

# Can provision of ART be equitable when the (whole) health system is inequitable?



Drawing on experiences from Malawi

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# The Health system is inequitable



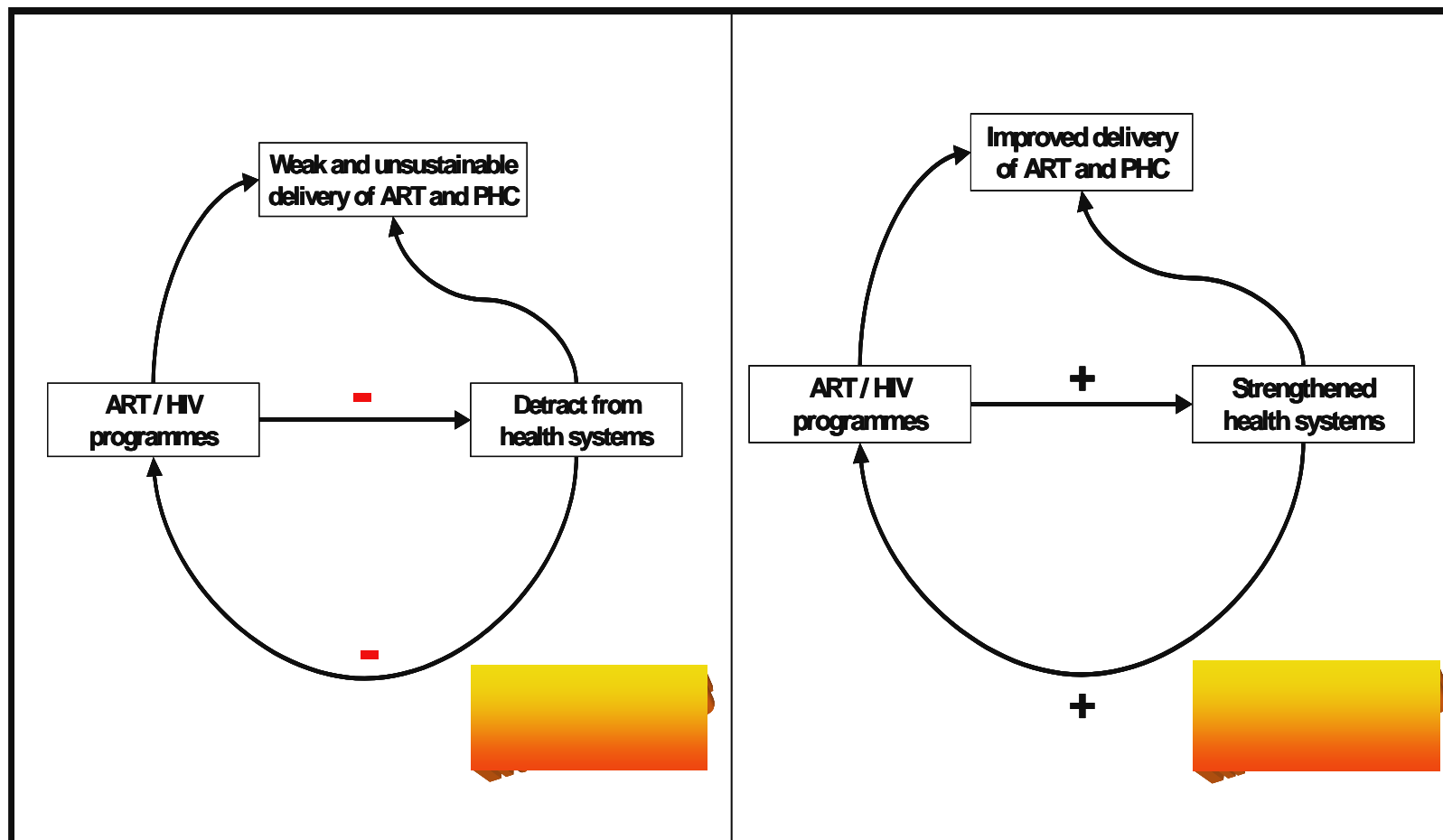
- Severe shortage of health personnel
  - 1.1 doctors per 100, 000 population
  - 25.5 nurses per 100, 000 population (WHO,2004)
- Most public health facilities lack capacity to deliver the Essential health package
- The ultra poor spend 7.4% and 10% of their annual consumption on health care
- 84% of the population has access to a health facility within an 8KM radius –
  - this masks some variations e.g. in Chitipa and Kasungu districts, over 50% live more than 8KM from a health facility.



# Equity and Health systems

- Limited resources available for HIV and AIDS treatment programmes raises two major concerns
  - 1. Equity of treatment programmes (who and which population groups have access)
  - 2. Impact of ART provision on the wider health system
- EQUITY: Addressing *differences* in health status that are judged to be unnecessary, avoidable and unfair
- HEALTH SYSTEM: All activities that promote, restore or maintain health

# Impact of ART/HIV programmes on health delivery



# How to make ART equitable: EQUINET initiative



- EQUINET conducted studies on issues relating to health sector responses to HIV and AIDS
- Lessons were learned from health system responses to nutritional deficiencies and tuberculosis
- Through regional consultations policy principles for equitable and sustainable ART roll out were elaborated
- Indicators for monitoring the principles were identified using routine health information

# Policy principles for monitoring ART programmes



## *Two areas of equity, justice and accountability*

- Fair policy development, monitoring and fair process
- Equitable access to ART with realistic targets

## *Five areas of sustainability and efficiency*

- Fair, sustainable and accountable financing
- Integration into the delivery of the essential health package
- Human resource development to deliver the essential health package
- Sustainable and accountable purchase, distribution and monitoring of drugs and commodities for ART
- Ensuring private sector provision of ART is complementary to and enhances public health system capacity

# ART and health system monitoring: Malawi



## Methods

- Working with key stakeholders, conducted equity Analysis of data

### **Data sources:**

- Routinely collected Data
- Sentinel analysis
- Synthesis of findings from operational and qualitative research
- Key informant Interviews
- Participation in technical working groups

# ART Scale up in Malawi



- Malawi aimed to have 80, 000 people started on ART by end 2005, and 250,000 people by end 2010
- ART is provided free of charge in the public sector including CHAM facilities on “first come first served basis”
- The number of people ever started on ART increased from about 4, 000 patients in June 2004 to 57,366 patients by end June, 2006.
- 39% were Men and 61% were women.
- 94% were adults while 6% were children.
- 17% (9633) of all patients were started on ART because of TB.
- 1% (588 women) were started after referral from PMTCT

# Free ART



- **Free ART** has improved access for the poor and vulnerable.
- However qualitative research findings revealed the following barriers to access and adherence:
  - Lack of food
  - Transport costs for patient and guardian
  - Stigma/discrimination
  - Long distances to health facilities
  - Long waiting times at health facilities

# Lessons on access to ART



- Free ART at point of delivery has enhanced access
  - User fees hinder access for the poor and reduce long term adherence
- More women accessing treatment than men
  - Need to consider access vs prevalence by gender
- Services are biased towards urban areas
- Child uptake of treatment is low
- Free treatment at first come first serve may favour urban, higher educated, non poor people
- Involvement of the private sector – 38 private facilities providing ART (1596 patients by end March 2006)

# Human resources for ART



- Human resource crisis is a key challenge for scaling up
- HIV/AIDS impacts on staff workload, morale, occupational exposure to HIV/AIDS.
- The Malawi Human Resource Emergency Relief plan costed at US\$273 Million (funding from GFTAM, DFID and SWAp)
  - Expand training capacity by 50% on average
  - Improve retention and re-engagement, 52% salary top ups for 11 critical cadres, staff housing
  - Stop-gap external support for critical posts – volunteer doctors, nurse tutors
- Salary top ups for some cadres/members of staff and not others in similar sectors raises equity questions

# HRH: The role of communities & volunteers



- Involving community members and PLWHA can
  - make services accessible to the poor and the marginalised.
  - Reduce stigma
- Particularly critical in the context of the crisis in HRH
- Encourage involvement of community health workers
  - have been critical in interventions such as immunisation
  - Developing their role in improving treatment access could strengthen PHC

# Financing For ART



- Treatment activism has motivated increased funding for ART
- High donor dependency – necessary but raises sustainability challenges.
- Slow disbursement of funds
- Current GFTAM funding for ART expansion ends in 2008
- Need a holistic view of financing – patients face costs even when ART is provided for free
- Health expenditure as a percentage of total income should be lower for the poor
- Adequate and long term funding for health systems

# Recommendations for making ART more Equitable



- Further decentralisation of services with focus to rural areas – to primary health care level
- Strengthen links with other health programmes especially PMTCT through maternal health services
- Monitoring impact of ART on socio-economic status, livelihoods, poverty alleviation etc.
- Monitoring of Equity in ART programmes and impact of ART on wider health system
- Including simple equity and health systems monitoring indicators in routine M and E systems



- Thank you very much