

Global Equity Gauge Alliance (GEGA)

*Building Global and National Coalitions
for Action in Health Equity*

REPORT

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



Sponsored by: Rockefeller Foundation, Swedish International Development Agency,
World Health Organisation

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13-14 June 2004
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Background

The GEGA Conference on Equity in Health was held June 13 and 14, 2004 in Durban, South Africa at the Tropicana Hotel. The conference theme was “Building Global and National Coalitions for Action in Health Equity.” This theme recognised the primary focus of GEGA in working at the national level to reduce health inequities while also reflecting the need to address some issues through mobilisation of the global community.

The conference brought together representatives from country level Equity Gauge groups in Asia, Latin America, and Africa with individuals from a wide range of organisations and networks in the South and the North.

The first day of the conference, structured around key themes of the Global Health Watch, provided an opportunity to discuss and debate these issues, thereby strengthening the international perspective of country level work while grounding some of the global debates in country level experiences. Discussion was also used to generate input for further developing the GHW as well as the advocacy campaign strategy building on the Watch.

The second day of the conference provided delegates an opportunity to discuss a number of specific challenges found in promoting health equity at the national and local levels within different contexts, such as working with the media, using a human rights framework to promote the equity agenda, the pros and cons of working with executive and legislative bodies, strategies for generating evidence on equity from existing information, strategies for working with the media, and intersectoral strategies for intervention, to name a few.

In addition to the conference, GEGA presented the Health Equity Research to Action Short Course. As a result of the very large number of applications received for the course (over 200 applications from more than 45 developing countries, the course was presented both prior to and following the GEGA conference. This allowed us to accommodate approximately 70 participants from about 30 civil society and governmental groups working in health equity. Evaluations of the courses indicate substantial support for such learning opportunities. Although participants included both seasoned



equity workers as well as those recently introduced to health equity work, the continual focus on linking research and action, and the context-sensitive interpretation of equity findings provided a continually stimulating focus for discussion for everyone. Most participants indicated a strong interest in building institutional links with GEGA and further developing their work along the lines of an Equity Gauge. Participants also gained insight into areas where they need further skills training in order to improve the effectiveness of their efforts to promote pro-equity policies and interventions. Participants' comments and suggestions for future courses were documented and incorporated into the further development of the course.

In addition to the GEGA Conference and Course, GEGA members and the Secretariat made presentations on their Equity Gauge work as well as our cooperative organisational work at the conferences of the International Society for Equity in Health and Equinet, which were held directly prior to the GEGA Conference.

GEGA also organized an open consultation with WHO and civil society on health equity and health system research priorities, which was attended by more than 60 representatives from civil society and other organisations. The meetings targeted those involved in the research and policy arena as well as civil society groups such as NGOs and CBOs, and a deliberate attempt was made to encourage sharing of experiences and perspectives across these disciplines.

In all, the June events spanned almost 10 days, from June 7th to the 16th. A large community of researchers and practitioners in Equity and Health came together during this period (approximately 300 delegates), and there was substantial cross-over of delegates between the various conferences and courses. In addition to supporting cost-sharing for delegate subsidies among the organisations, delegate cross-over

between conferences provided for rich cross-fertilisation of ideas and discussions as well as excellent networking. There were representatives from over 50 countries (including 15 from Africa) and delegates ranged from those with a great deal of experience and who work on health equity issues explicitly on a daily basis, to those for whom health equity is a newer area of work (including students), or is implicit to their organisations' goals.

Common to all the events was the desire to move *beyond* knowledge as an end in itself, to foster awareness, understanding and strategic thinking designed to strengthen the *utilisation* of knowledge for the goal of enhanced equity. While the ISEqH Conference was oriented toward scientific knowledge, and the Equinet Conference was focused exclusively on southern Africa, the GEGA conference focused on global and national strategies for moving research to action as well as development of action plans.

What was achieved?

An important component of GEGA's strategy prior to June was promoting the Equity Gauge Strategy through building links with different groups and networks internationally. The June events provided an opportunity to strengthen these links further by directly exposing many of the participants to GEGA's work and providing fora for discussion. This exposure was reinforced through the GEGA course, which provided an introduction to the conceptual underpinnings and operational issues of the Equity Gauge Approach, and through the GEGA conference, which allowed participants to discuss how those concepts and ideas are being put into action in different contexts.

Arising from the interaction with the wide number of groups and networks brought together at these meetings, GEGA has been able to establish increased links with a number of like-minded organisations. It is anticipated that a number of these linkages will serve to expand the work of the organisation through the establishment of a number of new Equity Gauges and concrete steps towards this have already taken place in Pakistan. In addition there are also prospects of an emerging West African Regional Network on Equity in health, for which the June meetings served as a catalyst, and for development of Equity Gauges or Gauge-like groups in Tanzania,

Namibia, Mozambique, Bolivia, Guatemala, and Brazil, to name a few.

As a result of the interest in the Equity Gauge approach from many groups, GEGA made a number of informal commitments to provide support for equity enhancing work. It is anticipated that these interactions are likely to be mutually beneficial, thereby assisting GEGA in the further evolution of our own work and goals.

GEGA has already embarked on refining the 'Health Equity: Research to Action' Short Course as a result of experience gained during the two June courses. Regional level courses, based on the syllabus developed for June are being planned for presentation in Latin America, Southern and East Africa, West Africa and South Asia. GEGA has also been asked by a group in Italy, the CUAMM Doctors' Association, to conduct its Health Equity: Research to Action course from the 22nd to the 24th of November 2004.

This report summarizes the proceedings of the GEGA conference. Thanks are due to the presenters as well as the many participants who contributed to the discussions. The Coordinating Committee appreciates the support given to the conference by the Rockefeller Foundation, the Swedish International Development Agency, and the World Health Organisation.

Day 1

Plenary

Building Global Coalitions: GEGA and the Global Health Watch

Welcome and Introduction

Antoinette Ntuli, Chair of the GEGA Coordinating Committee, welcomed the delegates and briefly introduced participants to the Global Equity Gauge Alliance. She provided a brief introduction to the topics of the conference, noting the need to identify and share successful interventions to reduce health inequities based on evidence and experience.

The presentations of the first day introduce delegates to the Equity Gauge Strategy and provide some examples of its application at the national and global levels. It is hoped that this will spur delegates, many of whom work in health equity but do not work with Gauges, to think about how action for health equity might be best pursued in various contexts and perhaps in their own countries. The second day of the conference is structured to gather delegates in conversations about their experiences addressing specific types of interventions.

Ntuli hoped that the conference would prove useful in advancing the work of participants and in increasing the knowledge base on equity interventions more generally.

The Equity Gauge Strategy: Applying and expanding the concept

Lexi Bambas, Coordinator of GEGA, South Africa

Lexi Bambas presented an overview of the Equity Gauge Strategy and outlined some of the adaptations that have been made to the concept over the past three years. She described the founding beliefs of the concept:

- that monitoring of health inequities and continuous advocacy are necessary to raise public consciousness about population health injustices
- that effective interventions should be evidence based and propose specific strategies for action

- that a plan for research to action should be integrated into projects from the beginning, and
- that communities have a right to define priority issues and to participate in finding solutions.

These convictions led to the Equity Gauge Strategy, including three pillars of work that link bottom-up and top-down processes for change and create synergies: assessment and monitoring, advocacy, and support for Community Empowerment. The Strategy implies an integrated approach in which the flow from research to action, and back, is continuous; this integration is also essential to improving health equity for both technical and political reasons. Without the integrated framework, research lies dormant, and advocacy and community empowerment can fall flat.

She noted that improvements and sustainability in health equity depend on addressing not only the usual determinants of health but also determinants such as political participation, trade agreements, international migration of health professionals, levels of governance, and predatory economic structures.

Addressing these determinants requires not only national responses but also international coordination and advocacy. Further, many of the challenges to health equity within countries can only be addressed by working together with others at regional and even global levels. The Global Health Watch is one such effort to influence the international economic and political structures and architectures that determine those countries ultimate potential for reducing health inequities.

She described some of the differences in applying the strategy in different societies. In Ouagadougou, one challenge has been to sensitize the donor community to urban needs as well as poorly conceived urban development programs that further marginalized poor populations. The Ecuador

Gauge has worked from the bottom up by replicating its model of community-monitored health centers to cover municipalities all over southern Ecuador. In contrast, the China Equity Gauge is conducting household surveys on health equity for the population of over 1 billion. Finally, South Africa is now ten years into a democratic reform process fundamentally based on the rejection of anti-equity policies.

Monitoring of improvements in health equity is a barometer here of improvements to social and political structures. By partnering with parliamentarians, health equity has become a more regular part of budget and legislation debates affecting the health system, and increasingly during discussions related to other determinants of health.

Applying the concept in Chile

Liliana Jadue, Development University and the Equity Gauge, Chile

Liliana Jadue described several projects of the Chile Equity Gauge, focusing on the new Health Module added to the CASEN 2000 Survey, which improves monitoring of health equity in Chile; the Chile SOLIDARIO program, which integrates poor populations into the social welfare system, and the Gauge's training efforts which focused on capacity building for measurement/monitoring and increasing media coverage and public discussion of health equity issues.

She began with a quick profile of Chile, describing it as a free market economic model with high inequality in wealth distribution, strong governmental social investment, and pro-poor oriented with a mixed health system of public and private sectors since the 1980s. Public health insurers and providers cover 67% of the population, and there is some overlapping of the providers. Jadue emphasized that this model generated segmentation between the population from the public sector (higher health risk and reduced payment capacity) and private sector, generating inequities.

Chile has been undergoing health reform for a number of years. Solidarity and equity are its governing principles, which translates to separation of functions (planning and policies, provision of services and regulation); strengthening of primary health care services; and better regulation of private insurers. In terms of health services, the reform will implement guaranties to all the population in

terms of access to care, opportunity of care, quality of services, and financial protection.

The CASEN survey is the main instrument to evaluate social policies and socioeconomic level of the population in Chile. It has nationwide coverage and is conducted every 2 to 3 years. In the year 2000, 65,036 households and 252,748 individuals were surveyed. The survey collects detailed information in education, employment/occupation, housing, health services and use of preventive services, and income.

Through significant cooperation between the Chile Equity Gauge and the health reform unit of the government, the Health Module of CASEN was modified in the year 2000 to include questions about health needs, use of services, health perception, and equity of access to services. A collection of six factors were found to explain more than 70% of variability in 26% of the population that had unsatisfied health demand, including age, ethnicity, rural residence, low income, private insurance, and being a male.

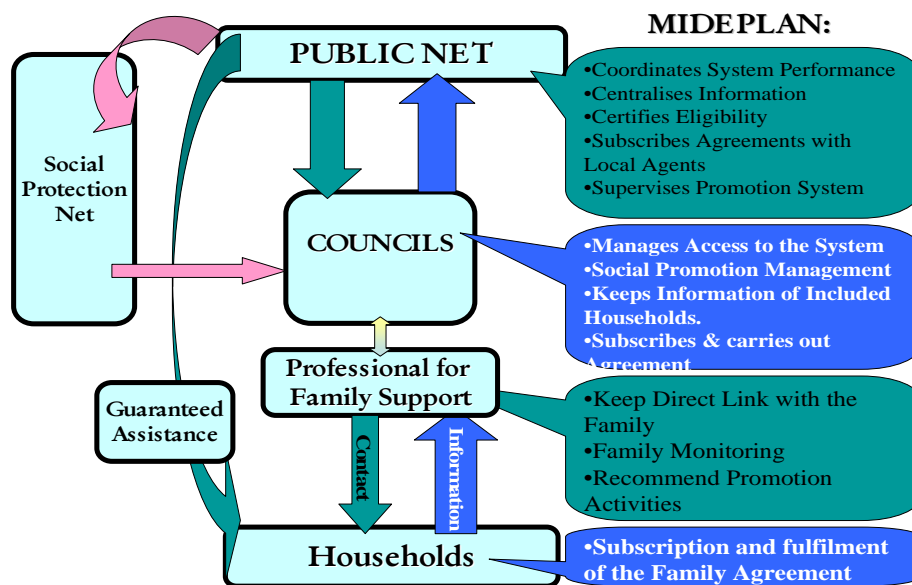
The results of the 2000 CASEN survey reject the myth that the private health sector responds better to care demand, because both systems take care of the demand with equal probability. The new questions added to CASEN survey proved to be useful to monitor health service access for the population and it is relevant to keep them in new applications of the instrument. Finally, the results proved useful in identifying points of entry for policy improvements.

The second major initiative of the Chile Equity Gauge is the Chile SOLIDARIO program, a social protection system aimed at scaling up poverty reduction initiatives. Poverty fell significantly between 1990 and 2000, from 38.6% in 1990 to 20.6% (3.8 million) in 2000; 5.7% (or 850,000) were in extreme poverty in 2000.

Reviews of case studies from other countries in relation to successful social protection systems suggested several key areas, including

- Getting the economics and the politics right
- Getting the focus on clients right
- Getting the implementation right
- Getting the support for innovation right

They found that support should not be thought of merely as a form of assistance but also as a promotional tool. The program should be



oriented towards empowerment and capacity building rather than hand-outs and subsidies. Benefits should be aimed at families rather than individuals, and there should exist a family commitment to overcome poverty conditions.

The new generation of policies against poverty see social protection as a system to assure social minimum standards to every citizen. Social exclusion is viewed as the primary issue, and the excluded are associated with or identified as the poorest; conversely, the poorest are identified as those with fewer opportunities and less freedom.

In 2002, the Chilean government took on a new challenge: to eradicate extreme poverty through the “Chile Solidario” system. The program focused on the 225,000 families in extreme poverty by “personalising” the social policy, wherein the state invites the families to participate. The program aimed to coordinate the public support network, including the sectors of health, education, housing, occupation and employment, justice, and others. The plan transfers responsibility for coordinating with families to the counties, and uses information from the CASEN survey to identify beneficiary families. The intent is to provide families with an ongoing relationship with a specialist who facilitates and provides support for linking with various social protection benefits. Ultimately, this is intended to provide a more holistic and continuous opportunity to meet basic needs and develop skills, and eventually help families rise from extreme poverty.

A World Bank loan through the MIDEPLAN program provides support to strengthen and maintain a national information system and system evaluation as well as training for all the system’s units & agencies.

The intervention strategy assumes that a family is empowered and should be able to overcome poverty when they achieve 53 minimum conditions of quality of life, including:

- Identification (securing an identity card)
- Health
- Education including literacy
- Healthy family dynamics
- Housing conditions
- Occupation
- Income

The program has already achieved positive results for families in extreme poverty:

- 14,764 new families have all their ID documents, relevant to access to any social program.
- 4,990 new families have secured access to the health system.
- 13,684 women over 35 years old have updated their PAP smears.
- Elderly members in 2,752 new families updated their health controls.
- 3,602 new families have sent their kids to pre-school institutions.
- Illiterate adults within 6,482 new families have learned to read and write.

- 7,331 new families have received training in conflict resolution.
- 10,978 new families now know of available community resources.
- 6,140 new families received training in family communication.

Achievements to April 2004 include:

- The program is operating in 332 out of 341 counties in the country.
- The Bridge program has contacted 112,444 families.
- 25 public institutions and programs have agreed on the services and activities to offer to these families and have committed the resources in their own budgets.
- MIDEPLAN has signed for our country 14 agreements to transfer funds to guarantee the programs and coverage in the public sector social network to achieve these goals.

Expected results in 2005 include:

- Institutionalization of the system and full operation.
- To have a national register of individuals/families associated to the system and for other individuals/families receiving governmental subsidies (non-indigent poor).
- To overcome indigence in elderly population (over 65 years old) who live alone, through a subsidy.
- To achieve the 225,073 families supported by the system.

The third major initiative of the Gauge has been the training programs. The first training program occurred in 2000, when researchers from a number of Latin American countries spent two weeks in Chile focused on building capacity for equity measurement and analysis. The Gauge hopes to repeat this training opportunity. The second training program is focused on increasing sensitization and capacity among journalists to understand and report on health equity issues. This project is described in more detail later in the conference by Rodrigo Burgos.

A Zambian response

T.J. Ngulube, CHESSORE and the Equity Gauge, Zambia

Dr. Ngulube focused on some of the lessons in interpreting the Equity Gauge strategy for use in Zambia. He laid out various challenges, including applying the concept of equity in a

poor performing economy with a high poverty level; mobilizing stakeholders; overcoming political factors and distrust; stimulating informed decision-making; judging the impact of the Equity Gauge in different districts; and discerning the extent to which the Equity Gauge initiative informs us about the challenges for general development in Zambia.

Although the Gauge is national in scope, four district Gauges have been formed to strengthen on-the-ground action and advocacy. The four district Gauges have very different socioeconomic and geographic profiles, demonstrating inequalities even in poor contexts. These differences play out especially in access to care and other health-affecting resources.

Recruitment of targeted stakeholders has been a particular challenge, in part due to the political distrust experienced. The Gauge implemented a multi-stage strategy of gradually integrating additional stakeholders, beginning with establishing the District Gauges comprised of various CBO's and interest groups. After a period of mutual cooperation, training, and priority identification, the Gauge was able to build a relationship with the Parliamentary Portfolio Committee on Health, a possibility due to the legislators' trust that the interests represented were those of their constituencies. The Gauge then joined forces with the Zambia media in order to bring their messages to the public, providing support and training to those working in various forms of media including print, radio, and television.

Despite progress, Gauge members from the districts and the national office perceive remaining challenges, including reducing lingering political distrust and a sense that the Gauge is a power threat. However, most also feel that legislators have become more knowledgeable and make more informed decisions, there is a sense that the Gauge is non-partisan, and there is growing interest in the work.

The four District Gauges have different perceptions of the impact of the Gauge work in their locality, with urban Gauges more confident that the work has had a positive impact, and rural Gauges still battling political distrust.

Dr. Ngulube concluded with a commitment to persevere to confront obstacles to development.

Applying the strategy in Bangladesh

Rumesa Rowen Aziz, ICDDR,B and the Equity Gauge, Bangladesh

Rowen Aziz presented the activities and findings of the Bangladesh Equity Gauge, including the Bangladesh Health Equity Watch, the status of inequity in Bangladesh, successes of BHEW, and challenges they have faced. This Gauge was established in 2001 as a civil society/government collaboration between the Bangladesh Bureau of Statistics, the Bangladesh Institute of Development Studies, BRAC, and ICDDR,B: Centre for Health and Population Research.

The Gauge's goals are to incorporate equity dimensions in existing data collection systems in various organizations; establish a new system in a nationally representative sample to be eventually adopted by any national system; develop national research capacity; and disseminate findings among policy makers, researchers, NGO leaders, and civil society.

The Gauge takes a comprehensive approach to assessing health equity, incorporating Social Dimensions including Economic Status, Gender, and Education as well as Geographic factors such as urban vs. rural comparisons and level of infrastructure development. Health Indicators measured include Mortality Rates and Disease Prevalence as well as access issues such as Utilization of healthcare facilities and Use of family planning.

Successes of the Gauge include sensitization of policymakers to equity issues; the inclusion of equity dimensions in national and sub-national data collection systems; and the formation of the new Poverty and Health Programme at the ICDDR,B. Perhaps most significant is that the Gauge has successfully supported incorporation of equity dimensions in several data collection systems, including

- ICDDR,B: Health and Demographic Surveillance System, Studies on Tuberculosis, Safer Motherhood, Adult Health, Child Health, Neonatal Health
- BRAC: BHEW Survey
- BBS: Low Birth Weight Survey
- UNICEF: Immunization Survey
- Save the Children, UK: Nutrition Survey and
- Government of Bangladesh: National Nutritional Programme Baseline Survey

Other successes include development of a multidimensional poverty measurement tool; hosting a round table seminar series; support to research fellows in the area of health equity; and establishment of a Poverty & Health resource unit in the ICDDR,B library.

The Gauge is currently undergoing an evaluation, exploring several questions about organizational structure, appropriate funding of a Gauge, and the effectiveness of the work.

The Global Health Watch

David McCoy, GEGA and Coordinator of the Global Health Watch, UK

McCoy presented an effort underway to mobilize the health and social justice movement, including a wide range of civil society organisations, around an alternative World Health Report, conceived by GEGA and led by GEGA, MedAct and the People's Health Movement. He presented the motivation for the Global Health Watch as a prelude to a discussion on the content and plans.

He mentioned several purposes to the report, including to provide information that is often ignored regarding the harms of market-based health care reforms; shrinking public sectors; smaller and weaker governments; and the commercialisation and commodification of health and health care. It would provide a more human comprehensive and multi-sectoral approach to health development, rather than the dominant model of technocratic, disease-based approaches that rarely address the underlying causes of ill health and fail to address barriers to significant and lasting progress.

The Watch would also monitor the performance of key global health and health-related institutions in order to strengthen accountability and provide a mechanism for continued and organised advocacy campaigns by civil society. Positive human rights and genuine development alternatives to current practices will be presented.

It is hoped that the Watch will mobilise the health community, broaden the support-base for a revitalisation of the Alma Ata principles, and recapture health sector ground lost to the corporate and commercial sector. The Watch is also intended to strengthen links between NGOs and networks working in various sectors, including environment, international

finance, agriculture and food security, war, housing, land rights, conflict and education. The Watch will be compiled and presented in a way that provides a forum for magnifying the voice of the poor and vulnerable and those who advocate for them through the use of case studies and experiences.

The Watch is targeted at both the broader health sector, including policy makers, health providers, NGO workers, as potential partners in developing and carrying out advocacy campaigns. The advocacy targets include senior technocrats, policymakers, the Banks and trade organisations, UN organisations and national health associations.

The content of the first part of the Watch addresses the political economy of health in the era of globalisation, including the design and effect of health systems, health sector reform, the commercialisation and privatisation of health care, the role of the state and government, and the role of technology and the medical-industry complex.

The second section of the report addresses health sector issues including access to medicines and IPRs, human resources: the lifeblood of health systems, responding to HIV/AIDS, and gene technology and the attainment of health for all.

The section on determinants of health includes environment; militarism and conflict; water; land, household food security and diets; and education. There will also be a section focused on indigenous peoples and disabled people.

Monitoring would likely include a number of institutions and projects, including WHO; the World Bank; the IMF; the Global Fund / PEPFAR; health research financing; WTO / GATS / regional and bilateral trade agreements; the US government, the European Community, and the donor community; and the corporate sector.

The final part of the report will present recommendations and strategies for action, on which advocacy campaigns will be defined and developed.

Authors will be drawn from progressive and highly respected civil society organisations with expertise in the area, and the Watch will be a highly collaborative effort with both formal endorsement and participation and ownership by all NGOs and individuals who share the values implicit in the report.

The Secretariat will be held by PHM, Medact & GEGA, and based out of the Medact office. A Coordinating Committee that includes representation from all areas of the world is being established to legitimise the Watch as an alternative World Health Report and develop advocacy networks. It is hoped that regional and local forums and networks will also emerge and develop in the process; these regional groups could then organise advocacy campaigns to create pressure at the regional and country level. It is also likely that forums and networks would emerge that are focused on specific chapter topics.

McCoy emphasised that the Watch is not only the report itself but also the campaign that is subsequently created, and that the process of producing the report is just as important as the actual content of it in order for it to be a tool of change. In order to facilitate participation, as many chapters as possible will be summarised and translated into Spanish.

Organisations that are currently actively involved include the North-South Institute, Canada; Public Services International; Open University, UK; University of Natal; Medecins sans Frontieres; Equinet; Greenpeace; LSHTM; International Physicians for the Prevention of Nuclear War; Municipal Services Project; Health Unlimited; Associazione Italiana Amici di Raoul Follereau; Dag Hammarskjold Foundation; Healthlink International; British Medical Association; University of Montreal; Save the Children; and Social Watch.

McCoy encouraged delegates to get involved in a number of ways, including contributing to chapter writing; submitting testimonies and case studies; endorsing the Watch; creating a demand for the Watch in their own region; launching the Watch in individual regions; initiating local, national, and regional health watches; helping with reviews; fundraising; and translation.

The launch is set for May 2005, and more information can be found at www.ghwatch.org or by contacting the secretariat by email at ghw@medact.org.

Discussion: Delegates raised questions regarding the choice of chapters of the report, and McCoy responded that many other issues could appropriately be included, but that these issues were chosen for the first iteration of the report based on available human and financial

resources and priority of issues for advocacy purposes. Delegates also asked about the funding of the Watch, which is in progress and the Secretariat is optimistic the funds will be raised. However, McCoy also invited groups to seek local funds to support regional and country-based advocacy campaigns.

On the topic of translations, McCoy welcomed the idea of translation into other languages, and asked for volunteers and assistance in identifying translators. The audience was reminded that the Watch will be available both in hard copy and on the web in order to encourage use of the information. Finally, McCoy asked the audience to submit case studies on their experiences, both positive and negative, related to the topics addressed in the Watch. More information on the Watch is attached in Annexure 4.

Parallel Sessions

Global Issues and Global Responses

These sessions were intended to highlight major global challenges for reducing health inequities. Although many health inequities can be improved through national or local policies, there are also political and economic pressures exerted on countries that they have little control over. Each parallel session consisted of a combination of presentation and group discussion.

Theme A: The global politics and economics of health

**Ronald Labonte, Director, SPHERU,
Universities of Saskatchewan & Regina,
Canada**

Labonte provided an overview of the global political economy and how this affects health, particularly in developing countries. It covered issues related to trade, debt and overseas development assistance.

Labonte began by contrasting one technical definition of globalization (“a process by which nations, businesses and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion (especially of Western culture and travel) with the real experience of globalization as witnessed in trade practices as well as economic and development theories. He summarised this more realistic concept of globalization as “new global rules that increase free capital flows for speculative profit-seeking, global production chains for profit-maximization and government de-regulation for increased privatization: in effect, the globalization of unfettered capitalism without the redistributive checks of ‘strong governments’.”

Labonte cited several summary effects of globalization on health:

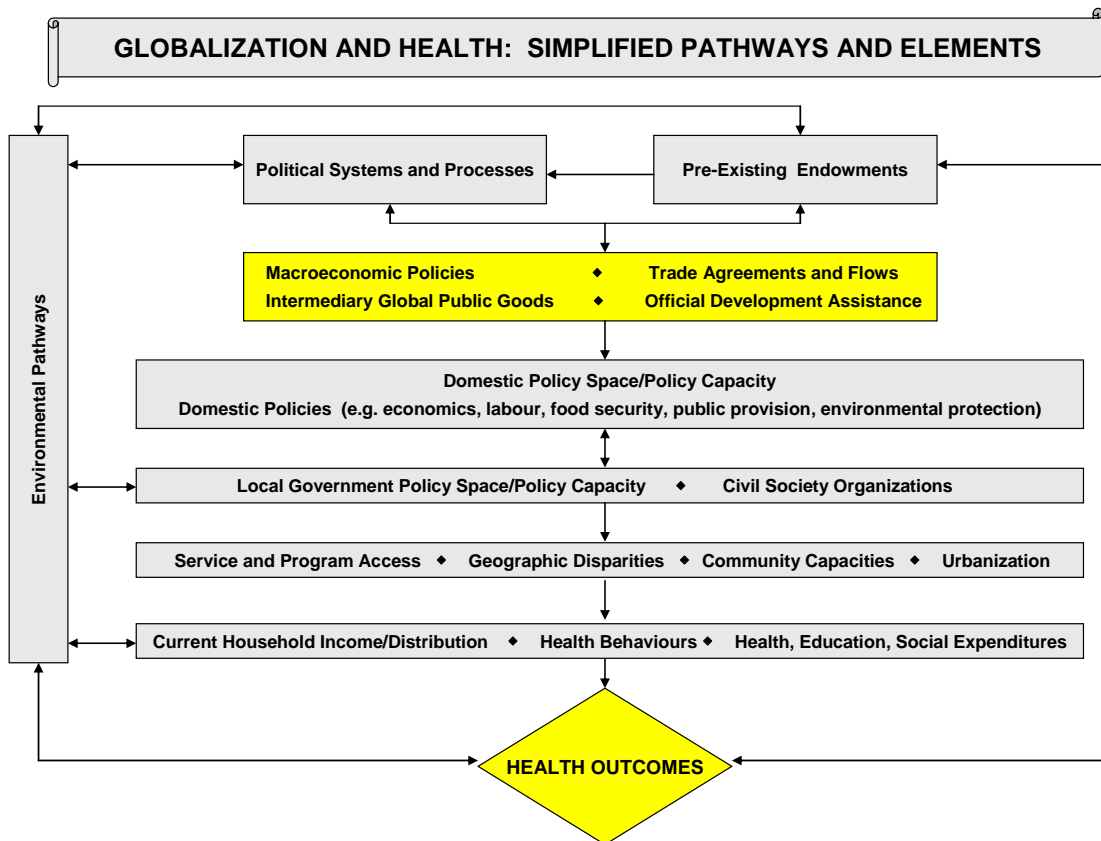
1. the indirect liberalization effects on poverty, inequality, economic development and other health determinants;
2. the indirect liberalization effects on states’ capacities to tax and redistribute wealth for health and development purposes; and
3. the Direct effect of specific trade agreements on government’s health regulatory and service provision capacities.

In relation to the causes of the debt crisis, Labonte mentioned corruption and



overspending as problems, but focused on several significant issues including large projects financed by the Banks and development organisations that failed, and often were not based on evidence or relied on flawed models. Wide variations in interest also play havoc for developing countries, as when countries borrow at 4% but repay at 16%. Currency liberalization, too, has proven to be a major problem for some countries, as local currency is de-valued through the effects of structural adjustment; in such cases, debt can double overnight. As a concrete example, Nigeria borrowed \$5 billion and has repaid \$16 billion, but still owes \$32 billion—an injustice and form of exploitation by any measure.

Processes such as currency liberalization and structural adjustment have been promoted by the Bretton Woods International Financial Institutions (IFI’s); the mandate of the IMF is to ensure balance of trade and macroeconomic stability, while the World Bank is supposed to ensure human development goals. However, since the early 1970s, the primary activity of both institutions has been to provide loans to developing countries on behalf of wealthy investors, and to promote the neo-liberal agenda of unfettered globalization by placing ‘conditionalities’ on loans and bail-outs, as through Structural Adjustment Programs (SAPs). Conditions are based on certain principles and beliefs, including



- *Liberalization*: Open markets work best
- *Privatization*: States shouldn't own profitable sectors
- *Enhance private sector*: States should open programs/services to private competition
- *De-regulation*: Few rules on private sector
- *State minimalism*: Reduce public spending & taxation, implement cost-recovery

However, SAPs have been shown by many studies, including the IFI's own data, to erode labour market institutions. Financial market liberalization worsens income inequalities, while shifts in taxation policies have proven to be less progressive. SAPs have had the effect of reducing public spending (on education, health, and environmental protection) both intentionally and incidentally through the economic effects on societies. Further, SAPs have clearly exacerbated inequalities between rural and urban populations, indigenous and dominant cultural groups, and various other more and less disadvantaged groups. The Banks have not necessarily denied these effects; rather, they subscribe to trickle down economics, despite its proven failure to create a fair distribution of greater wealth.

One response to the debt crisis by the IFI's was to develop a program of debt relief to very

poor countries with overwhelming debt. While noting that the Highly Indebted Poor Country (HIPC) initiative has increased funds available for health and education in many eligible countries, Labonte cited several limitations of the, including that the debt relief provided has been inadequate, and that these countries will remain highly indebted; that "sustainable" debt is defined with reference to volatile export earnings, rather than cost of meeting basic needs; that Poverty Reduction Strategy Papers have imposed new neoliberal conditionalities; and that it is likely that funds made available for HIPC may have been at the expense of development assistance flows of other kinds.

Labonte argued that it is especially important that initiatives not harm Global Public Goods for Health, which he suggests includes cures for disease, new treatment regimes for disease, control of air and water pollution emissions, uncovering basic research findings, monitoring disease, disseminating research findings, and curbing epidemics.

One such effort to promote such goods is the Global Fund for AIDS, Tuberculosis, and Malaria. However, the Fund's efforts have been undermined by US unilateralism through PEPFAR, a program which restricts funds for

AIDS drugs to only US patent drugs. Further, the structure of the Fund may unintentionally undermine health systems by establishing vertical delivery structures. Whether the health systems and health workers have the capacity to deliver the program is another important question that deserves attention, and likely suggests that capacity building and system strengthening are in order.

In the case of the Global Alliance for Vaccines and Immunizations, 90% of the first disbursement of funds has been used for developing new vaccines and injection technology rather than service delivery. Despite the adequacy of existing vaccines, their use is now declining as the pharmaceutical industry profits off of this development initiative.

Overseas development assistance as per cent of GNI among the G7 has generally decreased since 1985, although Denmark, Sweden, and Norway have maintained much higher levels of assistance than the other countries. Recently ODA commitments to health and education in Africa have increased; however, even if all the commitments were honoured and all were devoted to health, the total would still be less than the Commission on Macroeconomics and Health and World Bank estimated requirements for health alone.

One suggestion for securing further development funds is a proposal by the UK to establish an International Financing Facility (IFF), in which corporate bonds based on Monterrey pledges are floated, and future pledging rounds are held to double ODA in the short term. However, the IFF has not received much support by the other G8 countries, who will reconsider the proposal at the UK G8 2005 Summit. Further, the proposal has other limitations: conditionalities include that recipient low-income countries must open their borders to trade, the future pledging rounds cannot be counted on, and future payback could be at the cost of future ODA.

The pro-globalization argument goes as follows:

Liberalization	→	Increases Growth
Increased Growth	→	Increases Wealth
Increased Wealth	→	Decreases Poverty
Decreased Poverty	→	Increases Health
Increased Health	→	Increases Growth

Despite this hypothesized progression from liberalization to better health, wealth and

growth, the reality is that liberalization has resulted in growing poverty and income inequalities.

Liberalization has also had a profoundly damaging effect on the environment. Since *Indonesia* de-regulated logging, over 1 million hectares have been lost annually, leading to respiratory diseases due to the burning as well as the longer term damage of ecosystem loss. In *Argentina*, fisheries exports increased 5-fold in catches between 1985 and 1995; foreign companies earned \$1.6 billion while depletion of stocks cost locals over \$500 million. Privatized fisheries in Uganda led to over-fishing of the Nile perch and degradation of the Lake Victoria ecosystem. In post-NAFTA Mexico, illegal logging is increasing. And in Mauritania, the fish stock has been completely depleted; fish cannot be found in markets, and the wealthy eat fish raised in factories.

Labonte cited a number of examples of how liberalization has infringed on national sovereignty and undermined countries' ability to regulate, even in defense of public goods and citizens' protection and interests.

- TRIMS prevents "performance requirements" on foreign investment related to equity, local employment or domestic development
- TBT prevents domestic regulations that are other than "least trade restrictive": Exemptions existing under GATT XX(b) for human, environmental and animal health has been successful in only one of 50 cases
- GATS requires progressive liberalization; once a service is committed to the agreement, it cannot be withdrawn without penalty. This raises the question of whether the trade contradicts 'progressive realization' of the right to health.
- SPS requires "scientific risk assessment" even when there is no trade discrimination
- AGP requires governments to use only commercial criteria when issuing contracts, preventing equity-oriented discriminations
- TRIPS unduly extends patent protection, which favours wealthy over poor countries, and has prevented access to essential medicines
- Tariff reductions are hard on poor country finances, and generally create loss of revenue
- The costs of the WTO agreement implementation far exceeds development budgets of LDCs
- The WTO is only nominally democratic; while OECD countries have several dozen

negotiators, LDCs often have only 1 working part-time

- S&D exemptions for developing countries are opposed by many developed countries

Further, the G8 is maintaining if not increasing its demands on trade, expanding trade and involving more countries, and ignoring the commitment to strengthen special and differential treatment, a commitment expressed in Doha.

Labonte suggests that a number of reforms are necessary to secure global health and food security, including increased development assistance to 0.7% of GNP; debt cancellation for low-income countries; a global tax such as a carbon tax, Tobin tax, or GNI tax, in order to redistribute wealth; strengthen the practices of fair trade; and creation of a 'Development box' in AoA for food security and livelihood protection.

The right to health/food is actually supported by the WTO preamble, which declares that liberalization should be used only a means to development and sustainability. This principle could be supported by 1) subordinating WTO agreements to the right to health, including equitable access to health care, education, water/sanitation, housing, food—as stated the International Covenant on Economic, Social, and Cultural Rights; 2) subordinating WTO agreements to the Millennium Development Goals; and 3) allowing developing countries exemptions for human rights and development goals.

Labonte concluded with a group discussion on potential other issues related to the topic which might be included in an upcoming publication. He asked participants to think about what work they have been involved related to these issues.

Theme B: Privatisation and commercialisation of health services

Mike Rowson, Medact, UK

This session provided an overview of trends related to the privatisation and commercialisation of health services, and how and why developing and developed countries are embarking on programmes to privatise health care. It provided some evidence on the effects of privatisation. Mike Rowson approached the session by focusing on the potential inputs to the Global Health Watch

chapter on the commercialization of health. The focus is likely to be on ways in which health claims, and mechanisms of cross-subsidy and redistribution can be strengthened in low- and middle-income countries.

Participants from about a dozen (mostly developing) countries were present at the session. They drew out the following key principles as something they would like to see reflected in the Global Health Watch.

1. Defence of the public sector. Participants recognized its importance as a floor for the poor, and emphasized the need to demonstrate that the public sector works well, especially when adequately funded. They also discussed the ways in which the private sector can dump on the public sector, and highlighted increased costs of private sector.
2. A strong stand against the profit motive in health care.
3. International aspects of the shift towards privatisation need to be noted. Particular note was taken of GATS and the entry of multinationals.
4. Mechanisms to ensure accountability of public and private sectors.

'Public-Private Interactions' were also discussed. Participants felt that whilst there needs to be interaction between the two sectors in low and middle income countries especially, they also felt a need to clarify how the public sector can be ensured to gain from such an interaction.

Capacity for regulation emerged as another issue, in particular, the need to explore why governments have chosen not to regulate, or been unable to, and how these issues can be addressed, particularly in low-income circumstances. Participants condemned the way PFP providers regularly skimp on care; and suggested that advice be provided for how governments can deal with the explosion in private informal care. Some elaboration on how monitoring should be carried out was also suggested, as was who should be involved in monitoring.

Also discussed was the need to tackle the problems caused (especially for resource allocation) by health professional associations. South Asian participants particularly worried about this, although some also emphasised that there were good experiences to be learnt at local rather than national levels – i.e. groups of

professionals behaving ethically and in a non-commercial, pro-poor way.

A point was made that universalisation is possible even in quite poor circumstances and there were also interesting lessons to be learnt from places such as Thailand and Brazil. It was suggested that the Watch gather case studies.

Theme C: Poverty Reduction Strategies

Ellen Verheul, Wemos, Netherlands

Verheul discussed the development of Poverty Reduction Strategies, which were introduced some years ago as part of the deal for countries to participate in the debt relief process of the HIPC initiative. In order to qualify for debt relief, countries were expected to demonstrate plans for relieving poverty and targeting the poor. The development of these plans was also designed to ensure civic society involvement.

Verheul provided an evaluation of the PRSP process and then invited discussion from the floor. There have been criticisms from some quarters that the PRS process continues to be controlled by World Bank and IMF prescriptions, and amount to little change from previous structural adjustment programmes.

Participants were encouraged to raise experiences from their country of the extent to which the PRSP process has been transparent, has involved civil society involvement and has resulted in appropriate policies in the health and social sectors. They were presented examples of experiences and perceptions related to the influence of the World Bank and donors on the development process in their country. Particular issues discussed included whether the policies were harmful or helpful, or both, to countries; whether PRS processes are adequately coordinated; whether they are promoting an agenda of privatization; and positive examples of pro-poor poverty interventions that have been catalysed by the donor community.

Theme D: Developing advocacy strategies for GHW

Pat Morton, Medact and the Global Health Watch

Pat Morton focused on developing the GHW advocacy strategy and coming up with ideas and activities that will strengthen the application of an alternative world health report. Participants discussed the different ways in which national and regional initiatives can contribute to GHW, and presented some ideas of how they may be able to contribute to the Global Health Watch through case studies and the development of other material. Participants also discussed how GHW themes tie into national and regional priorities, and might be linked with existing advocacy campaigns. Emphasis was placed on the need to involve groups from non-health sectors as well as health sectors, and to generate solidarity among groups with similar goals.

Day 2

Plenary

Building National Coalitions: Sharing strategies for reducing health inequities, exploring linkages at the country and regional levels

GEGA's focus at the national level: where we've been, where we're going

Antoinette Ntuli, GEGA, South Africa

Antoinette Ntuli opened the 2nd day of the conference by tracing the two-year history of GEGA. Equity Gauges place health equity within the broader social justice framework and see health determinants broadly encompassing social, political, and economic factors and seek solutions to health inequities that are multi-sectoral in nature.

GEGA originated with bodies already working on equity issues in their respective countries, and encompasses groups from civil society organisations, the community, academia, and government ministries. Thus the focus of work is driven by national level challenges to equity in health from different perspectives within the national context. Given that the Equity Gauges are from 13 countries and on three continents, the collective experience and challenges within GEGA are diverse and multi-faceted.

Inherent to GEGA is pro-equity action to address the wider social injustice that gives rise to health differentials between social groups. Active engagement in advocacy and lobbying is core to the work of Equity Gauge teams. The composition of Equity Gauge teams is especially useful for this purpose. Team members from within government ministries and civil society organisations help identify strategies for effective advocacy, while research and academic institutions provide scientifically rigorous information that comprises the evidence for the strategy.

From the inception, GEGA acknowledged that supra-national forces give rise to inequities above and beyond the remit of state-level interventions, and that national level

challenges to health inequity cannot be addressed adequately without international collaboration. Integral to GEGA, therefore, is collaboration among Equity Gauges and other like-minded organisations at the regional and international level.

GEGA is involved in various activities designed to promote equity at an international level. GEGA's short-course titled 'Health Equity – Research to Action', an effort of the Equity Gauges, enables those interested in health equity issues to learn from the organisations collective experience. At a regional level, GEGA is collaborating with EQUINET and the SADC Parliamentary forum, in a project called 'Parliamentary Alliances for Health Equity'. At the international level, GEGA is involved in the conceptualization and production of an 'alternative World Health Report', the Global Health Watch. This biennial report represents collaboration between GEGA, the People's Health Movement, and MedAct.

She concluded by welcoming participants to actively engage with GEGA and encouraged them to get involved with the various regional and international activities of the organisation.

Perspectives on national challenges

Qamar Mahmood, Assistant Coordinator of GEGA, South Africa

Qamar chaired the session which was meant to highlight the roles that parliaments, as social institutions, can play in achieving health equity. While there are a variety of strategies to reduce health inequities, legislatures (parliaments) are in a key position to enhance processes and decision-making to support the development of equity sensitive policies and to the monitor the implementation and effects of those policies. Parliaments have an important

role in promoting health equity through their representative, legislative, and oversight roles. Parliaments can build alliances with the Executive branch of government, across political parties, between different portfolio committees and with civil society, health sector and other agencies at national and regional level in support of these roles.

Existing experience suggests that where parliamentarians are given the information and the requisite technical support, they are able to effectively carry out these responsibilities, with positive impact. Despite this, professionals and civic organizations working on health equity often do not sufficiently understand parliamentary processes to effectively support or work with them and parliaments may not be adequately linked with professional and civic networks working on health equity.

In this regard Qamar pointed to the work that GEGA, along with EQUINET and Southern African Development Community (SADC) Parliamentary Forum, has been involved in called Parliamentary Alliances for Equity in Health in Southern Africa. He highlighted some of the aims of this work which are to:

- strengthen and provide information and resource inputs for the partnership between parliament, professionals, and civil society to work towards building a common platform for health equity
- support networking of parliamentarians through their Portfolio Committees on Health, the secretaries/clerks to these Portfolio Committees, with technical and civil society personnel to enhance common work on health equity at the national level in several countries
- Provide information and technical support to national parliaments and to the SADC Parliamentary Forum on international protocols and agreements that have relevance to health in order to strengthen parliamentary responses and promote health equity within SADC positions on these policies.

This introduction was followed by inviting parliamentarians from Zambia, Zimbabwe, and Malawi to present their views on national challenges to achieve health equity.

Hon. Sakwiba Sikota, Parliamentary Portfolio Committee on Health, Zambia

Hon. Sikota outlined some of the primary challenges to improving health equity from a parliamentarian's perspective, and described his Committee's experience in working with the Zambia Equity Gauge. He noted that the nature of parliament, in which members are trying to get the most for their own constituencies, often goes against the principles of equity. The best response to this tendency is for empirical evidence to be available and in fact circulated in relevant discussions in parliament. However, often there are not sufficient resources to develop or gathering such information even if it is available. Another challenge is the timing of inputs to influence policy. As 70% of parliamentarians in Zambia in the election of 2002 were new, it took time to learn the timing and procedures for considering bills and budgets and for raising objections or commenting in an effective manner.

Hon. Sikota described the relationship working with the Zambia Equity Gauge. Although the Portfolio Committee on Health had an interest in working with the Gauge, it was a relationship that had to be built gradually and through community support of the Gauge, based on Committee's obligation to represent constituencies. The Gauge was able to present the Committee with community priorities for health and health equity, and also arranged for Parliamentarians to visit districts and talk with leaders informed on the issues. This strengthened the Committee's position when they returned to Parliament and raised the issues among colleagues. In addition to having a number of meetings on general health equity issues, the Gauge and the Committee worked on analysing the health budget from an equity perspective. This resulted in a challenge to the current budget, and a request for the budget to be resubmitted. Finally, Hon. Sikota noted the difficulty for national parliaments to address the range of challenges to improving health equity, and the need for multi-country alliances, such as the project on Parliamentary Alliances for health equity in Southern Africa, supported by GEGA, Equinet, and the Southern African Development Community.

Hon. Blessing Chebundo, Parliamentary Portfolio Committee on Health, Zimbabwe

After independence in 1980, the Zimbabwe Government established and maintained a sound health delivery system at all levels. The

policies put thrust on community-based health care, good infrastructure and well implemented programmes. Health budgets were equity-oriented, community focused, and constituted about 16% of the National Budget.

The late 1990s saw a decline in health delivery due to a multiplicity of factors, but chiefly due to a general economic decline and continuous under-funding of the health sector. Government expenditures on health have been declining in Zimbabwe, and while the World Health Organization recommends a health per capita of US\$21, Zimbabwe currently has a per capita of between US\$8 and US\$12. Another primary challenge is the HIV/AIDS pandemic, as its high prevalence has strained the meager resources of the country. Massive staff exodus from the Region has compromised health care delivery since health is a specialized area; such personnel are not easily replaced.

In 1999, a Health Service Commission was established to look into the deteriorating health sector and came up with reform recommendations to decentralize the public health sector in trying to solve the problems outlined earlier. At the same time, through Parliamentary reforms, it was recommended that Portfolio Committees should be established and that Parliamentary Committees should invite participation by civil society. Parliament, through the Committees, should provide effective oversight over the executive through participation in the enactment and review of policies and legislation and through participation in the budget process.

In relation to legislation enactment and review, the Portfolio Committee on Health has analysed some pieces of legislation for review including the Public Health Act, which is outdated, at the instigation of the Committee and its stakeholders. The Committee conducted public hearings on a bill at white paper stage (Government Hospitals Management Bill) to gather public opinion. The Government used evidence gathered to fine-tune the legislation. The Committee looks at all delegated legislation and relevant bills, e.g. the Statutory instrument on medical aid services and the recently passed Radiation Protection Authority Bill with immense contributions from stakeholders.

In relation to the Committee's oversight role, constant interaction with the Ministry of Health and stakeholders has resulted in several positive developments, including the government re-introduction of the Village Health Care Programme as a measure to focus

on Primary Health Care. The government has also reintroduced the State-Certified Nurse Training Programmes to improve the staffing situation at district and lower level health institutions. Other developments include the Initiative for Harmonisation of all health personnel in government and local authorities, and strong lobbying for the establishment of a Health Services Commission and Quicker implementation of reforms. In relation to the budget process, Civil Society has been better engaged as the budget is crafted to prioritize issues, and there has been better participation during quarterly budget performance reports of ministries.

When analysing the sectoral budget allocation and implications to the health sector, several issues have emerged. Local authorities attend to the majority of residents both in rural and urban areas, but they cannot charge competitive tariffs. Local authorities' grants from Central Government need to address needs like equipment, transport and human resources and be paid timeously. The Private Sector requires, through Parliament, concessions which benefit the majority, such as low taxes on importation and tariffs on raw materials so that drugs are either imported or manufactured at prices affordable to the consumers. In relation to HIV/AIDS, there should be constant monitoring of the disbursement of the National Aids Trust Funds. There should also be interviews with beneficiaries, inspection of projects, and gathering oral evidence from stakeholders like service providers). Hearings should be conducted on the effectiveness and relevance of policies. The government should support advocacy for mainstreaming HIV/AIDS in all Public, Economic and Social Activities, and for provision of ARV Therapy (including through WHO's 3X5 Initiative). These suggestions initiated the convening of an all-inclusive HIV/AIDS Conference 15-18 June 2004. Further, members of the Portfolio Committee on Health undertook Public Voluntary Counseling and Testing on May 7 2004 in order to encourage public testing, which continues to be under-utilised.

The Committee makes constant follow-ups on issues raised during deliberations. After the meeting on Parliamentary Alliances for Health Equity in Southern Africa held in August 2003: the report of the meeting was tabled in Parliament. Linkages were enhanced with Civil Society and private sector involvement in health care delivery was enhanced. Also, the children of Members of Parliament were

engaged on issues affecting them such as adolescence reproductive health. The Committee has also made a collective effort to identify an agenda that has implications for WTO talks, and the Ministry responding by giving assurance that in the future there will be wide consultations and stakeholders will be given feedback after the talks.

Hon. Austin Mutukwa, Parliamentary Portfolio Committee on Health, Malawi

Hon. Mutukwa presented an overview of some of the challenges of health equity in Malawi, including the HIV/AIDS crisis and underfunding of the health sector. He mentioned some of the particular challenges of parliamentarians, but also spoke of the broader challenges of health equity in creating a just society. He called for persistence and dedication in pursuing equity in society.

Parallel sessions

Strategies to support implementation and reduce inequities

These sessions provided a chance for participants to exchange experiences in applying intervention strategies in different economic, political, and social environments. Each session began with a presentation, which jumpstarted discussion and sharing on the topic.

Building networks and alliances, working with the media

Rodrigo Burgos, Equity Gauge, Chile

Burgos presented the Chilean Equity Gauge's experience in working with print media to support dissemination of Gauge findings, promote advocacy, stimulate public discussion, and spur action. Chile has a fairly sophisticated media, with highly educated journalists. However, as in many countries, journalists' knowledge of health issues, and especially of health equity issues, is often lacking. Burgos described the need to sensitize journalists to health equity issues and to increase their capacity to report on the issues.

He described the Equity Gauge's training course, which involved selecting journalists from an applicant pool. The course reviewed concepts of health equity as well as some basic techniques in measurement. Recognising the implications of data was emphasized. As a final assignment for the course, participants were required to write articles on health equity issues for publication, which not only demonstrated competence but also served the need of the Gauge for media coverage of equity issues. Upon completion of the course, participants received a certificate, which Burgos emphasised was important to journalists in Latin America.

Laxonie Mdhluhi, Equity Gauge, Zambia

Laxonie Mdhluhi described the Zambia Equity Gauge's work with media, which differs significantly from Chile's strategy. Because media in Zambia has a much shorter history than in Chile, the level of general development is also lower. Sensitisation to health equity issues is also low, as are skills for covering such issues. Further, media independence is still emerging in a country that only recently

gained its own independence and established democratic principles.

The strategy was to build the capacity of the media, including those working in television, radio, and print media, both in a structured environment through training workshops and in a less formal setting by working closely with the Gauge to promote a national campaign launch for health equity.

Training workshops increased capacity for understanding health equity and general development issues, for recognising pro-equity and anti-equity oriented actions, for interpreting inequalities in health and determinants of health, and for critiquing policies and programs in terms of health equity. These workshops were conducted in several sessions over a period of weeks and included production of reports on Gauge activities and issues.

Media workers also coordinated with the Gauge to promote a national campaign on health equity, including newspaper articles as well as radio and television interviews and call-in shows, and coverage of launch events. Coverage was coordinated to coincide with the week during the launch, and included interviews with parliamentarians, District Equity Gauges, international visitors as well as the Gauge's cultural competitions.

One of the reasons that the initiative and strategy was successful in Zambia is that demand for specific training among media workers is high, and workers have stated that they are particularly interested, and feel an obligation, to actively participate in promoting human development in Zambia. That is, they want to move from a more descriptive capacity to one that interjects analysis of situations.

Difficulties including that in Zambia newspaper space must be paid for, and radio and television time must be purchased. Media

workers often wanted allowances, probably because their salaries are extremely low.

Prem Kumar, One World South Asia, India

Kumar provided an Asian perspective on building networks and working with the media, based on the experience of a grassroots social justice group in India that includes health as a focus area. The primary areas of focus for One-World South-Asia are sustainable development and human rights, tackling poverty, and promoting empowerment.

One-World South-Asia uses a multimedia strategy to actively promote communication between NGOs and to convey messages to advocacy targets. Activities include communication for development, news syndication, capacity building, advocacy, pro-poor ICT research, and partnership development including with UN agencies and civil society organizations.

Kumar stressed the importance of networking in order to coordinate with others on specific themes (such as the MDGs), to disseminate credible research and to share knowledge and expertise. Strategies include have regular meetings such as an annual meeting; using both online and offline communication methods; establishing information repositories; providing training; working with smaller groups as well as mother NGO's; and supporting exchange visits with partners.

ICT and media are major components of One-World's efforts, allowing the organisation to function as a conduit for promoting the messages of many NGO's. The organisation attempts to provide information in local languages, and related to local issues, as much as possible, often using basic tools such as the telephone and loud speakers to reach the most isolated groups.

One-World South-Asia works with groups that support a number of specific efforts to promote networking, communication, and access to information among NGO's and other groups. Radio South Asia provides local language broadcasts on topics of local import, an especially valuable contribution in societies with multiple languages, which can often hinder networking among groups. The Open Knowledge Network provides internet kiosks to promote 2-way grassroots communication. Although the project is in its early stages, the test period has proven very successful and the

project is now proposing to set up 100,000 kiosks in rural areas.

Media Lab Asia researches and develops various technology solutions specifically to promote grassroots communication. Information management is a very important aspect of supporting networking and communication; to that end the Ek Duniya Project provides multilingual web content management solutions. The project also supports publication of partner web sites in English and 4 primary local languages.

Strategies for promoting internet based governance mechanisms with a pro-poor, bottom-up orientation are also being developed by Prerna Delhi. GKP provides online training modules to empower female journalists in using ICTs. "D groups" and open source offices provide information to civil society organisations as well as for information analysts, lobbyists, legal groups, etc. These centres are supported and managed by a number of organisations and institutions.

Kumar offered several strategies for receiving a favourable response from media, including contact with the media in their working environments ("infiltrating newsrooms"), investing in journalists through building relationships and taking time to build their knowledge base and capacity, and producing resources and materials expressly for the media.

Discussion

There were a number of contrasts drawn among the three contexts presented, and a few commonalities. For each of the countries, and for those of the participants, there was general agreement that there is a universal problem of low sensitization of media to health problems and especially for health equity issues.

There was also agreement that working with the media was most effective when conceived as a process rather than a specific event (e.g. training workshop), using coordinated campaigns, relationships with particular journalists, and ongoing networks.

While Chile felt that working with print media alone could be effective, Zambia chose to use a media blitz, integrating print, radio and television. It should be noted, however, that access to radio and television media is probably easier in Zambia than it would be in

Latin American countries, if one can afford to purchase it.

In a more technical sense, discussants agreed that securing commitment from journalists to attend the duration of training sessions can be a challenge, especially if they last more than a couple days. In India, a two-day training course on sex selection issues was held outside of the local setting in order to maintain participation; even so, it was difficult to get a two-day commitment from journalists. In Chile, the training was longer, but the certificate of participation was helpful in securing attendance. Attendance was less of a problem in Zambia, perhaps because of demand for the training or because of fewer professional demands on time.

Another topic of discussion was targeting journalists by their specialty. The Zambia Gauge invited all interested journalists to participate, especially focusing on young journalists. Their strategy is to place health equity issues within larger social development issues and human rights, which increases journalists' interest as well as the audience. In Chile, they targeted health journalists, and attempted to mainstream equity issues in the journalists' health issues of interest.

Participants from South Africa are working with a media/advocacy group called Soul City. They are thinking of targeting journalism schools to incorporate an equity focus in health issues. They are also feeding information to journalists who seem to be particularly interested in and sympathetic to specific equity issues, and building a relationship with them, for instance, by providing them with "scoops." Zambia also approached the college to get equity integrated in training for journalism students.

Participants discussed choice of outlets, too. Chile found a focus on print media most useful, as they were trying to reach a more educated audience as well as decision-makers. On the other hand, Zambia complemented print articles with television and radio in part because they were attempting to build a more expansive movement within the population and needed to access the various ways people get information, including people in rural areas and less educated people.

A participant from Mexico raised the issue that perhaps we need to go beyond training, and to be more political and strategic, taking advantage of the tendency toward

sensationalism to our own benefit. Chile mentioned that newspapers there are very conservative and see equity as a political issue, making it difficult at times to get coverage.

A final challenge discussed was the issue of countries where media is paid for (a "market media"), including Bangladesh, India, and Zambia among others. In particular, given that equity is an issue of the poor, advocates are often at a particular economic disadvantage to get coverage. However, it was also noted that if media outlets are government institutions, equity issues may be censored or omitted from coverage, since they often criticize the elite and the status quo, and are politically incorrect.

Participants concluded that there are many strategies for involving media in covering equity issues, and that it is worth continued study and discussion.

Intersectoral and upstream interventions

Margaret Whitehead

Whitehead highlighted a more direct role that the health sector can play in reducing poverty through job creation and thereby reducing unemployment. She demonstrated with the example of the North West (NW) region of England of the health sector's potential to combat poverty and inequalities. Health sector could potentially:

1. Match health services to need in areas of high inequality or focusing on resource allocation;
2. Minimise/ameliorate the health damage caused by exposure to risk conditions; and
3. Tackle more directly unemployment and poverty.

She informed that equity is a longstanding objective of the National Health Service (NHS) in Britain. In 1999 the NHS agreed to allocate resources to contribute to decreasing preventable inequalities. The NW region of England has approximately 7 million people and is the poorest of 8 English regions plus it is an unemployment "hot spot". The only chance of meeting national inequalities targets is if improvements are made in the NW region. Focusing on what the health sector can potentially do, she pointed to the following statistics:

- The purchasing power of the health and social care sector in NW is strong – 7.3% of regional GDP
- The health sector is a major employer in the region – 200,000 staff; 6.8% of jobs in the region; major employer of women and ethnic minorities
- One strategy for the health sector is to harness the economic power that exists for local regeneration by linking with the regional development agency to integrate health's contribution as an employer into sustainable development and regeneration plans for the most disadvantaged areas. Some ways in which the health sector can then contribute include:
 - Recruitment and training of people from disadvantaged areas for vacancies in the NHS
 - joining up with local training agencies
 - Purchasing goods locally and using local services to boost the local economy.

Here she quoted a specific example in which one local Primary Care Trust Scheme created 350 jobs; 400 people who participated in Fit for Work training programs obtained a formal qualification; and 100 new businesses were started

HOWEVER

This approach is currently being undermined by a range of emerging threats including:

- Privatisation & private sector financing of health services
- Contracting out to private sector companies to provide health or health related services (eg. laundry) where these companies have poorer employment rights and conditions
- Assets/purchasing power is going out of local control – even going overseas to US based companies
- Exporting neo-liberal influence to the globe.

Baya Banza, Equity Gauge Ouagadougou.

Baya shared his experience of an intervention in an urban area in Burkina Faso. Urban areas are perceived as better off than rural areas and most interventions to reduce inequities focus on rural settings. However, global indicators tend to hide existing disparities and disparities within countries. With rapid urbanisation (an annual growth rate of 4.3%), urban area inequities are increasing significantly.

In this context, the Equity gauge in Ouagadougou decided to analyse the determinants of access to and utilisation of social services. The intervention was to provide children less than 7 years of age living in poor households in an urban area with affordable anti-malarial drugs and to take care of the children. This was based on a similar project undertaken by the National Centre for Training and Research on Malaria in a rural area that had been successful, especially in terms of poor households being able to afford anti-malarial drugs and care for their children. Community health workers were used to provide the medication to families; medication was affordable because families only had to purchase the tablets required (eg. 1 or 2) rather than an entire packet as they are usually prescribed. Aim was to identify if the intervention would be as successful in an urban setting.

The potential challenges were:

- The better off don't trust community health workers because they are not health personnel
- Sustainability of the intervention especially for the least well off, in case of success.
- Incentives for the community health workers to continue the program?

Action research at the local level

Itai Rusike, Community Working Group On Health (CWGH), Zimbabwe

Rusike began with a short description of the grassroots organisation with which he works. CWGH is a network of Civic/ Community Based Organization founded in 1998, whose main concern is to collectively enhance community participation in health and to create discussion fora between health service providers and communities. Rusike described a particular project to provide community evidence for the budget process, working with a number of actors, including Health Centre Committees, CWGH District Health Forum, Ministry of Health and Child Welfare (MoHCW), Parliamentary Portfolio Committee on Health (PPCH), Local Communities, Traditional Leaders/ Elected Leaders, Civic Leaders, and Civic Organizations/ CBOs.

Rusike cited a number of reasons why local information is not only useful but also highly

appropriate. First, communities are the primary beneficiary of the budget process, as 70 % of hospital beds in the district are rural. Other justifications include the falling life expectancy (62 years in 1993 to 55 years in 2002), increased hospital based mortality (1.9 in 1990 to 4.7 in 1998), a collapsing referral system, and a falling budget allocation to health (US\$21 in 1990 to US\$9 in 2000).

Rusike described their approach to community evidence gathering as bottom-up and participatory. The evidence gathering process involved a number of steps:

- Integrated budget debate into civic education programme
- Surveyed people's priorities in districts
- Research on the priorities
- Preparation of a CWGH position paper using community AND technical evidence

Specific priority issues within the study districts included drug access, affordability, health personnel, and quality primary health care. In relation to drug access, the public – private divide in health services was found to be a primary concern. In the public sector, consumers cover less than half the healthcare financing, and the sector is over-used and under-resourced; the private sector covers less than 20% of the population but employs the majority of specialists. While drugs are usually available, they are often unaffordable and inaccessible; further, the community felt that HIV/ AIDS has exacerbated drug unaffordability and inaccessibility. Issues on health staffing were also identified as important issues; the district studies found there were few qualified nurses in rural areas and that the workload was often shared with nurse aids.

The priority issues that emerged from the research, which CWGH adopted in its budget position, included the need for

- Effective primary health care systems, esp for HIV/ AIDS, Malaria, Maternal mortality
- Improved investment in prevention, eg sanitation
- Global budget to be at least 15% of total budget
- Allocations to clinic and district level

There were also a number of recommendations specific to allocating resources more equitably:

- Increase tax funding to health (increase +2.5% GDP, 12.5% public budget, +\$21/capita)
- Redistribute budgets to prevention and PHC
- Introduce equity and deprivation factors into resource allocation formulae
- Remove cost barriers at the point of service
- Back personnel with resources
- Ensure community health is funded

This evidence and these recommendations formed a position paper that was presented formally to the Parliamentary Portfolio Committee on Health (PPCH), at which time stakeholders were also invited to directly share their views. The PPCH then forwarded stakeholder views to Parliament for consideration. Finally, the CWGH position was successfully integrated into the PPCH position. In short, community evidence created a platform on which communities' voices could find an attentive audience.

Eventually, the health budget for 2004 saw increased pressure for PHC and prevention share from PPHC, an equity formula was introduced, and there were nominal health budget increases. However, the health budget share of the total budget fell from 12% in 2003 to 11.2% in 2004.

Developing participatory processes for building an evidence base

Khuzwayo Gondwe, Equity Gauge, Zambia

Khuzwayo Gondwe discussed the Zambia Equity Gauge's experience in developing a community-based process for identifying health equity issues and general community concerns related to health and development. This approach was especially useful in a context where communities often must find their own solutions and assert their voice in order to generate response.

The Zambia Gauge began as a national initiative, but found that the community voice would have to be magnified not only to increase impact but also to appropriately and ethically identify community priorities. The Zambia Gauge then established four District Gauges, which, together took the lead in developing a study of community priorities for health equity.

The process began with workshops on health equity, including the concepts of health equity,

its contribution to human development, simple measurement and monitoring issues, and an overview of advocacy and community empowerment initiatives. It covered issues of vertical and horizontal equity, . Participants discussed the various concepts of equity in relation to their own context, where poverty is extremely high and the health sector is greatly underfunded in general. That is, they considered the meaning of health equity, an essentially distributive concept, in a context where the main problem is level of resources and not simply distribution. Participants explored the two-way relationship between health and wealth, and the production of health at the household level.

These workshops were perceived to be extremely useful by the District Gauges in building their understanding of issues as well as their ability to articulate and discuss issues with others. The District Gauges—comprised of a variety of community leaders, health workers, religious leaders, local decision-makers, and others—identified a variety of issues they believed the community might identify as priority issues, and developed a questionnaire to gauge responses. The questionnaire asked not only opinion questions on priorities, but also empirical questions on issues such as availability of drugs, access to care, etc.

This survey was administered to almost 3700 households in the four districts. Findings were reported for several priority issues identified by the District Gauges, including distributions of wealth, access to health, economic barriers to access, access to public preventive services, food security, NGO activities, and health status outcomes.

Findings include:

- Wealth distribution in Zambia, between districts, and within districts is very uneven; rural districts are more disadvantaged on wealth distribution than urban districts.
- Overall, the amount of money available to spend per person per day in a household is LESS than the average user fee charged at local health facilities per sick person.
- The poorest tend to live farther, travel longer distances and take longer to reach health facilities than those from rich households.
- In general, Ambulance services are not available; the commonest means of transporting sick poor people to health facilities is either by walking, use of bicycles or use of wheel burrows

- User Fees at health facilities still pose a major barrier to utilization
- The deterrent nature of User Fees is Most pronounced among the Poorest sections of society, but nearly 50% of the richest quintile urban areas oppose user fees
- The poor in society are poorly served by public preventive services, such as malaria control as well as water and sanitation services.
- Water and sanitation services are better provided in urban areas when compared to rural areas.
- Appropriate subsidies, as in the case with ITNs has helped increase the uptake of this intervention by many of the poor in rural areas, especially in targeted districts. Thus the targeting of public health interventions may be an effective strategy in Zambia.
- Some 0.87% of surveyed households could not afford even a meal per day.
- None (0%) of sampled households could afford to eat each of the 3 main meals per day
- No more than **13%** of Lusaka households were confident of feeding their families over the next 12 months. The corresponding proportions for other districts were **6%** for Chingola, **3%** in Choma and **5%** in CHAMA.
- The Poorer and/or Rural the District, the greater the proportion of households that are **NOT ABLE** to feed themselves
- NGO Activities are better known in smaller and less affluent districts (Less known in Lusaka and best known in CHAMA), and better known by the poor than the rich
- NGOs are thus better placed to play the re-distributive role in resource allocation.
- The proportion of respondents who felt better now than in the previous 12 months was highest in wealthier districts, and decreased according to district wealth. Within the category of feeling worse than last year, the proportion was greatest in the poorest groups.
- Overall, the poorest experienced the worst health outcomes compared to those in the richest groups.

This baseline study was then presented to the Parliamentary Portfolio Committee on Health, Community Development and Social Welfare. The Committee immediately responded to it as a demonstration of community empowerment which gave them a mandate to raise the issues within Parliament.

Oscar Lanza, AIS, Bolivia

Oscar shared experience of successes and failures and some solutions that were identified in the Bolivian context. In Bolivia civil society organizations (public interest organisations) came together with the aim to promote public health. In the year 2000 there was a national dialogue on loans which was mainly initiated by donors as part of the Poverty Reduction Strategy. This started a dialogue between government and civil society organizations on loan payments which were unfair and excessive. Civil society organizations used the National Legislation 2000 to demand their right to information for public policy and to monitor and evaluate public policies for this purpose.

One of the first pieces of work involved investigating government expenditure of US loans towards transparent and efficient allocation for the poor. This process also assisted in building social accountability. During 2002-03 proper follow-ups were done which demonstrated that a total of US\$ 8.5 million was allocated as health sector investment to improve health actions. This amount was being spent on recruiting 2,200 health personnel. This raised the question whether such allocation would solve health problems. Also, the main issue relating to this was that this recruitment was being done on the basis of political party affiliation rather than on experience and skills. The loan repayment agreed upon was US\$ 100 million but the actual payment being done was US\$ 227 million. Data collection revealed that this extra amount was being linked to currency fluctuation. This highlighting of facts led to an outrage and thus a process of social accountability was started.

Human rights and Health Rights for monitoring and advocacy

Ravi Duggal, Centre for Enquiry into Health and Allied Themes (CEHAT), India

Duggal described CEHAT's strategy for monitoring and advocacy for health and human rights, using a health and human rights framework. The framework recognizes health as a human right, according to the United Nations International Covenant on Economic, Social, and Cultural rights. This document provides for the respect, protection, and fulfillment of the right to health care. More specifically, this standard includes, he argues, guarantees to the availability and

accessibility—including non-discrimination, physical access, economic access and access to information. It also includes care of acceptable quality, as well as principles of universality and equity.

There are a number of other bases for Monitoring and Advocacy for H&HR:

- Country's constitutional and legal position and policy framework
- Present healthcare system
- Structure, provisions, financing and regulation
- Access, inequities and ethics
- Social and political environment to steer change and accountability

Methods of monitoring include tracking access to information on provision and outcomes, using already established local level participatory accountability mechanisms, performing social audits, undertaking budget and policy analysis, and tracking public pressure and demands.

Advocacy strategies that have proven successful for CEHAT include:

- Public campaigns on right to healthcare
- Raising the budget / allocations
- Dialogue with parliamentarians
- Dialogue with civil society groups
- Public Hearings
- Policy briefs and info packs
- Media use
- Legislative/ Constitutional changes and
- Public interest litigation

Duggal concluded by describing several examples of monitoring and advocacy from India. The first involved a CEHAT project to monitor a local health budget, combined with advocacy for transparency and public participation in an effort to increase accountability and responsiveness. In response to denials of health care and violations of health rights, the NHRC organised hearings in which testimonials were publicly presented. Other examples included:

- Right to healthcare campaign (JSA)
- Research support for right to healthcare (CEHAT)
- Monitoring sex selection and advocating for changes in and implementation of PNMT Act (CEHAT, MASUM...)
- Regulation of the medical profession (CEHAT)

- Reproductive rights and right to abortion (CEHAT)

Audrey Chapman, American Association for the Advancement of Science, USA

Chapman addressed various approaches to monitoring health as a human right, also focusing on compliance with international standards. The key question, as she put it, is “How well is your government complying with its immediate obligations, particularly nondiscrimination and assuring the human rights of poor, vulnerable, and otherwise disadvantaged groups?”

Chapman identified several UN documents as establishing standards, including the number of countries which have ratified them:

- International Covenant on Economic, Social and Cultural Rights (149 states are parties)
- Convention on the Elimination of All Forms of Discrimination Against Women (177 states are parties)
- Convention on the Rights of the Child (192 states are parties)

In relation to the ICESCR, Article 12

"recognizes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health...to that end, mandates that states parties to the Covenant undertake the following steps to achieve its full realization

- The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- The improvement of all aspects of environmental and industrial hygiene;
- The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- The creation of conditions which would assure to all medical service and medical attention in the event of sickness."

Chapman outlined the structure of the Committee on Economic, Social and Cultural Rights, noting that it has three meetings per year; accepts reports and letters from nongovernmental organizations and uses the information; meetings are open to nongovernmental organizations to observe; and it has one open session at each meeting to hear from NGOs.

Chapman also outlined the Core Obligations of State Parties Related to the Right to Health, according to the UN General Comment No. 14 (2000)

- to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- to ensure for everyone access to the minimum essential food which is sufficient, nutritionally adequate and safe, to ensure their freedom from hunger;
- to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- to provide essential drugs, as from time to time defined by WHO’s Action Programme on Essential Drugs;
- to ensure equitable distribution of all health facilities, goods, and services;
- to adopt and implement a national public health strategy and plan of action.

Additional obligations of comparable priority include

- to ensure reproductive, maternal (pre-natal and post-natal) and child health care;
- to provide immunization against the community’s major infectious diseases;
- to take measures to prevent, treat and control epidemic and endemic diseases;
- to provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- to provide appropriate training for health personnel, including education on health and human rights

Each of these obligations can be used as indicators for monitoring.

Chapman mentioned several approaches to monitoring violations, including those caused by what a government does itself, by what a government fails to prevent others from doing, and by what a government does not do (that is, a failure to realize its obligations).

In order to assess progress in realizing rights, we can use systematic and scientific measurements and indicators to assess policies and progress. These indicators can assess the overall status of a particular situation; changes or trends over a period of time; achievements towards targets (benchmarks); differences between particular groups in the population; or

differences between geographic regions within a country.

Potential uses of the data include reports to international treaty monitoring bodies, collaborative assistance to governments, court cases (e.g. TAC in South Africa over AIDS policy), and mobilization of public opinion.

Working with government, linking ministries

Frederick Mugisha, Equity Gauge, Kenya

Mugisha provided a short background on the Nairobi Equity Gauge's program, which is a collaborative effort between the African Population Health and Research Council, the Ministry of Planning, the National Council on Population and Development, the Urban Slum Development Project of Nairobi City Council (USDP/NCC) and the Nairobi Informal Settlement Coordinating Committee (NISCC). The Gauge is focused on reducing inequities between slum residents and other residents of Nairobi—a complex and growing problem, requiring cooperation between a number of institutions and groups.

Discussion among participants focused on a number of issues. Government lack of trust and misunderstanding was cited as a significant problem, suggesting the need for advocacy groups and research groups to build longer term relationships rather than trying to influence government without prior contact. One practical strategy is to include identifying key people in government who are interested in action-based research and attempt to institutionalize the process, thereby improving chances for continuity. Working with community elders to influence district government and parliament was also discussed, as was developing supportive partnerships with others in similar work.

One successful strategy cited was to provide technical support to government, especially providing data/evidence that is useful for them and their needs; this is especially useful as an entry mechanism to building a relationship. However, we should also be strategic in providing technical support in terms of processes and where we put energies; for instance, although providing technical support to parliamentarians has been effective in southern Africa because Committees are generally under-resourced and often have little background in health, such a strategy might not work in Latin America, where

parliamentarians have much more in-house technical support and the politics of issues can overwhelm the discussion.

The important role of the Ministry of Finance in health issues was also discussed, as was the common need to involve a number of Ministries in discussions from the beginning, perhaps including the Ministries of Finance and Planning as well as Health, depending on the issue involved. Related to this was the need to get general equity indicators (not just health equity indicators) into and used by other ministries. In addition to promoting values of equity in general, this would support the health equity agenda by increasing information that could be useful for health equity analysis specifically.

One participant suggested that ministries themselves, especially Ministries of Health, need advocacy skills when working with the Ministry of Finance, since “the Ministry of Finance's first priority is to keep the bureaucracy satisfied.”

Participants also raised the larger question of how to engage public officials, noting that the institutional environment is important. For instance, while levels of resources are extremely important for most countries in Africa, in Latin America, the issue is more about how the health sector allocates resources rather than how much the health sector gets. It was noted that in Ecuador, the Ministry of Planning not only decides the general health budget but also specific allocations within the health budget.

Because budgets don't vary much from year to year, and because they are mostly linked to human resources (usually about 80% of the health budget is salaries), they are difficult to change in terms of geographic allocations or line item distributions.

One participant suggested that advocates be creative in their arguments, citing that the treasury in Australia supported more primary health care as an economic issue/decision rather than a health decision. One particular area of interest that is often needed by governments is where governments should invest in social sectors in order to get the best bang for their buck. Another suggestion is that there may be issues around which several sectors have an interest; for instance, in Australia an inter-ministerial task force banded together about a specific issue (child health)

and requested a single pool of money to divide themselves.

Another issue mentioned was the difficulty of working with various sectors and levels of government simultaneously. One example was implementation of Poverty Reduction Strategy Papers, where there might be a need to work with, for instance, the Ministry of Health and Directorate of Health, and the Division of family planning. Related to this issue is how to work effectively given the commonly significant influence of donors, as with PRSPs. That is, how do we work with governments when they have been weakened, lost power, and maybe even lost political will?

Influencing other policy levels: local to national and national to global

Ted Schrecker, David Acurio

Evidence for advocacy

Martin Valdivia, Kausar S Khan, Community Health Sciences Dept., Aga Khan University, Pakistan

Dr. Khan provided an overview of the use of evidence for advocacy, especially focusing on how concepts of advocacy vary between contexts. She presented a range of synonyms for “advocacy”, including advancement, aid, assistance, backing, campaigning for, championing, defense, encouragement, justification, promotion, promulgation, propagation, proposal, recommendation, upholding, and urging.

She said that advocacy starts with a core group of people who share concerns about a particular issue and who are prepared to commit time, expertise and resources to bring about change. Advocacy core groups, advocacy goals and objectives, and advocacy environments vary widely. Therefore, the advocacy process is more like a network than a step-by-step process. Khan suggested that advocacy works best if advocates start from the particular, composite knowledge and the skill base of the core group, since that will help them establish their expertise and authority on the issue. Additionally, she said that in order to attract people to the cause and build momentum, “it helps to start off with an activity with high visibility and high probability of success.”

Khan also presented some cultural interpretations of advocacy:

- Colleagues in India describe advocacy as an organized, systematic, intentional process of influencing matters of public interest and changing power relations to improve the lives of the disenfranchised.
- Other colleagues in Latin America define it as a process of social transformation aimed at shaping the direction public participation, policies, and programs to benefit the marginalized, uphold human rights, and safeguard the environment.
- African colleagues describe their advocacy as being pro-poor, reflecting core values such as equity, justice and mutual respect, and focusing on empowering the poor and being accountable to them.

Regional processes to support Global and National Coalitions

Parallel sessions were held in the afternoon on how to develop and coordinate regional processes to support global and national coalitions. Discussion was focused on particular ways in which national pro-equity initiatives could feed into the Global Health Watch, and how the Watch can feed into and support national campaigns on specific issues.

Closing

Antoinette Ntuli, Chair of the GEGA Coordinating Committee, chaired the closing session, noting the intensity of discussions as well as the breadth of participating groups at the conference. Ms. Ntuli thanked the many contributors to the conference, including the staff of HST, the institutional sponsors, SIDA and the Rockefeller Foundation, as well as the delegates themselves.

Ms. Ntuli invited delegates to remain connected to GEGA activities and conversations, including exploration of future opportunities for collaboration, training, and developing Equity Gauges. A number of groups thanked the hosts for providing stimulating and useful discussions, and expressed interest in developing Equity Gauges in their own countries.

The conference closed with a commitment to continue working together and building solidarity for health equity.

Summary of GEGA's major initiatives and areas of cooperation

Health Equity Research to Action Short Course

The Secretariat, in cooperation with individual Gauges, has developed a 3-day course "Health Equity: Research to Action", based on the Equity Gauge Strategy. Prior to the June conferences, GEGA received a large number of applications for the course (over 200 applications from more than 45 developing countries, despite little advertising), indicating significant demand for such training opportunities and potential for such work in the neediest countries. Consequently, we presented the course twice at the June events in Durban, allowing us to accommodate approximately 70 participants from about 30 groups working in health equity.

The course focuses on the use of research for development of policy recommendations, community action, and advocacy for health equity. The course introduces participants to the links between the concept of health equity and working with various kinds of information, the design of efficient and effective action-oriented research, and strategies for using research for change.

Evaluations of the courses indicate substantial support for such learning opportunities. Although participants included both seasoned equity workers as well as those recently introduced to health equity work, the continual focus on linking research and action, and the context-sensitive interpretation of equity findings provided a continually stimulating focus for discussion for everyone. Participants also gained insight into areas where they need further skills training in order to improve the effectiveness of their efforts to promote pro-equity policies and interventions.

Feedback from the June workshops indicates strong support for continuing and developing the workshop, and participants contributed a number of useful suggestions for future courses. Most participants indicated a strong interest in building institutional links with GEGA and further developing their work along the lines of an Equity Gauge.

The GEGA Secretariat and several Gauges are currently working to revise the course and to

modify and translate it for regional adaptation. Due to the high level of public interest in this initiative, a course subcommittee has been formed with an overarching responsibility of strategically planning future courses. Within the next few months, we expect to offer the course in West Africa, Latin America, East/Southern Africa, and South Asia.

Global Health Watch

Conceived as a global-level Equity Gauge, the Global Health Watch has developed as an effort led by a number of Southern-centred organisations and highly respected advocacy oriented groups, including the People's Health Movement and MedAct. In contrast to global reports that commonly restrict their analysis to micro-level technical fixes without attention to the context of decisionmaking, the GHW focuses on the equity impact of global processes and decisionmaking and bases recommendations on analysis of political and economic as well as technical challenges to equity.

Chapters are currently in development, and cover issues including health systems development, commercialization of health care, pharmaceutical companies, human resources, HIV/AIDS, gene technology, environmental challenges, militarism and conflict, water, the right to food, marginalised groups, and monitoring institutions and research flows. The Watch concludes with a summary of policy recommendations as well as strategies for action.

It is expected that this document will be used to globally unite campaigns to address the issues at the national and regional levels, and to stimulate discussion on many of the social, economic, and political features that underlie health inequities (see appendix for more information on the GHW).

Parliamentary Alliances in Southern Africa

GEGA's work on Parliamentary Support in Southern Africa, in cooperation with Equinet, has progressed significantly in the last year. Since then, we have assembled equity researchers and members of parliamentary

committees on health at a meeting in August to discuss priority equity issues for Southern Africa and to identify strategies for cooperative progress and support. A number of common issues were identified, and a regional approach was seen to be especially useful on issues of human resources for health, food security, and trade issues. The participants also developed a set of resolutions intended to promote priority issues and suggest solutions for addressing them, which was circulated at the Cancun Ministerial Meeting of the WTO and distributed electronically and at various other events (see appendix).

In February, Equinet and GEGA met with equity researchers and advocates in Tanzania to help develop a country-based equity organisation with membership from a variety of institutions in Tanzania, and to further develop parliamentary work there. At the June meetings, Equinet and GEGA jointly hosted a workshop session on the Parliamentary Alliances work, after which representatives from SADC invited the Alliance to work with them to integrate the priority issues into SADC's agenda. Currently, we are working with Equinet and SADC, as well as the Alliance members, to identify next steps.

Health Metrics Network

GEGA served as co-chair of the Health Equity Task Force for the HMN, overseeing the development of recommendations for rapid integration of equity information into health information systems. These recommendations were incorporated into a proposal to fund the work of the Network. A workshop on HMN was presented at the ISeqH Conference by GEGA and WHO, and we are now in the process of publishing the recommendations. Future work with HMN will depend on whether the Network receives funding.

Commission on Social Determinants of Health

GEGA participated in a planning meeting for the Commission on Social Determinants of Health. This Commission is intended to focus attention on the underlying causes of ill health within and among populations, broadening the conversation from restricted health care approaches. The Commission is expected to be launched in early 2005.

Additional work with WHO

GEGA has been providing input to WHO on its equity-oriented work and to identify Health System Research priorities, and also to plan for the upcoming Mexico Summit to ensure that equity concerns are represented. During the June meetings GEGA organised a consultation with more than 70 representatives of civil society and other organisations to discuss these issues.

Annex 1: Program

GLOBAL EQUITY GAUGE ALLIANCE

Building Global and National Coalitions for Action in Health Equity

*Tropicana Hotel
Durban, South Africa
June 13-14*

PROGRAMME

Saturday 12 June 2004				
1700-1900	Registration			
Sunday 13 June 2004				
Building Global Coalitions: GEGA and the Global Health Watch				
0830-0900	Registration			
0900-0915	Welcome and Introduction to the day <i>Antoinette Ntuli, Chair of the GEGA Coordinating Committee</i>			
0915-1030	The Equity Gauge Strategy Applying and expanding the concept <i>Lexi Bambas, Coordinator of GEGA</i> The Chile Equity Gauge <i>Liliana Jadue, Chile Equity Gauge</i> A Zambian response <i>TJ Ngulube, Zambia Equity Gauge</i> Applying the strategy in Bangladesh <i>Rumesa Rowen Aziz, Bangladesh Equity Gauge</i>			
1030-1100	Tea			
1100-1215	The Global Health Watch <i>David McCoy, GEGA and GHW Secretariat</i>			
1215-1345	Lunch			
1345-1515	Parallel Sessions: Global Issues and Global Responses			
	The global politics and economics of health <i>Ron LaBonte, Saskatchewan Population Health & Evaluation Research Unit</i>	Privatisation and commercialisation of health services <i>Mike Rowson, Medact</i>	Poverty Reduction Strategies <i>Ellen Verheul, Wemos</i>	Developing advocacy strategies for GHW <i>Pat Morton, Medact</i>
1515-1545	Tea			
1545-1645	Group feedback and discussion on the GHW <i>Facilitator: Mike Rowson, Medact</i>			
1645-1730	Sharpening the focus and linking the Watch to Country level work Identification of priority issues <i>Abhay Shukla, CEHAT</i> The Contribution of National Level Work to GHW <i>Pat Morton, GHW</i>			
1830	Dinner reception			

Monday 14 June 2004	Building National Coalitions: Sharing strategies for reducing health inequities, exploring linkages at the country and regional levels			
0900-0915	GEGA's focus at national level: where we've been, where we're going <i>Antoinette Ntuli, GEGA</i>			
0915-1000	Perspectives on national challenges <i>Chair: Qamar Mahmood, GEGA</i> A View from Zambia <i>Hon. Sakwiba Sikota, Parliament of Zambia</i> The Zimbabwe Perspective <i>Hon. Blessing Chebundo, Parliament of Zimbabwe</i> A View from Malawi <i>Hon. Austin Mutukwa</i>			
1000-1130	Parallel sessions: Strategies to support implementation and reduce inequities			
	Building networks, working with the media <i>Rodrigo Burgos, Development University; Laxonie Mdhluli, CHESSORE; and Prem Kumar, One-World South-Asia</i>	Intersectoral and upstream interventions <i>Banza Baya, University of Ouagadougou & Margaret Whitehead, Liverpool School of Tropical Medicine and Hygiene</i>	Action research at the local level <i>Itai Rusike, Community Working Group on Health</i>	Developing participatory processes for building an evidence base <i>Khuzwayo Gondwe, CHESSORE and Oscar Lanza, AIS</i>
1130-1200	Tea			
1200-1330	Parallel sessions: Strategies to support implementation and reduce inequities			
	Human Rights and Health Rights for Monitoring and Advocacy <i>Ravi Duggal, CEHAT and Audrey Chapman, American Association for the Advancement of Science</i>	Working with government, linking ministries <i>Frederick Mugisha, African Population Health and Research Council</i>	Influencing other policy levels: local to nat'l and nat'l to global <i>David Acurio, ALDES & Ted Schrecker, Saskatchewan Population Health & Evaluation Research Unit</i>	Evidence for advocacy <i>Martin Valdivia, GRADE and Kausar Khan, Aga Khan University</i>
1330-1430	Lunch			
1430-1530	Parallel Sessions: Regional processes to support Global and National Coalitions			
	Latin America <i>Armando Negro de Filho, ALAMES</i>	Africa <i>Antoinette Ntuli and Mwajuma Masaiganah, People's Health Movement</i>	Asia <i>Siriwan Grisurapong, University of Mahidol and Narendra Gupta, Prayas</i>	Developed Countries <i>Paula Braveman, University of California, San Francisco</i>
1530-1600	Tea			
1600-1645	Feedback from regional groups			
1645-1730	Discussion of major conclusions and plans Closing			

Annex 2 : Participants

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Annex 3: WHO consultation with Civil Society Organizations on Equity and Health Systems Research Priorities

2-5 (and later) PM, 12 June

Room 6

Holiday Inn DURBAN-ELANGENI

This meeting is a brainstorming workshop to discuss WHO's equity agenda and health systems research priorities to be presented to the Ministerial Summit on Health Research (November 2004 in Mexico).

Participants

Representatives of civil society organizations attending the GEGA and ISEqH Conferences.

- Researchers of Health Systems/social determinants of health - especially those who research the interface between health systems and the community and health systems and social determinants of health.
- Activists/campaigners experienced in health interventions and health systems research.

Meeting Structure

Time and date		
12 June 2-3pm	WHO Equity Proposal Coordinated by Dr. Jeanette Vega	How should all departments of WHO approach equity? Discussion on a plan of action for WHO in terms of equity.
12 June 3:15-7pm	Health Systems Research Priorities Coordinated by Dr. Ulysses Panisset	Discussion on: 1. Priorities for Health Systems Research- ranked in order of status <ul style="list-style-type: none"> • Participants are encouraged to prepare their list of priorities for health systems research. • An Equity Approach will cross cut all priorities, but the workshop will attempt to identify research areas with equity as a subject (* see examples below). 2. Innovative methodologies, particularly with the active participation of civil society 3. Knowledge gaps identified in the list of health systems research priorities
13 June Morning	Consolidation	Meeting of not more than five people to draft a report of the consultation. Once drafted, this report will be circulated to participants for feedback. The final report from this consultation will be presented to the Lancet. If considerably different from the current report that is being drafted on health system research priorities by WHO, two reports could be presented for publication.

E-mail discussions before the meeting could enable more people to be involved.

The following are examples of research areas with equity as a subject:

- Barriers in access according to social exclusion: (i.e., differentiation in services, detection, access to treatment, treatment of new cases, completion, race/ethnicity; income as equity stratification, gender)
- Successful interventions to improve equity in health care (combining analytical expertise in equity with health systems research expertise)
- Stewardship (how to include equity into HSR planning & policy/ priority setting.
- Framework for assessment of health equity (how to assess if policies and implementations avoid inequities: going beyond an efficiency and performance narrow focus; looking for evidence of successful interventions that are equitable, how to assess that people who really need it are having access, and what type of interventions)
- Ongoing monitoring of health systems information (information in most countries do not include stratifiers, coding, indicators of determinants, geographic inequities within: sub-districts, sub-national; what is needed for indicators, countries without health information systems.
- Structural inequities and health determinants: Changes in health systems in developing countries confronting a situation in which populations are already with a huge deficit, an enormous “social debt”.
- Impact of Health Reform on Equity: one model-fits-all approaches of decentralisation, decrease of state spending & size, regulation & control with small budgets, changes in financing: how this affect specific groups.

The consultation included participants from institutions including Aga Khan University in Pakistan, University of the Western Cape, Health Systems Trust in South Africa, GEGA, Harvard, CEHAT in India, People’s Health Movement, BRAC in Bangladesh, ICDDR,B in Bangladesh, Mahidol University in Thailand, Equinet, Prayas in India, Development University in Chile, Aldes in Ecuador, GRADE in Peru, Flinders University in Australia, TARSC in Zimbabwe, Community Working Group on Health in Zimbabwe, CHESSORE in Zambia, APHRC in Kenya, UERD (University of Ouagadougou) in Burkina Faso, University of Zambia, Doctors for Global Health, and the newly formed West African Health Equity Network, among others.

Annex 4: Update on Global Health Watch

Global Health Watch **Mobilising Civil Society around an *Alternative* World Health Report**

Brief update on Global Health Watch progress - June 2004

1. So far, about half the budget has been committed by various organisations (Wemos, Exchange, Medact, GEGA, Save the Children, IDRC and the Nuffield Trust); a number of other organisations have expressed a potential interest in funding the report – these are being followed up on.
2. Authors have been identified to write most of the chapters. Chapter authorship is also bringing in NGOs for example, Health Unlimited for the Indigenous Health Chapter, MSP for the water chapter, Greenpeace for the environment chapter, Public Services International for the commercialisation chapter, Equinet for the Human Resources Chapter among many others.
3. The first steering group meeting was held in March 2004. The meeting made a number of decisions relating to financing, administration and the content of the report. The steering group will be accountable for the work of the secretariat based at Medact. Members of the steering group represent the three collaborating organisations and include:

Mike Rowson	Medact (Secretariat for GHW)
Patricia Morton	Medact (Secretariat for GHW)
Dave McCoy	Global Equity Gauge Alliance (Secretariat for GHW)
Antoinette Ntuli	Global Equity Gauge Alliance
Amit Sen Gupta	People's Health Movement South Asia
David Sanders	People's Health Movement Southern Africa
Armando de Negri Filho	People's Health Movement South America
Samer Jabbour	People's Health Movement Middle East

A broader co-ordinating committee is being formed to encompass all regions of the world. The functions of the co-ordinating committee members are: (a) to ensure regional issues are in the report; (b) to mobilise support for the Watch in their region; and (c) to provide support or advice on general issues related to the Watch. People so far recruited for the Co-ordinating Committee include:

West Africa (Nigeria)	Abdulrahman Sambo
North Africa	unfilled
East Africa	Eva Ombaka
Southern Africa	David Sanders
Francophone Africa	unfilled
Australasia	Fran Baum

Caribbean	Jerome Teelucksingh
Central Asia	Bakhyt Sarymsakova
Eastern Europe	unfilled
China / Far East	unfilled
South America	Armando De Negri
Central America	Maria Zuniga
Middle East	Samer Jabbour
SE Asia	Chan Chee Khoon
South Asia	Amit Sengupta
US	Paula Braveman, Lexi Bambas
Western Europe	Marjan Stoffers
GEGA	Antoinette Ntuli
PHM	Ravi Narayan

4. Timeline: First draft is due at the end of August, second draft at the end of October. Launch of the report at the World Health Assembly in May 2005 and at the People's Health Assembly II in July 2005 and regional launches in between.
5. Advocacy activities past and future include:
 - Presentation of the GHW initiative at various conferences and forums around the world;
 - A major consultation with UK-based NGOs in London at the time of the steering group meeting (March 2005) and in South Africa (June 2005);
 - A report in the British Medical Journal on the Watch, future reports in other journals are planned;
 - Ongoing calls for testimonies and case studies;
 - Ongoing liaison with NGOs, CSOs, trade unions, social movements to encourage their involvement and endorsement of the watch;
 - Planning of forums to discuss contents of various chapters (especially the last chapter on recommendations and strategies);
 - Support to regional coordinating committee members to develop demand for the report in their regions;
 - Launch of the GHW website- www.ghwatch.org; launch of the GHW newsletter; development of GHW flyer (which outlines the content).

A broader advocacy strategy is being developed to coincide with the launch of the Watch and its development thereafter.

The Global Equity Gauge Alliance currently includes member-teams, called Equity Gauges, in the Americas, Africa, and Asia. Each Gauge works to promote health equity through an integrated strategy of:

Assessment and Monitoring of health inequities, Advocacy for pro-equity policy, and support for Community Empowerment.

GEGA is governed by a Coordinating Committee involving institutions and institutions involved in GEGA and Gauge work: Antoinette Ntuli, Health Systems Trust, South Africa; David Sanders, University of the Western Cape, South Africa; TJ Ngulube, CHESSORE, Zambia; Banza Baya, University of Ouagadougou, Burkina Faso; Frederick Mugisha, African Population Health and Research Council, Kenya; Liliana Jadue, Development University, Chile; David Acurio, ALDES, Ecuador; Martin Valdivia, GRADE, Peru; Yuanli Liu, Harvard Univeristy, USA; Mushtaque Chowdhury, BRAC, Bangladesh, Siriwan Grisurapong, Mahidol University, Thailand; CEHAT, India.



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