

# **MONITORING EQUITY IN ART PROVISION IN THE CONTEXT OF HEALTH SYSTEMS**

**MEETING REPORT  
August 29-30, 2005  
Lilongwe, Malawi**



**World Health  
Organization**

**REACH Trust Malawi  
Southern African network on Equity in Health (EQUINET)  
with World Health Organisation (WHO)**

**Supported by World Health Organisation  
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## **1. Background**

Approximately 15 million adults and children in southern Africa are currently infected with HIV and an estimated 700, 000-1million currently have AIDS. HIV and AIDS have had, and continue to have, a deep impact on health and health equity issues in Southern Africa, imposing challenges in mounting a response to an epidemic that cuts across its economic, social and public health dimensions. As HIV and AIDS related mortality rates have fallen with new treatments available in high income countries, treatment access has become a central issue in the response to the HIV and AIDS epidemic even in developing countries. Treatment activism has opened a real window of opportunity for meeting rights of access to treatment and overcoming unjust barriers to ART (EQUINET, Ensuring universal treatment access through sustainable public health systems, Discussion Documents: Guiding Principles, February 2004).

A regional meeting (hosted by EQUINET/Oxfam working with SADC in February 2004) identified the need to monitor equity in access and health systems issues as critical to supporting visibility, policy dialogue and programme planning on these issues of equity and health system strengthening. EQUINET, through Training and Research Support Centre, carried out work to assess the existing monitoring taking place in relation to expanding ART coverage and contracted the Equi-TB Knowledge Programme – now REACH Trust - Malawi, to write a paper on the area of monitoring equity and health systems impacts of ART expansion at subnational and national level, with recommendations for regional level monitoring. Malawi was used as an example to illustrate which equity-related data are available or can be collected to measure equity in ART implementation, and their sources. In October 2004 a regional meeting of state, academic, and civil society representatives held in Malawi reviewed the policy commitments/ issues/ questions being monitored and proposed parameters for monitoring equity and health systems issues at national and regional level. The meeting also identified the follow up pilot work, training, and other measures to be taken to implement all or part of the system and roles in taking this forward.

WHO, EQUINET, REACH have developed a proposal to monitor equity and health system in ART expansion. This proposal aims to build working examples of equity and health systems monitoring and analysis at country level in southern Africa for country planning of health systems strengthening approaches to ART expansion. It aims to provide input to WHO and SADC regional reports to the Integrated Council of Ministers on equity and health systems outcomes in ART scale up.

The work conducted through the joint co-operation of EQUINET, WHO and the REACH Trust will:

- test, build capacities for and produce reports on monitoring of equity and health systems strengthening in ART expansion and health sector responses to HIV and AIDS (development of country reports on equity in ART scale up and health systems strengthening that use pre-existing quantitative data)
- develop and implement qualitative research projects to explore key questions that arise from the quantitative analysis. (identify and systematise the health systems elements that act as facilitators or barriers to equity in access to preventive and therapeutic services for HIV/AIDS control )
- develop a risk exclusion index for vulnerable groups in ART access.
- feed into the development of training materials and regional guidelines on equity in ART provision

- promote dialogue on and use of the monitoring and evidence of barriers and facilitators at district, national, regional level to propose equitable health system development and ART policy and programme interventions and to inform WHO work and technical advice
- promote dialogue around equity in ART provision and recommendations on interventions for strengthening health systems (at multiple levels - district, national, regional, SADC).

The work will also lead to the development of a training module on equity and health systems monitoring, that outlines how available monitoring evidence under unified national monitoring systems can be analysed to provide information for planning on equity in health systems outcomes in ART provision.

A regional meeting was therefore hosted by WHO, EQUINET and REACH Trust, to launch this initiative and put together a plan of action. The aim of the meeting was:

- for all the different parties to meet each other;
- to present the work that has led up to the proposal, the proposal and proposed terms of reference for REACH, EQUINET and WHO/EIP;
- to present and discuss the Malawi equity report;
- to agree the timetable to produce the quantitative reports for all partner countries;
- to develop a strategy to identify and support qualitative researcher in all partner countries;
- to agree the time table to produce the qualitative reports for all partner countries;
- to discuss the proposal on Gender equity analysis – WHO;
- to discuss the proposal on Health worker’s access to CT and ART - WHO; and
- to finalise budgets for all partner countries.

## **2. Opening**

The meeting was opened on 29<sup>th</sup> August 2005. Dr Sally Theobald, REACH Trust welcomed delegates. Welcome remarks were also made by Dr Eddie Limbambala, representing WHO WR, Malawi, Jeannette Vega WHO-EIP. Dr Erik Schouten, HIV/AIDS Coordinator, Ministry of Health formally opened the meeting on behalf of the Secretary for Health, Ministry of Health, Malawi.

In her remarks, Dr Theobald thanked the participants for coming and anticipated a fruitful discussion during the meeting. Dr Limbambala welcomed the participants to what he termed a “historic” meeting. He thanked REACH Trust and EQUINET for choosing Malawi as the venue for the meeting. He described scaling up of ART as a journey on an equity linear scale pointing out that in rolling out ART there is need to look beyond available technologies and ask questions. Dr Limbambala stated that WHO was proud to be part of the meeting.

Taking her turn, Jeannette Vega stressed the need to work in an integrated manner to achieve sustainable development. She indicated that the Canadian government has provided funds to implement the programme. In working with the countries, Vega stressed that WHO would just be supporting the countries and not defining what the countries should do. She finally thanked REACH Trust for agreeing to coordinate the process with the support of EQUINET and WHO.

Making his remarks on behalf of the Secretary for Health-Malawi, Dr Eric Schouten presented the current picture of ART provision in Malawi as well as challenges being faced. Expressing happiness that the meeting took place in Malawi, he pointed out that a working group has been established to monitor ART in Malawi. Among the challenges faced, he stated that Human Resources remained a great challenge, explaining that a programme is currently in place to help boost the salaries of health workers in order to retain them in the country. He stated that there are also challenges in decentralising services to the rural populations, pointing out that the poor find access to free ART costly. Dr Schouten said that there is need for innovative approaches in the provision of ART. Innovation, he stated, would be needed in how to reach the poor and how to make effective use of HR emphasising the need for countries to learn from each other and share ideas. He finally thanked WHO and EQUINET for making the meeting possible.

### **3. Monitoring equity and health systems strengthening in ART programmes in SADC**

Dr Boniface Kalanda presented the background work which had led to the current proposed programme of work. He outlined the principles of equity and health system strengthening in the SADC and how this programme of work fits in with the SADC Business Plan. In his presentation he highlighted:

- The 2003 EQUINET programme to inform policy debates on health sector responses to HIV and AIDS in the region which explored dimensions of the policy channels on health services, treatment access and resources for health care.
- The Regional meeting in February 2004 to discuss policy interventions and follow-up work arising from the 2003 programme.
- The 2003 SADC Summit which noted the devastating effects of HIV, AIDS, Tuberculosis and Malaria in the region, and SADC Heads of States signed the Maseru Declaration which recognized that the response to HIV and AIDS should be through strengthened health systems.
- SADC consultations with National AIDS Commissions & stakeholders on its five year Business plan which identifies priority areas for an effective HIV/AIDS response to be prevention, care, treatment, resource mobilization, & strengthening health systems. Unified Principles in the SADC Business Plan propose that actions to expand access to ART are enforced, sustained and meet equity principles through strengthened health systems.
- A proposed framework for a comprehensive national monitoring system for **equity** in access and **health systems** support in ART programmes in southern Africa commissioned to EQUI-TB Knowledge Programme, Malawi framework, which was presented in October 2004. The framework identified 7 thematic areas, which are:
  - fair process for policy development and monitoring implementation;
  - equitable access to ART with realistic targets;
  - fair and sustainable financing and accountable financial management;
  - ART programme integration into the delivery of the essential health package;
  - prioritised human resource development to deliver the essential health package;
  - sustainable and accountable purchase distribution and monitoring of drugs and commodities for ART and EHP; and
  - ensuring private sector provision of ART is complementary to and enhances public health system capacity.
- The meeting in October 2004 agreed on the thematic issues and reviewed the principles of a monitoring system at sub national, national and regional level agreed on 3 core indicators for monitoring ART equity and agreed on a set of 13 other indicators.

Following the presentation, it was agreed in the discussion that countries would have to use the WHO estimates of number eligible for ART which is based on 10-15% of HIV prevalence at any given time. Participants also observed that equity should be something that should be practically happening on the ground. They advised that ART provision should begin with districts before getting to the communities. It was noted that there are long waiting lists and that delays encountered are enormous. As a result people get discouraged, go back home and wait for their death.

As regards drug procurement systems, it was noted that there should be means of tracking down fake drugs especially in rural areas. Such drugs, the participants noted, worsen the situation of the patients.

Boniface Kalanda inquired how far along the process of monitoring had progressed in the different participating countries along the following five points:

- 1.- audit of whether the core(3) and shortlist (13) indicator were already being collected within existing monitoring and evaluation systems.
- 2.- status of development of guidelines
- 3.- status of preparation of first annual report
- 4.- use of regional monitoring to share good practice and lessons
- 5.- status of complementary monitoring by population/sectoral surveys/ operational research and community assessment

The situation was as follows:

	<b>Country</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
1	Malawi	<b>X</b>		<b>X</b>		<b>X</b>
2	Mozambique	<b>X</b>				
3	Tanzania	<b>X</b>				
4	Zambia	<b>X</b>				
5	Zimbabwe	<b>X</b>				
6	South - Africa	<b>X</b>	<b>X</b>			

Given that countries were only asked to audit availability of indicators until the full project was launched this situation is not surprising. Malawi was given support by EQUINET to field test the indicators in a country report to identify any issues or problems prior to its application in other countries and this was implemented in the first half of 2005 and is separately reported. This situation thus sets the baseline for all countries to now proceed with the work at country level through similar quantitative assessments and this is incorporated as the first phase of work under the current proposal.

#### **4. Malawi health equity analysis report**

Lot Nyirenda, Dr Sally Theobald and Ireen Makwiza presented a country equity analysis of ART access and health system monitoring based on the monitoring framework developed in 2004 using the 3 core indicators and the 13 other system wide indicators. The report also used qualitative studies to support findings from the quantitative analysis. The paper concluded that it was critical to have an annual equity picture to determine:

- Who is accessing and adhering– disaggregated by sex, age (socio-economic status); also for prevalence.

- What implications ART provision has on the wider health system.
- The need for findings to be widely circulated as they provide opportunities for reflection and adaptation of ART provision processes.

In the discussion that followed, participants indicated the need to make free ART sustainable. As the private sector gets engaged in ART provision to take pressure out of the public sector, there is need for close monitoring considering that the private sector is there for profit. One area that should attract such close surveillance, the participants noted, is the administration of fake and expired drugs by some private hospitals.

It was also noted that in trying to take pressure out of the public sector, there is need to provide capacity in the homes/communities. An observation was made that Uganda and Senegal have shown that community based activities work. Participants emphasised that strengthening of health systems from local to national level was the lasting solution. The need to reduce stigma associated with HIV/AIDS in general and ART in particular was also reiterated.

### ***5. Overall proposal and terms of reference for work in 2005/6***

Dr Sally Theobald presented the overall proposed study and the draft terms of reference for the study for REACH, EQUINET, WHO and the partner countries. In the presentation she outlined the objectives of the study, and that the work aims to inform:

- local and district level programming
- national policy and planning
- regional exchange of information and policy monitoring
- policies and programmes of international agencies and donor institutions.

She also outlined the expected outputs from the study which included:

- annual equity and health systems reporting in four countries;
- strengthened regional and SADC networking and capacity to support country policy and programming;
- an agreed framework for routinely monitoring and reporting on equity and health systems; and
- identifying operational research issues on equity and health systems issues in ART roll out.

In the following discussion it was agreed that there would also be need for formal communication channels in order to enhance response from different countries. Participants were asked to help in identifying key people especially from the government side and also to identify researchers to push the work forward.

### ***6. Gender equity analysis in ART scale up***

Dr Avni Amin, Department of Gender, Women and Health, World Health Organization presented on ***Equity and Access to HIV Treatment: The Case for Gender***. The presentation aimed to describe WHO GWH work on gender and access to treatment and to highlight key issues in monitoring gender equity and access to treatment. She presented about the Gender and HIV Guidelines which aim to raise awareness about the impact of gender inequality on different aspects of HIV/AIDS and provide guidance on what programmes can do to address gender issues in their design and implementation. She explained that the guidelines cover:

- HIV testing and counselling

- PMTCT
- Care and Support
- **Anti-Retroviral Treatment**

On monitoring she explained that the WHO GWH examines sex and age disaggregated data on key treatment access indicators in five to six countries. However several challenges have been faced in conducting this work. These include the availability of indicators that are comparable across sites, countries, availability of HIV prevalence estimates by sex and age and routinely collected data disaggregated at sub-national and national levels.

In the discussion following the presentation it was noted that there was need to include children in the gender analysis as male and female children may be treated differently in some contexts and are most of the times left out in interventions.

### ***7. Health worker equity access ART analysis***

Orielle Solar from the EIP/Equity Team, World Health Organization presented on the health care worker access to ART. She noted that HCW are at risk of HIV infection just as the general population, however in addition they are also at risk of infection through occupational exposure. She also noted that HCW are crucial to the successful delivery of ART services. Therefore it is a basic right to protect exposed and infected health care workers so that they continue to work and care for patients. She noted that working in the field of health services may be both a facilitator and a barrier to accessing HIV services for the HCW. Therefore the key questions for research included, HIV prevalence amongst HCWs, Are they accessing ART, what are the barriers and facilitators to accessing ART services.

The following presentation was on a proposal that REACH Trust had developed whose aim is develop an intervention that results in increased uptake of CT and ART amongst health workers in Malawi. The presentation was made by Grace Bongololo. The specific objectives of the study which would start to be implemented in October would include to:

- explore qualitatively factors related to health care workers' decisions about accessing CT and ART services;
- use quantitative approaches to scale the importance of the factors that determine the uptake of CT and ART amongst health workers;
- review evidence of intervention effectiveness from elsewhere; and
- disseminate findings and design and budget for interventions in collaboration with key stakeholders.

There was a discussion following the presentation. Few participants felt that researching health care workers was not a priority as there were other more pressing issues for research. For instance, PMTCT was mentioned as one of the areas that needed to attract some attention as far as operational research was concerned. Following a rich debate, however, the majority of participants felt that the study was a crucial one as health care workers were pivotal to the scale up of ART. It was noted that health workers and community leaders have been ignored for a long time in as far as operational research is concerned. There was an observation that stigma was propagated by health workers more than by community members. It was also suggested that occupational exposure by health care workers should be seriously considered.



## **8. Panel discussion**

A panel discussion was then held with the following panellists: Erik Schouten, HIV/AIDS Coordinator Ministry of Health on The Malawi ART Equity Policy, Godfrey Musuka, on EQUINET work and Jeanette Vega, WHO EIP on the 3x5.

Erik Schouten explained that the policy has been developed and stipulates that patients will be seen on the first come-first served basis, however there should be efforts to influence who comes first through targeted health promotion. The scale-up plan has been done on district by district approach but it is still recognised that distances to services are still great for most patients.

Godfrey Musuka started his contribution with a background to EQUINET and highlighted the work that the organisation is involved in. He pointed out that the organisation is currently working with 14 institutions. Among the services offered by EQUINET, Godfrey pointed out the provision of accessible information on health equity, creation of forums for dialogue and engagement, the promotion of country level equity networks and the encouragement of alliances and exchange visits. To engage on policy, Musuka pointed out that EQUINET presents/gathers information and evidence on health equity, engages civil society as well as the promotion of good practice, among many strategies.

Jeanette Vega proposed to expand the engagement in the process to all relevant actors in each country. She presented EQH work on effectiveness coverage using the Tanahashi framework to be used particularly for the qualitative component of the project. The framework discusses first how to ensure access: that is, that the medicines really reach the people that need them, in particular those groups that are generally excluded and which suffer greater vulnerability. To reach this goal, we need to identify and evaluate the barriers to access among these highly vulnerable groups today. While some studies have been carried out in this area, they have been narrowly focused and have failed to provide a systematic view of relevant barriers according to levels of care and programme components. Barriers to access to VCT are different from those to PMTCT or from those relevant to the distribution of ART per se. Identification of barriers according to specific programme components and to the local and national realities of each country are required to establish recommendations on strategies and action that can overcome the obstacles. Given that attacking certain structural and social barriers will demand profound changes in current models, and that the results of these efforts will at best be seen only in the medium and long term, it is vital to move quickly on research to identify facilitating factors among those members of vulnerable groups who *have* accessed treatment. In this way, factors which positively favor non-exclusion can be brought to light and translated into recommendations for favorable strategies and actions. A second aspect which must be ensured is adherence to HIV/AIDS treatment programmes. This is possible to the extent that we can identify the factors associated with the abandonment of therapy, as well as those that limit adherence. This will enable treatment providers, together with communities, to focus actions and special support programmes on the groups that are at greatest risk of non-adherence. Identifying barriers and facilitators will enable the construction of an index of ART exclusion risk for each country and for each phase or component of ART, including access, adherence and programme sustainability. This index will serve to prioritize vulnerable groups which are usually excluded from treatment and to help identify specific actions that can be carried out in relation to barriers and facilitating factors, such that these actions will simultaneously contribute to equitable strengthening of the health system. The main objectives of the qualitative component of the project are as follows:

- identify and evaluate the bottlenecks, obstacles and facilitators of equitable access to HIV/AIDS programmes , according to different programme levels and components.
- Develop specific guidelines for interventions by local health systems and governments to address barriers and facilitators for the achievement of an equitable programme of HIV/AIDS service delivery in each of the three countries.
- Construct a classificatory tool (the Exclusion Risk Index) that can be used to estimate people's risk of (1) being excluded from access to ART; (2) experiencing non-adherence and loss to treatment if they do begin therapy. The Risk Index will use factors such as gender, age, socio-economic status, geographical location, educational attainment, cultural background, etc. to calculate risk levels for individuals and communities so that those at highest risk can be supported with special services. The Risk Index will "weight" different factors based on specificities of national and local context.

Jeanette Vega proposed the engagement of multiplicity of actors. These, she suggested should include the governments, EQUINET and REACH Trust, WHO. She also suggested multiplicity of products. In carrying the work forward, she stressed the need to deliberately make sure that gender issues are considered, not forgetting the involvement of children. In addition to this, she pointed out the need for training activities as well as the engagement of communities to sustain the work. Jeanette finally laid emphasis on the need for communication and coordination in the process of carrying out the work.

## ***9. The country quantitative monitoring and reports on health systems and equity***

The second day of the meeting concentrated more on the proposed study. The program also changed from what had been originally to reflect the discussions from the previous day which showed that partners might have to lobby for support from their respective countries to conduct the study as well as to identify the appropriate research teams to carry out the study.

The participants then divided into country groups and there were altogether six groups representing Zimbabwe, Tanzania, Zambia, Mozambique, South Africa and Malawi. The group discussions considered the following questions:

- Is it possible to collate the three core indicators and the 13 wide health system indicators?
- Is the data accessible and to who?
- Ideas of qualitative research which could be conducted?
- What support would be required from WHO?
- How funds should be disbursed to countries?

Following the group work country partners gave feedback in plenary. The discussions from the country teams are briefly presented below.

### **9.1. South Africa**

South Africa is a diverse country, and has a district Information system in place which works to various degrees in the different provincial area. Data is supposed to move

from the district level to the provincial level and finally to the central level. The national level monitoring and evaluation framework has been developed though it has not been operationalised yet. The major challenge for the proposed study would be access to information as health departments do not release information easily.

It was reported that it was possible to collect information on the three core indicators. Data on PMTCT and TB is also available as long as permission can be granted to access the information. There is some available information from the private sector however there would be challenges to capture data of patients receiving treatment through Medical Aid.

It was felt the Health Systems Trust was in a well placed position to conduct the study and WHO could assist with supporting documentation of the importance of the proposed work.

On qualitative studies, several topics were suggested, i.e.:

- To understand how rationing happens at the health facility level – how HCW target ART recipients.
- Pathways to access care and to identify at what stage people fall off from the process.
- Why eligible people do not come back to receive treatment and also to see what impact partnerships have on health facilities i.e. with researchers.

In terms of funding flows he suggested that WHO should work with REACH and allocates funding as required.

## **9.2. Zimbabwe**

Zimbabwe's ART programme relies on domestic funding. The ART services are linked to government and therefore it is easier to collect data from the public health facilities. However it is difficult to collect data from the private sector as they are not well organised. A number of people in the work place are also funded through Medical Aid insurance – it is difficult to capture this information.

NAC developed a monitoring and evaluation system which started to roll-out in July and through this each organisation has to register and report data to NAC. NAC acts as the focal point for all organisations and they have decentralised to the district level. A database has been created so that data can be available through a website. MoH also developed a database to link between PMTCT and ART.

They reported that in Zimbabwe it would be possible to collect the three core indicators though this would need collaboration with the primary data sources. Human resource for health indicators could also be collated.

It would be difficult to capture data on Fair financing indicators as not all finances go through government; some aid is in kind, for example drugs. However the National Health Accounts exercise will take place soon which would determine government funding and individual funding. He also reported that it would be difficult to respond to the indicators on private-public mix.

They reported that NAC could take the study forward as they act as focal point for bringing other stakeholders together and TARSC would assist with the planning. Ideas for qualitative research included a study to explore factors affecting uptake of ART, as uptake has been slow.

### **9.3. Mozambique**

The team reported that it would be possible in Mozambique to collate information on age and sex. A team would be put in place for the study which would include the epidemiology department, medical assistants, pharmacy, NAC and an adviser from WHO. They brought to the meeting the quantitative protocol that was subsequently discussed in the group work.

In terms of qualitative research adherence was seen as a priority area and pathways to ART access. For the qualitative part of the study they reported that they could incorporate the Centre for Population Studies into the protocol.

The team reported they would brief MoH, HIV/AIDS group and other authorities about the study.

### **9.4. Tanzania**

Tanzania reported that data is routinely collected from the facilities. The AIDS coordinators from the districts analyse the data and forward the information to the region and then information is reported to the national level.

ART scale up started in October 2004 and therefore a report has not yet been produced at national level. The first national report is expected early 2006. Data is available disaggregated by certain age groups, by level of care. The level of care stops at district level. And the data may not reflect urban and rural residence.

A national task force has been formulated and information on ART access is available to every one. Guidelines for ART provision have been formulated and distributed. There has also been training of Human Resources for the provision of ART. A human resource audit is also being done at the moment. It was also pointed out that ART in Tanzania is free in the public sector.

### **9.5. Zambia**

NAC in Zambia is under the Office of Cabinet and therefore has greater reach towards government/cabinet decisions. Data is collected through various stakeholders and reported to NAC. He reported that access to information is relatively easy as meetings are held regularly to share information. For the study, there would need to be greater collaboration with the Monitoring and Evaluation unit. And also consent from NAC and MoH would be required.

Support would be required from REACH, EQUINET, WHO in capacity in data analysis, equity analysis and advocacy. They reported that it would be convenient for funding to go through WHO-AFRO to assume accountability to the researchers.

### **9.6. Malawi**

The team reported that MoH collects the data and report to NAC. Plans have been laid out for an organisation – Malawi Business Coalition Against HIV/AIDS to monitor and collect data from the private sector. NAC are also planning a computerised system for collecting data through the district assemblies.

Data is available to every one and HIV/AIDS unit circulates reports and updates to stakeholders. It is possible to collate data disaggregated by sex and age but it is challenging to classify urban and rural residence unless through sentinel analysis which poses a set of challenges. Classification by level of care will be possible as decentralisation is taking place. Currently, there are also no sex disaggregated

prevalence data so the data cannot look at gendered access by eligible numbers of women and men.

REACH would like to collect and synthesis data in collaboration with NAC and MoH. There is also impetus to conduct equity analysis as part of the Malawi policy on equity in access to ART. REACH sits on various TWGs which provides opportunities fro information exchange and interaction’.

Support would be required from EQUINET and WHO on accessing studies reports in Malawi and beyond, peer review of reports, funding for dissemination through meetings, reports and policy briefs.

Priorities for qualitative work would include in depth analysis on reasons for defaulting in order to develop strategies to support adherence; Identifying and supporting community structures to enhance access of poor women and men in rural areas; and identifying the best ways to increase uptake of CT, PMTCT, ART through the ANC setting? What is acceptable for pregnant women and their families? How can services best be integrated?

Some participants commented on the need to strengthen the health systems functions of stewardship and generation of health information and the importance that these functions are developed and capacity is built within the MOHs and not be outsourced to the private or other NGO's or academic institution as a means of strengthening health systems and assure sustainability as opposed of creating parallel processes that weaken even further the health systems in the region.

The following points summarise the key issues that emerged from the country presentations:

1. Colleagues were keen to take forward to equity monitoring work – both quantitatively and qualitatively.
2. There are different challenges involved in accessing and collating the secondary data. For example in South Africa it is difficult to access MoH data on ART. This contrasts with Malawi where ART access data is relatively freely circulated. The who and how of data collection varies in the different country contexts.
3. WHO AFRO and WRs could play a key role in facilitating access to data where appropriate.
4. It is not possible to collate all the indicators in all countries. The proposals will focus on what is possible and appropriate to collate in the different country contexts.
5. There were a number of interesting and exciting ideas about how to take forward complementary qualitative work, for example the barriers faced by different groups of patients to access and adhere to ART. These will be further developed in the proposals.
6. Different colleagues/country partners had different ideas about how funds to take forward this work should be disbursed. Some said it would be easier to disburse directly through REACH Trust. Others said it would be easier and more strategic to disburse through WHO country offices. Country partners are asked to state their preferences on the best way forward within the full proposals.

## **10. Way forward**

The agreed way forward was that between the time of the meeting and 15<sup>th</sup> October , country teams would send mini-protocols to WHO/REACH Trust/EQUINET with the following information:

1. The information that can be collated end of January (please note ideally countries collate the 3 core indicators and what is possible and appropriate of the 13).
2. The individual and their institutions /set of individuals and their institutions responsible for collating the data.

The resource/budget needs for collecting this data are:

1. An individual/group who could take forward the qualitative work.
2. Initial ideas about priorities for the qualitative work:
  - questions
  - where to conduct the research
  - methods
  - sampling.
3. The easiest way to disburse funds for the country.

It was agreed that WHO EIP would come back to countries with details of a budget ceiling by the end of the week of the meeting.

## **11. Closing Remarks**

In closing, Jeanette Vega, Ireen Makwiza and Dr Sally Theobald thanked the participants for making the meeting a success by coming. They expressed hope that what had been discussed at the meeting would be implemented.

## Appendix 1: Program



**World Health  
Organization**

### **Monitoring equity in ART provision in the context of health systems**

### **REACH Trust Malawi / Southern African network on Equity in Health (EQUINET) with World Health Organisation (WHO)**

**DATE: Monday 29 – Tuesday 30 August, 2005**

**VENUE: Lilongwe Hotel, Lilongwe, Malawi**

#### **Brief**

With support from and in co-operation with WHO, REACH / EQUINET are working to support, resource and facilitate country teams to

- Test, build capacities for and produce reports, using available indicators, on equity and health systems strengthening in ART expansion
- Identify and systematise information on health systems elements that act as facilitators or barriers to equity in access to preventive and therapeutic services for HIV/AIDS control
- Use the reports of the work to promote dialogue on and propose interventions for strengthening health systems and equity in ART roll out.

This meeting will provide an opportunity to launch this initiative and put together a plan of action. REACH Trust Malawi is co-ordinating this theme area of work in EQUINET.

#### **Objectives of the meeting**

1. For all the different parties to meet each other
2. To present the work that has led up to the proposal, the proposal and proposed terms of reference for REACH, EQUINET and WHO/EIP.
3. To present and discuss the Malawi equity report
4. To agree the timetable to produce the quantitative reports for all partner countries
5. To develop a strategy to identify and support qualitative researcher in all partner countries
6. To agree the time table to produce the qualitative reports for all partner countries
7. To discuss the proposal on Gender equity analysis - WHO
8. To discuss the proposal on Health worker's access to CT and ART - WHO
9. To finalise budgets for all partner countries

## Program

<b>Monday 29 August , 2005</b>	
07.30-08.30	<b>Registration for the meeting</b>
08:30 - 09:00	<b>Introductions and Welcome</b> Erik Schouten, HIV/AIDS Coordinator, MoH, Malawi Dr. Jeanette Vega EQH/EIP/HQ Dr. Eddie Limbambala, WR, WHO, Malawi Dr. Sally Theobald & Ms. Ireen Makwiza, EQUINET/REACH Trust
09:00 - 09:30	<b>Presentation: Principles of equity and health systems strengthening in SADC, the SADC business plan and the background work for the current proposed programme</b> EQUINET / REACH Trust ; , Dr. <i>B. Kalanda</i>
09:30 - 10:00	<b>Discussion and questions</b> – Chair <i>Dr. Julia Kemp, DFID</i>
<b>10:00- 10:30</b>	<b>Tea Break</b>
10:30- 11:00	The Malawi health equity analysis: <b>REACH Trust</b>
11:00 - 11:30	<b>Discussion and questions</b> – Chair <i>Ms. Bertha SImwaka, REACH Trust</i>
11:30 - 12:00	<b>Update on national activities to monitor equity in HIV/AIDS access to care: Zambia, Zimbabwe, South Africa, Tanzania, Mozambique .Chair Dr. Boniface Kalanda</b>
12:00 - 12:30	<b>Comments and questions</b>
12.:30 13.30	LUNCH
13.30-14.30	<b>Overall proposal and terms of reference for work in 2005/6</b> Ireen Makwiza, Sally Theobald, REACH, Jeanette Vega, WHO <b>Discussion and questions</b>
14:30 – 15.00	<b>Gender equity analysis in ART scale up</b> Dr. Avni Amin, WHO Chair Dr. Eddie Limbambala
<b>15.00 – 15.30</b>	<b>Tea break</b>
15.30 – 16.00	<b>Health worker equity access ART analysis</b> Dr. Orielle Solar, WHO and Grace Bongololo, REACH Trust, Chair Dr. Eddie Limbambala
16:00-17.00	<b>Closing for Day 1 : Malawi on equity policy; EQUINET work; WHO AFRO on 3x5 and discussion</b> Erik Schouten, MoH, Malawi, G Musuka EQUINET, Jeanette Vega, WHO, Chair Dr. Eddie Limbambala
<b>Tuesday, 30 August, 2005: Logistics to take the work forward</b>	



8.30 – 10.30am	<b>The country quantitative monitoring and reports on health systems and equity.</b> <i>Discussion</i> : Aims, roles, Workplans, resources, human resources, outputs and timeframes Facilitator: REACH Trust/EQUINET/WHO
<b>10:15 - 10:45</b>	<b>Tea Break</b>
10:45 - 12:45	<b>The country complementary qualitative work</b> <i>Discussion</i> : Aims, roles, human resources, Workplans, resources, outputs and timeframes Facilitator: REACH Trust/EQUINET/WHO
12.45 – 13.45	<b>LUNCH</b>
14:30 -16:30	<b>Plenary : Feedback from country teams and discussion</b> Facilitator: REACH Trust/EQUINET/WHO
16.30- 16.45	<b>Tea Break</b>
16.45 – 17.00	<b>Closing remarks and Vote of Thanks – REACH</b> Trust/EQUINET/WHO

## Appendix 2: List of participants

Person and role	Institution	Email address	ADDRESS	COUNTRY	PHONE
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