

Review of the Equity Watch work in East and Southern Africa

Regional review and skills workshop REPORT



B Goddard Malawi 2006

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**Regional Network For Equity In Health In East and
Southern Africa (EQUINET)**

through

**Training and Research Support Centre
with Healthnet Consult**



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



with support from IDRC Canada

Table of contents

1. Background and objectives	2
1.1 Objectives	2
2. Opening session.....	3
3. Skills building sessions on equity analysis	3
3.1 Concepts and parameters for monitoring equity in health	3
3.2 Measures of absolute and relative inequality	5
3.3 Measuring and decomposing inequality in health	5
3.4 Measures of inequality in income and wealth	7
3.5 Measures of fair financing and benefit incidence.....	8
3.6 Equity, governance and integrated health systems	9
4. Review of the country Equity Watch work.....	9
4.1 Kenya Equity Watch	10
4.2 Uganda Equity Watch	11
4.3 Zambia Equity Watch.....	13
4.4 Zimbabwe Equity Watch	14
4.5 Mozambique Equity Watch.....	16
4.6 Discussions on the country equity watch work.....	17
5. Issues in carrying out Equity analysis	19
5.1 Getting and using evidence for equity analysis at district level	19
5.2 Disaggregating health expenditure	22
5.3 Social determinants of health equity and universal health coverage	23
5.4 Linking equity analysis to the Millennium Development Goals.....	25
6. The Regional Equity watch.....	27
7. Group Discussions and areas for follow up	30
7.1 On the Regional Equity Watch findings.....	30
7.2 On disseminating and using evidence on equity regionally and in the MDGs	31
7.3 On follow up country work and institutionalising the Equity Watch.....	31
8. Closing.....	32
APPENDIX 1: Meeting delegate address list.....	33
APPENDIX 2: Meeting Agenda.....	35

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1. Background and objectives

Most countries in the East, Central and Southern Africa have made explicit commitments to equity central to their health policies. Recognising the longstanding policy commitment to equity, and the threat that inequality is posing, in February 2010, the East Central and Southern Africa Regional Health Ministers Conference (RHMC) adopted a resolution to track and report on evidence on health equity and progress in addressing inequalities in health. This is based on a premise that to advance health equity, inequalities need to be made visible and discussed in planning and in social dialogue.

Since the 2010 RHMC, EQUINET (co-ordinated by Training and Research Support Centre (TARSC) as cluster lead) has worked in dialogue with ECSA HC, particularly through its monitoring and evaluation expert group, to implement country processes to take the regional resolution forward. In 2007 EQUINET analysed progress towards health equity in ESA, documenting inequalities in health and the measures being taken to address them (EQUINET SC 2007). The EQUINET steering committee drew on the regional analysis to propose 25 progress markers that are relevant and possible to track trends in health inequalities and in progress made in addressing them. This was called an 'Equity Watch'.

Working with EQUINET, technical institutions working with Ministries of Health in five countries have now implemented a country Equity Watch (Mozambique, Zambia, Zimbabwe, Uganda and Kenya), while Tanzania and other countries are implementing or initiating equity analysis. At regional level, analysis of equity has been implemented by WHO AFRO; while UNICEF ESARO has implemented analysis with EQUINET of MDG4,5 and 6 indicators. In 2012 EQUINET has used the progress markers in the Equity Watch (EW) to carry out a second regional equity analysis in ESA, including evidence of good practice from the country Equity Watch reports and other sources. The Regional Analysis has been written by TARSC with input from the country reports, from Healthnet Consult (HNC) and from the EQUINET steering committee.

1.1 Objectives

The Regional methods workshop was held to gather the lead institutions of country teams in the Equity Watch work, the EQUINET steering committee, regional and international agencies and networks involved in work on health equity to strengthen capacities for equity analysis and to review the experience, evidence and learning for future work of the country and regional equity watch work to date.

The workshop thus aimed to

1. Provide training on equity analysis and discuss future approaches to capacity building on equity analysis
2. Review Equity Watch work at country level and the learning and implications from the work for future monitoring of health equity within countries
3. Review and discuss the draft regional Equity Watch and the follow up and dissemination

The meeting was organised by TARSC for EQUINET, in association with the ECSA-HC and held at the Cape Town International Convention Centre after the Global Forum for Health Research. The delegate list is shown in Appendix 1 and the programme in Appendix 2. The meeting was supported by IDRC (Canada) The meeting report has been prepared by TARSC.

2. Opening session

Ruth Kitetu chairperson of the ECSA Monitoring and Evaluation (M+E) Expert Group welcomed delegates on behalf of the ECSA Health Community. She gave the background to the meeting and informed delegates on the November 2011 ECSA HC M+E meeting resolution to include skills training on equity analysis in the regional review meeting on the Equity watch work. She appreciated EQUINET support for this and, together with COHRED, for delegate participation in the Global Forum for Health Research.

Sibusiso Sibandze from the East Central and Southern Africa Health Community (ECSA-HC) had welcomed delegates the previous evening at the Equity Watch session at the Global Forum. Due to other commitments he was not able to attend the full meeting, but noted the support from ECSA for the work and collaboration with EQUINET. ECSA HC had begun to report back on the health situation in the region and would integrate equity into this reporting. He communicated ECSA support for the work to date, for the skills building and welcomed delegates to the workshop.

Delegates introduced themselves, their institutions and the work they are doing related to health equity.

Dr Rene Loewenson, co-ordinator of the Equity Watch cluster in EQUINET added her welcome to the EQUINET steering committee members, the country equity watch teams, the ECSA M+E expert group members, the UN and international agency representatives and resource people present. She thanked IDRC Canada for their support for the meeting and the equity watch work. She introduced the aims and objectives of the meeting, shown above, and the agenda.

The delegates reviewed and adopted the programme and the first skills building sessions were chaired by Chris Moyo, Ministry of Health, Malawi.

3. Skills building sessions on equity analysis

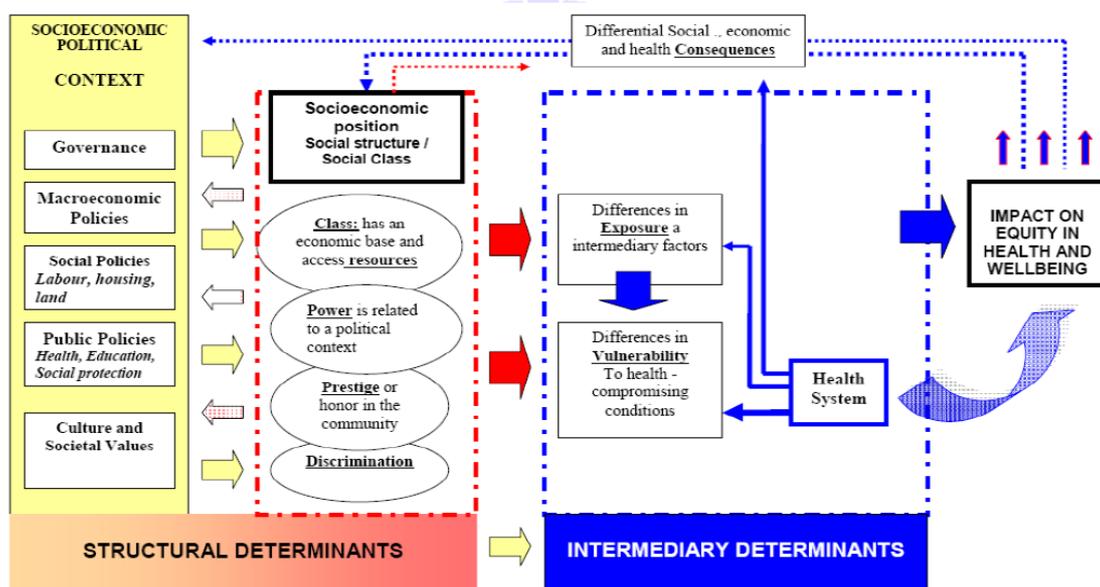
Skills building sessions on equity analysis were held at various points in the programme. They are briefly reported here in sequence as longer handouts and background documents were provided for each session that give further information on each area. Due to time constraints the skills building sessions introduced the concepts and methods for key areas of equity analysis but did not go into significant hands on practice, which it was understood that delegates would do after the workshop. In the final group discussions delegates proposed areas for follow up on skills building on equity analysis.

3.1 Concepts and parameters for monitoring equity in health

Rene Loewenson gave an overview of the concepts, conceptual frameworks and parameters for monitoring equity in health. While inequality refers to a description of differences in health, health care and other outcomes across social groups, equity implies that the differences are avoidable and unfair; that everyone should have a fair opportunity to attain their full health potential and that resources should be allocated in relation to health need. After reviewing the EQUINET, WHO and other definitions of health equity, delegates agreed that equity goes beyond the description of inequalities to assigning value to those inequalities, because they are deemed to be avoidable and unfair, and addressing the allocation of resources to address those unfair and

avoidable inequalities. Dr Loewenson presented the conceptual framework used by the Commission on Social Determinants of health, that shows the contextual factors or structural determinants (institutions, values, policies) that stratify populations according to income, education, occupation, gender, race/ethnicity and other factors. These structural determinants and the socioeconomic positions they lead to shape intermediary determinants of health status (material, behavioural and psychosocial determinants, and the performance of health systems) that lead to different experiences of exposure and vulnerability to health-compromising conditions. The health or illness status that arises as a consequence can itself “feed back” on people’s social position or the functioning of institutions, such as by compromising employment opportunities or reducing income.

The CSDH Framework summarizing the major categories of determinants and the processes and pathways that generate health inequities



Improving equity implies

1. Remedying health disadvantage – this is done through interventions that target at specific populations, such as free services for poorest households;
2. Reducing gaps between groups - such as through incentives that encourage retention of key health workers in peripheral areas or that encourage uptake such as by overcoming transport barriers through vouchers;
3. Reducing the gradient across the population – such as through measures that mobilise resources according to ability to pay and allocate resources according to need.

She introduced the methods for measuring differentials in health and health care; for comparing absolute or relative differences between groups, comparing coverage (gaps) against a reference group or target; associating inequalities in causes with inequalities in health outcomes; and measuring the benefit incidence, or the extent to which different social groups benefit from areas of health spending. She noted that this calls for identification of stratifiers of social positioning, including by income, wealth; education attainment ; age; sex; residence; geographical area; ethnicity and employment. Finally she outlined the criteria for selecting parameters for health equity analysis, in terms of the stratifiers and parameters for assessing differentials in health outcomes and relating them to the different resources for health, including within the health system.

3.2 Measures of absolute and relative inequality

Shepherd Shamu, University of Zimbabwe, outlined the measures that can be used to reflect inequality in the distribution of a health variable and the differences in health among values of a social or economic variable, as summarised in Table 1 below.

Table 1. Overview of summary indices

		Summary index (with example of an interpretation)	
		On the 'absolute' occurrence of health problems	On the 'relative' occurrence of health problems
Indices that compare two groups	Compare groups	Rate Difference - e.g. the difference in mortality between different groups of workers	Rate Ratio idem, but the <i>proportional</i> mortality difference
Regression-based indices that take into account all groups separately	Based on 'absolute' socio-economic status (SES)	'Absolute effect index' e.g. the absolute increase in health associated with an income increase of \$1000	'Relative effect index' idem, but the <i>proportional</i> increase in health
	Based on 'relative' SES	'Slope Index of Inequality' (SII) e.g. the health difference between the top and bottom of the income hierarchy	'Relative Index of Inequality' (RII) idem, but the <i>proportional</i> health difference
"Total impact" indices that explicitly take into account population distributions	The PAR perspective (<i>equality by levelling up</i>)	Population Attributable Risk (PAR) e.g. the total number of cases that would be avoided in the hypothetical situation that all people would have tertiary education	PAR (%) idem, but as a <i>proportion</i> of all cases (of death, disease, etc) in the total population
	The ID perspective (<i>equality by redistribution</i>)	Index of Dissimilarity (ID) e.g. the total number of cases to be redistributed between groups in order to obtain the same average rate for all groups	ID (%) idem, but as a <i>proportion</i> of all cases (of death, disease, etc) in the total population

3.3 Measuring and decomposing inequality in health

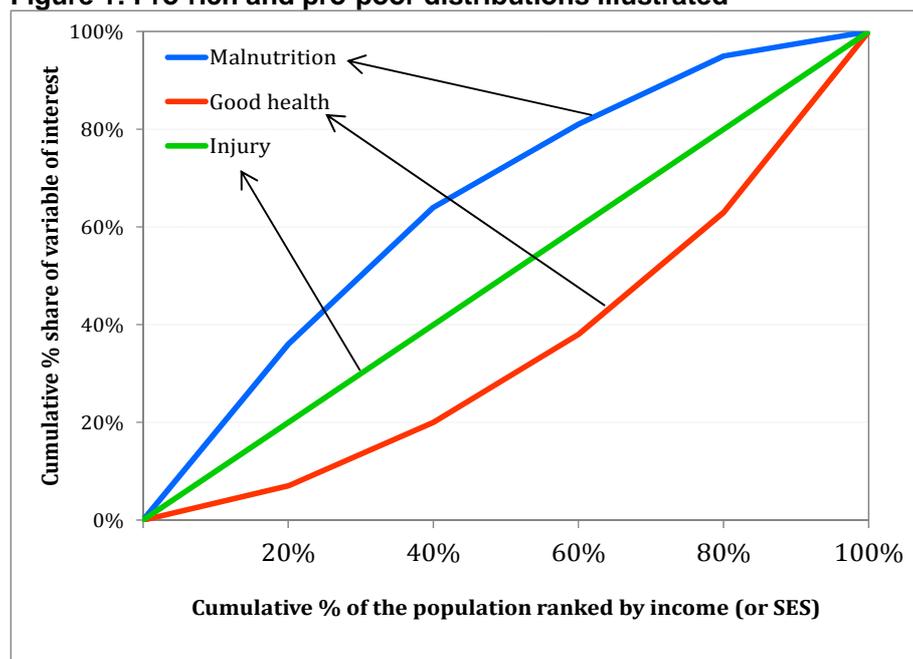
John E. Ataguba, Health Economics Unit, University of Cape Town explained how to assess health variation univariately, bivariately or multivariately. Univariate assessments looks at inequality in the distribution of health in a population without reference to any other distribution. In bivariate analysis, the distribution of health is related to another important/relevant variable such as gender, region, or socio-economic status (SES).

Multivariate analysis involves comparing inequality in health simultaneously in relation to at least two other variables, such as immunisation by wealth and gender.

He introduced the use of regression analysis to explore the factors that are associated with the variation in health/ill-health outcomes. In particular he focused on decomposition analysis for quantifying the extent to which inequalities in the factors that 'determine health' explain observed inequalities in health. Such decomposition is based on regression analysis of the relationship between 'health' (or any measure of it) and the factors that 'determine' health (which we call correlates). This is descriptive in that it measures association not causality but enable understanding of correlates that contribute most to health inequality.

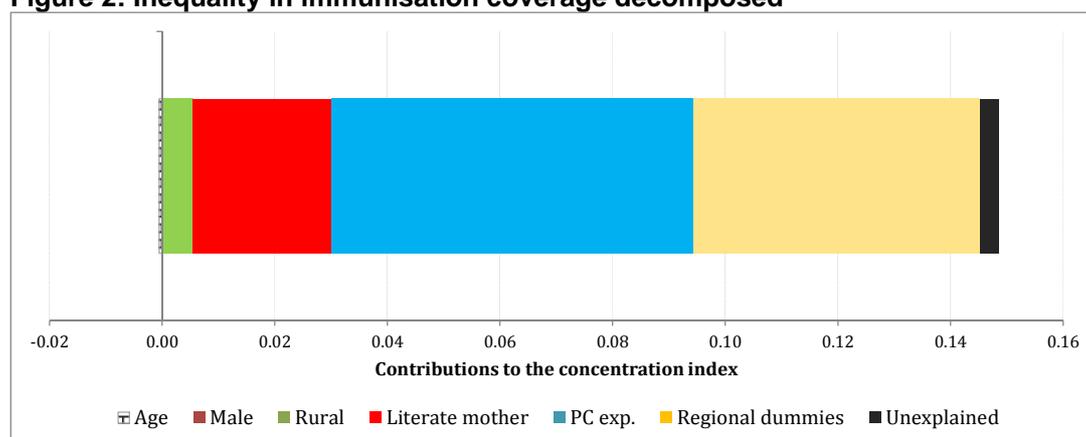
He outlined calculation and use of the concentration curve, used to show the extent to which the health variable of interest (say malnutrition) is distributed among groups ranked at different levels of socioeconomic status in a population. He also demonstrated how the concentration curve is interpreted when it falls above or below the equality line (See figure 1 for example; above the line implies). John outlined how the concentration index provides a summary index of the extent of inequality in health (defined as twice the area between the concentration curve and the line of equality) that ranges from -1 (if the curve is above the equality line) to +1 (If the concentration curve is below the equality line).

Figure 1: Pro-rich and pro-poor distributions illustrated



1. Good health is below the line and concentrated in the richer groups
2. Malnutrition is above the line and concentrated in the poorer groups
3. Injury is on the equality line and equally distributed.

Figure 2: Inequality in immunisation coverage decomposed



Decomposing the concentration index uncovers the underlying 'causes' of inequality. He introduced the method for disaggregating the contribution of different factors to the inequality measures in the concentration index, as exemplified in Figure 2.

3.4 Measures of inequality in income and wealth

The skills sessions on economic and financing issues were chaired by Dr Yahya Ipuge, Ifakara Health Institute, Tanzania. Shepherd Shamu, University of Zimbabwe, outlined the measures that can be used to assess income and wealth distribution, including

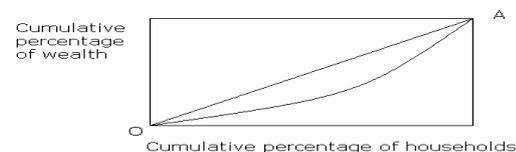
- Income, Expenditure, Consumption
- Wealth
- Poverty

He noted the debates in the use of these measures and what they tell about capabilities and access or deprivation in relation to a wide range of resources that are necessary for health. He introduced that measures may be absolute or relative. For example absolute poverty refers to a set standard which is the same in all countries and which does not change over time (such as the percent below a poverty line), while relative poverty / wealth / income refers to a standard which is defined in terms of the society in which an individual lives and which therefore differs between countries and over time (such as the wealth quintile). Purchasing power parity allows us to compare countries with different costs of living. Relative measures of economic wellbeing do not merely measure the level of an indicator, including against a universal minimum or basic standard of that measure, but quantify the degree of variation between socioeconomic groups to identify the “gap”, gradient or “difference” between these groups and groups. He outlined how wealth indicators can be disaggregated, such as Multidimensional Poverty Index (MPI) that shows deprivation aggregated across three dimensions: health, education, and standard of living, measured using ten indicators, with each dimension equally weighted.

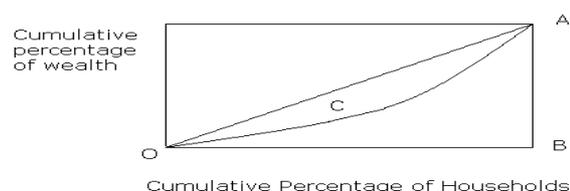
Wealth quintiles are one way of assessing relative inequality that has been useful in *equity* analysis is through measure is through sorting households on where they position ordinally on the index and dividing the Index into quintiles (fifths) of the national household population. These quintiles are based on the distribution of the household population rather than on the distribution of households (concerned about poor people rather than poor households). In the discussion it was noted that the assets used ion wealth quintiles, such as access to safe drinking water, cannot then be disaggregated by the same wealth quintiles. Further the relative weighting of assets such as land owned or rented, or of other assets, may be socially defined and change over time. It is thus important to triangulate such quantitative data with other estimates of inequalities in income and wealth, including as reported by communities.

Shepherd introduced how measures of wealth inequality are calculated, including

i. the Lorenz Curve showing the cumulative population proportion against the cumulative wealth. If wealth is highly concentrated, the curve will be further from the equality line.



ii. The Gini Coefficient which is the ratio of the area between the Lorenz curve and the line of absolute equality. A value of 0 represents perfect equality, a value of 1 perfect inequality. The line of absolute equality forms the numerator and the whole area under the line of absolute equality forms the denominator. So as in the figure adjacent the Gini Coefficient = C/OAB .



He cautioned on how these measures are interpreted, noting that they do not consider the size of the economy, its absolute levels of wealth, or how changes over time reflect social mobility across different groups. Countries may, for example, have identical Gini coefficients, but differ greatly in wealth.

3.5 Measures of fair financing and benefit incidence

Charlotte Zikusooka Healthnet Consult outlined fair financing principles in terms of:

- Financial protection - that no one in need of health services should be denied access due to inability to pay and that households' livelihoods should not be threatened by the costs of health care;
- Progressive financing - that contributions should be distributed according to ability-to-pay, and that those with greater ability-to-pay should contribute a higher proportion of their income than those with lower incomes;
- Cross-subsidies – (from the healthy to the ill and from the wealthy to the poor) that are promoted in the health system.

She outlined a number of ways of measuring these dimensions of fair financing, defining the terms and showing how they are measured, particularly in terms of

- financial protection measures- catastrophic health spending and impoverishment from health spending
- progressive financing- financing Incidence analysis, progressivity assessment; benefit incidence analysis.

Catastrophic spending on health, or the spending on health that exceeds a particular threshold in relation to the household's pre-payment income less deductions for other necessities (e.g. food, clothing, etc). The catastrophic headcount refers to the percentage of individuals or households exceeding the threshold. The choice of threshold is, however, often arbitrary. In order to assess the effect of out-of-pocket health expenditure on household welfare, it is possible to assess the incidence and intensity of 'catastrophic' health care expenditure, in terms of the extent to which health costs incurred exceed different fractions of pre-payment household income. The impoverishment from health spending is measured by the extent to which out-of-pocket payments on health push households (deeper) below the poverty line.

To measure financing incidence, we need to ask the following questions:

- Who pays for health care?
- For each socio-economic (or income) group, or ethnic group or location, etc., what % of income is devoted to health care financing?
- In assessing progressivity, to what extent are payments toward health care related

She explained how these measures are calculated and the summary indices of progressivity useful for making comparisons (the Kakwani index, the concentration curve and index, and the Lorenz curve). She then outlined the progressive nature of different sources of health financing.

Measuring benefit incidence allows us to find out who, in terms of socio-economic groups, is receiving what benefits from using health services. Benefit incidence analysis combines data on who is using what services (outpatient & inpatient) with data on the costs of providing each service, and compares the share of spending with a measure of the distribution of need. She outlined the methods for conducting benefit incidence analysis, through

- Estimating the distribution of health services (public, private) in relation to a measure of socio-economic standards such as the wealth quintile;
- Estimating the unit cost of each service multiplied by the utilisation rate for each service to obtain the monetary benefit of each service;
- Aggregating the monetary benefits of utilization for the different health services for each socio-economic group;
- Through the above assessing the distribution of the financial benefit for the service compared with the distribution of the need for health care.

3.6 Equity, governance and integrated health systems

Mr Qamar Mahmood International Development Research Centre IDRC led a brainstorming exercise on the concepts of equity, governance and the integration of health systems. Delegates were divided into two groups and asked to write short phrases/ideas regarding the three concepts on cards. The cards were laid out and discussed both in terms of the understanding of the concepts and of the relationships between them. After some debate there was consensus on the perception that “governance” and “integrated health systems” were both “inputs” and “equity” an “output” in the relationship and that the two former areas were necessary dimensions in the achievement of the latter.

4. Review of the country Equity Watch work

Since the 2010 RHMC, EQUINET has worked with country teams to implement country analysis of 25 progress markers shown in box 1 below of trends in health inequalities and in progress made in addressing them, called an ‘Equity Watch’.

Box 1 Progress markers in the Equity Watch

Advancing equity in health

1. Formal recognition and social expression of equity and universal rights to health
2. Reducing the Gini coefficient to at least 0.4
3. Eliminating differentials in maternal mortality, child (neonatal, infant, <5) mortality, underweight, wasting and stunting
4. Eliminating differentials in access to immunisation, in treatment for pneumonia, in contraceptive prevalence, in antenatal care and in deliveries by skilled personnel
5. Achieving universal access to prevention of vertical transmission, condoms and antiretroviral treatment,

Household access to the national resources for health

6. Achieving the Millennium Development Goal of reducing by half the number of people living on \$1 per day by 2015
7. Increasing the ratio of wages to Gross Domestic Product;
8. Achieving and closing gender differentials in attainment of universal primary and secondary education
9. Meeting standards of adequate provision of health workers and of vital and essential drugs at primary and district levels of health systems;
10. Abolishing user fees from health systems, backed by measures to resource services
11. Achieving the Millennium Development Goal of halving the proportion of people with no sustainable access to safe drinking water by 2015
12. Overcoming the barriers disadvantaged groups face in accessing and using services.

Resourcing redistributive health systems

13. Achieving the Abuja commitment of 15% government spending on health
14. Achieving the WHO target of \$60 per capita public sector health sector expenditure;
15. Increasing progressive tax funding to health; reducing the share of out-of-pocket financing in health;
16. Harmonising the various health financing schemes into one framework for universal coverage;
17. Establishing and ensuring a clear set of comprehensive health care entitlements for the population;
18. Allocating at least 50% of government spending on health to district health systems (including level 1 hospitals) and 25% of government spending on primary health care;
19. Implementing a mix of financial and non-financial incentives agreed with health workers organisations
20. Formally recognising in law and policy and earmarking budgets for training, communication and functions of mechanisms for direct public participation in all levels of the health system.

A more just return for ESA countries from the global economy

21. Reducing debt as a burden on health - Debt cancellation negotiated, with debt relief allocated to health and social sectors, and control of debt stress;
22. Allocating at least 10% of budget resources to agriculture, with a majority share used for investments in and subsidies for smallholder and women producers;
23. No new health service commitments in GATS and inclusion of all TRIPS flexibilities in national laws;
24. Health officials in trade negotiations and clauses for protection of health in agreements;
25. Bilateral and multilateral agreements to fund health worker training and retention measures, especially involving recipient countries of health worker migration.

An Equity Watch

- Gathers and organises evidence to make visible whether progress is being made on health equity, at national and regional level;
- Gathers and organizes evidence on whether policy commitments and measures to improve equity are being acted on;
- Makes proposals and promotes dialogue on the findings, and what it means for policies
- and actions to strengthen health equity;
- Points to knowledge and evidence gaps for research; and
- Shares country evidence at regional level, for exchange across countries, on common trends and on promising practices.

Technical institutions working with Ministries of Health in five countries had by the time of the meeting completed country Equity Watch reports, ie Mozambique, Zambia, Zimbabwe, Uganda and Kenya. In sessions chaired by Hon Blessing Chebundo, the chair of the Parliamentary Committees on Health in East and Southern Africa (SEAPACOH) and Member of the Parliament of Zimbabwe, countries reported on their work in terms of the key findings, issues raised and recommendations for carrying out equity analysis and for future work.

4.1 Kenya Equity Watch

Mr Charles Dulo, Kenya Health Equity Network reported on the Equity Watch (EW) work implemented by the team in Kenya¹. In the period under review Kenya made a major commitment to the right to health in its new 2010 constitution, that needs to be implemented and monitored to realize the rights included. In particular the EW pointed to the need to ensure that communities are aware of their rights and how to claim them.

He reported on positive trends found, particularly in maternal and child mortality, less so in neonatal mortality, although with some reversal in the previous gains in maternal mortality in the 2005-2008 period. This makes reducing maternal and neonatal mortality a key area for policy attention, and for better understanding the social differentials in these areas of mortality and their determinants. While there is evidence in infant mortality of worsening urban performance and wide geographical differences, the EW report highlighted the need to gather evidence to understand who is at greatest risk and to better plan equity oriented responses in respect of neonatal and maternal mortality.

In relation to health resources, the EW found high and improving aggregate levels of child health services such as immunisation coverage, with low rural urban differences but wide differences by region and only 43.8% of children in North Eastern province fully vaccinated. However despite rising health need as reflected in maternal mortality, maternal health services have much lower coverage, with only 59.9% and 43.8% of urban and rural women respectively reporting more than four antenatal visits, and only 36.8% of rural women having been assisted by skilled health workers during delivery compared to 74.8% in urban areas. He noted that the distribution of health resources in relation to need thus still needs greater attention.

One factor that he presented that undermines redistributive investments is that the EW found a downward trend in relation to the Abuja target of 15% of total government spending going to health, with a fall from 9.1% in 2001 to only 4% in 2009. In contrast external funds have increased dramatically from 16.4% of total health expenditure in 2001 to 34.5% to 2009, raising issues of sustainability and equity in distribution of these

¹ KEMRI-Wellcome Trust Research Programme, Mustang Management Consultants, Ministry of Public Health and Sanitation, Training and Research Support Centre (2011) Equity Watch: Assessing Progress towards Equity in Health in Kenya, KEMRI, EQUIN ET, Nairobi and Harare

resources. The EW points to a need for improved government allocations to the health sector accompanied by approaches to increase absorptive capacity in services in regions of high health need and low health resources. One focus for this is to improve the retention of health personnel in the poorest regions.

Mr Dulo thus reported a number of areas flagged by the Kenya EW as key areas for attention to improve health equity, including

- Supporting and monitoring the implementation of the right to health in the constitution;
- Obtaining disaggregated evidence (including in the DHS) on neonatal and maternal mortality to identify where disadvantage is greatest and what social factors are associated with this;
- Exploring reasons for low coverage on maternal health services (ANC, delivery by skilled personnel) and the availability and uptake barriers to be addressed for improved equity in these services;
- Disaggregating evidence on health worker retention incentives, medicine availability and use to orient universal coverage strategies to better address the specific conditions and needs of more disadvantaged regions and communities;
- Making stronger links across sectors to understand and address the social determinants of health equity.

The team implementing the EW in Kenya recommended that future work on the EW requires stronger commitment from both ministries in the health sector (Medical Services and Public Health and Sanitation), and more time, people and resources to bring together and analyse the significant amount of evidence available. The team recognized the value of having a 'one stop shop' for the information on health equity issues, noting that it needs then to be used in various ways to realize this value. One issue it has flagged, for example, is the limited documented evidence on how the mechanisms function, or resources or capacity support flow for community roles in health equity, suggesting that this is an area the needs greater attention to move from policy to practice.

4.2 Uganda Equity Watch

Dr. Isaac Kadowa, Ministry of Health Uganda reported on the Equity Watch (EW) work implemented by the team in Uganda². The EW showed that Uganda has recorded improvements in health outcomes such as child survival and maternal mortality, but with wide regional and social disparities in infant and under-5 mortality and nutrition, and the distribution of maternal mortality not measured. The report highlighted the need for a survey to better understand the social differentials in maternal mortality and measures to target resources and interventions towards regions with higher health needs.

The EW highlighted some of the factors affecting efforts to ensure equity in health resources in relation to health needs. There are inadequate numbers and outmigration of health workers, but also an unequal distribution, with skilled health workers concentrated in urban areas. The incentives to work in "hard to reach areas" have not been sufficient to overcome factors such as low wages and further policy dialogue is needed on attraction and retention strategies and on a 'hard-to-reach' policy, that addresses conditions and raises incentives for work in these areas, including through salary enhancements.

The report points to other areas of aggregate resource constraints, including frequent stock outs and a shortage of pharmacists, related to low levels of funding. In 2006/07 only \$0.72 per capita was spent on basic supplies, way below the \$2.40 recommended in the health strategy.

² Zikusooka CM, Loewenson R, Tumwine M, Mulumba M, (2010) EQUITY WATCH: Assessing progress towards equity in health, Uganda, 2010, EQUINET, Kampala and Harare

There is already ongoing policy discussion on essential medicines and while the EW adds support for increased funding for medicines and expanded pharmacy training, it also points to the need for better chain management and resource allocation to ensure that resources reach areas where disadvantage is higher.

As in Kenya, the Uganda team also identified low levels of overall government funding limiting strategies for reallocation of resources, and the need to lobby parliament and Ministry of Finance to improve funding. Government spending on health remains low, at 9% of total GoU budget in 2010, far below the Abuja Commitment of 15%. Further, despite policies lifting fees at lower level services, out of pocket expenditure was still high, with increasing catastrophic expenditure, as people need to make private payments in part to secure medicines and services. The EW points to the need for policy dialogue and evidence on prepayment schemes such as the National Health Insurance to widen domestic revenue to improve service supply and equity in access.

Dr Kadowa argued that the EW reports and any research that follows should in future generate knowledge that explains the root causes of inequity and provides evidence on options to support the design and evaluation of policy interventions to address the inequities. Getting to root causes implies actively involving other sectors in action oriented research to address health inequities related to wider social determinants of health. He thus recommended reporting the findings in a way that is accessible and useful to different users, sectors and policy and civil society users.

In terms of institutionalization equity analysis, he called for standards and indicators for monitoring and assessment of health inequalities/health equity to be developed, and a matrix for evaluation of interventions and policies that aim to address inequities. This needs capacity building of people within key sectors to carry forward equity analysis.



Discussions at the meeting

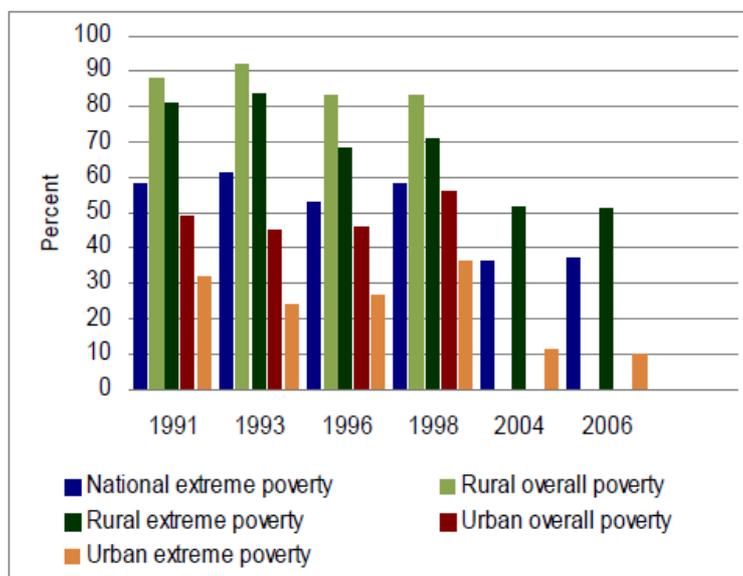
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4.3 Zambia Equity Watch

Professor Bonah Chitah, Department of Economics, University of Zambia presented the Equity Watch (EW) work implemented by the team in Zambia³. He reported inequalities, some increasing, across wealth, education and residence in child mortality, HIV, nutrition and access to maternal and child health care services. . He noted that urban-rural differentials have been closing, but that differentials by wealth in child, infant mortality and child under-nutrition are still wide, even through the aggregate rates have declined.

Figure Rural-urban differences in poverty, 1991-2006

He presented the EW findings on underlying measures of inequality. Zambia has had a relatively high level of income inequality in the past three decades, higher in rural than in urban areas. There has been some overall improvement and evidence of a closing of the gap between rural and urban areas in income inequality as rural inequalities have fallen. This trend he suggested was a positive one that should be tracked and



sustained as it may underlie the closing rural-urban gap in other areas, such as mortality, and also signal wider access to benefits of growth for poverty reduction. He raised that this distribution of benefit is particularly important given that achieving the Millennium Development Goal of reducing by half the number of people in poverty (and living on less than \$1/day) seems unlikely at the current rates of GDP growth.

Some of the determinants of the closing rural-urban gap were raised in the EW report. For example, gender parity is narrowing in education and rural environmental health has improved, although urban access to safe water and sanitation has worsened. Marked improvements in school enrolments and reduction of gender differentials was attributed to increased public investments in infrastructure, a recruitment drive for teachers and the abolition of primary school fees. Public investments in agriculture may also have supported improvements in child nutrition in rural areas.

He noted that since the 1980s Zambia has been struggling to improve health outcomes with decreasing health workers, and significant disparities in the distribution of existing health workers - urban-rural, by region and level of the health system. In the EW this was found to lead to service coverage inverse to need, eg differentials in antenatal care and skilled birth attendance that is higher in wealthier, urban groups than poorer, rural groups.

³ University of Zambia Department of Economics, Ministry of Health Zambia, TARSC, (2011) Equity Watch: Assessing Progress towards Equity in Health in Zambia, EQUINET, Lusaka and Harare

Health care financing has improved, and there has been an improvement in the distribution of resources between the primary level and the hospital sub-sector. However the EW highlighted that this redistributive effect may be limited by the fact that government's share of funding has remained constant, and that external funding has mainly risen for AIDS, TB and malaria through vertical channels, creating difficulties for wider pooling and purchasing functions. There has been progress in replacement of user fees with public funding, reducing the share of out of pocket funding, which has fallen since 2000. While OOP is being reduced to make financing fairer, the rising external share of public financing for health and segmented funding are threatening sustainable financing of the health system.

As a result, policy recommendations were presented from the EW report:

- To prioritise and track the outcome of interventions to eliminate differentials in access to immunisation, ANC and skilled deliveries, and in the latter case to address the wide area and wealth gaps in coverage.
- To widen the benefit found from user fees abolition so that user fees are abolished wholly or partially for selected services in other districts, and finally at all levels of health system, subject to rationalisation of the referral system and adoption of an essential benefits package
- To give consistent attention to measures to allocate additional resources to primary care levels, particularly in districts with low health coverage, and to track the results in terms of coverage indicators of rational drug use, staff–patient contact time and facility utilisation.
- To introduce the proposed social health insurance to increase pooled and support progressive health financing.
- To design of comprehensive financing modalities to address within area wealth related inequalities so that services reach the urban and rural poor and indigent.

For future Equity Watch work it was proposed that there is need for joint ownership of work with health stakeholders in health, academics and NGOs. In the review of the Zambia EW it was proposed that EW work be institutionalized through developing and implementing tracking systematically and continuously rather than as an ad-hoc event, and with tracking of resource support for and the implementation of access policies in primary health care, given limited roll out of the policy on 'health posts' to date. The EW should develop an implementation matrix for addressing issues arising in the reports. He also noted the usefulness of a periodic comparative regional analysis as a context for country specific analysis.

4.4 Zimbabwe Equity Watch

Dr Gibson Mhlanga, Ministry of Health and Child Welfare presented the Equity Watch (EW) work implemented by the team in Zimbabwe⁴. This is Zimbabwe's second Equity Watch report, the first having been done in 2008. Since 2009, there have been social and economic improvements, although with challenges of slow growth after a significant decline in GDP, a rise in urban food poverty, falling secure employment and wages, high and rising levels of external debt and a small increase in wealth inequality.

There is evidence of progress in health outcomes, particularly in 2010 data: significant reductions in HIV prevalence; improved child mortality and under-nutrition; better immunisation coverage; and an improvement in assisted deliveries, although still below 1994 levels. There is also evidence of gaps and widening social differentials. While

⁴ TARSC, MoHCW (2011) Equity Watch: assessing progress towards equity in health in Zimbabwe, EQUINET Harare

geographical inequalities dominated in child mortality up to 2005, socio-economic drivers became more significant after that. Child stunting remains high, with cost of food replacing supply as the major barrier after 2009, and poor child nutrition associated with economic inequalities, particularly in mothers' social and health situation. Maternal mortality levels are high and rising, and wealth, education and provincial differentials in antenatal care coverage and assisted deliveries are wide, indicating that vulnerable groups face supply, access and acceptability barriers to using sexual and reproductive services. There are social differentials in access to interventions for prevention and treatment of AIDS.

There are a number of barriers to households accessing the resources for health: While there has been improved school enrolment, and high gender parity, there has also been lower and more unequal completion rates and cost barriers at secondary school. Zimbabwe showed greater reliance for food on commercial supplies but trade liberalisation has introduced and popularised food and beverage products that are harmful to health, such as fast foods, alcohol etc. Access to safe water 2006-2009 was 80% higher in highest than lowest wealth group, and there were wide rural-urban, provincial differences in safe water and sanitation

Dr Mhlanga outlined the findings of the report on health systems In the health system, there were signs of inverse care in some areas, which showed higher need with lower coverage, especially for maternal health services. Inequity was more pronounced for services accessed beyond primary care level. There was found to be low inequality in HIV

prevalence but higher inequalities in HIV service coverage that could lead to future inequalities. Provincial differences exist but wealth and social differences are becoming more pronounced. Fee, drug availability, transport cost and distance are key barriers to access, while community health workers and social participation support uptake of services.

Total spending on health has risen faster than government spending, indicating increased private and external funding. Earmarked taxes and national insurance are being explored as possible fair financing solutions. That spending is not reported by level is an identified gap, given the importance of primary care spending for equity.

To inform stakeholder dialogue on equity and social determinants in universal health coverage (UHC), a national stakeholder and intersectoral meeting was held that made a number of recommendations,

PROGRESS MARKER in <i>EquityWatch</i> reports of	2008	2011
EQUITY IN HEALTH		
Formally recognising equity and health rights	Orange	Green
Halving the number of people living on US\$1 per day	Red	Red
Reducing the gini coefficient of inequality	Green	Orange
Eliminating differentials in child, infant and maternal mortality and under nutrition	Orange	Orange
Eliminating differentials in access to immunization, ante-natal care, skilled deliveries	Orange	Orange
Universal access to prevention of vertical transmission, antiretroviral therapy and condoms	Green	Green
HOUSEHOLD ACCESS TO THE RESOURCES FOR HEALTH		
Closing gender differentials in access to education	Orange	Orange
Halving the proportion of people with no safe drinking water and sanitation	Red	Red
Increased ratio of wages to gross domestic product	Orange	Red
Provide adequate health workers and drugs at primary, district levels	Orange	Light Green
Abolish user fees	Red	Orange
Overcoming barriers to access and use of services	Orange	Orange
REDISTRIBUTIVE HEALTH SYSTEMS		
Achieving the Abuja commitment	Green	Green
Achieving US\$60 per capita funding for health	Orange	Orange
Improve tax funding and reduce out of pocket spending to health	Orange	Orange
Harmonize health financing into a framework for universal coverage	Orange	Red
Establish and ensure clear health care entitlements	Orange	Red
Allocate at least 50% public funding to districts and 25% to primary health care	Orange	Orange
Implement non-financial incentives for health workers	Green	Green
Formal recognition of and support for mechanisms for public participation in health systems	Orange	Green
A JUST RETURN FROM THE GLOBAL ECONOMY		
Reducing the debt burden	Red	Red
Allocate resources to agriculture and women smallholder farmers	Orange	Red
Ensure health goals in World Trade Organisation (TRIPS, GATS) agreements	Green	Orange
Bilateral and multilateral agreements to fund health worker training	Orange	Orange
Health officials included in trade negotiations	Orange	Green

- To include the right to health in the constitution and law.
- For policy co-ordination to be strengthened
- For government to update and cost the essential health service benefit/entitlement including the essential social determinants, and integrate community views.
- For options to be identified for progressive domestic funding (earmarked taxes in high growth areas, VAT, sin taxes) to meet entitlements
- For government to move from fees to prepayments with local collections used for quality improvements.

On the social determinants, stakeholders proposed that there be increased investments in water infrastructure, including through public private partnerships, with the involvement of rural communities in user maintenance groups. Government should put in place legal obligations for toilets in all houses. It was also proposed that investment, trade, legal, and port health measures promote production and marketing of healthy foods and control trade in unhealthy foods and products and that local medicine production be prioritised as an economic sector.

A number of recommendations were made for institutionalising the Equity Watch, including to

- identify indicators for routine annual tracking of equity in UHC and SDH from the health and other sector information systems.
- implement annual budget tracking, including tracking of expenditures by level (community, primary, district etc),
- implement the wider EW review every 4-5 years using household surveys and other sources.
- set up an inter-sectoral steering group for the next EW to review indicators and contribute to the evidence and analysis, reporting and use of the evidence, and to
- include the private sector to be included in the process.

4.5 Mozambique Equity Watch

Dr Moises Mazivila, Ministry of Health presented the Equity Watch (EW) work implemented by the team in Mozambique⁵. Mozambique reported an improved economic context for health equity, which has resulted in improved availability of services but with inequalities in health and in access to health services by province, across districts and within areas across wealth and social differences. For example increased urban poverty is widening within area inequalities.

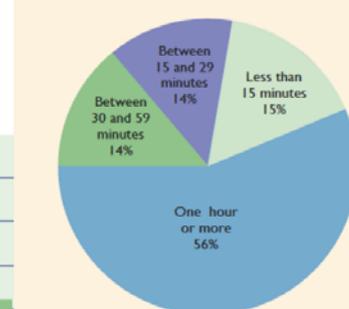
Improved aggregate funding to health is raising opportunities for more attention to equity in allocation of resources for health.

4) Inequalities in resources for health

Figure 31: Population per doctor by province, June 2007



Figure 37: Access to health facilities: time taken by households to reach the nearest health facilities on foot, 2005



⁵ Ministry of Health Mozambique, TARSC/EQUINET (2010) Equity Watch: Assessing Progress towards Equity in Health in Mozambique, Maputo and Harare

Access to immunization and antenatal care has improved, but with urban-rural inequalities, particularly in there are assistance at birth by skilled attendants. Mozambique is experiencing inequities in access to ART, reporting a large unmet need for ART in children aged 15 and younger. Many Mozambicans travel by foot for an hour or more to reach medical services. The distribution of scarce financial resources also exhibits inequalities, with widely varying per capita health resource allocations per province.

What are the implications for policy and planning? Dr Mazivila recommended an increase in financial resources for health, with greater interaction and coordination with the ministries of planning and finance and external funders. To ensure an increase in equity in resources for health, policy makers and planners are in the process of developing a resource allocation formula and a strategic plan for development of infrastructure, HR and equipment and coordination among different allocation processes. The EW report pointed to the need for improved capacity for health worker retention and distribution, as well as increased attention to specific needs, such as strengthening district and evidence-based planning and the role of civil society. Intersectoral action is also required, with strengthened collaboration with other sectors to improve access to health resources.

In Mozambique, stakeholders discussing the EW have recommended repeating the EW to explore trends, with in the interim continued improvements in collection of health system routine data for equity monitoring and analysis, equity analysis within provinces to understand the extent of and the factors behind inequity in health across districts, urban and rural areas and socio economic groups.

4.6 Discussions on the country equity watch work

After the presentations, delegates raised questions and comments on the country presentations.

While specific Equity Watch reports raised specific issues to countries, **the policy issues** that were raised in more than one country included:

- Supporting and monitoring the implementation of the right to health in the constitution;
- Strengthened intersectoral policy co-ordination and the role of civil society to understand, plan and act on the social determinants of health equity.
- Obtaining disaggregated evidence (including in the DHS) on neonatal and maternal mortality to identify where disadvantage is greatest and what social factors are associated with this;
- Updating and costing the essential health service benefit/entitlement including the essential social determinants, and integrating community views.
- Within this explore the access and uptake barriers to, prioritise and evaluate equity oriented interventions to eliminate differentials in access to key services, particularly immunisation, ANC, skilled assistance at deliveries, HIV prevention and AIDS treatment
- Strengthen progressive domestic funding through meeting the Abuja commitment, through domestic revenue options such as earmarked taxes, sin taxes, social health insurance to meet entitlements, with greater interaction and coordination with the ministries of planning and finance and external funders
- Develop and implement a resource allocation formula and a strategic plan for equitable development of infrastructure and equipment, and equitable allocation to health worker incentives, medicine availability, coordinating among different allocation processes and addressing the specific conditions, needs and absorptive capacity of more disadvantaged regions and communities;

- Give consistent attention to measures to allocate additional resources to primary care levels, particularly in districts with low health coverage, and track the results in terms of coverage and health outcome indicators.
- Abolish user fees progressively from key services (primary level, district level, priority areas) with rationalisation of the referral system and investment in the essential entitlements

Ministries of health have greater role in addressing the resources *within* the health sector, so much of the discussion focused on the health sector 'getting its own house in order'.

Delegates identified decreases in public health spending as a major problem in giving ministries the leverage over other sources of spending on health. They called for the tracking of the Abuja 15% commitment to be done in terms of government (domestic excluding external funding) expenditure (rather than allocation). We need to go beyond Abuja and track the extent to which we are raising progressive sources of funding, to which financial protection is being implemented, resources are reaching the community and primary care level of services and through benefit incidence analysis reaching the groups with highest health need. It was noted for example that outreach clinics are helping to narrow the delivery gap in Malawi's rural areas, and that outreach should move from vertical programmes like HIV and AIDS to primary health care outreach. Financial measures should not be isolated from a range of supporting measures in the system. In Uganda, the abolition of user fees was followed by an increase in service utilisation. While government funding increased in the initial stages, funding tapered off which in part explains the rise in household spending even where fees were lifted.

Delegates argued that the root causes of inequality are not only financial – government can't just inject money without considering wider policy, health worker, institutional, quality and social factors affecting uptake of services. More money does not necessarily translate into better health outcomes. The inequalities identified in the EW highlight that even relatively wealthy areas are showing widening within area gaps in health and uptake of services.

Delegates noted the importance of access to health workers and medicines in service coverage. It was argued that we should be more specific about which cadres are needed at different levels and track availability against these standards. There was some debate about whether we are aiming for and thus tracking mass production of physicians or other health workers. A consultation on access to health workers will be hosted by EQUINET and others in June 2012. Gaps in health workers and drug stock-outs open the way for private players to fill the gap, including unregistered players. This means that it is not only numbers, but also quality issues that must be addressed in equity analysis, such as the presence of substandard and falsified medicines in private sector markets.

It was noted however that these health sector measures need wider political and public support and involvement, management of the private sector and wider links with other sectors. The experience of the Kenyan inclusion of the right to health in the Bill of Rights was discussed in terms of the institutional mechanisms (eg Kenya Human Rights Commission), activities and public awareness processes and organisation that are being developed to clarify rights and the implementation of entitlements, monitor progress and ensure political respect for these entitlements.

The presentation of the 5 country equity watch reports highlighted issues in relation to follow up on **mainstreaming equity analysis in planning and institutionalizing the equity watch**, with issues raised on

- mainstreaming equity analysis in planning- with planning, monitoring and evaluation activities integrating equity and efforts to widen the involvement of other sectors that play a role in the social determinants of health;
- institutionalising the *periodic* implementation of the Equity Watch as a 'one stop' synthesis of evidence on equity for planning departments, civil society, parliaments etc linked to planning and review processes, complementing other planning and review tools such as health facility surveys, public expenditure tracking and community monitoring, and noting that the time, capacities and resources should be adequately catered for;
- linking the Equity watch with discussion by ministries of health, parliament, other sectors, civil society on health strategy, policy, budget and other processes
- including a matrix for evaluation of interventions and policies that aim to address inequities;
- identifying measures and analysis of routine data for annual analysis and reporting of key areas of equity at national and district level;
- tracking expenditures and resources (health workers, medicines) by service level, by district and by programme;
- identifying the essential health benefit / services and service norms to implement costing and gap analysis to negotiate and monitor resource flows; and
- carrying out follow up research or surveys to understand the causes of specific disparities, on how resources flow for community roles in health equity, to evaluate interventions aimed at improving equity and to better understand the inequalities within regions; and
- reporting the findings in a way that is accessible and useful to different users, sectors and policy and civil society users.

In terms of advocacy, delegates noted that we need to ask who exactly we are targeting: parliamentarians, non government organisations, civil society etc? The EW needs to identify champions to take the agenda forward. The implications of this includes speaking directly *with* politicians not *about* them, making sure the EW raises action points; and giving visibility to and roles for other sectors involved in the determinants of health.

It was noted that the EW intends to raise visibility and flag issues. It intends to act as a tool for dialogue, and that it needs to be used in policy and planning dialogue and complemented by community-level evidence and surveys to identify root causes, evaluate solutions or assess benefit incidence. Triangulating data, qualitative evidence and dialogue are important for the process.

5. Issues in carrying out Equity analysis

Mr Nasser Jeeanody, Ministry of Health and Quality of Life, Mauritius chaired a session on issues arising from equity analysis within countries.

5.1 Getting and using evidence for equity analysis at district level

Calvin Kalombo, Ministry of Health Zambia outlined issues and work in obtaining and using evidence for equity analysis at district level. On a national level, in Zambia, aggregate improvements do not tell the whole story of within area inequalities and may thus not be useful for planning at district level. For example, while extreme poverty has declined in both the rural and urban areas, rural-urban differentials have widened and

within urban areas inequalities have widened. This raises the need for equity analysis at district level linked to district level strategic and annual plans, and used as a tool for monitoring and evaluating district level performance. This is important as most ESA countries use the district as the unit of analysis and planning. District-level equity analysis will allow for a bottom up approach, as well as a means of validation of the routine data (DHIS or HMIS).

Calvin Kalombo raised challenges that have been identified in implementing district equity analysis. One challenge is data availability. The sources available at district level include routine data (from the Health information system), but this is institution based. Non routine data such as demographic and health surveys (DHS) and other surveys provide national level data and provincial disaggregations, but not evidence to and within district level. The DHS sample size is too small to provide statistically significant data to district level. These surveys provide evidence by residence (urban-rural) or region but this is too wide for many areas of planning on household access to the resources for health or health service performance. Further routine administrative data such as expenditure data may not always report within district disaggregations.

He put forward proposals for equity analysis at district level, such as through specific research to generate the household or health system data needed for district equity analysis. The possible unit of analysis for within district level surveys may include health facility catchment areas or council wards, to link findings to health and local government resource and planning frameworks. He also noted that the national census provides evidence that can be used for district and within district analysis.

He suggested that these methods issues need to be addressed within a demand driven framework, based on the demand for data relevant to equity from awareness creation activities, capacity building and involvement of other sectors in dialogue on health within districts.

Dr Laura Anselmi, Ministry of Health Mozambique discussed the experience within the work in Mozambique in getting and using evidence for equity in resource allocation at district level.

For health equity analysis Mozambique uses a number of data sources which measure health outcomes and health-related behaviour, living standards or socioeconomic status, together with complementary data such as health service supply and health expenditure data. The data sources include household surveys, such as the Living Standards Measurement Study (LSMS), Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and World Health Surveys (WHS). Survey data also includes exit polls and ad hoc surveys, which are often linked to facility surveys. Administrative data is also included, such as the health information system (HMIS), vital registration, national surveillance system, sentinel site surveillance and non-health administrative data. Census data is also used.

She identified a number of limitations in using data for district level analysis. Household surveys and other non-routine data are generally non-representative at district level and contain sampling and non-sampling bias. They are expensive to realize and difficult to compare. Routine data, such as HIS and administrative data, do not include socioeconomic or demographic characteristics, coverage may be incomplete or biased and quality may be poor. Census data may not include health and socioeconomic characteristics.

For resource allocation at district level, there are a number of data requirements that must be met. To meet the need for resources and capacity for resource absorption, data must be gathered on health status and health care needs, existing resources and gaps, and district specific needs/activities and planned intersectoral activities. The resources

available to distribute must be determined, namely financial resources (State budget and external funds) and non financial resources (human resources, equipment and drugs).

In the resource allocation criteria in Mozambique, there is a proposal that capital expenditure be based on a strategic plan for the development of health infrastructure, equipment and health workers, while recurrent expenditure across provinces is allocated according to a formula that integrates total population, demographic composition, under 5 year mortality rate, population density, and health care utilization by age and gender. Recurrent expenditure across districts is proposed to be allocated using the same formula together with a gap analysis that takes into account the number and conditions of health facilities and district costed plans.

She called for the collection of data to make equity analysis possible. Routine and administrative data should include health facilities data (for the gap analysis), the number of health facilities, human resources, equipment (including transport), health facilities conditions and norms on health facilities. District expenditure/budget data should include projections of budget allocations at provincial and district level from MoF and external funders, with records of expenditure by districts.

In terms of lessons learnt, Mozambique emphasizes that interaction with relevant institutions is crucial for data collection and for the improvement of routine/ administrative data. The institutions that they have engaged with for this in Mozambique include the National Institute of Statistics for Census data, the Health Information System for Health facilities data, the Provincial Directorates of Health for health facilities and expenditure data, the Ministry of Health Departments of Human Resources, Medical Assistance, Infrastructures, Finance and Administration (for health facilities norms), and the Ministry of Finance, Ministry of Planning and external funders for district level expenditure/budget.

A number of challenges still exist. Mozambique still needs to institutionalize data collection at district level for planning (HIS-Resources module, National Health Account, External Funds Survey), strengthen planning/budgeting capacity at district level (account for local needs not captured by the resource allocation formula or gap analysis), explore inequities in health and access to health care at district level, and continue to engage with Government's institutions at various levels (linking research and policy).

A plenary discussion was held after the Mozambique and Zambia presentations.

Delegates endorsed the need to conduct EW analysis at district level, given the within area inequalities that have been highlighted in the national EW reports. For equity we need to look at and address inequities and the interventions to address them lower down in the system, and not just at national level.

It was raised that this cannot be a simple 'cut and paste' of the national EW approach applied to district levels. It was suggested that countries conduct surveys and pilot analyses in a few districts to assess the demand and use of evidence, the availability and quality of data and assess what is feasible and useful. This should also raise the capacities needed and the direct benefits to planning from such analysis. It was noted that Zambia has already begun to implement equity analysis in four districts with UNICEF support and that the results are to be announced. There is scope to learn from this experience if it is documented and shared regionally, as well as from the work underway on resource allocation in Mozambique.

Delegates also proposed that pilot district level / small area surveys can be done in conjunction with the DHS surveys that can look at specific areas of within area inequality that are identified from discussion on the national reports, from the HIS or from district and community levels.

5.2 Disaggregating health expenditure

One of the issues in disaggregating resources to sub-district levels and to identifying benefit incidence was to better track spending by level of the health system within health expenditure reporting. **Mr Zwelakhe Nhleko, Ministry of Health Swaziland, reported on their work on tracking health expenditure.**

Swaziland's recently launched Essential Health Care Package (EHCP) maps health care services available at various levels. The component on staffing norms within EHCP is still under development, which would point out the skills mix that is required at each level of care. He outlined the five levels of health care in Swaziland, and the distribution of health facilities in urban and rural areas and across regions/provinces.

In terms of resource distribution, nurses are mainly concentrated in the hospitals, which are in the towns where only 27% of the country's population lives. Facilities in the poor regions were found to be lacking basic services, including even safe water supplies. While there has been a general increase in the number of doctors, nurses support staff and allied workers, the distribution still favours affluent regions and the urban sector.

He reported on how Swaziland tracks expenditures (See for example the tracking of expenditure by level below). Hospitals, which favour higher socioeconomic groups consume 50% of expenditure and per capita expenditure in hospitals is five times higher than that of clinics. However to understand the equity implications of this calls for a document that defines the costs for the performance standards, that can guide resource distribution. He also noted the need to position equity issues within such a guiding framework.

Ministry of Health Expenditure per patient by level of care, Swaziland

Budget (Lilangeni)	Per patient 2007/8	Per patient 2008/9
Hospitals	259.22	254.74
Health Centres	113.04	103.47
Clinics	50.12	44.00

He called for a strong infrastructure development roadmap and a document which will provide direction to policy makers towards meeting equitable distribution of health care services, including health workers.

In the discussion after the presentation, delegates noted that in Swaziland allocations and expenditures are skewed towards curative services and tertiary care (referral hospital), rather than primary health care (clinics). It was noted that it would be useful to assess whether the essential health care package has any impact on this distribution.

Delegates also noted that there is need to connect the tracking of expenditure with measures of value for money, such as comparing expenditure between different facilities for the same procedure. Mauritius has for example established cost centres to make these comparisons. Using hospitals as primary care facilities is a waste of resources – we need to look at type and severity of illness when deciding where patients have been treated.

Not every country is not collecting information at clinic level – how do we do benefit incidence analysis without this? It was noted that establishing the primary care and community level as a cost centre, tracking spending to these levels and linking expenditure to health outcomes is key to assessing benefit incidence.

5.3 Social determinants of health equity and universal health coverage

A session on various dimensions of health equity analysis at regional level was chaired by Mr Rangarirai Machedze of SEATINI.

Dr Benjamin Nganda, Health Financing and Social Protection Focal Point, Health Systems and Services Strengthening Cluster, World Health Organisation (WHO) AFRO presented on the social determinants of health equity and universal health coverage.

He made a distinction between inequality and inequity, as discussed earlier in the meeting. WHO has operationally defined "equity in health" as "minimizing avoidable disparities in health and its determinants – including but not limited to health care – between groups of people who have different levels of underlying social attributes."

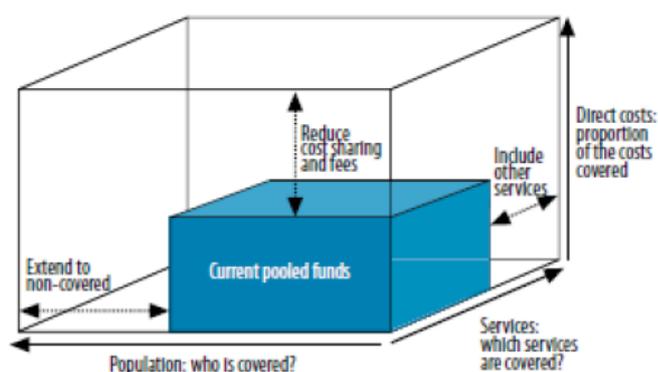
With regard to Universal Health Coverage, he noted that this calls for action within and beyond the health sector, to address the circumstances in which people are born, grow, live and work, as well as to ensure timely access to promotion, prevention, treatment and rehabilitation health services. He noted that overcoming the 'inverse care law', where those with lower health need have higher access to services, calls for a well-functioning and fair health financing system.

Member States of the WHO committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardships because of paying for them. This goal is defined within universal health coverage (UHC). According to WHO, a country can be said to have attained Universal Health Coverage when the whole population has access to needed health services - prevention, promotion, rehabilitation and treatment – without the risk of financial hardship linked to paying for the use of these services. UHC is a public health and developmental objective that embodies values and rights in international human rights law and the underlying theories of justice. This, inevitably means UHC must be accompanied by equity.

He discussed the key strategies of UHC to achieve these objectives. This implies that more money needs to be allocated to health; health reprioritized in government budgets and resources raised both locally and internationally including through innovative financing and development assistance. Governments should aim to remove financial risks and other barriers to access by reducing direct out of pocket payments for health services through prepayment and pooling mechanisms and promote solidarity of the whole population so that, for example, the rich subsidize the poor, and the healthy subsidize the sick. Governments should also promote efficient use of available resources and eliminate waste, resulting in "more health for the money".

In the past 50 years or so, the international health agenda has oscillated between a focus on medical technology based medical care and public health interventions on the one hand, and an understanding of health as a social phenomenon, requiring more complex

Three dimensions to consider when moving towards universal coverage:



forms of intersectoral policy action. The 1978 Alma Ata Declaration and the subsequent “Health For All” movement gave prominence to health equity and inter-sectoral actions on the social determinants of health. But the economic thinking of the 1980s and 1990s impeded the translation of these ideas into effective policies in many countries with macroeconomics policies that marginalized health and related services sectors. By the late 1990s and early in the new millennium, accumulated evidence clearly pointed to a failure of existing health policies to reduce health inequities and momentum grew for new, equity-focused approaches.

The Commission on Social Determinants of Health was launched by the then Director General of the WHO in March 2005 to advance health equity and propose actions to reduce health differences among social groups, within and between countries. The Commission developed a conceptual framework for addressing “the causes of the causes”, discussed earlier.

The pursuit of equity of access to health care is inherent to the health system objective of universal health coverage (UHC). Policies aimed at UHC must be therefore be assessed in terms of their effect on equity of access, which requires that their design and management specifically facilitate and enable access across the social gradient, particularly by disadvantaged groups.

The WHO Report on Health Inequities in the African Region has documented deep, systemic and persistent disparities based on household wealth, location, education and sex, as markers for disadvantage and major barriers to progress in health. The inequity in health is linked to wider disparities in the distribution of broader determinants of health, and perpetuated by policies that either tolerate or exacerbate an unfair distribution of life chances and fuel the transmission of poverty across generations. Decomposition analyses revealed that a large proportion of the observed inequality, for example, in access to skilled birth attendance at child birth and in childhood stunting is associated with socioeconomic inequality (e.g., wealth, education, partner’s education), inequality in health systems (e.g., quality of antenatal care) and place of residence (urban or rural areas).

Dr Nganda noted that these inequalities in health and access to health services that are documented in many countries in the Region are unacceptable. They are also inefficient, holding back economic growth, social solidarity and progress in other areas. Governments need to address this by putting health at the centre of all policies – by mainstreaming health equity. He raised a number of strategies for this:

- to integrate health equity into legal frameworks, health and other sector plans, and include civil society and non-state actors in policy dialogue
- to improve access to health services and health enhancing commodities/services by disadvantaged groups or excluded populations
- to promote equity in resource allocation (financial, human, etc.) within the health sector
- to disaggregate data by meaningful equity stratifiers within countries
- to integrating prospective health equity impact assessments into the development of all relevant policies, national development and poverty reduction strategies
- to institute investments in disadvantaged areas in infrastructure, personnel and other aspects of effective decentralized health services
- to strengthen political leadership, policy and regional dialogue and capacities to address health equity; and
- to share promising practices across countries on policies, strategies, data and other resources for mainstreaming health equity.

He noted that the process starts with the recognition and measurement of the extent of the problem – a situation analysis, that identifies problems and the pathways between the root causes and the problems, that is used for the development of policies and interventions.

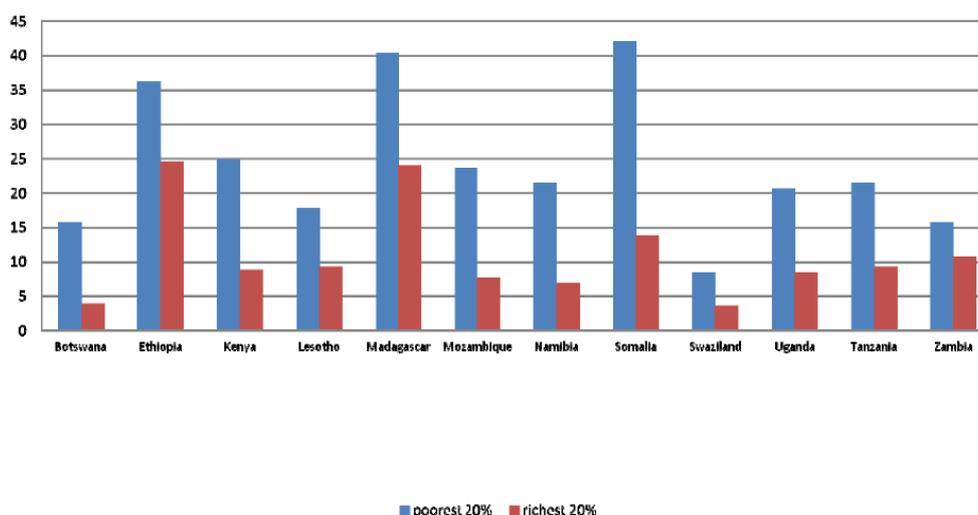
5.4 Linking equity analysis to the Millennium Development Goals

Tesfaye Shiferaw, Regional advisor for UNICEF ESARO presented an outline of the regional learning on health equity in the Millennium Development Goals (MDGs). The common view is that slow growth, insufficient aid, and/or poor governance means that the world will miss the 2015 MDGs targets. However, evidence points out that inequality within countries has had a more important effect in slowing global progress, making it almost impossible to meet the targets. People in bottom quintiles have not benefited fully from social progress and economic growth in several countries. Robust global economic growth and higher flows of trade and investment resources have also failed to narrow disparities in wealth, and have also often resulted in widening disparities in social progress.

For children, this is evident most in child survival, long held as a barometer of child well-being, where inequalities in under-five mortality have worsened since 1990 in many countries. He noted that regional, educational and poverty-related disparities were pronounced for all MDGs. In MDG4, despite improvements in aggregate mortality, wealth differentials are pronounced for under-5 mortality in all countries in the region. Disparities exist in child undernutrition, as shown in the Figure below.

Underweight prevalence in children US (%), 2006-2010

Source: SOWC 2012

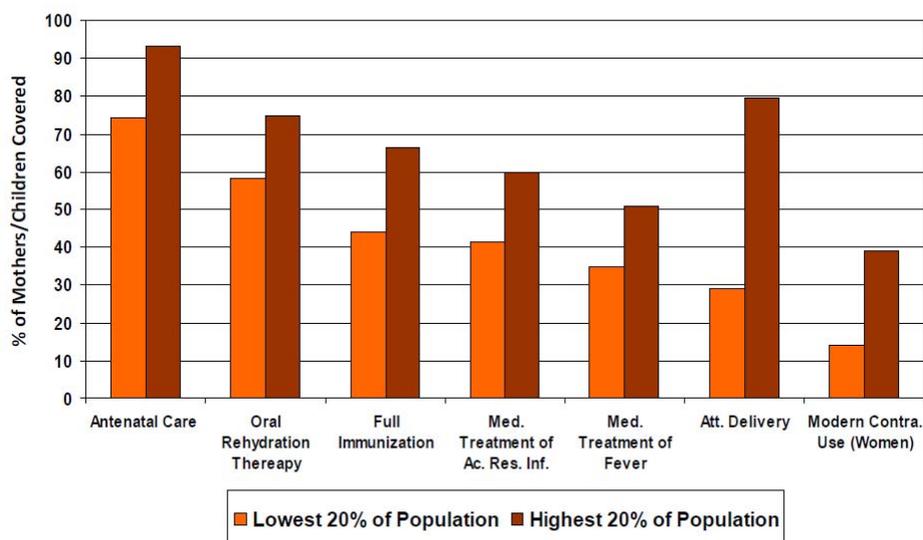


Low birthweight, mothers education and gender were found in Tanzania to contribute to the probability of child stunting.

Dr Shiferaw noted further that the delivery, financing, and use of essential health services for women and children and of resources for health such as safe drinking water and sanitation are inverse to need, in that they favour wealthier, more socially and economically advantaged households. Even where resources increase, he noted that wealthier groups tend to take greatest advantage of these resources unless specific measures are taken to address this. Differentials are pronounced not only by wealth but also by maternal education, geographic location, and urban/rural residence. He showed this for various areas of health service delivery in ESA countries, including assisted deliveries, and other maternal health services. (See Figure overleaf)

USE OF BASIC MATERNAL & CHILDHEALTH SERVICES

Coverage Rates among Lowest and Highest 20% of the Population in the 14 ESAR Countries with Demographic and Health Survey Data Available



A plenary discussion was held on the papers presented by WHO AFRO and UNICEF ESARO. Delegates discussed the range of root causes of health inequality. Corruption was mentioned as one possible reason, for example, that may lead to richer clients obtained better care. A bias towards inverse care emerges in countries at all economic levels. A UHC strategy needs to look at the root causes of why these policies are adopted, and to put more emphasis on the demand side of the problem. Cash grants and voucher schemes are being expanded for example to enhance uptake. However, it was felt that work is needed, as is being implemented by UNICEF, to carry out bottle neck analysis to determine why services are not delivering, such as in Uganda on child health services. The HIS is not enough to answer these questions. Work is needed on the social demand for health services, to assess and overcome barriers to services, to overcome factors like the lack of trust between service providers and patients and to raise demand through health promotion and education.

Delegates called for more collaboration between sectors. Poor nutritional outcomes are a result of poor infrastructure, like lack of decent roads, poor agricultural policies, poor markets and so on. High-level commitment is required for effective intersectoral action.

Delegates identified a knowledge gap in how to scale up services. In terms of resource-based financing, what happens to services that are not high profile like child mortality and maternal health? They argued that health could learn lessons from the environmental movement to ensure that health agendas address issues of sustainability and integration.

6. The Regional Equity watch

Dr Rene Loewenson presented an outline of the 2012 regional equity analysis that has been drafted using the framework of the Equity Watch. In 2007, EQUINET implemented a Regional Analysis of Equity in Health equity is advanced when: health is central to national goals and values; when households access the resources they need for health (the SDH); when health systems are organized for universal coverage and redistribution; when people are empowered to claim entitlements, and act on health; and when countries negotiate and attain greater global justice in the resources for health.

In response to ECSA HC and other regional policy resolutions, and the understanding that it will be difficult and in some cases not possible to achieve the MDGs without reducing health inequalities, the 2012 Regional Equity Watch gathered and organized evidence on the 25 progress markers of the Equity Watch for 16 countries in East and Southern Africa. It identifies progress in and priorities for enhancing equity and shares promising practice in ESA countries. Rene indicated that she was making a presentation of the major findings in the 2012 analysis and asked delegates to note as she presented their views on:

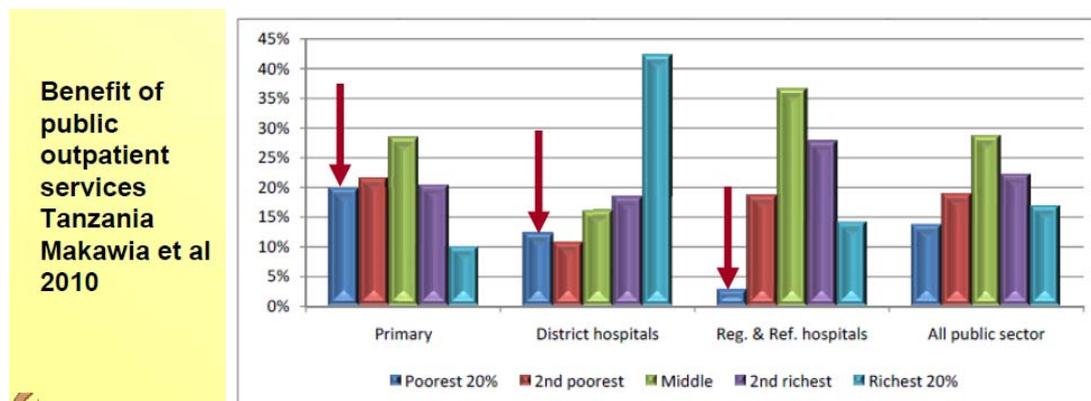
1. *evidence, analysis and conclusions that are important for policy or action*
2. *evidence, analysis and conclusions that contradict their experience/ are unclear*
3. *evidence, analysis and conclusions that they want to hear more about, and*
4. *other positive/promising practice that should be reported in the areas covered.*

She noted that equity values are deeply rooted in the region and that human rights treaties relevant to health have been ratified in all ESA countries. More constitutions in the region provide for rights to health care than social determinants like water, shelter and food. There has been progress in implementing rights to health in the constitutions in the region, with a shift to more comprehensive provisions in Kenya and South Africa. At the same time the biggest gap is in the capacity of duty bearers to deliver on the rights and citizens as rights holders to claim their rights, and in the institutional mechanisms for this.

In the social and economic contexts for health equity, she noted that unplanned urbanisation is a major factor, with faster urban growth in the region than the global average. The urban populations have doubled in Malawi, Mozambique and Lesotho in 20 years. This has created a cluster of problems of urban poverty and inequality. It is exacerbated by the poor progress made regionally in safe water and sanitation. She gave in contrast an example of how Angola has implemented intersectoral activities in urban informal settlements of Luanda with improved health and social outcomes.

She noted that there have been improvements in aggregate life expectancy and child mortality but persistent and increasing wealth differentials even in some countries where mortality has improved. Despite extremely wide differences in maternal mortality ratios globally and across the countries of the region, the socioeconomic differentials in maternal mortality are not consistently measured within countries. At the same time there is evidence that health system resources are not allocated according to health need, particularly in sexual and reproductive health services, and maternal health services, and services for HIV and AIDS. In contrast, there are examples of promising practice: Mozambique reduced its MMR from 692 in 1997 to 340 in 2008 through a presidential initiative that updated training of health staff, and stimulated a rise in births in health units with qualified staff from 44% in 1997 to 55% in 2009. Nevertheless there are still social gaps, with a 36 fold cumulative wealth differential across a range of sexual and reproductive health services.

In general the evidence suggests that social and area differentials are much lower for services offered at primary care level, such as child health and immunisation, ANC or where services are integrated within primary care services, such as where ANC is an entry point for antiretroviral therapy. Poorest communities also benefit more from primary care services.



The resource flows to these levels are more likely to grow when overall resources are growing. There has been slow but evident progress in meeting the Abuja goal, although the external share of public spending has also grown, making improvements insecure. This raises the demand to raise new forms of domestic financing to support health equity. While there has been a major policy focus in the 2000s on health insurance, few countries have yet implemented proposals. She raised a number of other tax and innovative financing options for domestic health financing.

Further, spending at primary care level cannot be assumed but must be advocated and tracked. Few countries disaggregate allocations by level, or track spending by level. Angola in 2003 increased primary level spending 415 times faster than other levels (to 41% by 2005). Kenya's spending for primary care rose from 14% in 2008 to 20% in 2009 due to stimulus package. Annual reporting of spending by level is essential to track equity and relate spending to health outcomes.

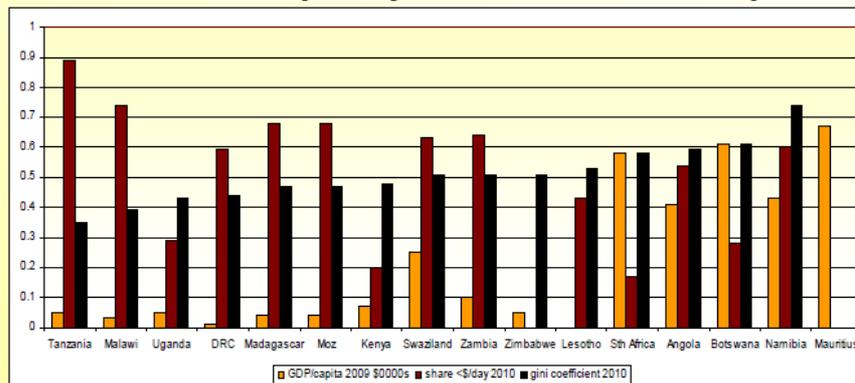
She noted that while gender equity has improved in education enrolment, there is high inequity in early childhood education and care (ECEC), with only two in five children in ECEC, despite its contribution to long term health and development. This arises due to high level of private provisioning and low public investment in ECEC.

There have been limited improvements in child undernutrition, with undernutrition a good barometer of wider social inequalities. She reported evidence from the 2011 Zambia Equity Watch and from Malawi on the positive impact of public sector investments in agriculture, subsidies to kick start smallholder farming, especially in women smallholder farmers producing food and using drought resistant foods. Despite this she showed evidence of negative trends in food and agriculture, including limited public investment in many countries and large and a land rush, with new land areas allocated to foreign companies for biofuel and agribusiness producers.

In the policy debates on universal health coverage (UHC) she thus noted that UHC cannot be assumed to support equity – it needs to have certain features, such as rights based entitlements of access to health care, definition of the health service and social determinants of health that should be provided at each level, domestic revenue sources and financing measures that improve health financing and measures to strengthen social demand for health and support for UHC.

She presented evidence of the wider inequality underlying these conditions. Inequality has risen with increased GDP, despite the evidence that economic growth and reduced inequality are needed to reduce poverty. Case study comparisons of poverty reduction between 1995 and 2005 in Mauritius and South Africa suggests that widening employment opportunities and social protection are important for reducing inequality and poverty.

Growth + reduced inequality needed to reduce poverty



This dysfunctional growth path is even more apparent at the global level, where, at current rates, it will take 800 years for the bottom billion to earn 10% of the world's income.

For African countries, this raises a question of how the MDGs are framed and the future MDGs after 2015. The lack of reporting of equity in the MDGs has meant that inadequate attention has been paid to equity globally, within regions and within countries. In March 2012, states and civil society at the Global Human Development Forum issued the Istanbul Declaration: *"A globally adopted vision that combines equitable growth with environmental sustainability, rooted in universal values and global social justice, is needed. It should include a strong emphasis on social inclusion, social protection, and equity—in recognition of the fact that economic development has too often gone hand in hand with environmental degradation and increased inequality."*

Delegates discussed the concept of equity at regional level. They noted that the regional level is important to allow for exchange across countries on why some countries are progressing and some not, and to allow exchange of knowledge on the causes and interventions. A regional framework is also important to negotiate global issues as a regional bloc.

Delegates noted the challenge in advancing intersectoral work. Examples of positive developments in food and agriculture in Malawi, of developments on safe water in Uganda are examples of successful intersectoral work that can be built on.

Concern was raised about how the work on equity adequately incorporates analysis and engagement of the political and social processes.

Dr Loewenson noted that the EW is watching progress, not watching problems. The exchange of evidence is to share and promote good practice, advance progress and engage globally to negotiate support for promising policies and practice.

7. Group Discussions and areas for follow up

Delegates went into three working groups to discuss the follow up work. Itai Rusike, Community Working Group on Health Zimbabwe chaired the report back.

7.1 On the Regional Equity Watch findings

In the comments delegates wrote on the key areas of evidence, the feedback was:

- i. on policy messages raised in the regional EW, delegates raised the importance of*
 - empowerment and capacity of people to claim their rights
 - public health laws that reflect health rights
 - intersectoral interventions to improve and close gaps in undernutrition, including attention to the impact of the large land acquisitions
 - public investment in ECEC
 - more active measures for resources to reach the primary care and community level of health systems, and of tracking benefit incidence at different levels
 - measuring the differentials in maternal mortality, and addressing inequities in reproductive and maternal health services
 - equity to be explicitly addressed in the MDGs, in the design of UHC, and in strategies such as the CARMA road map

- ii. on evidence, analysis that need further explanation, delegates raised*
 - the analysis of the dimensions of poverty
 - the differences in inequalities within and between countries
 - a need to understand within countries how resources for health have been used
 - attention not only to water access but to water quality,

- iii. on evidence, analysis that they want to hear more about, delegates raised*
 - the options for health spending in post conflict situations;
 - the link with the WHO/NEPAD regional strategy for Africa
 - the essential health benefit/ entitlement – its content and costing
 - the distribution of and interventions for non communicable diseases

- iv. and on other promising practice that should be reported, delegates requested*
 - inclusion of information on the promising practices from Angola, Malawi, Kenya raised in the presentation;
 - more information on closing gaps in maternal health services;
 - make clear the importance in Mozambique that the focus was on the system and not just the maternal services and that this produced wider impact including on maternal mortality
 - report of the positive experience of the review of Zimbabwe's Public Health Act

Given the policy messages above, the group identified that at regional level it would be useful to carry out

- regional solidarity on the right to health and constitutional reforms, harmonising legal reforms and building institutional capacities and activities on claiming rights;
- advocacy on primary health care, and advocacting and tracking resources to primary and community levels;
- advocacy on and research to generate evidence for domestic mobilisation of public financing as a more equitable means of funding health
- capacity building on equity analysis in different constituencies in countries.

7.2 On disseminating and using evidence on equity regionally and in the MDG reporting and post 2015 MDGs

The group noted that as inequalities exist in all countries, it will be important to bring to regional Ministers' attention the main inequities and the policy messages (as raised by the first group). It would be important to raise with the Ministers and officials the institutional measures and capacities needed to respond to inequalities, including

- increasing capacity for equity analysis for evidence-based policy and planning
- monitoring and evaluating policy measures to assess benefit incidence
- investment in information systems, analysis and reporting
- mainstreaming equity in laws, policies and strategies

The monitoring and evaluation framework for ECSA should include more equity indicators. The region should build capacity at local level, not just at MoH level, and disseminate information on equity.

In relation to the MDGs, delegates proposed that:

- The MDGs should be better integrated and connected in terms of their underlying determinants;
- Aggregate goals and measures are not enough – the monitoring and evaluation framework for accountability should include equity focused indicators and collect disaggregated data on progress;
- Governments should allocate more resources to social sectors and social protection in development goals and this should be monitored and reported;
- The MDGs should be linked to strategies for translating goals and evidence into planning and practice.

The group discussed the MDGs post-2015. They argued that there should be an emphasis on equity as a means to promote more rapid and sustainable development. Long-term policy documents exist, like Kenya's Vision 2000 and Tanzania's Vision 2005, which are tools for shaping this post-2015 landscape. These should help to inform the proposals from Africa for how equity is being addressed in national development policy, as a basis for regional negotiations. In taking this forward the group proposed that there be greater South-South co-operation and linkages with social movements for global solidarity.

7.3 On follow up country work and institutionalising the Equity Watch

The third group discussed the conclusions from the country work and the recommendations for institutionalising equity. The group proposed that equity be mainstreamed within all Ministries. The group proposed that:

1. Equity analysis be mainstreamed in planning- with planning, monitoring and evaluation activities integrating equity and efforts to widen the involvement of other sectors that play a role in the social determinants of health. Countries should start with the social sectors (health and education) and MDGs as a core, and widen to all sectors over time. Equity monitoring and evaluation tools also need to be developed linked to strategic plans. Continuous and incremental monitoring and evaluation of equity will allow for better implementation.
2. The Equity Watch should be institutionalised as a *periodic* (4-5 yearly) 'one stop' synthesis of evidence on equity for planning departments, civil society, parliaments etc linked to planning and review processes. It takes time, capacities and resources that should be adequately catered for.
3. To bring it alive the equity watch as a background resource needs to be taken to stakeholder discussion (parliament, other sectors, civil society etc), linked to health strategy, policy, budget and other processes and repackaged after production in

appropriate and simpler ways for its use within these different forums and processes. Governments should mobilise resources for communicating and disseminating the work.

4. It would be useful to identify options for how routine data can then be used to provide *annual analysis* of key areas of equity at national and district level and for resources and expenditure to be tracked to assess the relationship between health need and health resources. This includes tracking the distribution of *expenditures* (rather than allocations) and resources (health workers, medicines) by service level, by district and by programme.
5. The Equity Watch work complements other planning and review tools such as health facility surveys; public expenditure tracking; national health accounts and community monitoring.
6. Identifying the essential health benefit / services and service norms allows for costing and gap analysis that is useful for negotiating and monitoring resources to address inequalities in health;
7. Repeating the Equity Watch provides useful evidence on how policies have affected equity outcomes. However the Equity Watch as a synthesis of available evidence may not adequately address *why problems are arising*- the causes of the trends etc. It flags areas that may need specific follow up research or surveys, such as financing incidence analysis to assess proposed revenue options; benefit incidence analysis to assess the distribution of benefit from spending; surveys to understand the causes of disparities within districts; bottleneck studies on differential service barriers; or community level assessments to understand barriers and facilitators in social determinants and uptake of services and so on.
8. Mainstreaming equity into planning and review needs to be taken to district level in a manner appropriate to the functioning of health systems at that level- ie within the planning processes at that level; using and analysing routine evidence; encouraging district dialogue involving communities, health workers and other sectors on disparities, their causes and how they can be addressed. Specific indicators that are relevant at district level can be used to track equity at lower levels, such as attendance by skilled health workers of deliveries. Further work needs to be done to better understand how best to do this, through surveys and pilot district equity analysis exercises as in Zambia and Mozambique.

8. Closing

In the final session there was a brief update from Shepherd Shamu on STATA and information that delegates can apply to WHO AFRO if they wish to receive a license for STATA (numbers are limited). Dr Loewenson informed that the Regional Equity Watch will be completed and distributed within the coming months, including at the Regional Minister's conference and follow up work be built based on the meeting recommendations and country processes, and the report tabled with the ECSA M+E expert group. She acknowledged the valuable input of all delegates and resource people, and the importance of EQUINET's collaboration with the intergovernmental forums in ECSA-HC and SADC, with IDRC, WHO, UNICEF and other partners.

Dr Ruth Kitetu closed the meeting on behalf of the ECSA HC and the Monitoring and Evaluation Expert group. She thanked the delegates, the organisers, the resource people and partners and thanked EQUINET for its fruitful collaboration with ECSA. She indicated her commitment to ensuring follow up to the meeting, including at the next M+E meeting. She appreciated the skills sessions and indicated that this now needed to be followed up with deeper training within teams in Ministries and other stakeholders. Finally she wished delegates safe travel home.

APPENDIX 1: MEETING DELEGATE ADDRESS LIST

LAST NAME	FIRST NAME	COUNTRY	E-MAIL	ORGANISATION	ADDRESS
Chuma	Jane	Kenya	jchuma@kilifi.kemri-wellcome.org ; chumajc@gmail.com	KEMRI-Wellcome Trust Research Programme	P.O Box 230 Kilifi
Kitetu	Ruth Nzilani	Kenya	kiteturuth@yahoo.com	Ministry of Public Health and Sanitation	P.O Box 655 - 00515 Nairobi,
Shiferaw	Tesfaye	Kenya	tshiferaw@unicef.org	UNICEF Eastern & Southern Africa Regional Office	P.O. Box, 44145 - 00100 , Nairobi,
Dulo	Charles	Kenya	charlesdulo@yahoo.co.uk	Mustang Management Consultants	P. O. Box 48978 , Nairobi
Moyo	Christon	Malawi	moyochris@gmail.com	Ministry of Health	P.O Box 30377 Lilongwe 3,
Jeeanody	Nasser	Mauritius	njeeanody@mail.gov.mu	Ministry of Health and Quality of Life	Trio Road, Triolet Mauritius
Mazivila	Moises	Mozambique	mazivila@gmail.com	Ministry of Health	Av Eduardo Mondlane, 1008, 6 floor
Anselmi	Laura	Mozambique	l.anselmi@googlemail.com	Ministry of Health	Av Eduardo Mondlane, 1008, 6 floor
Hofman	Karen J	South Africa	Karen.Hofman@wits.ac.za	South Africa Wits/MRC Rural Public Health; Health Transition Unit Wits University	Room 10 B09, 7 York Road , Parktown, Johannesburg
Dambisya	Yoswa	South Africa/Uganda	yoswad@gmail.com	University of Limpopo	Dept of Pharmacy Private Bag X1106 Sovenga Polokwane
Zarowsky	Christina	South Africa	czarowsky@uwc.ac.za zwelakhen@yahoo.com	University of Western Cape HIV Research Centre	Private Bag X17, Bellville 7535, South Africa
Nhleko	Zwelakhe	Swaziland	jrubona@yahoo.com	Ministry of Health	P.O Box 5 Mbabane
Rubona	Josibert J	Tanzania	jrubona@yahoo.com	Ministry of Health and Social Welfare	P.O Box 9083 Dar es Salaam
Ipuge	Yahya A.	Tanzania	yipuge@ihi.or.tz	Ifakara Health Institute	Plot 463,Kiko, Avenue Mikocheni, Box 78373, Dar es Salaam
Sibandze	Sibusiso	Tanzania	ssibandze@ecsa.or.tz	East, Central and Southern Africa Health Community	P.O. Box 1009 Arusha
Zikusooka	Charlotte Muheki	Uganda	charlotte@healthnetconsult.com	HealthNet Consult	Box 35928 Kampala
Kadowa	Isaac	Uganda	kadisaac@yahoo.com	Ministry of Health	P.O Box 7272 Kampala
Mulumba	Moses	Uganda	mulumbam@gmail.com	Uganda Health Equity Network CEHURD	Box 16617 Wandegeya Kampala
Kalombo	Calvin	Zambia	cbmkalombo@yahoo.co.uk	Ministry of Health	P.O Box 20205 Lusaka
Chitah	Mukosha Bona	Zambia	mukoshya@zamtel.zm	Economics Department, University of Zambia	Box UNZA40, Lusaka
Loewenson	Rene	Zimbabwe	rene@tarsc.org	Training and Research Support Centre	Box CY2720, Causeway, Harare
Shamu	Shepherd	Zimbabwe	shamushe@yahoo.com ; shepherdshamu@hotmail.com	Training and Research Support Centre	47 Van Praagh Avenue, Milton Park, Harare

LAST NAME	FIRST NAME	COUNTRY	E-MAIL	ORGANISATION	ADDRESS
Mhlanga	Gibson	Zimbabwe	mhlanga.gibson@gmail.com	Ministry of Health and Child Welfare	P.O Box CY 1122 Causeway, Harare
Rusike	Itai	Zimbabwe	itai@cwgh.co.zw	Community Working Group on Health	114 McChlery Ave Eastlea Harare
Machemedze	Ranga	Zimbabwe	rmachemedze@seatini.org	SEATINI	20 Victoria Drive Newlands Harare
Hon Chebundo	Blessing	Zimbabwe	chebundobmc@yahoo.com , garaibmc@gmail.com	SEAPACOH: Association of Parliamentary Committees on Health for Southern and East Africa	Nelson Mandela Avenue 3rd Street, Harare
Nganda	Benjamin	Zimbabwe	ngandab@zw.afro.who.int	WHO AFRO	82 – 86 Enterprise Cnr Glenara, Highlands, Harare 263-4- 253724
Mahmood	Qamar	Canada	gmahmood@idrc.ca	IDRC Canada	150 Kent Street PO Box 8500 Ottawa, Canada K1G 3H9
Dossa	Shama	Malaysia	shama@arrow.org.my	Asian-Pacific Resource and Research Centre for Women (ARROW)	No. 1& 2, Jalan Scott, Brickfields 50470 Kuala Lumpur
Ataguba	John	South Africa	john.ataquba@uct.ac.za	University of Cape Town, Health Economics Unit	Health Economics Unit, Faculty of Health Sciences, Anzio Road, Observatory 7925
Norden	Pierre	South Africa	nordenpj@gmail.com	EQUINET – meeting rapporteur	



Delegates at the meeting, Cape Town 2012

APPENDIX 2: Meeting Agenda
DAY ONE – THURSDAY 26TH APRIL

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
13.45pm	Registration	Registration and administration.	TARSC, EQUINET
14.00-1430pm	Opening and Introductions	Opening remarks Welcome and objectives Delegate introduction, Adoption of the agenda	R Kietu ECSA M+E gp chair R Loewenson, TARSC
EQUITY ANALYSIS SKILLS BUILDING SESSIONS – Chair Chris Moyo, MoH Malawi,			
14.30-15.15pm	1. Concepts and indicators for analysis	Conceptual frameworks and concepts in health equity analysis; Indicators, social group categories and the criteria for monitoring; Discussion	R Loewenson, TARSC
15.15-16.00pm	2. Measuring the dimensions and magnitude of inequality	Measures of absolute and relative inequality; Rate ratios, rate differences, differences across groups and across time; comparisons against targets/ reference points and coverage gaps Discussion:	S Shamu, University of Zimbabwe/ TARSC
16.00	TEA		
16.15-17.15pm	3. Measuring relationships in equity analysis	Ways of associating inequalities in causes with inequalities in outcomes - Regression, decomposition analysis, concentration curves Discussion	J Ataguba, University of Cape Town Health Economics Unit
17.15pm	END OF DAY		
16.00pm	EQUINET Cluster lead meeting: TARSC, UCT, CWGH, SEATINI, CEHRUD		

DAY TWO – FRIDAY 27TH APRIL

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
INTRODUCTIONS AND RECAP			
8.45-9.00am	Introductions and recap of day one	Summary review Introduction of new arrivals	R Loewenson, TARSC, Delegates
REVIEW OF THE COUNTRY EQUITY WATCH WORK - Chair: Hon B Chebundo, SEAPACOH			
9.00-1015am	4. Review of Equity Watch work at country level	1. Kenya EW 2. Uganda EW 3. Zambia EW • Findings / trends • Issues and recommendations for carrying out equity analysis	C Dulo I Kadowa B Chitah
10.15am	TEA		
10.45-12.00pm	5. Review of Equity Watch work at country level	4. Zimbabwe EW 5 Mozambique EW Moderated discussion of the country EW work	G Mhlanga, M Mazivila
EQUITY ANALYSIS SKILLS BUILDING SESSIONS - Chair: Y Ipuge Ifakara Tanzania			
1200-1300 pm	6. Measures of inequality in income and wealth	Options and debates: wealth, income, consumption measures, gini coefficient, wealth quintile Discussion	S Shamu, UZ/TARSC
13.00	LUNCH		
14.00-15.00pm	7. Analysing equity in health financing	Concepts and measures of equity in health financing Finance and benefit incidence Discussion	C Zikusooka Healthnet Consult
15.00	TEA		

DAY TWO CONTINUED – FRIDAY 27TH APRIL

MOVING FORWARD AT COUNTRY LEVEL - Chair: N Jeeanody, MoH Mauritius			
15.15-16.30	8. Key areas of work at country level	1. Getting and using evidence for equity analysis and resource allocation at district level 2. Disaggregating spending by level within health expenditure reporting	L Anselmi, MoH K Calombo, MoH Z Nhleko, MoH
16.30pm	9. Brainstorming session	What do we mean by “equity”, “governance” and “integrated health systems”	Q Mahmood IDRC
17.15pm	END OF DAY		
17.15pm	EQUINET Steering committee meeting		EQUINET SC members

DAY THREE – SATURDAY 28TH APRIL

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
EQUITY ANALYSIS SKILLS BUILDING SESSIONS - Chair: R Machededze, SEATINI/ EQUINET SC			
8.30-10.00am	10. Linking equity analysis to social determinants and universal coverage	Social determinants of health <i>equity</i> and linking equity analysis to policy dialogue on universal health coverage Linking equity analysis to the MDGs Discussion	B Nganda, WHO AFRO T Shiferaw UNICEF ESARO
10.00	TEA		
REVIEW OF THE REGIONAL EQUITY WATCH- Chair: M Moses, CEHURD/ EQUINET SC			
10.15-11.00	11. Presentation of the regional equity watch	Key evidence, trends and messages in the regional equity watch Discussion	R Loewenson, TARSC
11.00-12.00	12. Working groups on the regional analysis and work	Working group 1: <i>On the findings of the Regional Equity Watch</i> Working group 2: <i>On use of the regional EW, equity in MDG reporting and the post 2015 MDGs</i> Working group 3: <i>Conclusions from the country work and recommendations on follow up and institutionalizing equity monitoring</i>	
NEXT STEPS - Chair Itai Rusike, CWGH/EQUINET SC			
12.00-13.00	Plenary feedback of working groups	Plenary discussion of working group feedback	Delegates
13.00 - 13.15pm	Closing	Closing remarks and departure	R Loewenson, EQUINET Ruth Kitetu Chair M+E group ECSA HC
13.15pm	LUNCH		