

MEETING REPORT

Country meeting: Health systems approaches to treatment access in Tanzania



EQUINETA

With CEHPRAD, TPHA and the
**Southern African Regional Network on
Equity in Health (EQUINET)**

**Tanzania National Meeting on Equity in Health
Sector Responses to AIDS**
Lutheran Conference Center, Dar-Es-Salaam, 26 March
2004

Report produced by: **EQUINETA AND TARSC**
Financial support from EQUINET and Oxfam GB



Tanzanian Meeting on Equity in Health Sector Responses to AIDS March 26 2004 Lutheran Conference Center, Dar-Es-Salaam

1. BACKGROUND

Participants were welcomed to the meeting and it was explained that this was a follow-up meeting to the one held at the Bahari Beach Hotel, on 26 February 2004. The present meeting was specifically arranged to be held a day before the Tanzanian Parliamentarians Coalition Against AIDS (TAPAC) Meeting, who were to have met on 27 - 28 March. It had been planned to present to the parliamentarians on 27 March. However, they had since postponed this meeting to April. However, EQUINETA felt that it was still useful and important to hold the meeting as planned. The meeting was a joint meeting with CEPHRAD, and was focused on ensuring universal treatment access through sustainable public health systems. The goal of the meeting was to develop resolutions on the principles for strengthening health systems for treatment access, and to develop potential areas for work for EQUINETA related to EQUINET's programme of work areas.

In the introductory remarks, it was indicated that while there were various prevention activities, focused on for example, workplace education, condom promotion, sexually transmitted infection treatment and control, youth, women, commercial sex workers, men who have sex with men, etc, there was 2.2 million Tanzanians living with HIV out of which 800 000 have full-blown AIDS. About 50% of hospitalized patients were sick because of HIV related disease. Given this situation, there were important questions to be asked and issues to be examined. These included:

- Who can access ARVs? Only about 1 000 – 2 000 Tanzania were currently accessing treatment.
- To what extent are the formal guidelines on access to treatment, such as having a CD4+ count of 200 or less, being followed?, is realistic?
- Who gets treated, what criteria are used; who does not? Inequality of drug access.
- While the price of the anti-retroviral drugs have gone down to \$300 per year, are those on treatment, being treated according to the Ministry of Health published guidelines? There was also a need to link treatment to nutrition.
- What was the impact of effective treatment on sexual behaviour?

- What was the adherence to the drugs? Currently, two of the registered ARVs are Combivir and Triomune. Combivir needs to be taken together with a couple of other drugs twice a day, while Triomune was a combination drug, making compliance easier.
- What are the best practices on the implementation of treatment, in relation to equity?

The meeting was held as a follow up to the EQUINET/Oxfam GB Regional meeting on Health Sector responses on HIV/AIDS held in Harare on Feb 16-17 21004. Tanzanian delegates had not been able to attend this meeting and given the importance of the issues and outcomes had requested through EQUINETA for their airfares and allowances to be used instead for a follow up national meeting in Dar es Salaam of key delegates to update on the issues. The report of the EQUINET/Oxfam February 2004 workshop is available at www.equinet africa.org and the resolutions on health systems approaches to ART access are shown in appendix 2 of this report.

2. PRESENTATIONS

In his presentation, Dr. Swai, director of the National AIDS Council, confirmed that 2.2 million Tanzanians were estimated to be living with HIV. Between 50 000 to 60 000 new AIDS cases were reported annually. Approximately 400 000 – 500 000 people living with HIV were estimated to be in need of ARVs. Currently very few were getting ARVs, about 1 000 – 2 000. The government had planned that within the next five years, about 400 000 would be treated by year 5, with the plan in the first year to treat 16 000, 66 000 in the second year, until the target was reached. However, with the WHO 3 by 5 Initiative, government was now planning to offer ART to half (200 000) of the projected number of AIDS cases by 2005. The main limiting factor on the ART programme was the ability to buy the drugs, as 60% of the estimated \$539 million needed to treat 400 000 patients were needed for drugs only. The next limiting factor was the lack of adequate numbers of trained personnel, then infrastructure constraints such as laboratories, etc. Government had assessed the four referral hospitals in the country to be “ARV ready”, as they have the personnel and the required laboratories. So these sites would be utilized as pilot sites – “learning centres”. In addition, 14 regional centres, 26 district centres and 30 NGOs and private sector hospitals were assessed as “ARV ready”. These facilities would be supported to provide ART, provided that they met the human resource and infrastructure requirements.

However, there had been a lot of criticisms and objections to this plan, especially on the lack of human resources. It was estimated that 10 000 new personnel would be needed to roll out the ART programme. Government however, thought that that number might be available within the country, since for some years now there had been a freeze on hiring, while the training schools had continued to

graduate students. Consequently government was considering carrying out an audit to assess how many health personnel might be available from both retired ones and the newly graduated but unemployed ones.

Concerning funding for the ART roll out, \$100 million had so far been mobilized, but this was not sufficient. While the Ministry of Health funding for HIV/AIDS had doubled, the overall health budget had not increased, (it was still only 12% of the total budget), which meant that these additional funds had been taken from other health-related activities. Currently, the government has an application to the Global Fund for \$400 million. If a programme on this scale can be implemented, it would make a significant impact, as AIDS is crowding out the other diseases, creating a huge TB epidemic (TB cases had risen from 15 000 to 65 000), as well strengthen the health system. Much of the attrition among health workers was due to HIV/AIDS. Dr. Swai said that additional 7m US Dollars for HIV/AIDS was slashed from other healthy sector sections/divisions thus weakening the health sector. It would have been good if it were deducted from all ministries, as this current decision was not a rational one nor equitable.

In discussion Dr. Swai said that in order to be able to enroll 400 000 on treatment, 30 million would have to be tested, creating a huge challenge for counseling and testing, and for the provision of social supports for those tested. He also indicated that government was keen to work with the NGO/faith-based and private sectors as they provided 40% of AIDS care and treatment. He intimated that these sectors would be encouraged to implement ART first, as essentially they were "ARV ready" and already played a significant role in HIV/AIDS. Government was keen to have multiple entry points for ART, as this would also create equity. However, government needed to have social guarantees of compliance with treatment. There was also a plan to have community mobilisers so as to develop treatment literacy. The national treatment guidelines had been distributed widely in the NGO sector. These guidelines still need dissemination. However, there had since been some changes, so that government was planning to issue a circular with the changes.

2.1 Discussions:

The meeting discussed that HIV/AIDS ranked as the 6th or 7th in the burden of disease, but also agreed that it was not the only disease that affects Africa much. However, it was also noted that there are some areas in some countries where HIV/AIDS is alarming and gave an example of Dar-Es-Salaam district; Hai and Morogoro rural districts in Tanzania where the disease ranks first as cause of both morbidity and mortality.

Professor Woelk, representing EQUINET, then presented the issues relating to health systems approaches to ART access and the guiding principles for ensuring universal treatment access through sustainable public health systems, from the EQUINET meeting in February 2004. (See Appendix 2)). After the

presentation, the meeting then discussed each principle one by one, and developed resolutions to be tabled by EQUINETA. The following are the draft EQUINETA resolutions:

1. *Fair, transparent processes to make informed choices.*

Policies that have been or are being formulated should go through a participatory process that ensures active involvement and ownership.

2. *Joint public health and HIV/AIDS planning:*

There is need for a planning framework that can be used at all levels. The planning process for HIV/AIDS (including ART; ARVs, opportunistic infections, sexually transmitted infections, nutrition, counseling) and for other health activities should be integrated initially into the health plan, and later into a comprehensive development plan. This integrated planning process should be at district, regional and national levels.

3. *Integrating treatment into wider health systems.*

- a) **HIV/AIDS is a major health priority in Tanzania. However, verticalisation of the HIV/AIDS programme has the potential to weaken the health system as a whole. Therefore there is need to strengthen the existing health system to accommodate the burden of HIV/AIDS, TB, malaria etc.**
- b) **The Tanzanian government should establish an accreditation system for the private and NGO sectors in order to provide quality care, equity and accessibility.**

4. *Realistic targets for treatment access with clear guidelines and monitoring systems for ensuring equity in access and quality of care.*

Strengthening of the health system and provision of ARVs are inseparable.

5. *Treatment resources integrated into regular budgets and fair financing approaches.*

EQUINETA appreciates the role played by development partners in the fight against HIV/AIDS. However, EQUINETA advocates for dedicated AIDS funds to be integrated into regular budgets and comprehensive health sector plans. Government should also negotiate with development partners that 50-70% of the donated AIDS funds should be available for activities, and not for external logistics or external human resources. Additionally, in view of the massive resources needed for

ART, the government budget for ART needs to be increased from the recommended 15% by the Abuja Declaration to at least 20-30% of the total budget. Government should strengthen monitoring mechanisms and advocate for more effective use of resources to ensure sustainability.

6. Prioritise human resource development in the health sector

In view of the fact that additional personnel will be required for the ART programme, and it may be possible that there are trained health workers working in non-health sectors within the country, an audit of human resources for health in Tanzania should be carried out. In conjunction with the audit, government should examine approaches to attract health personnel into the public health system, retrain them and motivate them to remain.

7. Strengthen essential drug policies and systems at national and regional level

EQUINETA advocates that

- ♦ **essential drugs policies and systems at district, regional, national and supranational levels be strengthened**
- ♦ **strategies for manufacturing, procurement, price monitoring, negotiation and quality control of drug supplies should be supported**
- ♦ **ARVs should be included in the national essential drug list**
- ♦ **the ARV programme should learn from the TB control programme concerning the distribution, monitoring and evaluation of drugs.**

2.2 Conclusions:

In conclusion, EQUINETA resolved to advocate with the parliamentarians for:

1. Increasing the health budget from the current 12% to 20-30%.
2. Ensuring that funding for other programmes is not reduced in order to increase funding for HIV/AIDS.
3. The HIV/AIDS work is part of strengthening the overall health services.

The Honorable L. Mafuru would be approached by Professor Mwaluko to work with the parliamentarians.

Advocacy work with other groups would be as follows:

Civil Society:	Mwajuma Masaiganah
Government:	Dr. Swai/Mwele Malecela
Researchers:	Dr. Semali

RMOs: Dr. Kipendi
University: Peter Kamuzora

Research activities:

- Mapping of ART in Tanzania; who is doing what, where, etc.
- Document experiences on ART (best practices), at the 4 referral centers, and the Bukoba Regional Hospital for their Medicin du Monde supported PMTCT and the Kibongoto TB referral Hospital which has been funded by USA-based organisations for ARV trials together with the KCMC in Moshi as well as the Spanish NGO (Medicos Del Mundo) in the Coast Region, where ART is being done down to dispensary level.
- Undertake a human resource audit together with the Ministry of Health
- Utilise the monitoring tool on the equitable implementation of ART, currently being developed by Zambia

A request was also made for EQUINET support for EQUINETA to assist in revising the national treatment guidelines.

The meeting ended at 5 pm.

APPENDIX 1: Delegates
Tanzania National Meeting on Equity in Health
Tanzania, March 26 2004

Name	Institution and address	Email address	Phone and Fax number (show fax with (f) and give country and area code please)
Innocent Semali	MUCHS Box 65131 Dar es Salam	isemali@muchs.ac.tz	255-744-269838
Ms Tuzie Edwin	COUNSENUTH Box 8218 Dar es Saalam	C/o materu@ud.co.tz	Tel. 255-22- 2152705 Cell:0744279145
Ms. Beatrice Kamy	National Institute for Medical Research Box 9653 Dar es Saalam	C/o mmalecela@nimr.or.tz	255-22- 21252084
Gabriel Mwaluko	TANESA Box 434 Mwanza	gmwaluko@mwanza-online.com	0748-274545
Godfrey Woelk	Dept of Community Service, University of Zimbabwe Box A178 Avondale Harare	gwoelk@medsch.uz.ac.zw	263-4-791631 f 263-4-725166
Dr. R.O. Swai:	National AIDS Control Programme Director	swairo@raha.com	
Dr. Vicky Kipendi	Regional Medical Officer (RMO) for the Coastal Region		
Ms. Mwajuma Masaiganah:	People's Health Movement, East Africa		



Ensuring universal treatment access through sustainable public health systems

Southern African Regional Network for Equity in Health (EQUINET)¹

Discussion Document: Guiding Principles

February 2004

The Regional Network for Equity in Health in Southern Africa (EQUINET), Oxfam GB in cooperation with SADC, government, UN, civil society, health sector and international agency partners met in February 2004 to review the options for a sustainable and equitable path to realising the urgent imperative of making antiretroviral therapy (ART) available to southern Africans and the long term imperative of universal treatment access. The organisations identified principles to guide a sustainable and equitable response that would address the urgency of the need to act *and* the demand to do this in ways that build and do no harm to the already fragile public health systems in southern Africa. There is an opportunity for a virtuous cycle where programmes aimed at delivering ART strengthen health systems and thus widen access to ART. There is also a threat of a vicious cycle of programmes aimed at delivering ART diverting scarce resources from wider health systems and undermining long term access both to ART and to other critical public health interventions. These principles are the basis for the virtuous cycle. They are presented as a discussion document for wider dissemination, discussion and feedback. Feedback is welcomed! Please email your feedback to admin@equinetafrica.org

1. WHY TREATMENT ACCESS THROUGH SUSTAINABLE PUBLIC HEALTH SYSTEMS?

- ⇒ Approximately 15 million adults and children in southern Africa are currently infected with HIV and an estimated 700 000 - 1million currently have AIDS. With only one eligible person in 25,000 currently on treatment with antiretroviral therapy (ART), the shortfall is enormous, and widest for the low income communities using peripheral and rural health services. Responding to this scale of disease and shortfall will not be possible through scattered programmes and projects. It requires a comprehensive and co-ordinated approach that embeds treatment within an effective, accessible health system.
- ⇒ Treatment is only one of the multiple responses to the risk environments and factors that produce HIV and to the many areas of household vulnerability due to AIDS. Household food security, access to primary health care, social security, gender equity and income security are important factors linked to HIV and AIDS in southern Africa.

¹This briefing paper has been prepared by the EQUINET Secretariat (TARSC admin@equinetafrica.org). For further background information and practical options for implementing these principles see the EQUINET website (www.equinetafrica.org).

² Feedback is welcomed!!! Please email us at admin@equinetafrica.org

Treatment programmes may excessively shift attention to drugs as the response to AIDS if they do not reinforce the prevention, care and socio-economic programmes that deal with these factors influencing HIV infection and the impacts of AIDS.

- ⇒ After decades of macroeconomic measures weakening health systems, the capacities lost to public health systems, including the human resources for health, need to be systematically rebuilt to plan, manage and use the significant global and international resources for treatment of AIDS coming into Africa. Treatment activism has opened a real window of opportunity for meeting rights of access to treatment and overcoming unjust barriers to ART. It now needs to join with broader public health activism to ensure that these goals can be realised for all through sustainable, effective and equitable health systems.
- ⇒ All southern African Development Community (SADC) member states have policies on AIDS and treatment guidelines and some are developing explicit treatment access policies. While legal, clinical and pharmaceutical aspects of these policies are now developed, there is a gap in the health system aspects. This gap needs to be filled if treatment policies are to be implemented in the practical conditions found in southern Africa health systems and to reinforce wider health and social goals.

The current situation does not lend itself to prescription. Southern African countries vary widely in socio-economic status, health system development and in the availability and organisation of resources for health. The choices around how scarce resources are used need to be made in an informed, transparent and participatory manner at the national level. These guiding principles are thus intended to support fair country level processes to develop strategies based on the capabilities, resources and demands of national health systems.
[JK1]

2. PROPOSED GUIDING PRINCIPLES

2.1 Fair, transparent processes to make informed choices

The choices to be made around use of resources, around the clinical, social and systems criteria for rationing and around opportunity costs and trade-offs call for governments and relevant international and national non-government organisations to provide clear, transparent and accountable mechanisms for public and stakeholder consultation and debate to develop policy and to make policy choices.

2.2 Joint public health and HIV/AIDS planning

Strategic and operational plans as well as monitoring and evaluation frameworks at national and district levels should be produced through a process that integrates HIV / AIDS planning into broader public health planning.. This includes integrating AIDS treatment programmes into HIV/AIDS prevention and social care programmes. Integrated planning should be supported by investments in public health leadership and in the management and monitoring capacities needed to implement plans.

2.3 Integrating treatment into wider health systems

Governments, international and national agencies should integrate HIV and AIDS prevention, treatment and care programmes into a programme of health systems strengthening and development. Key elements of this programme include:

- Strengthening inclusive public health systems
- Prioritising district and primary level facilities and services as points of entry for ART services over tertiary level services.
- Locating treatment programmes within an effective District Health System, supported by effective district health management structures that provide all basic services for HIV and non-HIV related illness in an integrated and locally appropriate manner.³
- Ensuring adequate human resources for treatment programmes integrated within district health systems

- Co-ordinating and building national networking of information and experience from district sites
- Services provided by non-profit organizations should be integrated in the public sector framework.
- Private sector provision should complement public provision and not compete for public funding.

2.4 Realistic targets for treatment access with clear guidelines and monitoring systems for ensuring equity in access and quality of care.

The rapid expansion of ART can be achieved through targeting HIV positive current users of the health system, (particularly PMTCT, TB and VCT clients) and certain social and occupational groups (such as those with medical insurance or health workers). Such rapid expansion options should take place with simultaneous and equal investments to build the district health system and PHC infrastructure in areas without the current capacity to sustain effective ART services within clear time frameworks for wider rollout .

2.5 Treatment resources integrated into regular budgets, supported by long term external commitments and through fair financing approaches

Dedicated AIDS funding should be integrated into regular budgets and comprehensive health sector plans. The transfer and use of earmarked funds for AIDS should be transparent. 'Emergency transfers' to meet specific system shortfalls should be time-limited with plans for their integration into regular budgets and comprehensive health sector plans.

Additional funds and resources dedicated to HIV/AIDS should be system supporting (covering prevention, treatment, district health system and PHC responses) and include expenditure on broader health care infrastructure where required. This calls for longer term commitments from international agencies (minimum 5 years), in support of joint national HIV/AIDS and health plans, linked to budget and sector wide support with agreed exit strategies. Global and international funds should build predictable, consistent, long term and co-ordinated funding. African governments should increase their health budgets to 15% of total budgets in accordance with the Abuja declaration, and strengthen their governance and management capacities for resource planning and management. Ministries of finance should now integrate health systems demands into financial planning and budget frameworks and review their

³ The definition of 'basic' services will vary between countries dependent in large part on the available resources.

Medium Term Expenditure Frameworks with the IMF to take account of additional resource inputs demanded for system strengthening.

2.6 Prioritise human resource development in the health sector

Strategic plans, developed in consultation with health personnel, are required for the health personnel needs and commitments for a health systems approach to treatment access. This should include effective and sustainable in-service and institutional training approaches,, provisions for clear career paths, effective human resource management (payroll management, supervision and training), incentives for health workers to work in under-staffed areas and provisions for safe work. Plans for treatment access should not involve deliberate policies of recruitment of staff from other African countries or diversion of scarce personnel from broader health systems into vertical programmes. Any proposed new investment in HIV/AIDS or treatment expansion should include resources and measures for the training, sustaining and retaining of relevant health personnel and for their safe work environments and infection control.

2.7 Strengthen essential drugs policies and systems at national and regional level

National legislation should now take full advantage of the TRIPS flexibilities and the Doha declaration, particularly provisions for parallel importation and compulsory licensing. Drug regulatory and medicine control authorities should be strengthened, together with drug procurement and distribution systems. The expansion of ART should be included within the essential drugs programmes, through review and update of the essential drugs list. The essential drugs policy should cover the private sector and provide where necessary for mandatory generic substitution (available generic equivalent drug provided when brand name drug prescribed). SADC as a regional body should use TRIPS flexibilities and the Doha commitments to support regional strategies for procurement, price monitoring and negotiation, and quality control of drug supplies. Southern African governments and civil society should promote monitoring, regulation and advocacy within the region and internationally to prevent excessive profiteering and unfair monopolies in the pharmaceutical sector.

3. CONCLUSION

These principles are proposed as central to ensuring that actions to expand access to ART are reinforced, sustained and meet equity policy goals through strengthened health systems. They are proposed

- ◆ for national debate,
- ◆ for translation into practical strategies and programmes,
- ◆ to gather and share evidence on options for good practice,
- ◆ to provide a wider framework for understanding the costs and benefits of approaches to ART access,
- ◆ to inform international agency policy and practice and
- ◆ to inform advocacy and activism.

They are proposed as a framework for monitoring and evaluating our efforts to expand treatment access. They are as important as targets and are more directly linked to our longer term capacities and aspirations to sustain and expand access to treatment for all those who need it.