dramatic. Yet there remains considerable unmet need for HIV treatment and prevention services and additional resources are required. More resources are also needed to build broader health systems, and this cannot be met by a simple reshuffling of health resources toward more generalised health functions at the expense of effective disease-specific programmes

Pa6.7: Challenges to accessing HIV and AIDS prevention, treatment, care and support services amongst health care workers in Malawi

Lot Nyirenda, REACH Trust, Malawi

Grace Bongololo, Sam Phiri, Mindy Hochgesang, Ann Phoya: Ministry of Health, Sally Theobald, Ireen Makwiza

This paper explores HCWs knowledge, attitudes and perceptions about HIV counselling and Testing (HTC), Antiretroviral therapy (ART) and post exposure prophylaxis (PEP); determines the extent of access and utilisation of HTC, ART and PEP and the factors leading to utilisation or underutilisation and the availability of care and support services for health care workers and factors for utilisation or underutilisation We used both qualitative and quantitative methods to collect data. In depth interviews were conducted with 45 HCWs in two districts which were purposively sampled. These districts comprised both rural and urban settings. A survey informed by the qualitative findings was administered to 906 HCWs in 8 districts using random sampling (SRS) after stratifying by region and urban or rural set up. We purposively selected one district where we collected both qualitative and quantitative data to allow for a deeper analysis.

Most respondents had better knowledge about ART than about PEP. Most health workers (HCWs) (97 %) felt they were at risk of occupational exposure to HIV. Forty percent of HCWs reported experiencing an occupational injury twelve months preceding the study. Most injuries were due to needle sticks. Most respondents observed that HIV occupational brings anxiety, stress and is like a death sentence. Challenges to accessing PEP included unavailability of PEP, lack of knowledge of PEP and fear of going for an HIV test. Qualitative data showed that some HCWs tended to neglect universal precautions when handling clients deemed HIV free. Heavy work load and unavailability of protective materials prevented most HCWs from practicing universal precautions. Due to fear of occupational exposure to HIV, health workers reported that they feared offering care to people living with HIV and AIDS. Although qualitative showed few HCWs had ever gone for counseling and testing, quantitative data showed 76% had accessed HTC. Motivating factors for testing included: just to know status, occupational exposure and for marriage purposes. Most respondents felt it was more difficult for a HCW to access HTC than it was for other people. Amongst the HCWs who had not had an HIV test, "not being ready for a test" and "fear of stigma after an HIV positive test" were the major reasons for not accessing HTC. Forty one HCWs voluntarily disclosed their HIV positive status where 30 (73%) were on ART while 11 (27%) had not started ART- they were not eligible. Lack of confidentiality was the major challenge to ART services. From the qualitative research challenges faced by HCWs in accessing ART included: unavailability of special ART services for HCWs, fear of stigma and lack of nutritional support. HCWs face a number of challenges to access HIV prevention, treatment, and support services even where services are provided at their place of work. There is an urgent need to recognise these challenges and promote appropriate interventions for promoting access to such services.

Pa6.8: Strengthening the capacity of community health workers amidst a health worker crisis in Malawi: Case of community home based care providers

Lot Nyirenda, REACH Trust, Malawi

Grace Bongololo, Sam Phiri, Mindy Hochgesang, Ann Phoya: Ministry of Health, Sally Theobald

Community based organisations (CBOs) should be This study set out to investigate factors within CBOs that are necessary for the sustainability of the organisations mainly in the delivery of Community Home Based Care (CHBC). We aimed to 1) Investigate the extent to which there was proper co-ordination in provision of CHBC activities in Malawi; 2) Determine the extent to which funding towards CHBC activities is sustainable; 3) Explore the links that exist between CBOs providing CHBC and the formal health system as well as the strength or weaknesses of such links; 4) Investigate the extent to which people living with HIV and AIDS (PLHA) and men are involved in CBO and CHBC activities.

This was a cross-sectional study that used in-depth interviews and focus group discussions in four districts of Malawi. Stakeholders, including PLWHA, were interviewed. There was poor knowledge and lack of dissemination of CHBC policy. There was also poor co-ordination, despite existence of policy. Most CBOs depended on grant facility funding from National AIDS Commission (NAC) and other NGOs. There was weak linkage between the CBOs and the formal health system with weak referral and reporting systems and inadequate funding. Most Health Surveillance Assistants (HSAs) who link communities with health facilities were not trained in CHBC work and were ignored in most of the activities carried out by CBOs. Most PLWHA claimed that their names were just used by CBOs to acquire funding from donors. Gender analysis also showed low participation of men in almost all CBOs visited with the few men involved taking up most leadership positions. Most respondents indicated that at the time women volunteered to work for free with CBOs, men were busy with productive activities that could enable them to support their families. CBOs are an important part of the health system. With weak coordination and unpredictable funding, CBOs are bound to provide the worst services to their beneficiaries who are mostly the poor thereby perpetuating inequities. Government and stakeholders should put in place mechanisms to ensure PLHA are not abused and that men are involved in CHBC activities.

Pa7: Parallel Session: Participatory, Primary Health Care approaches to public health priorities

Thursday 24 September 2009 1100-1300

Meera Hall

Convenor: Rene Loewenson, Barbara Kaim, TARSC; Selemani Mbuyita, Ifakara Health Institute Tanzania

Pa7.1: Challenges facing women living with HIV on treatment in Kenya

Mary Aoko Awino, Rachuonyo Health Equity, Kenya

Although Kenya has declared HIV and AIDS treatment free of charge, the country sees many challenges facing women with HIV that is limiting access to treatment programme among them. Women with HIV in resource-limited areas are worse hit. Rachuonyo Health Equity (RHE) investigated the challenges facing poor women living with HIV on treatment in Rachuonyo District, Kenya. We conducted the study using a literature review, interviews and observations. We found that many clients walk up to 7km in search of ARVS from the District hospital in the District. Others for fear of rejection by spouses sneak into the clinics then resort to hiding their drugs in food containers or removing them from bottles and packing them in normal paracetamol packets. Nevertheless, in-laws are harassing widows and denying them their properties. Similarly, they throw out orphans from their homes and deny them access to education. School dropouts among orphaned girls are high with some resorting to sex for food as a survival strategy and others moving to early marriages. Some employers terminate contracts with HIV positive people, and women in the district feel the brunt. False teaching and misinformation around herbal medicine in the area are confusing responses. Health workers are overwhelmed with work, with limited services, congestion in clinics and a doctor to patient ratio of 1:150,000, and nurse patient ratio of 1:1,000. Only 60% of households can access services. While 68% of the 5,470 people enrolled for treatment are women, only 13% of the 43 375 infected people eligible for treatment are accessing it. Nevertheless, KADHICNADER is now working with frontline health workers in mobilising and sensitising the community to increase ART programs in the area and many women with HIV are beginning to attend clinics. We are working with Kasipul Division HIV Clients Network Against Defaulter Rates (KADHICNADER), a local network that PLWHIV started from our 2007 PRA-work with EQUINET support. The network has mobilised five member groups into community meetings and interviews thus reaching 521 patients in the community. HIV clinics need to be built nearer to the people, with more frontline health workers in place and trained on human rights and supported to handle cases of PLWHIV. Health care providers and civil society should empower PLWHIV to manage disclosure issues and treatment with ART. It should enforce policies guarding the rights of PLWHIV, and civil society organisations empower the locals to take up ART services, as well as to act on stigma and gender based abuse.

Pa7.2: Community mobilisation to improve management and adherence to ART in people with harmful alcohol abuse in Kariobangi, Kenya

Caleb Othieno, University of Nairobi, Kenya

Anne Obondo, Muthoni Mathai, Lorna Osendi, Teresia Mbugua

There is a high prevalence of HIV in Kenya. Efforts to treat those infected and to reduce new infection rates are hampered by behavioural factors that are linked to hazardous alcohol use. This project, built on ongoing community work to promote mental health in Kariobangi, Nairobi aimed to improve the management and adherence to ARV treatment among people living with HIV/AIDS (PLWHIV) who were concurrently abusing alcohol. A group of health workers and community workers through snowballing identified within the community a sample of 67 PLWHIV who were using alcohol hazardously. In the initial meetings, using participatory research and action methods the community's perception of alcohol use and how it affects compliance to ARV treatment was gauged. Among the perceived causes of alcohol use in this group were stigma and social acceptance, basic needs such as hunger and emotional problems of depression and loss of hope in the future; availability of cheap potent brews costing about US$ 0.2 per 750 ml coupled with high food prices; and lack of openness in discussing these matters with the health workers compounded the problems. A number of the participants were single or divorced women. Some of them admitted that they sometimes engaged in commercial sex to cater for their basic needs. In addition, a survey of the local health centres providing ARVs showed that screening for alcohol use was not routinely done and protocols for managing alcohol-related disorders were not available. Reflecting on these problems, the participants noted that psycho-education was important.The health workers were taught how to use the AUDIT in identifying problem drinkers and how

to recognise and manage alcohol related disorders such as withdrawal fits. The PLWHA were encouraged to form a registered group which could apply for funding on projects of their choice. During the project period compliance as measured by clinic attendance had improved for most of the clients. Although most of them said that they had stopped drinking, three clients had alcohol withdrawal seizures during one of the meetings. Longer term follow-up is needed. Problems encountered included great expectations at all levels fostered by handouts from other donors. Getting cognitively impaired people who have lost hope to plan any activity was extremely difficult. Perhaps a balance needs to be made in the use of directive and non-directive methods to get a model community income generating programme started that can serve as an example.

Pa7.3: Participatory approaches to increase community participation in prevention of parent to child HIV transmission in Kamwenge and Kiboga Districts, Uganda

Moses Mulumba, HEPS-Uganda

Aaron Muhinda

In Uganda about 21% of HIV transmission is currently believed to be due to mother-to-child transmission. Yet few pregnant women are being reached by prevention of mother-to-child transmission (PMTCT) services. We explored whether PMTCT programmes can become more effective by working with the community through the use of PRA methods to address barriers to uptake. This study used Participatory Reflection and Action methods (PRA) methods to increase community demand and utilisation of community oriented PPTC services in Kamwenge sub-county, Kamwenge district and Mulagi sub county in Kiboga District. A baseline and follow-up assessment was used to gauge changes in health seeking behaviour and uptake after implementing the project. In the PRA process community members, including affected women, and health workers identified the barriers for utilising PMTCT services and a community plan was developed to address them aimed at increasing community awareness and engagement with services. Participatory review of progress of the interventions was done by the community members. The major problems hindering the utilisation of PMTCT services included: lack of awareness and fear; poor health workers attitudes towards expectant mothers; and uncooperativeness of husbands. The PRA process and action plan activities increased the understanding and knowledge in communities and health workers of the role and delivery of PMTCT services and facilitated action on the social and health system barriers to utilising PMTCT services. This intervention, while limited in time and scale, demonstrated the roles community and health workers each play in overcoming barriers to uptake of PMTCT services at primary health care level. Interventions through participatory approaches that increase awareness on PMTCT services, particularly

through involvement of male partners, and that address health worker – client interaction are a critical part of Primary health care oriented responses to HIV and AIDS.

Pa7.4: Peer education to promote Ugandan students' sexual health

Amanda, Jones, University of Alberta, Canada

Adolescents are at high risk for poor sexual health and encounter numerous barriers. These barriers include a lack of appropriate sexual health information, preventing adolescents from being able to achieve improved sexual health. Additionally, little is known about how Ugandan adolescents would prefer to be informed about sexual health and few interventions exist that are initiated, organised and implemented by Ugandan secondary school students. This presentation discusses the development of a school-based sexual health peer education program in western Uganda using Participatory Action Research (PAR). It also examines outcomes from the research project, including participant empowerment, new partnerships and community mobilisation. The qualitative methodology of PAR guided the study's design, data collection and analysis. In late 2008 data was gathered through semi-structured focus groups and interviews, as well as researcher field notes, memos and observations. Participants were secondary school students and educational staff from two schools in Kabarole District, Uganda. Data was analysed through coding and thematic development and yielded findings suitable for practical application by participants.

In the initial stages of the project, student and teacher participants identified students' sexual health information needs and how necessary information could best be provided to students. Then, in collaboration with the researcher, the participants guided the development of a school-based peer education program to improve the delivery of information to students. The results demonstrate the usefulness of this approach in revealing the participants' actual needs. It provided participants with the opportunity and responsibility to direct the course of the investigation and intervention, with the researcher facilitating the creation of solutions. Not only did participants report increased sexual health knowledge, they also demonstrated team process skills, initiated new partnerships with health providers, community groups and individuals and emphasised community mobilisation. The findings reveal how PAR successfully contributed to the students' and teachers' empowerment and ownership of the peer education program, aiding in the future success and sustainability of the program. The participants demonstrated a clear sense of motivation to continue the project in the absence of the principal investigator. This project provides a practical example of a low cost, high quality approach to engaging adolescents in sexual health education and is suitable for health educators, community organisations and researchers. It also challenges researchers to relinquish control of

the project's course and outcome, and act in the role of guide and facilitator. Through this they can promote participant ownership, health equity and action.

Pa7.5: Civic education of rural pregnant mothers to take full Nevaripine dose: A tool to reducing HIV prevalence in Malawi

Caleb Thole, Global Hope Mobilisation, Malawi

Gift Trapence, Daphne Gondwe

It is estimated that 600,000 women get pregnant every year in Malawi. Primary health care plays a vital role. Prevention to Child Transmission of HIV education is important in a country like Malawi where prevalence of HIV positive mothers exceeds 20% than normal country prevalence of 12%. In the ultra-partum period Nevaripine has proved to be an effective drug in reducing transmission from mother to child. Accessibility of essential medicine like Nevaripine drug to women and neonates is especially a problem to rural areas where many women deliver at home due to difficulties in accessing health facilities. This civic education intervention aimed to increase rural HIV+ pregnant mothers uptake of Nevarapine tablets and syrup for infants' dose for Prevention of mother to child transmission of HIV and to promote hospital delivery.

Global Hope Mobilisation is providing education and counselling to women in rural setting to access basic medicines such as Nevaripine, as well as to promote hospital delivery in Lilongwe district rural setting. Households with pregnant women were included through a random sample and a total of 700 pregnant women were included in a programme to provide civic education materials, including leaflets; local meetings, counselling sessions, and home visits. Nevaripine tablets and syrup were also administered, ANC data were collected and used from the nearest health facility. The intervention was assessed through one-to-one interviews, focus group discussion, and questionnaires. 100% of the pregnant women were sensitised on taking Nevaripine, counselled and referred for HIV testing. To date 98% of women have attended pre- and post-VCT counselling testing and ANC at health facilities and at private clinics referred to. Of these women 66% were found to be HIV positive. Nevaripine tablets and instructions were issued to them when they reached 32 to 34 weeks of gestation. 60% Infants received Nevaripine syrup within 3 days after birth. Of these 6% are not known to have taken syrup and were lost to follow up, while 60% returned for post-counselling. The major barriers of the intervention were home delivery, traditional beliefs and lack of knowledge of HIV status and on the course of Nevaripine. The main risk factor for lack of full take up of Nevaripine for HIV+ women is home delivery and lack of knowledge on their HIV status. A civic education on Nevaripine and hospital delivery among HIV positive pregnant women in this

rural population setting can reduce HIV transmission from mother to child.

Pa7.6: Building networks of support for orphans and vulnerable children in Malawi

Wilson Damien Asibu, Country Minders For Peoples Development, Malawi

Ireen Makwiza, Rene Loewenson

Care and support for orphans and vulnerable children has been inadequate to meet the needs of this growing group in Monkey-Bay Malawi. To survive, vulnerable children, especially young female orphans have opted for strategies including commercial sex that have predisposed them to more Sexual and Reproductive Health (SRH) problems including HIV and AIDS. Due to poor relationships between health workers and community members, these young female orphans have shunned public health services, while community based We used Participatory Reflection and Action (PRA) methods to identify, prioritise and strengthen support for equitable responses to health needs of orphans and vulnerable children, and to more effectively co-ordinate resources within the district towards this.

Methods: We used focus group discussions, participatory reflection and action (PRA) workshops and monitoring and evaluation meetings. Children, community members, community organisations, and health workers were included. Change on indicators of support for orphan and vulnerable childrens health was assessed through a baseline and follow up questionnaire.

Through the PRA process it was identified that the three main priority needs of vulnerable children in Monkey-Bay are lack of adequate food, clothing and education support. Lack of adequate care and support to vulnerable children was attributed to lack of adequate resources, but the PRA process also identified poor co-ordination of available resources and weak links between formal institutions and community organisations. A health forum was facilitated to strengthen communication between community members, health workers, Community Based Organisations (CBOs) and community support groups and an action plan developed based on feasible responses for prioritised issues. Community farming activities were set up to support care and support activities in Monkey-Bay and Village Child Protection Groups formed in six villages to protect vulnerable children from exploitation, abuse and violence. The assessments indicated positive changes in indicators of social protection. Vulnerability from the impact of AIDS is creating a vicious cycle of risk for HIV in vulnerable children. This can be responded to at community level through processes that empower the children and their communities and that better co-ordinate local resources. There is still need for effective support for community level organisations from NGOs, government

and donors and we suggest use of participatory approaches to give greater consideration to the views, needs and roles of the children and their surrounding community when developing interventions. This PRA project has been technically and financially supported by the Regional Network for Equity in Health in East and Southern Africa (EQUINET).

Pa7.7: Improved social support and health care of orphans and vulnerable children through improved child participation in Victoria Falls, Zimbabwe

Dumisani Masuku, Holistic Child Support Initiative (Together for Children Project), Zimbabwe

Sithabisiwe Ntini, Hlupho Mhlanga

A high number of orphans and report of child abuse indicates the vulnerability of children affected by HIV and AIDS. Children experience weak support due to a weakened primary health care services and the high cost of accessing treatment in Zimbabwe. We aimed to strengthen childrens support through primary health care services through a participatory reflection and action (PRA) project in Victoria Falls Town. We aimed to involve children in identifying health needs and responses to these needs. The study also sought to assess the current situation concerning the primary health care delivery system and propose recommendations, including for organisations supporting orphans.

The study used participatory tools and questionnaires with community representatives (adults), health workers and orphans and vulnerable children, selected through random sampling method.

The PRA process revealed that:

*   Children have limited access to ARV treatment as there is very little attention given to the children's health needs.

*   Access to primary health care services is limited by high cost of consultation fees as well as the cost of drugs.

*   There is poor communication between health workers and the children. The health workers view children as passive participants in their own health.

*   There is still stigma and discrimination against children living with HIV.

*   There is lack of child participation in planning for their health.

These findings were used to come up action plans to enhance the delivery of primary health care, with the involvement of the children. These focused on key areas identified in the PRA work, to support children in need of ARV accessing ARV treatment; to strengthen childrens participation at all stages and for nurses to be trained in child friendly services in order to enhance the delivery of primary health care services. We review this experience to assess the extent to which giving children the opportunity to contribute towards the identification of their health needs and the responses to these needs helps in ensuring effective programming, and to reflect on the difficulties encountered in bringing vulnerable children into these roles.

Pa8: Parallel Session:
Valuing and retaining health workers

Thursday 24 September 2009 1100-1300

Majestic Hall

Convenors: Scholastika Iipinge, University of Namibia, Yoswa Dambisya, University of Limpopo, Helen Lugina, ECSA-HC

Pa8.1: Future intentions of medical students in Malawi

Dr Kate Mandeville, University College London, UK

Tim Bartley, Dr Kara Hanson

Pre-service training of health workers has increased considerably under the Malawi government's Emergency Human Resources Plan. Enrolment at the national medical school has increased from fifteen students in 1992 to 312 in 2008, with plans for 600 by 2010. However, many qualified health workers continue to leave the public sector in order to work or train abroad. We explored the postgraduate plans of current medical students, and also their background with regard to town of origin, secondary education, and parents' professions. The study aimed to investigate postgraduate plans of medical students currently at Malawi College of Medicine and the extent to which this is influenced by their background. After an initial focus group, a written questionnaire was developed and piloted on a range of other students. The modified anonymous questionnaire was distributed to all five years in the medical school, and also pre-medical students (a non-government funded one year access course for medical school). One reminder visit was made to each class. Data was analysed using Stata-10 statistical package. 49 students responded to our questionnaire (a response rate of 59%, rising to 76% if students on clinical placements in year 5 are excluded). 81.5% of students are from rural areas. For their secondary education, 38.4% had been to a private school, 27.4% boarding schools (government run, but fee-paying), and just three students had been to a government day school (nominal fees only). The majority of students had completed the premedical course before admission to medical school (64%). 12% of medical students had at least one parent who was a health worker. When questioned on their plans for immediately after graduation, 38.9% of students planned to work or do postgraduate training outside Malawi, with only 52.4% electing to stay in Malawi. This decreased to 29.5% for plans at some point in the future, with 57.7% leaving for work or training. There was strong evidence that immediate plans to stay in Malawi was associated with type of school attended (X^2, p=0.023), with those from government schools being more likely to stay in Malawi. Students currently on the pre-medical course were also more likely to have

immediate plans to stay in Malawi compared to other years (X^2, p=0.037). However, there was no association with other aspects of background. The majority of current medical students plan to leave Malawi in the future. Students on the pre-medical course are more likely to plan to stay in Malawi than students in the actual medical school. The current increase in pre-service training in Malawi is unlikely to be effective unless more medical students plan to work in the public sector after graduation.

Pa8.2: Costs of health worker migration to training in health systems

David Mwaniki, Mustang Management Consultants, Kenya

Charles Dulo

This study aimed to assess the social and economic 'costs and benefits' of migration of health workers in Kenya, to assist decision makers in formulating policies that reduce negative impacts and maximise possible positive effects. We used the WHO 2004 framework on health systems performance and assessed impacts on resource generation, stewardship and service provision. Through field survey of sampled health facilities, information was gathered through interviewer-administered questionnaires. A sample of health workers, administrators and key informants were interviewed. The cost of migration of HRH was estimated through a methodology adapted from Kiriga et al (2006). The emigration rate of 51% for doctors is high. More worrying is the finding that more than 71% of the respondents indicated an intention to emigrate. An attempt was made to quantify income in remittances sent home by emigrant doctors and nurses but data proved inadequate. We made a rough estimate of inward remittances of about US$90 million annually while the government lost an estimated US$95 million invested in training doctors due to migration and our estimates suggest losses may be higher. Secondary data and field study suggests that there are negative impacts on workloads, especially at peripheral facilities and in some rural districts, which may impact on health service provision and the referral chain. For example, there are only two doctors in Wajir district hospital who serve a population of about 200,000; whereas about 12 doctors are actually needed (the average is

six doctors per 100,000 populations). We suggest that government review its current freeze on employment to ameliorate the situation. Increased workloads caused by understaffing result in stress, burn out and demotivation, which are the factors that 'push' remaining health workers to leave. We did observe some improvement in workloads in 2005/6 despite increases in service uptake, suggesting that there has been some policy response to the staff crisis in those facilities surveyed. In other cases, young interns are left alone to carry out work without supervision, at the risk of making an incorrect diagnosis and prescribing inappropriate treatment. Unqualified personnel are also left to perform duties that may be beyond their scope of practice, which increases risk patients. It was not possible to accurately measure the impact of migration on the quality or availability of service delivery or patient satisfaction. However the evidence indicates that gaps in staffing result in increase workloads and reduced supervision and skills support. This increases the push factors in migration, reduces the skills transfer within the sector and reduces the quality of services delivered.

Pa8.3: Non-financial incentives and the retention of health workers in Tanzania

Michael Munga, National Institute for Medical Research, Tanzania

Deogratious R Mbilinyi

The Tanzanian public health sector is losing its workers to internal migration, migration from the public sector to the private sector and international migration, usually to wealthy, developed nations in the North. Non-financial incentives are one way of encouraging workers to remain in their posts. We conducted a study to examine the implementation of policies to govern non-financial incentives to retain health workers in Tanzania. We used a triangulated methodological approach, namely a literature review, qualitatitive and quantitative techniques of data collection and analysis. The literature review covered policy documents, published and grey literature concerning Tanzania from the mid-1980s to 2007, when most of the country's major health sector reforms (HSR) started. Data for the field study was collected from seven districts, including five under-served districts with fewer health workers per capita based on the latest health workforce census in Tanzania. Even though non-financial incentives are institutionalised by government policies and standing orders, their sustainability is eroded by the absence of special earmarked funding for their implementation. Decentralised districts also lack adequate powers and authority to manage health workers, weakening their ability to implement non-financial incentives. It was learnt that interventions such as training and education, promotion and the provision of safe working and living environments can be strong motivators if implemented in an effective and sustainable manner. It was further highlighted that lack of transparency in

the implementation of programmes, such as those for promotion and training. Available non-financial incentive policies were felt to not match well with the reality in health facilities, due largely to the shortfall in resources for these. The priority given to senior officers (e.g. in provision of housing) was felt by some to be unfair, as all workers need adequate housing. Favouritism was seen as a problem in appointing people who go for training, especially short courses. Inadequate feedback from employers and supervisors, poor or inadequate assessment of staff training needs and delays in promotion, without information to workers on the causes of delays, were consistently mentioned. Strategic efforts are needed to address (in a holistic way) critical health worker issues ranging from recruitment, placement and retention, taking the needs of specific cadres, levels of the health system and areas. Analysis of issues driving retention needs to take into account both individual and structural factors that shape individual health workers' preference structures and the complex nature of the health care labour market. A trivialised pull and push factors framework in analysing complex problems like retention, will not guide sustainable solutions. This needs to examine factors that not only guide the design of incentive regimes, but also the resources, management systems and other factors that enable their implementation in practice.

Pa8.4: Zimbabwe government strategy for retaining health workers

Moses Chimbari, University of Botswana, Botswana

D. Madhina, F. Nyamangara, H. Mtandwa, V. Damba

Zimbabwe is one of the southern African countries whose health sectors have been seriously affected by loss of critical health professionals (CHPs) through migration to other countries. In order to curb further deterioration of the health delivery system, the Zimbabwe government instituted measures aimed at retaining staff that are still in the country and attract those in diaspora. The measures include financial and non-financial incentives. This study identified the retention incentives, assessed how the incentives package is perceived by the beneficiaries and made an analysis of the situation regarding movement of CHPs. The study was conducted in public health institutions, private health institutions and faith based health institutions. Review of key documents on human resources for health (HRH), in-depth interviews with key informants, questionnaire survey targeted to different categories of CHPs and Focus Group Discussions with CHP trainees were conducted. A rampant tendency of CHPs to migrate was observed and the movement of staff seemed to be no longer sequential, i.e. movement from lower levels of the public sector to higher level of the public sector and from higher levels of the public sector to private institutions within the country or outside the country. A greater tendency of staff at low levels of the public sector leaving for other countries in the region or abroad was observed. Bonding of

staff was unpopular and tended to promote desertion of staff. The major driver for the tendency to migrate was the unfavourable macro-economic environment that made financial incentives unattractive. However, efforts made by government to improve the conditions of service of HRH seemed to be appreciated by the beneficiaries. The study concluded that unless the economic performance of the country improves it is likely that the loss of CHPs will rapidly increase in the near future.

Pa8.5: Strategies to retain health workers in Enugu State, Nigeria

Ijeoma Okoronkwo, Department of Nursing Sciences, University of Nigeria, Nigeria

Ada Nwaneri

The health workforce has been identified as the key to effective health services and the growing gap between the supply of health care professionals and the demand for their services is recognised as a key issue for health and development worldwide. One of the most damaging effects of severely weakened and under-resourced health systems is the difficulty they face in producing, recruiting, and retaining health professionals. Low wages, poor working conditions, lack of equipment and infrastructure all contribute to the flight of health care personnel. However, staff shortages are the most commonly reported staff-related problems, especially in resource-poor countries. In Nigeria the migration of health workers in pursuit of greener pasture is already adding to shortages of skilled health professionals. This has significant implications for care provision and achieving improvements in health status. This study therefore seeks to determine factors influencing health workers' retention in a tertiary institution of Enugu State, Nigeria. The study will help to inform policy-makers on areas for intervention with potential impact to improve retention of qualified health workers. The study was a descriptive design with the use of both qualitative and quantitative data. The qualitative consisted of in depth interview on management staff. The quantitative data was a pre-tested self administered questionnaire to health workers (doctors, nurses, physiotherapists, pharmacists, lab scientist, radiographers) to elicit factors that enable retention or attrition in the work place. Data from interview was coded and transcribed while the questionnaire was analysed with SPSS software. The study revealed that most of the health workers were not satisfied with the jobs they performed and preferred to leave the organisation if offered a comparable job elsewhere with better working conditions. In order to identify strategies that would attract retention in the organisation, findings revealed that prospects for promotion, adequate compensation for work done, communication about what is happening, use of initiative etc, while bitter political differences and tribalism, lack of materials to work with and not recognising hard work were factors affecting their job performance. The service condition under which an employee finds himself influences his productivity. If

s/he is not satisfied with the conditions, his/her stay in the establishment will probably be short. To attract and retain health workers requires the provision of competitive rewards and definition of career paths by which the personal goals of the individual may be attained within the organisation.

Pa8.6: Incentives for health worker retention in Kenya

David Ndetei, University of Nairobi, Africa Mental Health Foundation, Kenya

Lincoln Khasakhala, Jacob Omolo

The importance of health workers to the effective functioning of healthcare systems is widely recognised (Ndetei et al, 2007). Shortages of health workers which are aggravated by unequal distribution constitute a significant barrier to achieving health-related Millennium Development Goals (MDGs) and expanding health interventions in developing countries. In Kenya, internal migration of workers, from rural/poor areas to urban/rich areas, is just as serious a problem as international migration. The crisis calls for investment in incentives to recruit and retain personnel in poorer, rural areas to service communities that need them most. This study was undertaken within the Regional Network for Equity in Health in East and Southern Africa (EQUINET), in co-operation with the Regional Health Secretariat for East, Central and Southern Africa (ECSA) and the Universities of Namibia and Limpopo and TARSC to explore the application of non-financial incentives for health worker retention. We conducted a literature review and field research to obtain data on strategies for the retention of health workers in various institutions in Kenya. Focus group discussions and interviews were held and policy documents were reviewed to understand the existing schemes on health worker retention incentive schemes and the challenges faced. Staff in the various institutions was offered a number of financial and non-financial incentives and allowances. The incentives that were highly valued included: improved working conditions; training and supervision; and, better living conditions in terms of health care and educational opportunities for the staff and their families. The management of incentives varied: terms and conditions of service in private and teaching facilities were reviewed regularly and health workers were informed of any changes of services through improved human resource management. However, in public facilities, there were many unfilled positions despite high unemployment rates for health workers in the country. Primary health care facilities were severely understaffed, with relative overstaffing of hospitals (district, provincial and national hospitals). This imbalance causes health workers in public institutions to migrate from primary health care (PHC) facilities to district hospitals, provincial and then national hospitals, where they were assured of shorter working hours and more income-generating opportunities. A system where incentives introduced to retain health workers depended for their effective implementation on the facility left better organised

facilities, often in higher-income areas, were more successful in providing incentives, although lower levels of the health system (in rural and poorer areas) had greater need for incentives. We recommend that government put in place national-level policies to retain health workers in rural areas, in lower-income districts and at lower levels of the health system, including financial and non-financial incentives.

Pa8.7: Shortage of human resource in the context of maternal and child health (MCH) policies in Malawi: Analysis and retention strategies to ensure an effective workforce

Judith Daire, University of Cape Town, South Africa

The Government of Malawi in general and the Ministry of Health in particular is challenged by an acute shortage of skilled personnel. This study aimed at exploring lessons and gaps in MCH policy implementation in Malawi by investigating types of constraints encountered at government and private health facilities in implementing MCH policies. A qualitative approach was deployed for the study and data was collected through official document review (MCH government policies), self-administered questionnaires, and interviews. Study participants were drawn from public health facilities and while key informants were drawn from MoH national headquarters; local and international NGOs; and the private sector. Analysis of data used content analysis approach to identify pre-corded categories and themes from the data. Data from each data source was analysed separately and then triangulated.

Results from review of official policy documents showed that shortage of human resources is one of the constraints encountered in both public and private health sector in Malawi. Responses from questionnaires and interviews indicated that the government and its donor partners are implementing strategies for addressing shortage of human resource in the health sector. For example, giving top-up salaries for professional health workers and, increasing enrolment in training institutions. However responses from questionnaires and interview also revealed that the government is training more staff but it is failing to retain them within the public sector. Information from interview responses indicated that most of the health workers are within the country but working in private sector, training institutions and in NGOs. Reasons cited for health workers leaving the government included poor human resource management, i.e. no reward for hard working and no supportive supervision; and poor working conditions i.e. low pay, poor infrastructure, workload and lack, of resources. On the other hand the study found out that some of the strategies for dealing with shortage of staff further deplete the health systems workforce and compromise the quality and equitable access to health services. For example, task shifting has

resulted in unqualified staff performing critical clinical procedures, worse still without training and supervision. It is a well known fact that providing maternal and child health care requires a viable and effective health workforce, yet the numbers of health workers still remain inadequate across all the levels of the health system in Malawi. Although the government is training a lot of health workers, it is still failing to retain them within the public health sector. The study recommends that apart from taking urgent corrective action on salaries and increasing training capacity of health professional workers, conditions to ensure effective workforce in the health sector, strategic decisions must be made in three areas: training, deployment, and retention of health workers. Even though retention strategies seem to be of low priority, they can attract health workers from the private to public sector as well as further reduce brain drain from public to private. The study further recommends that in addition to staff salary and benefits retention strategies should also look at effective human resources management systems and styles, work environment and provision of resources to work with. Furthermore, retention strategies for health professional workers should also be applied to non-health professional workers who support health workers in delivery healthcare to the population.

Pa8.8: A Review of the Impact of HIV and AIDS Programmes on Health Worker Retention

Yoswa M Dambisya, University of Limpopo, South Africa

Sehlapelo I Modipa, Norman Z Nyazema

Sub-Saharan Africa has a disproportionate number of persons living with HIV and AIDS deaths, coupled with a low health care worker (HCW) density. We reviewed published and grey literature on the effects of HIV and AIDS programmes on HCW recruitment, distribution and retention, and attrition, and on human resource management and information systems. Early studies reported negative effects of HIV and AIDS and the delivery of HIV and AIDS services on HCW morale through stigma, burn-out, resignation and deaths, while more recent ones suggest hope, high prestige, motivation and better retention of HCWs in HIV and AIDS programmes, due to antiretroviral therapy (ART) which has improved the prognosis of AIDS. HIV and AIDS programmes have attracted funding through global health initiatives (GHIs) such as the Global Fund and PEPFAR, which funds have been used for general health system improvements. But such programmes may fuel internal brain drain, by attracting HCWs from other programmes to HIV and AIDS ones. There are reports of integrated programmes, such as HIV and TB, and even those where HIV and AIDS services are part of the public health system. Integrated programmes reportedly benefit the whole system, and there are reports of successful public health and equitable approaches to HIV and AIDS services delivery. To

optimise utilisation of GHI funds, system-wide support such as SWAP or budget support, coupled with country driven processes such as the 'Three Ones' and IHP+ are promoted to strengthen health systems. HIV and AIDS services have led to the development of new HCW cadres including expert patients, and innovations, such as task shifting and integrated management of adult and adolescent illness (IMAI), for more efficient utilisation of available HCWs. There has been an expansion of HCW numbers through training and other support for HCWs. Many HIV and AIDS programmes offer incentives, such as higher salaries, better furnished facilities, appointment at higher levels and treatment for HIV infected HCWs. Selectively applied incentives tend to demoralise and discourage those who are excluded. In contrast, more inclusive approaches have fared better. HCWs on ART improve and return to work; treatment of infected HCWs signals to HCWs that they are valued. The balance of evidence suggests that HIV and AIDS programmes benefit the health system by attracting and retaining HCWs within the health system, and that it is possible to take advantage of the HIV and AIDS resources to benefit the whole sector.

P4: Plenary:
Building alliances and people's power in health

Thursday 24 September 2009 1400-1515

Victoria Ballroom

P4.1: Experiences and lessons on empowerment from participatory methods

Rene Loewenson, Barbara Kaim TARSC Zimbabwe; Selemani Mbuyita IHI Tanzania

Our concept of equity includes the power and ability people (and social groups) have to direct resources to their health needs, particularly for those with worst health. When health systems are organised to involve and empower people, as 'people centred health systems', they can create powerful constituencies to protect public interests in health, reinforce the functioning of participatory democracy within the state and support a more collectively organised and informed society. The paper reflects on learning from an EQUINET programme using participatory approaches to strengthen social empowerment in health, led by TARSC and Ifakara Health Institute. The programme involved researchers, trainers, academics, community health activists, health workers and others from around the region, and the paper briefly outlines the processes within the programme to build capacities for participatory methods, integrate these within ongoing work, particularly at the primary care level interface of health services and communities, and to build a learning network in the region. The experience raises a number of issues around social empowerment in health systems and the processes we need to embed within health systems to facilitate and support it. For example, participatory methods can provide for more community-based profiling and analysis of health concerns, structured in such a way as to explore underlying causes of barriers to good health and leading to action. Dialogue across community members and health service providers was found to lead to positive changes in attitudes and perceptions, improved communication, and joint planning. Other positive outcomes of such processes will be explored. Yet health systems are poorly organised or able to produce such outcomes, and there are challenges in integrating

the intensive reflection and action processes used in the programme within the functioning of health systems, particularly for those previously marginalized. We examine the types of changes and incentives needed to move from the more widely accepted practices in health systems associated with 'participation', such as awareness and social mobilisation, to those associated with 'empowerment'. From the regional programme we present learning about the strategies for health systems to encourage a more active, engaged population, and to be more responsive to their views, claims and actions, in ways that promote health equity. Finally we raise some cautions and challenges from the experience, to open dialogue within the conference sessions on how to strengthen and improve work using participatory methods within and beyond the network.

P4.2: Health civil society experiences in building peoples power for health: Lessons learned

Itai Rusike, Community Working Group on Health, Zimbabwe

In 2005 health civil society in east and southern Africa proposed to strengthen networking across civil society to promote a vision of a health system where communities participate fully, where decisions flow from the grassroots level where the people are to higher level authorities, and not from top down, and support action at the base of the health system. This paper explores the experiences of health civil society in the region in taking this vision forward in a range of ways, and in building peoples power for health. Specifically it examines the manner in which health civil society in different countries of the region have sought to influence different areas of policy and resource allocation for health and health services, including experiences of

- district and local health committees and health centre that take up local health issues, dialogue with health autrhorities and implement programmes that are area-specific

- national level engagement on different areas of policy affecting health, including on access to water, access to treatment, privatisation, trade and other issues;
- national and international level advocacy for health rights, including the right to full participation in health issues, and of association, assembly, advocacy, access to information and to decision makers,
- provision of health information and health and treatment literacy outreach to support health action;

The paper explores different approaches by different civil society organisations in the region, drawing on experiences of health civil society in EQUINET (such as Community Working Group on Health, Malawi Health Equity Network and others) to explore the forms of action, and the results in relation to health equity achieved and reported from these actions. It suggests that civil society is critical for health equity, to support the partnerships needed between the community and health authorities and services, to manage often volatile environments with significant power imbalances within which people engage and use services or lobby for health resources, and to support vulnerable groups to claim entitlements in health. However civil society does this also in alliance with other institutions, such as the parliament portfolio committee on health. Finally the paper raises issues about the ways health civil society itself needs to be strengthened or transform to empower and inform social action, and to drive the shifts in political will required for policy change.

P4.3: Experiences and lessons from parliamentary roles in health in the southern and eastern Africa region.

Hon Blessing Chebundo, Alliance of Parliamentary Committees on Health in East and Southern Africa (SEAPACOH)

This paper describes the way parliaments and Members of Parliament (MPs) responsible for health in the region are networking in the Association of Parliamentary committees on Health on East and Southern Africa (SEAPACOH) to create opportunities and overcome challenges to advance good health policies and practices through their budget, legislative and oversight roles. It highlights the advantages of regional networking for committees to inform and

strengthen committees, and presents the challenges encountered. Committees on their own face limits in achieving results, but by collaborating with civil society organisations have made noticeable improvements. For example, the use by the parliamentary committees of research work and other technical information produced by national and regional civil society for health have influenced the outcomes of national health budget allocations of a number of member states. Committees have used research information to analyse Bills and related reports, with input from various technical and civil society institutions in the region named in the presentation supporting the Kenya committee's influence on the outcome of Kenya's Population Bill of 2004; the Zambian Portfolio Committee work on a number of issues, including the National AIDS policy; the South Africa and Zimbabwe adoption of resource allocation formulae and budget tracking strategies; the increased parliamentary oversight on health rights and health related trade issues; and the inclusion with technical support in parliament committee workplans of oversight of regional and international undertakings, such as on implementation of the 'Maputo plan of action', Abuja declarations, Millennium Development goals and others. MPs face challenges in working with academics and civil society, with competing interests amongst these individuals and institutions. This calls for effective coordination and synergies in such work. The hallmark of every modern parliamentary democracy and society is the development and sustenance of its public health system as a basis for social and economic development and therefore political viability and stability. The future of African countries and their social and economic development and political viability and stability rests on the resolution of their public health crisis.

Pa9: Parallel Session: Policy engagement for health equity

Thursday 24 September 2009 1530-1730

Victoria Ballroom

Convenor: Lucy Gilson, University of Cape Town, South Africa

Pa9.1: Exploring the concept of power in the implementation of South Africa's new community health worker policies: A case study from a rural sub-district

Uta Lehmann, School of Public Health, University of the Western Cape, South Africa

There is widespread concern among public health practitioners and scientists about poor policy outcomes. Decades of health sector reform initiatives, particularly in low- and middle income countries have, as a rule, not generated substantive and sustained improvements in access, coverage, quality and equity of health care for large populations. While the reasons for this are complex, discrepancies between policy intent and policy outcome, which emerge in the process of policy implementation, as well as unintended outcomes of policy processes, have been identified by many authors. In this study the author explored how policies are shaped and transformed in the process of implementation, using as a case study the implementation of two community health workers policies in a rural sub-district in South Africa. More specifically, the study investigates how role players at different levels of the implementation process interacted with each other and the policy and how they used power at their disposal in this process. Within the policy-action dialectic of the implementation process, the study is particularly interested in the way in which communication is used by different role players to exercise both authoritative and discretionary power. Results show that tensions between role players as well as selective communication and lack of information led to a 'thinning down' of a complex and comprehensive policy to focus solely on the payment of stipends to community health workers. As frontline implementers at the district and community levels did not have information to understand the content and scope of the policy, their actions were shaped by what they were informed about. While they did not have the power to change the rules which were set and implemented by the provincial actors, they used their knowledge of local conditions, control over local knowledge and distance from the provincial capital to shape implementation at the service level. The study highlights our incomplete understanding of policy implementation processes and in particular how relational issues and power constellations shape policy practice. It argues the need for policy developers and managers to understand that 'implementation should be regarded as an integral

and continuing part of the political policy process rather than an administrative follow-on' which requires flexibility and negotiation in the managerial processes of implementation and practice.

Pa9.2: Mobilising human resources for eye health in Zambia

Joseph Munsanje, Sightsavers International, Zambia

Mary Miyanda

Zambia signed the WHO Global Programme for the Prevention of Avoidable Blindness, commonly known as Vision 2020, in 1998, but made little progress in developing eye health services. In particular, services were unavailable to the poor and those in rural areas, outside Lusaka and Copperbelt provinces. Accordingly, the country developed its first *National Plan for the Prevention of Blindness, 2003 to 2006*. However, implementation of the plan remained a challenge. A public-private partnership helped facilitate an analysis by the National Committee for the Prevention of Blindness (NCPB) to identify gaps and key constraints affecting the implementation of the national plan. This revealed that the country lacked capacity for national co-ordination and had an acute shortage of trained ophthalmic personnel. A campaign was launched to advocate for policy change by the Ministry of health. The policy change was directed at the establishment of the National Eye Care Co-ordination office in the Ministry of Health, a training school for mid-level ophthalmic personnel, a structure for ophthalmic personnel within the Public Service Commission (PSC). A new Strategic Plan for the Prevention of Blindness was developed in order to create a supportive policy environment. Policy change was achieved with the establishment of the National Eye Care co-ordination position and office in the Ministry of Health; the commencement of a training programme for mid-level eye care personnel at Chainama college of health sciences, approval of other eye care positions and the opening of an eye care budget line within the Ministry funding basket. The Ministry has since drafted a new eye care policy which will come into effect once ratified by various processes which are still on going. In order to attain the above results, Sightsavers had to mobilise the eye care sector stakeholders into a formidable structure able to dialogue with the Ministry of Health and parliamentarians. A policy change process had to be created supported with researched evidence from across the region that strengthened the call for change.

Policy recommendations from the parliamentary committee debates on eye care submissions were also used to create a policy change environment. Sightsavers worked with other stakeholders to document and facilitate including massaging government to accept sign off the policy changes. Once the position of National Eye Care Co-ordination was achieved within the Ministry of Health headquarters, it became a turning point in the achievement of the other policy issues.

Pa9.3: Exit, voice and loyalty in the South African public health sector: Young doctors' responses to government human resource policies

Joanne Stevens, Google, USA

With the commercialisation of healthcare, health services and health professionals are increasingly viewed as commodities to be traded on global health markets (Koivusalo, 2006). This market paradigm is reinforced by the dominant Human Resources for Health (HRH) model of migration, which suggests that dissatisfied health workers move between competing health systems in response to 'push' and 'pull' factors, much like a customer moves between firms. The only behavioural response to dissatisfaction that is described by this model is exit. It does not capture any attempt to engage with the system to bring about improvements, nor does it acknowledge the role of intangible variables such as loyalty or a sense of vocation. The 'push-pull' model has influenced South African HRH policies. Bilateral agreements and bonding systems like community service (CS) represent interventionist policies designed to ensure that the distribution of health professionals is determined by more than market forces alone. By contrast, Hirschman's Exit, Voice, and Loyalty (EVL) model (1970) offers a more comprehensive framework for analysing responses to job dissatisfaction. It predicts that rather than opting to simply exit, employees may choose to use voice to address sources of grievance in the workplace. This decision is mediated by the costs associated with each action, and the loyalty felt towards the organisation. Drawing on qualitative data from participant observation in a rural hospital, and interviews with 25 young doctors and twelve stakeholders from academia, government and civil society, I have used the EVL model to critically analyse how young doctors have reacted to initiatives – notably CS – to retain medical staff within the South African public sector.

Inadequate opportunities to engage with policymakers, obstructive middle management, and the lack of viable feedback channels to the National Department of Health (DoH), have reduced avenues for voice within the public sector. For a proportion of young doctors, the high cost of voice has led to a tendency to exit when this option becomes available. While young doctors display a loyalty to the patient population that is often increased by CS, this is not matched by loyalty to the DoH. Any attempts to retain doctors within the public sector defeat their own ends if they focus too narrowly on preventing exit, but fail to acknowledge the importance of constructively channelling voice and fostering loyalty.

Pa9.4: Integrating HIV/AIDS in legislation: Experiences from the Uganda Parliamentary Standing Committee on HIV/AIDS and related matters

Apophia Agieraasi, Parliament of Uganda, Uganda

Uganda has had long-standing political will and leadership in responding to HIV/AIDS. The strong leadership and openness paved the way for increased multi-sectoral approaches and increased participation from political leadership, although much has rested on the shoulders of the President. With the increased interest in Uganda and its indigenous response to the epidemic, there has been a heightened awareness for other elected leadership to get on board and translate their mandated functions in a manner which would further enhance the political will and strength in addressing the epidemic. The gravity of the situation and the challenges facing Uganda in not becoming complacent in its successes, led to the establishment of the standing committee on HIV/ADS to strengthen the capacity of all members in collectively getting involved and improving a coordinated parliamentary response in the fight against HIV/AIDS. Thus the main task of this committee is to enhance the capacity of all Members of Parliament to effectively discharge their advocacy, representative, legislative and oversight functions in all aspects of the intensified national response to HIV/AIDS. This paper aims to document the background of the Ugandan Parliamentary Standing Committee on HIV/AIDS and related matters and its progress so far. This paper is based on a desk review of literature on the accomplishments of the Parliamentary Standing Committee on HIV/AIDS and related matters and how it came to be. The first ever Parliamentary Standing Committee on HIV/AIDS in Uganda's history was fully constituted on August 16th, 2002 and was made of fifteen members of Parliament. Since then the committee has networked with other Parliaments and local partners on HIV/AIDS issues, published an HIV/AIDS communication toolkit, carried out oversight visits to monitor and evaluate activities of government, established a resource centre to provide HIV/AIDS information and is currently working on a comprehensive HIV/AIDS prevention and control bill that is meant to protect human rights and advance effective HIV prevention, care and treatment programmes. High-level political commitment and support right from the highest office in government (the presidency) played a pivotal role in the establishment and influence of the committee. Lack of an overarching HIV/AIDS policy framework and limited financial resources are

some of the obstacles that bedevil the work of the committee. The Committee has proved pivotal in the national response to HIV/AIDS with regard to advocacy, legislation and representation.

Pa9.5: Assessing Uganda's public communications campaigns strategy for effective national health policy awareness

Wilson Okaka, Kyambogo University, Faculty of Education, Uganda

Uganda government's national health policy communication campaign strategy is being done in a socio-cultural, economic, legal, and environmental context dominated by chronic poverty, ignorance, disease, and cancerous corruption. The major stakeholders in the policy implementation drive are: the central government, the districts, local communities, donors, and households. The current deficiencies in the national health policy awareness, knowledge, risky behaviour, and superstitions have heightened the incidents of illnesses, diseases, deaths, and poverty in Uganda. This paper discusses the role of effective national health policy communication campaigns strategy to create, raise, develop, and sustain awareness to combat HIV/AIDS, malaria, and other diseases among the key actors in the national health policy delivery and implementation efforts in Uganda. Published evidence on the effectiveness the national health communication campaign strategy for stakeholders' empowerment was obtained and reviewed. Additional information was accessed using internet search engines and libraries. All documents that were obtained during the review process were used to broaden the search for primary information sources. Initially more information was sought from the databases of national, regional, and international agencies. In the searches, the author looked for documents on effectiveness of the objectives of effective health policy communication campaign strategy in influencing the audiences' knowledge, attitudes, perceptions, and behaviour towards adaptation to health seeking behaviour. It emerged that the use of both mass media and interpersonal communication channels provide the maximum audience exposure to the messages for effective health policy implementation among the intended audiences in Uganda. Effective health policy communication campaign strategy plays a pivotal role in creating, raising, developing and sustaining the national health policy awareness and education levels for positive health behaviour change among all the major stakeholders. The campaign should be participatory, sustainable, theory driven, gender sensitive, and regularly evaluated for better performance in delivering quality healthcare benefits in Africa. The current national strategy is wanting. It does not synchronise epidemic dynamics with prevention messages. It focuses on the mass media per se while compromising the role of interpersonal communication to individuals in making personal decisions. The message design is too general

to attract or appeal to an individual audience. In some cases, the focus of mass media messages is poorly aligned to favour some audiences at the expense of others who are also expected to benefit from the same messages.

Pa9.6: Leveraging opportunities for health equity in Kenya

Jacob Ongala Owiti, Rachuonyo Health Equity, Kenya

Charles Okigbo

As Kenya gives attention to developing policies to address health concern of its people, inequities continue to kill many lives, in the country. Today the country is witnessing diminishing health care provisioning not only among the rural poor but also the slum dwellers. This paper examines existing body of health policies in Kenya in the last eleven years (1998 to 2008). We aim to investigate the attention that major actors in the health policy arena pays to the management of equity-oriented policy development and implementation, especially among under-resourced communities. We are working with the Ministry of Health incorporation with health CSOs in Kenya and are producing a compilation of major health policies enacted by Parliament and Executive Branch (President/ Prime Minister and cabinet) as part of a larger study of policy making and policy engagement in east and southern Africa region. Along side, we are reviewing reports on Participatory Reflection and Action (PRA) work conducted among the rural communities in Kasipul Division, Kenya since 2007 with support from TARSC/ EQUINET. We are also looking at results from empirical analysis of longitudinal data on health equity collected from the Nairobi Urban Demographic Health Surveillance Surveys of two slums, Korogocho and Viwandani over a nine-year period. The study found that situations and experiences that urban slums and rural communities undergo are illustrative cases of widening gap between national policies and actions on the ground that fuel health injustices among them in Kenya. In addition, an upper-class bias in national policy making process is reducing access to comprehensive primary health care among these social groups. Yet disempowerment among these groups and weak civil society gives powerful national and international social interests and forces chance to oversee unfair distribution of resources for health in the country. Still, use of top-down approaches in advocacy, policy engagement and promotion of health equity programmes is disabling more than enabling health systems in Kenya. However, where PRA approaches have been used communities have become empowered to take charge of own health. Therefore, major actors in national health planning should integrate PRA approaches in their work to leverage opportunities for health equities in Kenya. If people in national positions of power neglect to pay attention to managing equity oriented policy development and implementation, communities must take responsibility for reclaiming resources for their health.

Pa10: Parallel Session: Trade, technology and health

Thursday 24 September 2009 1530-1730

Regal Hall

Convenor: Rangarirai Machemedze, SEATINI, Zimbabwe

Pa10.1: The Kenya Anti-Counterfeit Act, 2008: Limiting access to health care or protecting intellectual property?

Anthony Laibuta, Health Rights Advocacy Forum, Kenya

Taking into account the fact that economic and trade policy does affect the realisation of the right to health, an analysis of the Kenya Anti-Counterfeit Act, 2008 is inevitable. Health equity is paramount and should be realised and protected against policies that limit or do away with the right to health. International, regional and municipal agreements promote the realisation of the best attainable state of health. Of specific relevance are the World Trade Organisation's Doha Declarations on Trade Related Intellectual Properties and Public Health. Further, provisions of the WTO General Trade Agreements on Trade and Tariffs protect trade and health at the same time but there are the dangers of adopting TRIPS-Plus principles in dealing with health related matters. The International Covenant on Economic, Social and Cultural Rights and The African Charter on Human and Peoples Rights also offer guidance in terms of recognition and protection of health as a human right. Health equity includes guaranteed equitable access to essential medicines. In developing nations this entails access to affordable medication in the form of generic drugs. The Anti-Counterfeit Act, 2008 may limit access to essential medicines to Kenyans who heavily depend on generic medication as it does not specifically distinguish between generics and counterfeits especially as relates to medicines. Further, the authority bestowed upon the Anti-Counterfeiting Agency is excessive and susceptible to abuse. This may lead to arbitrary seizure or destruction of generic medication. Tanzania has adopted Merchandise Marks Regulations, 2008 that deal with the fight against counterfeiting but with no indication as to the position of generic medication that should be dealt with care. Equitable access to essential medicines including generics should be distinguished with counterfeiting of non-essential goods due to their life-sustaining nature. Uganda on the other hand has no solid laws directly tackling counterfeiting of essential goods. Monitoring of economic and trade policy by civil society organisations and their participation in bringing about positive change in health policies that are both economically viable and human rights sensitive in terms of the right to health is vital in ensuring health equity. This is in line with a human rights based approach in formulation, discussion, enactment, monitoring, evaluation and amendment of economic and trade policy such that all stakeholders in the sector comprehensively contribute and participate in policy making and regulation. Economic and trade policies should be enacted after an all inclusive and viable process. Vigilance from health rights advocates should be high as economic and trade policies that may be adverse to the realisation of the right to health may often be enacted.

Pa10.2: In defense of national interests: Consumer participation in IPR reforms

Arthur Mpeirwe, HEPS-Uganda

Uganda is involved in reforms for its intellectual property laws in order to conform to the minimum standards set out in the World Trade Organisation TRIPS Agreement. It is acknowledged that affordability is a key determinant of access to medicine. The higher the price, the less the number of people that can afford the medicine. There is international consensus that a flexible patent regime affords greater access to medicine and consequently improves health. Achievement of greater access to medicine through patent law can be achieved by making "full use of TRIPS flexibilities". HEPS UGANDA undertook a study aimed at analysing the draft Patent Law and key informant interviews with government technocrats, civil society and IP experts on the process of the reform to establish whether the bill is conducive to access to medicine and whether the process was inclusive. The study found that the reform process was spearheaded by government agencies with financial and technical backing backing from USAID, potentially increasing the influence of foreign (trade) interests in the reform process. The process of reform was not inclusive of all stakeholders weakening input to and advocacy for the full uptake of TRIPS flexibilities. The effect of patents on the price of medicines as an issue was not raised in the review of the law. As a consequence, it is argued, the draft patent law produced failed to incorporate to a desirable extent, the TRIPS flexibilities. Uganda's failure to make full use of TRIPS flexibilities in the current draft patent law is likely to prejudice the country's interventions in making medicine affordable to the majority poor Ugandans. The study showed the importance of inclusiveness and transparency in the procedures and process by which patent laws are developed for the outcome of those laws. There is need for increased involvement of and advocacy by civil society in trade policies to raise health issues with policy makers, particularly the effect of patents on the price of medicines.

Pa10.3: Monitoring the Global Strategy and Plan of Action for Public Health, Innovation and Intellectual Property in Africa (GSPA)

Patrick Mubangizi, HAI Africa, Kenya

Christa Cepuch, Peter Munyi

In May 2008, the World Health Assembly's Resolution 61.21 on the Global Strategy and Plan of Action (GSPA) heralded a new era of fulfilling the right to health. This Resolution is a culmination of Member States' negotiations on public health, innovation and intellectual property. It seeks to secure, inter alia, enhanced and sustainable needs-driven, essential health research and development for medicines to treat the diseases that disproportionately affect developing countries. As a medium term framework, the GSPA contains clear objectives and priorities for research and development, including estimated funding needs. It may be the most important directive to address access to medicines since the landmark Doha Declaration of 2001. The GSPA has eight elements, the eighth being monitoring and evaluation (M&E) of the strategy's implementation. The primary responsibility for implementing an M&E system for the GSPA lies with the World Health Organisation (WHO), however other stakeholders are encouraged to, and should, be involved in monitoring. As organisations active in the process and negotiations leading to the GSPA, HAI Africa and IQsensato (a Geneva-based research and communications organisation whose goal is to shape international policy-making on development) have now developed the first tool to monitor the implementation of the GSPA. This tool represents the interests of civil society and is intended to be complementary to WHO's M&E system, once it is established. Given the whole concept behind the GSPA is equity-based, the M&E should reveal whether this equity is being achieved. Together with civil society partners, HAI Africa and IQsensato are piloting the monitoring tool in five African countries (Ghana, Kenya, Rwanda, Uganda, and Zimbabwe) from May 2009. Preliminary findings arising from this monitoring process will be analysed and presented. It is expected that the preliminary results will indicate whether the GSPA is being implemented by Member States. If being implemented, the results will show the kind of support that implementing countries are receiving and the challenges they face. Through these results, it will be possible to discern further work needed to be done by civil society to ensure the full implementation of the GSPA, with the ultimate goal of increasing access to medicines to meet real health needs of our populations. The presentation will focus primarily on the findings from monitoring on the policy and systems obstacles to access, and secondarily the use by civil society of monitoring as a means of advancing entitlement claims to essential medicines.

Pa10.4: BANG (BITS ATOMS NEURONS GENES): New technologies & health

Pat Mooney, ETC group Canada

Three powerful shocks will come together in the coming decades. The environmental meltdown being created by old industries, new climate chaos, and biodiversity loss will create justification for a massive techno-fix. This techno-fix can best be characterised as technological convergence at the nanoscale – the scale of atoms and molecules. Corporations will argue that BANG (technologies that relate to Bits Atoms Neurons Genes) is our only hope and that this convergence requires an unprecedented partnership with corporate consortia strengthening patent monopolies, suspending competition policies, and regulating societies. The emergence of BANG very much affects the health movement. Medical applications of nano-scale technologies have the potential to revolutionise healthcare by delivering powerful tools for diagnosing and treating disease at the molecular level. But the current zeal for nano-enable medicines could divert scarce medical R&D funds away from essential health services and direct resources away from non-medical aspects of community health and wellbeing. Although nanomedicine is being touted as a solution to pressing health needs in the global South, it is being driven from the North and is designed primarily for wealthy markets. This has direct implications for health equity. Crucial questions remain about the health and environmental impacts of nanomaterials that are being used to develop nanomedicines. The nascent field of "nanotoxicology" is awash with uncertainty. Nanoparticles too small to be seen by the immune system – that can pass through the blood/brain barrier and the placenta – could lead to a major health risk. Despite the fact that nano-scale products have already been commercialised, and are currently being assembled by workers in labs and factories around the world, no government in the world has developed regulations that address basic nanoscale safety issues. History shows that it takes at least a generation for a major new technology to overcome its original defects.

Pa11: Parallel Session: Access to health care: Addressing barriers in vulnerable groups

Thursday 24 September 2009 1530-1730

Meera Hall

Convenor: Mwajuma Masaigana, TARSC, Tanzania

Pa11.1: Improving access to HIV and AIDS services for commercial sex workers: Case of Lilongwe Urban (Area 25)

Kingsley Rex Chikaphupha, REACH Trust, Malawi

Patnice Nkhonjera, Ireen Namakhoma, Thokozire Nkhoma, Hazel Chirambo, Jonathan Chilombe, James Chipeta, Rene Loewenson

The HIV prevalence rate in Malawi is at 14%. The 2006 Malawi behaviour Surveillance survey indicates that up to 70% of sex workers are HIV positive. The policy for promoting equitable access to ART in Malawi highlights commercial sex workers (CSWs) as a key group to be targeted in increasing access to treatment. The aim of this study was to explore barriers to access to HIV prevention and treatment services among commercial sex workers. The study used participatory action research to assess CSWs health needs on HIV and AIDS in urban - Lilongwe. Formative survey and impact evaluation were done to measure the impact of the intervention on CSWs. Key informant interviews and PRA workshops were also used. Results showed that CSWs are knowledgeable of HIV and AIDS information and health facilities where they can access HIV and AIDS prevention and treatment services. However, they indicated that they do not access counselling and testing for HIV due to abuse from health workers, police and stigma from the general public. Most CSWs had stayed for two to three years since their first HIV test. Of the 45 CSWs that participated in the baseline survey; over half rated their access to HIV Testing and Counselling (HTC) as very low or low. During the HTC exercise that was conducted within the study, out of over 60 CSWs approached in brothels, 25 consented to be tested and all of them were diagnosed and treated for STI problems, while nine tested HIV positive. Poor communication between providers and CSWs was also noted as a challenge to access HIV and AIDS services. HCWs were reported to treat CSWs rudely which sets up a cycle of rude and sometimes violent interactions between HCWs and CSWs, undermining CSW willingness to attend services. Commercial sex workers further reported that shortage of drugs to prevent or cure sexually transmitted infections (STIs) and opportunistic diseases demotivated them to access HIV and AIDS services. Hence even CSWs reporting awareness that they have an STI also reported that they do not seek care. CSWs are generally willing to access services but fail to do so due to stigma and abuse. However, when engaged in behaviour change initiatives, CSWs are very active and willing to participate. We suggest that health providers facilitate involvement of CSWs in decision making on actions related to their health needs as an entry point to improve their access to services.

Pa11.2: Evaluation of the HIV prevalence, risks for HIV infection, access to health care, and human rights context among men who have sex with men (MSM) in Malawi, Namibia, and Botswana

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In the generalised epidemics of HIV in southern Sub-Saharan Africa, men who have sex with men have been largely excluded from HIV surveillance and research. Epidemiologic data for MSM in southern Africa are among the sparsest globally, and HIV risk among these men has yet to be characterised in the majority of countries. A 2008 cross-sectional anonymous probe of 537 men recruited through snowball sampling who reported ever having had sex with another man in Malawi, Namibia, and Botswana using a structured survey instrument and HIV screening with the OraQuick© rapid test kit. The participants tended to be young overall with mean ages of 24-26 in each of the three countries. The majority had at least a secondary education, and approximately half were currently employed. All study participants were recruited from urban areas. The HIV prevalence among those between the ages of 18 and 23 was 8.3% (20/241); 20.0% (42/210) among those 24-29; and 35.7% (30/84) among those older than 30 for an overall prevalence of 17.4% (95% CI 14.4-20.8). In multivariate logistic regressions, being older than 25 (aOR 4.0, 95% CI 2.0-8.0), and not always wearing condoms during sex (aOR 2.6, 95% CI 1.3-4.9) were significantly associated with being HIV-positive. Sexual concurrency was common with 16.6% having ongoing concurrent stable relationships

with a man and a woman and 53.7% had both male and female sexual partners in proceeding six months. Unprotected anal intercourse was common and the use of petroleum-based lubricants was also common when using condoms. Human rights abuses, including blackmail and denial of housing and lack of health care was prevalent with 42.1% (222/527) reporting at least one abuse. MSM are a high-risk group for HIV infection and human rights abuses in Malawi, Namibia, and Botswana. Concurrency of sexual partnerships with partners of both genders may play important roles in HIV spread in these populations. MSM lack equal access to health care that meet their specific health needs. Further epidemiologic and evaluative research is needed to assess the contribution of MSM to southern Africa's HIV epidemics and how best to mitigate this. These countries should initiate and adequately fund evidence-based and targeted HIV prevention programs for MSM.

Pa11.3: Bridging the gap in medical service provision among people with disabilities in Uganda

Ivan Masembe, Hope Restoration Community Foundation Uganda

Mukiibi Ronald, Annette Birabwa

People with disabilities are less likely to access medical services in health centre facilities and communities, which are often insensitive to their health needs.

This assessment explored stigma, perceptions and local understandings of medical, care and treatment disregard perpetuated against people with disabilities but went further to determine how and where they can easily access medical services. Purposive sampling was applied in selection of participants from four sub-counties namely Kalangala central, Kawujjo, Gutujja and Kabimbili. The selection took into consideration the need to reflect geographical, religious and social diversities so that lessons drawn there from are more likely to be applied to the east and southern-African region as a whole. It was carried out in 50 schools - 30 primary and 20 secondary, three rehabilitation centres, five referral government hospitals and six deaf VCT centers.136 respondents with different degrees of disabilities and a 30 able bodied medical personnel were interviewed for this data collection. Only 15% of the disabled people found in the study reported that they were able to satisfactorily access medical services. The assessment found the gap in access to medical services by people with disabilities to be due to stigma, poverty, lack of government policy and negative social attitudes towards them. The demand for support and lack of resources overwhelm the few available NGO's supporting people with disabilities. I n order to improve access to care for people with disability there is need for specific attention to their needs by all stakeholders, especially government. This should include preparation of guidelines on the management of people with disabilities at health centres.

Pa11.4: Empowering communities in Kenya towards the abandonment of female genital mutilation/cutting

Anne Khasakala, Population studies and Research Institute, Kenya

Female Genital Mutilation (FGM) is a deep-rooted traditional practice that is prevalent in Africa. According to the World Health Organisation, it is practiced in 28 out of the 52 countries in sub-Saharan Africa, where national prevalence ranges from 5% in the Democratic Republic of Congo to 98% in Somalia. In Kenya the national prevalence stands at 32% with a wide variation among communities that practice it. FGM/cutting may be regarded as a violation of the basic human rights of women and girls. It reflects deep-rooted inequality between the sexes, constitutes discrimination against women and is associated with maternal morbidity and mortality. Studies have shown that women who have undergone FGM especially types II and III excision and infibulations have increased likelihood of scarred and/or tightened vulva which can contribute to obstructed labour. This therefore requires concerted efforts to eliminate the practice. This paper highlights social dynamics of FGM/C abandonment relating to alternative rite of passage (ARP) and Intergenerational dialogues IIDGs) as strategies aimed at eliminating the practice in some communities in Kenya. Social convention theory has involved the identification of champions that eventually pioneer or lead the process of abandonment of perceived harmful practices. The theory was first applied to the practice of foot-binding in China.. This paper assesses whether this theory is applicable to FGM practices in Kenya. Review of relevant literature was used to identify documented efforts aimed at abandonment of FGM/C by offering alternatives. Qualitative research was used to gather primary data during field visits to six sampled districts (e.g.focus groups, In-depth interviews, key informant interviews). Community Based Organisations that are leading the efforts towards abandonment of FGM/C practice using ARP and IGDs were targeted. The study findings indicated that the girls are now being circumcised at the tender ages of 5 - 12 years in the districts that still value this practice. The reasons for this are varied but revolve around cultural identity and the myths that surround the uncircumcised girls such as being unclean, promiscuous, reduction in sexual urge and being unable to get married among others. It is mainly the parents of the girl who are supposed to make the decision. However, the mother-in-law is one of the main perpetrators. Some women are forced to be circumcised when they are giving birth if they are discovered not to be circumcised in these communities. This causes severe bleeding and sometimes death. Despite legislation against circumcision of girls, this is not easy to enforce in communities that believe it is their cultural right, since those to enforce it within these communities support the practice.

The efforts being made towards abandonment are being spearheaded by community based organisations (CBOs)

with financial support from development partners. These have focused on empowering the girl at the expense of the community as a whole. A value-centred approach (a variant of ARP) appears in contrast to be making some in-roads in one division of one of the sampled districts. This is based on the premise that when people are given information that enables them to make informed choice they practice it for their own benefit and that of their families and this eventually spills to the rest of the community. With this approach, an initial cluster, or group of influence within the community was created. This group then became the champions through public declaration that they would not allow their daughters to be circumcised. The girls instead are secluded for a week during which time information regarding their sexuality and other reproductive health aspects are imparted and they graduate in a public ceremony. FGM/cutting is a relational as opposed to individual behavior and as such, for it to end, it is proposed that a core group emanating from those that go through Alternative Rite of Passage (ARP) and intergenerational dialogues (IGDs) lead the process of abandonment.

Pa12: Parallel Session: 'Eye on Equity': Approaches to keeping a watch on equity

Thursday 24 September 2009 1530-1730

Majestic Hall

Convenor: Rene Loewenson, TARSC, Zimbabwe
With M Mulumba HEPS, E Zulu APHRC and the 'Eye on Equity' photography team

Building a sustainable basis for improved health in the region calls for improved tracking of the extent to which disadvantaged individuals and households access a larger share of national resources, not only for health care but also for wider social determinants of health. Giving policy profile to health equity demands monitoring and production of measurement of progress on key dimensions of health equity and of action on it. This session explores approaches to monitoring equity at country and regional level.

The session introduces the analytic framework and implementation of "equity watches", drawing on experience of the regional equity analysis in east and southern Africa and of country equity analyses in selected countries (Zimbabwe by TARSC, Uganda by HEPS). It presents the quantitative and qualitative targets and indicators monitored and reported on at country and regional level across the ESA region, through an "equity watch", to monitor key processes, investments and policy decisions that contribute to health equity outcomes. The session explores the capacities, evidence, analysis and processes for developing the equity watches and their use to advance equity within national strategies and plans, within parliamentary budget and oversight, within civil society advocacy, in engaging with international partners and in identifying areas for further research. During the session presentation of a district equity analysis implemented in two districts of Tanzania by Ifakara Health Institute explores the additional evidence gained from such district level analysis, which may be poorly captured in national databases, and its contribution to understanding the trends in and reasons for differentials in implementation of national policies at local government level.

The experience of African Population Health Research Centre in using data from the longitudinal demographic surveillance sites (DSS) will be presented to discuss how combining the DSS data with other national surveys like the Demographic and Health Survey give illuminating data on equity. The presentation will explore how expensive, intensive and local approaches like the DSS, mostly unrepresentative of the national picture, can provide important evidence about communities, households, and individuals over time that track changes in inequities within defined geographical areas over time. These approaches will be discussed to propose the content and processes for collecting and engaging on evidence on equity, and to discuss the future forms of equity monitoring in EQUINET and more widely.

Finally the session explores ways of widening engagement on equity monitoring through innovative and visual approaches. It reviews how GIS, used to depict health inequities visually, strengthens policy communication on equity. The session will review the eye on equity photography work and process being displayed at the conference and with the involvement of the community photographers, to discuss how these alternative approaches can be more effectively developed, disseminated and used to raise and advance issues.

Pa13: Parallel Session:
A dialogue on research methods and evidence on private capital flows in the health sector

Thursday 24 September 2009 1720-1800

Regal Hall

Convenor: Greg Ruiters, ISER, South Africa

Proponents of private for profit sector expansion in health care have argued that the private sector is cost-effective, provides quality care, is able to complement government in expanding coverage, while relieving pressure on public funding. In this session we explore the methods and evidence from research underway on the growth of private capital flows in health systems within east and southern Africa, and particularly within selected countries. The programme is being implemented under the umbrella of the Regional network for Equity in Health in east and southern Africa led by the Institute of Social and Economic Research (ISER), South Africa, with the Training and Research Support Centre, Southern and East African Trade and Information Negotiations Institute (SEATINI), and in co-operation with York University, Canada. It is supported by the Southern Africa Trust and by EQUINET. The mode of expansion in privatised health is primarily shaped by state action or inaction. We explore the legal basis, patterns of financing, health care utilisation and impacts of private capital flows on the health system in east and southern Africa. Through presentation and facilitated discussion we explore the effect this has had on national health systems and equitable access to health care.

The session draws on a three year research programme that seeks to better understand the flows of private capital that lie behind the growth of the for-profit health care sector in the region. The work particularly focuses on changes in ownership of medical infrastructure and of health related services that support health care, such as drug production and procurement, laboratory services, the 'hotel' aspects– accommodation, food, waste and hygiene; the transport and communications services - ambulances, communications - and the health worker and knowledge support, including medical and other training schools. We also focus on changes in ownership and share of financing by private-for-profit financing - voluntary health insurance, medical aid, prepayment schemes and health management schemes in the formal sector. The session will outline evidence from the project to date, and discuss issues around the research methods for examining these issues, and around the evidence emerging. Researchers implementing work in this area and those interested in the issues are invited to join the forum.

P5: Plenary:
Country alliances and regional networking
Friday 25 September 2009 0900-1100
Victoria Ballroom

P5.1: Experiences of networking to advance health equity at country level

This session will include presentation and discussion of report of experiences from different countries in east and southern Africa on networking to carry out and disseminate research, build capacities, engage in policy advocacy and strengthen implementation of programmes advance health equity. A general discussion of how to strengthen country networking will be held.

P5.2: EQUINET's organisation and mission into the future
EQUINET Steering Committee

The EQUINET Steering committee will, building on its research, analysis, capacity building, communication, networking, alliance building and policy engagement between 1998-2008, outline its plans to take forward work identified for strategic and technical reasons to be important for advancing equity in health in east and southern Africa:

- Empowering people to build primary health care oriented health systems - learning from processes for social empowerment in health (rights claims, health literacy, participatory approaches, governance mechanisms and social alliances with parliament and civil society), and assessing their impact on strengthening the PHC orientation and equity in health systems at local, national and global level.
- Fairly resourcing national health systems- building an evidence base and analysis to inform state, civil society and parliamentary actions to engage on fair resourcing of health systems, through domestic resource mobilisation, engaging global health initiatives, integrating equity into resource allocation and exploring policy alignment between financing policies and those for the production, deploy-

ment and retention of health workers
- Engaging globally on regional priorities for health equity - to analyse the major global / international policy contexts and processes that impact on health equity in ESA to support regional responses to these policies, with specific attention to building capacities on negotiating on health impacts of global and bilateral trade agreements.
- Implementing a health equity watch at district, country and regional level within the region -using a shared core framework of measures of health inequity, and application of policies and measures that promote equity, and use the findings in policy, civil society, parliamentary and government platforms to promote dialogue on policy and research priorities to promote health equity.
- Strengthening national and regional capacities in advancing health equity- to build leadership and support for capable, informed and self determined collective institutional responses to health equity in ESA countries.

To support this work we will promote the effective networking and communication across the network, and build capacities, communication tools and strategic review and alliances to promote visibility, uptake and use of the work of the network and its various stakeholders. The proposed programme to 2015 is presented for review and discussion.

P5.3: Presentation of the draft resolutions from the conference
EQUINET Steering Committee

The draft resolutions drawn from the various sessions of the conference will be presented for discussion by the plenary.

P6: Closing plenary

Friday 25 September 2009 1130-1245

Victoria Ballroom

P6.1: Presentation and adoption of the resolutions and next steps

EQUINET Steering committee

The final resolutions will be read and adopted in a session open to the media. Closing remarks will be presented from the EQUINET steering committee on the next steps to take forward the plans adopted at the conference.

P6.2: Closing remarks

Uganda local organising committee

A representative of the Uganda local organising committee for the conference will give closing remarks.

P6.3: Closing views and commitments

Conference delegates

Speakers drawn from different constituencies across the conference will give brief reflections and commitments to action drawing from the conference against a background of slides taken during the conference depicting the debates and engagement around the issues, and slides of the resources for health that we have in the different countries that we are returning to. The session will end with music from countries in the region.

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

MUNYONYO, UGANDA 2009