

**Report of the Equinet  
Workshop and Inputs to  
the Second Conference of the International  
Society for Equity in Health (ISEqH)**



Toronto, 14 –16 June 2002

In collaboration with IDRC (Canada)

Report produced by  
Regional Network for Equity in Health in Southern Africa  
(EQUINET)  
and Training and Research Support Centre (TARSC)

TARSC/EQUINET 4/2002

**REPORT OF THE EQUINET WORKSHOP AND  
PRESENTATIONS AT THE  
SECOND CONFERENCE OF THE INTERNATIONAL SOCIETY  
FOR EQUITY IN HEALTH  
June 2002**

**TABLE OF CONTENTS**

1. **INTRODUCTION** page 2
2. **EQUINET WORKSHOP AND PRESENTATIONS** page 3
  - 2.1 Shared time with a NEPAD/G8 report card page 3
  - 2.2 Challenges to Equity in Health in southern Africa page 3
  - 2.3 Geographical analyses and health system equity page 4
  - 2.4 Community control in health: The work of the Governance and Equity Research Network (GOVERN) in EQUINET page 5
  - 2.5 Building a rights driven movement for equity in health page 7
  - 2.6 Health service issues in equity in health page 8
  - 2.7 Equinet mission and work page 10
3. **DISCUSSION** page 11
4. **Appendix A:** page 12  
**Equinet Steering Committee and ISEQH delegates**

**Report of the Equinet Workshop.  
At the Second Conference of the International Society for  
Equity in Health (ISEQH)  
June 2002**

## **1. Introduction**

ISEqH was formed to promote equity in health and health services internationally through research, education, publication, and communication. Its specific objectives are to facilitate scientific interchange of conceptual and methodological knowledge on issues related to equity in health and health services; to advance research related to equity in health; to provide a forum for those interested in contributing knowledge to further the cause of equity in health; and to maintain relationships with other international and regional organizations devoted to achieving equity in health.

The theme for this years gathering was **Equity: Research in the Service of Policy and Advocacy for Health and Health Services**. Equinet along with representatives from other organisations around the world was invited to share its expertise and experience within an international cross-disciplinary forum. The network was given a workshop slot for this purpose, involving the members shown below.

### **Workshop 10 Southern perspectives on equity in health**

- Professor Lucy Gilson, Centre for Health Policy, South African Institute for Medical Research, Johannesburg.
- Prof. Diane McIntyre, Health Economics Unit Department, Public Health and Primary Health Care University of Cape Town
- Itai Rusike, Community Working Group on Health
- Dr Firoze Manji, Oxford Learning Space
- Thumida Maistry, Regional Co-ordinator - Equinet, Southern Africa
- Dr Godfrey Swai, Tanzania Public Health Association
- Dr TJ Ngulube, Centre for Health, Science and Social Research, Zambia

The focus of this workshop will be on the equity issues that concern us in the south, covering the disproportionate emphasis on vertical equity, the dimensions of inequity: in health, in health care and the policy responses to these. We will also explore how change in participation, rights and power need to be built into health-equity approaches, implications of a rights based perspective for equity issues. We will discuss the role of Equinet, looking at regional responses to issue of equity - specifically activities and program of Equinet in this regard i.e. research and advocacy

Prior to the workshop, the conference agenda included concurrent sessions on policy, pathways, evaluation and methods. It provided a strong slant towards methodology and evidence of inequities at intra country level. Some issues more

relevant to the realities faced by people working on Equity in Southern Africa were not highly profiled, such as HIV/AIDS, community roles, global inequalities and the link between technical work and the wider call for social justice.

During the general assembly as a call for ISEqH to recognise and take on board a wider call for social justice that would see its role extended to include some advocacy.

## 2. Equinet workshop and presentations

### 2.1 Shared time with a NEPAD/G8 report card

Equinet shared its time slot with a workshop on NEPAD where a report card on the G8. Health and Development commitments and the New Plan for African Development (NEPAD) was presented by Ronald Labonte and David Sanders of the University of the Western Cape. The presentation outlined the G8 commitments, the potential of NEPAD to address specific health inequities, and the investment issues that would need to be addressed to deal with such inequities. The authors noted that “Without challenging the causes of poverty and inequity and without addressing the functioning of health systems, NEPAD’s health project is unlikely to achieve its goals.” They called for more investment in health and health related sectors for infrastructure and recurrent expenditure to enable retention strategies, training, support and supervision of personell. It was noted that each year Africa subsidises \$500 m of training for health personnel for rich countries in response to the climate in free trade of health professionals. The Equinet workshop as compressed and not all the information prepared could be presented so this report provides both the full papers prepared for the meeting and the discussions that took place.

### 2.2 Challenges to Equity in Health in southern Africa

Lucy Gilson, CHP, had in the earlier sessions of the conference outlined the problems of equity in health in southern in terms of rich – poor health inequalities:

<b>Dimensions of inequity</b>						
<b>Country</b>	<b>HDI</b>	<b>HPI</b>	<b>Gender related Dev Index</b>	<b>Adult Literacy</b>	<b>% without access to safe water</b>	<b>% without access to sanitation</b>
<b>Medium Human Development</b>						
South Africa	0.695	19.1	0.689	84.0%	13	13
Swaziland	0.644	27.6	0.636	77.5 %	50	41
Botswana	0.609	27.9	0.606	74.4%	10	45
<b>Low Human Development</b>						
Zambia	0.431	38.4	0.425	75.1%	62	29
Tanzania	0.421	29.8	0.418	71.6%	34	14
Mozambique	0.341	49.5	0.326	40.5%	37	46

She noted

- Within country inequalities and inequities between population groups
- Extent of poverty

- Between country inequalities
- A focus on vertical equity: preferential allocation of resources towards those with greatest need
- That health is a function of political, social and economic opportunity, not only health care

By the late 1990s, the fifth of the world's population in high income countries had:  
 –86% of World's GDP (bottom fifth had 1%)  
 –82% of world's export markets (bottom fifth had 1%)  
 –68% of world's foreign direct investment (bottom fifth had 1%)  
 –74% of world's telephone lines (bottom fifth had 1.5%)

The Range of determinants of health requires range of policy responses:

- In the Social sectors (not only health services)
- Through Macro-economic policies – increased engagement by health professionals:
- Through dealing with the Debt burden
- Through Economic + human development (policies on labour, land, credit access etc.)

In the Social sectors, relatively more emphasis has been placed on improving health of worst-off, through identifying the most disadvantaged (in context of poor data), factoring in socio-economic / deprivation indicators, eliciting community views and community preferences for use of resources in the context of the PHC approach

## 2.3 Geographical analyses and health system equity

**Di McIntyre, Health Economics Unit, University of Cape Town** noted that there are two forms of intra-country geographic analyses that have shown promise in exploring health system equity issues within the South African context, that are likely to have relevance for other low- and middle-income countries (LMICs). The first is that of small area analyses of the distribution of deprivation, ill-health and health services. The main purpose of the small area analyses conducted in South Africa was to draw attention to areas with high levels of deprivation, poor health status and limited public sector health care provision in order that these areas can receive greater priority in resource allocation decisions.

Deprivation is a particularly useful concept to use in such analyses as it focuses on a wide range of human capabilities rather than simply income insufficiency. There is a strong relationship between deprivation and ill-health. Given that many LMICs have inadequate morbidity, let alone mortality, data, the distribution of deprivation within a country will provide insights into the likely distribution of ill-health. As small areas contain relatively homogenous populations, the potential pitfall of regarding health system inequities as a simple rural-urban divide is avoided. Instead, one is able to identify pockets of extreme deprivation within large urban areas, which generally have low average levels of deprivation.

Small area analyses are not only useful in informing and monitoring resource allocation policies, they also provide a basis for deeper consideration of factors influencing equity in health outcomes. For example, more detailed research can be undertaken in areas that have similar levels of deprivation and health service access but substantial differences in health status. Identifying the factors mediating the potential impact of deprivation on health status, including the nature and extent of

social capital within communities as well as areal influences, are of value in informing future health policy directions.

The second type of analyses focuses on the implications of fiscal federalism for health system equity. A growing number of LMICs are choosing the route of devolution in health system organisation, i.e. decentralisation of health (and usually other social) service responsibilities to a regional/local government level. This is associated with the introduction of fiscal federalism, i.e. granting decision-making autonomy about resource allocation and use to the lower level. The introduction of fiscal federalism in South Africa in 1997 resulted in a concerning trend towards greater disparities in public sector health care spending between provinces. There are three key areas of research arising from these concerns.

Firstly, health researchers and policy-makers need to investigate the mechanisms used by national treasuries in determining the allocation of general-purpose grants to individual provincial or local governments. The extent to which general-purpose grants are equitably allocated has a significant impact on geographic equity in health care resources. Ultimately, this requires that health researchers and decision-makers engage in debates about the prevailing macro-economic policy, as this frequently underlies the construction of the resource allocation mechanism.

A second area for research relates to understanding better the political process of determining inter-sectoral allocations at provincial or local government level. The relationship between provincial or local government treasuries and social service departments, and the process of deciding on inter-sectoral priorities by local politicians, are of particular importance. An understanding of health determinants in different contexts is also critical in informing these local level debates to ensure that a simple 'more money for health services' argument is not adopted.

Finally, researchers should explore alternative ways of promoting health and health system equity within a fiscal federal context. Based on the insights gained in the first two research areas, one can consider policy strategies for overcoming some of challenges posed to equity by fiscal federalism.

Di McIntyre's input demonstrated positive actions pursued by Equinet to support and engage opportunities for addressing health inequities.

## **2.4 Community control in health: The work of the Governance and Equity Research Network (GOVERN) in EQUINET**

**I Rusike Community Working Group on Health Zimbabwe** presented a paper co-authored with , **Rene Loewenson, Training and Research Support Centre** on the work done by Equinet in Governance in Health.

The presentations so far indicate that equity in health is a long stated policy goal in southern Africa, and some significant advances were made, many through joint and complimentary action between the public health sector and communities.

However, the health and health care gap between communities is still wide or widening, with differences based on gender, geographical area, income, access to public or private services, education and other factors. More recently the combined impact of AIDS, structural adjustment, and real reductions in the health budget and in household incomes, has reversed many health gains. The quality of health care has, and health workers and their clients have become demoralised.

While these issues demand technical responses, it is our argument that reversing inequities depends in the main on social and political factors. This goes beyond the fact that social networking is important for service outreach and health seeking behaviour, and that social exclusion as a dimension of deprivation or poverty affects health outcomes. What we would argue is that unless the people affected by ill health have greater control over the resources needed for health care or to be healthy, then equity goals will remain a dream. Equity without this socio-political dimension is not equity.

What is the level of community control in health and health care? From work we have done to date we have found that participation of communities is higher in implementing actions than in decision making, and health services are still weakly responsive to community inputs. In part this is due to the lack of a sustained institutional framework for participation and inadequate investment in the capacities and systems needed to support it. Unfortunately as public health systems have themselves become weaker this too has undermined the possibility for meaningful participation. Declining primary health care, falling access to primary care services might generate more demand, but weakens the voice needed to direct resources towards these levels and to underserved communities. Individual fee charging approaches are also less effective in building collective participation than collective financing approaches, like taxes, insurance or even community pre-payment schemes managed at local level.

Local communities have little control over budgets and planning, and decision making in health makes relatively weak and unsystematic use of local evidence, especially evidence on community preferences and priorities. Health workers often lack the communication, management, negotiation, facilitation skills to support participatory mechanisms.

This situation is one of the motivations for my own organisation, the Community Working Group on Health, which covers 28 national civic organisations in Zimbabwe. We formed a network to add weight to our input into health policy negotiations and maximise the effect of our joint actions in the health sector. Since 1998 we have carried out various actions to give voice to community health demands, lobby, discuss and liaise with health providers, parliament and local government and make public policy more accountable to communities and build community action in health. We have promoted civil society as a key player in health, with a regular presence in the deliberations of the parliamentary committee on health, invited input to the health budget, participation in new health policies and increased attention given to issues raised through the civics, like primary health care, the role of village health workers, accountability in public health funds and so on. We have begun work to set up or revitalise health centre committees to ensure that communities have a say in planning and management of their health services and to ensure civic participation in district and national decision making structures.

The question we face, and that has now been posed by EQUINET more widely is, **“Does participation by communities make any difference to the allocation of resources to and responsiveness of services to community priorities?”**

We are seeking to answer this in Zimbabwe by investigating whether community mechanisms health centre committees make any difference to equity in resource allocation to health centre and community level and to health system performance (availability of drugs, staff and inclusion of community priorities).

More widely, EQUINET has set up a Governance and Equity Research Network (GovERN) co-ordinated through TARSC (Zimbabwe) and Chessore (Zambia) that

aims to assess the impact of participation in governance mechanisms for health on resource mobilisation, integration of community preferences in health planning and equitable resource allocation. The research will be used to identify common positive features of governance systems that enhance participation, effective tools for integrating community evidence and preferences into health planning, and assess their impact on resource flows within the health sector and communities towards public health priorities.

While we are doing work in Zimbabwe, parallel work is also taking place in **Mozambique** to assess the community based 'council of community leaders' for their representation of vulnerable groups / communities, their role in the management of community health resources and their role in the management, mobilisation and allocation of health resources. In **Zambia** one group are examining the effectiveness of the district Health Boards (DHBs) in information flow to and from communities, and in representing community preferences in resource allocation. A second **Zambian team** is looking at the factors that determine the performance of the health centre committees (HCCs) and the extent to which and manner in which they incorporate community preferences in their health plans. All these research activities are being carried out through processes that involve the key stakeholders and using participatory and action research approaches. We want to involve the communities in discussing the issues and identifying the possible actions, while also collecting quantitative evidence. By mid 2003 we will hopefully have collected information across three countries to point to those features of health systems, especially at local level, that not only enhance participation, but also enhance the flow of health resources to community needs.

At this stage Zimbabwe faces serious problems in health and health care. We have a massive food crisis, serious decline in health services, rising poverty, political polarisation and social instability. This does not detract the basic issue for us: the people, and the civil society groups that organise them are the root of the solution. As much as we need sophisticated tools for health services, we need more greater skills and more capable organisations to enable the people to play this critical role.

Itai Rusike related his experience as programme manager of the Community Working group on Health in Zimbabwe, discussing the importance of participation and shared allocation of responsibility in health management for addressing inequities

## **2.5 Building a rights driven movement for equity in health**

**Firoze Manji, Fahamu (UK)** raised the Question:

Is "equity in health" about making poverty palatable for the poor? Or should it be about contributing to the struggle for social emancipation?

He described Nairobi with a population of 4 million, 55% of which live in 100 slums crammed into less than 1% of the land that is not their own. He noted that a home in these areas often consists of a single 2mx3m room, made of cartons, sticks, mud and/or sheet metal, housing a family of five, with poor sanitation, no public utilities - electricity, water, sewage, non-existent security, violence over rent and other property issues and rampant crime, with drugs and drug-related crime taking a heavy toll, especially among the youth.

This leads to poor health outcomes (Cholera; Diarrhoea; Malaria; Respiratory tract infections; STDs/HIV/AIDS; Trauma).



The traditional responses include emergency response (cholera etc), first aid “preventive care” (oral rehydration, anti-malarial, condoms, health education, etc). The infrastructural response includes building latrines, water, drainage with community participation.

In an era of globalisation the SAPs/PRSPs social policy set in Washington and the state is absolved of responsibilities and its social contract with the people. State resources are used to subsidise the rich and NGOs, like former missionaries, deliver services and stave off social protest.

In the Mathare slum in Nairobi in 1995 the people met together to find a way to address their problems. It was clear that the government wasn't going to do anything to help them, so they would have to help themselves. Residents, many of whom lived there for generations, live in constant threat of violent forced evictions by the government and wealthy land developers who unlawfully seize land. Government illegally and arbitrarily allocates slum dwellers' land to private developers who demolish and brutally evict residents, by burning structures and destroying personal property. Residents are prevented from building sewage drains and latrines destroyed or their use charged for. A molotov cocktail was thrown into camp and 2000 lost everything else they owned. The fire was no accident. it was meant as a warning -- leave or die. Muungano wa Wanavijiji (a Slum Dwellers Federation) was formed in 1996 as an alliance of 100 slum villages around issues of land, security, health and credit . Their attempts to build drains, sewers, services were crushed by state. Many were injured, arrested and killed when community meetings were held.

We tend, as health workers, to look at health outcomes and treat the symptoms. But the problem caused by illnesses is in the social, economic and political domains, it only manifests in the health domain. Equity in health is inevitably a political struggle Its starting point should be the defence of social, economic, political and civil rights Either our agenda is explicitly emancipatory, or ...We shore up existing powers.

## **2.6 Health service issues in equity in health**

**Prof Godfrey Swai, Tanzania**, was not able to participate but his paper reviewing equity issues in the Global Health Fund was prepared and is included here.

HIV/AIDS, Tuberculosis and Malaria are diseases of poverty or deprivation. Effective rolling back of the three diseases must equally roll back poverty. Equity in health and poverty reduction are intimately linked issues that the international community cannot dismiss and a challenge for effectiveness of the Global Fund. However share of the global burden of the three diseases for the Sub Sahara Africa / region is unacceptably high, is increasing, deepening poverty and threatening human survival. This situation deserves special consideration/ relief under the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)

UNAIDS estimates that the global requirement for prevention and care per year for the three diseases ranges from US\$ 9.3 to 12.3 billion (HIV/AIDS: US\$ 7-10 billion, Tuberculosis: US\$ 0,3 billion and Malaria US\$ 2 billion). To date the GFATM has raised US\$ 2.08 billion (17 to 22%) of the annual requirement. The current low level of international commitment and contributions by far falls short of the requirement of rolling back the three diseases. Grants from the first round (April 2002) amounted to US\$ 0.616 billion for a period of two (2) years; an amount which translated to 0.308 billion per year or 2.5 to 3.3% of the estimated need. The practicability of the GFATM is in doubt. The UN and The World Bank should intervene with highly concessionary

loans /grants. The flow of fund to GDFM gives little hope of rolling back the diseases in the Southern African region.

Information and data support the fact that Sub Sahara Africa is the most severely affected region in the world. The global share for the region is; 70% of all people infected with HIV (28 million persons); 16 % of all TB cases (1.5 million). The region accounts for 59% of global infection for the two diseases. In addition, the share of 90% of all death (900,000 persons) from the 300-500 million malaria cases per year. The effects are catastrophic given her small population (11% of Global population) relative to that of the world. The share grants from GFATM for the whole Africa was 52%. On the basis of the global morbidity and mortality data, Sub Sahara Africa fair share is about 73% of the estimated requirement or GFATM grant region. There is a need to develop fair indices for allocation of the GFATM than the call and evaluation of the proposal for life threatening or catastrophic situation

Experiences over the past 20 years support the approach of factoring poverty reduction in roll back initiatives of the three diseases. Abject poverty is a neglected issue in the Southern Africa region. About 20% of households are food poor and 50% of households are basic need poor in Southern Africa region. GFATM needs to develop basic indices for the diseases and level of household deprivation in order to do just to resource allocation to affected countries. The data is there.

The current criteria for call of proposals leaves room for excluding the most affected, disadvantages (technically and organizationally) and the poor. The later are least advantaged to compete for the GFATM through the calls for proposals mechanism. and most likely to be from Southern African regional countries. During the first call for GFATM, forty (10%) of all programs from 31 countries qualified for award out of a total of 300 proposals. What happens when one of the most affected countries cannot put up a credible proposal in the long run? I wonder how many Southern African countries failed to qualify!

Coverage of a least 80% of the target population for interventions in prevention and care is necessary to effectively rolling back the diseases and poverty. Over the past 20 years, experiences for good practices in particular Sub Sahara and southern African countries underscore the importance of supporting community based initiatives (CBI). GFATM should therefore support CBI in accessing basic diseases information, basic healthcare, food security and income generation (basic technology and micro financing). Such support can transform the community initiatives into sustainable, cost/resources effective social apparatus for rolling back of the diseases (prevention and care) and above all respect for health equity. This is essentially a bottom up approach with top down support from GFATM. The issue of poverty reduction is easily and effectively dealt with at the community level. The GFATM should adequately support the affected countries according to their objectively quantified needs to roll back the diseases. The countries should in turn mobilize and support community based initiatives for measurable outcome and impact.

To which areas should resources for prevention and care be allocated? GFATM proposal mechanism is to support twenty eight (28) countries to fight HIV/AIDS from the total of 31 awards. Twenty one (21) countries; a third of all countries are to receive HIV/AIDS grant for purchase of antiretroviral treatment for people living with HIV/AIDS. Treatment is therefore a major resource allocation decision by the Fund. In fact the fund seems to have set a precedent: global demand for antiretroviral treatment. However, the cost of antiretroviral treating for 28 million HIV+ persons Sub- Sahara Africa is over US\$ 11 billion per year (US\$ 1.00 per day/ person). The low level of commitment, contribution and the limited grant award cannot support

antiretroviral interventions. The intervention may benefit a few urban elite but not the majority poor rural population of Sub Sahara /Southern Africa. The resource allocation model for GFATM to known intervention may not roll back the diseases. Support to informed resource allocation model of CBI for prevention and care offers better chances of rolling back the deceases

Action Plan:

- The UN/World Bank has the humanitarian obligation to explore other means of urgently bridging the funding gap of GFATM.
- GFATN should develop indices for fair allocation of adequate resources to affected countries for rolling back the diseases according to need.
- GFATN should commit eligible countries to directly (fund) promotion and support CBI to roll back the diseases. Submission of Coordinated Country Proposals (CCP) based on Country's CBI should receive outright funding on the basis of section (b)
- Communities should be supported to integrated poverty reduction and gender issues initiatives in the CCP.
- National and International academic institutions should be involved to evaluate, monitor and conduct operational research in support of CBI against the diseases

**TJ Ngulube, Chessore Zambia** discussed his experience of Malaria, and how trying to address the problem was difficult in a context of a lack of access to resources through sensible options such as the idea of microcredit facilities. He blamed this on financial expedience of the private sector in conducting business with bottom line targets.

## 2.7 Equinet mission and work

Thumida Maistry described the mission and work of Equinet in the region around evidence gathering and policy alternatives, networking and regional response, information provision and exchange as well as challenges and plans for the future around advocacy. She emphasised the issue of health inequities as a reflection of Sub-Saharan poverty, and referred to this as part of the cost of globalisation being borne by those already most vulnerable in the world.

Equinets focus on vertical equity was noted to be a reflection of the need to deal with the reversal of historical gains in health, and to hold those in charge to the promise for prioritisation of equity goals as widely articulated in the region. Equinet sought to promote a Resolution made in SADC on equity to turn values into action.

To date Equinet has

- ⇒ Commissioned papers and policy briefs, and gathered evidence through research across countries.
- ⇒ Shared information, such as through an annotated bibliography, website, newsletter & briefings
- ⇒ Co-ordinated 'voice' on equity at various forums including with the SADC HSU

Equinet now seeks to continue to promote high quality research identifying and prioritising the equity issue, to network and exchange information, monitor the impacts of new policy on equity gains/goals and provide alternatives and best practice lessons. It also seeks to strengthen advocacy, through lobbying/working for equity /change beyond the public health sector and building alliances around key equity issues. There are a number of challenges to equity that we need to address:

- Retention of personnel
- Incorporation of our ideas/ evidence into policy
- How to support household use of public services in a supportive way rather than a parallel activity
- How does one access national funds to reach community level ?
- How to address the need for regulation of the private sector
- How to make public health delivery more responsive to reality of need
- We don't know of any powerful mechanisms to put health in its rightful place in regard to trade policy etc

In answering these questions we would like to hear from others what of this is common to them, what's different and the potential for working together in the future

### **3. Discussion**

During the ensuing discussion, Christina Zarowsky applauded the excellent evidence base produced by Equinet. The very brief discussion revolved around methodological concerns such as researcher independence and the need to ensure the production of high quality material. She asked people from the region to suggest ways in which a response from the North could be useful.

The provision of a session for regional brainstorming allowed some of the African delegates further time to look pertinent issues for Equinet. Although the time was not adequate to discuss with any depth the kinds of local action, networking and collaboration that could be pursued, several of the big issues came up. It was felt that there were few spaces for international advocacy around health inequity in Africa and therefore ISEQH needed to take on this role. It was agreed that links needed to be forged with more civil society organizations.

Debt servicing was regarded as the key problem for African governments and exacerbated the impact of unfair competition and trade rules that had seen most country economies in the region devastated. The introduction of PRSPs were regarded as dangerous in the context where the majority of people were poor and insidious in the requirement that they had to be drafted by the countries affected. Over and over, the problem of a mismatch between will and resources was raised. Frustration that the continued preferred use of outside consultants with the high cost to development budgets was also expressed. Delegates were frustrated at the relative absence of HIV from conference agenda, and the role of pharmaceutical monopolies on drugs.

The ISEQH conference provided an opportunity to raise the wider issues, to learn from other pathways, to share the commitment to a fairer world and to give Africa a voice at an international forum. In the next months, it may be expected that greater sensitivity will be given to the priorities of the region. Equinet should be able to participate more actively in ISEQH through the election of Lucy Gilson onto the Board and through the work of TJ Ngulube and Di McIntyre as nominating committee members. Equinet, also forged bonds with other African delegates and initiatives.

**APPENDIX A: EQUINET STEERING COMMITTEE  
DELEGATES TO ISEQH SHOWN IN BOLD**

Name	Representation	Address	Phone	E-mail
Rene Loewenson	TARSC, EQUINET Programme Manager Governance Theme	47 Van Praagh Ave Milton Park Harare	09263 4 705 108 Fax 737 220	rloewenson@healthnet.zw
<b>Firoze Manji</b>	<b>Fahamu ICT Coordinator</b>	<b>14 Standingford House, Cave Street, Oxford OX4 1BA, United Kingdom</b>	<b>Tel +44 1865 791777 Fax +44 1865 203 009</b>	<b><a href="mailto:firoze@fahamu.org">firoze@fahamu.org</a></b>
1.Abisha Nyanguwo  2.Benni Bundsgaard	SATTUC	5071 Kabelo Way Ext 10 PO Box 601 557 Gaberone  same	09267 393 4822 71700495	anyanguwo@info.bw
1.Godfrey Woelk  2.Steven Chandiwana	Zimbabwe	Community Medicine, Medical School.  Blair Research Institute PO Box CY 573 Causeway, Harare	09263 4 791631  Fax 092634253979 or 092634870403	<a href="mailto:gwoelk@healthnet.zw">gwoelk@healthnet.zw</a>  chandiwana@blair.co.zw
<b>1.TJ Ngulube</b>  2.CA Njobvu	Zambia/Governance theme  Institute of Economic And Social Research University of Zambia	CHESSORE Box 320168 Woodlands, Lusaka	09260 22 8359/ 263201 Fax 1 263201 M: 095 704446  260-1-294131 260-1-294673 260-1-295055 Fax 2601 294291 Res 260- 1293996	<a href="mailto:chessore@zamnet.zm">chessore@zamnet.zm</a>  <a href="mailto:njjobvu@library.unza.zm">njjobvu@library.unza.zm</a> <a href="mailto:inesor@zamnet.zm">inesor@zamnet.zm</a> <a href="mailto:chosaninjjobvu@hotmail.com">chosaninjjobvu@hotmail.com</a>
1.Lucy Gilson  2.Di McIntyre	South Africa  Resource allocation theme	1.Centre for Health Policy PO Box 1038 Johannesburg 2000  2.Dept of Public Health & Primary Health Care University of Cape Town	+ 27 11 48999 41 Fax 4899900  +27-21- 4066537 Fax: 4488152 home 021 685 2970 0824962345	<a href="mailto:lucyg@mail.saimr.wits.ac.za">lucyg@mail.saimr.wits.ac.za</a>  <a href="mailto:dimac@cormack.uct.ac.za">dimac@cormack.uct.ac.za</a>
Gertrudes Machatini	SC Mozambique	Gabinete Técnico de Planificação	09258-1- 312672	<a href="mailto:EFSMISAU@tropical.co.mz">EFSMISAU@tropical.co.mz</a>

<a href="#">Manuel Dimande</a>	Alternate SC	Direcção de Planificação e Cooperação (DPC), Ministério da Saúde (MISAU) C.P. 264 - Av. Eduardo Mondlane/Salvador Allende	Fax -42 2911  09 258-312672	<a href="mailto:efsmisau@mail.tropical.co.mz">efsmisau@mail.tropical.co.mz</a>
1. Gabriel Mwaluko  2. Dr Godfrey Swai	SC Tanzania  Alternate SC	1. TANESA Box 434 Mwanza Tanzania  2. Tanzania Public Health Association P.O. Box 7785 DAR ES SALAAM PO Box 77612	09255 282500236 Fax as above 09255 22131441  Fax 092552213623 6 cell 744491 339	<a href="mailto:gmwaluko@africaonline.co.tz">gmwaluko@africaonline.co.tz</a>  <a href="mailto:tpha@muchs.ac.tz">tpha@muchs.ac.tz</a> <a href="mailto:gbrswai@yahoo.com">gbrswai@yahoo.com</a>
Frank Dimmock  TBA	SC Malawi  Alternate SC	Malawi Equity Health Network PO Box 1266, Lilongwe Malawi	09265 750007/5	<a href="mailto:fdimmock@malawi.net">fdimmock@malawi.net</a> <a href="mailto:fdimmock@earthlink.net">fdimmock@earthlink.net</a> (until August)
Patrick Bond	Municipal Services Project	PO Box 601, Wits, 2050 South Africa 2 St Davids Place, Parktown, Johannesburg, South Africa	0927 717 3917 (w) 0927614 8088 (res) 0927 643 2336/ 0927484 2729 (fax) 083 633 5548 (cell)	<a href="mailto:pbond@pdm.wits.ac.za">pbond@pdm.wits.ac.za</a>
<b>OTHER DELEGATES NOT ON THE SC</b>				
<b>Itai Rusike</b>	CWGH	47 Van Praagh Ave, Milton Park, Harare, Zimbabwe	263-4-708835	<a href="mailto:tarsc@mweb.co.zw">tarsc@mweb.co.zw</a>