

EQUINET Regional Review meeting: A common platform for health equity in east and southern Africa

Meeting Report



**Regional Network for Equity in Health in east and southern
Africa (EQUINET)**

**10-12 OCTOBER 2005
Bronte Hotel, Harare, Zimbabwe**

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1. Background

The June 2004 EQUINET conference agenda of “Reclaiming the state, advancing people’s health, challenging injustice” was consolidated in the following year in the network to identify six main areas of focus for EQUINET work, policy engagement and support, shown below.

Within the east and southern African region, we are:

- 1. Founding our health and health systems on values of equity, social justice and the right to health.**
- 2. Revitalising and building national peoples’ health systems** so that we have publicly-funded comprehensive, people centred and people driven equitable and universal health systems.
- 3. Organising people’s power for health** to build a critical mass working together towards a common vision of the right to health for all as a constitutional right and within a democratic system.
- 4. Financing an equitable health system** through increased fair, sustainable and equitable financing for health at national, regional and global level in order to secure the universal right to health. At a national level, this means rising investment that strengthens the national health system through the public health sector, with mechanisms that ensure universality, solidarity and transparency and that promote public over commercial interests.
- 5. Ensuring the human resources for health** with adequate, well-trained, equitably distributed and motivated health workers.
- 6. Challenging trade liberalization and encroachment on health** by building popular participation and transparency to ensure a fair and just international trade system, where people are put before profits (health over commercial interests); and where our states and governments maintain sovereignty through regulatory flexibility for development. We are also organising towards reversing unfair flows of resources from south to north.

In April 2005, the EQUINET steering committee proposed two areas of follow up to take these priorities forward:

- i. To use the considerable body of work we have in the region to inform this framework, identify key knowledge gaps and increase practical work on the issues within the region; and
- ii. To translate this work and the positions above into bold, clear, easily understood and consistent messages that we communicate in different platforms.

The Steering Committee proposed that this more substantive critical debate and synthesis of knowledge across the network (and more widely) should be held annually and linked to the SC meetings. This could take the form of an annual equity analysis of health in east and southern Africa (ESA) that will monitor, report on, discuss progress and propose policy directions within the key areas of our framework above. This would act as:

- the basis of country-level reporting and review on health equity; and
- an entry point for strengthening the networking of equity actors within countries, linking the regional perspective with work and perspectives within countries.

Towards this EQUINET held in October 2005 in Harare, Zimbabwe a regional review meeting that brought together steering committee members; theme, process and country co-ordinators; colleagues working in key areas of work central to EQUINET's agenda; and civil society colleagues (see Participants list in *Appendix 1*). The meeting reviewed EQUINET current work to shape and critically debate the form and content for the annual equity analysis at regional (and country) level. The meeting also integrated participatory reflection to evaluate aspects of EQUINET's functioning. This evaluation is recorded in a separate briefing (See programme, *Appendix 2*).

The meeting was organised and hosted by the EQUINET secretariat at TARSC (G Musuka, R Loewenson), rapportuered by Rebecca Pointer and the report has been produced by R Loewenson and R Pointer (TARSC).

2. Introductions and objectives

Rene Loewenson, TARSC/ EQUINET opened the meeting and welcomed everyone; the attendees introduced themselves. She introduced the purpose of the meeting (outlined earlier). She outlined the global, regional and national challenges and the way EQUINET has responded to them.

At global level she noted that EQUINET work situates within a global arena where major global themes are influencing the regional situation and policy agenda. The 2005 UN Millennium summit indicated that there are conflicting processes towards policies and institutional actions to secure human security (freedom from want, freedom from fear, human rights) that are countered by those that see security as a response to external threats responded to through military means (based on fear, control, imposing power, pre-emptive strikes). Underlying these trends are powerful processes of expansion and accumulation of transnational wealth, and their consequences for population health in different parts of the world. Hence while global Millennium Development Commitments were made to freedom from fear and from want and Millennium Development Goals set as concrete targets for these, in fact deep economic, political and social processes have led to widening exclusion and growing inequality threatening the realisation of these goals. This is particularly true for Africa where outflows of wealth exceed inflows, where national public interest authorities are being threatened by global trade and financing arrangements and where formal public institutions and means for human security are weak. There are debates globally around what constitutes fair financing for the UN Millennium commitments, and on how the global governance system itself should be reformed, but these are still weakly reflected in global engagement north south. What does this mean for EQUINET? We have always drawn our agenda from the regional reality and built a southern led process that is based on shared values of equity and social justice as a basis for human security, that is not driven by global agendas. We will continue to deepen this 'centre of gravity'. A delegate to the meeting further added that this regional centre of gravity needs to be further deepened by strengthening the national and community rooting of EQUINET work, and the linkages to key institutions and processes within these levels.

Within the region and in relation to health she presented the SADC priorities in health set in 2002 and 2005 (See *Table 1* below). These have shifted from disease based priorities to the more

systems-based priorities that have always been the centre of EQUINETs preoccupation. To some extent this reflects difficulties in addressing disease based programmes in the context of increasing health system difficulties, as well as the long term effects of the underfunding and weakening of health systems due to World Bank Structural Adjustment Reforms.

Table 1: SADC priorities in health in 2002 and 2005

<ul style="list-style-type: none"> • Food insecurity • Access to safe water, sanitation, energy, transport, shelter • HIV/AIDS, TB, Malaria and other diseases • Illness and mortality related to reproductive roles 	<p><i>SADC 2002</i></p>	<ul style="list-style-type: none"> • HIV/AIDS, TB, Malaria and other diseases • Child health • Human resources for health • Access to essential drugs 	<p><i>SADC 2005</i></p>
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In 2005 there is resonance between EQUINETs priorities and those that are profiled in the implementation of the SADC Health Protocol. This meeting will identify how within those areas that EQUINET has given greatest profile to for equity reasons (outlined in the six points in Section 1) we profile the issues, areas for action and progress on action to feed into the SADC Health protocol and strengthen regional progress. While this meeting and the process of the regional analysis may give us signals of where we need to further develop future work, particularly across themes and with key constituencies, we will in the main use and enrich existing work through the process rather than opening up new themes of work. The current work that EQUINET is doing covers well the six priority themes.

It was noted in the discussion that EQUINET has an explicit commitment to building and strengthening the regional community both as a means of strengthening and supporting national policy space and to build where relevant regional responses to the global environment. Hence for example EQUINETs analyses on local production of pharmaceuticals or on responses to valuing health workers raise issues that demand regional mechanisms and responses, as a means to strengthen national health systems. EQUINET understands ‘regional’ as east and southern Africa and will engage with regional institutions like SADC, regional civil society, parliamentary and other institutions as well as through its work with countries and groups within the region. It was observed that EQUINET forge regional relationships based on shared values and goals.

Within this context she gave examples of how existing work in EQUINET feeds into the ‘messages’ and policy content to support a regional equity analysis that can itself be useful to strengthen and widen policy engagement, advocacy and programme support. These are not repeated here as they are largely covered again in the specific theme presentations and discussions in the next section.

Given this, our discussion of a regional equity analysis forms a focal point for us to bring the work and constituencies of the network together as a whole, to define the messages, content and outputs that will be useful to a wider spectrum of institutions in the region to advance health equity, to raise awareness and widen interest and engagement around these, to focus our work with constituencies on these areas, to strengthen our skills to take these forward and to prioritise future work and knowledge gaps to be addressed. The outcome of the meeting will inform the workplan for 2006-8, including our follow up work with countries, the parliamentary alliances and civil society, and with key national and regional organisations (SADC, the Commonwealth secretariat, WHO AFRO etc).

3. Framing the regional equity analysis

The meeting held four theme sessions and several consolidation sessions to identify the way in which current work feeds into the priorities identified, to identify the evidence that we have to support policy and programme work on these areas, and to identify knowledge gaps and follow up work. The theme sessions were carried out by theme co-ordinators reporting on their own area of

work within clusters to facilitate discussion of how individual theme areas of work relate to each other and to the overall '6 point' framework.

This section (3) outlines the theme area discussions. The next section (4) summarises the cross cutting and consolidation discussions. These are then brought together in an overall summary of the way forward for the regional analysis in Section 5 of the report.

3.1. Organising people's power for health and the right to health

Several streams of work in EQUINET have fed into this goal, including research and policy work on participation, governance and the right to health, and work with civil society and parliaments on strengthening community roles and voice in health.

At the level of research and policy EQUINET has implemented work that has built understanding on how health systems enable and limit effective voice and action from communities in health, particularly within the primary health care and district levels of health systems. TJ Ngulube CHESSORE reported that mechanisms such as health centre committees have been found through this research to be effective agents for ensuring greater equity as well as increasing resources for health and health care. They are a mechanism for shared communication and learning between communities and health services, and have made a difference to service delivery in resource constrained health settings. This message needs to be disseminated as their effectiveness continues to be limited by constraints in the health system: ambivalent legal status, poor recognition from the health system, sometimes hostile health worker attitude and inadequate information, skills, and resources for their functioning. These constraining factors have resulted in a distorted equilibrium in power relations between communities and health services. The work that is now following from this is exploring through policy analysis tools how health workers and communities relate on issues such as planning and budgeting to identify ways of making clear and overcoming these barriers and exploring the factors in the current organization of district health systems that enable or disable community inputs and authority through such community level mechanisms. Institutions in EQUINET are also developing training materials on participatory tools for research and training for strengthening community voice that will be used to stimulate a mentored follow up programme to reinforce positive practice and identify barriers within health systems to effective community roles.

EQUINET work on using rights as a tool for health equity reported by Nomafrench Mbombo UWC has shown that a rights approach is effective when it is linked to collective rights and social action. This has been demonstrated for example around treatment access, patient rights and community voice in health. It was noted that these approaches need now to be linked across the various themes so as to have maximum impact and lead to action. We also need to understand how they are formally incorporated, such as into constitutions and laws, and how the rights embodied in these laws and regional treaties are implemented in practice. For example what is the force of a regional protocol or treaty when a trade agreement potentially undermines a health right provided for. Hence while a regional equity analysis should send a message that we need to make stronger use of a collective rights framework, we need to link this to specific areas where equity is threatened to make this practically useful.

Itai Rusike CWGH and Mwajuma Masaigana PHM outlined the work with EQUINET and health civil society, noting the strengthening of shared goals within health civil society for equity and justice and to realize the right to health; to strengthen people's voice in decision making through organizing, uniting people and building public consciousness and to



build a people's watch dog of public interests and values. The civil society networks have a closely shared agenda with EQUINET, and the major tasks relate to strengthening the work with communities, engaging district and state officials and national leaders. A regional process would need to reinforce this, and overcome current weaknesses in civil society fragmentation, lack of joint vision, weak action and weak capacities.

Some of the specific processes that could be reflected in network wide regional work would be to use the work on participation and health rights to develop civil society mobilisation and capacity building in lobbying, advocacy and networking; to create alliances and strong relationships between health professionals and officials, civil society and parliaments particularly in areas where there are perceived conflicts, such as in community and health worker perceptions of how patients rights are implemented. We can also introduce training on the use of rights approaches within the programmes of work with civil society.

3.2. Financing an equitable health system

Lucy Gilson CHP and Vimbayi Mutyambizi HEU noted that EQUINET/CHP/ HEU work on financing an equitable health system has addressed how to strengthen the equitable allocation of resources and is beginning to explore the issue of resource mobilisation. There are messages on this that relate to reducing the level of out of pocket funding and strengthening the solidarity, universality and cross subsidies in financing arrangements. However we also have a number of knowledge gaps on

- what out-of-pocket expenses the poor are paying for health
- what collective financing mechanisms allow cross subsidies, especially through taxes and insurance arrangements.
- What tax arrangements are progressive and tax wealth rather than overburdening individual income
- What are the links to the options on dealing with financing flows out of countries (see later discussion)
- How are donor funding conditionalities influencing national authorities
- What regional social security and other arrangements are needed in the context of regional resource flows.

This work is only partly technical. Issues of privatisation and commercialisation of services signal that financing approaches affect how citizenship is understood, how states and citizens interact and how citizens claim their entitlements. To achieve equitable health financing and enable the achievement of rights, we need a muscular state and a muscular civil society. We need to be cautious in this of weakening the state through decentralisation. Fair financing in health is also not just about financing health care, but about equitable financing of everything that impacts on health, including essential services, food security and other social determinants of health. The later discussion on economic and trade justice indicates that our regional work will need to make links between options for fair financing and how we deal with external resource flows to enable the stronger regeneration and control over our own health systems.

3.3. Human resources for health (HRH)

Godfrey Musuka, TARSC/EQUINET outlined how work EQUINET and HST have done in this area has with other organisations the profiling of an HRH crisis in east and southern Africa that has become more marked with the inadequate resourcing of the health sectors under economic reforms. The migration of HRH *from* the region to high income countries and the outflows of health workers from primary and district levels of health systems and from the public to private sectors leaves many low income communities with high health need with inadequate personnel for their

health care services. This is a perverse outflow of public resources that undermines equity and the health system response to the major public health challenges in the region.

EQUINET has developed a policy thrust on addressing these issues within the context of building and strengthening the public health sectors in the region. Towards this three areas of focus were identified for action:

- **Valuing health workers** so that they are retained within national health systems. This includes reviewing and implementing policies on non-financial incentives for HRH
- **Promoting relevant production of HRH**, particularly in terms of the health personnel for district and primary care levels, and
- **Responding to migration**, and particularly to the perverse subsidy through international policy responses that provide for repatriation.

It was also noted that the outsourcing and privatisation of health systems has eroded conditions and employment of HRH, and added to financial and non financial push factors. In its regional analysis EQUINET should thus present both policy perspectives and innovative practices for regional learning and exchange, including programmes such as

- Botswana and Zambia rural/remote area incentives (considered in Tanzania and Malawi too)
- Namibia re-evaluation of the retirement age
- Malawi – top up of 11 cadres through DFID support over 5 years and work on barriers health workers face in accessing ART
- South Africa’s measures for compulsory community service.

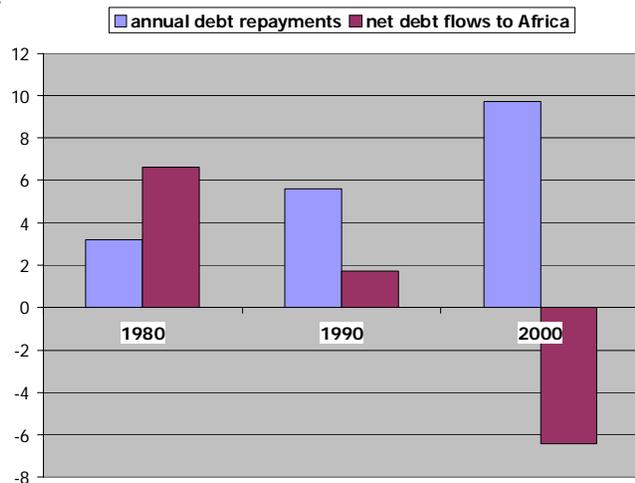
Knowledge gaps in relation to both the conditions of health workers, and the type of health workers needed for national health systems were raised. The latter should also be addressed in relation to voluntary and traditional health workers and in the training systems for them. To what extent are there regional options for addressing these issues.

Recognising that the *issue of health workers is not just an issue for the ministries of health to tackle*, but for government as a whole, we need to bring in wider sectors and strengthen *strategic alliances with trade unions and health professional bodies* to take forward the agenda of retaining health workers, address push factors (e.g. non financial incentives), insist on adequate working conditions and provisions and address management practices that demotivate health workers. Our work is primarily focused on valuing the health workers in the region as a strategy for retention. At the same time there are links with the work on resource flows on how we form alliances and propose mechanisms for reparations on perverse subsidies for outflows.

3.4. Macroeconomic policy, trade liberalisation and food security

Patrick Bond, Centre for Economic Justice in Southern Africa gave an overview of the work commissioned by EQUINET on the outflows of resources from Africa, including in:

- ‘phantom aid’ – \$42 billion of \$69 billion ODA 2003
- Debt - \$8.6 billion / year (up to 300% exports)
- capital flight, greater than remittances and about \$10billion / year
- trade subsidies to large northern producers- costing \$272 billion since 1980 and up to 4% of GDP
- change in domicile of capital, privatisation-related asset losses, tax fraud and transfer pricing.



- ecological debt – estimated at \$75 billion / yr from the carbon sink alone
- Labour flows with a perverse subsidy that exceeds total ODA inflow for HRD

As shown in the Figure above from 1980-2000, Sub-Saharan Africa's annual debt repayments rose, and new loan inflows slowed, leaving a net financial outflow (Source: World Bank). At the same time tied aid, phantom aid where flows go back in technical assistance to the north and conditional aid that narrows the space for policy making make the quality and conditions around ODA an issue for policy attention. The current global interpretation of inequality does not capture these issues. The World Bank WDR 2006 uses symbols - the terms equity, the paintings of Diego Reiveira,- but promotes market-driven processes as the best distributor of opportunities and incomes, despite global increases in absolute inequality and in intercountry inequality, excluding China and India. This is a matter for review and interpretation within the region.

Riaz Tayob SEATINI added to this introduction to note the manner in which work on GATS and TRIPS has exposed specific policy pressures through trade for commercialization of health systems, and the extent to which national policy on health systems issues like financing, regulation, drug procurement has been influenced by global and bilateral agreements. Promoting alternatives like the local production of pharmaceuticals are essential for addressing constitutional rights to health and building national health systems responses, but demand concerted and consistent action across political and technical institutions to create the conditions for this to happen.

Mickey Chopra MSRC noted that the decline of food security and nutrition in the region calls into question the dominant policy messages attributing this to a falloff in agriculture and cultivated areas, urban migration, and a consequent focus on farmers generally and on vulnerable groups such orphans. EQUINET needs to lead a more evidence based set of messages on what is happening on food security, where evidence indicates a growth in rural farmers and highlights the importance in health outcomes of initial levels of household vulnerability (assets, wealth) in a context of significant local variability in access to land and production resources. This raises the profile of particular issues on food security, particularly if local and national control over food production is to be emphasized in a food sovereignty approach. These include the manner in which commercialisation of farming has impacted on inequities amongst small-holders, included gender inequities, and the retailing and commercialisation of nutrition. It raises the direct links between trade measures, the food chain and household food security. For a regional equity analysis the evidence already supports messages about promoting specific arrangements for female-headed households, to remove restrictions on title deed and modify rules governing women's rights and access to resources; use nutritional status as indicators of the link between the macro changes and health and identify the role of health systems in linking specific health sector interventions on nutrition with wider changes needed to address commercialization of nutrition, and inequalities through trade and commercialization of production of access to production inputs.

EQUINET has the credibility, rigour and position to make strong, research-informed policy/ programme inputs to make a link between these broad areas of economic policies, trade and food security with health equity. A key priority is pushing for greater control of Africa's own resources to address rights to nutrition, primary healthcare, medicines and health care. These health issues are a good point of entry for resisting and confronting the globalisation trajectory and the limitations to national policy space currently imposed through neoliberal trade agendas.

The existing evidence we have can be used to frame the story, but we need to develop more case studies that link the macro- and micro- level. Some areas also need additional research (e.g. impact of debt on health financing). The case studies can be drawn from new research on how commercialisation of nutrition has influenced food security, and can also demonstrate opportunities for action within health systems. We can also draw from areas to like the struggles around water and electricity, where there is really good research and advocacy, to give content to the story. Some knowledge gaps were identified, such as on GATS and health insurance, on how options for managing external flows like taxes on currency flows relate to health financing strategies, that be

be addressed through integrating papers. We also need to use the regional equity analysis to strengthen south-south links with processes with shared perspective and issues in other regions.

4. Cross cutting issues

Beyond the specific theme areas of work and the key messages arising from them the meeting reviewed the cross cutting or network wide themes informing our work. This included our framework of rights and values, our overall consolidation of the different areas of work to characterise what we mean by 'reclaiming the state' for a national health system and our analysis of the policy space and process for taking positions forward.

4.1. Using an equity lens to analyse health systems

Sally Theobald of REACH Trust described the EQUINET programme on health systems strengthening and equity in ART roll out and the work done in Malawi on an equity analysis of the rollout process. EQUINET has developed a framework of indicators for monitoring equity and health systems features in ART roll out and REACH Trust research has worked in a participatory way with policy makers, practitioners and community members through multi-method approaches to pursue this. The work has also adopted different languages or discourses to discuss the findings.

The work has shown that partnerships have been key to the ART rollout in Malawi. The management of a health system is not just about the money and buildings, but also about the relationships which enable/ disable building collective, rather than individualist systems and improve societal functioning. This raises the question of who feeds into the process of trying build more inclusive health systems: how we listen to all the voices and build coalitions that capture those voices to build more inclusive and accountable health systems. In the Malawi ART program for example, the private sector was involved in the ART rollout, a partnership with Ministry of Health is monitoring and promoting the equity agenda and the system itself acknowledges and supports carers at hospital, community and household level.

This has raised attention to wider issues that surround health services, e.g. transport to get to health facilities, household practices, saving schemes, as well as complimentary therapeutic care (CTC), access food etc in ART provision.

This concept of the wider social determinants of health has informed EQUINETs work in understanding the role of health systems in the WHO Commission on the Social Determinants of Health. Pragmatically, it is important to know how social benefit compares to economic benefit in determining policy at all levels, from national to global. Within this approach a health system is not just about delivering or financing care, or even promoting health, but can be a promoter of broader social values and can be a place to contest social inequalities. If health systems can respond in ways that value people, it can contribute to wider equity and social justice issues, confronting unfair social differentials and providing new ways of building society. Health has a point around which mainstream economic discourse has been challenged, but this has not been consistent nor transformational.

The way we organise human resources, financing, people's roles is important for the social values this communicates. Cross subsidies and solidarity in health financing are mechanisms not just to enable access to care, but contribute back to social cohesion. EQUINET has through its work on ART and health systems and wider equity issues shifted the mindset of many players and need to project this very clearly as part of asserting people and national oriented approaches after the losses of the Structural Adjustment Programme period, when our health systems were forcibly realigned. Our regional equity work should ensure that these social issues and consequences of our policy decisions on health systems are given significant profile.

4.2. Reflecting equity values and advancing health rights

Itai Rusike CWGH outlined the difficulties in the current global environment with addressing rights to health, through vertical and target driven approaches. He noted that in environments of inequality, equity and social justice are central to respecting human rights in health. Human rights violations are not accidents but are linked to social conditions. Poor people who are victims or rights abuses have little voice and power to claim their entitlements. The Right to Health is perhaps one of the least contested social rights, but it has equally been eroded with little resistance. The commodification of health has particularly changed people from citizens with rights to consumers with purchasing power.

He noted that Peoples Health Movement is building a Global Right to Health campaign that will monitor and promote awareness on the right to health. It was noted that from previous discussion EQUINET has an understanding of the right to health and equity as a reflection of collective economic, social and civil rights that need to be formalised and claimed through social action. As a bottom line the right to health should be included in the constitutions of the region as a basis for state action towards universal, comprehensive health systems. It should be understood that rights and values form the framework of what we do in health, and the systems we build. It was thus understood that we will pursue this within the region and that this can contribute in a bottom up manner to global initiatives.

There was some discussion in the meeting on the understanding of equity. This primarily related to the understanding of equity as not simply addressing the poorest through targeted approaches, but closing the gradient between high and low income/ access etc to build greater cohesion and through solidarity. It was noted for example that addressing targeting *within* universal health systems is totally different to targeting poor people within segmented systems. In the latter case, there is little solidarity and sustainability in the systems. There is also evidence of the weaker effectiveness of outcomes for communities in the latter approach. Hence for EQUINET's regional work the definition of equity is as outlined in since 1998 in closing unfair differentials across groups, including in their power to control the resources for health. This is understood to call for universal systems that enable solidarity and cross subsidy, as well as addressing wider regional and global inequalities. Delegates proposed that process for the work should facilitate debate within constituencies and countries on these issues, as this is fundamental to EQUINET work.

4.3. Policy analysis to support policy engagement

Lucy Gilson CHP gave two sessions on policy analysis, both to understanding the policy context, actors and content influencing our work and to review how capacities for policy analysis could be strengthened in EQUINET to strengthen policy engagement.

Policy analysis considers the policy content, the actors (including organisations) and processes in policy creation and implementation, the context in which policy creation and implementation is taking place which could provide hooks for us to link our messages to, or could threaten the work we are trying to do.

EQUINET/ CHP process work on policy analysis intends to inform understanding and strategic action. For example it can identify which problems are identified as "worth" addressing and which not; the shape/form policy objectives/ statements (and why recognised problems are ignored); and how and why policy intentions are transformed and re-shaped in practice. Policy processes are thus not simply defined in terms of policy papers, but the processes through which they are shaped and institutionalised and the interests and alignment of forces that influence this.

In the delegate discussion it was noted that global and international conditions need to be understood as they have an influence on our work. The UN processes, the World Bank focus on

equity in its next WDR, the donor resource flows, and the advisors and consultants that inform international agency policies provide both opportunities and threats. In understanding how to engage in this environment, we need to reflect on how these actors and processes distort or facilitate our work.

At regional level the SADC protocol on health, regional integration around NEPAD, ECSA and AU processes offer could space to engage on equity. There are contextual concerns: while the social policy initiatives are complementary, the economic models may not be consistent with our approaches. We need to be clear about the impact of this engagement.

At national levels, there are opportunities and threats within different policy processes, and we would need in country equity analysis to identify those policy processes that open space for equity issues. We also need to be vigilant about policies being developed outside the public domain, such as on service provision with private providers or trade policies, and watchdog these areas to bring them into the public domain. We also need to understand and defend the space to take up equity and social justice, and examine the words and languages of policy, since in the milieu of “empowerment”, etc. language often creates a false sense of harmony and consensus when you don’t actually mean the same thing. We need to avoid space that belongs to civil society and national groups in engaging with the state being ‘taken over’ by international agencies and private sector.

Across all levels this engagement with policy also implies measures for transparency and social debate. We need to explore how to do this in the context of a regional equity analysis: what measures for informing and opening debate? What measures for media attention? In taking up a policy measure who is really being empowered and how does the work strengthen power within progressive forces in society, both within the community and within the state and other institutions. It was proposed that a more rigorous process of policy analysis around the regional work can be structured to support the process.

5. Framing the regional equity analysis

These broader discussions were focused in the final day on how we would in EQUINET take forward the regional equity analysis and use it to build our common message and work, while also strengthening our various areas of work and constituencies.

5.1 The framework

In terms of the content we agreed on a shared framework that will act as a template within which to organise the work:

For us a regional agenda of equity and social justice in health means:

- i. values of equity, social justice and the right to health;
- ii. comprehensive, universal and integrated national health systems;
- iii. people-led, people-centred health systems that organise, empower, value and entitle people;
- iv. fair financing with: debt cancellation, 15% government funding to health, equitable mobilisation and deployment of resources;
- v. ethical and equitable human resource policies at national, regional and international level that recognise health workers concerns, and confront perverse south-north subsidies; and
- vi. fair global policy (just trade, reversing unfair flows of resources) with national and regional policy flexibility to exercise policies that improve health.

We will use this framework to present the key messages within each, to build and integrate the different areas of evidence and analysis, to carry out work on the crosscutting issues raised in the discussions and to mobilise discussion, debate and provide voice on the issues raised.

Some general points of principle inform this shared work.

The work is underpinned by a values and rights driven approach. These, and the evidence on the issues we have prioritised through a social process over the past eight years, lead to our perspective. We use this perspective to examine the evidence on the priority issues and propose principles and options for addressing problems (not prescriptions and arbitrary targets). The options we propose are to support national dialogue and follow up work and to engage and share information regionally. We know that universality and equity are contested. We will therefore seek to organise the knowledge for and involve and amplify the voices of those who position health as central, who share our values and public interest perspective.

We approach this work with a specific understanding of health and health systems: health is understood in its widest definition (mental, physical and social) and we seek to address it to structural levels. We recognise that health and health care are social, public interest spheres, and should not be commodified for individual or private interest, but should be delivered through universal systems. We view health systems as both reflection and driver of national values. We understand that decades of undervaluing and underfunding our public sectors have meant that we need to rebuild the state to reclaim the state and to protect national authority. This rebuilt state would be participatory, strengthening and protecting the space for democratic engagement with communities, civil society and producers.

5.2 Key messages

The meeting has identified a spectrum of messages arising from existing work around which the evidence, knowledge, debates and engagement on the equity analysis can be organised.

i. Comprehensive, universal and integrated national health systems

Health systems should:

- be underpinned by constitutional right to health and health care;
- reinforce values, understanding the wider social value of health systems and designing for : systems that affirm and change social values, people, health workers, etc.;
- build equitable local-central government relations: 'gutting' of the state particularly at district and local level undermines universal access and ability to absorb resources;
- confront privatisation and commodification: ownership of services should not be individualised and individualising (e.g. fees and prepaid systems) but social and public (e.g. tax funded; social insurance)
- have an appropriate mix of health workers with training and recognition that is relevant to a national health system.

Programme priorities should be located within universal, comprehensive health systems. We have an opportunity to use the lessons learned from ART outreach to deepen our understanding of what we mean by this.

ii. People led, people centred health systems that organise, empower, value and entitle people

We understand that this calls for health systems that

- Promote collective rights defined and claimed by social action
- Provide space for a robust and transformative civil society – state engagement, working with institutions like parliaments to support such engagement.

- Reaches all people through universal, equitable systems that are internally organised to reinforce peoples role
- Democratises health at all levels: Globally, protecting national authority; Nationally, keeping open spaces for transformation, At district level in how district systems enable or block participation; balancing central, local and community roles, authorities and resources
- Provide in law for mechanisms for community inclusion at local level
- Bring in trade unions of health workers to decision making

iii. Fair financing

Fair financing of health systems implies,

- Rebuilding the state, with a strong civil society
- Finance health and health care
- Linking financing to public control and accountability in a manner that makes clear the health system benefits and entitlements
- Building collective financing mechanisms that close gaps across groups (vs just targeting poor): and that allow cross subsidy – within and across mechanisms
- Using taxes and understanding their equity impact
- Resist commercialisation through financing mechanisms
- Being clear about donor funding impacts through conditionalities and consolidation of power
- Reversing external outflows to strengthen domestic resource methods and control
- Promoting intra regional transfers (eg through social security) as one means for addressing uneven development across the region

iv. Ethical and equitable policies for health workers

Our work on health workers responds to the negative repercussions for ordinary people of missing health workers and the need to value our health workers and ensure reparation for perverse south-north public subsidies based on deliberate under-training in the north. We understand that HRH losses are linked to wider underresourcing of health systems, and need to be addressed through HRH policies that

- recognise that health workers have rights;
- recognise and value health workers so they are retained within national health systems; and
- support new health worker roles.
- improve health worker working conditions now (through financial and non-financial incentives);
- improve management practices in the public health sector;
- create institutional latitude for MOH to train and retain health workers;
- promote the relevant production of HRH, understanding relevance in terms of the mix of appropriate personnel for national health systems
- give ministries of health the institutional latitude to train and retain health workers.
- respond to HRH is an issue for governments as a whole, not just the ministries of health, led by the highest levels of government.

In relation to international flows our work will explore provisions for reparations, including the role of international funding for training and supporting public sector employment.

iv.. Fair global and trade, economic policy

Our approach to this is centred on debunking myths. This includes understanding Africa as a “donor continent” and its implications for our policies and for how we engage in global processes to promote perspectives that give us control over the resources for health, such as through a food sovereignty approach, that provide for national policy space and authority and that bring wealth into the public domain to be used for human development and security. Our first focus will be on :

- access to food: especially smallholder, gender dynamics, and trade-food and health system interface;
- access to drugs – costs, TRIPS, local production; and

- access to health care: particularly exploring the finance flows and the implications for health financing.

5.3. A priority focus message for the 2006 report

We debated the issue of whether a strong focus on one area would enable us to manage and give evidence within a complex and wide framework, but also give emphasis and prominence to a particular area of focus. The positive aspect of this would be to

- gives direction and unity of purpose;
- prioritise messages and content; and
- make the report more powerful and help communicate a message.

We would however not want to exclude the six major areas and the evidence we have so that this would be complementary to this wider framework.

A focus may be an area that is

- a gap in the debate that is not given sufficient attention;
- an opportunity to act or engage differently;
- a nuance in a current debate;
- an opportunity for community to get a voice in a particular area;
- something marginal that needs to be amplified in a key area of policy; or
- an area of unfinished business that needs to be taken to its logical conclusion.

After significant discussion we identified that reclaiming the resources for health – covering both fair financing and human resources – was a potential area and that we would revisit this once we have further content accumulated for the report.

5.4 Form of a Regional equity analysis:

We agreed that a regional equity analysis is not just a report but a network-wide process of analysis, dialogue, shared learning and experience and networking that builds alliances, identity, feeds into work and supports action and policy engagement. It aims to reposition debates, debunk myths, affirm the work we are doing and share experience, evidence and options with the region. The analysis should be rooted in, owned by and take place within the different actors in the region. Using a regional perspective, it should provide a strategic focus and present concrete and specific existing work. Its inputs should draw from multi-methods and communicate with different actors through various communication tools (quantitative evidence, analysis, narratives, images etc) .

The content must be multi-language, multi-medium and multi-method. We already have a lot of content that we can pull together in the form of:

- positive examples and concrete case studies
- perspectives and analysis
- evidence and data
- experiences
- voices: from civil society (real stories from community life), ministers and parliament, government commitments
- resolutions
- photographs and graphics
- specific examples from a global perspective.

5.5 The products

Given that the equity analysis is not only a report, but also a means to create space for dialogue between people, research institutions, policy and health institutions we would build a process that is transparent and that raises issues, calls for input, makes it available, calls for feedback and builds towards a product that it is collectively owned by the time it is produced. We would want the

various processes of work in EQUINET to collectively reflect and be captured in this. We also anticipate that the materials will be usefully repackaged for different audiences and for training.

A final written equity analysis for 2006 for east and southern Africa would be professional, colourful and appealing, and would include:

- perspective and analysis that builds our ability to reclaim the state;
 - messages that could catalyse action to lead to dialogue and shared learnings;
 - learning around what has and has not worked; and
 - profiling of key actors and key voices, and of their opportunities for taking the options forward
- Once the report has been reproduced, we would repackage the output in different formats, and make sure that it becomes part of public debate, using radio, press briefs and training.

5.6. The target groups

We would target key stakeholders in east and southern Africa, including

- national research institutions and medical schools;
- civil society (HCS, PHM), health workers (SATUCC, SAMWU, NEHAWU), unpaid health workers, faith based groups; including northern institutions with equity perspectives
- SADC; and other regional platforms (ECSA, WHO AFRO)
- state actors, especially to strengthen social policy actors;
- ministerial forums;
- parliamentarians, including SEAPACOH;
- media organisations still to be identified;
- funders.

5.7 Country level equity analyses

Our regional equity analyses would be strengthened by country-level equity analyses. Country level equity analysis would highlight some shared concerns, but also a diversity of priorities, practice and experiences. Two countries gave examples at the meeting about how they understood the process may work within their setting.

i. Tanzania

Mwajumah Masaiganah (PHM) presented the input from EQUINETA . She noted that the issues in the regional framework that had resonance with Tanzanian priorities included

- The Right to Health, particularly in relation to access to treatment and to health care
- People led/centered Health Systems, particularly through strengthening relationships between civil society and parliaments
- Building alliances with parliamentarians on the health budget and dealing with donor conditionalities that weaken health systems
- Strengthening mechanisms for community inclusion and active participation at local level in health systems
- Engaging on issues of food sovereignty to demonstrate bottom up engagement on global processes and national policy space in health and trade through the case of the roll back malaria programme

Tanzania also proposes that the regional work use Ifakara's framework for ensuring that research in the region takes cognisance of relevant issues raised in the regional equity analysis and at country level.

ii. Malawi

Alinafe Kasiya from the Malawi Health Equity Network (MHEN) reported that an equity analysis in Malawi would provide space for learning and advocacy – generating issues and evidence, strengthening the voice of civil society and communities and monitoring progress in relation to the agenda. We need to think about what overall message would be most useful. Before we undertake an equity analysis, we need a clear focus and consensus amongst various key stakeholders

through a country level review. This would define roles (including technical and resource support from EQUINET) and would strengthen country level mechanisms/ space for engagements and learning from the analysis. Possible foci for analysis that have national relevance within the regional framework include

- The constitutional right to health and health care
- Access to health care and medicines drawing for example on the work on monitoring equity in ART.
- Strengthening alliances within civil society and with Malawi parliament
- Current trends of decentralization and SWAPs in Malawi in terms of how district systems enable/ block participation of local communities
- Health budget tracking to examine increased financing for health, equitable and efficient allocation of resources within system (especially urban vs. rural)
- Demonstrating the negative repercussions of missing health workers on health and exploring the financial and non financial incentives to value and retain health workers
- Exploring food sovereignty

It was agreed in discussion that country work should *fit into the regional framework*, but that this should not be a straight jacket but a means to bring out experiences, positive examples, evidence, policy debates, and country priorities. Different foci will emerge from different countries; we need to have room for that, while having a simple regional focus that enables complexity, taking into account what broadly unifies and amplifies our work. Where there are gaps, we can prioritise knowledge development for future processes.

With regard to *process issues*, we need a dynamic process that can build across years. Country processes will inform the regional processes, but regional processes could support and catalyse national action. In EQUINET we have strengths in being close to the ground, and we need to take those strengths seriously and develop some processes around this at a country level. The country level equity analyses will have to draw in a variety of stakeholders, therefore, internal country processes are needed to determine how to broaden networking. In countries with existing networks it might be easier to build consensus, but in countries without networks, creating the report could strengthen knowledge, networks, values, etc. Different institutions and partners contribute to EQUINET, but the consultation processes are an opportunity to extend our network.

In terms of *follow up steps*, we will start with country level analyses in countries with existing country level processes. Each country needs:

- a brief *planning process* to find out what work is already being done and draw together people around six areas (we can't accommodate everyone at once, so we should take gradual but smooth process towards inclusiveness);
- an *initial meeting* which creates an opportunity to introduce EQUINET (giving out a range of publications and resources), *build consensus* on the content of the equity report and *allocate responsibilities*; and
- *document the process* (who came, their contributions, what worked, methodology, etc.) to share with other countries.
- *Gather evidence and feed into the regional equity analysis and into country networking and dialogue and to review the issues from the regional process.*

iii.. District level equity analysis in Tanzania

The meeting proposed to commission a district level equity analysis along the relevant aspects of the six major areas that would give greater depth of evidence at district level. It was noted that Ifakara has extensive experience and existing evidence and could lead this as a first stage in one or more districts in Tanzania towards developing a framework that could be used in other countries and regions.

6. Follow up work

Delegates outlined a follow up work process in several stages:

October 2005 to April/May 2006: a process of consultation and gathering of evidence

- A consensus statement from EQUINET on the Regional Equity Analysis as a collective vision and a call for inputs
- briefings on key areas of the framework through use of existing evidence from theme work
- outreach through themes, processes, country meetings, parliament and health civil society meetings to trigger input and debate on the issues in the framework
- use of ICT mechanisms, e.g. our website, newsletter, mailing lists to gather inputs and debates on key areas
- Possible SMS feedback on one or two focal issues
- Specific commissioned studies and analyses on technical areas, health indicators, voice on issues, etc
- An inclusive gathering and listening process, pulling together existing and new work

April/ May 2006: compilation and edit

- An editorial meeting of the SC plus to compile the collected work within the framework and identify major emerging issues, messages, policy and programme options and platforms
- Policy analysis sessions to review and focus on where options and policy space and opportunity exists and where engagement should begin to take place.

April to October 2006

- A drafting and peer review process (with peer review and inputs ending in August to enable drafting of the final report)
- Issue briefs for consultation on key areas with specific constituencies through theme co-ordinators
- Use of a draft for debate within country, civil society, parliamentary networking and feedback
- Links into existing theme and process work
- Links into the promotion of the SADC Health protocol and other policy processes
- Raising policy interest in the ongoing research work and in uptake of the research findings
- Finalising country and district equity analyses
- Finalising the regional equity analysis

November 2006

Launch and dissemination (to be planned in April).

To be scheduled

Evaluation and review

7. Closing

Rene Loewenson said the report would be distributed in next few weeks and thanked everyone for their contributions, including TARSC and Godfrey for local logistic work in organising the meeting, Rebecca for rapporteuring and Barbara for her role as facilitator in the evaluation discussions. Thanks to everyone for enriching, always moving us forward around challenging agendas and producing outcomes that are concrete, that reflect complexity and commitment, and are yet simple enough for us to keep moving forward. More than the specific product of the regional equity analysis, the process of engaging with each other, outside the silos of our own area of work and using this to understand the shared systems we are affirming has been important for the network

and has build a shared understanding. We also understand better the collective resources, information and capacities we can bring to bear on particular issues. This is the type of dialogue we hope to build through the regional equity analysis, starting with the health civil society meeting that will be held on the following day.

Alinafe Kasiya, the newest participant to the network, said in closing that it is so difficult as a new person entering a space, as you are trying to find your position. He obserbed that he now had enough food for thought for a month to take home. “As a new person, I came by accident as it was supposed to be my colleague. But I am happy because of way process has gone. By the end of the day I have grappled through discussion and developed my understanding and sense of where I am going from here. The process has been accommodative in terms of allowing my input here and I feel I could fit into discussion. This says for EQUINET that we need a sense of continuity and the history and background of EQUINET”. He thanked everyone for a good meeting.

Appendix 1: Participants

DELEGATE NAME, Major area of work in EQUINET	ADDRESS	PHONE/FAX
Patrick Bond Macroeconomic, Financial flows	University of KwaZulu-Natal CCS Durban 4041 SOUTH AFRICA pbond@mail.ngo.za	Tel; +27 31 2602954 Fax: +27 31 2602502
Dr Mickey Chopra Food security	Medical Research Council 3 Acorn Street, Newlands, Cape Town, 7700 Mickey.Chopra@mrc.ac.za	Cell: +27 834124527 Tel: +27 21 9380247
Hon Blessing Chebundo SEAPACOH	Parliament of Zimbabwe PO Box CY298 Causeway Harare ZIMBABWE chebundob@yahoo.com	Tel; +263-4-700181/9 Fax; +263 4 252935
Yeukai Chikwizo Civil society	MWENGO 20 McChlery Ave Eastlea Harare Thomas@mwengo.org.zw	Tel: +263 4 700090/721469 Fax: +263 4 738310
Lucy Gilson Policy analysis Fair financing, health systems	CHP Wits PO Box 1038, Johannesburg 2000 SOUTH AFRICA Lucy.gilson@nhls.ac.za	Tel :+2711-489 9936 Fax: +27 11 4899908
Alinafe Kasiya Malawi country work	Malawi Health Equity Network C/OArwa House,P/bag A/89 Lilongwe,Malawi. alinafek@caremalawi.org .	Cell: +265 8201 761 Tel/Fax: +265 1752099
Rene Loewenson Co-ordination	TARSC, /EQUINET 47 Van Praagh Ave, Milton Park Harare, ZIMBABWE rene@tarsc.org	Tel: +263 4 708835 Fax: +263 4 737220
Vimbayi Mutyambizi Fair financing	The Health Economics Unit, UCT Medical School, Anzio Road, Observatory 7925, Cape Town, RSA vmutyam@heu.uct.ac.za	Tel: +27 21406816 Fax: +27 214488152
Mwajuma Masaiganah Civil society	PHM PO Box 240 Bagamoyo Dar Es Salaam, TANZANIA masaigana@africaonline.co.tz	Tel: +255 23 2440062 Fax:+255 23 2440154
Charles Mayombana Health systems research	Ifakara Health Research and Development Centre Mikocheni Area Kiko Avenue P.o. Box 78373 DAR ES SALAAM C.Mayombana@unibas.ch	Cell: +255 748934029

Nomafrench Mbombo Health rights	School of Nursing University of the Western Cape PO Box 17, Belleville SOUTH AFRICA 7535 ymbombo@uwc.ac.za	Tel : + 27 21 959 2271 Fax: + 27 21 959 1478
Godfrey Musuka Co-ordination	TARSC,/ EQUINET 47 Van Praagh Ave, Milton Park Harare, ZIMBABWE godfrey@tarsc.org	+263 4 708835 Fax +263-4- 737220
Edward Njogu Civil society	16 Barnes Road Brixton, 2092 Johannesburg elephant.giraffe@telkomsa.net	cell: +27 825605531
TJ Ngulube Participation, governance and health	CHESSORE P. O. Box 320168, Woodlands, LUSAKA chessore@zamnet.zm	+260-1-228359 +260-95-914844 Fax 228359
Rebecca Pointer Co-ordination	TARSC/ EQUINET 9 Albertyn Road, Muizenberg, Cape Town SOUTH AFRICA 7945 reb@wfeet.za.net	Tel: +27 21 788 3847 Fax: +27 21 788 3847
Greg Ruiters MSP (essential services)	MSP Politics Dept, Rhodes University, Grahamstown, SOUTH AFRICA g.d.ruiters@ru.ac.za	Tel: 27-46-603 8663 or 27-83 694 4409
Itai Rusike Civil society	CWGH PO Box 1376 Belvedere Harare, ZIMBABWE itai@cwgh.co.zw	Tel; +263-4-788100 Fax; +263 4 788134
Riaz Tayob Trade and health	SEATINI P O Box 1558 Crown Mines SOUTH AFRICA 2025 riazt@iafrica.com	Tel: +27 83 778 7222 Fax: +27 83 1187787222
Sally Theobald Equity and health systems in HIV and AIDS	REACH Trust P.O. Box 1597 Lilongwe, MALAWI slt@liverpool.ac.uk	Tel/fax:+2651751247

Appendix 2: Programme

Monday 10 October 2005

Time	Item	Facilitation/ Resource inputs
0800-0845	Registration	G Musuka
0845-0945	Welcome, introductions, objectives and the EQUINET vision Framework and targets for a regional analysis of equity in health	R Loewenson
0945-1100	Policy analysis on strategic opportunities and areas for policy engagement	L Gilson
1100-1130	Tea/coffee	
1130-1300	Working group Session 1: (* see guidelines below) Macroeconomic policy, Trade liberalisation and food security Organising people's power for health, health rights	R Tayob, P Bond, M Chopra T Ngulube, I Rusike, N Mbombo, M Masaiganah
1300-1400	Lunch	
1400-1515	Feedback session and plenary review of working group discussions (**) See guidelines below	
1515-1530	Tea/ coffee	
1530-1630	Evaluation reflection and discussion session 1: Relevance to the health equity agenda?	
1630-1730	Consolidation session 1: How does our analysis reflect and engage the right to health and a values based approach	I Rusike

Tuesday 11 October 2005

Time	Item	Facilitation/ Resource inputs
0800-0845	Administration	G Musuka
0845-1000	Working group Session 2: Financing an equitable health system Human resources for health	LGilson, V Muyambizi , G Ruiters G Musuka
1000-1030	Tea/coffee	
1030-1130	Feedback and plenary review of working group discussions (**) See guidelines below	
1130-1245	Consolidation session 2: Using an equity lens to analyse health systems	L Gilson, S Theobald
1245-1345	Lunch	
1345-1500	Consolidation session 3: Framing the regional equity	R Loewenson

	analysis * analytic framework and debates * priority areas, messages and evidence * knowledge gaps and follow up work * policy targets	
1500-1515	Tea/ coffee	
1515-1645	Evaluation reflection and discussion session 2: Partnerships and targets	B Kaim
1645	TARSC Reception and launch of the Auntie Stella kit	

Wednesday 12 October 2005

Time	Item	Facilitation/ Resource inputs
0800-0900	Co-ordination, networking and planning meetings	
0900-1030	Co-ordinating work across areas: Will an annual equity analysis at country level to support country networking, learning and action? What should be done?	M Masaiganah, A Kasiya
1030-1100	Tea/coffee	
1100-1230	Co-ordinating work across areas: What are our needs on policy analysis and how can we address them?	L Gilson
1230-1300	Co-ordination, networking and planning meetings	
1300-1400	Lunch	
1400-1500	Taking the regional equity analysis forward	
1500-1515	Tea/ coffee	
1515-1645	Evaluation reflection and discussion session 3: Internal functioning	
1645	Summary of the agreed outcomes of the meeting Closing and reflections	R Loewenson A Kasiya

(*) Guidelines for Working group Sessions:

Each working group session will using inputs from facilitators review within the area under focus

- What are the areas of policy focus and messages that we should profile in the annual regional equity analysis in 2006
- The evidence that we have that can support these policy debates and messages
- the analytic debates and knowledge gaps that we need to address
- how we will do this follow up through existing theme work or otherwise

(**) Guidelines for Feedback Sessions:

The feedback will provide an opportunity for each group to debate the issues in the other group with facilitators and for plenary review of the proposals on *policy messages, evidence, knowledge gaps and follow up work*.