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

Reclaiming the state:

Advancing people's health, challenging injustice

REPORT

of the Regional Conference on Equity in Health Durban, South Africa

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

Report of the Third Southern African Conference on Equity in Health 8-9 June 2004 Durban, South Africa

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BACKGROUND

The EQUINET Southern African Conference on Equity in Health on June 8 and 9 2004 was held in Durban, South Africa under the conference theme *'Reclaiming The State: Advancing People's Health, Challenging Injustice'.* The conference theme was chosen to raise debate on and give visibility to the determinants and forces driving or impeding equity in health in our region, southern Africa.

One hundred and thirty delegates from Africa, particularly from southern Africa, and from other regions of the world gathered at the conference to debate, present ongoing work and identify strategies and policies for advancing people's health, based on shared values of fairness and justice. The delegate list is shown in Appendix 1. Delegates came from government, parliament, civil society, research institutions, non-government organisations and other agencies working in health as well as from the Southern African Development Community (SADC) and other regional networks.

The conference was hosted by EQUINET, a network of institutions in Southern Africa who aim to develop and widen the conceptual understanding of equity in health, to engage stakeholders in the health sector and to influence policies and agendas that have an impact on health. This was the third such conference in the region. The first was held in Kasane in Botswana in 1997 and the second in South Africa in 2001. This third conference offered an opportunity to assess progress towards equity in health and towards implementation of commitments made at the previous conferences on equity in health. The network was formed in 1998 after the Kasane conference and by 2001, individual institutions in the network reported on work in key areas identified as priorities for equity in health.

While the third conference gave an opportunity for presentation of the work underway and the findings for policy and practice, it also reflected the development within EQUINET of widening networks of analysis and action around health equity issues, within countries and across different constituencies. The conference was thus structured to enable debate and exchange of information across different groups on key areas of work and on

broad policy goals for health equity and social justice. It also provided an opportunity to share information on country level work and on EQUINET. The programme is shown in Appendix 2.

This report summarises the proceedings of the conference. It has been compiled by TARSC. The EQUINET steering committee acknowledges the contribution of the many southern African institutions and individuals who have carried out the work on equity in health presented at the conference. The steering committee acknowledge the support to the conference given by the Rockefeller Foundation, SIDA (Sweden), the Dag Hammerskold Foundation and IDRC (Canada). Finally we thank the health authorities and institutions in South Africa, and particularly in Kwazulu Natal and Durban, for their warm hospitality and support during the conference.

2. OPENING PLENARY

Opening and Welcome

Barry Kistnasawmy, Dean of the Nelson Mandela Medical School, chaired the opening session of the conference and welcomed the delegates. He highlighted the many equity challenges that need to be addressed at the conference, including tackling human resource issues, ensuring fair financing in the health sector, responding to challenges posed by HIV/AIDS on service delivery, massive poverty and poor nutrition in the SADC region, and the need to build strong networks and alliances between organisations of state, civil society, researchers and parliamentarians. He expressed his hope that the conference would go a long way towards developing strategies for tackling these challenges.

Firoze Manji welcomed delegates on behalf of the Equinet Steering Committee. He pointed to the conference theme, chosen to raise debate on the forces that are driving equity in the region, and to identify strategies to advance equity and peoples health. He observed that EQUINET has now grown over the years: we can now move from researching equity and providing evidence to taking more direct actions to improve health equity through the many stakeholders in EQUINET. He urged the conference to use the well-developed research and analysis to define what we as a community can do to improve equity and social justice.

Keynote paper: Reclaiming the state, advancing people's health

Adebayo Olokushi, Executive Secretary of CODESRIA in Senegal presented the keynote paper to the conference. The full paper is available on the EQUINET website at **_www.equinetafrica.org_**

He described an accelerated processes of globalization that was impacting on the ability of states to tackle equity in social sectors, including health. The current process of globalisation has not been accompanied by social gains and has, instead, eroded achievements recorded in an earlier phase of development. The free market policies inherent in this current process has failed to deliver growth in Africa, and has instead widened levels of poverty.

"Although, globalisation appears to promise opportunity for progress and advancement, the process has been accompanied by a sharpening of socio-economic disparities and inequalities among nations and within countries. ….the main winners from globalisation represent a small and diminishing minority even as millions, including many who once formed part of or aspired for the middle class, have been pushed to the bottom of the social ladder into poverty and misery."

While globalisation offers opportunities for greater international exchanges, it also accelerates the spread of disease across countries, propelled by the increased cross-border mobility of people. In the absence of a coherent global strategy to deal with these matters states are extremely vulnerable to the impacts of globalization.

The state in both developed or developing countries has always played an important historical role as a social actor. After the Second World War, various social democratic and welfare regimes emerged in response to domestic pressures from the working poor in Europe and the spreading Bolshevik Revolution in Eastern Europe and Asia. Even in the late colonial states, there was investment in "development" including infrastructure, local industrial processing and the expansion of health and educational facilities. Post independent African countries were able to various degrees to achieve social goals of improved life expectancy and health.

He outlined the change in the 1980s, with orthodox structural adjustment programmes introduced, triggering attacks on the social policies of the post-colonial state, and leading to states curbing of social expenditures. The IMF/World Bank structural adjustment policies had a deflationary, market-oriented thrust that saw and treated the post-colonial state as the problem and not a part of the solution. This approach drew heavily from an ascendant global neo-liberalism which was one-sidedly anti-state and which was committed to "freeing" the forces of the market under the banner of "getting prices right", curbing inflation, and promoting the private and/or non-state sector. The consequences of this strategy were many and devastating for the health sector and for health in Africa.

The shift in developmental activities away from the state to the market triggered a brain drain from the social sectors generally and the public health system in particular, even while newly qualified health personnel roamed the streets in many countries unable to find gainful employment. The brain drain weakened the capacity and social function of the state, and led to a degradation of the public health infrastructure and a collapse of professionalism.

"The immediate post-colonial health system definitely had many problems but there was also a clear vision which underpinned it and which sought to improve livelihood and well-being. During the crisis and adjustment years, this vision was lost and the alternative that seemed to replace it was preoccupied primarily with winning the battle to roll back the frontiers of the state and enthrone the market. Little initial attention was paid to ways in which the health gains that had been recorded in the lead up to and immediately after independence could be safeguarded"

The pleas for 'adjustment with a human face' led to a series of interventions being introduced under the rubric of the 'social dimensions of adjustment'. They included social safety nets, various funds targeting poor households, and programmes for the mitigation of the social costs of economic reform. Various initiatives designed to alleviate poverty were also introduced. Most of these programmes failed to achieve the objectives for which they introduced, were inadequate to address the outbreak of the HIV/AIDS pandemic, accelerating at a time when the capacity of the state and the public health system had been severely eroded.

"One of the fundamental lessons from the failure of the social dimensions of structural adjustment… equally relevant for the PRSPs which have been put in place across Africa during the last two years, is that no progressive policy of social advancement can be successful if it is treated as a residual category to serve targeting needs, even as the "serious" business of macro-economic policy-making is carried on without a clear social objective in mind. To be truly effective, social policy must be an integral part of macro-economic policy-making, not a residual add-on. This can only be done if there is a conscious effort to avoid the decoupling of social policy from macro-economic policy formulation as has happened over the last two decades. Such an approach will require the harmonization of economic policies and instruments with the goal of social renewal and advancement built on foundations of equity and justice."

EQUINET Steering Committee paper: Reclaiming the state: advancing people's health, challenging injustice

Rene Lowenson, programme manager of EQUINET presented the EQUINET steering committee paper to the conference. The full paper is available on the EQUINET website at ***www.equinetafrica.org.***

It is six years since EQUINET was formed to support the Southern African Development community (SADC) in its commitment to secure equity in health. In those six years many challenges have been faced, much has been achieved and much remains to be done. The EQUINET steering committee report to the conference details the opportunities for equity that lie in the region and highlights the obstacles to equity that we must confront. It offers a vision of health systems that serve equity. It presents a rallying call for those striving to work for justice hand in hand with the poor and marginalised.

She noted the guiding concept of equity in health developed by EQUINET in 1999:

'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 Steering committee,
Policy Series #2, 1998

The 2000 regional EQUINET conference issued a 'Call to Action' , that urged that greater effort be put into dealing with differences in health status and access to health' care that are unnecessary, avoidable and unfair. She noted the progress towards the issues raised in this call, but also the obstacles.

" We faced increasing challenges: from an unfair global trading system, from the accumulated impact of war in some countries and from the huge outflow of financial, human and other resources through debt and migration. Our efforts towards equity locally, nationally and regionally are located in a context of widening global inequity in health. This places even greater pressure on us to develop and organise around a uniting alternative vision, analysis, perspective and practice that delivers on our shared values of equity and social justice in health."

She proposed 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, 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.

In Southern African this means tackling food insecurity, access to safe water, sanitation, energy, transport, shelter; ensuring that health systems function effectively, ensuring access to essential medicines, services and community support, and addressing illness and mortality related to reproductive roles. Health gains were made in Southern African when public policies redistributed budgets to prevention and primary health care, improved district health services, deployed personnel to major health problems, backed personnel with resources, ensured a fairer public and private mix, removed cost barriers at the point of service, invested in community health and stimulated service use through information. These policies have more recently been endorsed by SADC Health Ministers.

'Total cereal production in the SADC region has remained stagnant for over a decade remaining at the same level in 2003 as it was in 1990, with an estimated 22,753 000 and 22,062 000 metric tonnes respectively. In the same period the population has grown from 152 million to 212 million.'

2004 SADC Heads of State and Government
Summit on Agriculture and Food Security

More recently, however, there have been warning signs that some trends within the SADC region do not reflect these values and goals. She presented evidence of
  1. A deterioration in selected key health indicators of population health in some countries
  2. Essential public health measures persistently not reaching the poorest, and
  3. Shortfalls in public health spending

These trends reflect a policy shift in health that has occurred in the past two decades globally, that has affected health systems within the region. Policies have increased emphasis on private - public mixes for delivery of health care, promoted market liberalisation and a reduced state role, replaced tax funding with out-of-pocket and private insurance funding and increased commercialisation and corporatisation of curative services.

"The values motivating this shift have not been made explicit, the proposals have often presented as purely technical in content and the evidence base for the policy proposals has often been weak. Nevertheless these shifts imply profound changes to our policy values and commitments and to the services used by the low income majority. The three warning signs above call for caution around these policies in the region and indicate that they may be 'harmful to health" .

Access to basic facilities according to income
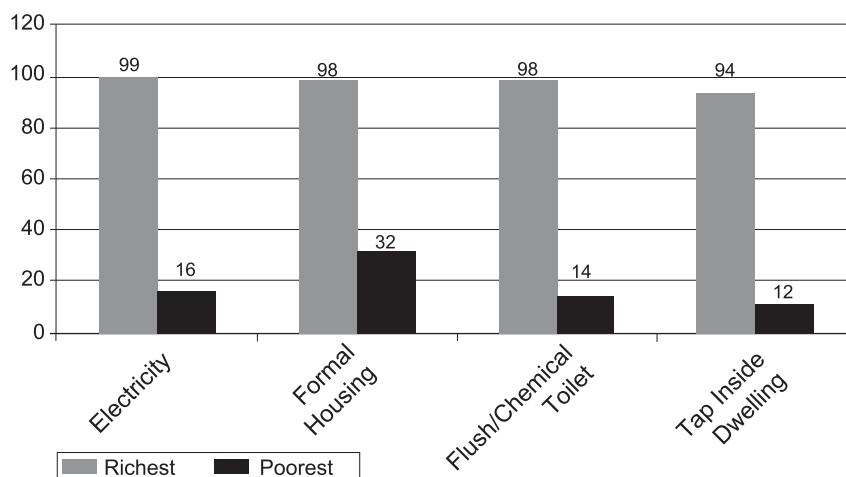
Source: Stats SA 2000 in Ntuli et al 2003 (Access to electricity is defined as using electricity for cooking)

"In the highly unequal societies of southern Africa, this demands health systems that assertively redistribute the resources for health and policies that reflect values of equity, solidarity and universality. We argue that this can be achieved through rising investment through the state and public sector."

She outlined the major features of the public policy response to these health challenges from a health equity perspective. The steering committee noted evidence of how, internationally, when countries have faced major health challenges,

their responses have centred on rising investment in health through the state and public sector. Commercialized health care has not been 'a system preferred by the better off but an affliction of the poor'. Similarly in southern Africa there has been a preference for public over private health investment with rising national income and improved health outcomes associated with increased public health spending and an association between increased economic equality and increased public health expenditures. The paper presented evidence of the positive health gains from these policy choices.

Correlation between the GINI Coefficient and % Public Expenditure of Health Budget among countries in SADC
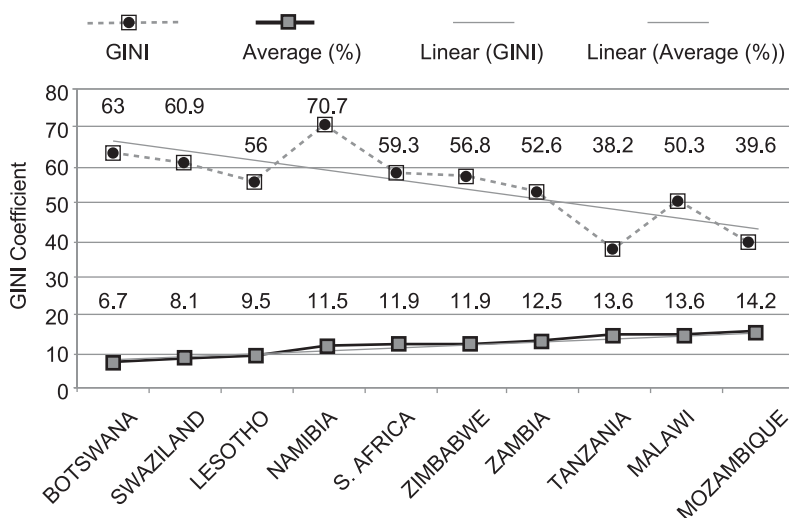
Source: World Health Report 2002 ("http://www.who.int/whr/2002/en/whr2002_annex5.pdf");

She noted that the space to implement these policies is being increasingly eroded by trade and economic policies in the current neoliberal globalisation, despite the fact that they were used and continue to be used, by the now developed countries to promote their own development. These policies are being made illegal for southern African countries and the policy flexibility within which to address development needs is shrinking in the south. The returns from these same policies to Africa had been largely negative on balance, based on evidence cited from many sources including UN Commissions.

"We propose two broad implications:
➢ *Firstly, countries in southern Africa should have the right to refuse to apply trade rules in their social sectors, particularly in health, and should pursue policies to reverse commitments made under duress and which have negative social consequences.*
➢ *Secondly, countries in southern Africa should exercise greater circumspection in the international trade system if they want to maintain their sovereign right to meet the needs of their people."*

To achieve this the paper outlined some of the key areas where national authorities need to be strengthened for public health, and reinforced by a process of regional integration and negotiation that builds the policy space for goals directed at equity and social justice. At national level, it was argued that this policy space be used to defend and advance two fundamental principles, that
➢ Equitable health systems should be able to redistribute and direct resources towards those with greatest need.
➢ This needs, as its absolute precondition, an effective public sector, able to exert leverage over the system as a whole.
The key components of such systems were presented in the paper, as summarised below:

1. Provides for rising investments through the state and public sector in health.
2. Uses these resources to build an effective state and public health sector able to exert leverage over the system as a whole
3. Values and entitles citizens in health systems
4. Strengthens organized action of social groups to make claims for their social and economic rights against states, multinationals, private actors and global institutions
5. Redistributes and directs resources towards those with greatest need.

6. Prioritises collective, population oriented strategies and comprehensive primary health care oriented health services
7. Meets the Abuja commitment of 15% government financing to the health sector, hand in hand with debt relief,
8. Finances health through cross subsidies that serve vertical equity and allocates resources within health systems in reflection of health need
9. Widens the application of essential drugs policies to all health providers
10. Mobilises greater levels of public, non profit financing globally for pharmaceutical research and development
11. Ensures delivery on ethical and equitable human resource policies at national, regional and international level, including north-south transfers to address regressive south-north subsidies from migration of health personnel

"Achieving this implies that we challenge injustice and claim the space and flexibility to make decisions in the public interest. …This means more effectively and decisively exercising our right to refuse policies and practices harmful to our public interests and to people's health."

EQUINET, as a network that has been explicitly formed to promote and realize shared values of equity and social justice in health, has produced research, evidence, stimulated debate and supported analysis on these elements of equity oriented health systems, and has supported networking regionally to support national and regional institutions in global engagement around these policies. As a result the conference has brought together a breadth of disciplines, institutional backgrounds, countries and experiences as a collective strategic resource to each other and to SADC on equity in health.

The steering committee noted that importance of the conference to consolidate on an affirmative vision for and goals in the equity oriented health systems we are trying to build perspective, and to strengthen the organisation and networking of equity actors, at the level of both people and institutions, across the region. The conference was noted to offer an opportunity for learning, debate, peer review and strengthened networking and the steering committee asked delegates to use this to propose and give direction and mandate to EQUINET in its future work.

'Despite a hostile global environment, which has the potential to subjugate us to political and

economic imperatives not of our choosing, we can and must mobilize collection action to chart and implement our positive vision and policies on the equitable health systems that we want.'

Discussion

The comment was made on the keynote paper that only the negative impacts of globalisation were presented, while a number of delegates responded that the current globalisation policies had undermined not only health, but also the provision on other basic services such as water, electricity, housing, and public transport. It was noted that further analysis was needed of the role of the state and state driven political and macro-economic strategies in meeting the challenges of equity. It was not sufficient to talk about strong states they also needed to be fair and responsive states if equity issues were to be addressed.

On the steering committee paper the delegates noted that the warning signs presented in the paper showed a worrying trend in the delivery of equitable primary and public health care and should be responded to before further deteriorations took place. It was requested that copies of the presentation be tabled at the SADC Ministers of Health meeting in Gaberone in June.

3. PLENARY 1: ADVANCING PEOPLE'S HEALTH

The first plenary, chaired by Moussa Samb, IDRC, Senegal and Lucy Gilson, CHP, South Africa, explored some of they key issues affecting our ability to advance people's health, from addressing rights to health to the specific challenges of food security and nutrition and of HIV/AIDS identified as priorities by SADC and constituencies within southern and East Africa.

Health rights as a tool for health equity

Leslie London, University of Cape Town and EQUINET health rights theme co-ordinator asked the question what human rights can do for health equity in the context of increasing global health inequalities, increasing globalization disempowering national states, and increasingly stark resource constraints for health in developing countries.

"At a generic level, most public health practitioners acknowledge the value of human rights in promoting human wellbeing. However, at a specific level there is concern that rights approaches might interfere with public health, and that human rights approaches are ill-suited to tackling problems in Africa, such as HIV/AIDS. There are also concerns that human rights expressed as individual entitlements might impact negatively on resource allocation".

He presented three case studies in Southern Africa to highlight how human rights were used to promote health equity: Treatment access for HIV in South Africa, the use of Patients' Rights Charter in Malawi, South Africa and Zimbabwe and civic organising for health in Zimbabwe.

The studies demonstrated 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; when the operationalisation of rights confers agency on the part of those most affected, and When rights include the complete spectrum of civil, political, and socio-economic rights.

The synergy between public health and human rights in relation to equity lie in the social processes and consciousness and the interface with the state that secures collective rights. 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.

In discussion, delegates raised the difficulty posed by regarding rights as indivisible, when social and economic rights are not being addressed in resource-poor countries.
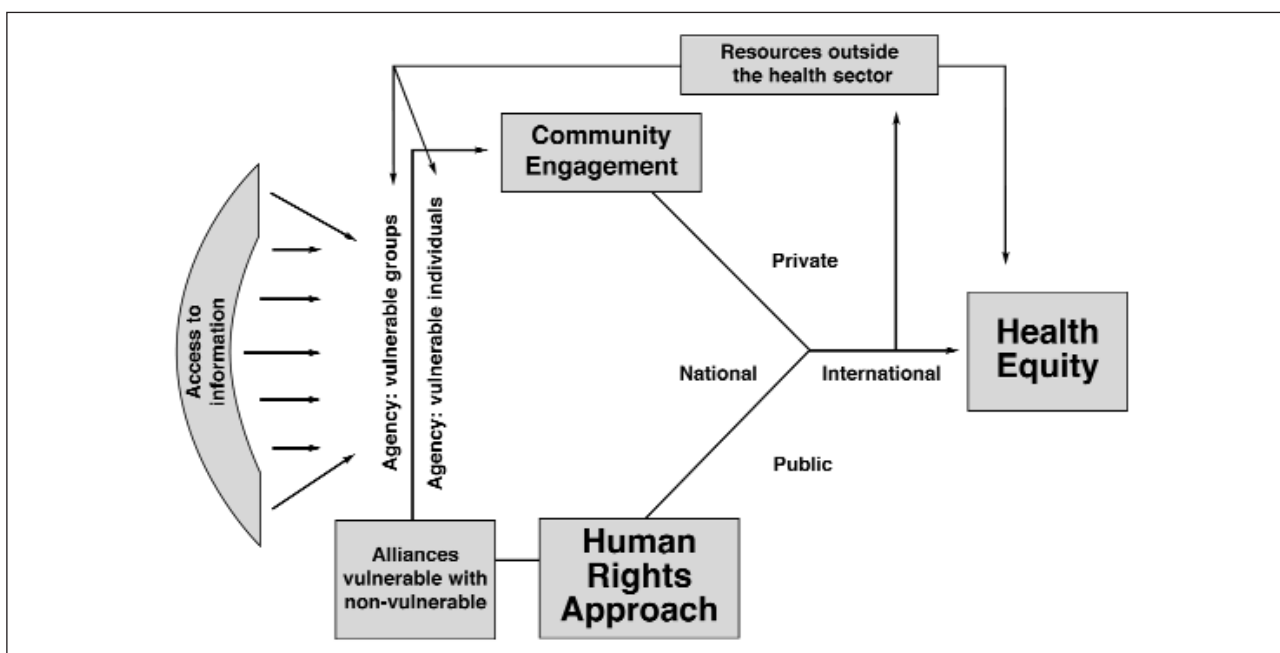
Food security and nutrition

Mickey Chopra School of Public Health University of Western Cape presented a paper co-authored with David Sanders, UWC, on food security and nutrition. The lack of household food security, and subsequent poor nutrition, continues to blight the lives of millions of people in Southern Africa and is the major cause of death worldwide. Only 3 out 10 African countries showed a decrease in severe maternal malnutrition in the last decade.
He noted that deprivation of the right to good nutrition stunts educational development, increases risk and severity of infectious diseases and undermines child health and development. The lack of household food security has led to increased vulnerability, especially of women, to disease and contributed to an intergenerational transmission of poverty.

Despite a widespread recognition of the integral relationship between AIDS, poverty, food security and under-development, there has been inadequate systematic investigation of these relationships. He outlined a number of ways in which AIDS increases the impact of such external shocks: through household-level labour shortages result from adult morbidity and mortality, loss of assets and skills from increased adult mortality; an increase in the burden of care for sick adults and children orphaned by AIDS; negative interactions between malnutrition and HIV and lost institutional capacities to respond to production and health issues.
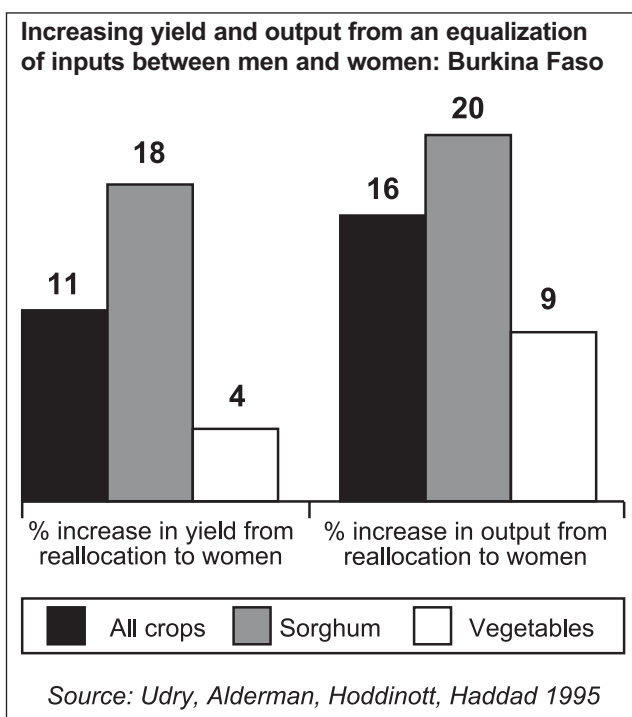
These factors are in turn over-determined by the worsening macroeconomic context in most Southern African countries, including negative terms of trade, domestic food and agricultural polices not adequately supporting food production and micro level factors such as intra-household food distribution, gender roles and caring practices. Women contribute 70 to 80 percent of household food production in Sub-Saharan Africa, 65 percent in Asia, and 45 percent in Latin America and the Caribbean. They achieve this despite unequal access to land, to inputs such as improved seeds and fertilizer, and to information.

He proposed that an equity oriented response to malnutrition thus needed to include addressing inequalities in land distribution, improved access to small-holdings and information about agriculture, addressing the persistent inequalities between rural and urban households, and the inequalities in the investment of inputs to men and women in agriculture.

Dr Erika Malekia, SADC and Mary Materu COUNSENUTH gave discussant inputs on the paper. Dr Malekia noted that household food security is fundamental to equity and calls for intervention in the macro- and micro-economic factors that produce inequalities in land distribution and gender equity in access to production inputs and food. The humanitarian crisis in southern Africa highlights that AIDS and hunger have placed the region in a state of severe vulnerability and reduced the threshold for crises to turn into major disasters. The SADC HIV & AIDS Summit in July 2003 identified food security as an area requiring urgent attention and action. A joint Ministerial meeting in Tanzania in April 2004 highlighted important strategies and regional commitments to address this issue.

This meeting called for unified multisectoral and holistic programming response from SADC countries, support for local leadership and good practice, particularly aimed at women and youth and development of community safety nets to provide and institutionalise social programmes for extremely poor households, including those impoverished by AIDS. The SADC meeting also called for increased research and action with local, national and regional partners to improve understanding of and intervene in the vulnerability of communities, particularly long term heavily impacted farming communities and household made vulnerable by AIDS, to understand and address the impact of gender imbalances on food insecurity and to explore and address the links between HIV and AIDS and nutrition.

Increasing yield and output from an equalization of inputs between men and women: Burkina Faso

Source: Udry, Alderman, Hoddinott, Haddad 1995

Mary Materu of the The Centre for Counselling, Nutrition and Health Care (COUNSENUTH), Tanzania noted the need for equity and social justice in dealing with food security and nutrition. Although the world produces enough to feed everybody, more than 800 million people, most in developing countries, do not have enough food to cover their nutritional needs. She noted that education, water and sanitation have great impact on food security and nutrition, especially community and national levels. The relate back to inequalities in the control and management of resources, themselves a result of economic, ideological, political and social-cultural factors. She agreed that women are vulnerable, while also playing the role of the main food producers and processors. To address equity and social justice in food security and nutrition, EQUINET will need to take stock of and examine existing policies and guidelines at global, regional, national and community levels, how they are implemented, and identify policy changes to be made and key intervention points for improving equity in food and nutrition.

Universal treatment access through sustainable public health systems

David McCoy (EQUINET) presented a paper co-authored with Rene Loewenson that called for joint treatment activism and public health activism to ensure that treatment access is extended in ways that are sustainable, effective and equitable. He commended the recognition of rights to treatment in Africa as a great civic and public health victory. He noted that the way these rights are implemented can either enhance or undermine equity and health, particularly given the current weaknesses in health systems.

He called for a virtuous cycle between programming for Antiretroviral therapy (ART) expansion and strengthened health systems. For this HIV and ART must be placed within the broader frame of development and comprehensive health care, without negating the fact that HIV/AIDS and the lack of access to ART are emergencies.

To build this virtuous cycle, work and consultations carried out by institutions in EQUINET in the region have identified a number of principles, including ensuring:
- Fair, transparent processes to make informed choices
- Joint public health and HIV/AIDS planning
- That treatment is integrated into wider health systems

- Realistic targets for treatment access with clear guidelines and monitoring systems for ensuring equity in access and quality of care
- That treatment resources are integrated into regular budgets, supported by long term external commitments and through fair financing approaches
- That human resource development is prioritized in the health sector
- Essential drugs policies and systems are strengthened nationally and regionally
- That the challenge of ART expansion is linked to the challenge of reforming the broader global political economy.

The risks of not following a virtuous cycle are already emerging: Plans for ART provision that have not adequately factored in the human resources needs or other aspects of the treatment cycle have been difficult to sustain or have led to diversion of resources from wider health systems. He cited as one example the attractive salaries paid by international donors cause disruptions in human resources, leaving major staff and service gaps in other sections in health. Although the problem of the 'brain drain' has always existed, with local doctors and nurses seeking employment overseas, this issue has been compounded partly by the massive influx of money earmarked for HIV and AIDS programmes, where staff can access better working and better salaried positions. Inability to sustain delivery or ART if systems are weak not only undermines the patient, but may lead to drug resistance.
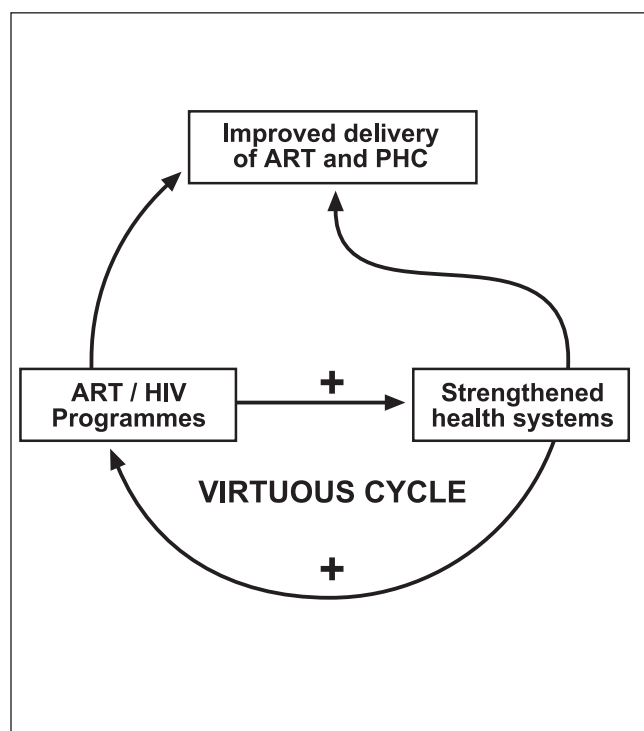
"Although the problem of the 'brain drain' has always existed, with local doctors and nurses seeking employment overseas, this issue has been compounded partly by the massive influx of money earmarked for HIV and AIDS programmes. At Lilongwe Central Hospital, a 970-bed facility authorised to employ 520 nurses, currently only 169 nurses are available for clinical care. In the hospital laboratory, only six technicians are now working where 38 were previously employed. When asked where these workers are, the response is invariably the same – projects".

Lancet 2004; 363: 1478.

The greatest loss however is in 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. There is an opportunity to revitalise health systems, catalyse HIV prevention, strengthen primary health care and challenge the patent regimes on medicines if we set out explicitly to do this.

While this calls for national level decision making around ensuring the adequacy of funding the core health systems needed to respond to AIDS, it also calls for changes at the global level to support this: debt cancellation, a fair global financial and trading system, development assistance and a strengthened campaign against pharmaceutical profiteering.

In the discussion on the paper delegates endorsed the concept that if ART programs were delivered through the primary health care system they would be more sustainable. They thus supported the demand to make drugs available as rapidly as possible, whilst not using NGOs as a substitute for the primary health care system. This also means that the state needs to acknowledge the rights of citizens, and that citizens allow for equitable social responses around individual rights. Reversals in the social contracts between citizens and state need to be dealt with to build the trust needed to deal with the difficult choices around ART access.

The delegates noted that while it was important to avoid totally unrealistic targets, we need to push for targets at global level and get commitments from the G8 for targets that reflect greater global equity. We need also to drive demand for rights to treatment to ensure that the resources are made available to strengthen capacities for ART delivery. We also need to address the gender inequalities that are central to both the spread of and unfair burdens due to AIDS.

4. PARALLEL WORKSHOPS

After the plenary four parallel workshops were held to take up the issues raised in the plenary in greater detail and to share information on work in the region. These are briefly reported here. The abstract book prepared for the conference and available on the EQUINET website provides detail on each of the presentations and this report provides an outline of the key issues raised, debates and recommendations of the workshops.

4.1. Health rights as a tool for health equity

This workshop was chaired by Leslie London, University of Cape Town and explored further what kinds of rights approaches strengthen health equity and why. Two case studies were presented by Davie Kalomba, CARE Malawi on the use of a score card in Malawi to promote health equity in health service delivery and by Nomafrench Mbombo, UCT South Africa, on the obstacles to access of maternity services in the northern areas of Cape Town, South Africa.

The Local Initiatives for Health (LIFH) Project in May 2002 presented by Davie Kalomba used a scorecard to put the rights based approach into action. This enabled dialogue between service providers and users to deal with non discrimination in drug dispensing, in the overall treatment of patients, in the provision of supplementary food and maintaining a first-come first-served policy. The participatory rights based methodology built organisations of rural health care consumers able to identify and address priority health issues. The project increased access to services by the community, increased access to information by service users, built dialogue between service users and providers, encouraged participation in decision making, and improved the capacity of service users to claim their right to health. The social mapping process has the potential to identify vulnerable groups in communities and link them to health service providers and other social support systems. The

methodology also has the potential take community voice to higher level decision makers.

Nomafrench Mbombo's focused on the identified problem of delay and failure or infrequent attendance of maternity care during pregnancy as the major contributory factors to maternal deaths in South Africa. The study identified reasons why maternity women fail or delay to attend antenatal, intranatal and postnatal care from a human rights perspective, through interview of women attending Midwife Obstetric Units were interviewed. Women gave their reasons and perceptions on why they fail to attend maternity care and these were grouped into rights related themes. The findings were then interpreted in the context of the South African Constitution and the International Bill of Rights.

The case studies were discussed and it was noted that rights approaches can and should serve as an entry point for dialogue between health care workers and users, to build a shared set of values which will enable them to tackle the reasons for poor access in clients and for personnel leaving services. A rights approach can raise the awareness of users of services and ensure policies are implemented. The delegates felt that there were many methodologies to advance a rights approach and the various options needed to be explored.

> *The workshop resolved that:*
> * *EQUINET should advance a concept of rights that recognizes the moral claims of vulnerable groups, particularly in ways that capture non-Western (African) traditions;*
> * *The South should teach the North as to what kind of Human Rights conception has liberatory potential;*
> * *A human rights analysis should be used to critique government and donor policies*
> * *EQUINET should build capacity across the region to undertake action-oriented research to advance rights.*

4.2. Health systems approaches to HIV/AIDS

David McCoy (EQUINET) chaired this workshop which aimed to present and review evidence and issues towards building a health systems approach to treatment access.

Elizabeth-Ann Schroeder, Department Of Economics, University Of Natal/ National Perinatal Epidemiology Unit, Oxford University presented comparative investigation of food security of rural agriculturally dependent families in areas of high HIV prevalence between families who had adopted orphans compared with those who had not. The research was undertaken in Ingwavuma - 'one of the poorest areas in South Africa'. The study examined various proxies for food security including food reduction activities, food supplementation activities and the proportion of staple food consumed by the household.

Both groups showed a high incidence of illness and death and the presence of orphans was correlated to 'larger numbers of household occupants'. An increase in the number of household occupants was associated with an increased probability of the household engaging in food reduction activities, of the household not producing sufficient food to satisfy its household consumption requirement, and 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. She recommended food and health monitoring and early warning famine systems such as those implemented in Mozambique in all rural areas with high HIV prevalence rates. She also called for more research into the value of foster care grants, home-based care and their levels of sustainability and impact on communities.

Helen Schneider (CHP, South Africa) described the South African AIDS epidemic and policy responses in a context of inequality. She questioned why southern Africa has experienced an explosive HIV epidemic. She trached this to the political economy of apartheid and South Africa's economic, political and cultural transitions. 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". AIDS has now 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. The roll out of ARV's presents a major challenge in terms of the principle of equity and plans for this need to be critically assessed for the extent to which they enhance equity.

Julia Kemp (Equi-TB Malawi) presented work on health systems issues in relation to ART access in Malawi carried out by Julia Kemp, Jean-Marion Aitken, Sarah Legrand, And Biziwick Mwale. This work is documented in EQUINET discussion paper 5 on the EQUINET website. She outlined the background context of widespread poverty, an under-resourced and inequitable health system, well developed policies for the health sector response to HIV/AIDS with patchy coverage with "islands of excellence", depending on specific donor inputs. She described the national consensus 'position' on providing equitable access to ART through public sector provision: ART is to be provided free-of-charge on a first-come, first-served basis. 'Equity' measures include targeted health promotion to groups selected according to the following guidelines: situations of moral obligation to treat (e.g. women receiving PMTCT), essential human resources in front-line services (e.g. health workers and teachers), maximum multiplier effect (e.g. people living positively with HIV/AIDS), principles of non-discrimination and pro-poor measures (e.g. orphans, remote rural dwellers, sex workers), and cost-effectiveness maximization (e.g. TB patients). In the private sector, ART will be provided at 20% of cost and ART providers will be trained and will participate in national monitoring activities. Barriers to access remain for poorest and most vulnerable, but there are many initiatives

to promote equity, although even with Global Fund, it may not be possible to translate dollars into the additional health personnel required because of an absolute lack of nurses and doctors. Equity analysis should consider equity in access to benefits of the investment of ART provision, particularly in relation to the impact on resources for the Essential Health Package.

Ian Couper (Wits South Africa) presented equity concerns around the South African Comprehensive HIV and AIDS Care, Management and Treatment Plan, particularly in terms of health worker capacities, the adequacy of the Primary Health Care Package, disparities in the distribution of resources at district level, vertical implementation of programmes, weak co-ordination with NGOs and traditional healers and conservative attitudes to HIV/AIDS. These barriers need to be addressed as it is essential that treatment be clinic based and integrated into other care. He proposed that solutions included improved drug supply – for TB too, capacity building for clinical monitoring, innovative approaches to lab monitoring (batching of tests, regionalisation of lab facilities, SMS results, etc), development of one standardised, clear, rational and national approach, with standardised records and monitoring systems. A team approach is essential with doctors initiating treatment, PHC nurses providing ongoing care and monitoring patients, with support from clinic doctors, lay counselors in clinics to ensure understanding, adherence, do VCT, community health workers doing home based care, treatment supporters in community and experienced HIV clinicians for referral and consultation.

Marie-Paule Philips presented work on access to health care in Burundi as a basis for understanding the issues around ART roll out in a post conflict situation. After ten years of civil war, the public health sector has been eroded, with an impact on availability, quality and access to care. Most of the health expenditure is spent on salaries, and user fees introduced since July 2002 were found through a country wide survey to have undermined on access to health care and caused further impoverishment. Hence even while drug costs are met, clients to not access services to benefit from this. She noted that it does not work therefore for specific areas of care to be subsidised or free within an overall paying health system. She recommended that essential care be free for all patients, with possible reimbursement for transport and other costs..

In the discussion the call was made for a more comprehensive monitoring system that includes

issues such as food security. Research evidence is needed to understand household level issues: the value of foster care grants for home based care; the way families access grants; and the differences between male and female-headed households. Greater synergy should be sought between households and services to make resources easier to access. The work on health systems and ART needs to engage and network the health professionals, especially in the district and primary health care systems.

The workshop delegates agreed that in combating the HIV/AIDS epidemic, health providers, communities, countries and global institutions must pay greater attention to addressing the underlying social, economic and political determinants of the epidemic. These include socio-economic inequalities and power imbalances operating at the global, regional and national levels. The HIV epidemic is more than a manifestation of a viral infection but is also a manifestation of social, political and economic relations. The delivery of comprehensive HIV/AIDS programmes, including the expansion of access to ART for people living with HIV/AIDS in southern Africa was agreed to be an urgent humanitarian, public health and economic priority for the region and the global community. The choices around the use of scarce health resources, as well as the criteria for rationing access to ART must thus occur through clear, transparent and accountable mechanisms. They delegates also agreed that while plans to expand access to ART must be strengthened, they must be designed in a way that strengthens the delivery of other priority health care services and strengthens the development of effective, efficient, equitable and inclusive health systems.

This workshop resolved that EQUINET, together with its partners:
- *Continues to advocate and lobby for broader reforms of the global political economy to ensure a fair and just environment under which southern African countries can develop and sustain adequate access to essential health care for all;*
- *Challenges the macro-economic and political limitations on the ability of governments to finance and develop effective and equitable public health systems, capable of proving access to treatment for all in southern Africa;*
- *Advocates for the expansion of access to ART within the context of plans to develop equitable, inclusive and participatory health care systems capable of ensuring essential health care for all who need it;*

> • *Institutes a programme of monitoring and research to carefully document the impact of ART programmes on the broader PHC and health systems agenda;*
> • *Institutes a programme of advocacy and social mobilisation for the development of appropriate health care infra-structure in all southern African countries, paying particular attention to the human resource needs of health systems, as well as to effective and accountable public sector leadership.*

4.3 Parliamentary alliances for equity in health

Lexi Bambas of the Global Equity Gauge Alliance (GEGA) outlined the workshop aims to highlight issues and add perspectives in consulting parliament and communities in support of parliamentary alliances for equity in health. She highlighted for example the need for leadership and legislation around agriculture, food security and in national budgets. This called for involvement of parliamentarians at national and regional level, in southern and east Africa. Civil society and communities need to push for strategic links with parliamentarians, including analyzing current budgets and strengthening resolutions to take forward in parliaments.

Aillet Mukono from the Parliament of Zimbabwe noted the challenges facing health care in Zimbabwe. In 1999, a Health Service Commission was established to look into the deteriorating health sector. A parliamentary portfolio committee on health was established to provide effective oversight over the executive through participation in the enactment and review of policies and legislation, and participation in the Budget process. She outlined some of the contributions of this committee in review of laws such as the Public Health Act, in promoting policies, such as the re-introduction of the Village Health Care Programme and State-Certified Nurse Training Progammes and in monitoring public funds, such as the National Aids Trust Funds. The committee has worked closely with civil society and with the Ministry of Health in its work.

The Hon Sakwiba Sikota, previously chair of the Zambian parliamentary health committee, outlined experiences of this committee in coming up with an equitable way of sharing health resources, carrying out analysis budget allocations and making Zambia's 187 parliamentarians aware of health issues. He noted the contribution of organisations like CHESSORE, GEGA and EQUINET to this. In Zambia, parliamentary work

was complemented by visits to districts to assess health needs and provision in order to tackle health inequalities. He noted that the equity gap in districts required wider issues to be addressed, including national budget allocations to health and dealing with how trade issues impact on health.

The Hon Holman Malaka of the Malawi parliamentary health committee noted three critical issues that had been identified as needing attention: HIV/AIDS, budgets and reproductive health. Malawi has been drawing on the example of Tanzania to develop and implement better health systems, and they are moving towards decentralising health delivery.

It was noted in the discussions that youth are often not adequately involved in these processes and need to be involved. It was agreed that work was needed to strengthen parliaments in setting budgets, and in understanding the impacts of the budgets and regulations they pass on health. It was also noted that parliaments need to look beyond the public sector to ensure that the private sector is taking on its health responsibilities.

In working with parliaments delegates discussed a need to ensure understanding of and balance in the relationship between the executive layer of government and parliamentarians. This is sometimes a contested and uneasy area and needs to be managed with flexibility. Additional resource support is also needed to strengthen health committees.

> *The workshop thus resolved that we need to strengthen parliaments to:*
> • *Build an effective public sector, able to exert leverage over the system and to invest further in the role of the state as a whole through rising investments through the state and public sector in health;*
> • *Monitor and report on through civil society and parliament, government performance in meeting the Abuja commitment of 15% government spending to health alongside efforts to relieve debt;*
> • *Protect our right to refuse to apply trade rules in our social sectors, particularly in health, and pursue policies to reverse commitments made under duress and which have negative social consequences;*
> • *Promote greater circumspection in trade relations such that sovereign rights to meet the needs of our people are maintained;*
> • *Ensure review of trade issues are part of terms of reference for Health Committees*

> *and build capacity of legislators for analysis and establishment of regular processes to monitor trade/treaties;*
> * *Build clear, transparent and accountable mechanisms for public and stakeholder consultation and debate, with public health guidance, on choices in ART expansion.*

4.4. Using ICT as a tool for equity and social justice

Firoze Manji of Fahamu welcomed all present and introduced the workshop agenda, to examine the role of ICTs in contributing to social justice and Health Equity.

Riaz Tayob of SEATINI Zimbabwe noted that technology is a useful tool, given the that Africa was under siege from imperialism, free trade and liberalisation. SEATINI had developed a program with OSISA, the Open Society Foundation of Southern Africa to benefit e-riders and use open source networks. On a shoestring budget, SEATINI had now linked 20 organsations to two sites and the sites were being used by policy makers. Although their impact had been modest, they had been able to reinforce with information the protest at Cancun against unfair pressures for further trade liberalization and to reinforce the African positions. A communication system regularly updated delegates with information about Cancun and Ministers and experts informed through mobile phones and palmtop computers, linked into a dedicated channel of information and a knowledge management system. Technology was used to link those inside and outside the conference so as to enhance capacity and the flow of information. Websites, email, mobile phone communication and SMS technology was used to spread information.   The system could be improved by more capacity building and training prior to events, by improving the customisation of knowledge management, by marketing more well before the event and by collaborating widely.

Patrick Burnett at Fahamu noted that while there are 52 million mobile phone users in Africa and 5-8 million email users, Fahamu research found in 57 healthworker personnel, only 3,5% had access to internet and less than half had access to telephones in their offices. Healthcare workers thus need to be supported in their information needs trough radio, satellite and SMS technologies. The power of electronic information was highlighted in the growth of Pambazuka News, a weekly text Fahamu publication, which in 1997/1998 had 60 000 readers. Fahamu aimed in its work to enable absolute access. They did not yet have a policy on how to cross language skills barriers, although

Fahamu has initiated work to provide distance learning certified by Oxford University on skills relevant to human rights work through an internet course that provides mentoring through assignments workshops and email groups.

Tendayi Kureya of the SAfAIDS ICT programme noted that access to email and the internet becomes a big issue outside South Africa. Based on the assumption that most NGOs had email and internet access, the SAfAIDS ICT program was initiated in 2001 to improve communications about health. This programme has encountered the digital divide. SAfAIDS has thus provided cyber training of 200 program managers in Zambia, Swaziland, and Lesotho from 100 different organisations. The network resource centres initially received 50 information requests per week, but this has now risen to 100 information requests from organisations, with 50% of these requests coming from yahoo or hotmail accounts (free internet-based emails).

The discussion highlighted some critical issues for future work if ICTs are to be used for equity and social justice. Information is not neutral and needs to address the underlying power dynamics. Firstly information access needs to be improved. Public libraries need to be built and used to provide wider access to information, especially information related to local activities and debates on local issues. Services that are available need to be used effectively. It was noted for example, that 50% of NGOs have internet in the office of their general manager, inaccessible to staff.

> *The workshop thus resolved to promote and develop innovative communication technologies which support health equity through:*
> * *Disseminating information on and facilitating debate and discussion about health equity issues;*
> * *Networking and awareness raising;*
> * *Developing existing tools for more strategic use including advocacy, lobbying and mobilisation;*
> * *Building on the synergies created between traditional communication channels and ICTs in expanding the outreach of public health messages;*
> * *Seeking to maximise, explore and enhance the use of ICTs in all EQUINETs interventions in the region; and*
> * *Evaluating the appropriateness and impact of the different technologies for interventions such as trade negotiations, health systems support, SADC meetings, policy forums, petitioning and advocacy.*

5. PLENARY 2: RECLAIMING THE STATE

Dr Erika Malekia of SADC and Itai Rusike, EQUINET SC member, CWGH chaired the plenary session that explored the different dimensions of health systems, in response to the challenges raised of advancing people's health. The session presented perspectives and work on some of the key issues confronting the vision of public sector health systems proposed in the opening session, including fair financing, availability and distribution of health personnel and participatory governance in the health sector.

Parliamentary impact on equity in health

The session began with a view from the parliamentary constituency within EQUINET, presented by the Hon Sakwiba Sikota of the National Assembly of Zambia.

He noted the critical role parliaments play in promoting health equity as they are the final authority on the allocation of government resources to the health sector and government is the leading provider of health services. It is unclear as to whether the parliamentarian of today has had enough time and capacity to absorb and appreciate the importance and enormity of the roles and responsibilities expected of them. This role has been complicated by instability in the governance arrangements of the past few decades, with changing roles and values. Zambia, for example, went through shifts from a multi-party culture to a one party state and back to multi-partyism wthin 15 years. The concept of multi-partyism developed with no stable democratic base from which to build, making the systems strewn with theoretical and practical disputes between key stakeholders.

"This scenario can cloud the focus and attention of parliamentarians such that it may tend to be divided between when and how best to serve personal, political party, constituency and national interests. Decisions along these lines tend to be influenced by a number of factors that could include time, political pressures faced, donor interests, technical complexity of issues, and numerous other factors. With or without adequate education; with or without prior exposure; with or without political party support; and with or without other stakeholder support, the parliamentarian must deliver and be seen to deliver in a way that balances the various interests."

As one of the three wings of government responsible for enacting laws, authorizing government expenditure and overseeing government activities, parliament uses its . committees to provide more detailed focus in its work. These committees also need support to perform their roles, to scrutinise budgets, to deal with the brain drain amongst the medical professionals, with HIV/AIDS and high poverty levels. Dealing with these issues calls for periodic exchange of experiences among policy makers and technical persons from civil society working in equity, such as Equity Gauges and with health workers. There is also a need to understand that parliamentarians are not "meddling" when they comment on issues of public health and that they have legitimate interests in the many stages and processes that affect health outcomes, including ensuring that equity and social justice prevails in the distribution of health benefits.

He called for a concerted effort to get issues of health equity on top of the agenda everywhere across the region.

Fair financing from the Household Perspective

Lucy Gilson, Centre for Health Policy, University of the Witwatersrand presented a paper co-authored with Di McIntyre, Health Economics Unit, University of Cape Town, co-ordinator of EQUINET theme work on equitable health resource allocations.

Households currently spend a rising percentage of their total expenditure on health, often more than 10% of household costs.

Dealing with Malaria in Malawi, for example, contributed to between 7.2% of household budgets for high income families and 32% of the total budget for the lowest income families.

These costs led to dropout from care or endangered household livelihoods in order to access care. She noted that the poor should not be forced to do without care due to costs nor be impoverished by costs of care. Payment for care should be based on the ability to pay rather than the risk of illness, and the rich should pay greater proportion of their income for health care than poor people (progressive). Payments by the rich and healthy should be used to support costs of access for poor & sick (cross-subsidy) and adequate health care financing mechanisms should be in place to

limit the level of out of pocket payments borne by households. This calls for removal of user fees for public primary care and strengthened risk-sharing mechanisms through tax-based funding, pre-payment and social insurance schemes.

To support this enough international and domestic resources should be allocated to public health systems, supported by appropriate debt relief measures, to support overall health system strengthening. Within this, resources should be allocated not only on the basis of traditional' needs-based resource allocation formulae but also incorporating social and material deprivation and public prioritises. She noted the need therefore for:

- more funding to public health systems (meeting the Abuja declaration of 15% government spending to health) supported by debt cancellation,
- removal of user fees at primary care level,
- the development of equitable resource allocation mechanisms,
- regulating the private sector, and
- ensuring wider social and economic policies supportive of poor households.

This framework for fair financing calls for civil society action, monitoring and research including on approaches to increasing the cross-subsidy in health care financing, taking account of public preferences and community capacity to benefit in public sector resource allocation and mechanisms for ensuring that the private sector supports equity goals. Work is also needed at household level to explore the role of social networks/provisioning in supporting health care access.

Confronting challenges in health personnel

Antoinette Ntuli, Health Systems Trust South Africa and theme co-ordinator of work on Human Resources for Health (HRH) presented evidence on the wide variety of HRH challenges facing SADC countries, in the absolute shortages of personnel, the maldistribution of personnel between: public and private health sectors, urban and rural areas and tertiary and primary levels of the system and the huge out-migration of personnel from countries within the region. She noted that Africa is currently a net-provider of aid to health services in high income countries. Poor HRH planning in these countries is to some extent a deliberate strategy to acquire "cheap labour, and the flows follow a hierarchy of 'wealth' resulting in a global conveyor belt of health personnel moving from the bottom to the top, increasing inequity.

The 'knock-on' costs of this healthcare worker migration include a negative effect on overall functioning of health systems, loss of institutional memory, unmanaged disease burdens, and increased costs to households of seeking care at higher levels.
She highlighted the factors that influencing healthcare workers to leave their countries of origin, and conversely those that cause healthcare workers to stay.

She outlined various policy and stakeholder responses to the crisis in migration of healthcare workers. These include proposals for ethical recruitment and distribution of skilled health professionals, reorientation of curricula to suit the needs of particular countries and increased healthcare worker training. They also include appropriate recruitment strategies and the decentralisation of the location of training institutions, provision of financial and non-financial incentives, bonding to community service, bursary schemes and loans and enabling health personnel with HIV to work for as long as possible.

These approaches have led to policies for reducing migration out of the SADC region including, for example, the UK Code of conduct on International Recruitment, immigration restrictions in receiving countries, restricting the use of expatriate technical co-operation and the Commonwealth Code of Practice for international recruitment of health workers. Other measures have been proposed, including compensation in the form of a "brain drain" tax, programmes to channel remittances to development, facilitating the return of skilled migrants and the effective utilisation of Brain Gain through utilisation of skills via knowledge networks.

She noted the range of areas of work this implies, adding further that with limited resources, we need to focus on areas where we can have maximum impact, identify those factors and practices that have a major impact negatively or positively and explore how national, regional or international policies can enable and reinforce positive practice.

Governance and Participatory Mechanisms in Health Systems

TJ Ngulube CHESSORE Zambia and theme co-ordinator of the EQUINET Govern Theme presented work done with M Macwangi, C Njobvu, A Ngwengwe, R Loewenson, I Rusike on the effectiveness of participatory mechanisms in representing community views and enhancing health equity. The structures investigated included

Factors influencing health personnel availability and distribution

Source: Padarath et al 2003
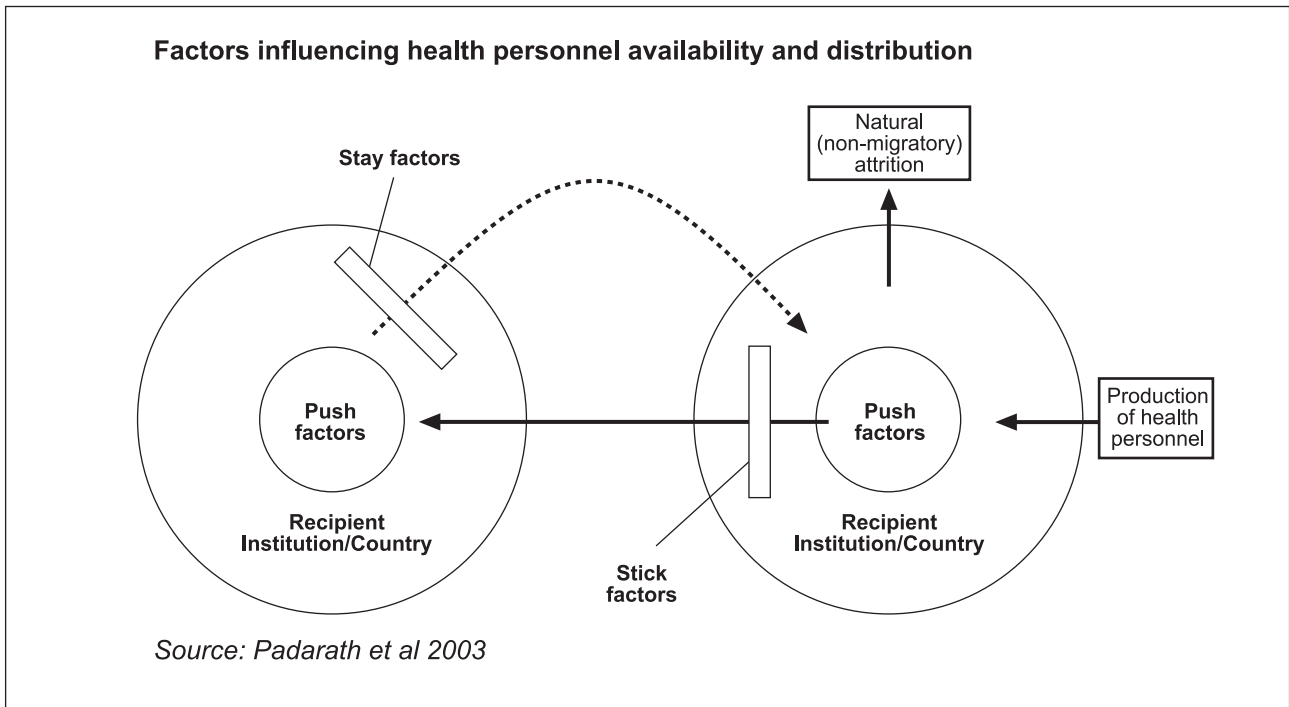
the Health Centre Committees (HCCs) in Zimbabwe, and the District Health Boards and Health Centre Committees in Zambia. Field studies aimed to understand how these structures performed, what impact they had on resource allocation and health service outreach and quality, and that influenced these outcomes.

The studies found that while social groups at either end of the extreme of the spectrum of wealth and poverty did not participate in these mechanisms, they were otherwise broadly representative of the community. Areas with functional participatory mechanisms generally had better Primary Health Care (PHC) statistics (EHT visits, ORS use) and better ccommunity health indicators (health knowledge, health practices, knowledge and use of health services) than in those without. The HCCs were taking part in many health activities and being increasingly relied on by health workers, particularly given staff shortages.

HCCs had however had a limited impact on management issues at the health centres, in meeting the needs of vulnerable groups, as well as in clinical care issues. Constraining factors included lack of information and asymmetry in knowledge.
The studies suggested an association between HCCs and improved health outcomes, even in the highly under-resourced situation of poor communities and poorly resourced clinics.

Despite this HCCs were 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. The performance of governance structures was influenced by the attitude and responsiveness of the health authorities and the participation of strong community leaders, both highly variable across districts. The HCCs noted their lack of knowledge and/or training on the health system and the lack of resource investment in their functioning.

Even with a somewhat ambivalent attitude from health authorities, a strong will to sustain and maintain their participation in health service delivery exists. This needs to be built on and enabled. There are clear signals in these studies of the virtuous cycles of positive health outcome between HCCs and performing clinics. What is missing perhaps is to translate this into wider national policy and practice.

6. PARALLEL WORKSHOPS

The following day parallel workshops were held on the issues raised in the plenaries. These workshops covered issues of human resources for health, governance equity and health, fair financing and civil society alliances for health equity.

6.1. Confronting challenges in health personnel

Antoinette Ntuli presented the workshop aims 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.

Anthony Zwi, University Of New South Wales Australia presented work on skilled health personnel migration to Australia And Ethical Recruitment, carried out with Anna Whelan, Rachelle Arkles and John Dewdney. Australia historically has been an importer of personnel and the impact of these migrations on the source countries has historically not been a feature of Australian debate. A massive 20% of total medical staff in Australia is now recruited internationally, making it essential to look at the factors pushing people out of source countries, to consider personal perspectives, prevent grab factors and limit pull factors.

Scholastika Iipinge, Namibia, noted that in her country health workers move from rural to urban, public to private, abroad and from health to other sectors. The reasons for this are not specific, but are usually related to career advancement, immediate environmental factors (lack of support, poor supervision, stressful environment, no feedback on personal performance, risks involved etc), lack of job satisfaction and the wrong placement. Mostly health workers moving abroad move to the UK, followed by the USA, Canada, Saudi Arabia, Ireland and Australia. To deal with this it is essential that we improve conditions of work, improve communication in interpersonal relations, create a caring environment and attend to immediate environmental factors.

Mike Rowson, Medact, United Kingdom discussed the need to act 'beyond' ethical recruitment. The recruitment of health workers from other countries to Britain to work in the NHS has been steadily increasing over the past few years, despite a ban on active international recruitment implemented in 1998/1999. He questioned whether such bans are effective strategies for dealing with health worker mobility.

He noted that monitoring and constraining the movement of health care workers is not fair those from non-targeted countries have freedom of movement. Alternative strategies are needed,

Ethical recruitment in UK

BAN

BAN STRENGTHENED

Increase over time (below) in UK nurse registration rates, during a period when a ban on active international recruitment had just come into effect:

Growth Index 98/99-2001

1400
1200
1000
800
600
400
200
0

in 98/99   in 99/00   in 00/01   in 01/02   in 02/03

Growth in registered nurses from Africa
(Randomly selected countries)

Zimbabwe   Ghana   Zambia   S. Africa   Kenya   Nigeria

possibly those such as compensation and partnerships. For financial compensation to be effective, it would need to be channeled back into healthcare in the country of origin in order to boost healthcare there. Partnerships are another option, which would mean a circulation of healthcare workers.

Gugu Khumalo (CHP south Africa) presented work done with Lucy Gilson, Ermin Erasmus and Sandi Mbatsha to explore the influence of workplace trust over health worker motivation in South Africa. Their study examined health workers' motivation in terms of equity, efficiency and service delivery. They found that clinic management and leadership style are crucial in terms of informing motivation and performance. A delegation of authority and process leads to higher motivation, whereas feelings of powerlessness in determining the running of the clinic, access to training and decision making undermine healthworker motivation. The personal attitudes and competence of clinic managers provide a foundation for inter-personal trust.. Clinic mangers are viewed as the personal face of the wider bureaucracy, trust judgments are commonly made on the basis of experience of leadership within facilities and health workers emphasise influence of trust in supervisor over motivation and performance.

The workshop discussion focused on the factors that will lead to people staying in the health system in SADC countries. The major factors identified were support, learning opportunities, financing, personal development and excellent work experience. These all needed to be explored in further depth.

The workshop delegates resolved that better functioning health systems are needed if push factors 'forcing' people out of the public sector are to be reduced. These should develop skills and good practice in promoting good workforce planning and appropriate training, human resource management, career development, supportive supervision, mentorship, job satisfaction and related issues for heath workers in the region.

The workshop proposed that EQUINET
- *Support the training of health workers that is responsive to the needs of the people in the region, in terms of types, levels and mix of health workers, the curriculum and process of training;*
- *Support the development and field testing of mechanisms that will optimize and manage this HR flow towards greater equity in the region;*

- *Support local parliaments, NGOs and government negotiators to focus attention on reducing the push factors and enhancing salaries and conditions of work for health workers in the region;*
- *Call on international development banks and other multilateral, and bilateral agencies to facilitate an increase in health worker salaries and terms and conditions of work;*
- *Establish and support national, regional and international documentation of human resource flows and provide analysis that can contribute to action;*
- *Promote work in wealthy countries to focus attention on how their failures to address their own human resource needs has major knock-on effects for poorer countries;*
- *Use international and regional fora such as the G8 meetings, Commonwealth, SADC, WHA and other fora to call for support to developing country health systems, formulate frameworks through which real costs of HR migration to developing countries can be identified and addressed.*

6.2. Fair Financing in Health Systems

Lucy Gilson introduced the main objective of this workshop as being to draw conclusions for SADC countries about key issues to consider in pursuing the fair financing of health systems. The issues for discussion in the workshop included financing mechanisms, equity in public sector resource allocation and equity in the the public/private mix in health care. The workshop was be structured around a set of key questions. Each aspect was covered in a poster, with presenters given time to make inputs on these questions, where relevant, on the basis of their poster. Wider discussion among participants then drew on broader sets of experiences.

Slim Haddad, University of Montreal, Canada presented a paper coauthored with Adrien Nougtara, Jacques Ouédraogo, Salimata Ky-Ouedraogo.   Despite being supported by substantial resources, the widespread application of patient fees for services and the promotion of the private sector in Burkina Faso has reinforced inequalities and undermined use of health services, particularly in disadvantaged populations. Family health expenditures impoverish households, creating new poor and impoverishing the already poor. Health expenditures have increased impoverishment, especially in remote rural areas. While geographic availability of primary-care services

has generally improved in the country, access is now constrained by the cost of services and poverty of households. 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 focusing on families identified as already poor. He estimated that combining two courses of action—one centred on supply (geographic access) and the other on demand (health insurance) could reduce the current impoverishment caused by health expenses by about 40%.
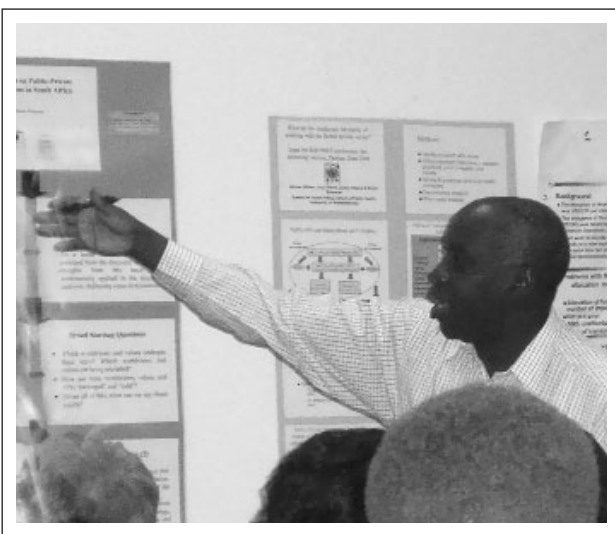
Peter Kamuzora, University of Dar es Salaam, Tanzania outlined work on the Community Health Fund Policy In Tanzania. As part of the health sector reform policy, the government of Tanzania has been implementing financial reforms geared towards mobilizing additional resources for financing health services. 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 when they used health facilities. In its CHF policy, the government stated that it would honour its commitment to equity'. The policy envisaged an exemption system to address equity concerns. However, experience of CHF implementation in Tanzania shows that there have been weaknesses in this scheme, with little information outreach to the beneficiary communities, weak capacity to assess financial ability of the households and a failure by District

authorities to honour exemption proposals from sub-district committees dampening grassroots initiative to identify poor households for exemption. Lack of community involvement has also given CHF officials greater decision-making powers over the scheme. He posed that these factors need to be addressed for equity in the scheme to be achieved.

Angelo Stefanini of Cuamm Medici Con L'Africa, Italy also reported that while user fees at hospitals may be an important source of revenues, they may also affect access, use and equity. A survey in ten hospitals of the Uganda Catholic Medical Bureau found that 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.

Gradeline Minja, Ministry Of Health, Tanzania reported how 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. She outlined the challenges of allocating public resources fairly:

the management information system – which is not computerised – makes it difficult to get reliable and valid data for analysis; the system does not capture people who move across districts or even countries and the absence of a costing study makes it difficult to estimate the actual cost for delivering health services in different areas of the country. While many variables were considered in designing the new formula, only four variables were finally used, population, poverty count, vehicle route mileage and Under five mortality rate. The process of developing the formula involved consultation with various stakeholders. Implementing change in the formula leads to other problems: absorption capacity issues for those with large increases, and shortages for those with reduced funding. These extremes need to be 'smoothed out'.

The discussion of these issues highlighted that it is essential to allocate health resources fairly in order to promote trust. We need to look at the values that underlie the evaluation of financing practice and we need to be open to change as we implement policies. It is best to keep policies and formulas simple. Much more research is needed into fair financing and national level reallocation of health resources. User fees do not belong in the public health care sector for the purposes of equity and user fees should be abolished, coupled with adequate funding of health care systems.

The workshop thus resolved that EQUINET lobby:
- *For fair tax-based financing, including improving revenue collection;*
- *Against profit through health care, as profit maximization and health don't mix;*
- *For the reallocation of all available resources to equity in order to strengthen provision of preventive care/ services and address multi-factorial determinants of health; and*
- *For the removal user fees.*

EQUINET should also:
- *Support the implementation of new approaches to financing by research and advocacy, demonstrating feasible alternatives to current approaches including cross-subsidisation;*
- *Develop research to uncover the international inequities in resource flows and prescriptions (debt, human resources conditions, etc.); and*
- *Improve the rigour of research into financing issues and provide a stronger evidence base for change.*

6.3. Community voice and agency in health systems

TJ Ngulube, CHESSORE, Zambia explained that this workshop aimed 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. The workshop reviewed 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. The main function of the workshop was to assess the research done, develop a common framework and identify resolutions.

Mubiana Macwan'gi, Alasford Ngwengwe, of the University Of Zambia, presented work done in the EQUINET GovERN programme on the effectiveness of District Health Boards in interceding for the community in health delivery. District Health Boards (DHBs) look after community health interests by approving district health plans which reflect community needs; ensuring equitable allocation of resources; and ensuring accountability of the health care system to the community. A cross-sectional survey in 2 provinces of Zambia found that information flow between the community and governance structures was weak and linkages informal or non-functional. Meetings are only held irregularly and there is a lack of involvement/consultation of the wider community in health matters in the context of a lack of sense of community belonging and unity. There was also a lack of awareness of procedures for removing board members from office. The survey found that the DHBs are not functioning as envisioned and do not provide a voice for the people in health planning and decision making.

Itai Rusike presented work by Rene Loewenson, TARSC, Itai Rusike, CWGH and Memory Zulu, TARSC in Zimbabwe on 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. The research found that the HCCs had weak decision making roles but high contribution. HCCs were associated with improved health outcomes in terms of improved community health knowledge, improved use of primary health care and improved knowledge of health systems. Areas with HCCs had stronger outreach and improved EPI coverage. HCCs have improved the service-community interface and led to more organised communities tackling environmental health issues and addressing service uptake and quality. To reinforce these gains the survey proposed strengthening communication and feedback between HCCS and communities, improving dialogue to formalise HCC roles and authorities, providing training and support for skills, capacities and roles and strengthening representation and organisation of some community groups.

Godfrey Mubyazi, NIMRI Tanzania presented a review carried out with Guy Hutton Swiss Tropical Institute on community participation in health planning, resource allocation and service delivery. He noted that while community participation (CP), 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. Involvement of communities builds ownership and support of health systems. Under-use or misuse of health services could be avoided if service users were involved in planning for their delivery. The means for this is often through local health facility committees and health boards with democratically elected community representatives who hold regular meetings to evaluate the service delivery system, collecting opinions through systematic community and patients surveys and through political meetings or other meetings with the general public. Despite this there is often professional arrogance and neglect of voices of lay persons and top-down approaches are favoured over bottom-up approaches. Sometimes communities are given a chance to give opinions but fail to use it because they place their trust in medical professionals. In Tanzania, he presented evidence of how community participation is weakened by inadequate planning skills at local levels, inadequate information-sharing across sectors, including on budgets from government for

community initiated projects and a focus on national priorities rather than local context problems when developing district health plans. Motivation is also weak – from community health workers and local government leaders in mobilizing the public to participate and of the public to attend local meetings. Distrust and political conflict also impede participation.

Yugi Nair presented a paper co-authored with Catherine Campbell, Sbongile Maimane And Zweni Sibiya, Center For Hiv/Aids Networking (Hivan), University Of Kwazulu-Natal on fighting the symbolic and political exclusion of youth in

HIV/AIDS. In a case study of youth HIV-prevention activities in a peri-urban community in KwaZulu-Natal, young people in study had accurate knowledge about HIV transmission and prevention but various factors hindered behaviour change. Sexual curiosity competes with knowledge and there is often a sense of fatalism or bravado. There is also information overload. While young people need dialogue and debate, the emphasis is currently on awareness raising. The social aspects of transmission (poverty, peer pressure, gender norms) are not adequately tackled. Peer influence is still a key determinant of behaviour and risky sexual behaviour is probably approved by peers. Most youth lacked supportive social networks, and have little support to challenge stigma. They called for 'bridges' between small local projects and more powerful local and extra-local actors or agencies. This is an important challenge as the HIV/AIDS problem is too complex for any one group to deal with. HIV-prevention efforts must promote supportive social environments and address the gender, poverty and youth of dimensions of social marginalisation. When youth are excluded in undermines the likelihood of effective HIV prevention.

Ian Couper, School of Public Health, University of the Witwatersrand, South Africa noted in his paper that there is an ongoing crisis in rural health care that calls for co-operation between health professionals and civil society. Civil society has an important role as a pressure group in improving service standards in rural areas and in enhancing the performance of hospital boards and clinic committees. Civil society can educate patients about their rights, provide role models and support training.

It was generally agreed that more communication to people on the ground and information sharing is essential. Mechanisms for participation need to be backed by by formal recognition, and increased resources for their functioning. They need investment in skills development for both HCCs and health workers in ways that strengthen dialogue between HCCs, health workers and government.

We also need to better understand and research the sexual activities and communication around sexual activity of youth, parents, women, and poor people. Local role models and positive media are needed. Communities should have facilities to offer training in health care, including scholarship schemes which make scholars accountable to their communities. More research is needed to find out where and how youth can become more involved in health care provision.

The workshop delegates recognised that community participation is a necessary component for enhancing health service delivery and health outcomes under different settings and that the management of some health situations (HIV/Aids, TB etc) require higher levels of community-based responses alongside health facility based actions. Community participation involves shifting the power balance for shared real power and real empowerment to make a difference in outcomes and distribution of benefits.

EQUINET should thus undertake applied research to:
- *Determine critical levers for shifting power balances in favour of real community participation for equity in health;*
- *Create and support models of participation; and*
- *Determine optimal level of equilibrium in the balance of power under different settings and at different levels of health system in SADC.*

6.4. Civil society alliances for equity in health

Rene Loewenson EQUINET opened the meeting explaining the aims of the workshop, to 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; to develop a framework of perspective and analysis within which evidence can be collected and gathered and debate held at country grassroots level for input to the health civil society alliances and for presentation at the regional meeting of health civil society in late 2004 and to identify areas of action and follow up work defined are priorities by health civil society.
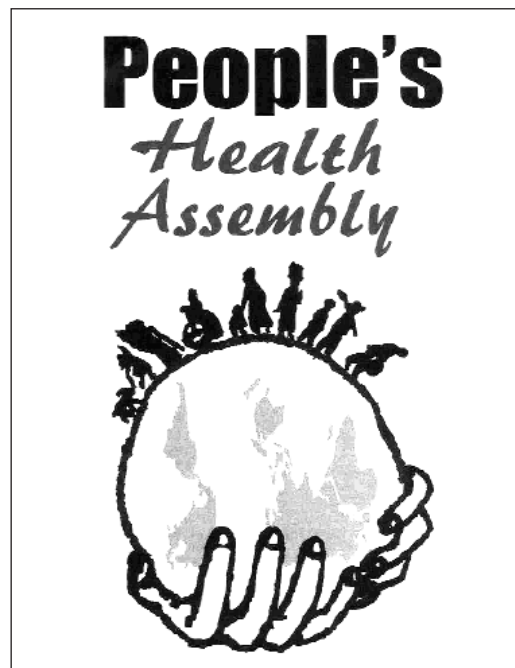
David Sanders University of Western Cape South Africa and Peoples Health Movement noted that EQUINET is seeking to strengthen its links with civil society, such as with the trade unions, the Pan African Treatment Access Movement, and other civil society groups. The People's Health Movement is a large global civil society network of health activists supportive of the WHO policy of Health for All and organised to combat the economic and political causes of deepening inequalities in health worldwide and revitalise the implementation of WHO's strategy of Primary Health Care. The PHM believes that health and human rights should prevail over economic and political concerns. PHM has implemented a People's Health Charter which calls for broad-based popular movements to pressure governments to incorporate health and human rights into national constitutions and laws. This

demands transformation of the global trading system in favour of public institutions, not private interests; addressing environmental challenges; and supporting campaigns for peace and disarmament.He described how the new activism is now often single issue focused. In South Africa the PHM aims to build a broad based movement to identify and work with key health specific campaign issues as well as issues impacting on health, to provide a forum for networking and mobilising around key issues and to advocate for the Primary Health Care approach.

Soraya Elloker of the South African Municipal Workers Union and Trevor Ngwane of the Anti-Privatisation Forum South Africa outlined the challenges facing people in accessing essential services, Health Workers in the public health sector in South Africa are faced with many issues including neo-liberal capitalist policies, health budget cuts, inadequate measures to combat AIDS, restructuring of health services and its impact on service delivery, occupational health risk, poor consultation and negotiation with organised labour, international migration of health workers, lack of care for the carers, and the disunity of the working class. Civil society and labour movements are calling for 16% of the national budgets to be allocated to building a health care system that can provide for the needs of the poor. Civil society rejects privatization of the health system, including of basic services such as water, electricity, housing, education, transport and telecommunications. Governments should develop a human resources strategic plan that will work towards equitable staffing levels at PHC level.

Caroline Mubaira of the Community Working Group on Health presented the views of the CWGH on rights to health and to a people centered health system, co-authored with Itai Rusike, and Stewart Nyamuranga. The Community Working Group on Health (CWGH) is a network of Civic/ Community Based Organization (CBOs), founded in 1998 to collectively enhance community participation in health and create discussion fora between health service providers and communities. She noted that the CWGH believes that participation, not manipulation, in health systems is essential in building a People Centered Health System which is accessible, acceptable, affordable and friendly. This calls for features of transparency and accountability in the distribution of public funds on equitable and nonpartisan and nonracial grounds and a national health budget and health policy that has been developed through widespread consultation.

These introductory positions were debated in the meeting. It was felt that for civil society more focus needs to be given to the impact of the corporate sector and profit interests in health, particularly where this undermines public interests. We are not holding capital to account. Corporate level taxation is being reduced at a time when corporate profits are rising, so there is a need to focus on tax policies. The civil society co-operation in the region must address and go beyond health services and take up issues of education, housing, food security, access to safe water and other inputs to health, especially where these are being commercialized or privatised. Debate on the substantive areas should inform our regional people's charter for health. It should also inform our advocacy around policies like NEPAD, around trade agreements and around AU and SADC commitments. We also need to pursue a process that is inclusive and empowering. Internally within civil society we need to bring on board groups that often get marginalized, like rural women and youth. The strong civil society organisations need to be a focus for widening the collective strength of all groups. Work in testimonies, research and evidence can be used to feed into civil society education, so that we

build advocacy on key issues. We need to use common values and a common vision as a basis for our relationships with government and we need to build an informed and supportive state and media.

The workshop resolved to:
- *Build, support and inform a united and inclusive movement for health of trade unions and other organs of civil society across countries and regionally;*
- *Include health worker, traditional health sectors, rural and urban civil society and union organisations in the processes;*
- *Implement research, gathering of testimonials, exchange of experience and dialogue, analysis and debate to promotion of advocacy and engagement within trade unions and other organs of civil society for health; and*
- *Develop, inform and take action on a joint civil society platform on equity and social justice in food security.*

7. PLENARY 3: CHALLENGING INJUSTICE

The third plenary session was chaired by the Hon Blessing Chebundo, Parliament of Zimbabwe and TJ Ngulube of CHESSORE. This session focused on the issues and tools for challenging the injustices that undermine equity in health.

Globalisation, Trade and Health

Riaz Tayob, SEATINI and theme co-ordinator for EQUINET work on trade and health highlighted the joint features of deteriorating health indicators in Africa and increasing influence of multilateral organisations like the World Bank, International Monetary Fund and the World Trade Organisation in national systems. These included trade agreements like the 1995 WTO imposed TRIPs regulations, that impacted on countries' abilities to import patented medicines or GATS that deals with trade in services. When countries have resisted these policies and won space at multilateral forums like the round of negotiations in 2003 over TRIPS for Cancun, bilateral agreements and donor policies have reversed these gains.

There has been a massive commodification of health services. This has led to a much stronger commercial presence in health, which, combined with the imposition of limits on the ability of governments to regulate the private and public sectors due to the lock-in of liberalisation and privatisation policies, has undermined the public health movement. It has also led to significant resource outflows from the public to private sector. The new pressures to liberalise trade in health related services is a reflection of this. Market access and elimination of export credits has been made conditional upon services offers and tariff reduction and there are now a host of Regional Trade Agreements that include services such as the US–SACU Free Trade Area, the EU & ACP Countries Economic Partnership Agreements, and World Bank and IMF policies.

Global Trade and Health

How the Public Health Movement is Being Outflanked

This commodification, liberalisation and shrinking of national authority not only relates to health services but to the inputs for health. Agreements on agriculture allow countries to subsidise food production, but this generally favours Northern countries more than the South, and African countries are unable to get through the trade barriers created by the highly-subsidised US and European market. At the same time African countries are forced towards cash cropping instead of food production, undermining nutrition. As speculative wealth searches for good returns or safe havens, the commodification of health has become one way of assuring profit, leading to numerous mergers and acquisitions and giantism, such as in the pharmaceutical sector.

The response demands work that makes community input, public interests and social values as powerful as private sector interests and profits. We need to strengthen our monitoring of Regional Trade Arrangements to ensure that health and related insurance and distribution services are not included, that bilateral commitments do not undermine gains made at WTO, and that our national governments retain the policy flexibility of the State.

Civil Society's Struggle for Health in Africa

Mwajuma Masaigana of the Peoples Health Movement and EQUINET reinforced the message of the previous speaker, noting that neoliberal policies have influenced many states are currently reversing their policies on public service delivery undermining access to services and health care and deepening poverty. She further endorsed other issues raised earlier in the conference- that health is a fundamental right and that health services should be provided through public sector, comprehensive primary health care oriented approaches. For this she called for a coordinated health civil society movement for Health for All – nationally, regionally, globally with a shared vision and platform.

Civil society needs to protest against unhealthy and unaccountable finance institution policies and WTO trade agreements, oppose international conditions undermining sustainable health and development, resist imposition of the neoliberal

agenda and of instigated conflicts and wars. We need to offer an alternative agenda, beyond medical approaches, to better politics and pro-poor policies that protect rights. She called for. African countries to put more investment into research to control our own technologies for health, including vaccines and AIDS therapies.

She informed of the joint meeting hosted by EQUINET and PHM of civil society groups on equity and social justice in health in November 2003, that resolved to build a wider common affirmative vision and solidarity actions around this. From this Brigdet Lloyd of PHM South Africa then outlined the priorities defined in the workshop session at the conference (outlined earlier) to take this forward.

Using ICT for health equity: the EQUINET website

Firoze Manji, Fahamu UK and process co-ordinator in EQUINET for ICT informed delegates that the new EQUINET website (www.equinetafrica.org) was 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,
- explore the potentials of information and communication technology in promoting health equity.

He presented the resources available from the site, including databases on equity in health materials, and how to search and access the information. The searchable databases contain research reports, policy briefings, latest publications and an annotated bibliography organized into thematic sections. EQUINET News enables those denied access to the web to still receive content, to know what is being produced and to disseminate reports, debates and information on actions.

"Technology is not a thing; it is a manifestation of social relations and it reflects the balance of power between the rulers and the oppressed. It has the potential to oppress as well as being a tool for liberation - depending on who controls and uses it. Information is not neutral – it does not simply exist to be collected, but is constructed in ways that reveal the ideologies, intents, aspirations and values of those who conceptualise and construct it."

CNN, BBC World, SkyNews etc, all claim to disseminate "information", but in reality promote a particular world view - the imperial world view. Using news services like Pambazuka News and EQUINET News is an opportunity to legitmise an alternative world view and change the balance of power, which is necessary, but not sufficient to bring about social change and transformation. Any information process needs to be built on and used to support a programme of action based on achievable and focused objectives. EQUINET needs to define this programme.

8. SOCIAL AND CULTURAL EVENT

An evening event was held for people to meet, to meet and hear from the political leadership in health in the area and to experience some of the culture of Kwazulu Natal. Gabriel Mwaluko, EQUINETA Tanzania and EQUINET steering committee member hosted the event. He welcomed everyone and introduced the Honourable MEC for Health for Kwazulu Natal, Dr Zweli Mkhize.
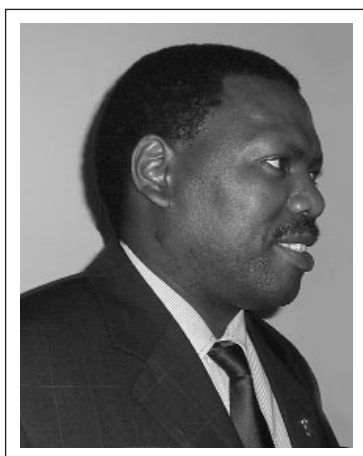
Dr Mkhize welcomed the conference delegates and thanked the conference organizers for inviting him to share ideas with conference. He recognized that the conference theme was a challenging one. He posed that since government is about power, the only chance of achieving health rights was through democracy. Health inequities in South Africa had, for example, arisen out of a context of general inequity arising from apartheid. The national government now sought to address these health inequalities, through its budget allocations, legislative framework, through the activities of different government departments, such as housing, water, environment and energy, and through investment in health care. In KwaZulu-Natal alternative cost-effective methods are being sought for health delivery and many primary health care clinics have been built recently. There is a process of gradually increasing primary health care budget allocations and reducing the amount spent on curative care, while at the same time maintaining a regulation of services. This effort towards equity has not been without challenge.

For example, a constitutional challenge was launched with regards to the government's allocation of resources to primary health care as opposed to curative care, when a patient needing dialysis was turned down for treatment. The constitutional court found that while the patient had a right to life, the state had to balance that right

with the need for appropriate resource allocation. He also noted that equity may not be achieved without suitable human resource strategies, and noted the loss of human resources to northern countries. He welcomed the contributions of community, NGOs, churches and traditional healers in ensuring equitable healthcare delivery. This needs to be underpinned by social and economic strategies impact on the health status of the poor. We need to a totality of strategies if we are to achieve equitable health care.

Professor Mwaluko thanked the Minister, noting that his input had deepened our understanding of the equity challenges in the host region of the conference. A group of local traditional healers performed a ritual to 'bless' the conference. A dance/drama group, iZingoma and Indlamu, performed dance and music from Kwazulu Natal.
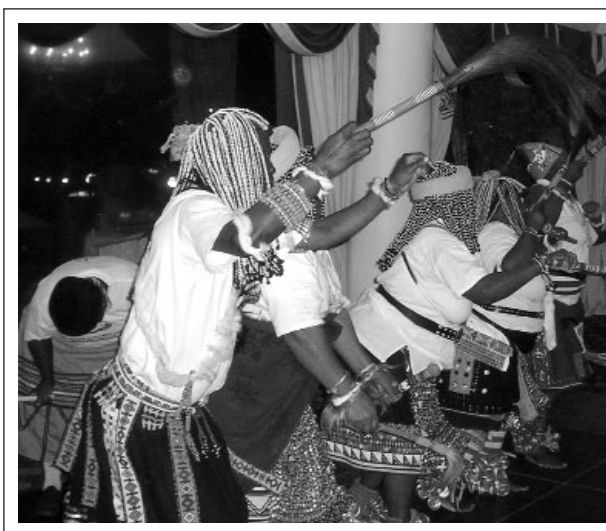
Following this an award was presented for the best student grant proposal on equity in health in the EQUINET student grant programme. Professor Mwaluko explained the importance EQUINET gives to supporting new health equity actors and students and thus has initiated a student grant programme based on a proposal for this first proposed by Adamson Muula, EQUINET steering committee member Malawi. The grants are given out in areas relating to health equity to students from all disciplines, on the basis of proposals submitted. Prof Mwaluko introduced Christina Zarowsky IDRC to present the award, noting the

huge support IDRC had given to EQUINET and health equity research.

The award was presented to Zindaba Rehema Yiwombe, a 22 year old final year Journalism student in the Department of Media Studies at the University of Malawi, The Polytechnic. Zindaba is attached to Malawi Health Equity Network (MHEN) as an assistant researcher to identify the household determinants of accessibility of insecticide-treated bed nets in Blantyre, Malawi. The study proposal for which she was granted the award aims to do a content analysis of the discussions on health that the Malawi National Assembly has had over the past ten years (1994 –2004). This is in view of the fact that Parliamentarians are increasingly being recognized as important target groups for public health advocates as the former occupy an important role in health policy formulation and acting as watch dogs. It is a known fact at least in my country that issues of health have reduced in importance. The degree of relegation is however not known. She hoped the study will assist to motivate parliamentarians to focus more on health equity in their debates.

"You will agree with me that in any relationship, among other means, love is affirmed through the number of times a simple "I love you" is mentioned in a particular period. This is no different from issues of health. It is yet to be established as to how often our Honorable Members of Parliament cover issues of health in the house and how much time is allocated for the same."

9. PLENARY 4: ORGANISING FOR HEALTH EQUITY AND SOCIAL JUSTICE

Anthony Zwi, University of New South Wales, Australia and Godfrey Musuka, Training and Research Support Centre, EQUINET Secretariat co-chaired the plenary session that reviewed the country challenges, capacities and work towards health equity and the regional mechanisms and resources available through EQUINET. In this session the draft resolutions drawing from all the workshop discussions were presented and debated, and the final resolutions developed for presentation in the closing session.

Zimbabwe

Itai Rusike CWGH outlined the equity priorities for Zimbabwe as improved budget allocations to health, access to health care and essential drugs, including ARVs, and good nutrition. He presented the various health equity activities taking place in Zimbabwe, linked to EQUINET and to other programmes. He noted that networking is essential to strengthen local, national, and regional awareness, voice, monitoring and policy engagement. In Zimbabwe work on equity is being used to build strong community voices and parliamentary links.

Swaziland

Zanele Mhlongo, Swaziland, noted that there is no health equity network in Swaziland and much work needs to be done to build such a network. She proposed that this called for a national steering committee, with a base for operations, a liaison officer and resources. Swaziland has high quality health practitioners and health training institutions, but salaries for healthcare workers are low and the brain drain is a problem, adding to the threat of HIV/AIDS to the health system of Swaziland.

Zambia

TJ Ngulube CHESSORE noted the high importance given to health in Zambia, particularly given the impact of HIV/AIDS. Through EQUINET, GEGA and other networks work is taking place in Zambia on governance in health and with parliament and media. , He noted that they needed greater and more innovative advocacy, including the creation and exchange of information for equity, to improve networking. EQUINET has an ongoing role to play in co-ordinating and promoting dialogue and consensus, interacting with global stakeholders and providing intra-country, regional and sub-regional support via its networks.

South Africa

Lucy Gilson Centre for Health Policy noted that South Africa needs to develop a vision of health systems, with government capacity to roll-out ARVs, and with problems of resourcing in the health system allocation. There is significant work in South Africa on health equity, on resource allocation, on human rights, on treatment access, on human resources for health and on essential services. There are also two equity gauges. While there is much informal interaction, she noted that there was a challenge to strengthen links and broaden the debate at a national level and use this to encourage and support government in promoting equity across different dimensions of the health system.

Malawi

Adamson Muula of the Malawi Health Equity Network noted that in Malawi the priorities are to build human resources that are able to tackle issues like HIV/AIDS with particular emphasis on ART rollout; to be more involved in the budget process and to build parliamentary alliances. The Malawi Health Equity Network is functioning and has useful partners in the National Assembly, the EquiTB network and the National AIDS commission. However, there inadequate skills and resources undermines the demand to create a critical mass of equity players, to strengthen linkages nationally and to move from national level into communities.

Tanzania

Gabriel Mwaluko, CEPHAD and EQUINETA echoed the priority challenges of other countries, including the shortage of healthworkers, equitable ARV rollout using lessons learned from PHC and TB programmes. Tanzania has formed a country health equity network (EQUINETA) and is currently documenting on-going ARV best practices and disseminating the findings in order to influence policy, participating in the revision/updating of the current ARV guidelines and proactively supporting dissemination,

analyzing the human resources for health in the country, sensitizing policy makers on the issue of generic versus brand ARVs and opening the debate on the equity issue of ARV access and focus on rural versus urban areas, rich versus poor. EQUINETA now seeks to identify comparative advantages amongst its members to carry out specific activities in line with a country plan of action, ensuring a harmonisation with the work being done regionally. EQUINET needs to mobilise resources to develop this work further.

Democratic Republic of Congo

Theresa Kabale, DRC, noted the challenges of equity in access to ARVs in DRC, through the standards, the criteria for eligibility, the availability of health personnel, the provision of follow up and the mobilisation of community support. National level work to put in place an effective drug distribution and health delivery system needed to be supported by regional assessment of drug resistance and sharing of good practice. EQUINET has a role to play in this dissemination and in capacity building.

Namibia

William Kapenambili, Ministry of Health Namibia noted the need in Namibia to generate evidence to evaluate health-related policies in terms of their equity implications, develop needs-based resource allocation formula and assess the efficiency and equity implications of the current user fee scheme. We are currently busy with an equity study, a hospital costing study and a National Health Accounts survey. Networking in Namibia is still at the conceptual stage and there is no organized equity network at this stage. Therefore we need to identify research projects and share experiences and evidence. This calls for financial support from EQUINET to strengthen our country team and to develop capacity building on equity research.

EQUINET as a vehicle for health equity and social justice

Rene Loewenson TARSC and TJ Ngulube CHESSORE presented an overview of EQUINETs organisation, mechanisms and resources on behalf of the EQUINET Steering Committee. EQUINET aims to promote and realize shared values of equity and social justice in health. As a network formed by professionals, civil society members, policy makers, state officials and others within the region, EQUINET works through existing institutions in southern and east Africa. EQUINET supports the building of a perspective and knowledge on equity in the priority theme areas reported at the conference. It does this through the provision of research grants and studies, including multi-country studies, of training, skills development and mentoring, of publications, through meetings and forums for dialogue, and through its newsletter and website. EQUINET supports equity actors and equity oriented social action, and their networking through information tools, issue forums, exchange visits, country level equity networks and alliances with parliaments and civil society. The evidence produced is used for policy engagement, to support SADC policies, to promote good practice and build skills.

Through the country networks, we support country actors and keep them informed of regional processes, opportunities and work. The organizational structure of EQUINET reflects these areas of work, in themes, processes and at country level, with co-ordinating institutions in each who participate in the governance mechanism of EQUINET, the steering committee and who direct its work. The programme defined by the steering committee is implemented by the secretariat, who do this through supporting, resourcing and networking the institutional co-ordinators. It is an open and flexible structure and has grown and changed as the work being done and the institutions co-ordinating the work have changed.

EQUINET provides opportunities for fellowship with likeminded reseachers/professionals /activists, etc. It broadens understanding, analysis of and perspective in equity issues and supports skills building. Work on equity in health accesses resources (funds, mentoring, materials) from EQUINET, and it builds links for with other programmes, and between research, policy and practice. The steering committee noted the current challenges to build a strong, effective, network, to support equity analysis and work, build regional

EQUINET Organisation

STEERING COMMITTEE → SADC

STEERING COMMITTEE → SECRETARIAT

STEERING COMMITTEE → COUNTRY CO-ORDINATORS, THEME CO-ORDINATORS, PROCESS CO-ORDINATORS

COUNTRY CO-ORDINATORS, THEME CO-ORDINATORS, PROCESS CO-ORDINATORS → NETWORK MEMBERS

STEERING COMMITTEE → CO-OPERATING INSTITUTIONS
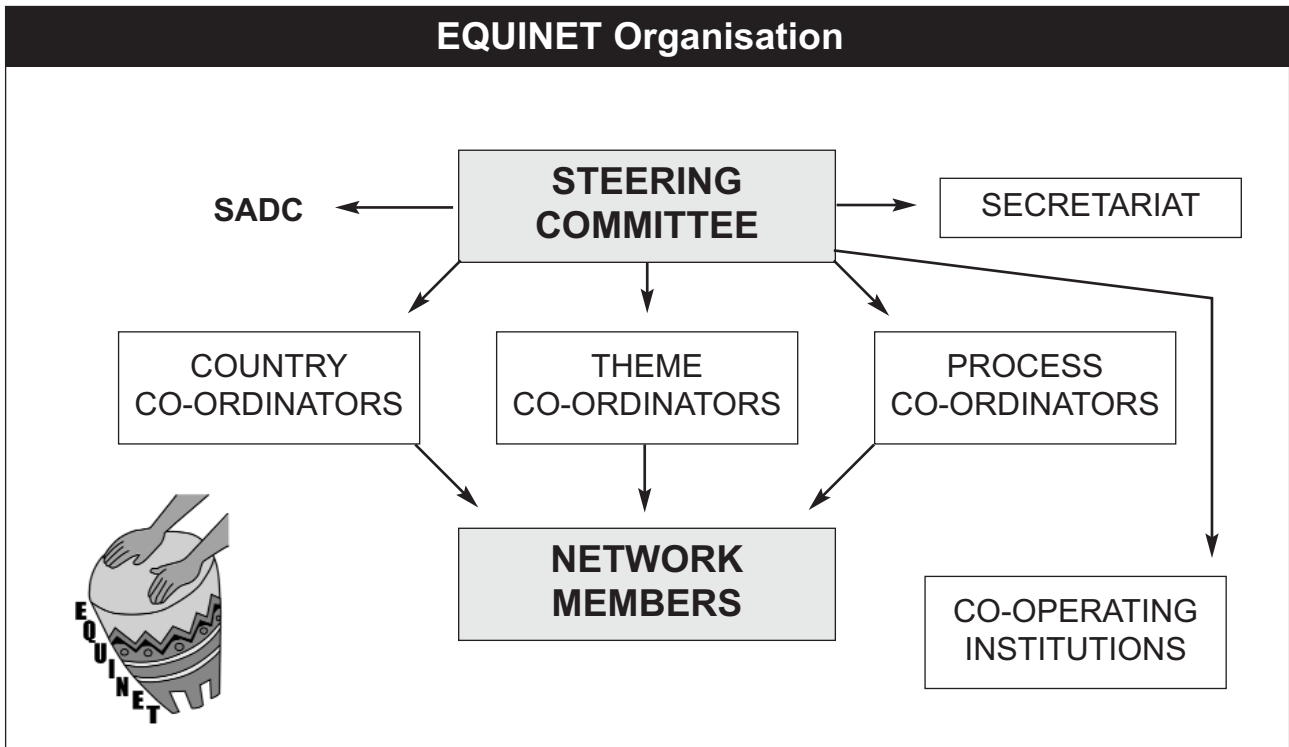
action, enhance transparency and communication and improve on efforts to provide fair and flexible governance of the network. As a network, the steering committee called for strengthened policy engagement through cooperation with governments and SADC and improved

partnerships and alliances. The conference had demonstrated the significant community of equity actors and we need to think about how we can we strengthen and sustain this, and support an action programme that strengthens our local action and our southern voice in global engagement.

10. Plenary 5: Closing session

David Mametja, director of Health Systems Trust and Rene Loewenson, EQUINET co-chaired the closing session. David Mametja commended the conference on an intensive two days of deliberations and on reaching a constructive and inspiring outcome. He thanked EQUINET for facilitating this. Dr Loewenson gave thanks on behalf of the steering committee to all those who had contributed in many ways to the conference, the South African government and institutional hosts, including HST, the EQUINET secretariat at TARSC, particularly Godfrey Musuka, Mevice Makandwa and Rebecca Pointer, the local

conference organizers PPR, the rapporteurs, the hotel, the delegates, the organisations who partnered with EQUINET in the conference workshops (GEGA, PHM) and the conference sponsors, Rockefeller, SIDA, Dag Hammerskold and IDRC. She thanked SADC for the constructive and positive co-operation towards a mutually shared goal.

The conference resolutions, which were debated by the delegates were read out and adopted by the conference. They are overleaf.

Southern African Regional Network on Equity in Health (EQUINET)

Reclaiming the State:
Advancing Peoples Health, challenging Injustice
RESOLUTIONS

Noting:

- The 1997 Kasane meeting on Equity in Health that confirmed the commitment to equity in health at all levels in southern Africa; the 1999 Southern African Development Community (SADC) Protocol on Health, the 2003 Maseru Declaration on HIV and AIDS and the resolutions of the SADC Heads of States Summit on food security held in Tanzania, 2004;

- The formation of EQUINET and our work since 1998 in support of these commitments, to strengthen the understanding of, the evidence for, advocacy of and implementation of this policy commitment to equity and social justice;

- Our conception of equity and social justice in health, which aims to address unfair differences in health and in access to health care through the redistribution of the societal resources for health, including the power to claim and the capabilities to use these resources;

- The widening constituency we are building for equity and social justice in health amongst governments, parliamentarians, health professionals, trade unions and other organs of civil society, researchers and communities at national and regional level;

- The challenges posed by neoliberal globalisation to our values of equity and social justice, to government ability and flexibility to implement the public policies that we choose and to the public sector health and essential services and that are critical for our health.

The June 2004 EQUINET conference in Durban South Africa affirmed that we stand for:

- Equity and social justice in health;
- Public interests over commercial interests in health;
- International and global relations that promote equity, social justice, people's health and public interests;
- Increased unconditional resource flows from the North and fairer terms of trade;

- Reduction and where possible restitution of flows of resources from South to North;
- A conception of human rights that affirms the agency of communities in claiming social and economic entitlements, the primacy of vulnerable groups and that captures African traditions of communitarianism;
- Equitable health systems that provide healthcare for all and redistribute and direct resources towards those with greatest needs;
- Rising investments in the state and public sector in health;
- Health (care) systems which promote collective, population oriented strategies for health and comprehensive primary health care;
- Trade and agricultural policies that ensure food sovereignty and household food security through land redistribution and investment in small holder farming in ways that promote gender equity and sustainable food production;
- At least 15% of government budgets invested in the public health sector, as committed in Abuja, together with debt cancellation;
- Progressive tax-based funding of health systems;
- Fair financing for health, in which the rich contribute a greater share of their income to health than the poor, with strengthened cross subsidies for solidarity and risk pooling;
- Equitable and affordable access to generic drugs, with application of essential drug policies across all health providers;
- Ethical and equitable human resource policies at national, regional and international level, backed by compensation for regressive south-north subsidies incurred through health personnel migration;
- Equitable public health and multisectoral responses to HIV and AIDS for prevention and health promotion, treatment and care and to mitigate the impact of the epidemic, particularly within and for young people and vulnerable groups;
- The expansion of access to anti-retroviral therapy for people living with AIDS in Southern Africa as an urgent priority, through funding and approaches that strengthen, and

do not compromise, our public health services and systems;

- Democratic and accountable states, with full authority to exercise policy measures necessary to protect the health of people;
- Powerful and effective participatory and representative mechanisms at all levels of our health and social sectors and in the state more generally;
- Effective and accountable mechanisms for public and stakeholder contribution to decision making in health;
- Regional integration and co-operation within Africa to strengthen democratic states, advance the health of people and challenge injustices to health;
- Values based leadership across organisations working to promote equity in health.

The conference set out a programme of work and action for EQUINET and its partners to implement these goals.

In the key areas of work the priority actions were defined as below:

ACTION PROGRAMME: Towards achievement of these goals, EQUINET will:

Globalisation
- Continue to strengthen formal and working links with SADC and its organs and with institutions in southern and east Africa and more generally that share the values of equity and social justice;
- Organise, inform and lobby parliaments, governments and civil society to resist global trade measures and national policies that are harmful to public interests in health;
- Protect our governmental authority to safeguard people's health and equitable health systems and monitor the public health implications of trade agreements;
- Support debate, analysis and sharing of experience on alternatives to the current neoliberal forms of globalisation.

Human rights for health
- Promote health as a human right.
- Carry out action-oriented research and promote public awareness and action to advance rights, particularly social and economic rights;
- Use human rights as an entry point to build a

shared set of values between communities and health care workers through dialogue on key equity issues;
- Use a human rights framework to monitor and challenge policies that are in conflict with health equity and social justice;
- Develop new methods to operationalise the fulfilment of social and economic rights and the right to health in the region.

Food security
- Build an integrated programme of research, policy analysis, monitoring, advocacy and programme support around the national and global determinants of equity in food security and nutrition;
- Strengthen regional food security monitoring, backed by research, training and social welfare security systems that supports household and national food security;
- Enhance advocacy around food security, in particular covering issues of access to land and inputs, food production and gender equity.

HIV/AIDS
- Challenge international and national measures, macroeconomic prescriptions and financing approaches and programmes that undermine sustainable and equitable health systems approaches to HIV and AIDS;
- Provide evidence for and support development of proposals that deliver comprehensive HIV/AIDS programmes and the expansion of equitable ART access through strengthened health systems;
- Monitor and promote good practice in equitable ART expansion.

Health systems
- Provide evidence, strengthen analysis, build public awareness and promote policy on equitable health systems, on strengthened investment in public sector health services and in support of primary health care and district health systems;
- Identify effective approaches to regulate the commercial health sector and to resist and reverse health service liberalisation;
- Resist the encroachment of GATS on the authority of government to regulate the commercial health sector.

Fair financing of health systems

- Monitor our performance in meeting the Abuja commitment of 15% government spending to health, accompanied by advocacy for debt cancellation;
- Propose and support implementation of mechanisms for cross subsidies in health financing and for equitable resource allocation within the public health sector;
- Lobby for debt cancellation, for progressive, tax-based financing for health systems, for the removal of user fees at primary care level and for financing of community activities in health;
- Promote caution in the implementation of pre-payment mechanisms;
- Propose and support equity oriented legislation and its implementation in the private for profit health sector;
- Do more and better research on financing issues to build a stronger evidence base and propose alternatives for fair financing of health;
- Reallocate available resources to strengthen preventive and promotive care and those services which focus on addressing the determinants of health.
- Work with not for profit providers where these serve public health goals

Human resources for health

- Support the development and field testing of mechanisms that will optimize and manage HR flows towards greater equity in the region;
- Support local parliaments, NGOs and government negotiators to focus attention on reducing the push factors and enhancing salaries and conditions of work for health workers in the region;
- Develop regional skills and good practice in health workforce planning, training and management practices;
- Lobby international development banks and multilateral, and bilateral agencies to lift limits to increases in health worker salaries and conditions;
- Challenge wealthy countries to counter their human resource failures leading to the pull of health workers from Africa;
- Formulate frameworks through which the real costs of health professional migration from developing countries can be identified and addressed;
- Support health worker campaigns for a living wage.

Community voice and parliamentary representation

- Develop training and promote good practice in mechanisms for community voice and agency in health systems, from primary health care to global level;
- Provide evidence, analysis and activities that support parliaments to analyse and monitor public expenditure, to promote equitable health policies and to monitor the performance of health services.

Civil society alliances

- Build, support and inform a civil society movement for health that is united by a common vision and values across countries and regionally;
- Ensure that civil society processes include trade unions, health workers, traditional health sectors, rural and urban civil society, women and youth;
- Implement processes of research, gathering of testimonies, exchange of experience and dialogue, analysis and debate to promotion of advocacy and engagement within civil society for health;
- Develop, inform and take action on a joint civil society platform on equity and social justice in food security.

ICT

- Promote and develop innovative communication technologies and tools which support health equity through raising awareness, disseminating information and raising debate on health equity issues;
- Use existing tools more strategically to support our goals and work, especially for scientific debate, lobbying and mobilization and sensitisation locally and globally, and for capacity building;
- Evaluate the appropriateness and impact of different ICTs for interventions such as trade negotiations, health systems support, SADC meetings, policy forums, petitioning and advocacy.

Closing Remarks

Dr Erika Malekia from the SADC Secretariat gave the closing remarks. Her full paper is available on the EQUINET website at **_www.equinetafrica.org._** She conveyed SADC's gratitude to EQUINET for the invitation and opportunity to close the conference, and for EQUINET's continued research and promotion of the health issues of the SADC region.

"EQUINET has been a major partner to the sustainable development efforts for SADC in the health sector."

She thanked the South Africa Government , particularly the Department of Health for hosting the conference in their country, and the delegates, funders and many others who contributed.

The SADC countries with a combined population of only 3.5% of the world's population (approximately 207 million people) account for 35% of people living with HIV/AIDS and about a half of all infections in Africa, with an average adult HIV prevalence of 13.7%, compared to 9% for sub Saharan Africa as a whole. Close to 10 million people are estimated to have died of HIV/AIDS related diseases in the region, with over 1 million HIV/AIDS deaths in 2001. Currently, only 300,000 people infected by HIV in developing world have access to ARVs. In Africa's worst hit countries, HIV has already reduced GDP by 1 % and studies forecast that by 2015 the economies of such countries would grow by 2.5% and 1.1% points less because of the epidemic.

At the Southern Africa level, the breath and depth of poverty leaves governments and societies with difficult resource allocation decisions regarding treatment and care in the Region. Although many SADC countries have good policies, equity remains a distant ideal. Health Sector responses to AIDS, to food crises and to poverty are delivered in a resource poor setting with a weak health staff leading to incapacity to deliver the Essential Health Package for all.

She noted that the SADC Heads of State and Government have identified food security, AIDS and poverty as the most urgent priorities for the region. In response, in 1997, the SADC Summit approved the SADC Policy on Health which seeks

"to attain an acceptable standard of health for all citizens by promoting, coordinating and supporting the individual and collective efforts of Member States." She outlined the steps that have since been taken towards this, including the development of a Strategic Framework and Program of Action. The overall objective of the SADC programs is to decrease the numbers of suffering individuals and families in the SADC region, to ensure equitable public health and well-being and sustained socio-economic development of member states. The programmes to achieve this are based on principles of multi-sectoralism, of subsidiarity , of prioritisation to concentrate the response on those issues that are crucial for overall success of the region, of gender mainstreaming and of human rights. She urged member states and stakeholders to strengthen prevention strategies and to mobilize communities and sectors towards this. In this light she noted that it is important that we take serious measures in implementing the recommendations and output of the conference objectives.

"President Mkapa the current chair of SADC Region said that: "it is a matter of life and death and no weapons in the cultural and scientific arsenal should be off limits.
And certainly, no concern for intellectual property protection should supercede our people's very basic right to life. The Chair urges SADC member states to make regional cooperation and integration a tool for development that benefits all member countries".

She noted that while the challenges were substantial, they were not insurmountable. There are already rays of hope in the region. With these words she declared the conference closed.

APPENDIX 1

TITLE	FIRST NAME	LAST NAME	ORGANISATION	COUNTRY	ADDRESS
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APPENDIX 2 PROGRAMME

Tuesday 8 June 2004	
Time 0830-1000 Coral 1&2 OP	**Opening Plenary: Reclaiming the state: Advancing peoples Health, Challenging Injustice** Chair: B Kistnasamy, Nelson Mandela Medical School, F Manji Fahamu Key note paper: *A Olukoshi Exec director CODESRIA* EQUINET steering committee paper: *R Loewenson EQUINET/TARSC* Discussion
1000-1030 Hotel Foyer	Tea, coffee
1030-1230 Coral 1&2 P1	**Plenary 1: Advancing peoples health** Chair: M Samb IDRC, L Gilson CHP Health rights as a tool for health equity: *L London UCT, EQUINET theme co-ordinator* Food security and nutrition *M Chopra, D Sanders UWC* *E Malekia, SADC, M Materu COUNSENUTH* Challenges of HIV/AIDS and health systems responses *D McCoy EQUINET/HST* *O Kabale DRC PATAM* Discussion
1230-1330 7 Palms restaurant	Lunch, poster viewing
1330-1530 PW1-4	**Parallel workshops**

1:Health rights as a tool for health equity *L London* Coral 1	2:Health systems approaches to HIV/AIDS *D McCoy* Bahama 1	3:Parliamentary Alliances for equity in health *A Muula, L Bambas* Panorama 1	4:Using ICT as a tool for Equity and social justice *F Manji, T Kureya* Bahama 2

1530-1545 Foyers	Tea/coffee
1545-1730 Coral 1&2 P2	**Plenary 2: Reclaiming the state** Chair: E Malekia SADC, A Muula MHEN Parliamentary Alliances for health equity *S Sikota Parliament of Zambia* Fair financing in health systems *D McIntyre, L Gilson, UCT&CHP EQUINET theme co-ordinator* Confronting challenges in health personnel *A Ntuli HST EQUINET theme co-ordinator* Governance, equity and health *TJ Ngulube CHESSORE, EQUINET GoVERN theme co-ordinator* Discussion
1830-2000 Panorama	Reception Drama: iZingoma and Indlamu MC: G Mwaluko, EQUINET steering committee Speakers: Hon Zweli Mkhize, MEC for Health, KwaZulu-Natal Student research grant award presentation: C Zarowsky, IDRC

Wednesday 9 June 2004				
Time 0800-0830	Poster viewing			
0830-1030 PW5-8	Parallel workshops 5:Confronting challenges in Health personnel *A Ntuli* Coral 1	6:Fair financing in health systems *D McIntyre,* *L Gilson* Bahama 1	7:Community voice and agency in health systems *TJ Ngulube* Panorama 1	8:Civil society alliances for equity in health Bahama 2
1030-1100 Foyers	Tea,coffee			

1100-1230
P3
Coral 1&2
	Plenary 3: Challenging Injustice
	Chair: B Chebundo, Parliament of Zimbabwe D McIntyre UCT
	Globalisation, Trade and Health
	          R Tayob SEATINI EQUINET theme co-ordinator
	Civil society struggles for health
	       M Masaiganah PHM/EQUINET and Workshop rapporteur
	Using ICT for health equity: the EQUINET website
	        Manji, Fahamu EQUINET process co-ordinator
	Discussion			

1230-1330 7 Palms restaurant	Lunch			
1330-1400 Bahama 2	Poster viewing Rapporteurs drafting session			

1400-1545
P4
Coral 1&2
	Plenary 4: Organising for health equity and social justice
	Chair: A Zwi UNSW/EQUINET, G Musuka TARSC/EQUINET
	Country reports (5 minute reports x 9)
	         EQUINET country focal points and others
	Discussion of conference resolutions: policies and actions
	         Representative of the drafting team
	EQUINET as a vehicle for health equity and social justice
	         EQUINET SC and secretariat
	Discussion			

1545-1600 Foyer	Tea,coffee			

1600-1645
P5
Coral 1&2
	Plenary 5: Reclaiming the state: Advancing peoples Health challenging Injustice
	Chair: D Mametja HST, R Loewenson TARSC/EQUINET
	Adoption of conference resolutions
	         Representative of the conference
	Closing paper
	         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;
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