GLOBAL EQUITY GAUGE ALLIANCE

(GEGA)

Technical Workshop

Equity Gauge Progress Reports

Entebbe, Uganda

hosted by

The Institute of Public Health - Makerere University

in collaboration with

The Rockefeller Foundation

EQUITY GAUGE PROGRESS REPORTS

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Bangladesh Health Equity Gauge
Progress Report, January - December 2001

Introduction

Bangladesh Health Equity Gauge (BHEG) is a collaborative project of four organizations. The organizations are BBS (Bangladesh Bureau of Statistics), BIDS (Bangladesh Institute of Development Studies), BRAC, and ICDDR,B (International Centre for Diarrhoeal Disease Research, Bangladesh). Initially the project has support for two years from the Rockefeller Foundation beginning January 2001.

BHEG has four objectives to fulfill. They are 1) incorporation of equity dimensions, such as socioeconomic groups, geographical location, health outcome, and healthcare utilization variables and the like in the existing data collection systems in various organizations (this will also include assessment of the impact of the poverty alleviation and community development oriented health progarmmes in reducing health inequity); 2) establishment of a new system in a nationally representative sample which can eventually be adopted by the national system; 3) dissemination of findings among the policy makers, researchers, NGO leaders, and members of civil society in a regular fashion to facilitate actions to minimize inequity; and 4) development of national capacity to carryout equity focus research and analysis.

The activity package to achieve the above objectives included the following:

1. Coordination
2. Formation of Health Equity Forum
3. Inclusion of equity focus in collection and analysis of existing data (ICDDR,B; BRAC; BIDS; BBS; Helen Keller International)
4. New data collection system (implementation, data processing and report writing)
5. Dissemination workshops
6. Publication of report

Progress

Coordination: Memorandum of understanding between the four partner organizations has been signed and is operative.

Formation of Health Equity Forum: List of possible members to be included in the Forum has been prepared. The official launching will take place during the first quarter of 2002.

Inclusion of equity focus in collection and analysis of existing data: Several meetings of the relevant organizations with data collection system were held. The organizations agreed to include equity dimensions in their data collection system. The group representing the organizations also agreed to analyse the existing data on the basis of specific themes. Immunization issues were selected to be the first theme. A draft paper entitled "The immunization divide: who gets immunized in Bangladesh" has been prepared and circulated among the relevant individuals for review and feedback. It is envisaged that this paper on immunization will be presented in launching meeting of the Forum.

New data collection system: After a careful review, plan for new data collection has been slightly changed. Instead of introducing a new system now the possibility of an add-on to an existing system has been under active consideration. Such existing system may include Health Watch of BRAC, which is also nationally representative.

Dissemination workshop: First workshop will take place during the launching of Bangladesh Health Equity Watch some time during the first quarter of 2002.

Publication of report: A 'Research Report' series on health equity related issues has been on the plan. Preparatory work, such as design of the cover page, themes of reports etc. has been progressing well.

The Chilean Health Equity Gauge
Advance Report- December, 2001
Executive Summary

The Chilean Equity Gauge has defined as its general objective: "to improve the monitoring of health equity in Chile and to build capacity for research, advocacy and community participation to improve health equity". To achieve this purpose, four pillars have been designed:

- Measurements and data monitoring.
- Community participation.
- Advocacy/dissemination.
- Human resources training center.

Since March 2001, a working team with different backgrounds is developing the activities within each pillar. The participants are:

Name	Profession	Role
Dr. Jeanette Vega	MD, Epidemiologist	Director
Dr. Liliana Jadue	MD	Executive Director
Dr. Paula Bedregal	MD	Academic Director
Iris Delgado	Statistician	Data analyst
Rodrigo Burgos	Journalist	Communications and dissemination
Carolina Flores	Social Worker Social	Community participation
Francisca Browne	Sociologist	Social research
Vicente Zúñiga	Social Program Consultant	Interactive Forum production
Claudio Sapelli	Economist	Economic analyses
Dr. Hernán Sandoval	MD, Public Health	Policy consultant

1. Measurements and data monitoring.

One of the tasks of this component is to develop data analysis from primary and secondary databases from different sources within Chile. Databases come from national surveys run by different ministries: like Planning, Education, and Health. Vital and demographic statistical data, morbidity and mortality data are obtained from different sources like the National Institute for Statistics, governmental ofices and other sources. Up to date, most of all required databases have been gathered and data analysis is in process.

The principal instrument to monitor social policies in Chile is the CASEN survey, a serial national survey applied by the Ministry of Planning every 2 years, that includes information on education, income and employment, housing and health. The last survey was carried out in December 2000. As an initial task developed by the Initiative, important improvements were made to the health module making possible to better monitor health care needs and access to health care. These improvements were the first objective designed within the context of the health equity initiative.

Another important product under development is the Policy Lever Analysis. The study will review the health equity situation for the Chilean population and will describe and analyze

all possible policy levers to identify possible intervention that can be implemented to improve equity. The first report has been released and the complete policy lever analysis will be ready in 2002.

A study reviewing the situation for gender and health equity in Chile has been implemented during 2001 with the support form PAHO. The results will be published in the Pan American Journal of Public Health in the next issue.

2. **Community participation.**

This area of development is focused in the identification of community resources to empower them in strategies to improve health equity. The activities included the elaboration of a catalogue of community organizations in the country, the characterization and identification of different organizations to establish alliances and interventions. Two other activities are under current development, first, a case study to analyze participation models in Chilean communities and second, the elaboration of a proposal to intervene poor families to generate strategies to get them out of poverty, with general strategies addressed to the communities where they live and other specific focused on their health needs, with equity perspective. This proposal will be funded by FOSIS, a governmental organization dependent on the Ministry of Planning and Cooperation.

3. **Advocacy/Dissemination.**

After a period with activities and strategies that had no impact in the media, our communication team is more consolidated. The efforts have been focused in building our own capacities to elaborate messages to different audiences that we want to reach and developing an advocacy plan for 2002.

It has been difficult to implement this strategy because it is a new area of development for a team originally created by public health researchers in a country with little development in analytic journalism and almost none communicators specialized in health issues different from medical technology.

The products up to date include the implementation of a web page, with information on our results and the launch of a "Health Equity Forum" within the web page designed as an initial interview to national relevant authorities in a selected subject followed by a discussion open to all participants who want to express themselves or give opinions on the interviews. The forum subject is changed every 6 weeks.

4. **Human resources training center.**

A workshop on Benchmarks of Equity, developed by Dr. Norman Daniels, and co organized with the Ministry of Health was developed in October 2001. The workshop was addressed mainly to health service professionals. A follow-up workshop to implement the benchmarks in Chile, as a tool to evaluate our health system on a district level will be implemented as part of 2002 activities.

A Public Health Summer School has been organized with the collaboration of Harvard School of Public Health and the Panamerican Health Organization. This activity will be held in January 2002. We expect participants form Chile and different countries from Latin America.

5. Strengths, Weaknesses and Challenges

The Initiative includes a multi-professional working team conformed by highly motivated professionals committed to their tasks, with an adequate physical infrastructure and administrative support to develop the activities.

All components are in the process of developing their objectives, thou some of them at a lower pace; but there are some products that will contribute to make visible the health equity concept in Chile. Some of the activities worth to be mentioned include the implementation of the web page, the development of a corporative image with a logo that identifies the Initiative, production of scientific information and monitoring data and the Policy Lever study currently under progress, with a preliminary report already released.

Developing the Advocacy and Dissemination component has been more difficult than the others because of the need to create the experience within the team and the characteristics of the mass media in Chile, where the installation of a new social subject in the public agenda is a challenge.

Given that the Initiative is being supported by an academic institution and funded by external resources from the Rockefeller Foundation, most of the collaborators work part-time. This issue can be seen as strength in the sense that helps to create networks with different people and organizations, but sometimes it makes it difficult to coordinate activities within the members of the staff.

Last but not least, the need to look after financial resources to develop new activities is a permanent stress for the researchers.

6. Required Technical Support

- Training in advocacy strategies and techniques to mobilize relevant social actors and communication media.
- Training in strategies and techniques to develop community participation.

Support to further develop some of the components that were not part consider initially as part of the Initiative:

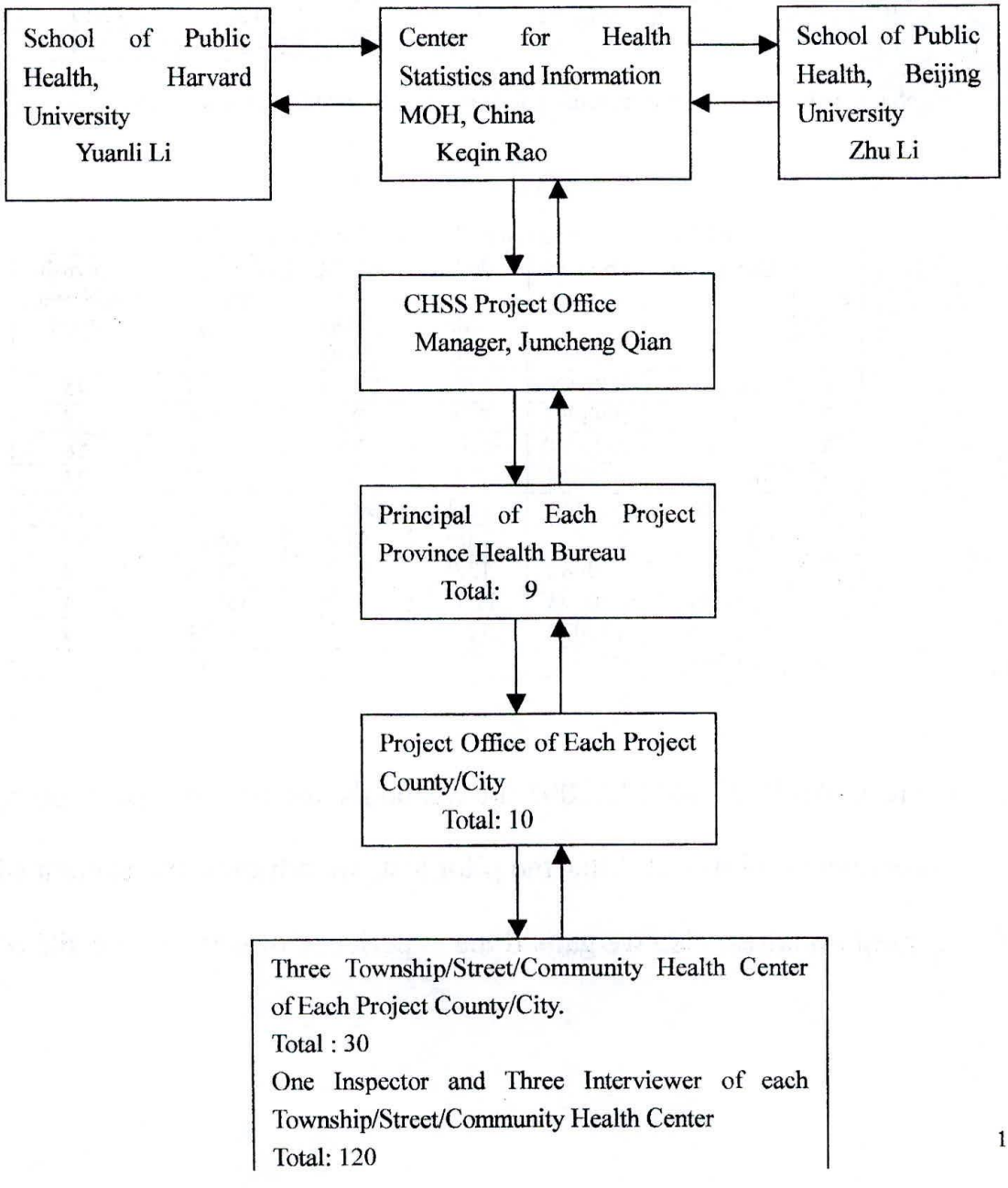
- Community participation intervention activities.
- Advocacy and mass media involvement.
- Workshop and training activities for human resources.

All of these activities are not currently funded.

The Progress Report on the China Equity Gauge

1□ On Dec. 10, 2000 in Beijin Xinhengji Building, the Central Group discussed the feasibility of conducting China Health Surveillance Survey(CHSS). The Central Project Office was set up meanwhile. From then on, we started the design of CHSS. We also design the structure of CHSS as follow:

CHSS organization structure of membership



2□ From April 17 to 19, 2001 in State Second Hotel□ the Central Group discussed the survey design and the questionnaires. The ten project counties/cities were ascertained primarily.

Tab1: The basic situation of surveillance site

code	Urb/Rual	Area	province	City/County	Code of administration	Households to be surveyed
1	1	d	Guangdong	Shenzhen	440301	540
2	9	d	Guangdong	Nanhai	440682	540
3	1	d	Jiangsu	Suzhou	320501	540
4	9	d	Zhejiang	Tongxiang	330483	540
5	9	z	Hebei	Xianghe	131024	540
6	1	z	Shanxi	Taiyuan	140101	540
7	9	z	Hubei	Xiaonan	420902	540
8	1	x	Sichuan	Yibin	512501	540
9	9	x	Shaanxi	Langao	612426	540
10	9	x	Gansu	Yuzhong	620123	540

Note:1 means urban, 9 means rural, d for eastern, z for middle, x for western

Tab2: The basic situation of the surveillance site-specific

code	City/County	Population 2000	IMR Per 1000 2000	MMR Per 100000 2000	Per capita income Yuan 2000	Townships/Streets 2000
1	Shenzhen	4329400	5.99	28.36	20240	45
2	Nanhai	1094994	7.74	9.1	6764	18
3	Suzhou	2070000	6.84	7.8	9274	58
4	Tongxiang	655737	7.5	0	4807	24
5	Xianghe	306216	15.2	97.99	3692	17
6	Taiyuan	2274816	7.00	33.9	6019	57
7	Xiaonan	820982	13.0	89.7	2618	18
8	Yibin	750298	11.12	64.48	3829	34
9	Langao	170072	21.4	85.6	1172	19
10	Yuzhong	422440	31	72	1381	27

3□ From April 20 to 22, 2001 in Suzhou's town area and suburb, conducted pilot test. After the pilot test, we adjusted the content of questionnaires, also we gained the experience of survey. The site of

pilot test is Yangzhi community in urban area and Meihua community in suburb area.

On Apr. 20, we discussed with leader, staffs of the Health Bureau of Suzhou City, the staffs of Community Health Center. The discussing content included two aspects. One is their needs about health information in their working of promoting people's health. Another is about the questionnaire content and how to organize household survey in community. On the morning of April 21, we interviewed each membership of two households by the questionnaire, visited the community health center, in the afternoon we interviewed one farmer household in Meihua Community. On April 22, we discuss with each involver the pilot test situation, last we finished a summary about this test survey. It is very helpful for formal survey.

4□ After the pilot test in Suzhou City, the questionnaire was adjusted. We have to try it in one county. From June 27 to 28, 2001 we used adjusted questionnaires to conduct the pilot test in rural area----Xianghe County. We gained the experience of such survey in rural area.

On the morning of June 27, we discussed with the leaders, staffs of the Health Bureau in Xianghe County about their needs and the questionnaire and the survey organization in rural area. In the afternoon, we conducted household survey. Professor Yuanli Liu,

Manager Juncheng Qian, the member of Central Office Miss Jing Wu and Miss Chunyu Li interviewed one farmer household respectively. On the morning of June 28, we went to a poorer township in Xianghe County. Two households were interviewed by local interviewer from the Health Bureau of Xianghe County. In the afternoon, we met together to discuss the situation of this pilot test. We obtained the experience on four aspects. One is to find questions how to fit for the rural conditions. The second is if the questions are understood completely by the interviewee. The third is how to efficiently organize the survey in rural area. The fourth is to test how long interviewing one household cost in rural area.

5□ On July 16, 2001 the official correspondences were sent to each project province health bureau by Center for Health Statistics and Information(CHSI), which was about getting their agreement to set up the China Health Surveillance System in the province as a site. All project province health bureau answered to agree with the plan.

The project principal of ten provinces

Tab3: Agreement situation and the project department or principal of each provinces

province	principal	telephone
Sichuan	Bugang Ma	028-6137801
Zhejiang	Yaming Gu	0571-87709038
Gansu	Huaiqi Wang	0931-8821301
Jiangsu	Jingmao Chen	025-3611764
Guangdong	Zhe Yang	020-83820687
Hebei	Jingbo Zai	0311-7043766
Shannxi	Mingxia Dai	029-7344900-3035
Hubei	Yanqing Cao	027-87821870
shanxi	Jianwu Zhao	0351-3283763

6□ On August 21, 2001 the official correspondences were sent to each project county/city health bureau by CHSI, which informed them to attend the training and working meeting.

7□ By September 7, 2001 we accomplished the booklet Design of China Health Surveillance System and Guideline of Household Survey, the booklets and questionnaires were printed by the printing factory.

8□ From September 19 to 20 , 2001The training and working meeting took place in State No2 Hotel in Beijing, one leader and one technical staff were trained. Meanwhile on the meeting, a microcomputer was sent to each project county/city.

Training content include: 1.why should we want to set up the China Health Surveillance System? 2. The whole design was introduced. 3. How to sample the project township and street, how to sample the surveillance household. 4. To introduce all questions in the questionnaire and to explain the key indicators and any doubt the trainee have. 5. Simulating training of interviewing by

listening to the recorder for each trainee. 6. All trainees fill household's member situation of themselves in the questionnaire.7. To demonstrate how to use the software of data entry for the trainee, which is made by the Central Project Office. 8. All trainees enter the questionnaire data of simulating interviewing and self-filling in.

Except for receiving one personnel computer, each project county/city got 600 sets of questionnaire, 6 books of the guideline and the design, one recorder tape for simulating interviewing and all training paper materials, one data entry software.

9□ After the training and working meeting, on Sep. 29,2001 the official correspondences were sent to each project counties/cities to demand to start the project working.

10□ On Nov. 5,2001 the official correspondences were sent to each project counties/cities by CHSI to demand good field working and quality control, meanwhile inform that the Central Project Office would inspect the field working.

11□ From Nov. 7 to 19, 2001 the central group members of CHSS were divided into four subgroups to supervise the filed working over ten field sites. The supervising main content included: 1.organization situation for each site, 2. training situation to the interviewer, 3. check the questionnaires, 4. talking with each interviewer about the interviewing conditions of households, listen to their any

comments, 5. follow the interviewer to the surveyed household to observe the whole interviewing process.

Tab 4: The supervising schedule of CHSS to the site

Oct. 29, 2001

City/county	Supervising date	Supervising persons
Yuzhong	Nov. 7 to 9	Yuanli Liu, Juncheng Qian
Xiaonan	Nov. 9 to 11	Yuanli Liu, Juncheng Qian
Yibin	Nov. 12 to 13	Keqin Rao, Yuanli Liu
Shenzhen	Nov. 13 to 15	Keqin Rao, Yuanli Liu
Nanhai	Nov. 15 to 18	Keqin Rao, Yuanli Liu
Xianghe	Nov. 8 to 9	Rongwei Ye, Jing Wu
Suzhou	Nov. 13 to 15	Rongwei Ye, Jing Wu
Tongxiang	Nov. 16 to 18	Rongwei Ye, Jing Wu
Langao	11□ 14 to 16	Juncheng Qian, Chunyu Li
Taiyuan	Nov. 17 to 18	Juncheng Qian, Zhu Li, Chunyu Li

12□ On Nov. 20, 2001 four central subgroups members discussed the findings of supervision in the 502 room of MOH, at the same time the next arrangement was made including the schedule of data analysis.

13□ On Nov. 23, 2001 the Central Project Office sent the correspondences as a summary of this supervising to each project county/city to notify the experiences and existing problem in each site in the name of CHSI, also to inform the next arrangement including the deadline to send the database and related material. The main results of this supervising as following.

The Project office of each city/county has been set up. Most of the

principal are the leader of health bureau. Each project city/county had a training meeting for the interviewer. Each project city/county make a good sampling by the demand of Guideline. Before the survey, much propaganda was conducted in each site in newspaper, television, open letter to the residents with official seal and so on. Resident's meeting took place in some surveillance site. It's very important to make sure the surveyed households know CHSS and to obtain their cooperation. A small gift was made in most project site for the surveyed household. Many difficulties were overcame by each project site using different method. A little interviewers need to understand more about little questions such as some social and psychosis questions. Some interviewers have to translate the standard Chinese into the dialect using in the local place, then the question can be understood by the interviewee. The most inspectors checked the questionnaires in time and repeat interviewing part of the household. We found Some psychosis question was answered by other family member when the interviewee was unavailable. So we demand the interviewer to tick the question and the name in the questionnaire answered by other family member.

14□ Form Dec. 15 on , the Central Project Office was collecting and cleaning the data base and related material.

By now, we received the data of 8 project city/county. One project site was postponed by some reasons. One project site have some problem in

computer ability.

Tab 5: numbers of the surveyed households and all kinds of member demanded to be interviewed

City/County	Urb/Rual	Area	households	members	Two week morbidity	inpatients	Childr en under 7	adults	marter nals
Shenzhen	1	d							
Nanhai	9	d	556	2069	190	59	158	1585	21
Suzhou	1	d	543	1546	246	49	72	1410	17
Tongxiang	9	d	540	2180	173	62	202	1743	40
Xianghe	9	z	541	2013	140	35	82	1626	8
Taiyuan	1	z	541	1647	169	58	83	1408	15
Xiaonan	9	z	540	1842	365	39	146	1293	28
Yibin	1	x	540	1699	277	77	110	1468	21
Langao	9	x	541	1844	308	37	124	1474	35
Yuzhong	9	x							

15□ After the data cleaning, we will conduct data analysis and writing report. We will finish the writing report before May 30.

16□ A workshop will take place for ten counties/cities before June 30, 2002.

REPORT OF PROGRESS, PLAN AND ACTIVITIES OF THE EQUADOR EQUITY GAUGE TEAM

January 10 of 2002.

1.- List of primary institutions responsible for managing the Equity Gauge.

Alternatives to Social Development Foundation (ALDES).

Stakeholders:
Health Commitment of El Tambo. (Unit of Ministry of Health, Communitarian Organizations, Teachers, Municipality).
Mastery in Public Health – Cuenca University.
Municipality of El Tambo

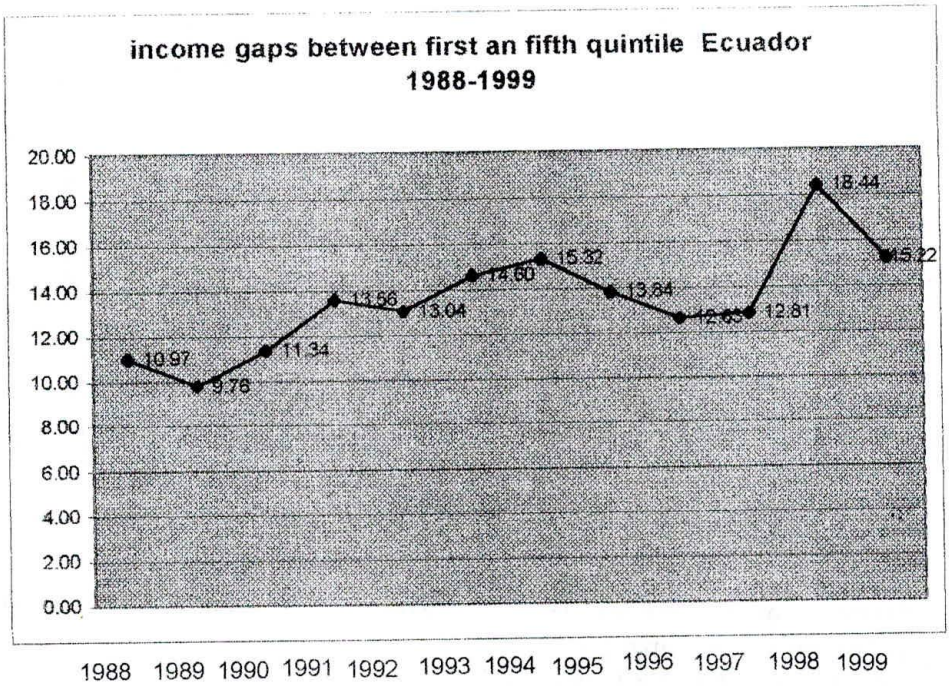
2.- Briefly description the scope of the Equity Gauge.

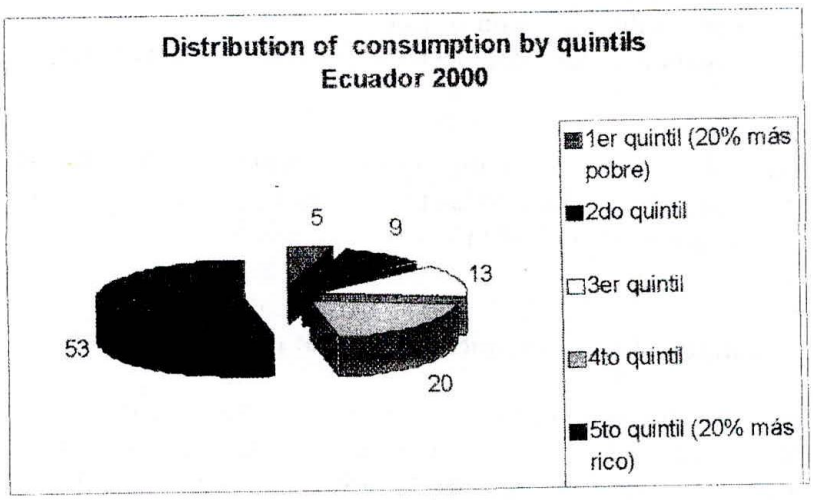
Our Equity Gauge is focused in a municipality based (same to county) This is the smallest unit the administrative and politic division in Ecuador; also smallest unit with the capacity to generate policies (with the local value). Our scope is done/ take in urban a rural areas.

El Tambo is a municipality with 9.000 habitants living in a urban center (downtown) and 28 little rural communities, The population has a 90% of indigenous people and 10% of mixed race. The rural area is where the majority of indigenous people live.

3.- Description of the political, social an economical context of the Equity Gauge.

Ecuador is one of the countries in the Americas with the most inequities. According to the Human Development Report of 2001, it is located in the 72nd place of the index of Human Development, with a Gini index of aprox. 0.58, that reveals the existence of large internal inequalities. National studies show the huge disparity which exists in the distribution of the country's wealth: in 1998, 10% of the wealthiest population held 42.5% of the national revenue, while the poorest 10%, had barely 0.6%



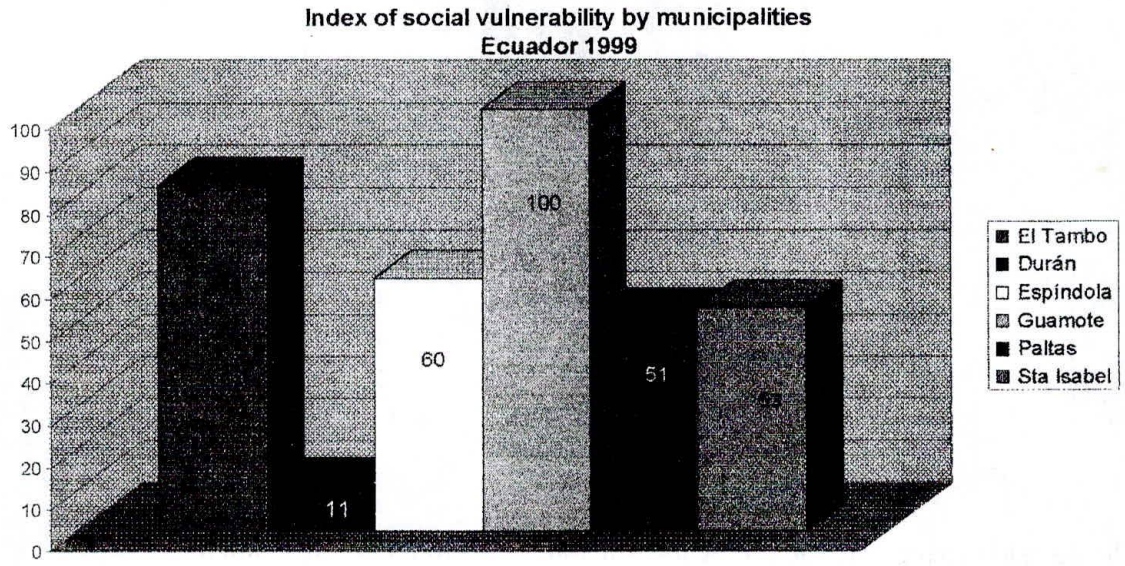


The poverty index reaches 80% (44% in urban areas and 77% in rural areas); access to basic services is at 55.6% (urban 64% and rural 44%). The differences in the functional aspects and development indexes are permanent between the city and the countryside, with the education index at 68.9 in the city and 44.2 in the countryside, health at 68 in the city and 43 in the countryside.

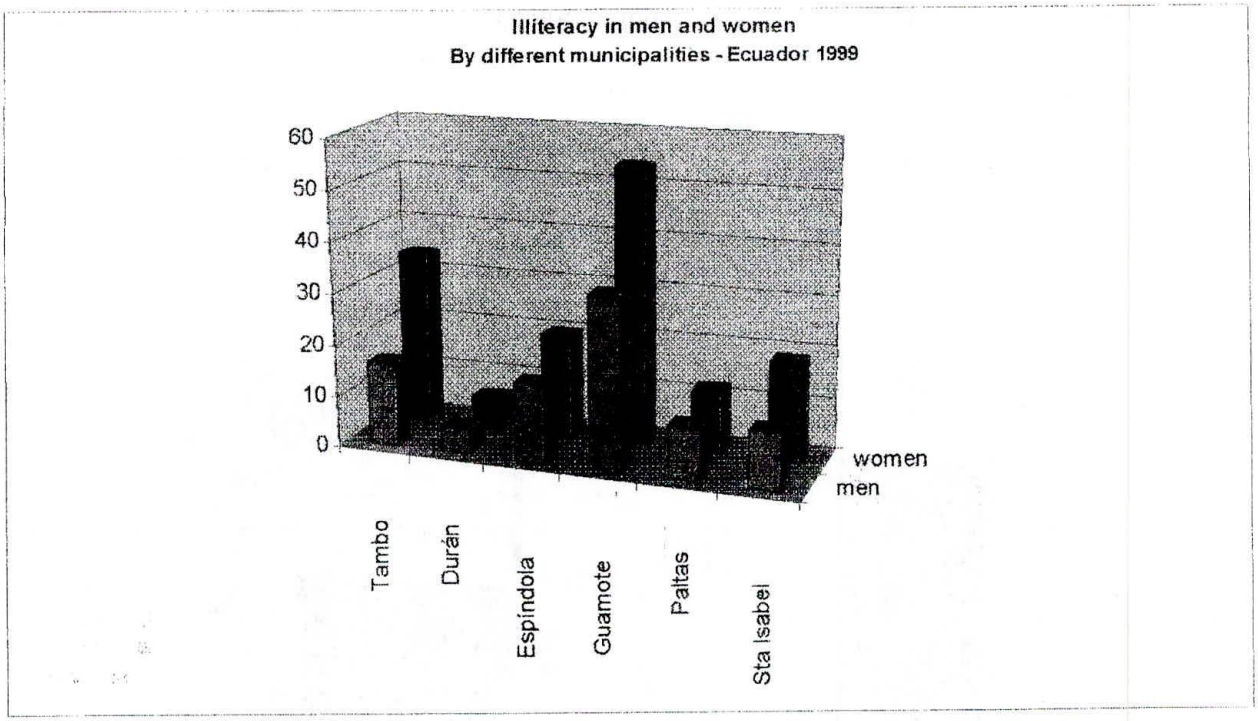
These disparities also express themselves on the local level; if we compare urban and rural areas in the province of Cañar, which are predominately indigenous (approx. 80% of the population), we see that the incidence of poverty between the urban and rural zones rises to 79% (71% urban and 82% rural), the infrastructure or access to services index, is

barely at 53%. Chronic malnutrition in minors under 5 years of age is at 43% (urban 32.5 and rural 47). These macro-determinants of rural living and ethnicity are important elements in the origin of the current inequalities.

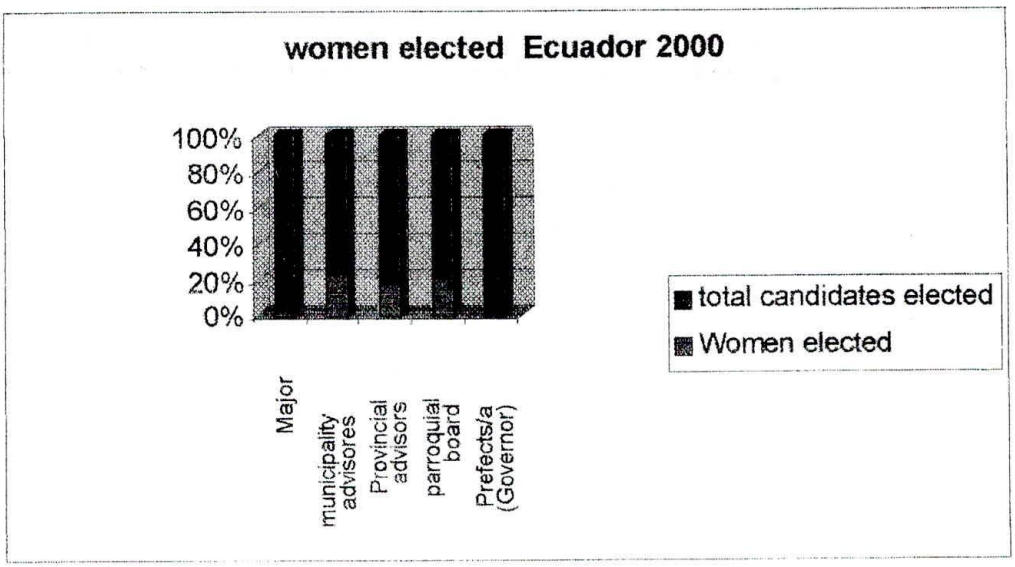
The municipalities with majority Indian population have more vulnerability, as you can see in the following graphic.



Differences based on gender can also be observed, such as access to education: illiteracy in men is at 9.5% (4.3 urban and 17% rural) while it is believed to be at 13.8% in women (8% urban and 25% rural).



The decision spaces and the political participation is limited to the women



4.- List the comparative population groups that you have selected for your Equity Gauge

Categorization of population groups	Disparities in health outcomes			Size of disadvantage group			Public awareness		
	High	Moderate	Low	High	Moderate	Low	High	Moderate	Low
Socio Economic	X			X				X	
Gender	X			X					X
Geography location	X								X
Race ethnicity	X			X				X	

5.-List the quantitative equity measurement indicators that you have selected for your Equity Gauge.

Dimension of health / Population group	Underlying health determinants	Health status	Health care financing	Access to health care	Social Participation
Socio Economic	• Illiteracy rate • Population below the poverty line • Percentage of malnutrition in under-5 year olds. • • Percentage of homes with female heads of household	• 5 primary causes of mortality • 5 primary causes of morbidity	Amount Per capita financing by the Minister of health. Family health expenses	• Third dose of DPT vaccination • Percentage of Pre-natal and birth care • Distance in minutes to he nearest health center	Percentage of civil society with representation in the committee of health. Number of spaces of coordination between institutions and population. Percentage of decisions taken in the health committee enforced.
Gender	• Illiteracy rate • • Percentage of homes with female heads of household	• 5 primary causes of mortality • 5 primary causes of morbidity	Family health expenses	• Third dose of DPT vaccination • Percentage Pre-natal and birthing care • Distance in minutes from the nearest health center •	Percentage of women's representation in health committee

Geography location	• Illiteracy rate • Population below the poverty line • Percentage of malnutrition in under-5 year olds. • Family health expenses • Indoor running water costs • Percentage of homes with female heads of household	• 5 primary causes of mortality • 5 primary causes of morbidity		• Third dose of DPT vaccination • Percentage Pre-natal and birthing care • Distance in minutes to the nearest health center	Percentage of rural representation in health council

6.- Describe the use of any qualitative information / data in your Equity Gauge.

We are using 3 qualitative indicators specially about the services:

Time spent in a medical consultation
Availability of medicine at public health center.
Reason to assist to this health center.

7.- Describe your public participation plans and activities.

We defined 4 sector to our public participation:

Indigenous organizations:

Workshop to discus use of alternative health.
To implement a leadership school

Decision makers in the local level.

Support the elaboration of the municipality budget
Have a "Day of health and Equity" in El Tambo

National Movement of municipalities

Decentralization and health – experiences and positions -

Health Sector.

National workshop to discus indicators of inequity in health.
Presentation of our experiences in different events about decentralization, health reform, and human resources.
To Implement the course about local management and equity
International seminary "Participation, Health and Decentralization"
Course

8.- Describe your advocacy plans and proposed "actions" to help to reduce inequity in the setting of Equity Gauge

Advocacy Actions	Actors	Strategy	Outputs	Time frame
Dissemination of materials	Health Ministery. (national and local) University	Translation of texts.. Memory of meeting and workshops	6 documents of national circulation	2002
Constructing arguments, policies, proposal and recommendations	Municipality. AME (association of municipalities) MoH (national) University	Workshops. Promote people to training in Public haealth. Program in training in local management and health to municipalities and health sector institutions		April 2002 August 2002 Jun 2002
Direct engagement and active lobby with policy-makers	Municipality AME PAHO / MoH	Give technical assistance Department to Social Development to El Tambo Municipality	2 agreements with Municipality and Ministry of health.	March 2002
Empowering the poor and disadvantages	Indigenous Organization Health Committee	Leadership school and equity.	1 school functioning.	July 2002
Civil Society campaigns and challenges to policies	Health Committee Indigenous Organizations. Women Organizations	Health Party. Workshops, debates about the health and local development	Celebration of 3 key days. 3 workshops in the year.	January 2002

9.- Wrap-up What has been going well in our Equity Gauge?.

- Reactivation of the health committee and definition of new roles.
- The number of members in the committee increased, an have a indigenous representation.
- The women advisors of municipality are participating in the committee.
- 2 professional are assisting to the mastery of public health.
- Designed draft of program to course in local management with national influence
- National workshop about monitory of health with participation of represents of Pan-American Health Organization, United Nation Women Found, Ministry of health, National association of Municipalities, NGOs, and functionaries of El Tambo.
- Implementation of actions in health. With volunteers and public health center.
- Advance in the analysis of inequities in El Tambo

What has been difficult and less successful ?. (Limitations, difficulties and actions less successful):

- The knowledge about of the indigenous world is insufficient.
- The mayor don't have a strong incorporation in the process.
- In the advocacy and in the political process we don't had to build a framework in the municipality – local council of development or assembly with social participation.
- The analysis of inequities is incomplete.,
- The train about measurement do not started.
- Is necessary count with national support.

What are we main constraints?.

We are establishing a specific process with indigenous organizations, and To begin a learning of them leaders
To implement at local management and health equity learning program.
To define a agreement with municipality to technical assistant from Equity Gauge.
To agreement with Ministry of Health.

What additional support we needed?.

We needed support in analysis and presentation of information to the users.
To support in the learn in equity.

10.- What thoughts, ideas and suggestions do you have for a Global Equity Gauge Alliance.

In GEGA we needed to development a process to interchanges and forums about equity between nearly countries.

The advocacy to global institutions (united nations, etc..) must a interesting process of the GEGA.

Could GEGA to provide, assistance and consultant in decentralization and equity to governments of the national or local level?

Université de Ouagadougou
UERD

Save the Children
Pays Bas

The Population
Council

Global Equity Gauge Alliance Workshop
Entebbe, February 10-16, 2002

The Ouagadougou Urban Health and Equity Initiative (Status summary as of January 2002)

Background and rationale

The French-speaking countries of sub-Saharan Africa (SSA) are witnessing a mounting population and health crisis. Mortality remains extremely high and trends to lower infant mortality and longer life spans observed since the 1950s have stagnated and even reversed themselves in several countries. The prevalence of STDs including HIV is growing rapidly, especially in cities. Fertility in SSA is double that of any other region of the world and there are increasing rates of premarital adolescent fertility. Population growth is also very high, on the order of 2.5% per annum and, unlike the rest of the world, the net increment to population size in SSA is projected to continue growing until 2040. This places increasing stresses on the natural environment, complicates the design and implementation of policies to deal with health problems, and the rapid growth in cohorts of children limits the ability of governments and families to invest in their health and schooling. While the region is one of the least urbanized parts of the world, with less than 35% of the population living in cities, most population growth is now urban owing to strong rural-urban migration. As a consequence, the number of city residents in the region is projected to nearly triple between 2000-2030. Many of these new city dwellers will live in overcrowded slums or in peripheral semi-urban informal settlements where health conditions are poor. This urban growth, combined with a breakdown of traditional norms and a weakening of the family's ability to govern the behavior of youth, facilitates the spread of STDs, the occurrence of unwanted pregnancies, unsafe abortions and illicit drug use, and is also leading to a rising inequity in access to basic health services.

Ouagadougou, the capital of Burkina Faso, exemplifies the emerging urban health and social crisis. The health services in Ouagadougou are unprepared to serve the basic health needs of its residents as the city's population continues to increase by 4.3%.

Increased disparities in health, education and general welfare in Ouagadougou are concealed by current statistics. Despite 'visible' and alarming signs of increasing inequities and of worsening social malaise in Ouagadougou, social development policies continue to focus almost exclusively on rural areas.

In 2001, the Burkinabe Government published the '*Cadre Stratégique de la lutte contre la pauvreté*. This document states that one of the Governement's principal aims is to ***guarantee access to basic social services for the poor and more specifically (1) promote access for the poor to education and (2) promote access for the poor to health*** (Ministère de l'économie et des finances, 2000). The same document also states that all development policies must be *equitable*.

Objectives

An experimental study will be launched in Ouagadougou to test the hypotheses that outreach activities and community mobilization can i) improve health and ii) reduce

infant and child mortality in disadvantaged urban neighborhoods of Ouagadougou, thereby improving health equity.

Partners and stakeholders

Partners in the Ouagadougou Health and Equity Initiative

Partners are the lead agencies and individuals who are promoting the Ouagadougou initiative to institutional stakeholders and the wider community.

Unité d'enseignement et de recherche en démographie (UERD)

In accordance with the Government strategic plan to combat poverty, UERD has re-organized in 2001 its research and training agenda into a main objective: To provide evidence-based policy recommendations to increase access and improve the utilization of basic social services (health, education, housing). In Ouagadougou, the three focuses are integrated into the "***Observatoire de Ouagadougou***". The cross sectional theme of gender inequities in health and education is coordinated by Christine Ouedraogo of UERD.

Figure 1: Partners in the three components of the Ouagadougou Observatory

		Component		
		Health	Education	Habitat
EQUITY GAUGE PILLAR	Measure (Observatory)	**UERD*** (Baya, Pictet) Univ de Montréal The Population Council*	**UERD** (Pilon, Kobiane) IRD	**UERD** (Dabire) Univ de Montréal
	Intervention (Initiative)	**SCPB** (Zina), Mwangaza		
	Advocacy (Initiative)		Diakonia	

The pilot research activities of the health component of the Ouagadougou Observatory is supported by the Rockefeller and Mellon Foundations; the measure/research pillar is also supported by *Aire - Développement*.

Save the Children Pays Bas (SCPB)

SCPB is a Dutch NGO founded in 1980 and a member of the International Save the Children Alliance whose members operate in over 120 countries in the World. SCPB has been operating in Burkina Faso since 1982, notably in the rural district of Kaya (see below).

Mwangaza Action

Mwangaza is a Burkinabe NGO affiliated to the Cooperative League of the United States of America (CLUSA). It is specialized in community mobilization and the participatory learning approach around health issues. It has worked on a number of projects with UERD: in the rural province of Bazega LSC with the Population Council on reproductive health and female genital mutilation, and the province of

Sissili on community-based services, as well as on the *Programme de participation communautaire pour la santé de la reproduction et la sexualité des jeunes.*

Institutional Stakeholders

Stakeholders in health are institutions who have a mandate to improve health (and equity) in health: the Ministry of Health, The Ouagadougou Regional Health Department, The Ouagadougou Municipality, WHO, Unicef, UNDP, le Comité national de lutte contre le sida (CNLS), Health NGOs, bilateral donors and embassies, etc. UERD and SCPB have discussed the initiative with The Regional Health Department, WHO, UNDP, CNLS, INSD, the Italian Cooperation, the Dutch Embassy, IRD[1] and the Centre Muraz. While all these stakeholders have shown their support for the initiative, most are constrained by their lack of resources to devote to the capital city (rural areas are their priority) and/or their own agendas (HIV/AIDS, child welfare, etc.). Discussions with local stakeholders have shown that the term "equity in health" is sometimes used but that the concept's definition and programmatic implications need to be clarified before the stakeholders can fully contribute to the initiative (i.e. in its intervention and advocacy components). Stakeholders in Health are therefore the first targets of our advocacy efforts.

This also true for education. The Ministry of education and its partners have targeted 20 priority districts all of which are rural. As Ouagadougou has the highest enrolment rates of the country, it is not expected that the government and bilateral donors will invest in Ouagadougou in the next five years. UERD and Diakonia are advocating for more research on the specific problems that it has identified in Ouagadougou during its exploratory research: inequity in access to the formal sector (both private and public), increased costs, large classes, 'double flow' management, low parental demand for quality.

Indeed, the preliminary results of the coordinated contextual mapping activities in health and education show that both sectors in Ouagadougou encounter the same problems in terms of equity in access and in the utilization of services. Moreover, health and education are intimately related at the individual and family levels (ill health in the household is an obstacle to child education and low educational attainment is related to inefficient health seeking behaviors). On the aggregate level, the 'disadvantaged groups' usually suffer inequities in both sectors. Finally, equity research in both fields use the same type of conceptual framework, data and indicators (see Figure 3 page 9). UERD organized a workshop in September 2001 where, together with Nouna and Niakhar teams we developed the instruments to integrate population-based studies on education the three observatories, thus allowing for cross-cultural and urban-rural comparisons.

Pilot activities and results

The Ouagadougou Health and equity initiative pilot was officially launched in July 2001 with a series of contextual mapping and data collection activities:

[1] UERD and IRD plan to collaborate on a Health Geographical Information system for Ouagadougou.

Contextual mapping

The contextual mapping aims to answer the following questions:

1. What are the healthcare problems in Ouagadougou? How are they inequitable? How different are they from healthcare problems in rural areas?
2. What characterizes the urban/Ouagadougou setting? How is the urban social setting different from the rural setting?
3. What intervention do we envision that a) solves at least part of the healthcare problem in Ouagadougou and b) takes into account the socially diffuse urban setting? Can/should it be community-based?
4. How can we test this strategy in Ouagadougou?

Data and methods

- Nationwide survey on migration and urban assimilation, 2000-2002 (UERD, University of Montreal).
- Health Survey in Ouagadougou, October 2001 (UERD)
- Pilot demographic surveillance system: baseline census (January 2002)[2].
  UERD adapted the HRS design to the Ouagadougou setting. The Ouagadougou HRS takes into account
  - heterogeneity of habitat and household living arrangements;
  - social groups other than the household;
  - expected individual and household mobility;
  - health related infrastructure;
  - use of pocket pcs to collect data.
- Interviews with religious opinion leaders, health professionals and individuals on contraception and abortion.
- Survey of maternity wards.
- Analysis of referral system in maternity wards.
- Mapping and observation of two urban "communities".
- Discussions on the concept of equity in Burkina Faso.
- Interviews with key stakeholders.

Preliminary results

What are the healthcare problems in Ouagadougou? How are they inequitable? How different are they from healthcare problems in rural areas?

A) The healthcare problems in Ouagadougou:
   1) Healthcare in Ouagadougou is expensive and health related costs have greatly increased in the last decade (cost recovery schemes, CFA Franc devaluation and "informal tariffs")
   2) Healthcare is of poor quality, particularly for the disadvantaged groups who do not have access to the private clinics and medical doctors
   3) People have low expectations of health service delivery, to the point that people do not even go to the public health center.
   4) Client-provider relations are very unequal. Patients are passive, intimidated and feel socially inferior to the heath service provider. The health providers, consciously or not, exacerbate this unequal relationship and often use it to cover-up their

[2] The baseline census for the education component of the Niakhar and Nouna population observatories are currently being fielded.

unwillingness to serve, their incompetence, or simply to extort money from their patients.

5) Traditional beliefs about witchcraft are highly prevalent in Ouagadougou and effect health seeking strategies.
6) The Health system is under increased pressure with the expansion of HIV/AIDS. The pressure is strongest in the cities (and particularly in Ouagadougou) where the general hospitals and clinics are located.
7) Migration and social change in Ouagadougou are creating additional stress on the health system as demographic pressure increases and traditional social control and solidarity mechanisms break down.
8) Increased demand has lead to an increase in the cost of healthcare in the public sector and an increase in the supply of private and informal health care.

B) Consequences in terms of equity:

High cost, poor quality, low expectations and unequal social relationships between client and provider increase health inequities as the socially vulnerable groups

1. are discouraged to seek "modern healthcare"
2. receive less attention and inferior healthcare from service providers
3. are more often victims of predatory practices

than less disadvantaged social groups

C) Difference with the rural areas

Inequities are greater because there is a greater range of health service providers (public/private; modern/traditional; formal/informal)

Inequities are not geographical but social and economic

There is no 'village solidarity' in the city (though there is in certain settings something akin to neighborly solidarity

What characterizes the urban/Ouagadougou setting? How is the urban social setting different from the rural setting?

Contextual mapping preliminary results show that 'communities' in Ouagadougou (if they exist at all) are non-territorial, socially diffuse, heterogeneous, conflict ridden and that people are mobile : Neighborhoods in Ouagadougou are not urban villages, even in the semi-rural periphery.

Non territorial : neighborhoods in Ouagadougou are not isolated, autarchic, self contained spatial entities. Neighbors do not have the same sense of collective ownership of their surroundings that they may have in rural areas or in some slums in other cities in the developing world. Each individual has his own 'territory" depending on his activities, his mobility, his sex, his age. People leave their neighborhood daily and some are never there during the day. Many neighborhoods do not have physical boundaries, and residents living in the same area define the boundaries of their neighborhood differently.

Diffuse : community relations are looser than in rural areas. Traditional systems of social control and information circulation are less efficient; social networks are more varied and are non territorial. Networks in the city vary from one individual to another, depending not just on gender, but on the individuals' activities, educational attainment, social class, migration history and economic resources.

Heterogeneous : the urban seeting varies greatly between residential and business districts, the loti (zoned) and the non loti (occupied land that is not yet zoned), the rich and the poor neighborhoods. People may settle according to ethnic groups or their village origins, but tend to leave their culture, values and kin in the village.

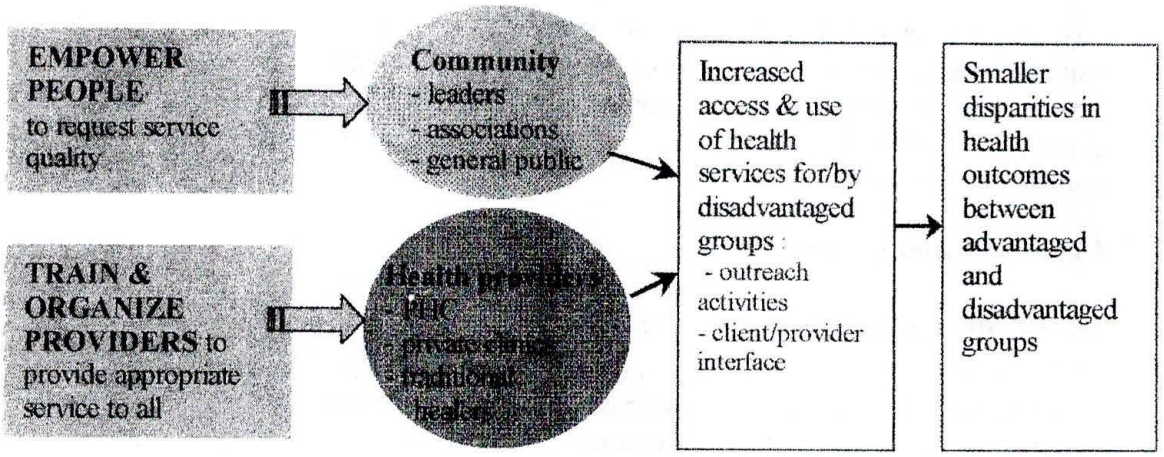
Conflict-ridden: the city is the setting where traditional and modern values coexist and clash, where the younger generations are exposed to different ideologies and have the most freedom to adopt new lifestyles. More "traditional" conflicts that exist in rural communities are exacerbated in the city.

Mobile: Preliminary results from the Migration and Urban Assimilation survey show that among the 2,838 adult residents of Ouagadougou that we interviewed, 88 % had moved at least once (to or within Ouagadougou). Many return to the village for extended periods of time or on a seasonal basis.

What intervention do we envision that a) solves at least part of the healthcare problem in Ouagadougou and b) takes into account the socially diffuse urban setting? Can/should it be community-based?

Figure 2 shows the two pronged strategy that the partners in the health initiative propose to test this year. The two pronged approach was successfully implemented by SCPB in the rural province of Kaya. It now needs to be adapted and tested in the urban setting. The SFPS projects have attempted this approach in Ouagadougou with the Programme d'assurance *qualite* (AQS). The traditional *AQS* implemented in Burkina focus exclusively on improving the quality of family planning services, and in Ouagadougou, the *AQS* are Health Center-based and do not have a community-based component. SCPB will therefore build on its AQS experience in Kaya, where it extended AQS to other health activities. SCPB will adapt the tools it has designed for the Kaya program, and, with Mwangaza action, design and test outreach activities and community mobilization schemes around themes such as patients rights, equity, quality of care and basic hygiene and healthcare. The interface provider/client is part of the problem that is addressed by the intervention AND the proximate variable where impact is achieved.

Figure 2: A two pronged intervention strategy to improve equity in healthcare



How can we test this strategy in Ouagadougou

UERD, SCPB and Mwangaza will launch a pilot project in three neighborhoods in Ouagadougou to identify and test simple health strategies that, if successful, would be gradually up-scaled and integrated in the two-celled experiment described below.

A two-cell stepped-wedge experiment is envisioned to test whether community participation and service outreach around the themes of quality of care will have an impact on project endpoints.

Project experimental cells. The treatment cell will include all the health center catchment areas where NGOs, in collaboration with the health center staff, will involve the community in the organization, the management and evaluation of health services and outreach activities. A comparison cell will be composed of catchment areas where no community involvement nor outreach activities will be organized before the end of the experiment.

Stepped-wedge design. A step-wedge design is needed to take into account the characteristics of Ouagadougou, the institutional capacity of local NGOs, the experimental nature of the intervention and the ethical principles relative to the use of comparison cells.

The first step of the experiment will be launched in two of Ouagadougou's four health districts. In each of these two districts, two health centers will be selected where NGOs will assist the health personnel and the community in planning, implementing and evaluating service outreach activities, as described above. Intervention outputs, coverage, community involvement and changes in health perceptions and behavior will be monitored. Simultaneously, health perceptions and behavior in two comparison areas in the same two districts will also be monitored.

Step 2 : Once the intervention activities are successfully running in the four initial treatment areas, two more treatment areas and two more comparison areas from the two initial districts will be added.

The experiment is thus scaled-up by increments of four treatment and four comparison areas in the first two districts. Once all the catchment areas in these

districts are included either in the treatment cell or the comparison cell, the experiment expands, at the same pace, in the other two health districts.
The experiment ends when there are 16 catchment areas in each cell (32 total). If the experiment shows that the community outreach strategy is effective, then it will be implemented in the remaining areas.

Challenges and questions

Measuring improvements in health equity

- Designing an experiment to evaluate the impact of the intervention on health indicators. Can we reasonably expect that increased access to health services by empowered clients can be measured with the classic health oucome indicators such as child mortality?

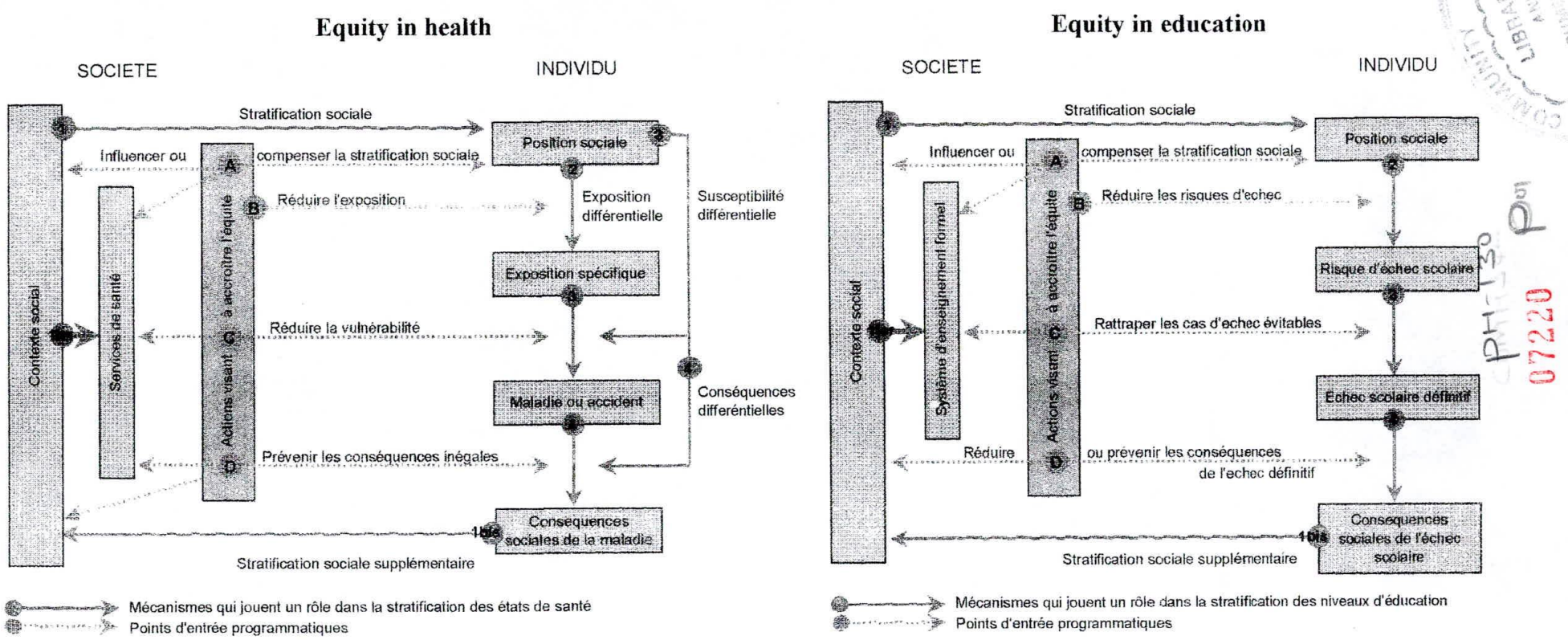
Interventions to improve equity in health

- designing relevant community strategies adapted to the Ouagadougou setting: how can a community based intervention be implemented in a city where social interactions are non territorial and diffuse, where districts are heterogeneous, and where the population is very mobile…?
- involving the private-for-profit, the non-profit/charity organizations and the informal health providers in the promotion of patients rights and the improvement of healthcare: the private and informal sectors are heterogeneous, their markets vary greatly,
- Involving public stakeholders in health in an intervention that undermines personal interests.
- Taking into account / involving the 'parallel informal sectors (drug peddlers, soothsayers) to understand and "rationalize" health seeking behavior.

Advocate health equity

- adapting the notions of equity, patient's rights, quality in health care to the Ouagadougou context into operational concepts that
    - are culturally relevant
    - mobilize local stakeholders and
    - empower people.

Figure 3: Diderichsen framework applied to health and education



Source: Adapted from Diderichsen, in *Challenging inequities in health, from ethics to Action,* chapter 2, Evans, Whitehead, Diderchsen, Bhuiya and Wirth (eds), Oxford University Press, New York, 2001

The Nairobi Health Equity Gauge
May 2001-December 2001

The Nairobi Urban Health Equity Gauge (NUHEG) is a partnership between the African Population and Health Research Center (APHRC), the National Council on Population and Development (NCPD) and the Urban Slums Development Project of the Nairobi City Council (USDP/NCC). The Nairobi Gauge is currently being funded by The Rockefeller Foundation for an initial period of two years starting May 1, 2001. This brief report provides an overview of activities that have been carried out since then.

1. Project equipment

On August 8, 2001, a meeting was held at the National Council on Population and Development offices in Nairobi to hand over computers and printers to the partners. The Rockefeller Foundation sent a representative to attend the ceremony. All partners are now connected to e-mail facilities to ease communication between them.

2. Contextual Mapping

Understanding the national and local context of the Nairobi Gauge is a crucial initial step for implementing the project. The project partners have completed first drafts of the following documents:

a) Macro-Economic environment (by NCPD)
b) Socio-economic differentials in Nairobi (by APHRC);
c) An inventory of NGO activities in the slums of Nairobi (by USDP/NCC)
d) Human right situation (by USDP/NCC); and
e) Health sector reform and policy in Kenya (by APHRC – in progress)

3. Data Analysis

Data analysis is still on-going, mainly using the1998 Kenya Demographic and Health Survey and the 2000 Nairobi Cross-Sectional Survey. The APHRC, in charge of the Measurement pillar of the Nairobi Gauge, has been working on the indicators that will be used to disseminate the findings from the project. So far, APHRC has completed analyzing the data along the following indicators: infant, child and under five mortality, child immunization, prevalence of diarrhea, fever and cough, and type of delivery care.

3. Advocacy and Community participation

Initial contacts are being made to start off these two pillars. Substantial groundwork is needed to deal properly with this aspect of the Nairobi Gauge because of local political intricacies and the volatile nature of the slums of Nairobi.

4. Dissemination

A pamphlet introducing the Nairobi Health Equity Gauge has been printed and is being distributed to key Kenyan governmental institutions, local and international NGOs, and the donor/policy community in Kenya and abroad. A brief description of the Nairobi gauge appeared in the first issue of the newsletter of the APHRC. A member of the Nairobi Gauge team participated recently in an important radio broadcast on health equity issues. Upon invitation by the California Family Health Council, the project made a presentation at the "Work and Health Conference" held in San Francisco in March 2001. Another presentation on the Nairobi Gauge was made at the annual meeting of the American Public Health Association held in Atlanta in October 2001.

Health Equity Gauge Association of Uganda

1. **Primary institutions responsible for managing the Equity Gauge**

   - The Health Equity Gauge Association of Uganda is a registered non-profit making concern. It's members are multidisciplinary professionals who have worked together for close to 18 months. They are drawn from the Institute of Public Health; Decentralisation and Innovative Consultancy Services; Ministry of Health. Plans are underway to expand membership to include other stakeholders.

2. **The scope of the Equity Gauge**

   - The design of the EG is based on the three pillars of : measurement, community participation and advocacy.
   - Measurement: study and document the status and distribution of selected indicators at regional/district level. The districts in the study are taken from four regions in Uganda each corresponding to a ranking by quartiles of the Human Poverty Index
   - Community Participation: Involve communities in identifying and confirming the socio-economic rankings; involve communities in defining their health equity concerns
   - Advocacy: For all three pillars, study findings will be disseminated with a view to providing timely, relevant and accurate decision making and/or altering policy direction in the short and long term
   - Decentralisation
     - The gauge will review how decentralisation affects: control of resources for health care at the implementation levels; capacity to implement decisions to improve essential medical supplies; distribution of human resources for health care e.g. potential to attract and retain staff
     - The gauge will also make a comparison of the districts based on phasing of decentralisation thus: Group 1(1994) – Mbale; Group 2 (1995) – Rukungiri; Group 3 (1997) – Kiboga and Adjumani

3. **Describe the political, social and economical context of the EG**

   - ***Political Reforms:*** Uganda has undergone political reforms over the last twenty years geared towards good governance, community involvement and participatory decision making and democracy
   - ***National Health Policy:*** subscribes to the two national goals for poverty eradication – expanded economic growth and increased social development. The Poverty Eradication Action Plan of 1997 ...
   - ***Constitutional provision:*** the constitution states that "Every Ugandan shall enjoy good health"
   - ***Health Sector Reforms:*** there is further emphasis on further decentralisation; reaffirmation of Primary Health Care with the principles of quality, gender mainstreaming and a minimum package of health care services

4. **Comparative population groups that you have selected for your EG**

   - District populations in the four quartiles ranked by Human Poverty Index. Thus Mbale is in the 1st quartile, Rukungiri in the 2nd; Adjumani in the 3rd and Kiboga in the 4th. Each district population is regared as homogenous.

5. Quantitative equity measurement indicators for the EG

- Indicators of health status (children's growth and nutritional status, Child (under 5) mortality, life expectancy at birth, maternal mortality ratio, measures of disability in general)
- Indicators of major determinants of health status (safe water and sanitation, food supply, adequate housing, poverty, educational attainment, income inequality in the society
- Indicator to assess the equity in health care financing (burden of payment for health care
- Indicators for health care resource allocation (public expenditures for health, distribution of qualified health care personnel in the public sector, distribution of health-care facilities at the primary, secondary, tertiary an quaternary levels)
- Indicators for utilisation and quality of health care (immunisation coverage of infants, antenatal care coverage, safe delivery coverage, contraceptive prevalence rates, quality of primary care services (availability of essential drugs at HC II and HC III)
- Access to health care referral services

6. Use of qualitative data in the Equity Gauge

- Obtained through Key Informant Interviews (KI) with health providers, focus group discussions (FGD), participant observations in health care and rapid participatory rural appraisal (RPRA)

7. Public Participation Plans

- Strategy will be involvement of the public/communities in the identification of inequities, discussion of inequities, and advocacy to responsible agents for the purpose of addressing these inequities
- Involvement of the stakeholders in the primary research (i.e. at community level, confirmation of key concerns in health equity)

8. Advocacy plans and proposed 'actions' to help reduce inequity in the setting of the EG

- All findings packaged and disseminated to policy makers, implementers, consumers and other stakeholders in Ministry of Health, Parliament and the community in general
- In particular, this feed-back is expected to change the flow and allocation of resources for health care services

9. Progress of the EG

- Doing well: Equity Gauge and advocacy messages have been well received by policy makers at the central level as well as other stakeholders in health care provision. There is good collaboration between Ministry of Health officials and the EG
- Difficult: Interpretation of secondary data for measurement indicators
- Main constraints: lack of critical mass of personnel versed in measurement
- Additional support: T/A for interpretation of findings; fora to exchange ideas and experiences between gauges on global and regional basis

South African Equity Gauge Project

Project Management

- The project is a partnership between an NGO, the Health Systems Trust (HST), South African Legislators (both National and Provincial) and Local Government. HST has strong partnerships with the Department of Health in work that is being done in other projects. These partnerships assist as a conduit for providing qualitative information on inequities and possible strategies for reducing inequities to the Equity Gauge, as well as for allowing an "Equity Gauge Lens" to be highlighted in our interactions with the DoH.

Project Scope

- The Equity Gauge Project attempts to monitor, and promote, progress towards equity nationally, across a range of socio-economic, health and health status indicators. Wherever data permits indicators are compared across provinces, rural and urban settings, socio-economic groupings, race, and gender.

Political, Social and Economic Context

- South Africa is the 2nd or 3rd most inequitable country in the world.
- Trends in equity have only recently begun to be monitored – data prior to 1994 was woefully inadequate, with almost no reliable data on the health of the black population.
- Apartheid policies resulted in huge inequities between black and white, between rural and urban, and between areas which were formerly "SA" and those which were formerly "homelands".
- Almost every indicator, whether it be socio-economic or health related, highlights a huge gap between white communities and poor black communities living in rural areas and informal settlements. In recent years the impact of HIV/AIDS, whilst disproportionately affecting disadvantaged communities is serving to increase existing inequity.
- South Africa has a democratic government with a commitment (although not always realised) to a culture of accountability and transparency.
- Commitment to Equity is enshrined in our constitution, in our legislation and is the focus underpinning most policies developed since 1994.
- We have a federal system of government with a national assembly and nine provincial parliaments.
- Our electoral system of proportional representation mitigates against national and provincial parliamentarians being as fully accountable to their constituencies as is desirable.
- Local government was reorganised in 2000 and there is a commitment to devolve responsibility for the provision of PHC to this sphere of government. This will hopefully improve accountability of service providers to their constituencies.
- At provincial level 85% or more of spending is allocated to health care and other social services. However health care spending remains skewed to the tertiary level.

Macro-economic environment

- South Africa is a middle income country with a neo liberal public sector and macro-economic policy. Over the last 7 years SA has established a stable and (slowly) growing economy. The proportion of government spending to service debt repayments has been significantly reduced in the last two to three years.

- In 1994 SA had a commitment to a Reconstruction and Development Programme (RDP) which emphasised redistribution of resources to previously disadvantaged areas and communities alongside job creation.
- During the last four to five years a Growth, Employment and Redistribution programme (GEAR), which emphasises economic growth and fiscal restraint as its first priority has replaced the RDP.
- The extent to which the macro economic policy was shifted in response to international pressure is unclear.

The Health System

- Prior to 1994 there were 17 Departments of Health in SA, all very "hospital oriented". Since 1994 emphasis has been upon integrating departments into one unified DoH, which is District based with an emphasis upon PHC.
- The greatest inequity in health care provision is between the private and public sector with approximately 60% of funding spent in the private sector on 20% of the population.
- Re-organisation of local government in 2000 has cleared the way for devolution of responsibility of providing PHC from the provincial sphere of government to the Local Government sphere. This devolution is intended to promote equity by improving accountability. However serious constraints of capacity and finance available to about 50% of municipalities have the potential to do the opposite and, increase rather than reduce inequity.
- Health care financing to provinces is allocated using a formula, which although containing a "backlogs" component, is in fact regressive.
- Since 1997 Provinces have been allocated a block grant from which they individually decide upon amounts for education welfare and health. This has reversed equity trends in health care spending, but it is unclear what impact this has had upon promotion of equity in health status.
- Community involvement in the planning and delivery of health services is problematic, despite the existence of clinic committees and hospitals boards.

Advocacy and Public Participation Environment

Judicial and legal system

- South Africa has a strong commitment to human rights enshrined in the constitution.
- The right to basic needs being provided by the state was tested in the courts recently, with a slightly ambiguous outcome.

Other non-governmental agencies and initiatives

- NGO activity is relatively subdued (especially in comparison to activity prior to 1994).
- The notable exception is in the field of HIV/AIDS where there has been a growing amount of high profile and successful activism. In 2001 The Treatment Action Campaign (TAC) took the Government to Court over the issue of access to Nevirapene, and the court ruled in favour of TAC.

The Media

- The media is in theory free. Sometimes it appears that what might be deemed "critical reporting" is constrained through the contradiction imposed for journalists with the desire to support a relatively inexperienced democratically elected government,

whilst at the same time wanting ensure that the press fulfils its function of exposing malpractice and wrongdoing.

Qualitative Data
The project has not utilised qualitative research as such, although we have used participatory forms of needs assessment throughout our activities.

Public Participation
Public participation was initially limited to working with stakeholders and to encouraging media participation in Equity Gauge activities. In order to begin to place more focus upon this component we have established a pilot community participation project. During the latter half of 2001 we began to build links with communities in one of the poorest parts of the country. This area is one in which a number of NGOs have been active for some considerable time and yet it has been very hard to bring about change. However, because of the work that has been undertaken there, there exists a large amount of information on health and health status. The aim of the work planned by the Equity Gauge is to use the information we have, particularly on health status, and to make this information available to the community in a format which is meaningful to them, and then to support the community in using the information to promote change.

Advocacy Activities and Plans
Effective and strategic dissemination of IEC materials
This has been one of the strongest components of the work of the Gauge. We have produced a number of publications, written in an accessible format which target "non-technical" audiences.
Direct engagement and active lobbying with policy makers and decision-makers
The nature of how the SA Gauge evolved has meant that this component is very strong. Much of the work of the gauge has focused upon direct engagement with key policy makers in national and provincial parliaments.
Constructing convincing and effective arguments, policies, proposals and recommendations for improving levels of equity
This has been a part of the work of the Gauge and has been integrally linked with the two areas of activity outlined above.

What has been going well?

- The SA Project was developed in conjunction with legislators and academics, and this has facilitated what has become a successful ongoing relationship with our partners.
- An integral component of the project has been capacity building, which has taken the form of workshops, site visits and the production of materials in accessible formats, specifically targeting legislators. The project has documented inequities across a range of indicators.
- The project has successfully focussed upon providing information about financial resource and allocation issues and how these are impacting upon equity.
- We have had some success in raising the profile of the huge equity gaps existing in the country. For example, from anecdotal evidence it appears that the project has impacted on legislators knowledge and understanding of health and equity issues, and resulted in more equity-oriented questions being tabled in the national assembly and provincial parliaments.

- Whilst we have been most successful in getting coverage through the print media, we have had some success in coverage in other media.
- The re-organisation of local government, and the policy intention to decentralise health care, has created a need for the project to develop links with local government political and administrative structures. It appears that the project been successful in beginning to build links between national and provincial legislators and councillors at the local level.

What has been less successful?

- We have been less successful in promoting action to reduce equity gaps.
- Our work at community level is not yet as strong as it could be.

Challenges and Questions for the way forward

Capacity Development

Capacity development has turned out to be a basic component of the Equity Gauge. Capacity development is by definition a slow and time intensive process. What should be the balance of capacity development and other activities within the project?

Advocacy

How do we keep a focus and energy for promoting change in a way that is relevant and meaningful for partners? Our current monitoring is broad, and reflects the range of indicators which impact upon equity in health and health care. Whilst this is important in assisting stakeholders in monitoring progress towards equity, it presents difficulty for promoting action and advocacy – there is just too much that needs to be done. We are considering the possibility of continuing to monitor a broad range of indicators, whilst focusing upon one or two issues around which to develop advocacy campaigns.

Public Participation

Defining what community participation in a national equity gauge should be – are pilots to demonstrate models of good practice the way forward? Or should we be building broad based coalitions with other organisations undertaking community action projects?

Measurement

Updating an Equity Gauge regularly when much of the data on key indicators is only collected every four or five years. With the process of decentralisation of health care to the district level set to become a reality over the next few years, indicators will need to be monitored at the district level. This requires a substantial collection of data in order to provide baseline information.

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Progress Report
Monitoring of Equity in health service systems in Thailand

Thailand is a country facing with high differences of health status and health care utilization among population in different socioeconomic groups. Although the pro-growth economic development strategy is quite succeeded in raising GDP per capita and reducing the ratio of population under poverty line but it also bring the problem of a wide income gap. Inequity in health status has been reported among population in different geographical areas. Although Thai health care system is under reform for more effective health care services, equity is not explicitly written as a main goal of the health care reform. In order to put equity as a high priority in health development plan, Thai equity gauge has been carried out to raise awareness of the existing inequity level and monitor progress towards reducing inequity gap.

Objectives of the project

1. To describe and document the situation of inequity in health service system in Thailand
2. To identify sets of equity indicators for monitoring progress towards equity
3. To provide training on equity concept and equity indicators to local health care staff
4. To advocate use of equity indicators for monitoring of inequity in health and health care among related stakeholders
5. To establish network for monitoring on equity at the provincial level

In order to monitor progress towards equity, sets of indicators on inequity have been established by analyzing data from secondary sources. These data can be classified into population-based and facility-based data. Data from National Socioeconomic Surveys, National Health and Welfare Surveys, Provincial Statistics, Resource Allocation Reports, Mortality and Morbidity Reports and other statistics and reports from related government agencies have been analyzed. Indicators on inequity in health and health care included: health status indicators, determinants of health indicators, health care financing and resource allocation indicators and health care utilization indicators.

To make the monitoring more effective, participation of the related stakeholders such as community leaders, women's groups, local health workers, staff of subdistrict administrative organization and media & journalist are necessary. These related stakeholders have been included to discuss about the existing inequity level, equity in their own 's view and sample indicators that they can use in their work for monitoring of equity. Concomitantly with public participation activities, advocacy actions have been planned. Indicators and information on inequity will be disseminated to media and politicians at local and national level to raise awareness and provide tools on reduction of inequity in health and health care. Empowering community leaders, civil society group and government staff at the local and provincial level has been planned so that they can challenge to health policy makers for more equity.

What has been done in Thai equity gauge ?

✧ Data from secondary sources have been analyzed and several sets of indicators on equity at the national, regional and provincial level have been established. However, these indicators have to be identified for their appropriate use at the national or international comparisons. Some more specific indicators such as perceived health status, perceived quality of care and accessibility to health services among population in different socioeconomic groups are needed for program implementation towards progress in equity in details. Data collection from primary sources have to be carried out to establish these indicators.

✧ Survey and mapping of related stakeholders from the selected province to participate in the Thai equity gauge have been performed. Project orientation has been made to these stakeholders to make them understand objectives of the project and ready to participate in the activities of the project.

✧ Workshops have been organized to discuss among health care staff, staff of subdistrict administrative organization, community leaders and women's group from the selected province to discuss about the existing situation of inequity, equity in their own views, how to pursue for more equity, and equity concepts and equity indicators for their own use.

✧ Training in equity concept and measurement to health care staff, staff of subdistrict administrative organization, community's leaders and women's group have been carried out after discussion about equity in their own' s view. Equity under the views of local health care staff and people focused only to equality in receiving of health care services. When process leading to equity has been discussed, they have recommended to improve equality in resource allocation, accessibility to health services, quality in health care provision and reduce existing inequality in service provision. In addition, they have proposed some simple indicators which can be established by data from health facilities records such as utilization rate, mortality rate and length of stay by insurance schemes, type of diseases and age group.

✧ Small grants project have been announced for related stakeholders to submit proposals on equity issue. To date, 2 postgraduated student have been granted to carry out their Master's theses on equity. Two more proposals from local health care staff and I proposal from staff of Faculty of Social Sciences and Humanities, Mahidol University have been submitted and under review and consideration process.

Lesson learned

✧ Equity is quite abstract for government staff at the provincial level and community people. Because of its ambiguous meaning, they are unclear for "What to do" and "How to do" to pursue for more equity. In order to encourage for public participation or make an advocacy, other issues such as "health care reform" may be easier to use as existing point rather than equity itself.

✧ Culture plays an important role in inequity. Buddhists people usually believe that those who are not equal to other people in any aspects are their own karma. They tend to accept inequity or inequality rather than to try to reduce it.

✧ To establish indicators from secondary data, one may face problems with reliability, validity, comparability and fluctuation of data, particularly, when data from several sources have been compared and combined.

What activities remain to be completed

✧ Additional data collection: In order to establish some specific indicators such as perceived health status, perceived quality of care; primary data collection have been planned. Rapid survey by exit interviews of clients using health facilities has been considered to fulfill these objectives.

✧ Public participation plan: In order to make the effective monitoring of equity, raising awareness and policy formulation will be focussed. Raising awareness will be performed by feeding information through media and civil society group. To put equity as a high priority in health agenda, working with administrators of subdistrict administrative organization, local and national politicians will be considered.

✧ Advocacy plan: In order to disseminate information on inequity to related stakeholders, particularly to local and lay people, emphasis will be made on how to translate information and indicators into friendly, attractive, simple and interesting message.

Assistance needed

Measurement

✧ Identification and selection of indicators on equity for different purpose

✧ Management of reliability, comparability and fluctuation of data from secondary sources

Public Participation

✧ Strategies to identify level and at what scale for participation of different stakeholders.

Advocacy

✧ Selection of techniques and appropriate time and person for messages we want to transfer

The Equity Gauge of Zambia

Summary Progress & Achievements

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Introduction

With funds released in July 2001, the equity gauge of Zambia commenced on formal activities. The initial desire was to start with a national launch of the equity gauge programme at national level involving legislators, policy makers and national level NGO's. However, the rapidly changing political landscape made this step difficult as parliament went into an unusually long recess (March to November 2001). Legislators were gearing up to defend their seats and the wheels of government could not move at their usual normal pace.

This scenario resulted in changes to the order of carrying out programmes. Instead, work had to start at district level. In spite of the efforts made to complete the activities well before the start of campaigning for the national elections, it was still not possible to get legislators at district level to attend equity gauge activities. Many were in the process of changing political parties and were not sure whether they would make it back to parliament. Nonetheless, workshop activities went ahead, with the first one done for Lusaka district (September) then Chama District (October), Choma District and Chingola District (both in November, 2001).

Methodology

Consent to undertake the equity gauge project was obtained at central level from the ministry of health and the central board of health through the offices of the director planning and the director of public health and research, respectively. In order to ensure local ownership of the equity gauge programme of activities at district level, the district health authorities (at the DHMT) were given a copy of the equity gauge proposal and asked to identify and invite stakeholders in their districts from a suggested set of stakeholder category as contained in the proposal document. All logistical arrangements for districts workshops were made by and through the offices of the district directors of health.

The equity gauge of Zambia has used workshops as a major tool for establishing equity gauge activities and equity gauge culture in the health services in Zambia. It is planned that TWO workshops' programmes on equity in health be held in each of the 4 districts where the programme has started. The first series of workshops were planned to mobilize people and views on equity in

health in the 4 districts. In this set of workshops, definitions of equity in health were arrived at and key stakeholders as well as equity issues of concern identified. In addition, the roles to be played by the various stakeholders were identified as well as the desired activities to be undertaken by each category of stakeholders in order to bring about and enhance equity in the districts. The workshops were participatory in nature with stakeholders subdivided into 3 or more groups to discuss an issue of equity. After the discussions, each group chose a spokesperson that presented and justified their deliberations during plenary sessions. Where necessary, the views were adjusted/ amended following input from the audience. Three plenary sessions were held to share views on issues in each of the three pillars of advocacy, community participation, and measurement.

Each workshop was concluded with an estimate of the desired quantity of resources needed to undertake the desired activities and participation by the identified stakeholders. The stakeholders selected some participants from among them to undertake this task. These budgets were later incorporated into annual district budget of health activities by the DHMT.

Results

The results from the workshop are presented below, firstly to give the views on issues affecting equity in Zambia from the 109 participants that completed a semi-structured questionnaire. This is followed by a presentation of views and ideas expressed and consensus reached at the district workshops.

(a) CURRENT PERCEPTIONS ON EQUITY ISSUES & EQUITY IN HEALTH CARE IN ZAMBIA

The background to the Equity Gauge of Zambia activities is one of socioeconomic divisions between people within each district (97, 89% of respondents). It is perceived by 89% that these socioeconomic divisions are either very deep or deep, while 6% felt that they were not deep. These divisions are reflected by a number of visible characteristics in the two main categories of rich and poor (Annex 1, Box 1 and Box 2).

There is a feeling that the government in Zambia is democratically elected through free and fair elections (Yes = 60.6%, No = 33% and 6% didn't know). Similarly, the feeling on local council representation was 62.4% (Yes), 24.8% No and 11% didn't know, respectively. In terms of governance, the general impressions were 20.2% that government is accountable and transparent, 74.3% that it is not and 5.5% did not know one way or the other. Similarly, for local government the impressions were 15.6% that there is transparency and accountability, 77.1% there is none of these and 6.4% did not know. With respect to the administration of justice, the performance of the Judiciary in Zambia was rated not to be very independent (53.2%), very independent (15.6%) and not independent (28.4%).

Overall the human rights culture was rated to be very strong (19.3%), weak (67.9%) or that it did not exist at all (11.0%). As such, it was felt (by 57.8%) that there are still some people who are denied their human rights and a number of group categories identified (Annex 1, Box 3).

Perception on Equity Issues and Equity Perspectives in Today's Zambia

The existence of socioeconomic divisions in Zambia has given rise to inequities in the provision of social services to the people such that it was felt (71.6%) that poor people in Zambia had NO access to fair legal representation and that the judicial system in Zambia (the courts) generally do not uphold (safeguard) the interest of poor people (Not Very favourable, 58.7%; Not favourable at all, 25.7%). In addition there is a feeling of corruption or patronage (86.2%) within the government circles, which was rated to be (Very High, 53.2%; Moderately High, 11.9%; High, 16.5%; Low, 4.6%; and very low, 9.2%). The corresponding ratings for corruption within communities were 35.8% as very high; 20.2% moderately high; 22.0% high; 12.8% low; and 6.4% to be very low, respectively.

Up to 43.1% felt that there was **freedom of the press** in Zambia today (48.6% No, 5.5% didn't know) and that the press in Zambia is not concerned with highlighting the plight of the poor (37.6%) with others feeling otherwise (42.2% as being moderately concerned and 19.3% very concerned). In addition, there is a communication gap between the POOR and the RICH groups in Zambia today, which is thought to be growing (80.7%), rather than narrowing (14.7%).

Zambia is considered a poor country (52.3%) like most respondents thought of their districts to be similarly poor (65.1%, poor district; 25.7%, rich district).

In addressing issues of governance and development, the perception was that the government was influenced by outside forces (92.7%), such as by the IMF, the World Bank and donor agencies to varying extents (56.9%, influenced very much; 35.8%, influenced to some extent, and 3.7% felt not influenced at all). As such, these development agencies are stakeholders in the development efforts in Zambia.

It was felt (78.9%) that the Government funding to the Health Sector was not adequate, and that the majority (55%) believed that the consideration for EQUITY was a key public policy objective in Zambia today (35.8%, felt NO while 8.3% did not know). A number of issues were identified to be part of the equity objectives in the current policy guidelines, principally community participation initiatives (Annex 1, Box 5). However, the feeling was that more effort was needed in order to strive and achieve greater equity in health (Annex 1, Box 4). Otherwise as things currently stand 71.6% of respondents felt that the POOR and the RICH used different Health care Systems, where (a) The rich have better services at private health facilities, while the poor had no access to the same; (b) The rich had access to better health services outside the country-while the poor did not; (c) The rich had access to high cost facilities at Government Health Centers, while the poor did not have access to the same; (d) that the poor resorted to the use of traditional healers who were a cheaper and more convenient alternative; and (e) that the rich had a choice of going either to private or to public health facilities, while the poor had no choice but to go to public health centers where services were thought generally poor, including lack of medicine.

It was felt (49.5%) that the private health care sector had not expanded in most districts in Zambia over the past 10 years (40.4% said yes and 2.8% did not know). It was recognized that this would have an effect on equity in health and health care. The view was that in its present set up, the private health care in Zambia serves to Increase Inequity (37.6%) largely as a result of economic

and distributional access to these services (28.4% thought it decreased inequity, 15.6% did not know).

Perception on Health Policies and Health Reforms In Zambia Today

Workshop participants recognized a number of stakeholders who were thought to be party in making Health Policy Decisions in Zambia (Annex 1, Box 6). In addition, 40.4% thought that the Non-Governmental Organisations (or Civil Society) were involved in Health Policy decision-making (with 36.7% saying NO while 17.4% did not know). With respect to the financing of the health services, several stakeholders were similarly recognized as playing a role (Parliament (52.3%), Cabinet (16.5%), Ministry of Finance (27.5%), Ministry of Health (25.7%), Donor community (4.6%), NGOs (0.9%), CBoH /or the DHMTs (2.8%). Some 3.7% of the respondents did not know where this was done.

Respondents identified the following areas as being in need of urgent policy initiatives in the next 6 months: (1) On issues of equity; (2) Community participation; (3) Supply of essential drugs; (4) Motivation of health workers; (5) Funding to the health services; (6) HIV/AIDS; (7) Salary increases for health workers; (8) Conditions of services for health workers; (9) Provision of Health care for all; (10) Exemption guidelines to provide free health services for selected poor people; (11) Capacity building to increase trained personal; and (12) Further health reforms' initiatives to be implemented. Up to % of respondents did not know which areas the health reforms needed to focus on in the immediate future.

The participants were aware of the on-going major Health Reform initiatives in Zambia (55.0%), while 15.6% said they were not aware and 11.9% could not commit themselves either way. Participants recognized both some positive and negatives attributes from the on-going health reforms in Zambia today (Annex 1, Box 7 and Box 8).

(b) DELIBERATIONS FROM THE ZAMBIAN EQUITY GAUGE WORKSHOPS

The view from participants was that this was a good initiative worth pursuing. In order to have meaning, it was suggested that the equity gauge of Zambia should have two clear objectives to it, these being (a) to bring about equity in health and health care, and (b) to bring about a culture of equity in the community. It was felt that the two needed to go together if there were to be a positive impact on equity in health care. It was agreed that in order to have these two objectives met, there is need for increased efforts with regard to community participation. Current arrangements, though good in themselves, do not appear sufficient to attain desired stated goals. The arrangements and community participation structures can be frustrating and exact a high cost in terms of time and other opportunity missed [the opportunity costs], (Annex 1, Box 9a & Box 9b). A need exists to have greater involvement of community groups and structure as a way to have influence and impact on health and health care.

Increased Stakeholder Involvement: The above examples were cited as a justification for greater and wider community involvement in health and health care as outlined in the proposed GEGA model. In this model of approach, there are three pillars around which the activities will be centred – these being Advocacy, Community Participation and Measurement. The district workshops planned to come up and constitute a main district committee (serving as a district board on equity)

and one or more sub-committees to perform assigned tasks. Under guidance of the sub-committees, a number of stakeholders (Annexes 2 & 3) will carry out assigned activities and tasks with the objective of developing a culture of equity as well as improving on equity in health and health care whether on advocacy or community participation. The impact and outcomes from these activities will be assessed and quantified using agreed upon indicators (as suggested in Annex 4).

Follow-up Work

As part of the initial set of activities, the equity gauge of Zambia remains with three major tasks to implement and accomplish successfully. These are as follows:

(a) With national elections now out of the way (held 27th December 2001), a new parliament is expected by January 2002. Depending on the work programme of the new parliament a national inaugural Zambia Equity Gauge workshop can be expected around March or April (with the GEGA meeting in Kampala taking place in February 2002). But in reality, we anticipate that the national inaugural equity gauge workshop meeting would be held after the second round of district workshops.

(b) In the meantime, the research team is studying and consolidating the views expressed in order to come up with suggested activities for the next workshop sessions. The key thrust in the next rounds of district workshop sessions will be to optimize, prioritize and agree on the desired set district indicators on equity in health and health care as well as on work activities as a way to implementing equity in health in each of the four starting districts. When completed, the data and experiences will feed into the national inaugural equity gauge workshop. The second year of our work activities will see increased activities in the equity gauge of Zambia implementation programme.

(c) It is planned that by the end of the second year of activities the experiences gained from the pilot phase will be used to extend the equity gauge programmes to other districts of Zambia. Additional resources and funding will be required in extending the coverage of districts with equity gauge activities. Due to the tight work schedule and (in part) the uncertain political environment then, it was not possible to obtain donor participation and funding for our equity gauge programmes. This is another area we plan to do more work in. The participation in equity gauge activities from district health authorities and the Central Board of Health (CBOH) were both excellent and supportive.

There was also good participation from other stakeholders/partners taking part in this project work, such as the Participatory Assessment Group (PAG) and the University of Zambia, School of medicine (Department of community medicine).

ANNEX 1: CURRENT PERCEPTIONS ON EQUITY ISSUES & EQUITY IN HEALTH CARE IN ZAMBIA

Box 1: How can you tell that someone in your district is well-off (RICH)?

Usually with posh cars
Have good jobs.
Are able to go out of country for medical treatment.
Have good clothes/shoes.
They don't join the queues when they go to a health centers.
They behave as though everybody knows them.
Have access to clean water & sanitation.
Their children go to private schools.
By the way they talk and carry themselves.
Associate with well to-do people in society.
Go to private medical centers.
They don't get involved in local neighborhood activities.
Good accommodation & leave in quiet conducive residential areas.
Have big bank accounts.
Usually with cell phones
They tend to have no respect for others.
Their children go to study abroad.
Can afford food (Good nutrition).
Have a lot of property.
Can afford anything they want.
Have access to electricity.
By the business someone runs.
Can afford cable TV.
Are usually educated.

Box 2: How can you identify a poor person in your district?

Have poor shelter.
Become ill frequently.
Have poor clothing.
They look miserable.
Unemployed.
Mostly not educated.
No access to clean water and sanitation.
Have poor or no medical care (Unable to pay for medical care).
Cannot send children to school, especially higher education.
Mostly depend on traditional healers and Government health services.
Are generally and mostly malnourished - Don't have adequate food.
They usually expect help from others-Begging.
Don't talk too much, shy and humble.
Most walk long distances.
They don't have property.
Have no shoes.
Cannot afford basic needs of life.
They are crime prone.

Box 3: The following Groups were identified as (at risk of being) denied of their Human Rights?

On Economic Grounds	On Physiological Status
The poor.	Women.
Civil servants.	Children and the youth.
Police officers.	The disabled.
	The aged.

On Social Grounds	On Expression of their Conscience
The illiterate.	Politicians that go against those in power.
The vulnerable.	Journalists-Independent Media.
Street kids.	Individuals who say their minds on national issues.
Sex workers.	Opposition members.
Orphans.	Opposition parties.

People detained for a long time without hearing.
Foreigners, especially those in prison
Those without relatives in high offices

Box 4: Issues on EQUITY in Health to be emphasized on as part of Government policy on Health?

Press freedom.	Equal access to health care for both the rich and poor.
Staff motivation.	Preventative rather than curative measures.
Community participation.	Free X-Ray and other surgical conditions.
Eradicating corruption.	Introduce cost effective health services.
Availability of drugs.	Free medication for all vulnerable groups.
Equity measurements.	Monitoring and evaluating equity issues.
Accessibility to health care.	Capacity building for health staff.
Adequate funding.	Pay more attention for the poor.
The rich to pay more than the poor.	Issues must be implemented fully.
Increased salaries for health workers.	Re-train health staff.

To send any person out of the country for medical services where necessary.
Conduct workshops/seminar for communities and other stakeholders - empowering people.
Involve the grassroots in the planning process, implementation and evaluation of health issues.

Box 5: The main HEALTH EQUITY issues identified in current Government policies

There are the health reforms.
Community involvement.
There is equal access to health services.
There has been training of health care providers.
Have provided training to community health workers
Policies have made it cheaper for all to afford health care
There is community mobilization, senstization and empowerment.
Efforts are being made to close the gap between the rich and the power
Exemption categories including treating the very ill even if they have no money to pay
Efforts made to take affordable and quality health care service closer to communities.
Provision of drugs
There is fairness
Decentralization of Health delivery system
Affordability of available resources

Box 6: Group Categories of people and Organizations thought to be involved in making policies on Health

CBoH.
Counselors.
Members of parliament.
District Administrators.
DHMT/Provincial Health Office.
Cabinet.
Politicians.
Donors.
The Government.
Ministry of Health.
The community.
Health workers.
Stakeholders.
Ministry of finance.
Provincial Medical Officers (PMO).

Box 7: The POSITIVE elements brought about by Health Reforms in Zambia

Accountability-Health providers.
Decentralization in decision-making
Nothing Positive (Nil)
Capacity building-Staff and community
Partnerships between various stakeholders
Improvements in health centers i.e. infrastructure.
Formation of Neighbourhood Health Committees (NHCs)
More health centers have been established, bringing Health Centres closer to the people
Community participation
Change of attitude by health workers.
Sharing of costs with beneficiaries
Increase efficiency in services delivery

Box 8: The NEGATIVE elements brought about by the Health Reforms in Zambia

Increased inequalities
Exodus of health workers for the countries
Increased bureaucracy
Increased abuse of equipment and transport facilities
Poor attitudes by staff
Loss of trained manpower through voluntary separation
Delinkage of staff from Ministry of Health to Boards
None sensitization of the community on the reforms
Shortages of essential drugs
Lack of loans and leave benefits
No or delayed payments for retires
Poor conditions of service for workers
The poor cannot afford to pay fees at Government HC's (cost sharing)
Increased corruption at Health Centres (Bribery, Pilfering of drugs by health workers, etc.)

Box 9a: Attempts at Implementing Community Participation can be Frustrating

"I feel that the main stumbling block preventing the top hierarchy in improving community participation is inaction at the health facility level. As example, if you hold meetings and would like to follow up on issues as a health centre committee (HCC) chairman, you find that minutes are not available or not done (by Health Centre staff who serve as the HCC secretariat). Sometimes they tell you that the minutes have already been forwarded to the District Health authorities. But when you follow up to check with the district authorities, you are told that there are no minutes from your health centre. At this point, you do not know whether to report the Health Centre staff (to higher authorities) because you fear developing bad relations with them. Hence you keep quiet. This frustrates the whole effort, enthusiasm and concept on community participation". (Male HCC Chairperson, Chingola).

Box 9b: Attempts at Implementing Community Participation can be Time Consuming and incur high Opportunity Costs (in terms of other activities and opportunities foregone)

"The issue of minutes depends on the individual effort and commitment of the NHC chairperson. When minutes are recorded of a meeting, I personally make sure to have them recorded, then I take them to DHMT offices for typing and then I make sure I leave a copy behind while also taking a copy with me. In this way, I ensure that minutes of meetings held are available". (Female HCC Chairperson, Chingola).

Annex 2: The Advocacy Pillar Set Up for Chingola District (Group 2 = Mixed Gender)

Advocacy Action	Groups to be Involved	Activities to be Undertaken
To Develop Convincing & Effective Arguments, Proposals and Recommendations for the NEED to reduce inequities in Health & Health Care	**Health providers** MOH through CBOH;	Sensitize the Community on Equity through Print & Electronic Media
	Health Providers at Community Level	Intensify and Facilitate on Equity Practices as practical examples to be followed
	NGOs (e.g. SFH, WVI, CHEP, Round Tablers)	Amplify Equity Issues, Offer Support Through Funding of Community activities that promote Equity, Carry out their own Equity in their Health Care Activities & Programmes
	Traditional Healers; Community Health Workers; Neighbourhood Health Committees	Promoting NHC Meetings on Equity, Liase with Community and Health Care Providers on Equity issues arising
	Non-Health Care Providers, e.g. Churches,	Sensitize the Congregation on Equity
	Schools through the MoE, etc)	Providing Additional Lessons on the syllabus for Equity, School Competitions through Debates and the Performing Arts on Equity Issues.
	Business Communities (e.g. KCM)	To Fund Community Activities on Equity To Put in Place Activities for their Workers to be sensitized on Equity
	Agricultural Workers (e.g. Extension Workers)	To help spread the messages on Equity in Health through their programmes / Activities.
	Politicians	Represent in Parliament on Equity programmes Foster Community Participation on Equity issues, Include equity dimensions in their talks
To Develop Convincing & Effective Arguments, Proposals and Recommendations for the Establishment of an Equity Gauge in the District	Church Leaders, Businessmen & Business women, NGOs, Politicians, Health Workers (includes CHWs, TBAs, NHCs)	Form the Equity Gauge Sub-Committee that will meet to formulate an EQUITY GAUGE for Chingola District
To Establish Direct Engagement of Policy Makers and Decision Makers	Sub-Committee formed in (2) above to form and Serve as a District Equity Committee (for Local Policy Decisions on Equity)	Ensure that/monitor implementation of Equity Policies and Decision Needs To influence Change of policies detected by situation /incidents

To Actively Lob by and Campaign for the Equity Gauge Activities/ Programmes	District Equity Committees, NGOs	Holding meetings with other NGOs, Politicians, Church Leaders & Business managers (such as Company Directors, etc)
To Empower People and Disadvantaged Groups with the Knowledge Necessary for them to use in Striving for Greater Equity	Health Care Providers, DEC (District Equity Committee)	Intensify people on good health and health care Persuade business communities to provide employment to the local community to sustain their health and health care through their fair share of wages/ incomes (businesses such as KCM); Meetings with Communities for the dissemination of information on Equity To follow up Community Health Support Committees, e.g. KCM (a Mining Company)
To Carry Out Peaceful Civil Society Demonstrations in Support for Greater Equity and the Implementation of Equity Gauge Activities	Judicial Department NGOs (WVI, HBCs, CINDI, LIONS, Round Tablers, etc) Politicians; Church Leaders; NHCs	Re-enforce the Rule of Law Peaceful Society Civil Demonstrations Fund raising Ventures
Establish an Effective and Strategic Communication System for the Dissemination of Information about the Equity Gauge	District Equity Committee (Main and Sub-Committees)	Communication committee that should ensure establishment of an account which they will administer in favour of equity programmes
Any Other Actions You May Think of		
Other Actions 1	Social Welfare Department	To Identify for Needy groups/ areas, such as orphans, widow/ers, destitute, the physically handicapped, etc
Other Actions 2	NGOs	To Hold workshops on Equity
Other Actions 3	Department of Social Welfare	To empower people and disadvantaged groups by providing them with information about sources of funding according to their abilities and needs
Other Actions 4	DEC (District Equity Committees)	To facilitate workshops on Equity, To serve as Trainer of Trainers on Equity

NHCs = Neighbourhood Health Committees; HBC = Home Based Caregivers; CINDI = Children In Distress; WVI = World Vision International; KCM = Konkola Copper Mines plc; CHEP = Copperbelt Health Education Project; SFH = Society for Family Health; CBOH = Central Board of Health; MoE = Ministry of Education; MoH = Ministry of Health

Annex 3: The Community and Public Participation Pillar (CHOMA Workshop)

Community Group	To take Part?	Role to Play in the Equity Gauge Initiative	Expected Contribution to the Equity Gauge Activities/ Initiative
Policy & Decision Makers, Senior Public Office Managers	YES	Sourcing for funds, Supervision, Make and issue policy directives with equity considerations (through brochures, circulars and meetings)	Funds made available, Equity policies made, Improved Health Care.
Elected Representatives (MPs, Councilors, etc)	YES	Advocacy role (lobby for equity) and same as above	People sensitized on equity, Equity culture created, Funds available
Donor Agency Representatives	YES	Advocacy and Funding, Assist with logistical support	Funds available, People sensitized, Equity attained
NGOs and Human Rights Groups	YES	Lobbying, Campaigning and Peaceful demonstrations for equity, Empower people with knowledge on their rights and equity, Source funds for equity activities (civic education through meetings, drama, pamphlets, posters and workshops)	People sensitized, Funds made available and Equity attained.
Research & Academic Institutions	YES	Undertake research on equity and issues of equity, Make recommendations for equity, develop convincing proposals for equity, advocacy and training on equity.	Implementation on equity guided, Guidelines on equity available; appropriate updated information on equity made available; Reliable data on equity made available.
Members of the General Public	YES	Advocate & Lobbying for equity, attending workshop, campaign for equity, hold peaceful demonstrations for equity and involvement in equity activities (through practice & participation)	Equity awareness created, Sense of self worth increased; Sense of ownership of equity initiative created; Public involvement in Equity stimulated
Public Health Workers		Mobilize and Sensitize communities on Equity, Advocate for equity through talks and practices in care provision; Train CHWs to aim for increased coverage for easy access to services.	Equity gauge activities implemented, Equity objectives attained.
Private Health Workers	YES	Mobilize and Sensitize communities on Equity, Advocate for equity through talks and practices in care provision; Provide affordable health care services	Equity gauge activities implemented, Equity objectives attained. Quality care attained

Traditional Healers	YES	Attend workshops and participate actively on equity; Participate & contribute to research on equity. Collaborate with health institutions on equity	Influence people positively for equity; Sense of ownership developed. Well focused service delivery
Traditional Rulers (Chiefs, Headmen, etc)	YES	Mobilization of communities, Hold meetings on equity, Lobbying and advocating for equity & source for funds	People enlightened, funds made available and public participation increased on equity.
Journalists and the Media	YES	Publicize Equity Issues and stories; Project equity dimensions in their writings; help to promote the equity gauge initiative, generally	Public awareness on Equity issues and thinking created and promoted
Trade Unions, Workers' Committees	YES	Lobbying for Equity in their activities; Advocate for fair work conditions; Advocate for medical schemes at work places and Sensitize their members on equity	Equity awareness created; Workers well informed on equity, Equity of access to medical services improved
Political Party Agents / Representatives	YES	Lobbying Government for equity through legislators (MPs), Local Counselors; Incorporate concepts of equity in their manifestos	Equity awareness created, Equity gauge concepts become non-partisan (Not politicized as such)
Artists (like Musicians, Drama Groups, Painters, etc)	YES	Entertaining with equity messages in their performances, Publicity and sensitization on equity through songs, drama and poems.	Equity awareness created and sustained in the community.
Other Categories	YES		
Churches	YES	Educate Communities through Sermons	Equity awareness created
Teachers	YES	Educate Communities through Seminars	Equity awareness created

Annex 4: The Measurement Pillar – Some Proposals on Indicators of Value

Incidence and Prevalence of Tuberculosis in Adults (Incidence, prevalence and Case fatality rate due to TB)

HIV/AIDS amongst the Youth (Number of funerals due to HIV/AIDS; Incidence and prevalence of orphaned children, Percentage of STDs, Prevalence of abortions among couple and single women, Availability of mobile voluntary testing)

Safe Motherhood and Maternal Mortality Rates (Number of mothers dying during child birth, Coverage with TBAs, Skills of TBAs, Infant Mortality among those delivered by TBAs; Attendance at Antenatal Clinics)

Water and Sanitation (Number of families per well; % Families with rubbish pits; % Families with pit latrines; Number of bore holes per every 1.5 km)

Utilization of Health Services (Impact due to User fees – Proportion able to pay for medical schemes, Proportion able to pay for ambulance services, Attendance levels; Time spent waiting for services at OPD; Access to health care – geographical Spread, facilities per population unit, distance to nearest health centre, number and frequency of outreach services; Proportion not able to pay in communities/ villages; Availability of Drugs at health facilities; Staff workloads – staff to patient ratios)

Morbidity and Mortality Rates (Incidence rates of diseases like Malaria and Measles; Numbers of People brought in dead at health facilities – Deaths in homes)

Morbidity & Mortality among the 0 – 5 Year olds: (Immunization coverage; Prevalence of Anaemia; The top 10 diseases in Children)

Literacy & Education: Percent of children IN and OUT of Schools among the school age population; Percentage able to Read and Write

Utilization of Family Planning Services (Percent attendance at Antenatal Clinics and Percent Attendance at Post Natal Clinics)

General Socioeconomic Indicators in Society

(Urban: – Poverty level = % poverty, % malnourished; Asset possession (property); Level of Prostitution, Number of Beggars and Proportion of the disabled in community)

(Rural: - Food Production and Household food security e.g. How many meals per day eaten; Availability of cultivable land; Proportion of malnourished persons/ children)

(General: - Nutrition Contents of Foods and average Nutrition Intake; Access to transport services in districts per population unit (Motor vehicles or bicycles)

ENHANCING STAKEHOLDER PARTICIPATION AND IN HEALTH BUDGET PROCESSES IN ZIMBABWE

Institutions: TARSC (Dr Rene Loewenson, Freckson Ropi
Ministry of Health and Child Welfare (Dr P Sikhosana)
Other: Mr T Zigora

REPORT OF ACTIVITIES
TARSC September 2001

1. BACKGROUND:

The MoHCW and other public and community stakeholders have a strong policy commitment to redressing inequity within the health sector. The Zimbabwe Health Equity Gauge Project seeks to address both technically, and in terms of important social and political processes, the need for clearer articulation of equity demands in budget allocation processes both to and within health.

i. To use evidence and stakeholder review to support equity oriented outcomes in the public budget allocation to and within health
ii. To develop consensus amongst key stakeholders on the goals, mechanisms, principles and factors used in developing a transparent equity oriented resource allocation formula to be used for the allocation of resources to and within the health sector and for monitoring the use of those resources
iii. To establish a steering committee of key stakeholders (Govt, Parliament, Local authorities, others) to review the technical information and processes involved and that can widen understanding on equity oriented resource allocation processes.

In early February 2001 Rockefeller Foundation under the Health Equity Gauge project allocated TARSC Usd98 250 for its proposed work with Ministry of Health Zimbabwe on health equity. In terms of the contract, this is the first report to Rockefeller of the work done to date in the project. It covers the 5 month period to end June 2001.

2. AIMS OF THE FIRST PHASE

The work to be done in the first phase included

1. Setting up the institutional base for the project (contracts with the research co-ordinator FT Ropi) and with core project personnel in government and TARSC
2. Obtaining equipment (computer etc) and setting up the project contract with TARSC for administrative support of the project
3. Setting out the agreed parameters of the project design with project partners through a small steering committee set up to monitor the project.
4. Carrying out the background policy literature review of equity policies to identify key priorities for health equity outcomes
5. Assessing the current resource allocation formula and system

6. Carrying out a survey of stakeholder perceptions of priorities amongst equity indicators identified from policy review and using this to identify identified priority equity indicators for resource allocation.
7. Carrying out the literature review for and designing an agreed methodology for the next stage of analysis of equity indicators for inclusion in resource allocation.
8. Agreeing on a wider steering committee for review of the next phase of the project.

3. ACTIONS IMPLEMENTED.

All the above actions except items (7) and (8) had been implemented by end June 2001 and the remaining two items are anticipated to be completed by end September 2001.

The relevant contracts, office support, equipment etc were organized for the project and a review committee set up including the co-operating institutions. A workplan was prepared and adopted by this committee. A bank account was opened for the project and separate accounts maintained for the project. (The TARSC audit report for year ending June 2001 has already been sent to Rockefeller). The interim finance statement covering the period February 1 2001 to June 30 2001 is attached to this report.

Analysis was carried out and a report prepared that identified the current situation, the available data sources for health-equity indicators and the current resource allocation formula. The report produced outlined the current situation in Zimbabwe on resource allocation to and within the public health budget in terms of (I) the institutional framework (ii) the criteria/ factors used in allocations made (ii) the processes in which these criteria are applied. A report was also prepared of current policy positions drawing from 5 major policy documents and the major stated policy goals viz a viz the performance of public health systems, and their relationship with health equity goals identified.

This summary report was reviewed by the small steering committee set up by the co-operating institutions and a list of key indicators identified.

A survey was then carried out using a questionnaire that included these indicators to identify priorities from key stakeholders (health providers, regulatory authorities, health financers, communities, elected leaders) to identify from stakeholders the benchmarks that they perceived best measure these objectives.

A sampling frame was defined from key categories of stakeholders involved in health, representing health providers or purchasers at international, national, provincial and district levels, from government, non-government and private sector, and also representing communities, policy and elected organizations. A combination of stratified and purposive sampling was used to select 58 representatives from stakeholders.

A questionnaire was designed to solicit stakeholder perceptions on the suitable criteria for the budget allocation process in the Ministry of Health and Child Welfare. Suggested indicators were listed under relevant categories and respondents were asked to give a score to each indictor as measure of the significance of that indicator in allocating resources. The interview method was used to administer the questionnaire to identified representatives of the stakeholder organizations.

The report of the survey provided information on the perceived priority indicators within the areas of health needs, ability to meet health needs and health service performance that will be taken forward into the next stage of the analysis, variation between stakeholders on perceived priority indicators and perceptions of stakeholders on the current performance of the resource allocation system.

This information is now being used in three ways:

- To map the current distribution of the identified variables by key dimensions identified in the stakeholder survey as having distributional relevance for equity, viz geographical area, urban-rural, level of health services and income level (where feasible)
- To apply within the agreed methodology to assess the correlation between variables in order to identify those with greatest predictive value in health –equity outcomes and to identify potential single indicators that can be easily applied within the resource allocation formula.
- To apply these identified variables in a resource allocation formula and map the difference in allocation outcomes against the current formula.

This will be done in the next phase (September - Jan 2002) once the methodology is agreed. **(This work has now been delayed by Mr Ropi's situation).**

In the next phase the steering committee will also be widened and review of the work subject to wider stakeholder feedback and review, including representatives from MoHCW, MoFinance, Local govt, Parliament, civil society.

Publications produced to date:

Ropi T, Loewenson R, Sikosana P, Zigora T (2001) Literature review on policies and processes for inclusion of equity in Health Budget Processes In Zimbabwe. Report prepared under the Zimbabwe Equity Gauge Project, Training and Research Support Centre (TARSC), Ministry of Health (MOHCW) and TARSC/ MoHCW/ Equity Gauge Monograph 1/2001

Mbwanda L, Loewenson R, Ropi F, Sikosana P, Zigora T (2001) Stakeholder Views On Resource Allocations In Health: Report Of A Study On The Perceptions Of Interest Groups On Priorities For Health Resource Allocation, paper prepared under the Zimbabwe Equity Gauge Project Ministry of Health (MOHCW) and Training and Research Support Centre (TARSC), TARSC/ MoHCW/ Equity Gauge Monograph 2/2001