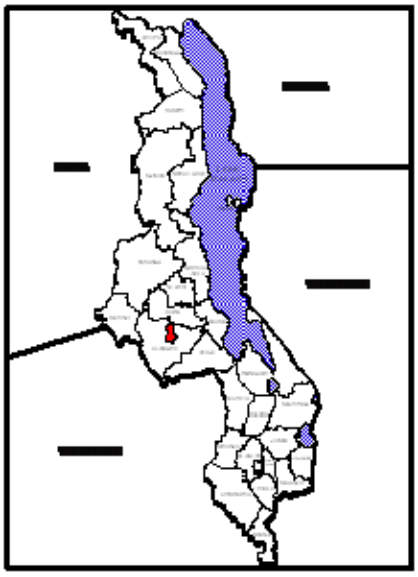
Country Health Equity Analysis Malawi



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This report was produced as a background report of policies, evidence and perspectives for health equity work in Malawi and as a contribution to the EQUINET regional equity analysis. The regional equity analysis brings the work and constituencies of the network together as a whole, to define the messages, content and outputs that will be useful to a wider spectrum of institutions in the region to raise awareness and widen interest and engagement around health equity. It signals priorities for future work and knowledge gaps to be addressed.

Executive summary

The Regional Network for Equity in Health in east and southern Africa (EQUINET) identified at its Regional Conference in June 2004 an agenda of "Reclaiming the state, advancing people's health, challenging injustice". To give profile to the issues and options for action to strengthen health equity, EQUINET is developing a *Regional Equity Analysis*. This report explores the health equity issues in Malawi, as a country equity analysis and contribution to this regional picture. It explores the current equity situation in Malawi, and the way forward to promote equity in health through a strong network of equity actors whose voice would advocate for equitable access to basic quality health care in Malawi.

Through a literature review and interviews with key informants, we gathered and reviewed existing evidence on health equity priorities. A country level meeting in Malawi in April 2006 shared evidence, perspective and proposed options for addressing these priorities. The country equity analysis meeting gave an opportunity to look at the available potential among equity actors to address inequities in health and highlight relevant priorities in Malawi.

Health outcomes in Malawi are affected by:

- high levels of poverty
- high illiteracy
- HIV/AIDS
- weak access to public sector health services due to low public financing available for health
- a huge shortfall in health workers.

Malnutrition is endemic in Malawi with 50% of children below age five being chronically malnourished. About 56% of pregnant women attending antenatal clinics are anaemic. Studies documenting inequalities in health and access to health care were compiled in the June 2006 edition of the Malawi Medical Journal (MMJ), an edition specially dedicated to equity. This found that Malawi's performance in reaching poor communities is stronger for antenatal care, attended deliveries and immunisation, but weaker for clinical management of acute respiratory infections and fever.

The Malawi health sector has undergone reforms which include the provision of Essential Health Package (EHP) and the Sector Wide Approach (SWAp). These are deliberate changes agreed on by all stakeholders in the health system and government. The EHP is a package of basic health care services to address targeted health problems that contribute to the increasing disease burden. The EHP forms an approach for both government and partners to provide equitable and accessible essential health care to the people of Malawi, especially the poor and disadvantaged groups, with prioritisation of EHP components to enhance implementation.

The SWAp gathers contributions from different public sources and uses systematic resource allocation mechanisms to address funding distortions and expand the resource base for services that have inadequate donor support, especially of government financial resources from district hospitals to peripheral health facilities and the community level. The SWAp integrates all vertical disease programmes into EHP so that technical efficiencies can be achieved.

The EHP and SWAp are monitored through a health management information system (HMIS) that aims to provide relevant, reliable, current and complete data from community to central levels. The HMIS provides indicators of service delivery and utilisation throughout the public and formal health sector. To support equity outcomes in health and in access to essential quality health care, government set up an *Equity and Access Sub-Group*, a forum where government, donors and civil society organisations monitor progress and advances towards equity. Decentralisation reforms have aimed to enhance district assembly, community and hospitals powers to plan and prioritise spending on pertinent disease and community health problems. In civil society, the Malawi Health Equity Network (MHEN) formed in 2000 has an advocacy role on health equity, influencing people-centred policy through the Parliamentary Committee on health.

Following the background compilation of the major equity issues and the key institutional policies and mechanisms in place in Malawi, a meeting was held with equity actors in the country in April 2006 to identify the priority areas for focus to strengthen equity in health systems in Malawi. These were identified as:

- fairly financing health services
- strengthening human resource capacity
- procurement and management of essential drugs
- improving the environment for safe motherhood
- ensuring equitable access to antiretrovirals (ARVs).

This report discusses the dimensions of these issues and the measures being taken to address them.

These approaches still face constraints. While programmes such as the Expanded Programme on Immunisation (EPI) has reduced childhood diseases, other issues such as access to ART, safe motherhood, TB services and other health care services remain problematic, and the social determinants of maternal mortality and HIV transmission still need to be addressed.

Challenges to equity and access in health care services not only lie in the community level factors that lead to social differences in use of services, but also in the adequacy and sustainability of financing and the adequacy and retention of health workers in the health system. The *Equity and Access Monitoring Sub-group*, MHEN and the network of equity players in the civil society organisations represent important institutional mechanisms to monitor, review and discuss these barriers and identify options for responses. While there is organisation of technical resources through research, government institutions, significant consensus on the challenges and direction, shared policy directions and the MHIS, the report points to the need for greater public advocacy for health equity to strengthen and sustain initiatives to address the priority areas.

Country health equity analysis: Malawi

1. Introduction

The Regional Network for Equity in Health in east and southern Africa (EQUINET) identified at its Regional Conference in June 2004 an agenda of "Reclaiming the state, advancing people's health, challenging injustice". Within the east and southern African region, drawing on common values of equity, social justice and the right to health, we have identified the key challenge to be revitalising and building national peoples' health systems that are publicly-funded, comprehensive, people-centred and universal.

Since 1998, EQUINET has carried out work to take forward an understanding of equity as closing unfair differentials in health and access to health care across groups, including in the power groups have to control the resources for health. The Kasane Declaration (1997) and the SADC Health protocol (2004) provide a policy context for this work. To give profile to the issues and options for action to strengthen health equity, EQUINET is developing a *Regional Equity Analysis*. This provides a focus to:

- bring the work and constituencies of the network together as a whole; and
- define the messages, content and outputs that will be useful to a wider spectrum of institutions in the region to raise awareness and widen interest and engagement around health equity.

It will also signal priorities for future work and knowledge gaps to be addressed.

This report explores the health equity issues in Malawi, as a country equity analysis and contribution to this regional picture. It explores the current equity situation in Malawi, and the way forward to promote equity in health through a strong network of equity actors whose voice would advocate for equitable access to basic quality health care in Malawi.

Offering health services to the people is not enough. Unless the services are accessible to all then there will be disparities and inequity in both the distribution and utilisation of the services. Acknowledging that poverty is an issue in the delivery of health care, overcoming poverty-related barriers to health care through equitable services is an issue for the Ministry of Health in Malawi, and for non government organisations (NGOs) and community based organisations (CBOs). In other words, while it is not in the power of health and equity actors to bail people out of the poverty trap:

- health services could be brought to where the people live;
- promotion of people's health behavioural change could be sustained; and
- communities could be involved in:
  - planning and implementing interventions; and
  - advocating for pro-poor policies that will shape their own health.

There are examples in Malawi of how the communities can be involved in health delivery at community level:

- The National Tuberculosis (TB) Control Programme decentralised the management of TB using DOTS to the community level, where 'guardians' are involved in supervising their patients to swallow drugs and make an appropriate recording.
- The REACH Trust, in collaboration with the Malaria and TB Control programmes, through the Extending Services to the Community (ESC) Project has trained store and grocery owners to advise mothers and carers of children on the correct dosing of

anti-malaria drugs as well as to refer potential TB cases for TB screening to the nearest health facility.
- Through another REACH Trust project, *Linking Civil Society with TB care* (LCS), the community is involved in health promotion to improve health (TB) seeking behaviour, identifying potential TB cases and delivering sputa specimens to and results from a nearby laboratory.

Networking country personnel working on health equity provides an opportunity to draw together perspective, evidence, experiences, and views, to strengthen dialogue and networking and to build shared learning and analysis within countries on equity priorities identified at country level. This process aimed to identify priorities within countries, the experience and evidence on these priorities and options proposed for addressing them.

Through a literature review and interviews with key informants, we gathered and reviewed existing evidence on health equity priorities. A country level meeting in Malawi in April 2006 shared evidence, perspective and proposed options for addressing these priorities. The country equity analysis meeting gave an opportunity to look at the available potential among equity actors to address inequities in health and highlight relevant priorities in Malawi.

We acknowledge EQUINET for the support for the meeting and for the desire that countries should have an opportunity to learn from and share experiences with other countries in the east and southern African region.

This report was prepared by Hastings T. Banda (Research on Equity and Community Health Trust), Ireen Makwiza Namakhoma (Research on Equity and Community Health Trust) and Judy Ng'ombe (CARE – Malawi). The report was peer reviewed and edited through the EQUINET Secretariat at TARSC (R Loewenson, R Pointer).

2. Overview

Malawi is a densely populated country in central/ southern Africa with an area of 118,484km^2, of which 20% is water. There are 109 persons per km^2 and 180 persons per km^2 of arable land. Malawi is a landlocked country and has no access to the sea. Administratively, Malawi has the Central and Local systems of government, with 27 administrative districts falling under local government (MoH, 2001).

Poverty is rampant in Malawi. Over 65% of the Malawian population was living below the poverty line (1998) and then only 9% of all individuals aged above 10 years and only 21.3% of household heads were employed in the formal sector (MoH, 2001). Public services are funded through taxes on individual incomes and on company profits as well as trade taxes and donor grants (MoH, 2001). As a result, local borrowing led to large debts with negative impacts on public sector spending by government. Between 1993/4 and 1998/9 there was no increase in functional distribution of public sector actual recurrent expenditure except for public debt service, as shown in *Table 1*.

Table 1: Functional distribution of public sector actual recurrent expenditure

Function	1993/4	1994/5	1995/6	1996/7	1997/8	1998/9
Defense	124.6 (5.6%)	159.4 (4.1%)	255.9 (4.1%)	339.8 (4.5%)	439.1 (3.6%)	439 (3.5%)
Justice	118.8 (5.3%)	180.2 (4.7%)	252.7 (4.1%)	378.6 (5.0%)	469.8 (4.0%)	- (0.0%)
Education	248.5 (11.1%)	351.8 (9.2%)	844.0 (13.7%)	1270.8 (16.8%)	2092.3 (17.3%)	1679.0 (13.3%)
Health	150.1 (6.7%)	228.5 (5.9%)	381.8 (6.2%)	616.0 (8.1%)	818.4 (6.8%)	762 (6.0%)
Community & Social Development	47.1 (2.1%)	31.5 (0.8%)	49.9 (0.8%)	60.5 (0.8%)	217.6 (1.8%)	- (0.0%)
Economic Services	583.3 (26.1%)	818.2 (21.3%)	905.0 (14.6%)	515.2 (6.8%)	940.0 (7.8%)	- (0.0%)
Public Debt Services	537.3 (24.1%)	1074.0 (28.0%)	2500 (40.5%)	2467.4 (32.5%)	2744.5 (22.7%)	4960 (39.3%)
Other	425.1 (19.0%)	997.4 (26.0%)	988.1 (16.0%)	1936.6 (25.5%)	4346.9 (36.0%)	- (0.0%)
Total	2234 (100%)	3841 (100%)	6178 (100%)	7584 (100%)	12068 (100%)	12614 (100%)

Note: Prices in MK millions (1999 prices). Parentheses are percentages of the total.
Source: MoH, 2001.

Health indicators for Malawi are among the worst globally. High illiteracy, poverty, HIV/AIDS and the human resource for health crisis are amongst the factors that aggravate the situation. *Table 2* portrays some selected health indicators for Malawi.

Table 2: A summary of selected health indicators in Malawi

Indicator	Year	Value
Life expectancy at birth (years) males	2004	41 years
Life expectancy at birth (years) females	2004	41 years
Infant mortality rate (per 1,000 live births)	2004	109 / 1000
Neonatal mortality rate (per 1,000 live births)	2000	40 / 1000
Maternal mortality ratio (per 100,000 live births)	2000	1 800 /100 000
Death among children under five years of age due to HIV/AIDS (%)	2000	14%
Under five mortality rate (per 1,000 live births)- rural	2000	210.3 / 1000
Under five mortality rate (per 1,000 live births)- urban	2000	147.9 / 1000
Children under five years of age stunted for age (%)	2000	49%
Physicians (number)	2004	266
Physicians (density per 1,000 population)	2004	0.02 / 1000
Nurses (number)	2004	7,264
Nurses (density per 1,000 population	2004	0.59 / 1000
Government expenditure on health as % total government expenditure	2003	9.1%

Source: WHO statistical information system (WHOSIS), 2006.

Malnutrition is endemic in Malawi with 50% of children below age five being chronically malnourished. About 56% of pregnant women attending antenatal clinics are anaemic (MOH, 2001). Such statistics raise concerns about equity in and access to quality health care services as well as equitable distribution and efficient use of resources. The biggest question such indicators raise is whether health services are people-centred, bearing in mind the greater health needs of poor communities.

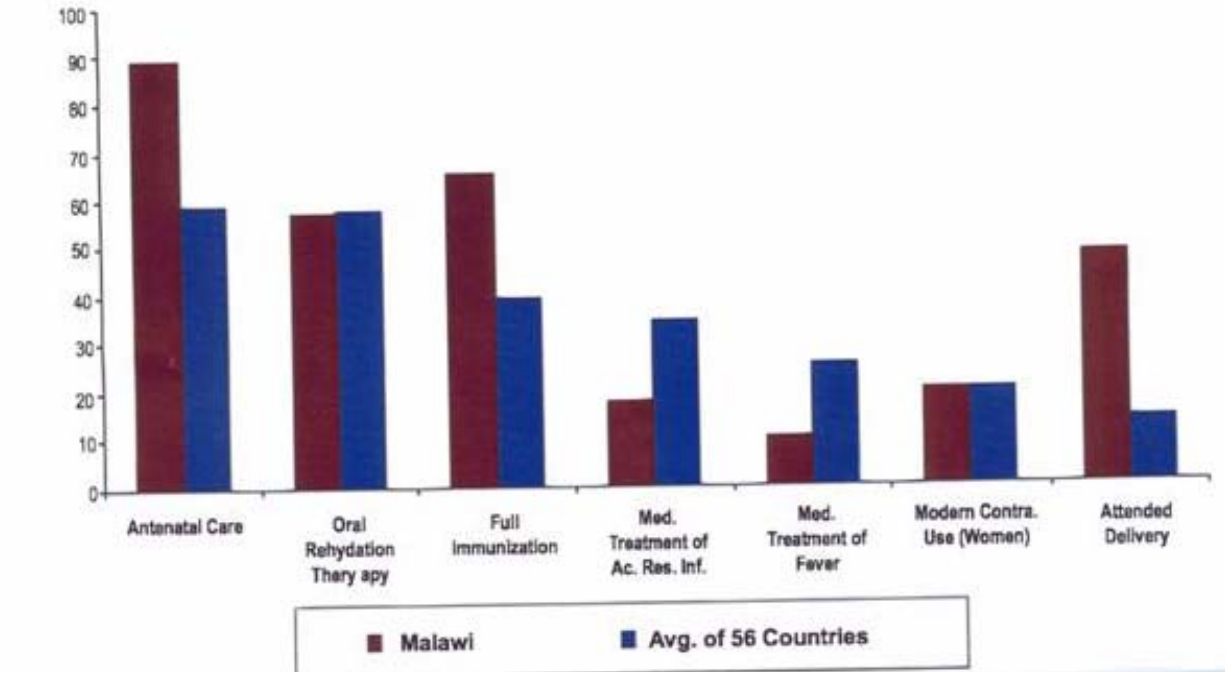
> *Equity in health implies addressing differences in health that are judged to be unnecessary, avoidable and unfair. These differences relate to disparities across socio-economic status, gender, age, racial groups, rural/urban residence and geographical region. Equity should therefore be achieved through the redistribution of the societal resources for health, including the power to claim and the capabilities to use these resources.*

Source: Makwiza et al, 2005.

Studies conducted by Malawian institutions for the Ministry of Health (MoH) have documented inequalities in health and access to health care, informing interventions and activities. A range of studies focussing on equity were compiled in the June 2006 edition of the Malawi Medical Journal, an edition specially dedicated to equity.

For example, as shown in *Figure 1* below, Malawi's performance in reaching poor communities is stronger for antenatal care, attended deliveries and immunisation, but weaker for clinical management of acute respiratory infections and fever.

Figure 1: Basic maternal and child health coverage among the poorest 20% Malawi population in relation to other countries



Source: Gwatkin, 2006.

3. Policies and mechanisms in support of health equity

3.1. The Essential Health Package (EHP)

The Malawi health sector has undergone reforms which include the provision EHP and SWAp. These are deliberate changes agreed upon by all stakeholders in the health system and government. The health sector reforms were introduced after recognising that investments made in the health sector had not produced significant gains in health status.

The EHP is a package of basic health care services to address targeted health problems that contribute to the increasing disease burden. The EHP policy aimed to achieve millennium development goals (MDGs) related to health. The Malawi MoH developed the Essential Health Package as an explicitly pro-poor strategy to deliver the minimum essential health service to rural communities. The EHP focuses on diseases of the poor and is meant to enhance equity in health and improve access to health care to Malawians in poor communities. There are eleven components of the EHP (see *Box 1*), with specified interventions for each component. These interventions are among the core business of MoH and are the health sector's contribution to the national strategy for poverty reduction.

Box 1: Malawi Essential Health Package components

1. Prevention and treatment of vaccine-preventable diseases
2. Management of acute respiratory infections (ARI) including pneumonia.
3. Malaria prevention and treatment i.e. using insect treated nets (ITNs) and active case management.
4. Reproductive health interventions to address adverse maternal/neonatal outcomes (family planning, maternal and neonatal health, PMTCT).
5. Prevention and control of tuberculosis.
6. Prevention and treatment of acute diarrhoeal diseases including cholera.
7. Prevention and treatment of HIV/AIDS and other sexually transmitted infections (STIs).
8. Prevention and treatment of schistosomiasis.
9. Prevention and treatment of malnutrition and nutritional deficiencies.
10. Prevention and management of common eye, ear and skin conditions.
11. Treatment of common injuries and emergencies.

Source: MoH, 2003b.

The EHP forms an approach for both government and partners to provide equitable and accessible essential health care to Malawians, especially the poor and disadvantaged groups, with prioritisation of EHP components to enhance implementation.

The Christian Health Association of Malawi (CHAM) is quite critical for the delivery of EHP considering their location in most rural areas where close to 90% of the populace lives. The GoM has, as a means of implementing its reforms, established agreements with CHAM hospitals to improve and promote the delivery of EHP to improve access to basic health care in rural areas.

The HMIS supports the EHP and is an integral part of the national health system. The information system is vital in health because it provides relevant, reliable, updated,

current, reasonable, and complete data for those managing health from community to central levels. A well developed HMIS facilitates effectiveness and efficiency of health services and informs policy making.

Box 2: Shaping the HMIS in Malawi

In response to the health sector reforms, the Ministry of Health implemented a comprehensive and integrated routine HMIS country-wide. All routine information systems have been integrated and the generation and use of data has been decentralised so that information generated is used for action and the system simple to establish and maintain.

The HMIS is designed to make timely provision of reports on how well each programme is functioning to programme managers and staff and to alert programme managers and service providers to take appropriate and timely corrective measures where necessary.

Four committees were set up:

- the Health Information Policy
- Health Information Management Technical Committee
- Health Information Management Committee at district and facility level
- the Health Information Management Secretariat.
-

Through such structures minimum data sets have been defined, standardised and approved, protocol on data release and access are in place, and revision of health data collection procedures and tools is periodic.

Source: MoH, 2003.

The HMIS reports on the EHP components in a way that act as indicators of service delivery and utilisation throughout the public and formal health sector.

3.2. The Sector Wide Approach (SWAp)

The SWAp is a sustainable organisation of partnerships led by national authorities involving different arms of government and civil society. The SWAp aims, through systematic resource allocation mechanisms, to:

- address funding distortions; and
- to expand the resource base for services that have inadequate donor support, especially of government financial resources from district hospitals to peripheral health facilities and the community level.

These measures under the SWAp are anticipated to contribute to the attainment of equitable essential health services. The third component of SWAp is the integration of all vertical disease programmes into EHP and pooling the resources into one basket so that technical efficiencies can be achieved, such as in drug provision. In order to maximise equitable resource utilisation the donor community also puts all the resources into one common basket.

3.3. Strengthening equity in planning and implementing services

Much of the disease burden arises from poverty-related diseases, hence affecting the poor more than the non-poor in the society.

> *Examination of expenditure by gender reveals that females spent more on health care in total and on average. This could be due to a number of factors: females' expenditure on deliveries, role as primary health carers of children, better health awareness on behalf of females, higher morbidity patterns for females, and so on.*

Source: MOH, 2001.

To support equity outcomes in health and in access to essential quality health care, government set up an *Equity and Access Sub-Group*, a forum where government, donors and civil society organisations monitor progress and advances towards equity. The goal is for 'equal access to equal need'. The group uses a broad definition of poverty as 'a lack of capabilities and substantive freedoms a person requires to lead the kind of life he or she would have reason to value'. This extends beyond the basic notion of income, to encompass a range of hardships amongst different groups; including lack of material well-being, infrastructure, livelihood sustainability, social capital, power and voice. The *Equity and Access to Health Care Sub-Group* was formed and sits within the MoH to assess the health sector's capacity and performance to achieve this goal, in the context of the health SWAp. It reports to and is accountable to the *Monitoring, Evaluation and Research Technical Working Group* (TWG).

Box 3: Organisations that sit on the Equity and Access Sub-Group

Government
Ministry of Health (the Group is chaired by the Deputy Director of Planning)
Ministry of Economic Planning and Development (Vice –Chair)
Donors/UN Family
DFID (Vice-Secretariat)
World Bank
WHO
UNAIDS
NGO, research, advocacy, service provision
National Association of People Living with HIV and AIDS in Malawi (NAPHAM)
REACH Trust (Secretariat)
Malawi Health Equity Network (MHEN)
Malawi Economic Justice Network (MEJN)
CARE – Malawi
Centre for Social Research
The Policy Project

The sub-group aims to:

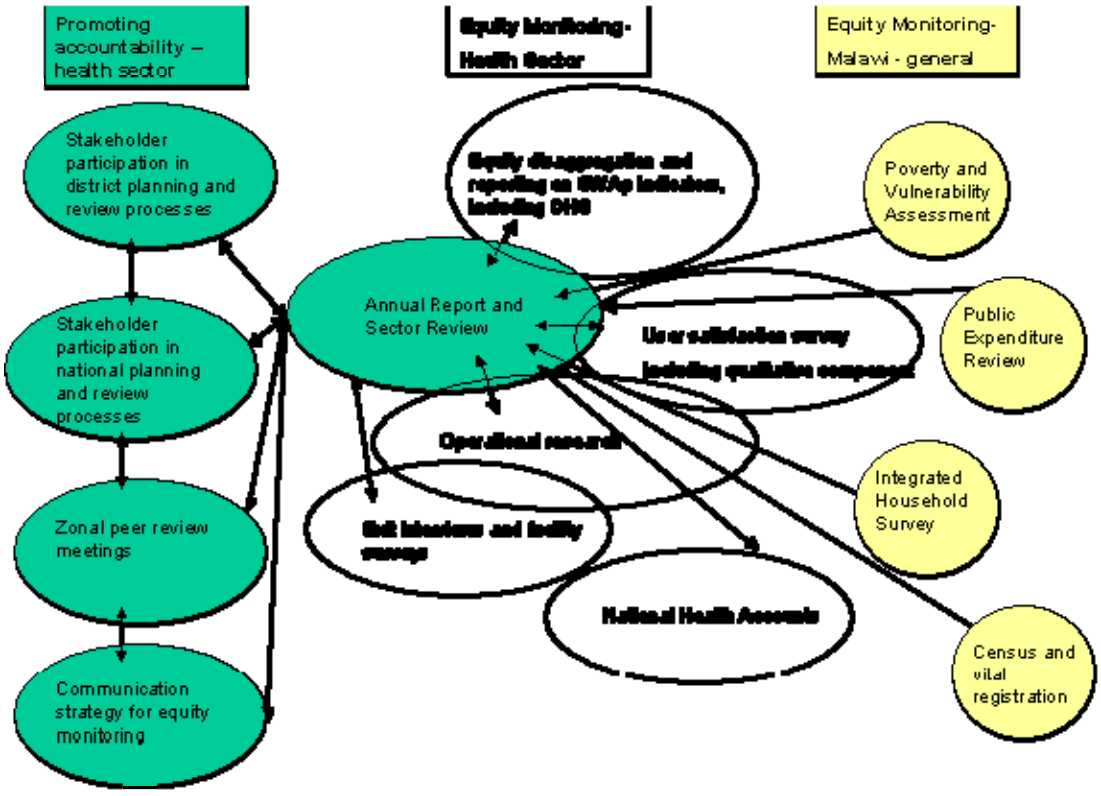
- appraise the ME&R TWG and MoH and partners more generally of relevant research on, or analyses of, the capacity of the sector to reach the poor;
- inform the ME&R TWG and MoH in general of wider poverty monitoring initiatives in Malawi, and their links and relevance to the health sector;

- oversee periodic analysis of existing data to assess the capacity of the sector to reach the poor, and to inform the MoH Annual Report and Mid-Year and Annual Reviews;
- ensure TWG's and MoH Departments across the sector are appraised of equity monitoring and relevant pro-poor interventions;
- technically support the implementation of pro-poor health interventions and research within the SWAp, such as:
  - review of district allocation formulae
  - distribution of resources between levels of healthcare, including, but not be limited to, review of equity considerations in relation to human resources;
- produce up-to-date National Health Accounts (NHA) and health benefit incidence analyses at the start, mid-point and end of the Programme of Work (PoW).
- review the accountability framework of SWAp and the PoW in reaching the poor.

3.4. Equity monitoring

The *Equity and Access Sub-Group* devised the equity monitoring framework as a tool to monitor progress towards equity and access within the SWAp programme of work and to assess how pro-poor SWAp performance is. *Figure 2* shows the five main elements to the equity monitoring in the health sector.

Figure 2: Overview of the Equity Monitoring Framework



The elements are illustrated in the white circles (e.g. equity disaggregation and reporting on SWAp indicators). This equity monitoring in the health sector will be informed by broader equity monitoring in Malawi (e.g. the Integrated Household Survey (see yellow

circles)) and will feed into the annual report, sector review and processes to promote accountability in the health sector (see green circles).

The sector's performance will be assessed according to its capacity to reach the poor by providing key inputs that influence coverage with EHP services. It will also be necessary to determine the extent to which the sector is able to channel resources to the poor by funding pro-poor interventions and minimising financial obstacles to accessing EHP interventions. Communicable diseases and maternal and child health problems represent the major causes of morbidity and mortality for the poorest. The performance of the sector will thus be assessed by analysing the key determinants of these and coverage for the poor.

One of the functions of the Equity Monitoring Framework is to determine the information needs for assessing health inequalities and to shape health information systems to meet those needs. The framework will be a tool to promote sensitisation on equity matters. The components or indicators of the Equity Monitoring Framework are shown in more detail in *Table 2 below*, and they include:

- equity monitoring:
  - equity disaggregation of SWAp indicators
  - other sources of information
  - user satisfaction survey
  - exit interviews and facility surveys
  - census and vital registration system
  - other operational research
- promoting accountability
  - annual report and annual review
  - district annual planning and review processes
  - zonal HMIS review meetings
  - communication strategy
- documenting lessons on integrating equity into SWAp process
- responsibility for equity monitoring of the SWAp

Some of the pro-poor determinants to be monitored include:

- physical accessibility
- availability of essential inputs
- service quality
- social accountability
- utilisation of services by the poor
- continuity and timing of interventions
- technical quality,

To the extent possible the assessment will include public, both for-profit and not-for-profit NGO and private services and facilities in order to obtain a complete picture of the health system.

Source: Gwatkin, 2006.

Table 3: Equity Indicators for SWAp Monitoring

Level	Indicator	Purpose	Data source	Monitoring frequency	Aggregation	Baseline
Reduced incidence of illness/ premature death	IMR	Impact	DHS	Quiennially	National	76/1000 (2000-2004)
	Equity stratifiers	- Socio-economic quintile analysis - gender disaggregation with trends, age and mother's education - urban/ rural and regional disaggregation.				
	U5MR	Impact	DHS	Quiennially	National	133/1000 (2000-2004)
	Equity stratifiers	- Socio-economic quintile analysis - gender disaggregation with trends, age and mother's education - urban/ rural and regional disaggregation.				
	MMR	Impact	DHS	Quiennially	National	1120/100000 (1995-1999) 2000-2004 figure awaited
	Equity stratifiers	- Socio-economic quintile analysis (? is this possible) with trends & age & woman's education - urban/ rural and regional disaggregation.				
	HIV prevalence 15-24 yr old pregnant women	Impact	Sentinel	Annually	National	18.3% (2003)
	Equity stratifiers	Based on DHS Plus data: Socio-economic quintile analysis & gender disaggregation with trends Urban/rural and regional disaggregation				
	Life expectancy (at birth)	Impact	NSO	Annually	National	37 yrs (2003 est.)
	Equity stratifiers	Gender disaggregation				
Objective 1:						
Increased utilisation and effectiveness of EHP and other services	OPD service utilisation	Access/ Quality	HMIS	Annually	District/ National	800/1000 population (HMIS 2004-2005)
	Equity stratifiers	Gender disaggregation & health facility type – six monthly HMIS record review; District performance assessment				
	% fully immunised children <1yrs	Access	HMIS	Annually	District/ National	55% (HMIS 2004-2005)
	Equity stratifiers	Gender disaggregation & health facility type – six monthly HMIS record review; District performance assessment				
	% surveyed pop. satisfied with services	Quality	Survey	Annually	District/ National	71% (CWIQ 2002)
	Equity stratifiers	Asset scoring & Socio-economic quintile analysis included in survey, plus gender, urban/rural, distance from facility and district performance comparisons NOTE: User Satisfaction survey can be expanded to entail exploratory qualitative component and operational research questions				
	CPR (modern methods)	Access/ Effec-tivness	DHS	Quiennially	National	28.1% (DHS 2004)

		Socio-economic quintile analysis & gender disaggregation with trends & age Urban/rural and regional disaggregation				
	% births attended by skilled health personnel	Access/ Quality	HMIS	Annually	District/ National	57% (DHS 2004), 38% HMIS 2004-2005)
	Equity stratifiers	Health facility type and district performance comparisons				
	Condom use at last high risk sex (with non-cohabiting partner)	Access/ Quality	DHS	Quiennially	District/ National	30%w 47%m (DHS 2004)
		Socio-economic quintile analysis & gender disaggregation with trends & age Urban/rural and regional disaggregation				
	% women and children who slept under a mosquito net the previous night	Access	DHS	Quiennially	District/Natio nal	26.7%w 47%c (DHS 2004)
	Equity stratifiers	Socio-economic quintile analysis & gender disaggregation with trends & age ; Urban/rural and regional disaggregation				
Objective 2:						
Increased availability of quality EHP services	EHP coverage	Access	HMIS	Annually	District/ National	9% (JICA 2002)
	Equity stratifiers: % population within 5 km of health facilities % facilities with functioning village health committees ; District performance comparisons					
	Cum # HIV positive cases receiving ARV	Access	HMIS	Annually	District/ National	23000 (HIV Unit, June 2005).
	Equity stratifiers	Gender & age disaggregation and facility type - six monthly HMIS record review District performance assessment				
	TB detection rate	Access	Survey	Every 10 yrs	District/ National	40% (WHO 2004)
	Equity stratifiers	Asset scoring & Socio-economic quintile analysis included in survey, plus gender, age, urban rural and district performance comparisons				
	TB cure rate	Quality	HMIS	Annually	District/ National	76% (HMIS/NTCP, 2004-2005)
	Equity stratifiers	Gender and age disaggregation – six monthly HIMIS record review District performance assessment				
	# of ITNs sold/distributed in the country	Access	HMIS	Annually	District/ National	1,253 ,663 (NMCP,2004)
	Equity stratifiers	Health facility type and district performance assessment				
	% of pregnant women starting antenatal care in the first trimester	Access	HMIS	Annually	District/ National	7% (HMIS 2004-2005)
	Equity stratifiers	District performance assessment; Possibly crude urban/rural differences				
Program 1: Human Resources						
Staffing norms at all health facilities	% health centers with minimum staff norms	Quality	HMIS	Annually	District/ National	23% (2002
	% health centers with minimum practicing	Equity and	PPMIS	Annually	District/ National	

	midwifery-trained staff	Access				
	annual output of trained personnel (by cadre)	Access	Survey	Annually	National	Doctors: 19 (2004) Nurse: 415 (2004)
	HSAs per head of population	Equity, Access	PPMIS	Annually	District/ National	
Program 2: Pharmaceuticals						
Supply chain functioning adequately	% health facililties without stock-outs of SP, ORS and cotrimoxazole for more than a week at a time % health facilities with tetanus toxoid vaccine stock out for more than a week at a time	Quality Equity and Access	LMIS LMIS	Annually Annually	District/ National District/ National	SP: 85% ORS: 81% Cotrimoxazole: 82% Composite: 89% (LMIS 2004)
Program 3: Essential basic equipment						
Essential medical equipment available at all health facilities	% health facilities equipment in line with standard equipment list % facilities with basic maternal health equipment	Quality Equity and Access	HMIS PAMIS	Annually Annually	District/ National District/ National	
Program 4: Infrastructure						
Adequate health facilities available	% health facilities with functioning water, electricity and communication	Quality	HMIS	Annually	District/ National	59% (HMIS 2003)
	% districts with functioning ambulances	Quality	HMIS	Annually	District/ National	
Program 5: Routine operations						
Routine operations at service delivery level adequately financed	% health facilities regularly supervised by extended DHMT using integrated supervision checklist	Quality	HMIS	Annually	District/ National	
Program 6: Central						
Central institutions support strengthened	% districts reporting timely data % facilities reporting data	Sustainability	HMIS	Annually	National	Timeliness 10% Reporting status:88% (HMIS 2004)
Health financing						
Entire health sector	% GoM budget allocated to health sector	Sustainability	MOF	Annually	National	16.09% (2004/2005

funded adequately	% budget to health center & community level % budget by cost centers (district, central hosp, MOH)		IFMIS IFMIS	Annually Annually	National National	
	% of budget received on time	Efficiency	MOF	Annually	National	N/A
	per capita allocation (GoM and donor) to health sector (US$)	Sustainability	MOF	Annually	National	US$5.1 (2003/2004) EPD
	out-of-pocket expenditure as % of income by poor & non-poor % households with catastrophic health expenditure		NHA NHA	Every 3 yrs Every 3 yrs	National National	

3.5. Social and institutional mechanisms promoting equity

Decentralisation of health care to the local assembly delivery has been implemented to empower district assemblies to make decisions, set priorities and implement policies with involvement of the community in the planning and implementation of health care delivery systems. Decentralisation reforms have also aimed to give hospitals powers to prioritise spending on pertinent disease and community health problems. Within the Equity Monitoring Framework a mechanism has been provided for district performance assessment and monitoring to support this local level planning.

In civil society, the Malawi Health Equity Network (MHEN) formed in 2000, has an advocacy role on health equity, influencing people-centred policy through the Parliamentary Committee on health. The Parliamentary Committee on health in the Malawi National Assembly is one of the institutional mechanisms for promoting equity and the MHEN acts as a lobby of the committee. The membership of MHEN has grown from 28 organisations in 2000 to about 50 in 2006. Its membership includes the MoH, private health sector, private-for-profit health sector, service users, professional health regulatory bodies, health training institutions, non-governmental and civil society organisations and so on (MHEN, 2004).

> ***Vision of MHEN:*** *All people in Malawi have access to equitable, quality, affordable and responsive essential health care services.*
>
> *The Malawi health budget, like that for other public services, is sourced mainly from taxes on personal income and company profits as well as trade taxes and donor grants. Domestic borrowing is resolved to quench deficits when they occur. It is MHEN's mandate to monitor how the budget is utilised to equitably benefit the poor. The Malawi Health Equity Network is conscious of the need for solidarity with the membership and as such strives to build a network in Malawi that will see to it that all the activities of its members eventually uplifts the health of Malawians equally across the socio-economic strata in line with its mission: 'to advocate for health systems that promote*

the delivery of equitable quality health care services by influencing policy and practice.

Source: MHEN, 2004.

The MHEN has noted a decline in investment in health with corresponding health problems. The network has pointed to the worsening of maternal mortality from 620/100,000 live births in 1996 to 1,120/100,000 in 2000 (NSO, 2000), and persistently high child mortality of 234/1000 live births (WHO, 2004).

4. Challenges and options to strengthen health equity in Malawi

Following the background compilation of the major equity issues and the key institutional policies and mechanisms in place in Malawi, a meeting was held with the country's equity actors in April 2006 to identify the priority areas for focus to strengthen equity in health systems in Malawi. These were identified as:

- fairly financing health services
- strengthening human resource capacity
- procurement and management of essential drugs
- improving the environment for safe motherhood
- ensuring equitable access to antiretrovirals (ARVs).

4.1. Human Resources for Health

Health workers are key to the delivery of health care services and the need for adequate health workers can never be over-emphasised. The type of cadre, type of training and in what ratios to the served population all matter if the health services are to be equitable and accessible. In order to improve health service delivery, investments in health workers and improvements in their welfare must be prioritised. This is therefore one of the areas MHEN is monitoring. The shortfall in health personnel is high across many categories critical for EHP delivery (see *Table 4* below).

Table 4: Vacancy rates for MoH and CHAM facilities by cadre (2003)

Staff	MoH			CHAM		
	Posts	**Filled**	**Vacancy rate (%)**	**Posts**	**Filled**	**Vacancy rate (%)**
Specialist doctors	151	27	82.0	n.a.	n.a.	n.a.
Medical officers	93	63	32.3	36	21	41.7
Clinical officers	563	425	24.5	123	79	35.8
Medical assistants	464	285	38.6	278	154	44.6
Nursing (combined)	5,966	1,932	67.7	1,933	905	53.2
Laboratory-related staff	190	76	41.0	183	73	60.1

Source: Makwiza et al, 2005.

In Malawi and beyond her borders, the problem has been appreciated, but so too is the initiative within the system:

There is no denying the difficulties that Malawi is facing in the health sector. But the way to move forward is to build on the positive steps that have

already been taken. For example, in spite of the challenging staffing situation, Malawi still manages to achieve surprisingly good results in some areas of health care. For example 100% coverage of TB Direct Observed Therapy (DOTS) in all 27 districts was recently reported. Morale amongst many health workers is low, yet it is possible to find very dedicated health workers working on the front line. And people continue to use opportunities to address the problems at all levels of the system. For example: Innovative ways of involving the community in health care are being developed. One initiative is working with shop keepers to improve early treatment of malaria and TB. In 2001 I met new district manager who was appalled by the late arrival at work of many have his staff. Not having real power to discipline them, he simply stood at the main door at the start of each day. As people realised he noticed who was late and who was not, there was a dramatic increase in the number of people who arrived on time!

Source: Martineau, 2005.

Figure 3: The first pre-med students during their 4th year, 2006

This health worker shortfall has a number of dimensions. For example, in the production of health workers, the Medical College could not get enough qualified entrants to study medicine, so it set up a "pre-med" course to bring school leavers up to standard. In 1999, as part of an emergency training programme, training schools were re-opened, more tutors trained and now more qualified staff are being produced. The next issue to be addressed was poor salaries, to reduce the number of staff leaving. *Source:* REACH photo library.

At the Malawi country health equity analysis meeting in April 2006, delegates noted that the establishment of the health service commission in 2003, as part of the health sector reform, was important to provide an institutional focus for efforts to improve the conditions of service for health workers. The Commission was keen to identify factors that would improve health worker retention by improving their working conditions. In 2006, the Commission has been carrying out a staff recruitment exercise targeting various cadres including those that either had resigned, been dismissed for absconding, retired or never joined the MoH after qualifying (see *Box 4*).

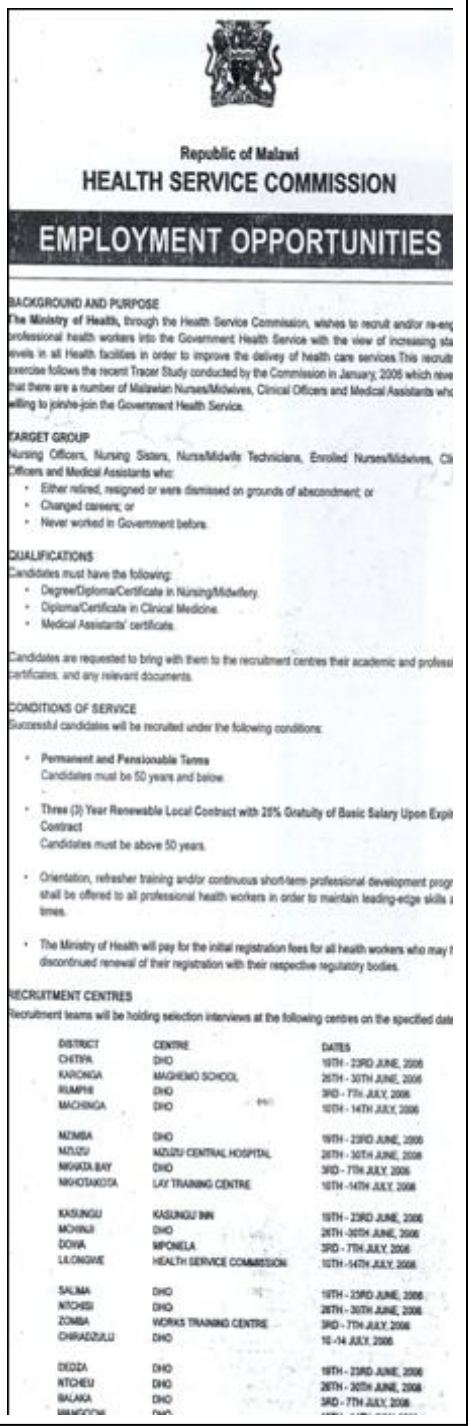
DFID has injected funds into the sector to help to train and retain health workers. This is a unique programme, the monitoring of which will inform countries in the region. At the country equity meeting, a presenter on HRH noted that together with DFID others supporting the health sector include GoM, Norwegian Embassy, UNFPA, World Bank, and Malaria Global Fund for AIDS, TB and Malaria. There has been an increase in donated funds in the 2004/5 financial year because of such concerted efforts from donors. The appreciation of the critical role of health workers is signalled by the fact that a total of MK 5,206,084,284 (US$37,8mn) has been spent on human resources between

July-December 2005. This represents 40.74% on budget and 70.4% of utilisation on funding (Araru, 2006).

US$95 million from the Global Fund for AIDS, TB and Malaria (GFATM) was approved for the retention of health workers and expansion of training in colleges. With the aid from donors, DFID and the GFATM, funds have now been obtained for financing staff retention and for training institutions to expand their training programmes. Financial agreements with College of Medicine, College of Nursing and CHAM training institutions have been made and intake will double to address the human resource crisis.

4.2. Procurement and management of essential drugs

Box 4: Health Service Commission advertisement



Republic of Malawi

HEALTH SERVICE COMMISSION

EMPLOYMENT OPPORTUNITIES

BACKGROUND AND PURPOSE

The Ministry of Health, through the Health Service Commission, wishes to recruit and/or re-eng professional health workers into the Government Health Service with the view of increasing sta levels in all Health facilities in order to improve the delivery of health care services.This recruit exercise follows the recent Tracer Study conducted by the Commission in January, 2006 which reve that there are a number of Malawian Nurses/Midwives, Clinical Officers and Medical Assistants who willing to join/re-join the Government Health Service.

TARGET GROUP

Nursing Officers, Nursing Sisters, Nurse/Midwife Technicians, Enrolled Nurses/Midwives, Cli Officers and Medical Assistants who:

- Either retired, resigned or were dismissed on grounds of abscondment; or
- Changed careers; or
- Never worked in Government before.

QUALIFICATIONS

Candidates must have the following:

- Degree/Diploma/Certificate in Nursing/Midwifery.
- Diploma/Certificate in Clinical Medicine.
- Medical Assistants' certificate.

Candidates are requested to bring with them to the recruitment centres their academic and professi certificates, and any relevant documents.

CONDITIONS OF SERVICE

Successful candidates will be recruited under the following conditions:

- Permanent and Pensionable Terms
  Candidates must be 50 years and below.
- Three (3) Year Renewable Local Contract with 25% Gratuity of Basic Salary Upon Expir Contract
  Candidates must be above 50 years.
- Orientation, refresher training and/or continuous short-term professional development progr shall be offered to all professional health workers in order to maintain leading-edge skills times.
- The Ministry of Health will pay for the initial registration fees for all health workers who may discontinued renewal of their registration with their respective regulatory bodies.

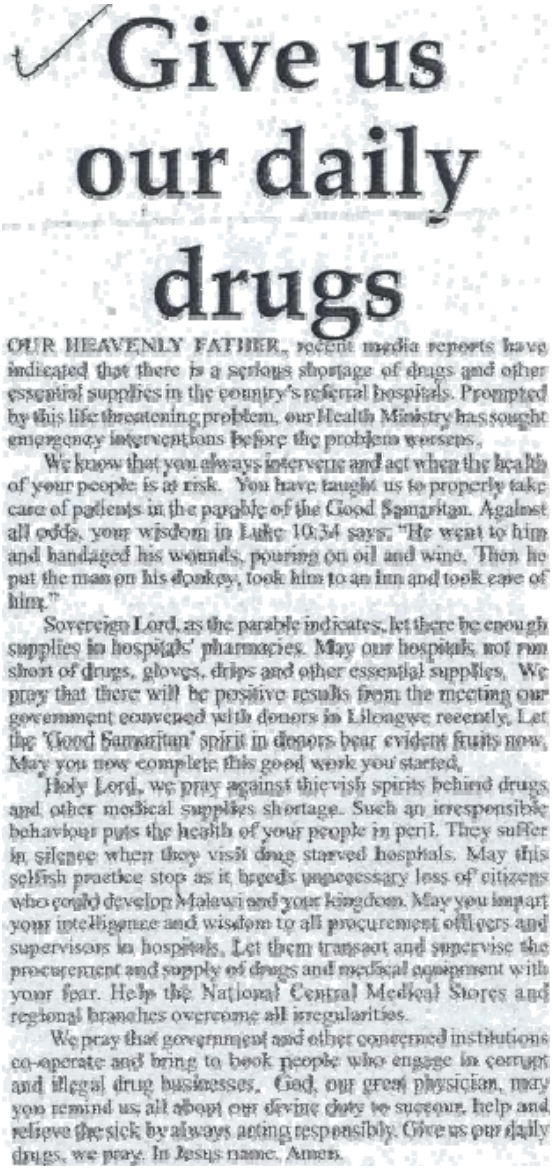
RECRUITMENT CENTRES

Recruitment teams will be holding selection interviews at the following centres on the specified date

DISTRICT	CENTRE	DATES
CHITIPA	DHO	19TH - 23RD JUNE, 2006
KARONGA	MAGHEMO SCHOOL	26TH - 30TH JUNE, 2006
RUMPHI	DHO	3RD - 7TH JULY, 2006
MACHINGA	DHO	10TH - 14TH JULY, 2006
MZIMBA	DHO	19TH - 23RD JUNE, 2006
MZUZU	MZUZU CENTRAL HOSPITAL	26TH - 30TH JUNE, 2006
MHAKTA BAY	DHO	3RD - 7TH JULY, 2006
MHOTAKOTA	LAY TRAINING CENTRE	10TH -14TH JULY, 2006
KASUNGU	KASUNGU INN	19TH - 23RD JUNE, 2006
MCHINJI	DHO	26TH -30TH JUNE, 2006
DOWA	MPONELA	3RD - 7TH JULY, 2006
LILONGWE	HEALTH SERVICE COMMISSION	10TH -14TH JULY, 2006
SALIMA	DHO	19TH - 23RD JUNE, 2006
NTCHISI	DHO	26TH - 30TH JUNE, 2006
ZOMBA	WORKS TRAINING CENTRE	3RD - 7TH JULY, 2006
CHIRADZULU	DHO	10 -14 JULY, 2006
DEDZA	DHO	19TH - 23RD JUNE, 2006
NTCHEU	DHO	26TH - 30TH JUNE, 2006
BALAKA	DHO	3RD - 7TH JULY, 2006

One of the greatest outcries in the country has been shortage of various drugs and other medical products and technologies. The media has had numerous reports of this problem (see for example *Box 5* and *6*).

Box 5: Public response to drug shortages



Give us our daily drugs

OUR HEAVENLY FATHER, recent media reports have indicated that there is a serious shortage of drugs and other essential supplies in the country's referral hospitals. Prompted by this life threatening problem, our Health Ministry has sought emergency interventions before the problem worsens.

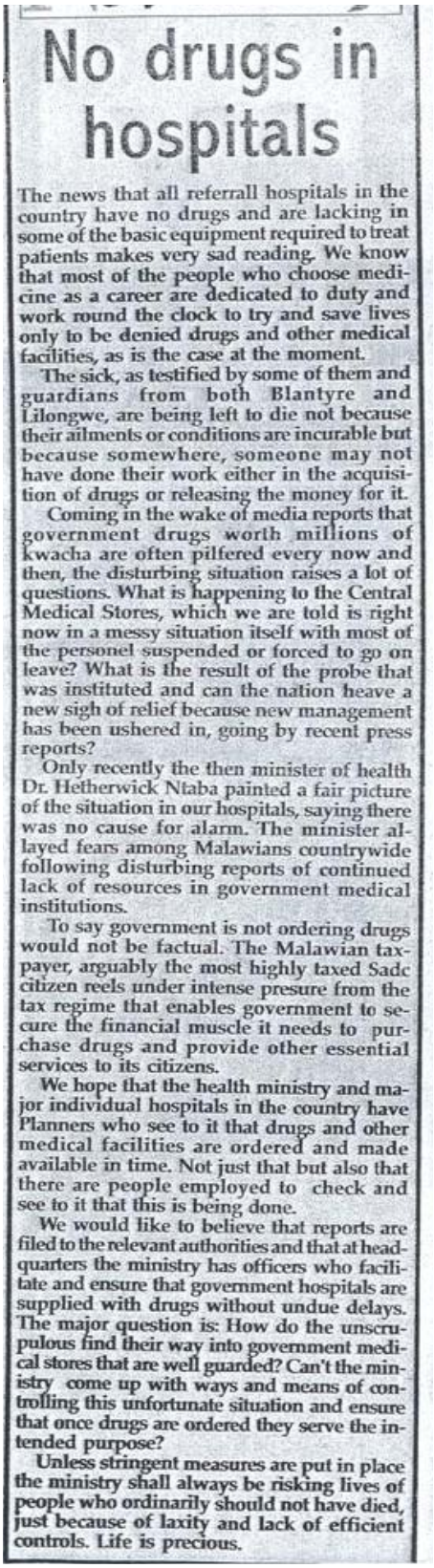
We know that you always intervene and act when the health of your people is at risk. You have taught us to properly take care of patients in the parable of the Good Samaritan. Against all odds, your wisdom in Luke 10:34 says, "He went to him and bandaged his wounds, pouring on oil and wine. Then he put the man on his donkey, took him to an inn and took care of him."

Sovereign Lord, as the parable indicates, let there be enough supplies in hospitals' pharmacies. May our hospitals not run short of drugs, gloves, drips and other essential supplies. We pray that there will be positive results from the meeting our government convened with donors in Lilongwe recently. Let the 'Good Samaritan' spirit in donors bear evident fruits now. May you now complete this good work you started.

Holy Lord, we pray against thievish spirits behind drugs and other medical supplies shortage. Such an irresponsible behaviour puts the health of your people in peril. They suffer in silence when they visit drug starved hospitals. May this selfish practice stop as it breeds unnecessary loss of citizens who could develop Malawi and your kingdom. May you impart your intelligence and wisdom to all procurement officers and supervisors in hospitals. Let them transact and supervise the procurement and supply of drugs and medical equipment with your fear. Help the National Central Medical Stores and regional branches overcome all irregularities.

We pray that government and other concerned institutions co-operate and bring to book people who engage in corrupt and illegal drug businesses. God, our great physician, may you remind us all about our divine duty to succour, help and relieve the sick by always acting responsibly. Give us our daily drugs, we pray. In Jesus name. Amen.

Box 6: News reports of drug shortages



No drugs in hospitals

The news that all referrall hospitals in the country have no drugs and are lacking in some of the basic equipment required to treat patients makes very sad reading. We know that most of the people who choose medicine as a career are dedicated to duty and work round the clock to try and save lives only to be denied drugs and other medical facilities, as is the case at the moment.

The sick, as testified by some of them and guardians from both Blantyre and Lilongwe, are being left to die not because their ailments or conditions are incurable but because somewhere, someone may not have done their work either in the acquisition of drugs or releasing the money for it.

Coming in the wake of media reports that government drugs worth millions of kwacha are often pilfered every now and then, the disturbing situation raises a lot of questions. What is happening to the Central Medical Stores, which we are told is right now in a messy situation itself with most of the personel suspended or forced to go on leave? What is the result of the probe that was instituted and can the nation heave a new sigh of relief because new management has been ushered in, going by recent press reports?

Only recently the then minister of health Dr. Hetherwick Ntaba painted a fair picture of the situation in our hospitals, saying there was no cause for alarm. The minister allayed fears among Malawians countrywide following disturbing reports of continued lack of resources in government medical institutions.

To say government is not ordering drugs would not be factual. The Malawian taxpayer, arguably the most highly taxed Sadc citizen reels under intense presure from the tax regime that enables government to secure the financial muscle it needs to purchase drugs and provide other essential services to its citizens.

We hope that the health ministry and major individual hospitals in the country have Planners who see to it that drugs and other medical facilities are ordered and made available in time. Not just that but also that there are people employed to check and see to it that this is being done.

We would like to believe that reports are filed to the relevant authorities and that at headquarters the ministry has officers who facilitate and ensure that government hospitals are supplied with drugs without undue delays. The major question is: How do the unscrupulous find their way into government medical stores that are well guarded? Can't the ministry come up with ways and means of controlling this unfortunate situation and ensure that once drugs are ordered they serve the intended purpose?

Unless stringent measures are put in place the ministry shall always be risking lives of people who ordinarily should not have died, just because of laxity and lack of efficient controls. Life is precious.

Within the health sector reforms, the Central Medical Stores (CMS) has been changed from a procurement agency to a store and new external management contracted in April 2006 to improve quality and timeliness of supply and delivery of drugs and medicinal/ pharmaceutical products. A procurement unit in the MoH manages drug procurement. An assessment of the new arrangement the procurement audit was underway in 2006.

There has also been a move towards establishment of autonomous hospitals where human resource management may offer better conditions of service, motivation and incentives and thereby improve staff retention. While it is presumed that service delivery and quality would improve consequent to the creation of autonomous hospitals, there still lies a concern about the possible financial barrier such a move would impose. This change thus needs to be monitored.

It is argued that Malawians are willing to spend on health care services if perceived to be of good quality in terms of availability of quality drugs, friendly service providers and a clean environment. Most public health facilities have been shunned if perceived to be user-unfriendly and poorly stocked with drugs.

4.3. Improving the conditions for safe motherhood

The trend of maternal mortality (MMR) in Malawi has not improved over the years (see *Table 5* and *Figure 3*).

Source: The Voice of the Nation on Sunday.

Table 5: MMR trends in Malawi (1986-2000)

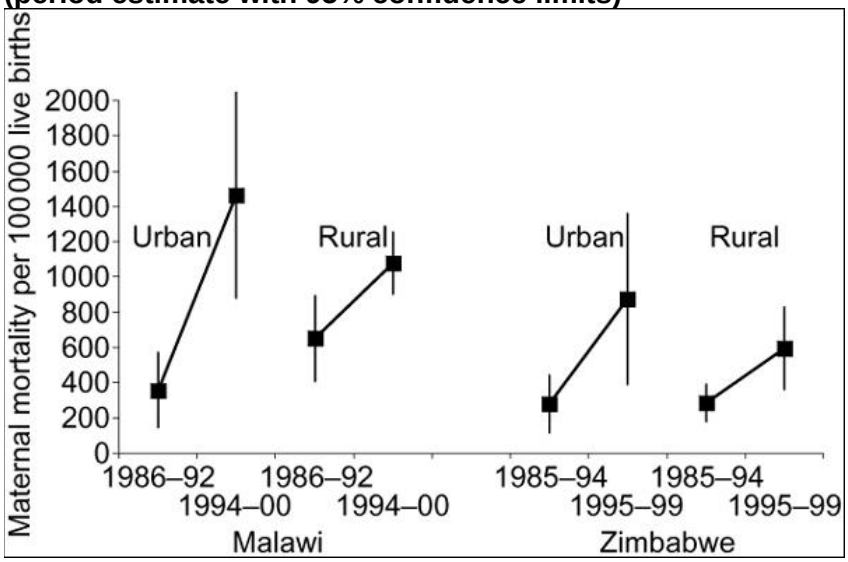
Country	Year of survey	Number of respondents (women 15–49 years)	Period of estimates	Overall mortality per 1000 women 15–49 years (person years)	Pregnancy-related mortality per 1000 women 15–49 years (person years)	General fertility rate per 1000 women 15–49 years	Maternal mortality per 100 000 live births (95% CI)[a]
Malawi	1992	4849	1986–1992	6.5 (51 951)	1.4 (51 951)	0.220	620 (410–830)
	2000	13 220	1994–2000	11.3 (145 174)	2.4 (145 174)	0.210	1120 (950–1288)
			Rate ratio[b]	1.76 (1.56–1.99)	1.72 (1.33–2.25)		1.81 (1.39–2.37)
Zimbabwe	1994	6128	1985–1994	3.3 (114 169)	0.5 (114 169)	0.162	283 (195–371)
	1999	5907	1995–1999	9.1 (58 052)	0.9 (58 052)	0.135	695 (471–919)
			Rate ratio[b]	2.80 (2.45–3.20)	2.12 (1.42–3.17)		2.50 (1.68–3.72)

CI, Confidence interval.
[a]Maternal mortality reported in demographic and health surveys is standardized on the household age structure.
[b]Age-adjusted rate ratio with 95% confidence limits.

Source: EngenderHealth and UNFPA, 2003.

The direct and indirect causes of maternal mortality determine the current services that respond to this mortality. Worse maternal outcomes in most cases arise from pervasive gender inequities that sometimes prevent women's access to transportation and emergency obstetric care. The timing or source of care is a decision women may not make on their own. This is usually made by an uncle (or, occasionally, husband); without their input, and a woman would be unlikely to seek care on her own (UNFPA, 2003).

Figure 3: Maternal mortality ratio trends in Malawi and Zimbabwe during the 1990s (period estimate with 95% confidence limits)



Source: McCoy et al, 2004.

Cultural context: *In some areas, it is traditionally believed that if a woman has prolonged labour, she has had other sexual partners and must confess in order for childbirth to proceed. Women giving birth for the first time are*

expected to deliver at home in the presence of relatives. In addition, women often lack decision-making power and must obtain permission from relatives before seeking health care.

Source: EngenderHealth and UNFPA, 2003.

There is thus a need to deal with the social health determinants of maternal mortality. Most services designed to improve maternal health have focused on improving delivery of health services, including:

- increasing health facility infrastructures
- increasing human resources
- training health providers in skills and knowledge
- increasing medical supplies).

However, services to address the underlying causes of poor maternal health at community level (where women stay throughout pregnancy and post-delivery and which have a lot of influence on health outcomes) are sidelined. Mann et al (2005) state that, social, cultural and economic factors lead to inequitable access to health services and contribute to poor maternal health.

The Safe Motherhood Initiative (SMI) in Malawi aims to draw attention to dimensions and consequences to poor maternal health, and initiate action to reduce maternal and child death rate and childbirth complications beyond using health service delivery interventions alone (Maine, 1993).

Existing maternal and neonatal health services are not serving every one equitably at community level due to social, cultural factors which determine accessibility, acceptability and quality of services and change in behaviour, attitudes and practices and role of community leaders. We believe that Safe motherhood is a right to every woman in child bearing age that will never be realised without equity in accessing maternal health services and community social support starting to every woman.

Source: Ng'ombe et al, 2006.

Strong evidence exists:

- of social barriers in maternal and neonatal health care and support; and
- that existing maternal and neonatal health services are not serving all.

New strategies are needed to deal with this, beyond health service provisioning. Many cultural beliefs and customs surround and jeopardise the outcome of the pregnancy. Improving knowledge and behaviour, attitudes and practices at community level would eventually increase access to health services. The role of community leaders is of paramount importance in this regard. It is also important that pregnant woman and community be empowered in decision-making on health and that they have the means and power to make appropriate choices in using health services to improve access to maternal and health services in general.

The discussion generated by CARE in the equity meeting noted that unless the underlying factors affecting MMR are dealt with, inequities would continue. To address inequalities, capacity building among community leaders is crucial in identifying and addressing these prevalent social inequalities. On the provider's side, equity in safe motherhood entails appropriate health services that are adequately available and sufficient, economically and physically accessible, acceptable in cultural and gender contexts and of good quality by meeting people's needs.

Figure 4: Community leader involvement in decision making in health in Malawi

Source: REACH Trust photo library.

Box 7: CARE International work on safe motherhood in Malawi

Care International in Malawi is trying to promote equity in safe motherhood through a three year pilot research project in Ntchisi district, Models for Inclusive and Equitable Sexual and Reproductive Health (MINERSH), aims at addressing social inequalities in maternal and neonatal health (MNH). The overall goal is to improve equitable social and health service support for all mothers and pregnant women with specific objectives of understanding social equalities in relation to MNH, building the capacity of community leaders in identifying and addressing social inequalities and developing a model for improving MNH at community level.

The project is being implemented in the communities of Mkhalapathumba, Mndimba and kafulu in Ntchisi district. It is working on the hypothesis that improvement in quality and access to health services alone does not improve MNH. There are social determinants which influence individuals from communities to utilise the available quality health services leading to inequitable access to MNH services.

The project is using social analysis and action approach to health development which uses a process that challenges social attitudes, structures, and norms. This approach directly addresses issues of human rights and equity by identifying differences in access and health outcomes between different sub-groups in the community and challenges the communities' acceptance of that status quo.

The challenge process directly addresses underlying causes of poverty and poor health by challenging community assumptions about equity, social exclusion, and gender. It also catalyzes their capacity to respond to these causes by encouraging reflection, mobilisation and action. Recognising that social support is often one of the variables that contribute to inequity and poor outcomes, increasing social support is one of these actions. This is different from a more "normal" project approach where specific needs are identified and the project is expected to work with the community to address them in more of a "service delivery" approach.

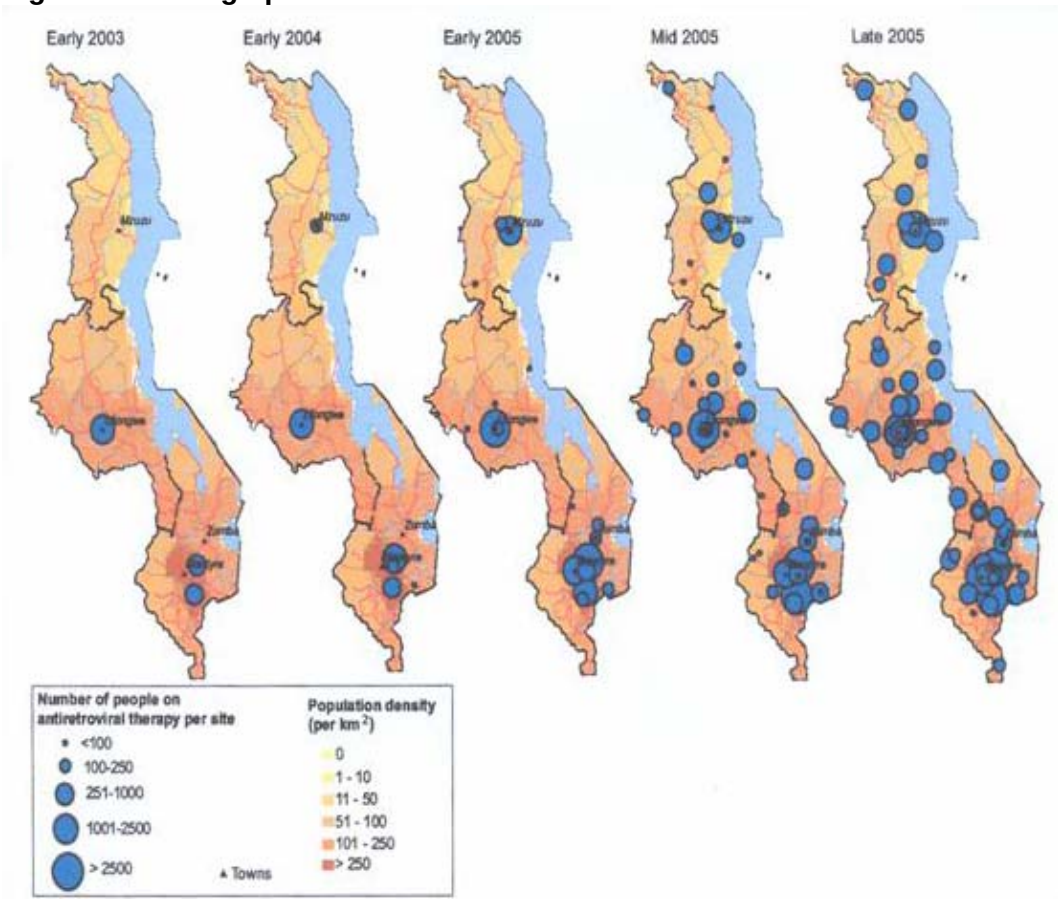
We are working with community core groups in each community with which we have developed MNH information package. This package is a minimum standard for maternal and newborn health care that every woman is supposed to receive. Together with the core groups, we are developing strategies for making sure that every pregnant woman gets the information and the prescribed care by the community. The community leaders have also developed mechanisms for tracking pregnancy outcomes and unsupported pregnant women and we are yet to develop mechanisms for supporting the unsupported in terms of social support when pregnant and accessing minimum standard healthcare. Although we have one more year before the end of the project, we have seen tremendous changes in the community leaders who are core group members. For example discussing sexual and maternal health issues in public, in mixed sexes, in the presence of chiefs, taking up responsibility for the health of community members, constructing a road and drawing plans for interventions to address identified inequalities.

Source: Ngo'mbe, 2006.

4.4. Equity in ART roll out in Malawi

The UNAIDS / WHO '3 by 5 initiative' (2003) ignited broad response to HIV and AIDS. Malawi decided to advance to cover the whole country in ART delivery and there has been a significant increase in the number of ART delivery sites; from three in January 2003 to 60 by September 2005 (see *Figure 4*).

Figure 4: Scaling up ART in Malawi 2003-2005



Source: WHO, 2006.

Fortunately, Malawi has seen a number of key stakeholders interested in the roll out of ART against the odds of human resource shortage and poor infrastructure. Of note are the National AIDS Commission and the UNAIDS who have been instrumental in advancing the provision of ART. Equity in access to ART has been a great concern for many equity actors. Oxfam, for example commissioned a study to assess access to ARV drugs in Malawi. A number of issues were identified in the April 2006 meeting to impinge on equity in the current roll out: The entry point to ART provision is counselling and testing services. Owing to the need for appropriate staff, the absence of such services hinders access to ART despite clear policy provisions for what has to be done. There are constraints in the capacity to distribute the drugs, considering the distribution of health facilities in the country that may bias towards those facilities in urban locations and the increased poverty and lower levels of education for those communities further from urban areas. Poverty and illiteracy impede access even where geographical barriers are lower and to enhance equity in public facilities, ART is given free at the point of delivery. Access to correct information about ART is paramount to equity and access to antiretroviral therapy. Knowledge about issues surrounding ART is the primary drive to making decisions on accessing the service (Ntata, 2005):

> *Equity comprises elements of an assessment of vulnerability (in terms of HIV infection and illness) and disadvantage in terms of access to care and treatment or ability to cope with the impact of the illness. Furthermore, in a health system where resources are severely limited, it is also important to include an assessment of the impact that provision of ART will have on 'equity' for the provision of essential health services. An analysis of 'equity' in access to ART, refers to the analysis of the provision of and benefit from ART according to 'need'. An analysis of equity therefore involves asking who benefits from ART and whether this corresponds to need. 'Who' refers to different social groups of people, usually disaggregated by axes of vulnerability such as gender, socio-economic status, age, location, or ethnic group. Inequities are inequalities in access to ART that are judged to be unfair; that is they are both unacceptable and avoidable.*

Concerns exist about the rapid roll out of ART delivery service. There is danger that ART provision might accelerate inequalities in health and health care services as more resources, financial and human are directed to ART services than to the EHP. Looking at the nature of the service, a vertical approach to ART provision would entail inappropriate and ill coordinated vertical programmes. Thirdly, due to centralised provision of ART unintended and undesirable opportunity costs related to the diversion of scarce health care resources to treatment programmes.

While progress has been made in ART provision in Malawi, there are also areas that need addressing if equitable access to ART is to be universal. Makwiza et al (2005) observe that there are geographical differences in accessing ART in Malawi with only 10% of all the people on ART from the northern region and 21% and 62.9% those from the central and southern regions respectively. Gender differences also exist with more females on ART in all the three regions; more remarkable in the southern region where 64% females against 36% males were on ART seconded by the northern region with 58% of females being on ART against 42 males and the central region with 51% of females on ART versus 49% of males. Further work needs to be done in the northern and southern regions to determine the factors that lead to such disparity between females and males accessing ART. Then there is inequity in age. Of those on ART, only 3.1% of children were reported to be on ART (Makwiza et al, 2005).

Studies show that HIV prevalence is nearly twice as high in urban as in rural areas, higher among young women than among young men and higher in the south of the country than in the north. This distribution does seem to follow the distribution of services (more in the south, more women) and means that to some extent services are following the burden of disease. However, the uptake of counselling and testing is lower among the poor and that coverage rates in the poorest 20% of the population is about half those found in the top 20%. Testing is also higher among urban settings and among the better educated people. (Makwiza et al, 2005)

The need to promote equity in access to ART is thus a persistent one. Suggestions made include promoting equitable access to ART, decentralising ART provision to the rural areas and to giving special consideration to poor, marginalised and vulnerable groups, like disabled people and children. In addition, adherence to ART should be promoted through strategic monitoring and support, including by engaging community-based organisations in different rural and urban settings.

5. Conclusions

This review and the meeting held confirmed that inequalities in health persist in Malawi, are affected by social determinants like poverty, gender and the social roles and status associated with these factors and by access to health care. Equity in access to health care is on the agenda in Malawi. Specific measures are in place to enhance equity and access, including decentralisation and SWAp as an instrument to deliver EHP, especially to rural poor communities. These approaches still face constraints and while programmes like the Expanded Programme on Immunisation (EPI) has reduced childhood diseases, other issues such as access to ART, safe motherhood, TB services and other health care services remain problematic and the social determinants of maternal mortality and HIV transmission still need to be addressed.

Challenges to equity and access in health care services not only lie in the community level factors that lead to social differences in use of services, but also in the adequacy and sustainability of financing and the adequacy and retention of health workers in the health system. The *Equity and Access Monitoring Sub-Group*, the MHEN and the network of equity players within the civil society organisations represent important institutional mechanisms to monitor, review and discuss these barriers and identify options for responses.

Figure 5: Participants to a Malawi meeting on equity

Source: REACH Trust photo library.

While there is organisation of technical resources through research, government institutions and the health management information system, one of the biggest challenges now is the public advocacy for health equity. This places a challenge on MHEN to mobilise a vibrant membership to embrace equitable and accessible quality health care focusing on the social and service needs for health equity and participating in the organisation of responses from local to national level. There is significant consensus on the challenges and direction, shared policy directions and many equity actors are in place. These are critical ingredients for the sort of concerted effort needed to achieve the goals and ideals of equity and access in health in Malawi.

List of Acronyms

EQUINET	Regional Network for Equity in Health in east and southern Africa
MoH	Ministry of Health
NGO	Non-Governmental Organisation
CBO	Community-Based Organisations
TB	Tuberculosis
DOTS	Directly Observed Treatment Short course
REACH	Research on Equity and Community Health
ESC	Extending services to the Community
LCS	Linking Civil Society with TB care
MK	Malawi Kwacha
NHA	National Health Accounts
EHP	Essential Health Package
SWAp	Sector-Wide Approach
ARI	Acute Respiratory Infections
ITN	Insecticide Treated Nets
PMTCT	Prevention of Mother To Child Transmission
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immunodeficiency Syndrome
STI	Sexually Transmitted Infections
HMIS	Health Management Information System
CHAM	Christian Health Association of Malawi
GoM	Government of Malawi
ME&R	Monitoring, Evaluation and Research
TWG	Technical Working Group
PoW	Programme of Work
MMJ	Malawi Medical Journal
MHEN	Malawi Health Equity Network
WHO	World Health Organization
HRH	Human Resource for Health
DFID	Department for International Development
UNFPA	United Nations Population Fund
USD	United States Dollar
CMS	Central Medical Stores
ART	Antiretroviral Therapy
ARV	Antiretroviral
CARE	Coordinating Assistance of Relief Everywhere
UNAIDS	Joint United Nations Programme on HIV/AIDS
IMR	Infant Mortality Rate
DHS	Demographic Health Survey
MMR	Maternal Mortality Rate
CPR	Contraceptive Rate

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Equity actors involved /consulted in the country report and meeting

CARE Malawi
Christian Hospital Association of Malawi
Consumers Association of Malawi
Malawi College of Health Sciences
Malawi Economic Justice Network
MANET
MANASO
NAPHAM
Nurses and Mid-wives Association of Malawi
Safe Motherhood Project
National TB Control Programme
REACH Trust
White Ribbon Alliance for Safe Motherhood
National AIDS Commission
Save the Children USA
Ministry of Health
Equity and Access Technical Working Group
SWAp Unit
Malawi Health Equity Network
World Health Organization
CHESSORE/ EQUINET

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Equity in health *implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.*

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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