# Reclaiming the state:

## Advancing people's health, challenging injustice



# ABSTRACT BOOK

**Regional Conference
on Equity in Health in Southern Africa
June 8-9 2004, Durban, South Africa**

EQUINET

# "Reclaiming the state: Advancing people's health, challenging injustice"
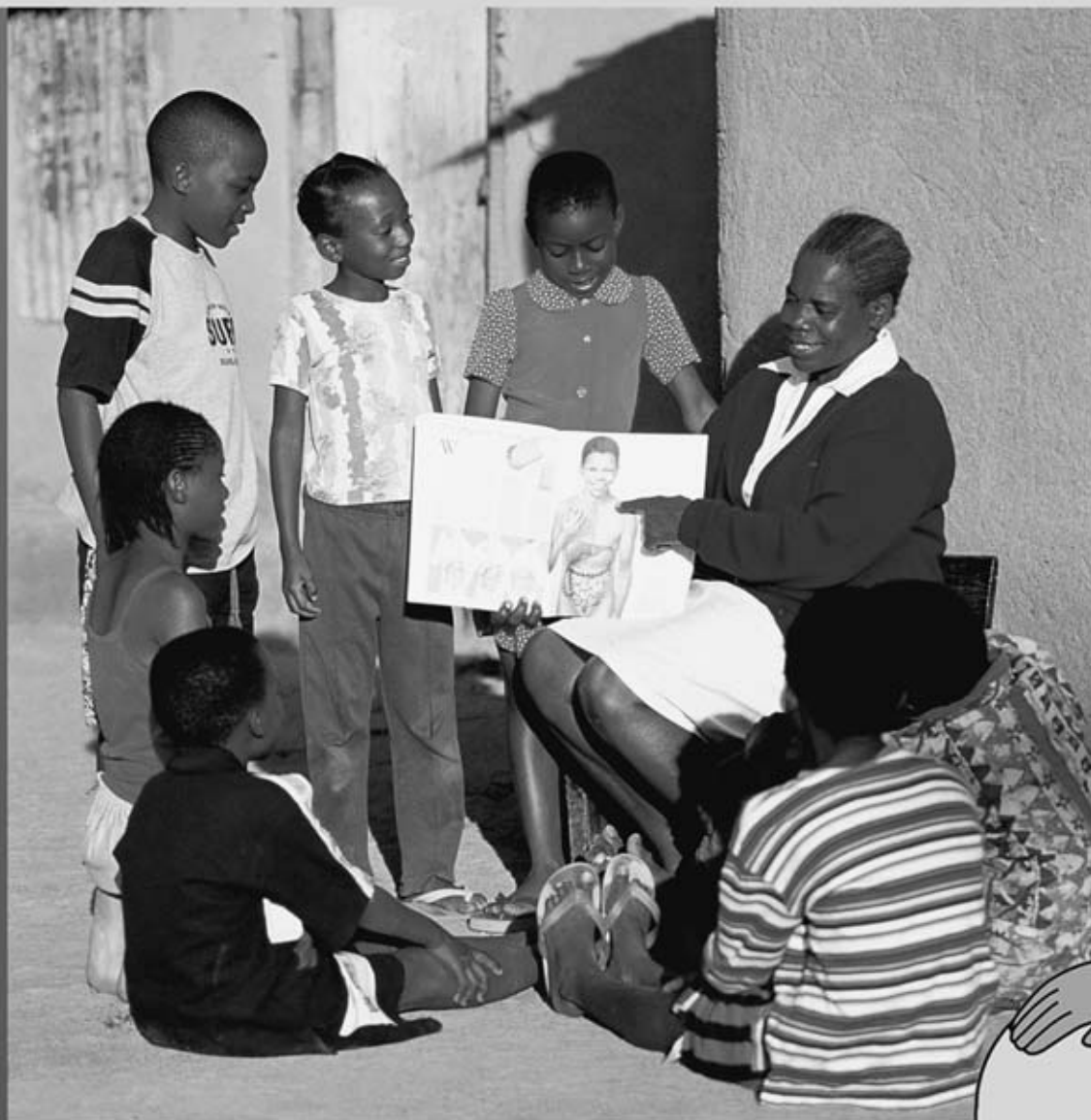
## Abstract Book

## Regional Conference on Equity in Health in Southern Africa, June 8-9 2004 Durban, South Africa



**Regional Network for Equity in Health in Southern Africa (EQUINET)**

Southern African Regional Network on Equity in Health (EQUINET)

## Reclaiming the State: Advancing Peoples Health, challenging Injustice

**THIRD SOUTHERN AFRICAN CONFERENCE ON EQUITY IN HEALTH**
**TROPICANA HOTEL,**
**DURBAN, SOUTH AFRICA.**
**JUNE 8 AND 9 2004**

On behalf of the EQUINET steering committee we welcome you to the EQUINET Southern African Conference on Equity in Health being held on June 8 and 9 2004 in Durban South Africa. We have chosen the conference theme 'Reclaiming The State: Advancing People's Health, Challenging Injustice' to raise, debate and give visibility to the determinants and forces that are driving or impeding equity in health in our region, southern Africa, and to identify strategies and policies for advancing people's health based on values of fairness and justice. This is the third such conference in the region since 1997, following the Kasane meeting in 1997 and the South African meeting in 2000.

The Southern African Regional Network on Equity in Health (EQUINET) aims to promote and realize shared values of equity and social justice in health. We are therefore honoured and happy to welcome delegates from state, civil society and non state organisations, parliaments, regional and international organisations and other institutions promoting and working on equity in health in southern Africa. The conference brings together a wide spectrum of work and views, drawn from the research, policy and advocacy work done by EQUINET and by others in the region on different dimensions and drivers of equity in health in southern Africa. We hope that the conference will provide you with an opportunity to assess progress towards equity in health. We also hope that you will identify key areas to be followed through by EQUINET and others in future research, policy intervention and programme design at national and regional level.

Southern African Regional Network on Equity in Health (EQUINET)

## Reclaiming the State: Advancing Peoples Health, challenging Injustice

THIRD SOUTHERN AFRICAN CONFERENCE ON EQUITY IN HEALTH
TROPICANA HOTEL, DURBAN, SOUTH AFRICA.  JUNE 8 AND 9 2004

# PROGRAMME OUTLINE

## Monday 7 June 2004

| | |
|---|---|
| 1700-1900 | Registration |

## Tuesday 8 June 2004

| | |
|---|---|
| 0800-0830 | Registration |
| 0830-1000 **OP** Coral 1&2 | **Opening Plenary: Reclaiming the state: Advancing peoples Health, Challenging Injustice**<br>Opening Key note paper:<br>Reclaiming the state: Advancing peoples Health, Challenging Injustice<br>EQUINET steering committee paper:<br><br>Discussion |
| 1000-1030 | Tea, coffee |
| 1030-1230 **P1** Coral 1&2 | **Plenary 1:  Advancing peoples health**<br>Health rights as a tool for health equity<br>Food security and nutrition<br>Challenges of HIV/AIDS and health systems responses<br><br>Discussion |
| 1230-1330 | Lunch, poster viewing |
| 1330-1530<br><br>PW1-4 | Parallel workshops |

| **PW1**:Health rights as a tool for health equity | **PW2**:Health systems approaches to HIV/AIDS | **PW3**:Parliamentary Alliances for equity in health | **PW4**:Using ICT as a tool for Equity and social justice |
|---|---|---|---|
| Coral 1 | Bahama 1 | Panorama 1 | Bahama 2 |

| | |
|---|---|
| 1530-1545 | Tea/coffee |
| 1545-1730 **P2** Coral 1&2 | **Plenary 2:  Reclaiming the state**<br>Parliamentary Alliances for health equity<br>Fair financing in health system<br>Confronting challenges in health personnel<br>Governance, equity and health<br><br>Discussion |
| 1830-2000 | Reception |

Southern African Regional Network on Equity in Health (EQUINET)

# Reclaiming the State: Advancing Peoples Health, challenging Injustice

THIRD SOUTHERN AFRICAN CONFERENCE ON EQUITY IN HEALTH
TROPICANA HOTEL, DURBAN, SOUTH AFRICA.  JUNE 8 AND 9 2004

# PROGRAMME OUTLINE Continued.

## Wednesday 9 June 2004

| | |
|---|---|
| 0800-0830 | Poster viewing |
| 0830-1030 | **Parallel workshops** |

| PW5-8 | **PW5**:Confronting challenges in Health personnel | **PW6**:Fair financing in health systems | **PW7**:Community voice and agency in health systems | **PW8**:Civil society alliances for equity in health |
|---|---|---|---|---|
| | Coral 1 | Bahama 1 | Panorama 1 | Bahama 2 |

| | |
|---|---|
| 1030-1100 | Tea,coffee |
| 1100-1230<br>**P3**<br>Coral 1&2 | **Plenary 3:  Challenging Injustice**<br>Globalisation, Trade and Health<br>Civil society struggles for health<br>Using ICT for health equity: the EQUINET website<br><br>Discussion |
| 1230-1330 | Lunch |
| 1330-1400 | Poster viewing                                         Rapporteurs drafting session<br><br>                                                                                  Bahama 2 |
| 1400-1545<br>**P4**<br>Coral 1&2 | **Plenary 4:  Organising for health equity and social justice**<br>Country reports<br>Discussion of conference resolutions: policies and actions<br>EQUINET as a vehicle for health equity and social justice<br><br>Discussion |
| 1545-1600 | Tea,coffee |
| 1600-1645<br>**P5**<br>Coral 1&2 | **Plenary 5:  Reclaiming the state: Advancing peoples Health challenging Injustice**<br>Adoption of conference resolutions<br>Closing Keynote paper:  Reclaiming the state: Advancing peoples health, challenging Injustice |

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## Reclaiming the state: Advancing peoples Health, Challenging Injustice

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*Convenor:  Leslie London, University of Cape Town*

## PW2: Parallel Workshop: Health systems approaches to HIV/AIDS
*Convenor: D McCoy, R Loewenson EQUINET*

## PW3: Parallel Workshop:  Parliamentary Alliances for equity in health
*Convenor: Adamson Muula, Malawi Health Equity Network, Lexi Bambas GEGA*

## PW4: Parallel Workshop:  Using ICT as a tool for Equity and social justice
*Convenor: Firoze Manji, Fahamu/EQUINET,  Tendayi Kureya SAfAIDS*

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## PW5: Parallel Workshop: Confrotning challenges in health personnel
*Convenor:  Antoinette Ntuli, Health Systems Trust*

## P3: Plenary:  Challenging Injustice

## P4: Plenary: Organising for health equity and social justice

## P5: Plenary: Reclaiming the state:
## Advancing peoples Health, Challenging Injustice

# OP: Opening Plenary: Reclaiming the state: Advancing peoples Health, Challenging Injustice

*Tuesday 8 June 2004 0830-1000*
Coral 1 and 2

## OP1: Opening Key note paper:
### Reclaiming the state:
### Advancing peoples Health, Challenging Injustice
*Adebayo Olukoshi, Director, CODESRIA, Dakar Senegal*

*Adebayo Olukoshi, Professor of International Economic Relations and currently the Executive Secretary of the pan-African Council for the Development of Social Science Research in Africa (CODESRIA) which is headquartered in Dakar, Senegal. He has previously served as Director of Research at the Nigerian Institute of International Affairs, Lagos, Nigeria and as a Senior Fellow/Research Programme Coordinator at the Nordic Africa Institute, Uppsala, Sweden. His current research interests centre around the politics of reform and transition in African politics, economy and society.*

Historically, the state has played an important role as a social actor. Indeed, the social function of the state was as critical to the constitution of the social contract as the quest for a secured territorial framework within which individuals and groups could exercise their livelihoods. The high point of the development of the social state came in the period after the Second World War with the growth and spread of different variants of social democracy and welfare states. Not surprisingly, African states at independence were invested with broad-ranging social responsibilities which they pursued with varying degrees of success. However; the onset of the African economic crises in the period from the early 1980s onwards and the rise on a global scale of the forces of neo-liberalism encapsulated the confluence of factors that culminated in the retrenchment of the social state - including from an institutional and expenditure point of view - and the enthronement of a narrow, market-based logic in the provision of social services - including, among other things, the pursuit of cost recovery, the imposing of user fees, the promotion of privatisation, and the employment of new public sector management strategies in the social sectors. At the same time, the social sectors, including especially the health system, were to suffer a serious erosion of capacity that was connected to the drain of talents, the degradation of the infrastructure of service, and the collapse of professionalism. Perhaps much more serious is the decoupling of social policy from macro-economic policy-making and its treatment as a residual category to which

targetting strategies such as safety nets, various programmes for the alleviation of the social effects of economic structural adjustment and a plethora of pverty reduction strategies would be applied. It is suggested that this decoupling of social and macro-economic policy making is at the root of the expansion of the boundaries of exclusion that defines the structural roots of injustice in the social sectors genrerally and the health sector in particular. The prospects for the restoration of a socially-cosncious state will depend on the capacity of governments to adopt an approach in which social policy is treated as an integral part of macro-economic strategies for growth and development.

# OP2: EQUINET Steering committee paper
## Reclaiming the state:
## Advancing peoples Health, Challenging Injustice
*EQUINET Steering Committee,*
*presented by Rene Loewenson, TARSC Zimbabwe*

This paper is the third overview produced by the Southern African Regional Network for Equity in Health (EQUINET) steering committee since EQUINET's launch after the Kasane meeting in 1997. The first paper in 1998 identified a concept of health equity that would guide EQUINET work, outlined the areas of policy commitment to this vision of equity in southern Africa, and the gaps in delivery on these commitments. The second paper in 2000 described the profile of poverty, inequality and ill health in southern Africa despite these commitments, and proposed policy measures that would better direct resources towards health needs, and the forms of health care most appropriate and accessible to those with greatest health needs, particularly through primary health care strategies. This paper highlighted the important role played by the social forces that drive policy choices, and proposed specific measures for organising and investing in opportunities for informed, authoritative participation of all social groups and particularly the poorest in their health systems, and for building health system responsiveness and accountability to social groups.

This third EQUINET steering committee paper in 2004 observes the need to go beyond mapping the problems towards proactively building the alternative vision, analysis, perspective and struggle that mobilize social action and technical work and inform political choice.

We propose that if we are to *advance people's health* equitably / fairly / within the broader context of social justice, then a positive vision of health must cover elements that are rooted in longstanding principles and practice
  • of public health, viz the protection and promotion of population health and prevention of ill health
  • of providing relevant, quality health services and care for all according to need and financed according to ability to pay
  • of building the human resources and knowledge to shape and deliver public health and health services, and
  • of protecting and ensuring the social values, ethics and rights that underlie health systems, including to participation and involvement.

We highlight, using evidence from southern Africa, the significant positive gains in health that are attainable when these principles are addressed by health systems, when health is supported by redistribution of the resources for health in an equity

oriented policy agenda supported by the state. We also highlight the . reversals and inequities that take place when these principles are not addressed, particularly for the poorest. We examine the role of the state and the non state sectors in addressing these core elements, and use this to argue for an alternative vision that is explicitly centred on rising investment in health through the state and public sector – *a reclaiming of the central role of the state.*

EQUINET has been implementing work in a number of areas, and this experience is used to highlight the role of and options for state led health systems in advancing people's health, (dealt with in more detail in the plenary papers to the conference): These areas of work all confront the fundamental challenge to a positive alternative that is posed by a globalization process based on unfair global trade relations, dominance of transnational corporation interests, reduced role and authority of the state and political and economic marginalization of southern and low income populations. We explore the economic and trade challenges to countries and states seeking to equitably meet the health needs of their people and to SADC as a region. We argue and pose options for resistance to these challenges and outline modes of resistance.

Resistance to processes that undermine equitable health systems and population health are driven by consciousness, perspective and shared values. We argue that to *challenge the injustices* undermining people's health, we need to build stronger and more informed and conscious networks in the region, able to make strategic decisions and alliances and use these to respond to immediate challenges and to build long term transformation. We point to opportunities in work with government, parliaments and civil society for achieving this. We also outline areas to strengthen our democratic practice in health, particularly through institutions and processes that provide for meaningful forms of participation and for the delivery of collective rights and values through promoting social agency.

We conclude by outlining the opportunities that EQUINET, a network based on shared vision and values of equity and social justice, offers for those seeking to build and implement equitable health systems in southern Africa. We outline our aspirations of the 2004 regional conference to strengthen our values, analysis, actions and institutional mechanisms for building health equity in southern Africa.

# P1: Plenary 1: Advancing People's Health

*Tuesday 8 June 2004 1030-1230*
Coral 1 and 2

## P1.1: Health rights as a tool for health equity

*Leslie London, University of Cape Town, EQUINET theme co-ordinator*

Most public health practitioners acknowledge the value of human rights in promoting human well-being. However, there is potential for tension between human rights approaches and public health objectives such as equity, access and efficiency, particularly in developing countries where resource constraints exacerbate balancing of competing priorities. This potential tension may stem from inappropriate conceptualizations of human rights and how they should be operationalised in a public health context. For example, where human rights are conceived as individual entitlements, public health officials could erroneously equate this to favouring individuals over the welfare of the community to the detriment of equity. Health and health care are recognized as human rights, which span the full range of civil, political and socio-economic rights, many of which are essential requirements for health. Human rights approaches include the use of internationally recognized standards for policy development, for analysis and critique government performance, and for the facilitation of redress for those who suffer rights violations. Considerations of social justice and social patterning are core to what constitutes a human rights approach. Human rights approaches, therefore, should fundamentally serve as important tools to support advocacy and civil society mobilization.

Three case studies in Southern Africa were explored to highlight a human rights approach for the promotion of health equity: (1) Treatment access for HIV (South Africa), (2) Use of Patients' Rights Charters (Malawi, South Africa, Zimbabwe), and (3) Civic Organising for Health (Zimbabwe). The main findings to emerge from the studies are that human rights approaches could offer powerful tools to support social justice and institutional transformation when:

- Rights approaches are predicated upon casting rights in a specifically vulnerable group context;
- The operationalisation of rights confers agency on the part of those most affected, and
- Rights include the complete spectrum of civil, political, and socio-economic rights.

Public health concerns for equity then become consonant with human rights-based strategies. The synergy between public health and human rights in relation to equity lie less in the setting and mechanisms for pursuing individual rights, but rather in social processes and consciousness, and the interface with the state that secures collective rights.

Key themes emerging from the study illustrated the importance of collective agency: Rights alone are insufficient, need to be coupled with community engagement and can both be realized by and, in turn, strengthen community engagement. When conceived in terms of agency, particularly collective agency, rights are the strongest guarantors of effective equity-promoting impacts. To build equity, rights approaches should address the public-private divide, provide opportunities for mobilising resources outside the health sector, utilize access to information and emphasise transparency. Numerous questions remain as to how to test out these preliminary findings in further depth and in the context of international inequities. It is evident, though, that important gains can be made for equity using a human rights approach. Health systems analyses need desperately to muster stronger rights arguments to ensure equity promoting transformation.

## P1.2: Food security and nutrition

*Mickey Chopra, David Sanders,*
*School of Public Health*
*University of Western Cape,*

The lack of household food security, and the subsequent poor nutrition, continues to blight the lives of millions of people in Southern Africa. Adequate food and nutrition is a basic right. The deprivation of this right has immense consequences for addressing inequities across the region. Poor nutritional status stunts educational development as well increasing the risk of acquiring, and the severity of, infectious diseases (including HIV/AIDS). The lack of household food security has led to increased vulnerability, especially of women, to diseases such as HIV. If the huge of burden of disease suffered by the poorest is to be tackled addressing lack of household food security and malnutrition is essential.  Despite a widespread recognition of the integral relationship between AIDS and poverty and under-development, little systematic investigation has been done into the  impact of AIDS  on underdevelopment, and virtually no studies have been undertaken on HIV/AIDS, food security, famine, and nutrition. However the recent food crisis in Southern Africa has been far more widespread and impacted much more severely than predictions based upon rainfall patterns had anticipated - illustrates the destructive effect AIDS is having. There are a number of ways in which AIDS increases the impact of such external shocks: (1) household-level  labour shortages result from adult morbidity and mortality, as  does the rise in numbers of dependants; (2) loss of assets and skills result from increased adult mortality; (3) the burden of care is large for sick adults and children orphaned by AIDS;  (4) vicious interactions exist between malnutrition and HIV; (5)  institutional capacity (e.g. health and social services, agricultural extension services) to respond has been lost.  These factors are in turn over-determined by the worsening macro-economic context in most Southern African countries.  An understanding of the causes of increasing food insecurity and malnutrition must include an analyses of macro level factors such as trade relations, domestic food and agricultural polices and micro level factors such as intrahousehold food distribution, gender roles, caring practices. This paper will delineate some of the more important macro and micro level factors and attempt to show how they are inter-linked. It is

only after developing an integrated understanding of the causes can comprehensive responses be formulated. The paper will conclude with examples of such comprehensive responses in the region.

## P1.3: Ensuring universal treatment access through sustainable public health systems

*David McCoy and Rene Loewenson,*
*Equinet*

There is no question that an effective and urgent response is needed to extend access to antiretroviral therapy (ART) in southern Africa. The efforts of treatment activists, national governments, the World Health Organisation and the Global Fund to highlight this unmet health need are commendable. However, after decades of under-investment, harmful structural adjustment programmes and de-skilling, many health systems face significant obstacles in rising to the challenge of meeting the treatment needs.  Treatment activism now needs to join with broader public health activism to ensure that treatment can be extended in ways that are sustainable, effective and equitable. This paper draws on work carried out by EQUINET and others to discuss the threats and opportunities entailed with the expansion of ART access in Southern Africa- threats that must be managed and opportunities tapped to realise aspirations of treatment access for more than a minority.

The threats are raised and exemplified in terms of the opportunity costs of expanding ART in under-resourced health systems, the possibilities of reinforcing or worsening health care inequities, the potential for harm to wider health systems in a disease-focussed  ART expansion; and the possibility of drug resistance if services are unable to ensure adequate treatment compliance. Evidence is led of ways in which poorly designed programmes  ultimately fail to deliver sustainable treatment access.

The greatest threat however is not tapping the significant opportunity that exists for  ensuring sustainable and widening treatment access through strengthening health systems, particularly given the global attention and resources being directed towards AIDS. The paper presents the argument from a wide range of southern African and international organisations that resources should now go towards ART expansion through

comprehensive health systems development. In order to ensure this outcome, a number of principles need to be adhered to:

- Fair, transparent processes to make informed choices
- Joint public health and HIV/AIDS planning
- Integrating treatment into wider health systems
- Realistic targets for treatment access with clear guidelines and monitoring systems for ensuring equity in access and quality of care.
- Treatment resources integrated into regular budgets, supported by long term external commitments and through fair financing approaches
- Prioritising human resource development in the health sector
- Strengthening  essential drugs policies and systems nationally and regionally
- Linking the challenge of ART expansion to the challenge of reforming the broader global political economy

These principles are informing national, regional and international follow up work to inform national debate; to gather evidence of good practice and for translation into practical strategies and programmes; to provide a wider framework for research aimed at understanding the costs and benefits of approaches to ART access; to inform policy,  advocacy and activism and as a basis for monitoring of  current practice.

# PW1: Parallel Workshop:
## Health rights as a tool for health equity
*Tuesday 8 June 2004 1330-1530*
Coral 1
Convenor:  Leslie London, University of Cape Town

*This workshop aims to tease out in detail what kinds of rights approaches strengthen health equity and why. We will start with three poster presentations to explore different general approaches to rights - the legal framework of international human rights law, the role of community participation and its relationship to rights approaches, and the place of culture and the rights of indigenous peoples to intellectual property. These presentations will seek to respond to questions raised through Equinet's work on the relationship between health equity and human rights, thereby providing some depth to the issues raised in plenary. The workshop will then hear two case studies, one on the use of a scorecard to promote health equity in health service delivery, and the other examining obstacles to access to maternity services. After general clarification, the workshop will break into groups to discuss a set of questions on each case study. Groups discussions will be fed back into a workshop plenary to close the workshop, and any feedback for Equinet passed on by the workshop facilitator. The workshop requires active participation by those attending, including sharing of own experiences.*

### PW1.1: Health rights as a tool for health equity
*Chloe Frommer Njuzu Reproductions (Non profit, Inc).*
*Chloe@culturalrights.com*

Cultural resources like traditional medicinal knowledge need to be recognized in their role tied to important regional practices in Zimbabwe. Zimbabwe has the chance to do this under a National Sui Generis Legislation designed apart from the international nexus of legislations that collapse cultural resources with biological and intellectual resources. Even further, because foreign pharmaceutical companies seeking plant genetic resources, called 'green-gold', benefit from the derivatives of traditional medicinal knowledge it is important to protect relevant cultural practices as part of an entire social and symbolic system. This system can be conceived when traditional medicinal knowledge is seen to be accessed, kept, shared, used and valued as a spiritual gift that links individuals, families and community in relationships. Change to this arrangement occurs when the derivatives of it are appropriated for local non-customary use in Zimbabwe's street markets, in a trade union of traditional-healers, as well as for research and development schemes. Acknowledging this spectrum of divergent interests and practices surrounding traditional medicinal knowledge is the most important prerequisite to creating a system of protections for

cultural resources. A National Sui Generis Legislation framework that clearly supports and protects the cultural right of local individuals and communities will thereby need to entitle customary and non-customary regional practices pertaining to traditional medicinal knowledge accordingly.

### PW1.2: Accessing health rights- A partnership between the South African Equity Gauge and the Communities of KwaZulu Natal, South Africa
*Sizwe Shezi, Health Systems Trust*
*sizwe@hst.org.za*

Community participation sa an essential pillar of Primary Health Care (PHC) dates back to the Alma Ata Conference of 1978. In south Africa efforts to facilitate community participation in health were fostered by the Progressive Primary Health Care Network, and subsequently more formally supported after the democratic government came into power in 1994. Community participation means community involvement to varying extents in planning, organizing, managing and monitoring and evaluating health activities, whether they be promotional, prevention, early diagnosis, treatment or rehabilitation.  Clinic Committees are important community structures that are intended to facilitate community participation in health, and there is a provision for all clinics in South Africa to have clinic committees. These committees are intended to be

community structures democratically elected with representation from all community stakeholders. Clinic committees are expected to work in partnership with clinics to improve service delivery in the clinic and to advocate for community health needs and interests and as well as ensure that there is communication between the clinic and the public. However, there are few active clinic committees, lack of clarity as to their role and function, and little support to strengthen this important organ of civil society. The South African Equity Gauge has been working with communities in one province and has identified a number of lessons from this work:

- Community involvement in health through structures like clinic committees is key to sustainable health programmes
- Political will is critical to ensure that policy makers place community participation at the center of policy development processes
- Clinic committees can and should play a supportive role to the clinic through participating in planning meetings of the clinic and serve as the channel of communication between the clinic and the public
- Health workers should be retrained and re-orientated to deal with attitudes and give them skills to facilitate community participation
- Understanding of the socio-cultural-political context in which poor communities live in is important so that the clinic can respond better to community health needs

The gauge is now helping clinic committees to develop capacity so that they can monitor and evaluate their clinics. We are also working towards forming a provincial health movement under the banner of the People's Health Movement (PHM) to advocate for quality and equity in health.

## PW1.4: Adopting a rights based approach to achieve equity in health in Malawi

*Davie Kalomba, Holman Phiri Care Malawi*
*davie@caremalawi.org*

CARE International in Malawi launched the Local Initiatives for Health (LIFH) Project in May 2002. The purpose of the project is to improve the ability of the rural households in the Central Region of Malawi to manage and address their basic rights to health. The project aims at developing innovative and sustainable models that seek to resolve issues of poor health standards and conditions amongst the rural poor communities. It therefore seeks to build collaborative capacity between the service users and partner organizations, such as government service providers, through an appropriate rights based framework. The project has mainly focused on the fundamental principles of human rights that include liberty, dignity, equality, non discrimination, and participation. Consequently, practical elements of human rights namely access to information, participation in decision making processes, accountability, transparency, equity and shared responsibility have been the core business of the project. Using the Scorecard process as the main methodology, the project has managed to achieve equity in access to health services at the health centre level in Lilongwe District in Malawi. The community and health centre scorecard is a multifunctional tool that has been used by the project to conduct participatory assessments; participatory planning; participatory monitoring; and performance evaluation. The tool has helped service users to claim and achieve their human rights, while holding duty bearers accountable, thereby facilitating a shift towards attainment of a more equitable health care delivery system. Participatory appraisal within the communities has generated thematic areas of the scorecard that include staff attitude; management of the health centres; quality of health care; and, equity in access to health services. By conducting community assessments and health centre self evaluation processes, the concerned parties are able to identify strengths and weaknesses of the health service delivery system and come up with suggestions for action in order to sustain good performance and improve on the weak areas. The major thrust of the process lies in the fact that it allows for dialogue between service providers and users. Experience has shown that over a reasonably short period of time, equity, (defined in this context as equal access to health services) can be achieved in areas of non discrimination in drug dispensing, non discrimination in the overall treatment of patients, non discrimination in the provision of supplementary food and maintaining a first-come first-served policy. Some of the key lessons about the use of the scorecard are that using indicators generated by the communities themselves facilitates their continued engagement in the entire process; and that the dynamism of the tool (in terms of the flexibility to change indicators as new issues emerge and as some become less important) correspondingly directs the focus of the subsequent action plan. It is well acknowledged that these improvements may not necessarily benefit different household

categories equally. An exclusive approach to ensure that the interests of the poor and vulnerable are addressed has to be gradual so that participation by the well off is safeguarded. The social mapping process has the potential to identify such categories of people amongst their own communities and therefore link them to the health service providers and other social support systems. On the whole, the methodology has the potential to influence policy development by taking the voices of the community to higher level decision makers.

## PW1.5: Human rights perspectives on the accessibility of maternity services in the northern suburbs

**Nomafrench Mbombo,**
**University of Western Cape**
*nmbombo@uwc.ac.za*

The South African Saving Mothers reports (1998, 2001) and Saving Babies reports (2000, 2001) identified the delay and failure or infrequent attendance of maternity care during pregnancy as the major contributory factors to maternal deaths in South Africa. A study using a human rights approach was conducted in Cape Town to identify reasons why maternity women fail or delay to attend antenatal, intranatal and postnatal care. In regard to maternity women the study intended to:

1. Identify and describe the reasons of presenting late or failing to attend antenatal, intranatal and postnatal care at a maternal health facility.
2. Determine and analyse human rights factors that impact on accessibility to antenatal, intranatal and postnatal care at a maternal health facility.
3. Develop a model on accessibility of maternity services using the human rights approach.

A qualitative multiple case study design was used where women attending Midwife Obstetric Units were interviewed. Data was analysed thematically. Women gave their reasons and perceptions on why they fail to attend maternity care and these were grouped into themes. Women are unable to access maternal health services because the health system does not promote and fulfil their human rights to access quality health care. The findings are interpreted in the context of the South African Constitution and the International Bill of Rights.

# PW2: Parallel Workshop:
# Health systems approaches to HIV/AIDS and treatment access

*Tuesday 8 June 2004 1330-1530*

Bahama 1

*Convenor:  David McCoy, Rene Loewenson, EQUINET, TARSC*

*This workshop aims to present and review evidence on health systems and equity issues towards building a health systems approach to treatment access. This workshop will draw from seven EQUINET commissioned studies  by Kemp et al (2003); Chopra (2003); Semali (2003); Ray and Kureya (2003); EQUINET/TARSC (2003); Ntuli et al (2003);  Aitken et al (2003) and McCoy (2003) published at www.equinetafrica.org  and from the abstracts presented below.*

## PW2.1: HIV/AIDS, food security and health in developing countries

*Elizabeth-Ann Schroeder*
*Department of Economics,*
*University of Natal – South Africa //*
*National Perinatal Epidemiology Unit,*
*University of Oxford UK*
*liz.schroeder@ntlworld.com*

Public Health concerns in developing countries are increasingly centered on the relationships between HIV, malnutrition and death, and healthcare. In developing countries (such as those in sub Saharan Africa) with large rural subsistence populations, this public health concern incorporates the effect of HIV on household subsistence and nutrition. A study to determine whether families who adopted orphans in a rural area of South Africa with a low employment rate and a high prevalence of HIV were food insecure when compared with families who had not adopted orphans was conducted in December 2001, allowing these issues to be explored. A case-control study design was used to determine the demographic, agricultural and socio-economic characteristics of 91 households in Ingwavuma, South Africa, with and without orphans. Cluster sampling was used and 19 localities were chosen from 10 larger wards. Information was obtained via a formal questionnaire, observation of the household's agricultural practices and a multidisciplinary meeting comprising agricultural and health service providers as well as local community leaders on completion of data collection. Logistic regression with SPSS was used for the data analysis, which analyzed three proxies of food security - compared between the two sample cohorts.

Forty-six percent of households in the area were single-parent headed and households with occupancy ranges of 11-15 people were female to male headed 7:1. Thirteen of the forty 'orphan' households were headed by a grandparent who would be likely to die sooner than an uninfected parent. Sixty three percent of households felt that they would not be able to obtain work at all if required due to crop failure; two percent felt they would source income for six months and two percent for three months. Both cohorts showed a high incidence of illness and death and the presence of orphans was correlated to 'larger numbers of household occupants'. For a unit increase in the number of household occupants, the probability of the household engaging in food reduction activities is 4.4%; 4.5% the probability of the household not producing sufficient food to satisfy its household consumption requirement, and 4.2% the probability of the household having to increase its food supplementation activities. Dependency ratios are increased with the adoption of orphans into rural households, reducing food security. Anticipated increases in children orphaned by HIV in rural subsistence communities may have possible long-term health effects if primary nutrition care and food security is not ensured. Food and health monitoring and early warning famine systems such as those implemented in Mozambique are recommended in all rural areas with high HIV prevalence rates, to avert malnutrition and crisis interventions.

## PW2.2: The past in the present: the South African AIDS epidemic and policy responses in a context of inequality

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As the focus of the response to HIV shifts towards large-scale distribution of anti-retroviral drugs and the building of health system capacity, a set of fundamental questions are likely to persist. For example, why has southern Africa experienced an explosive HIV epidemic? Why are there differences in the distribution of the epidemic in Africa? What is the role of political economy in explaining and addressing the epidemic? As a contribution to these debates, this paper reviews the social epidemiology of HIV in South Africa through the lens of historically produced inequities, which have made of HIV in South Africa not only a massive phenomenon, but also an unequal one. South Africa's past has created, in the words of Shula Marks, an over determined "epidemic waiting to happen". Drawing on available evidence, the paper reviews the epidemiology of HIV, outlining how its distribution bears the marks of the apartheid past as well as of economic, political and cultural transitions. The paper also discusses the pathways through which inequality mediates risk. While social dislocation and loss of social networks may lead to changing social norms and practices around sex, it is not entirely certain that multi-partner sex is the only factor in HIV spread. "Place" factors, such as high background levels of HIV and unequal male to female ratios may confer "abnormal" risk in "normal" sexual relationships. These features suggest that AIDS will not be easily dealt with in the short term and ultimately, requires a concerted focus on structural inequalities underlying HIV, rather than on "individual behaviour change" alone. Finally, the paper discusses how, in the context of persistent inequalities in the post-apartheid era, AIDS has emerged as a resource - politically in opening spaces for debate and contestation and creating a vibrant social movement, and economically in drawing attention to the needs of the poor and reallocating social spending.

## PW2.3: Scaling Up ARVs – The Rural Challenge

*Ian Couper, University of the Witwatersrand*
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The roll out of ARV's presents a major challenge in terms of the principle of equity. There are significant concerns about the "Comprehensive HIV and AIDS Care, Management and Treatment Plan", which may do nothing to enhance equity but may instead reinforce the inequity that already exists. Some of the issues that will be explored around this are:

- How will this affect the burden that is already placed on health care workers in rural areas?
- Who will prescribe and/or dispense ARV's in rural areas – doctors, primary health care nurses, pharmacists or other health workers?
- Where will treatment be given i.e. hospitals versus clinics?
- How will treatment be monitored in terms of laboratory tests, and the difficulties that arise from that?
- Who will do the counselling of patients
- How will the ongoing issue of transport, which is always a vexing problem in rural areas, be dealt with?

Some thoughts about possible solutions will be presented. Amongst others, there is a need for increased human resource capacity, clinic based treatment, integrated approaches, team work, improved drug supply and innovative approaches to monitoring.

## PW2.4: Access to Health Care in Burundi

*P. Delchevalerie, D. Cetinoglu, M. Van Herp, V. Parqué, M. Philips, MSF Belgium*
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In Burundi access to health care is recognised as a problem. After ten years of civil war, the public health sector is faced with an extreme lack of funds and this shortage of resources has a daily impact on availability, quality and access to care. Since July 2002 most provinces have introduced user fees (cost recovery system), encouraged by but without any control at the national level. This lead to drops of attendance rates, incomplete or interrupted treatments,… Some NGO's have obtained exceptions and are allowed to apply a low flat fee or a cost sharing system as a temporary measure.

The aim of the MSF survey is to determine the financial access to health centre and the degree of exclusion within various payment systems in place, on a countrywide basis.

Existing health centres in all the country were categorised in 3 groups according to the user fee system in place: cost recovery at 100% or more, cost recovery less than 100% and low flat fee. Inside each group, a two-stage cluster was chosen, with a sample size of 30 clusters of 30 households in each group. A total of 2866 households were surveyed between November 2003 and January 2004. Analysis was done with Epi-info. Among those people reporting illness during the last 3 months, non-consultation was significantly higher in the group with cost recovery of 100% and higher. Seventeen percent of people in this group did not attend any health facility. Most (80%) claimed lack of money to be the main reason. Where user fees had been reduced or where a low flat fee had to be paid by the patient, non-use was significantly lower, almost half of the exclusion rate. When controlling for perceived severity of illness, the level of exclusion remained high at 14% in the HC with cost recovery, double of the rate in the other groups.

Among those patients attending health centres, about 4% more failed to receive the complete treatment as prescribed, two third of these because of lack of money. Poverty levels proved to be high with over 85 % under the national poverty threshold (for Burundi this corresponds to +/- 1 usd per week). Exemption systems in place showed no relation between vulnerability criteria (such as displaced, landless, female headed households, …), nor with ownership of exemption cards. Only 7% of vulnerable households received some kind of reduction and less than 1% actually got a waiver as indigent person. In contrast, 70% of patients receiving reduction, do so because they are civil servant, military or health personnel. Average total prices to be paid at health centres with over 100% cost recovery corresponded to 12 days of income, while prices in those with 50% cost recovery and those with flat fees amounted to 6.5 and 3.5 days respectively. About 80% of patients attending health centres (hospitals not included) had to borrow money or rent out labour or sell an asset. A parallel retrospective mortality survey showed a crude mortality rate of 1.5 per 10.000 per day, well above the emergency threshold. For children under five the mortality rate was around 3.1, which is threefold the expected rate.

The user fees of the current cost recovery system are excluding almost one person in five. As the CR system is most widely applied, this corresponds to about one million Burundese without access to primary health care, mostly because of financial reasons. In spite of a situation of high mortality, high vulnerability and extreme poverty, the current public health services do not live up to their mandate of providing health care for all and the present system fails to protect the vulnerable groups in particular. The health

| | Fee for service & fee for drugs, per unit | | Flat fee all inclusive (n=903) |
|---|---|---|---|
| During last illness | Cost recovery 100% and more (n=941) | Cost recovery 50% (n= 924) | |
| Did not Consult | 17% [14-21] | 10% [ 7-12] | 9% [7-12] |
| Among those perceiving illness as severe | (n= 813) | (n=760) | (n=687) |
| Did not Consult | 14.5% [11.4-17.6] | 8.3% [5.4-11.1] | 8% [5.4-10.6 |

authorities and the donor community should acknowledge the high human cost of implementing user fees policies in such circumstances and should refrain from applying them without solid assurances about access to basic health care. It is urgent to do a similar investigation concerning hospital care, as the degree of exclusion and impoverishment is likely to be even worse.

## PW2.5: HIV/AIDS Treatment And Equity In Health In South Africa: Policy, Practices And Social Issues

*Samson James Opolot, Ida Kusiima University of KwaZulu-Natal and the Center for Basic Research, Uganda sopolot2002@yahoo.com*

Africa's HIV/AIDS burden has re-invigorated interest in equity issues in health, particularly given gross inequities in access to ARVs. One question that cannot be simply resolved, however, is whether equity and efficiency are mutually consistent goals and criteria, or whether they conflict. We re-examine policies, practices and social issues in health in order to advance a framework for improving equitable access to ARVs in South Africa and the developing world in general. The theoretical quandary over the equity-efficiency debates in health is avoided. Instead, we concentrate on critical analytical issues to draw new questions and lessons, particularly from 'good' performers like Uganda, for broader debate. To address the normative as well as technical questions in equity, the paper makes a contribution to the dilemma defining and understanding equity in heath. For example, how do we measure it? Are there alternative ways of measuring the distribution of health? How is this informed by context and what lessons can be drawn without reproducing failure?
First is the trade-off between equity and efficiency: Occasionally, equity and efficiency criteria in health appear to point to the same conclusion Given the great differences in urban and rural access and participation, for example, expanding health provision in rural areas is likely to serve equity objectives and also promote efficiency by encouraging the more rapid adoption of improved HIV/AIDS responses e.g. 'safe' sex and decline in 'risk' bahaviours. Similarly, increasing health access in general and access to ARV's would achieve greater equity where the focus is on the vulnerable categories like, among others, females.

Thus expanding health care and access to ARVs not only would be a profitable investment but also would promote equity, since in general access to health tends to redistribute resources towards the poor. As access to ARVs becomes more widely distributed, additional spending will be increasingly concentrated on backward rural areas and disadvantaged groups. What is the experience in South Africa in particular? What lessons can we draw from elsewhere? What are the policy, practice and social issues?
The second issues concern the equity-quality trade-off. What implications will democratizing access to ARVs have for the quality of treatment? Will it be access to the same recipes for all social categories of not? What are the policy, practices and social issues?

## PW2.6: Drug Therapy and psychosocial support enhances prolonged life among HIV+ children [an integrated approach]

*Mayanja Lubwama Wilberforce Rubaga Home Care Rubaga Hospital Kampala Uganda mayanjal@yahoo.com*

**Objectives:** To access the usefulness of drug and psychosocial support in improving the quality of life of HIV + children aged 1-15years. Rubaga Homa care in Rubaga Hospital run a weekly pediatrics HC clinic together with hospital staff at Rubaga Hospital Home care. Mother of HIV+ is referred from various testing centers for post -test counseling and ongoing support, drug therapy and social support. Group session, health talks, individual counseling sessions and questionnaires were administered to 100 positive mother of 100 children for two years from Feb. 2001to Feb. 2003.Antibiatics, pain killers and an inflammatory drug were used to treat opportunistic infection of positive children. Provision of social support [e.g. dry food, powdered, corn Soya bled, clothes, scholastic materials, cooking oil was done. At the beginning, positive children were sickly, resented their care takers and weighed between 10kgs-40kgs .At the end of intervention, they rarely fell sick, weighed up to 20kgs-50kgscoped with living with HIV/AIDS with a smile and lived a normal child life,[e.g. going to school ]. Integrated drug therapy, counseling and psychosocial support greatly improves the quality o f HIV positive children in Uganda.

# PW3: Parallel Workshop:
# Parliamentary Alliances for equity in health

*Tuesday 8 June 2004 1330-1530*

Panorama 1

*Convenor:  Adamson Muula, Malawi Health Equity Network, Lexi Bambas*

*This workshop aims to review and discuss experience of how Parliaments can promote equity in health through their oversight, legislative, budget and representative roles. It will identify ways in which equity oriented health professionals and civil society can support the role of parliaments in health equity. It will review experiences and views from Hon members of parliament from several countries  in southern Africa, including Zambia, Malawi, Zimbabwe, Tanzania and South Africa, as well as the evidence from the abstracts presented below.*

## PW3.1: State, Parliamentary and Civil Society Struggles for Health

*A Mukono Parliament of Zimbabwe*
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Financing Health Care Services in Southern Africa is a major challenge in this millennium. Central Governments (States) are obliged to provide health care for all citizens but over the years, this ideal has been rather difficult to attain mainly because;

- Government Expenditures on health have been declining. The World Health Organization recommends a health per capita of US21  Zimbabwe currently has a per capita of between US8 – 12.
- The HIV/AIDS pandemic, whose highest prevalence figures and of those  living with HIV/AIDS has strained the meager resources.
- The inherited colonial health care facilities are skewered as they benefit a small percentage, the elite at the expense of the majority, who are finding it difficult to access health care services.
- Massive staff exodus from the Region has compromised health care delivery since health is a specialized area; such personnel are not easily replaced.

The Private Sector and Local authorities have a role to play in assisting people access health services.  Most companies provide adequate health care and insurance for their employees. Local authorities also fill in gaps which the state can not meet but they too are overwhelmed as most people who require services are in their areas of jurisdiction. A new development has emerged in Zimbabwe.  With the Reforms by the State and Parliament, more players have been incorporated in the health arena.  There are almost about + or – 100 Non-Governmental Organizations or Civil Society active in the health Sector.  They provide health information, research; assist in provision of drugs to complement state efforts. The Parliament of Zimbabwe, through its Parliamentary Committees has  played a significant role to improve the health care delivery.

- The Committee engages civil society/stakeholders in its activities like participation in the formulation of the health budget; monitor the Ministry's expenditure's compliance with demands.
- Civil Society participates in outreach programmes, public hearings on health matters including legislation review and other important issues like use of the Aids Levy.
- The Committee compiles periodic Reports tabled in parliament, making recommendations to the State/Executive through the relevant Ministry.
- Civil Society is given feed-back on what recommendations will be taken aboard and constantly makes follow-ups on outstanding matters.
- Civil society and the general community can lobby the Committee for issues they  need to be addressed by the Executive through the committee any time.

Good governance should be considered as an underlying factor for effective state, Parliament and civic society's struggles for equity in health.  Also communities should be directly involved in health matters as in most cases they are marginalized and their voices are echoed through the civil society. SADC States, in a bid to improve the health status of their nations passed the Abuja Declaration in 2001 which stipulates that health funding should be at least 15% of the national budget.  Not many SADC countries have achieved this yet and it's a big challenge.

Although efforts by the Civil Society, Parliament and States are commendable more needs to be done and call is for greater involvement of the Private Sector and communities in health care access and delivery.

# PW4: Parallel Workshop:
# Using ICT as a tool for Equity and social justice

*Tuesday 8 June 2004 1330-1530*

Bahama 2

*Convenor: Firoze Manji, Fahamu/EQUINET, Tendayi Kureya SAfAIDS*

*This workshop will examine the role of Information and Communication Technologies (ICTs) in contributing to social justice and health equity. It will review how Information and Communication Technologies (ICTs) can make a meaningful contribution towards health equity through presentation on the equitable, ethical and effective dissemination of health information., This will review the overall opportunities, challenges and way forward for e-health in southern Africa. It will also explore how ICT's be used for social justice and health.*

# P2: Plenary 2: Reclaiming the State
*Tuesday 8 June 2004 1545-1730*
Coral 1 and 2

## P2.1: Parliamentary Alliances for health equity
*S Sikota Parliament of Zambia*

This presentation will report back on the discussions at the workshop on parliamentary alliances for equity in health, the positions and priorities for work with parliaments on health equity. The presentation will present the resolutions and follow up work identified at that workshop.

## P2.2: Fair financing in health systems
*Lucy Gilson, Centre for Health Policy, University of the Witwatersrand and Di McIntyre, Health Economics Unit, University of Cape Town*
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The starting point of this paper is to briefly discuss alternative definitions of 'fair financing'. The term 'fair financing' was popularised by the WHO in their 2000 World Health Report, which set about evaluating and ranking health systems around the world. The WHO has defined this concept as individuals paying for health services in proportion to their income. Others suggest that a more 'progressive' definition of fair financing would be appropriate. The focus of the paper is to review the key findings of work relating to health care financing that has been supported by Equinet over the past few years. In addition, other striking health care financing trends in the SADC region will be referred to.

There has been a particular emphasis in recent Equinet work on alternative mechanisms for allocating the limited government (and sometimes donor 'basket fund') resources available for health care in an equitable or fair way. Equinet funded case studies have been undertaken in Namibia and Tanzania, while other studies by Equinet-linked researchers have been undertaken in Zambia, Zimbabwe and South Africa. Key lessons from these country studies will be discussed,

particularly in relation to the relevance of composite deprivation indices compiled using statistical techniques and the importance of eliciting stakeholder preferences to guide resource allocation decisions. Equinet has also supported a range of research that raises issues related to increasing private sector involvement in the health system. In some instances, this relates to generating additional funds from private sources by introducing and extending community-based pre-payment schemes. In others, it reviews the potential for generating additional funds by opening private beds in public sector hospitals, or other forms of 'public-private partnerships'. In yet other instances, there has been a move in the opposite direction with some governments removing user fees from some or all health services, thereby reducing the relative reliance on private financing sources. This paper will consider some of the factors underlying these public-private financing shifts, any information on their impact, as well as key issues relating to the process of developing and implementing these policies. The paper ends with some ideas on what specific future areas of focus may be of relevance in pursuing 'fair financing' for the health sector in the SADC region.

## P2.3: Confronting challenges in health personnel
*A Ntuli HST EQUINET theme co-ordinator*
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The biggest and most important component of any health system is its human resources (HR). The effective, equitable and appropriate production, training and deployment of health workers has been associated with periods of high health gain in southern Africa. Despite this, many health systems in southern Africa now face a variety of HR problems and personnel scarcities have become a critical limiting factor in health interventions. Health worker migration is further compounding inequities and stresses. Responding to economic and social triggers, personnel flow from rural to urban areas, from public to private sectors, from lower to higher income countries within southern Africa and from African countries

to industrialized countries, exacerbating inequities and providing a reverse (poor to rich) subsidy. However a new policy momentum exists in relation to human resources for health. This draws from a number of political, economic, trade and labour rights trends, but also from the extent to which personnel scarcities have become a critical limiting factor in health interventions. Policy initiatives are being taken at regional, international and global level by government, private and health professional actors.

This paper highlights constraints to designing policies that neither punish workers nor leave poor communities unfairly underserved. These include the availability of timely and accurate information on health personnel distribution and movements, and the paper presents a conceptual framework for approaching and further developing a wider mapping of determinants of health personnel distribution and flows. It also argues that while a host of factors influencing personnel flows are identified, there is inadequate specific assessment of the relative impact of these factors in different settings with different mixes of personnel; and of how different policy measures have impacted on them, objectively and from the view of stakeholders relevant to the issue.  Available literature signals but does not adequately elaborate the role of institutional and governance factors in policy development on human resource issues, but provides sufficient evidence that it is an area where stakeholder perceptions and interests cannot be ignored.

Promising policy options and plans that may contribute to a more equitable distribution of personnel being developed by the HR network (a consortium of Southern based institutions with partners in Australia, the UK and Canada), will be presented with particular emphasis upon potential advocacy and policy responses.

## P2.4: Governance, equity and health: Impact Of, Participatory Mechanisms And Structures In Equity And Quality Of Health Service Delivery

*TJ Ngulube, R Loewenson, I Rusike,
M Macwangi, C Njobu, A Ngwengwe
CHESSORE, EQUINET GovERN theme*

In 2002/3 EQUINET implemented a multi-country research study to examine the impact of Health Centre Committees (HCCs) and District Health Boards (DHBs) in bringing about equity in the primary health care services in Zambia and Zimbabwe. The research work sought to examine equity from an EQUINET perspective, with emphasis that equity related work needs to define and build a more active role for important stakeholders in health, and to incorporate the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

The studies found that social groups at either end of the extreme of the spectrum of wealth and poverty do not participate in the Health Centre Committees (HCCs), which is otherwise judged to be relatively representative of community groups. The studies indicated that areas with HCCs generally performed better on Primary Health Care (PHC) statistics (EHT visits, ORS use), on contacts with their communities and had better community health indicators  (health knowledge, health practices, knowledge and use of health services) than in those without.   HCCs had taken up environmental health and service quality issues as an additional service outreach and link. They find out community needs and organize service inputs such as drug purchases, building waiting/ mother shelters, water tanks and toilets. They also provide health information. These roles appear to enhance their credibility with the community and the health staff.  They also mobilize additional resources for health from community and other sources. In Zambia, HCCs were increasingly taking part in health activities at facilities, and being increasingly relied on by health workers. Members of HCCs were credited with bringing about improvements in  the effectiveness of public health interventions, as well as bringing about the spirit of self-reliance and solidarity in their communities.

There were some failings and shortcomings too that hindered their efforts: HCCs had limited

impact on management issues at the health centres, in meeting the needs of vulnerable groups as well as in clinical care issues. Lack of information and asymmetry in knowledge were key factors that prevented the attainment of greater equity. On the other hand, deepening poverty levels in the country made community mobilization, the urge to volunteer and participation difficult. There was consensus that available resources were not enough to meet all the health challenges faced and such meager resources could not provide for appropriate incentives to encourage the spirit of volunteerism.

These studies suggest an association between HCCs and improved health outcomes, even in the highly under-resourced situation of poor communities and poorly resourced clinics. Despite the existence of any written guidelines, HCCs have weak formal recognition, are poorly resourced and poorly trained or informed for their role HCCs seem to be vulnerable to a number of factors limiting their effectiveness, including weak formal recognition by health authorities, lack of own area of authority, unclear reporting structures and role definition. Given this their performance is influenced by the attitude and responsiveness of the health authorities and the participation of strong community leaders, both highly variable across districts. The HCCs have noted their lack of knowledge or training on the health system and lack of resource investment in their functioning. Health authorities show some ambivalence and lack of consensus on HCC roles. The CHESSORE study on HCCs has shown that even with a somewhat ambivalent attitude from health authorities, a strong will to sustain and maintain their participation in health service delivery exists. This strong community will to be part of their health services needs to be built on and enabled. Their resource limitations arise within their communities and in the primary care level of the health system they operate in, particularly where there are falling resources allocated to district outreach, to primary health care and to quality of care at clinic level. The ambivalence around their recognition and functioning and the lack of resources directed at their activities reflects the general under-resourcing of the primary care level of the system. Increasing poverty levels make effective demand or organized voice at community level difficult to achieve and sustain, and may be defensively responded to in such a situation.  It may thus be argued that the strengthening of DHBs and HCCs as vehicles of community participation is thus deeply bound with the strengthening of the PHC and primary care level of the health system.

# PW5: Parallel Workshop:
# Confronting challenges in health personnel
*Wednesday 9 June 2004 0830-1030*
Coral 1
*Convenor: Antoinette Ntuli, Health Systems Trust*

*The ever quickening conveyor belt of health workers migrating from poor rural public sector facilities to urban and private care, or abroad, poses a serious threat to health care provision, especially for communities whose need is greatest. This workshop will aim to build and strengthen a shared understanding of the critical factors impacting on equitable national human resource policies and on international flows of health personnel. It will draw from and discuss EQUINET work to date. The workshop will identify possible policy and practical interventions to mitigate the negative impact of inequitable flows of health personnel. It will also explore policies and practices that strengthen equity in health personnel distribution and that encourage health personnel to stay within southern African countries.*

## PW5.1: Exploring the influence of workplace trust over health worker motivation in South Africa
*Gugu Khumalo, Center for Health Policy, University of the Witwatersrand*
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We have undertaken a study in South Africa to investigate the influence of workplace trust over health workers' attitudes and behaviours to patients. Although poor attitudes and abusive behaviour towards patients critically undermine the responsiveness of many health systems, little is currently known about the motivational weaknesses underlying these problems. The concept of workplace trust is considered within the literature on organisational behaviour, as a factor associated with good performance and client-orientation. It is comprised of three dimensions: trust in the employing organisation, rooted both in the style of organisational leadership as well as the practices, particularly the perceived fairness, of human resource management functions; trust in the supervisor, linked to the personal characteristics of the supervisor; and trust in colleagues, which may be promoted through practices that encourage and sustain teamwork. The central hypotheses of our study are that the level and nature of workplace trust influences health worker motivation to adopt caring attitudes and behaviour towards patients, and that a range of organisational and managerial factors amenable to intervention underlie workplace trust and worker performance. Using a case study approach, the study conducted qualitative and in-depth exploration of these issues within four public primary care facilities in a rural area of South

Africa. The emerging findings from the study address issues that include: the balance between extrinsic (specifically, salary and job security) and intrinsic forms of motivation; the ways in which community members influence health worker motivation; the influence of facility management and management styles over health worker motivation and performance; the importance of a caring employer to motivation; the difficulties of managing personnel in a time of health system transformation; possible opportunities for raising, and threats to, motivation and performance. These findings have bearing to discussion about the push factors linked to the migration of human resources, as well as to the managerial action important in addressing motivational problems.

## PW5.2: Attitudes Of Medical Students Towards Rural Practice
*Nompi Dlamini and Steve Reid, Centre for Rural Health, University of Natal*
*reids1@nu.ac.za*

In considering the various factors that contribute to the maldistribution of health professionals, particularly with regard to rural and under-served areas, the educational component is an important arena. Medical students, as our future medical workforce, spend 5 to 6 years at medical school, where their attitudes and aspirations are shaped by the experiences and role models that they come into contact with in the university and teaching hospital environment. Before they experience the real world, this forms the foundation on which they make decisions about their future careers. In South Africa, their reality immediately after qualification includes a year of

community service, which could take place in a public hospital in any part of the country. This study aims to describe the perceptions and attitudes of medical students towards rural practice, as they progress through the curriculum. A random sample was taken of 20 students out of an average of 170 per class in each of the 6 years of study at the University of Natal, and a standard questionnaire was administered to them. Variables measured included area of origin, career intentions, perceptions about remuneration, professional development, service to society, and family considerations with respect to rural practice.

The results show a number of unexpected and interesting trends through the class cohorts. As anticipated, more students of rural origin than those of urban origin, intend to practice in rural areas once they have qualified. While 30% of respondents overall plan to practice in rural areas in the long term, there are significant variations between students in different years of study. A significant majority overall believe that working conditions in rural areas are not conducive to good medical practice. The data suggest that specific experiences within the curriculum can influence students towards or away from considering rural practice as a career option. Recommendations to medical faculties are made arising from these findings.

## PW5.3: The Impact Of Rural Allowances On Career Plans Of Health Professionals In South Africa
*Steve Reid Centre for Rural Health, University of KwaZulu-Natal*
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The maldistribution of health professionals between rural and urban areas in South Africa demands specific strategies to address the imbalance. Financial and non-financial incentives have been used in other countries to recruit and retain health professionals in areas of need, and in 1994 a rural recruitment allowance was instituted in South Africa. However this allowance was granted only to medical doctors and dentists, and has remained at the same fixed rate since the time of its inception. Since then, despite the introduction community service for all health professionals except nurses, it remains difficult to recruit and retain professional staff at rural hospitals, health centres and clinics. The new rural allowance announced by the Minister of Health in her recent budget speech, is a national initiative

that aims to address this problem. This study aims to evaluate the effect of the allowances on the short-term career intentions of health professionals practising in rural areas. A random sample of 34 hospitals was taken from the 159 in the country that were designated for the rural allowance. Questionnaires were administered through the hospital managers to all health professionals in the sampled institutions, two months before and again two months after the implementation of the rural allowance. 300 responses were obtained. Variables measured were the factors that influence the respondents' career plans the following year, including financial, work-related, social and educational issues. The relative influence of financial incentives in comparison to other factors that determine health professionals' short-term career plans in rural areas, is assessed. Comparisons of the before and after responses will be presented and an analysis of these results will be made. Recommendations to the Department of Health are put forward on the basis of the findings.

## PW5.4: Why CSO's choose to remain in district hospitals In KwaZulu Natal, Eastern Cape and Limpopo Province
*Ross Aj, And Reid S,*
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Many district hospitals in South Africa are struggling to meet their service delivery obligations. The Community Service (CS) program was introduced to improve provision of health services and to allow young professionals the opportunity to develop professionally. Each year more than 1500 health graduates are allocated to community service with more than 25% going to district hospitals. By the end of each year these doctors, dentists and pharmacists are skilled, valued and valuable members of the health team. However very few of these CSO choose to remain at the district hospital where they did their CS. Legislation and enormous effort gets these CSO to government hospitals but little attention or effort has been given to retaining these valuable members of the health team.
This research paper looks at:
- How many CSO's stay on at the district hospital after completing their year of CS
- What factors influence CSO's to continue to work in the same hospitals after completion of their obligatory year

- What factors would encourage the current CSO's to remain for an additional year at the same district hospital in the district hospitals of the predominately rural provinces of KwaZulu Natal, Northern Province and the Eastern Cape  Two samples were identified
- Those CSO's from 2002 who have stayed on in the district hospital where they did their CS in 2002, were interviewed
- A random sample of CSO's from each professional category currently working in district hospitals in KZN, EC and LP. A questionnaire was administered to this sample.

Results show that a only a small percentage of graduates choose to remain in the same district hospital after the completion of their year of community service (16%). Race, rural origin, allocation to hospital of 1st choice, bursary allocation and excellent work experience where all shown to be statistically significant factors in choosing to remain at the same district hospital. The cohort of Community Service Officers who do their community service in 2003 in the Limpopo province are 5 times more likely to remain at the same district hospital as those who did their community service in KwaZulu Natal.  In conclusion only a small percentage of young graduates will choose to remain in the same district hospitals. Practical recommendations that Provincial Governments and Hospitals managers are able to initiate that will encourage young graduates to choose to remain at district hospital are explored.

To describe what happens in a situation where

## PW5.5
## The involvement of private General practitioners(GPs) in primary health care clinics.
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private general practitioners visit primary care clinics over a relatively long time with the view of demonstrating working examples. A case study was undertaken in the Odi district of the northwest province in which three primary care clinics which had a long lasting relationship with GPs were studied. Experiences of the doctors, clinics nurses, patients  regarding the GPs visits were elicited through in depth interviews. Details of the visits with regard to patient numbers, lengths of the visits, remunerations and preferences were also sought. Data was analysed using different

method to highlight important themes. Visits by GPs to the clinics were viewed as beneficial by patients and the clinic staff. In contrast to common views there was no fear that GPs take patients away from the government clinics to their practices. GPs were on the whole preferred to government doctors because of their skills patience and availability. The visits were also seen as a gesture of patriotism supported by IPAs and the academic institutions. There were however constraints such as shortages of medicines and equipment which could undermine such involvement. Involvement of GPs in primary care clinics is beneficial and desirable. It enhances equity in terms of access to services. Addressing constraints can optimize the public –private partnership at this level.

## PW5.6
## The problem of health human resources brain drain: where are the solutions?
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Southern African healthcare services are faced with a growing crisis of net loss of skilled human resources especially doctors and nurses. The public sector is severely affected as it suffers brain drain of its health professional to the private sector within countries and externally to mostly western nations such as Australia, Canada and the United Kingdom. The 'push factors' for health professionals have been studied and include; low promotional opportunities, low remuneration levels, poorly equipped/resources health facilities and heavy workload. The 'pull factors' to the private sector and developed nations include; higher remuneration, increased opportunity for training and reasonably resourced/equipped health facilities. In some countries, national political instability has been identified as responsible for 'pushing out' health professionals from the region. Some of the reasons for the increased demand for overseas health professionals are; the increased need for health workers as a result of the ageing population and the non-preference of the health professions among young people in their choice of careers. In the developing countries, increasing demand is also being experienced as a result of,

among other things HIV/AIDS, resulting in increased burden of ill-health and disability and therefore increased demand for services, loss health workers' time due to death, ill-health and care of family members.

We argue that the identification of the 'push' and 'push' factors is a necessary but not sufficient exercise in order to come up with solutions to the brain drain crisis facing southern Africa. Why can't salaries be improved, health facilities adequately resourced and health professionals appropriately promoted in a transparent manner? We suggest that meaningful solutions will involve health workers themselves getting organized, understanding the determinants of their situation and attempting to contribute to the solutions of their problems. We believe governments are not making financial savings by poorly paying their health workers this only leads to poorly motivated staff whose quality of work may be compromised resulting in higher costs to individual patients and households and the State. The role of the international community is also presented.

## PW5.7: Advancing People's Health It Needs An Integration Of Research, Training And Service Delivery: The Case Of Eatonside, South Africa

*Rajab Rutengwe, RM Vaal University of Technology*
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This paper aims at presenting knowledge and lessons learnt during two years of implementing a community-based integrated research and development project. Eatonside informal settlement dwellers were selected for the project based on the hypotheses that researchers had in mind. First, it is and urban informal settlement characterized with poor socio-economic and demographic parameters that negatively influence their health and nutrition status. On the basis of the findings of the baseline survey three community-based intervention projects are proposed to address poverty, chronic food insecurity and prevalence of stunting in the target population. Arguments are by integrating research, training and service delivery will bring desired impact, effects and better health outcomes. Also, this approach has brought together all key stakeholders in the Sedibeng district. Similar approach is encouraged for testing of its efficacy in other higher learning institutions in South Africa.

# PW6: Parallel Workshop:
# Fair Financing in Health Systems
*Wednesday 9 June 2004 0830-1030*

Bahama 1

*Convenor: Di McIntyre, University of Cape Town, L Gilson Centre for Health Policy*

*The main objective of this workshop will be to draw conclusions for SADC countries about key issues to consider in pursuing the fair financing of health systems. The workshop will build on the plenary paper on fair financing, by encouraging discussion of specific country experiences as well as more detailed discussion of the plenary paper's conclusions. The issues for discussion in the workshop will include financing mechanisms, public sector resource allocation inequities, and equity concerns associated with the public/private mix in health care. The workshop will be structured around a set of key questions. Each accepted abstract for this session will be presented as a poster, with presenters given time to make inputs on these questions, where relevant, on the basis of their poster. Wider discussion among participants will then draw in broader sets of experiences.*

## PW6.1: Poverty and health reexamined: Evidence and policy lessons from Burkina Faso
*Slim Haddad, Adrien Nougtara, Jacques Ouédraogo, Salimata Ky-Ouedraogo*

The findings of a study conducted by the Association Burkinabé de Santé Publique and the University of Montreal in Burkina Faso illustrate some key aspects of the health-poverty nexus. The study deals with 1604 households in three regions and focuses on one component of the burden, health expenditures. It also provides an illustration of distributive analysis and of the evaluation of equity in the health sector. Despite being supported by substantial resources, the health-sector reform in Burkina Faso, which went hand in hand with structural adjustment, has had only limited results. In fact, the widespread application of patient fees for services and the promotion of the private sector, two major components of reform, have helped reinforce inequalities and primarily affected disadvantaged populations. Over two thirds of households say they have difficulty meeting their health expenses and the consumption of healthcare is severely constrained by household ability to pay and by the proximity of public services: demand is income elastic, particularly in remote rural areas, where the relative price of primary healthcare services is higher. Disease is a major factor of impoverishment. Family health expenditures impoverish households, creating new poor and impoverishing the already poor. Impoverishment due to health expenditures is greater in remote rural areas, where there is a concentration of opportunity deficits. With reform, geographic accessibility to primary-care services has generally improved in the country, including rural areas; over 80% of the population lives no more than 5 km from a public primary-care establishment. However, available services are not necessarily accessible ones. There thus continue to be many pockets of non-access, where economic poverty is combined with remoteness, community spirit too weak to offer effective assistance to families in distress, limited availability of public infrastructure, and relatively high-priced health services. Such regions are poverty traps in the true sense of the word, loci of opportunity deficits. They are areas where the economic damage wreaked by disease is most marked and the need for financial protection for households against the risk of disease is most tangible. What strategies might authorities adopt to protect households? Given the unpredictability of the risk of disease and its associated costs, it is suggested to target opportunity deficits, poverty traps and barriers to access to care rather than only focussing on families identified as already poor. Combining two courses of action—one centred on supply (geographic access) and the other on demand (health insurance)—could reduce the monetary impoverishment caused by health expenses by about 40%.

## PW6.2: Practical Application Of Equity: Development Of A New Allocation Formula For The Health Sector Basket Fund

*Gradeline Minja, Ministry of Health, Tanzania*

The Ministry of Health in collaboration with pooled Basket Fund partners envisaged the need to devise a mechanism for allocation of resources in a more equitable fashion. The current health basket fund distributes resources among local governments in proportion with population alone (US$ 0.5 per capital). This allocation mechanism creates inequity as it favored the urban areas than rural. Equity as a pillar of health reforms has to ensure that access and use of available services is ensured. One of the way of achieving this is through equitable resource allocation especially the funds. The new formula aims at redirecting resources to priority populations and its application are in line with the government Poverty Reduction Strategy as an operational tool of the Government policy and vision 2025. In recognition of the individual as the main client-recipient of health care services 70 percent of the basket funds will be distributed in proportion to the population of each district. In addition to the overall population, councils will receive additional resources for three "special needs categories" namely the special needs of poor population (10% of the grant resources), the special needs of rural population (10%) and (10%) for Burden of Disease. The under-five mortality (U5M) is considered as an appropriate proxy for burden of diseases. The formula recognizes the higher expenditure needs of rural areas by including the mileage of the route regularly travelled by medical vehicles. As such, the formula takes into account the higher operational cost of delivering health services to a rural population and to scarcely populated areas, including higher costs faced in drug distribution, immunization and supervision. Under the new approach, there will be some districts which will benefit from the new formula as well as the ones which will lose, that is, receives less amount of money than would have received in the absence of the formula. To address this issue, the formulae has put in place a "Do no harm" mechanism to compensate the same amount of money the districts which will be the looser. Do no harm is intended to maintain provision of health care services to the population. Another way of doing so is expressed by "holding harmless" Implementation of the new formulae begun in January 2004. Similarly, the formula is in

cooperated in the National formula for allocating Block Grants to the Local Government Authorities starting with the social sector; Health & Education.

## PW6.3: Altruistic Willingness To Pay For Familly Planning Methods: A Study In Rural Communities Of South-East Nigeria

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Objectives: To determine (1) the maximum amounts women are prepared to pay for their own use of family planning methods(use value of WTP), and (2) whether these women were also willing to pay for the indigent community members who will be unable to pay (altruistic WTP). A cross-sectional study was carried out with contingent valuation method to elicit the Willingness to pay (WTP) for own family planning methods and altruism from 652 randomly selected women of child bearing age using an open-ended question in two rural communities of South-east Nigeria. Between 78.3% and 81.9% of respondents were willing to pay amounts ranging from 35 to 50 Naira (mean, 38.5 Naira) for oral contraceptive pills per cycle, 100 to 150 Naira (mean 125 .23 Naira) for IUD and 130 to 150 Naira (mean 139.65 Naira) for injectables. About 67% of the respondents were also willing to contribute to a community-managed distribution of Family Planning commodities (FPC). The median altruistic WTP amount was 50.15 naira, while the mean altruistic WTP amount was 51.65 Naira with a range and standard deviation of 10-120 Naira and 34.09 naira respectively. The ordinary least square-multiple regression analysis showed that WTP was statistically related to different variables. Education, parity, type of occupation and average monthly expenditure on health were positively and significantly correlated with WTP ($p<0.05$) in WTP for all the three FPC, while marital status was positively and significantly correlated with WTP ($p<0.001$ and $p<0.05$) in WTP for IUD and injectables respectively. Married women were more willing to pay than single women. Also average monthly expenditure on health positively influenced WTP ($p<0.05$). Women are willing to pay for own FPC and for indigent women in their communities. These findings could stimulate community financing for FP methods and increase the coverage of FPC in rural communities.

## PW6.4: Equity And Community Health Fund Policy In Tanzania

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As part of the health sector reform policy, the government of Tanzania has been implementing financial reforms geared towards mobilizing additional resources for financing health services. In this initiative, the government introduced a community-based, voluntary prepayment arrangement (founded on insurance principles) known as the Community Health Fund Scheme. The government expected that 60-70% of households would join the scheme through voluntary payment of a membership fee determined locally. Those households unwilling to join the schemes would be required to pay a predetermined user fee every time they sought services at the health facilities. In its CHF policy, the government stated clearly that while exploring various options to improve financial sustainability, it would honour its 'strong commitment to equity.' The policy envisaged an exemption system as one of the mechanisms to address equity concerns. However, experience of CHF implementation in Tanzania shows little progress in terms of achieving the intended objectives and demonstrates concerns about the equity impacts of the CHF. The main objective of this paper is to highlight some of the factors that may constrain achievement of the equity goals by discussing the experience of implementing CHF in Tanzania. In this regard, the paper discusses the findings of a study investigating factors influencing enrolment in CHF schemes in Tanzania. This study indicates that there has been lack of initiative on the part of the government to make exemption stipulated in the policy known to the beneficiaries (communities), CHF authorities have not put in place a clear mechanism to identify the households unable to pay the membership fee and lack the capacity to assess financial ability of the households, the belief that extending exemption to poor households would erode the financial base of the Fund prevented local governments from operating the exemption system in favour of the poor households, failure by District authorities to honour exemption proposals from sub-district committees killed the grassroots initiative to identify poor households for exemption, lack of community involvement in CHF affairs has led to little knowledge about CHF by the beneficiaries and gave CHF officials greater decision-making powers over the schemes, and

introduction of user fees along payment of CHF membership fee in the absence of a clear exemption mechanism prevented poor households to access services.It is possible to achieve equity in CHF schemes if authorities address these anomalies identified by the study.

## PW6.6: Public-Private Interactions in the South African Health Sector – the Equity challenge

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The private sector in the South African health system serves less than one-fifth of the total population, yet accounts for nearly 60% of total health expenditure. In pre-1994 policy development little attention was given to the private sector role. Towards the late 1990s attention was increasingly focused on finding a role for the private sector through the vehicle of Public-Private Interactions (PPIs). The overall purpose of this research is to contribute to policy debates on the relevance of PPIs to achieving equity in the health sector. The study design incorporated qualitative and quantitative methods. A wide range of data-collection tools was used allowing for validation and triangulation of data sources. The first step involved a literature review to provide insights into both national and international experiences of PPIs. The review fed into the development of a conceptual framework that could be used to describe and monitor health-sector PPIs. A range of policy documents were reviewed across the spheres of government and from within the private sector and civil society. 19 key-informant interviews were conducted with diverse public and private sector actors. A national postal survey was directed towards provinces and local government. A media analysis involving a 2-year review of the independent print media was undertaken. In addition the data-collection tools, namely the key-informant interviews, fed into the development of the conceptual framework used in the overall analysis. The main conclusions derived from the data analysis are the following: there is lack of vision around the pitfalls of PPIs both between and within spheres of government; the management of PPIs is complex and the public sector lacks the capacity to fully analyse the impact of PPIs; objectives differ between the public and private sector with the potential to fragment the health system even further as

opposed to strengthening it and; there is a lack of evidence on the impacts of PPIs on equity. PPIs should aim to improve subsidy from the private to the public sector and cross-subsidy from high-income to low-income population groups. Therefore, when thinking about PPIs policymakers should carefully assess the equity implications thereof. PPIs should not be treated as an end itself, but should be a means to an end – achieving equity. A cautious approach is therefore called for, one with a unified vision for the health system, not one that exacerbates existing inequities.

## PW6.7: Discourses on Public Private interactions in South Africa

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Public-Private Interactions (PPIs) and Public-Private Partnerships (PPPs) are important policy issues as far as the financing and delivery of health services in South Africa is concerned. I would like to report to the conference on exploratory, on-going research (funded by Equinet) that examines existing data about PPIs and PPPs - the South African government's PPP Manual, a policy document from the health sector and in-depth interviews with several other policy actors - from a discourse analytic perspective and specifically with the issue of equity in mind. This discourse perspective could perhaps be broadly described as being concerned with language in use. Language is not unproblematically seen as a tool for description and a medium of information transmission, but is instead regarded as central to the social, political and cultural order, in both the sense of reflecting these orders and shaping them. Against the backdrop of this broad definition, this research is concerned with questions such as the worldviews and values embedded in the above-mentioned texts and the ways in which these are "packaged" and "sold". This type of research may be of interest to other policy analysts in that it may alert them to other ways of engaging with the material at their disposal. Such alternative engagement may, in turn, broaden and enrich their understanding of the policy issues of interest to them. Because discourse analysis is not just inwardly focused on language, but also fundamentally concerned with the inter-relationships between language and society, research of this nature may also be of use

in thinking through issues such as actors' likely courses of action, strategies for effecting change and opportunities for and obstacles to achieving greater equity in the health system.

## PW6.8: Fair financing in health systems

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For private-non-for-profit (PNFP) hospitals, user fees may represent an important source of revenues, but they may also affect access, use and equity. This survey was conducted in ten hospitals of the Uganda Catholic Medical Bureau to assess differences in user fees policies and to propose changes that would better fit with the social concern explicitly pursued by the Bureau. Through a review of relevant hospital documents and reports, and through interviews with key informants, health workers and users, hospital and non-hospital cost were calculated, as well as overall expenditure and revenues. The percentage of revenues from user fees varied between 6% and 89% (average 40%). Some hospitals were more successful than others in getting external aid and government subsidies. These hospitals were applying lower fees and flat rates, and were offering free essential services to encourage access, as opposed to the fee-for-service policies implemented in less successful hospitals. The wide variation in user fees among hospitals was not justified by differences in case mix. None of the hospitals had a policy for exemption of the poor; the few users that actually got exempted were not really poor. To pay hospital and non-hospital expenses, about one third of users had to borrow money or sell goods and property. In two hospitals with available data, higher fees were followed by lower use, especially in children; the trend reverted when the fees were lowered. Our results confirm that user fees represent an unfair mechanism of financing for health services because they keep out the poor and the sick. To mitigate this effect, flat rates and lower fees for the most vulnerable users were introduced to replace the fee-for-service system in one of the ten hospitals after the survey. The results are encouraging: hospital use, especially for pregnancy, childbirth and childhood illness, increased immediately, with no detrimental effect on overall revenues.

A more equitable user fees system is possible.

# PW7: Parallel Workshop:
# Community voice and agency in health systems

*Wednesday 9 June 2004 0830-1030*
Panorama 1
*Convenor:  TJ Ngulube CHESSORE*

*This workshop aims to review the evidence and analysis from research work on and experience in community voice and agency in health systems  in the SADC sub-region. It reviews evidence from the EQUINET Governance and Equity network (GoVERN) programme and other studies to develop a framework of perspective and analysis, identify key areas of follow up work and further research to enhance community voice and agency at grassroots, national and regional  level.*

## PW7.1: Assessing the Effectiveness of Health Governance Structures in Interceding the Community in Zambia.

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In 1992 the government of Zambia introduced major health reforms (HRs) in the public health sector.  The vision the HRs is to  "provide Zambians with equity of access to cost effective and quality health care as close to the family as possible".  Within the HRs context.  The community is viewed as an important stakeholder and available resource.  To facilitate community involvement in health care delivery and to ensure equity in health the government through the act of parliament established health governance structures. However there has been no systematic studies, which show whether these structures are effective in interceding for the community. The overall objective of this study, carried out as part of an EQUINET multicountry study,  was to assess the effectiveness of health governance structures in enhancing equity of access and community participation in the delivery of health care services in Zambia. The specific objectives were to:
(i) describe the status of health governance structures in Zambia; (ii) examine the linkages between the health governance structures and community; (iii) asses how the health governance structures represent and respond to community inters and needs; (iv) determine the extent to which the community is involved in the planning of health care services and resource allocation and (v) propose option for enhancing equity of access and community participation in the delivery of

health care services. A cross-sectional study design was used. Both qualitative and quantitative data were collected using various techniques; interviews, focus group discussion and review of records.  Four districts (two rural and two urban) were covered in two provinces. The major findings are: (i) health governance structures were established but the community is not aware of their existence and roles (ii) there is willingness by the community to participate in health issues but lack of knowledge limits there participation (iii) these structures are not effective in carrying there functions mainly due to a weak link between the community and the governance structures and (iv) gender issues are not adequately addressed in terms of composition membership to the structures and  participation .The paper concludes by making recommendations to make the structures more responsive to community needs and interest as well as revitalise community participation.

## PW7.2: The impact of Health Centre Committees on health equity in Zimbabwe
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## PW7.3: Community participation in health planning, resource allocation and service delivery: illusion or reality?
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This study carried out as part of an EQUINET multicountry study sought to analyse and better understand the relationship between health centre committees in Zimbabwe as a mechanism of participation and specific health system outcomes, including representation of community interests in health planning and management at health centre level; provision of and access to primary health care services and community health knowledge and health seeking behaviour. A Case-Control study design was used, with four case sites with health centre committees and control sites selected in the same districts where there are no health center committees with sufficient distance between catchment areas to avoid spillover of results. This paper reports on the findings from the cross sectional community surveys OF 1006 respondents carried out in February 2003 and the health information system analyses. The study shows that public sector clinics are the primary source of health care for communities in Zimbabwe, but are not well resourced in terms of basic supplies and staffing. Health Centre Committees appear from the study findings to be associated with improved health resources at clinic level and improved performance of the primary health care services.. Communities in areas with HCCs had a better knowledge of the organization of their health services from the indicators assessed, making services more transparent to them. There was also evidence of improved links between communities and health workers in these areas. The study suggests an association between HCCs and improved health outcomes, even in the highly under-resourced situation of poor communities and poorly resourced clinics. This positive contribution of HCCs to health outcomes calls for greater attention to strengthening these structures as an important component of primary health care and of the health system generally.

Community participation (CP), a word that sounds attractive but difficult to justify in practical sense, has increasingly been reported in local and international literature. It is widely documented that well-designed, effective, equitable and sustainable health interventions and health management systems require CP. Although the latter has been talked about for decades, international experience shows that it is yet to be fully felt or practically established in many developing countries due to various drawbacks. This paper is a synthesis of international experience in CP in health planning, resource allocation and service delivery, based on a review of 157 articles, of which more than 100 were published in peer reviewed journals. Apparently most authors on this topic depict that the concept 'CP' has become part of the national health policies implementing health sector reform, but lack of clear policy guidelines on how to go about it, weak local decision-making structures, misconception of who is the 'community' and what 'participation' really means, mostly limit the actual translation of CP into practice. So far, there is no universal consensus or definition of 'CP', and many authors have accused the tendency of professionals to undermine or underscore the capacity of the community in designing, implementing and evaluating health programs. Meanwhile, there is a criticism of professional project evaluators who overstate CP in actual sense without appreciating the limitations of the techniques approaches used in evaluating it. Therefore, most authors conclude that achieving equity in health will remain an illusion unless deliberate attempts are made to ensure a common understanding of what the community is and the role it can play in planning, allocating and managing the available resources and evaluating the performance of the existing interventions towards meeting their desired or preferred needs.

## PW7.4: Fighting the symbolic and political exclusion of youth: implications for participatory HIV/AIDS management programmes

*Yugi Nair Catherine Campbell, Sbongile Maimane and Zweni Sibiya. Center for HIV/AIDS Networking (HIVAN), University of Kwazulu-Natal nairy3@nu.ac.za*

In this paper we report on a case study of youth HIV-prevention activities in a peri-urban community in KwaZulu-Natal. The research was conducted in partnership with a foreign-funded NGO seeking to limit HIV transmission in this group. The NGOs aim was to promote peer education by young people and to strengthen the wider community to support HIV-prevention efforts. They had a particular interest in systematically exploring factors which were facilitating or hindering their efforts. The research involved in-depth interviews with a wide range of community members, including youth and peer educators both in and out of school, teachers, a school principal, community health workers, community leaders (traditional leaders, the local ward councillor, youth leaders and members of the local development committee), CYA staff, a traditional healer, community health workers, clinic nurses, parents, PLWAs, church ministers, a government official and representatives of a multi-national company which employed local people. We examine the range of obstacles that undermined the likelihood of youth participation. These include AIDS-specific factors including stigma, and misconceptions about HIV/AIDS, health and sexuality. However, we also try and look at the way in which wider social contexts enable the likelihood of youth participation in health promotional activities. In particular we focus on the way in which youth were excluded from various aspects of local community life. At the level of respect and recognition, adults tended to speak of young people as 'mad, bad and deviant', with little appreciation of their positive value to the community. We refer to this as the 'symbolic social exclusion of youth'. We also discuss what we refer to as the 'political exclusion' of youth. At the level of political participation, the formal and effective representation of youth on local political, community, development, or voluntary organisational structures was minimal. We argue that low levels of youth participation in HIV-prevention activities must be explained not only in terms of AIDS-specific factors such as stigma, but also in terms of the way in which wider patterns of social exclusion have undermined young peoples' confidence in their ability to take control of their lives and to exercise leadership over youth-relevant issues. The struggle against AIDS involves not only the fight against stigma and the provision of better services for HIV/AIDS management, but also more general efforts to strengthen the participation of youth in important community and political structures, as well as raising levels of respect for youth in grassroots communities. We discuss the implications of our findings for HIV/AIDS management programmes which seek to empower youth to prevent HIV and to cope with the affects of AIDS.

## PW7.5: The role of Civil society in improving health care

*Ian Couper, School of Public Health, University of the Witwatersrand couperid@medicine.wits.ac.za*

There is an ongoing crisis in rural health care around the country. To address this issue, health professionals need to join hands with civil society in order to bring about improvement. Too often health care professionals and communities have not worked together, and civil society can assist in reversing this. There are a range of roles that civil society can play in helping to improve rural health care. Firstly civil society has an important role as a pressure group in improving service and standards in rural areas. Secondly the role of hospital boards and clinic committees is important and can be enhanced by civil society. Thirdly civil society needs to educate patients about their rights and to work with patients in order to improve the quality of care in rural areas. Fourthly there is an important role of supporting health care professionals in rural areas. Fifthly the development of local role models in the form of people who have come from the area and are working back in the area can be nurtured by civil society. Sixthly the involvement in training and supporting training is also important.

## PW7.6: Empowering Communities For Effective Participation In Health Care Delivery As A Right

*Sofo Ali-Akpajiak, Nigeria*
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Benue State health delivery systems have undergone a long process of transformation over the years. The State was one of the areas where the Bamako Initiative was implemented in the country. Since the late 1990s, other initiatives implemented as part of the health delivery system include the Benue Health Fund Project funded by DFID and the Health Systems Project funded by the World Bank. UNICEF and UNDP have provided other forms of support. Though these efforts have resulted in the improvement in the health care delivery system, the sector is still bedeviled with some teething problems. Problems identified with the health care delivery system in Benue include lack of a strategic focus for health delivery, gaps in capacity of various service delivery agencies, weak monitoring and evaluation mechanisms, inadequacy of drugs, inadequate infrastructure and poor community mobilisation and sensitisation. The cumulative effect of this scenario is the denial of the people's basic right to improved health care services and to participate in the decision-making process. It is in this regard that Development and Learning Centre (DLC) is proposing develop capacity of community-based institutions to demand for their health rights. The overall goal is to contribute towards improved well-being of the people of Benue State and develop sustainable mechanisms for improved health delivery for the poor and marginalized. DLC will be working with NGOs that have demonstrated their capacity to work with and mobilise communities. These organisations are Otia Foundation, OSA Foundation and the Ecumenical Commission for Justice and Peace (ECJP) based in Otukpo, Makurdi and Gboko respectively. The methodology proposed for the are as follows:

- Undertake a participatory action research on knowledge and perceptions about the health care delivery system
- Undertake institutional assessment at community level
- Assess the capacity of NGOs to provide the support needed by communities on issues related to health rights.

The major outcomes of this are:
- Capacity of NGO Partners and Community-based institutions built in agenda setting and advocacy
- Communication strategy based on people's knowledge and perceptions developed.

# PW8: Parallel Workshop:
# Civil society alliances for equity in health

*Wednesday 9 June 2004 0830-1030*
Bahama 2
*Convenor: EQUINET, Peoples Health Movement,*
*with southern African civil society organisations*

*This workshop will report on and consolidate the civil society positions and action agendas to strengthen health civil society  roles and campaigns for health equity and social justice.  It aims through presentation of positions from various civic organisations and networks in the region, including PHM, SEATINI, PATAM, CWGH, SAMWU, MSP/APF to develop a framework of perspective and analysis  within which evidence can be collected ands gathered and debate held at country  and grassroots level for input to the health civil society alliances and for presentation at the regional meeting of health civil society in November 2004. It will identify  for the EQUINET conference key resolutions,  areas of action and follow up work to be taken forward as defined by health civil society for the wider constituencies involved in health equity and social justice.*

## PW8.1: Challenges and opportunities workers and communities face to obtain reparation for preventable lung diseases from national and international companies
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Mineral dust lung diseases are preventable but are major causes of ill-health, poor quality of life, retrenchment, early retirement, unemployment and death among workers in industries where they are exposed to mineral dust. These diseases include silicosis, progressive massive fibrosis, lung cancer, coal workers pneumoconiosis and asbestos related disease. Exposure takes place in mining and associated industries, in construction, ceramic and motor industry, as well as the informal economy. Silica dust exposure and silicosis are risk factors for the development of tuberculosis (TB) and silico-tuberculosis is common especially in the gold mining industry. The mining of gold, asbestos and coal played a significant role in the industrial development of South Africa for more than 120 years. Mining activities generated a large proportion of the wealth but resulted in extensive exposure of workers and communities to disease causing mineral dust. The historic stratification of South African society along class and racial lines, land dispossession and the migrant labour system influenced the pattern of health outcome. Workers from neighbouring labour sending countries were

also affected. As a result of inadequate dust control measures, the previously disenfranchised and poor majority carry a disproportionate large burden of preventable lung diseases. This was aggravated by differential and unequal access of diagnostic, health, compensation, disability, and surveillance services to address diseases caused by unsafe and unhealthy industrial processes. The epidemic proportions of mineral dust diseases and silico-tuberculosis place an enormous drain on Public Health resources.

Several affected communities and workers have organised themselves into formal groups to challenge companies responsible for negligence and exposure. These groups and trade unions worked closely with human rights lawyers and concerned health workers to help ensure a just outcome to litigation processes. There have been notable successes where local communities challenged international companies on foreign soil and local companies at home. Efforts are ongoing to ensure the amount compensated is just and health care and sustainable community development programmes are funded. Future intervention challenges include responsive models of health service delivery; trade union members and community health workers trained in innovative notification programmes; improving the quality of life indices (education, skills level, employability, income, social security, health) of affected communities; rehabilitation of the environment as well as the ongoing struggle for one harmonised global ethical standard for health and safety.

# P3: Plenary 3: Challenging Injustice
*Wednesday 9 June 2004 1100-1230*
Coral 1 and 2

## P3.1: Globalisation, Trade and Health
*R Tayob*
*SEATINI EQUINET theme co-ordinator*

This paper will analyse the following issues and assess their impact on the sovereign rights a state has to regulate to support equitable health care in the developing countries, drawing from EQUINET/SEATINI work and wider sources. It posits that the International Trading System (ITS) is biased in favour of richer northern states. It argues that greater circumspection is required by developing countries within the ITS if they want to maintain their sovereign right to meet the needs of their people. The inequitable system of "globalisation" is imposed through the ideology of neo-liberalism, which the developed countries present as a "natural" form of globalisation. It is a very particular type of globalisation is being imposed on the world by the major economic powers, i.e. neo- liberal globalisation. This form of globalisation has worsened material conditions in developing countries. Developing countries domestic policy is heavily constrained, or threatened by constraints, by the current systems of globalisation and they have little or no flexibility to address their development needs. Policies that the developed countries used to improve the conditions of their people are summarily being made illegal for developing countries whether these relate to industrial development, intellectual property, and agriculture or services provision.

This paper focuses on some of the "trade" issues that have a direct bearing on the material conditions and health of the majority of the people in the developing countries. International Trade regulation, the mainstay of the World Trade Organisation (WTO), is becoming increasing invasive on domestic development policies and now cover issues like intellectual property, the provision of services and, health and, environmental standards. The development policies of the developing countries are conditioned and directed by the World Bank, International Monetary Fund conditionalities and the WTO, regional and bilateral agreements. The WTO specifically covers a host of issues under its ambit of trade and it includes:

- Access to drugs: Access to drugs is regulated by Trade Related Intellectual Property Rights (TRIPs) of the WTO and civil society has had mixed results in ensuring meaningful access to drugs for the worlds poorest people. Regional and bilateral agreements, which are permissible under the WTO, endorse and exceed TRIPs standards and countries can face severe sanctions for their violation.

- Regulation of Services and the provision of public services: The General Agreement on Trade in Services (GATS) also threatens public and accessible systems for the delivery of health care, water and sanitation, and energy. The GATS undermines domestic regulatory policy sovereignty by setting standards that are market related and not people centred. The GATS along with WB/IMF prescriptions of cost recovery and privatisation undermine a state's ability to ensure equitable access to services.

- Regarding access to food and adequate nutrition: Developing countries have been unable to secure agreements that will allow them to protect their agricultural sectors. This lack of policy flexibility in agriculture has lead to the breakdown of food security systems, resulting in preventable malnutrition.

The paper argues that assaults on governments' sovereign right to regulate trade, and consequently health, should be resisted. Developing countries have been showing resistance to WTO-type liberalisation and globalisation but are increasingly vulnerable to pressures at the International Financial Institutions, regional and bilateral level. By reducing government legislative and policy flexibility in areas critical to the well being of people (water, energy, food and health) these agreements and conditionalities legalise the structural and brutal violence on the majority of the people of the world. Developing countries face major challenges in securing the space to regulate and protect the public provision of health and inter-dependant services on an equitable basis.

## P3.2: Civil society struggles for health
*M Masaiganah PHM/EQUINET and Workshop rapporteur*

This presentation will report back on the discussions at the civil society workshop, the positions and priorities for health civil society on health equity and  social justice. The presentation will present the resolutions and follow up work identified at that workshop.

## P3.3: Using ICT for health equity: the EQUINET website
*F Manji,*
*Fahamu EQUINET process co-ordinator*

Fahamu will present the new EQUINET website (www.equinetafrica.org) launched in April 2004. The website aims to provide an information, research and policy resource to all those working on health equity in and beyond southern Africa. The presentation will outline the resources available from the site, what is available on the databases and  how to search and access the information on the site.

# P4: Plenary 4: Organising for health equity and social justice

*Wednesday 9 June 2004 1400-1545*
Coral 1 and 2

## P4.1: Country reports (5 minute reports x 8)
*EQUINET country focal points and others*

EQUINET covers 14 countries in southern Africa and is widening its work to include East Africa. The conference is inviting brief reports from representatives of countries on the priority areas of policy concern and work on health equity, on the work underway in the country and on the expectations from and contributions to regional networking.

## P4.2: Discussion of conference resolutions: policies and actions
*Representative of the drafting team*

## P4.3: EQUINET as a vehicle for health equity and social justice
*EQUINET SC and secretariat*

The Southern African Regional Network on Equity in Health (EQUINET) aims to promote and realize shared values of equity and social justice in health.

EQUINET is a network formed by professionals, civil society members, policy makers, state officials and others within the region. We work through existing government, civil society, universities, research and other institutions in the Southern African Development Community (SADC) region and in southern and east Africa. EQUINET commissions and funds research, and provides resources, training, mentoring, and resources for regional exchanges to strengthen perspective, analysis and capacity to develop and implement health equity oriented policies and programmes. EQUINET gathers policy relevant evidence on health equity issues, supports policy analysis and lobbies policy makers. EQUINET

facilitates and services alliances around policies and campaigns that promote equity and social justice. We build knowledge and perspectives through publication and dissemination of information. We support forums for dialogue, for learning and sharing of information and experience, for critical analysis and for peer review.

This session reviews and discusses ways of strengthening EQUINET as a network and the mechanisms and processes through which EQUINET supports equity oriented work within the region.

# P5: Plenary 5: Reclaiming the state:
# Advancing peoples Health, Challenging Injustice

*Wednesday 9 June 2004 1600-1645*
Coral 1 and 2

## P5.1: Adoption of conference resolutions
*Representative of the conference*

## P5.2
## Closing paper: Reclaiming the state: Advancing peoples Health challenging Injustice
*S Sianga, SADC*

**Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity).**

**EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.**

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

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

EQUINET is governed by a steering committee involving institutions and individuals co-ordinating theme, country or process work in EQUINET: Rene Loewenson, Godfrey Musuka TARSC Zimbabwe; Firoze Manji Fahamu UK/SA; Mwajumah Masaiganah Peoples Health Movement, Tanzania; Itai Rusike CWGH, Zimbabwe; Godfrey Woelk University of Zimbabwe, TJ Ngulube CHESSORE Zambia; Lucy Gilson, Centre for Health Policy South Africa; Di McIntyre University of Cape Town HEU South Africa; Gertrudes Machatini, Mozambique; Gabriel Mwaluko, Tanzania; Adamson Muula, MHEN Malawi; Patrick Bond Municipal Services Project; A Ntuli, Health Systems Trust, South Africa; Leslie London UCT School of Family and Public Health South Africa; Yash Tandon/ Riaz Tayob SEATINI, Zimbabwe.

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