

# **MONITORING EQUITY AND HEALTH SYSTEMS ISSUES IN ART PROGRAMMES IN SOUTHERN AFRICA**

**REPORT OF A REGIONAL MEETING  
Lilongwe Malawi, 7-8 October 2004**

**Southern African Regional Network on Equity in Health  
(EQUINET)**



**in co-operation with  
EQUI-TB Knowledge Programme, Malawi**



**With support from  
Training and Research Support Centre, Zimbabwe  
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# MEETING REPORT

## MONITORING EQUITY AND HEALTH SYSTEMS ISSUES IN ART PROGRAMMES IN SOUTHERN AFRICA

**EQUINET, EQUI-TB Knowledge Programme, Malawi  
October 7- 8 2004, Lilongwe, Malawi**

*'ART through strengthened health systems'*

### 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. In 2003-2004 EQUINET carried out a programme jointly with various institutions in southern Africa and Oxfam GB to inform the policy debates that have grown around health sector responses to HIV and AIDS in the region, particularly with respect to care and treatment access. This programme explored the equity dimensions of the policy choices that are being made within health policy around health services, treatment access and resources for health care. The programme commissioned and produced country research papers (from Zimbabwe, Malawi and South Africa) and a SADC regional paper and further papers on health personnel, nutrition and food security.

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. The work carried out in 2003 generated evidence from a number of countries that district-based ART approaches, extending to primary care and community level appear to combine coverage and equity, and have the greatest likelihood of being replicable within the reality of health systems in southern Africa. This approach uses the resources of the hospital and primary health care outreach for improving treatment access, and uses treatment resources to strengthen the health system.

To follow up on the work carried out by EQUINET in 2003-04, a regional meeting was hosted by EQUINET/Oxfam working with SADC in February 2004 to provide more substantive presentation of the papers and to discuss the follow up work and policy interventions arising from the work. Among other areas, this meeting identified monitoring equity in access and health systems issues as an important, informative and integral part of this approach.

Through the Training and Research Support Centre Zimbabwe, EQUINET carried out work to assess the existing monitoring taking place in relation to expanding ART coverage. EQUINET also contracted the Equi-TB Knowledge Programme, 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. The generic framework developed through this contract aimed to use Malawi as an example to illustrate which equity-related data are available or can be collected to measure equity in ART implementation, and their sources. The proposed Malawi case study would also be used to make recommendations on issues and areas of monitoring to inform regional monitoring activities.

In follow up to this work a meeting was held on 7-8<sup>th</sup> October 2004 in Lilongwe, Malawi. The **aim of the meeting was to:**

- Agree on the policy commitments/ issues/ questions being monitored
- Agree on and refine the thematic areas that respond to these policy concerns and the monitoring objectives in each
- Review and agree on the principles of a monitoring system at national and regional level
- Agree on or modify/add to the proposed indicators and sources and identify responsible institutions for their collection and analysis
- Agree on analysis of indicators and reporting to address policy issues
- Discuss and agree on the institutional framework for a monitoring system at national and regional level, with roles and relationships, in line with and incorporated into existing NAC M&E plans
- Identify 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

This report summarises the proceedings of the meeting. The delegates to the meeting came from countries in the Southern African Development Community (SADC) region and from government, academic, civil society, international and UN agencies and regional organisations. The delegates list is shown in Appendix I and the meeting Programme in Appendix II. The official opening speech is in Appendix III. The report has been compiled by Equi-TB programme and the Training and Research Support Centre.

## 2. Opening

The meeting was opened on the evening of 6<sup>th</sup> October 2004 with a welcome dinner. Boniface Kalanda of Equi-TB Knowledge Programme welcomed the delegates to Malawi and asked them to introduce themselves. The delegates were formally welcomed by Dr Bismark Mwale, the Executive Director of the National AIDS Commission in Malawi and a formal opening of the meeting was made by the Principal Secretary of HIV and AIDS and Nutrition, in the Ministry of Health, Malawi, Dr. Mary Shawa (Appendix III). In her opening, Dr. Shawa bemoaned the high HIV prevalence in the southern African region, with 15 million people infected and 700,000 to 1 million in the advanced stages of disease. She observed that the epidemic grows with high hidden costs, such as that of providing care for those with AIDS, which places a high burden on state and family and diverts resources from other important needs. Dr Shawa also noted that at hospital level, AIDS is putting enormous pressure on bed capacity. She cited Malawi as an example where close to 90% of hospital beds are occupied

by people with AIDS. She queried why out of the six most affected countries in Africa, five were in SADC, and whether factors other than poverty played a role.

Dr Shawa reminded the delegates of the poor access to ART in the region. Out of every 25,000 people in need, only 1 person had access, she said. Poor access was related to lack of money and long distances to clinics. In Malawi, plans provide for 61 clinics country wide scheduled to provide ART, of which twenty-one are providing ART already. From these sites, over 9,600 Malawians were reported to be on ART. Dr Shawa said that her ministry intends to have over 36,000 people across Malawi accessing ART by the end of June 2005.

Coming specifically to the objectives of the meeting, Dr Shawa said equity in access to ART is important. She noted the importance of looking at equity from the perspective of the whole population and from a gender perspective, due to the disadvantaged position of women in society. She noted that that monitoring equity in ART access and health systems support was a new area and must be done as a whole package taking into consideration issues of manpower needs, finances and other health system needs.

Dr. Rene Loewenson, EQUINET Programme Manager closed the evening session by welcoming the delegates on behalf of EQUINET. She outlined EQUINET's mission to support equity in health in the region, and particularly noted the importance placed by EQUINET on regional integration and thus on organisations like SADC. She noted that it was through regional co-operation that the full capacities and potentials of the populations, resources and capacities of the region could be tapped to face challenges such as widening treatment access for AIDS and preventing HIV. She thanked the Equi-TB programme and Malawi government for their work in this area and noted the significant expertise and experience in the meeting. She hoped that this would be shared to develop and take forward proposals to integrate monitoring of equity and health systems within national and regional monitoring of ART and AIDS programmes.

### **3. Overview: Equity & health systems issues in ART expansion**

Dr. Rene Loewenson, Programme Manager EQUINET presented an **overview on equity and health systems issues in ART expansion** using data from the region. She outlined a working definition of equity in health as addressing differences in health status that are unnecessary, avoidable and unfair. Equity motivated interventions seek to allocate resources preferentially to those with the worst health status (vertical equity). She noted that EQUINET seeks to understand and inform the power and capacities of people, social groups and national authorities to make choices over health inputs and their capacity to use these choices towards health.

Health systems include:

- ♦ public health, or the protection and promotion of population health and prevention of ill health
- ♦ the provision of relevant, quality health services and care for all according to need and financed according to ability to pay
- ♦ measures to build and secure the human resources and knowledge to shape and deliver public health and health services, and
- ♦ measures to protect and ensure the social values, ethics and rights that underlie health systems, including that of participation and involvement and protection of

domestic regulatory policy flexibility from encroachments by conditionalities on international agreements.

She noted that in dealing with treatment access, falling drug prices, the Doha provisions in TRIPS and the availability of large funds for drug procurement has meant that the focus has shifted somewhat from price and market access to the distribution systems for drugs, (ie the health systems) and to equity in access to drugs. She observed however that the gains in market access were fragile and easily reversed and called for longer term attention to issues of local production of generics for treatment of AIDS and other conditions.

Equity issues in treatment access are being dealt with against a background of wider inequities in health and health care. This meant that ART expansion should at a minimum not worsen inequities and should tap opportunities for and strengthen equity. This raises a number of challenges given evidence of existing inequities in AIDS programmes, eg in shortfalls in access to prevention interventions, the bias in interventions towards urban communities; the gender bias in VCT and other services, the social barriers to access to services (such as income, stigma and other demand side factors), and the real issue of limited health and treatment resources implying trade offs with other areas of service provision and choices to be made in who gets treatment.

To better deliver on equity goals, there is need to assess

- how far treatment is reinforcing prevention;
- the geographical distribution of interventions, including treatment;
- the explicit measures being used to overcome gender bias in access;
- the explicit social interventions and how access distributes across social and economic groups;
- the opportunity costs and trade offs of treatment programmes in relation to other areas of service provision and other public health needs;
- the fairness of the choices made and of the process for making these choices.

It is recognized that equity issues demand a wider strengthening of health systems. The July 2003 SADC Maseru Declaration called for responses to AIDS through strengthening health care systems, especially public health services. This reinforces evidence that investing in public sector health services is strongly associated with improved health equity. Despite this only one country in the region has been able to meet the Abuja commitment for public expenditure on health as percent of general government expenditure to be above the 15% target. Inadequate resources for health combine with a "human resource conveyor belt", where staff migrate out of public sectors in developing countries to the wealthier private tertiary health care system and to richer, industrialised countries. Market reforms that have weakened the prevention and primary health care level of health systems has exacerbated this trend. ART programmes operating in this environment can focus on curative care and emergency responses or reinforce public health planning, health systems and PHC. They can reinforce a virtuous circle of strengthened health systems and strengthened ART access, or weaken health systems and thus ART delivery in a vicious cycle. If a health systems strengthening approach is to be used, then various issues need to be addressed, including:

- How effectively resources for AIDS are being integrated within and absorbed by health systems?
- How far ART programmes are strengthening district health systems?

- How effectively are the wider systems resources needed for ART expansion (human resources, health infrastructure etc) being planned, invested in and organized?
- How well the different private providers are co-ordinated within national policies and systems?

She noted that while there are new global resources for ART, this should not distract from efforts to address the significant resource flows leaving southern Africa due to repayments on debt and health personnel migration, both of which are undermining the resource needs of public sector health systems.

EQUINET has identified areas of support to national strategic plans and the SADC Business plan to reinforce health equity, including to:

- Inform development of policy principles and guidelines on equitable health system strengthening approaches to treatment access in the region
- Support regional advocacy for these policy principles
- Strengthen health systems and equity literacy within treatment literacy
- Support exchange of information on good practice options in equity and health systems strengthening and treatment access in the region
- Support monitoring and reporting on health systems and equity policy principles at subnational, national and regional level
- Implement research and analysis on ART related equity and health systems issues
- Contribute to regional networking and exchange of information, knowledge, debate and options.

Dr. Erick Schouten, HIV/AIDS Co-ordinator in the Ministry of Health, Malawi presented **discussant comments on the overview paper**. He noted that all scaling up involves making choices, and that it is often after making those choices that equity is built into them. Given the need to address the major inequity of lack of access, “rapid scale-up” in all districts is critical. He outlined how these issues were dealt with in Malawi. In Malawi, it was decided to speed up expansion by making the ART regimen as simple as possible, making training for staff to administer ART as short as possible, by not requiring laboratory tests as a basis for initiating treatment and using WHO stage III and IV as criteria for putting people on ART provided the person also understands the lifetime implications of ART. Malawi decided to have free drugs through the public sector and to subsidize up to 80% in the private sector, to bring the private sector within the national training and monitoring framework. Malawi is discouraging mono and dual therapy because of their ease of developing resistance.

He estimated that health care per capita in Malawi costs about US\$14 per patient. Of this \$4 comes from the public sector, \$4 from donors and the rest from out of pocket spending. With a small public sector share of total funding, Malawi has inadequate finances to tackle the problem of HIV and AIDS. About 80,000 – 100,000 new infections occur every year and 250 people die of AIDS everyday. In light of this, Malawi had to decide to either save individuals or to save society, and the latter was chosen. This has led to choices of regimens used (eg use of a standardized first line regime suitable only for those over 13 years, due to the equivalent paediatric regimen not being available in liquid form required for young children) and treatment choices (e.g .not offering cesarean section for all HIV positive mothers) due to the opportunity costs. To promote equity, Malawi distributes ART on a first come first served basis but then has specific outreach measures to enhance service uptake among vulnerable groups. This system avoids putting frontline health workers in a situation where they have to decide on who accesses ART and who does not.

Various **comments and questions** were raised in the discussion. It was noted that equity is about values, and interest was expressed in the discussions and policy process that led to Malawi's position paper on equity in ART access. In response it was noted that the issue of equity was already a policy concern, that the technical work done on the EQUINET paper in Malawi fed into this and was used in a stakeholders' meeting which made recommendations to mandate NAC to make wider consultations on the issue. The wide social consultations then fed into the position paper in Malawi. It was however noted that the ART plan had preceded the equity position paper and the two needed to be 'matched'. Concern was raised that the health systems issues also needed to be addressed, particularly given the huge resource inflows from, the Global Fund to Fight AIDS, TB and Malaria. This drew attention to the human resource plan in Malawi. It was noted that Malawi had embarked on a six year human resource plan with UNAIDS and DFID support, noting that the country could not roll out ART with the present low level of staffing. For example it was noted that 75-80% of health staff positions were not filled in some institutions. There was some debate about local production for ART. It was noted that while cost and efficiency issues led to purchase of internationally produced drugs, local production could reduce longer term costs, but required regional co-operation to establish both the market potential and financial base for it. It also called therefore for regional standardisation of drug regimes (also needed for those who cross borders).

As a conclusion to the session Dr Erika Malekia, Public Health Specialist from SADC notified the delegates that the Chief Director of SADC was very supportive of the meeting particularly at this time when ART is being rolled out in the region. She gave an overview of SADC's organizational structure and of the SADC Regional Indicative Strategic Development Plan (RISDP) and how these carried out the health and HIV and AIDS activities. SADC is now setting up functional Directorates and units. The Social and Human Development Directorate; Health Unit will be responsible for Health Systems, Nutrition, Health Service Delivery and Pharmaceuticals - Medicines and Drugs. The HIV and AIDS issues as cross cutting have been placed in the Chief Directors Department of Strategic planning and Policy harmonization. She noted that she would take the deliberations of the meeting to SADC, and noted the benefit to SADC of the various institutional resources available in the region.

#### **4. Monitoring equity & health systems issues in ART expansion**

Dr. Antonica Hembe, HIV/AIDS Manager at SADC outlined the **principles governing unified systems for monitoring ART expansion**. She questioned the sustainability of the response if it continues to depend on external support and noted that SADC has established a Trust Fund to fight the epidemic to which South Africa has now contributed. She observed that the international community is expanding access to HIV treatment and care, expanding opportunities for ART access. There is now increased political will, financial resources for treatment, care and support and diagnosis and medicines are now more affordable. Despite these positive conditions, access to ART and other HIV-related interventions remains low. Universal provision of ART while feasible is expensive. SADC members states are aligning their national AIDS treatment goals to the '3 by 5' target (namely, aiming to treat half of those in need by 2005). She noted various obstacles impeding the roll-out, including lack of health workers and the need to ensure sustainability of ART expansion through strengthening of health systems, particularly of the public sector services.

To address these problems, SADC has identified unified principles for ART expansion in a new five-year Business Plan,. These include establishing a regional co-ordinating body and embracing the concept of the '3 ones' (one central coordinating authority, one national plan and one monitoring and evaluation system). The regional co-ordinating body will have prevention, care, treatment, resource mobilization, and strengthening health systems for effective HIV and AIDS

response. It will also be responsible for measuring progress toward national and regional commitments. To that effect, in July 2004 SADC held consultations with National AIDS Commissions and international co-operating partners and stakeholders on its Business Plan. The Business Plan highlights areas of activity, including sharing of good practice; resource mobilization, monitoring and capacity support to ensure strengthened and equitable health systems approaches to treatment roll out. Member states have agreed to implement one agreed AIDS action framework that provides the basis for coordinating the work of all partners in the country; one national AIDS coordinating body, with a broad-based multisectoral mandate and one agreed country monitoring and evaluating system.

Through consultation SADC has identified principles governing the implementation of ART roll out to include :

- establishing a fair and transparent process to make informed choices,
- establishing joint health and HIV and AIDS planning,
- integrating treatment into wider health systems and
- setting realistic targets for treatment.

To ensure equity in access and quality of care, SADC proposed having treatment resources integrated into regular budgets, prioritizing human resource development in the health sector and strengthening essential drug policies and systems at national and regional levels. She concluded by emphasizing that actions to expand access to ART should be enforced, sustained and should meet equity principles through strengthened health systems. This can be achieved through practical actions supported by evidence, cost-benefit analysis and continual reflection on lessons learned.

The background country case study for the meeting “**Proposed frame work for monitoring equity in access and health systems issues in antiretroviral therapy (ART) programmes in southern Africa**” was presented by Boniface Kalanda of Equi-TB Knowledge Programme, Malawi. He noted the background of the EQUINET and SADC processes to date, the principles of health system strengthening identified through this process and the priority given to monitoring equity in access and health systems issues in ART programmes. The paper presented a proposed framework of indicators for a comprehensive national monitoring system for equity in access and health systems support in ART programmes in southern Africa, using Malawi as a possible case study to field test their utility. The principles governing any such monitoring were that it be done within the one national monitoring system at local, national and regional level; be simple and relevant; use existing data sources and minimise the number of indicators. Analysis of the principles for health systems strengthening and equity approaches to ART roll out led to seven thematic areas being identified:

1. Fair policy development, monitoring and accountability through fair process
2. Equitable access to ART with realistic targets
3. Fair and sustainable financing and accountable financial management
4. ART programme integration into the delivery of the essential health package
5. Prioritised human resource development to deliver the essential health package
6. Sustainable & accountable purchase, distribution and monitoring of drugs and commodities for ART and the essential health package
7. Ensuring private sector provision of ART is complementary to and enhances public health system capacity

For each of these thematic areas, example indicators were given. The policy issues being monitored and the indicators and sources for this are set out in full in the background document which is separately reported. It was noted that while some indicators can easily be

constructed using routine data, some policy questions can only be answered through deeper research. Examples of these questions as identified for Malawi were cited in the report. Concerns covered issues of barriers in access to and adherence to ART for different population groups, assessment of the effectiveness of strategies used to promote demand among key groups, assessment of good practice and of the costs, benefits and trade-offs of ART programmes on general health service delivery.

He noted that monitoring equity in health is a new concept in Malawi, although national policies (e.g. National HIV and AIDS Policy and National Health Plans) clearly articulate equity principles. The National AIDS Commission has the mandate to co-ordinate and monitor HIV and AIDS activities in Malawi. Based on these institutional arrangements, monitoring equity in access to ART and system strengthening should be co-ordinated by the National AIDS Commission, with the collaboration of the Ministry of Health and Population and other partners. Equity monitoring needs to fit into the annual routine reporting and review cycle of the National AIDS Commission as an area of monitoring in the M&E Plan. He noted that an 'Annual Equity Picture' could be included in routine annual reporting and also disseminated through summaries in popular communication media, structured consultations with specific target groups, and national level consultations with representative organisations. SADC and WHO-AFRO could also use such equity analysis at regional level to lobby for increased resources for ART and health system strengthening in the region.

He welcomed the tabling of the case study at the regional meeting to discuss the thematic areas, review and agree on the principles of a monitoring system at subnational, national and regional level, review the proposed indicators, the institutional framework and identify the required follow-up work.

In the discussion following the presentation, it was proposed that the seven thematic areas be supported by an outline of the common underlying principles for all the areas, which could be equity, accountability (/transparency), sustainability and efficiency. Caution was expressed that the indicators being proposed really measured what was desired to measure. One delegate noted the need to understand what would motivate anybody to measure equity, and ensure that the system spoke to these motivations. It was further noted that the added value of regional monitoring needed to be made clear. There was general consensus of the need to condense the indicators as presented, make their meaning clear, prioritize and reduce them. It was further agreed that the proposed indicators needed to be easily integrated into monitoring systems to avoid overburdening them.

## **5. Areas for Equity and Health System Monitoring**

The meeting broadly endorsed the thematic areas and divided into six parallel sessions to review a presentation and have discussion on the key policy questions and proposed indicators for monitoring in each of the proposed thematic areas. These are shown below, with a brief summary of the initial presentations made by discussants to the case study prior to the discussion on the policy questions and indicators:

### **Session 1: Fair policy development**

Norman Daniels Harvard noted that even if we already agree that equity involves unfair health disparities between different social groups, there are reasonable disagreements about what is unfair and about how to make situation more fair. For example, people might disagree about how much access to give underserved rural populations at the expense of reaching some larger numbers of people in urban areas, even if they agree the unequal access should be eliminated

eventually. Equity is a value-based judgment, rooted in concerns about fairness and distributive justice, but views about this vary among reasonable people. There is thus a need for a procedure to determine what is fair. When we lack priori agreement about exactly what counts as fair, we may rely on a fair process to determine what we shall accept as fair. Fair process means decision-makers will be accountable for meeting this conditions: they must be transparent about the rationales for their decisions; they must involve relevant stakeholders in reviewing rationales to make sure they are based on relevant considerations; the decisions should be revisable in light of new evidence and arguments, and there must be enforcement of these conditions. To monitor fair process, there should be indicators on it transparency, on the inclusion of relevant stakeholders, and on its response to criticism. He pointed out that it is important to make clear the sources of data, to embed indicators in an integrated framework that is connected to outputs in terms of equity, with the rest of the health system. He suggested that a coalition using evidenced-based monitoring can be a useful instrument for policy review and change of unfair or ineffective policy. He also suggested that putting an emphasis on fair process in scaling up can serve as a model for improving fair process in the rest of the system.

### **Session 2: Fair financing**

Douglas Hamilton, DCI Mozambique noted that in looking at fair financing, it is important to look at both macroeconomic issues (eg: IMF ceilings on public expenditure) as well as national level expenditures as these wider policies affect the MOH, NAC and other national institution's budgets. On the whole fair financing calls for overall increases in health funding and this should be seen to be in line with overall public priority sector expenditures as in the PRSP to avoid opportunity costs on other priority sectors such as those areas servicing education, health, water and sanitation and food security. He then reviewed the proposed monitoring framework and made suggestions for improving the indicators proposed.

### **Session 3: Integration into health services**

Amon Mpfu of the National AIDS Commission, Zimbabwe, noted key equity and health systems issues in ART programmes. He noted opportunities that ART provide of new resources for public health systems, including:

- ensuring training and rewarding human resources,
- enhancing public financing,
- health infrastructure,
- laboratory and essential drug inputs and
- for wider chronic disease programmes.

ART can strengthen current home based care, VCT, PTMCT and testing programmes, and strengthen the services that provide these inputs, such as antenatal care. At the same time he observed some potential threats. The high level of donor funding threatens ownership and sustainability, there is a possibility of human resources being diverted from other health services, and there are many social and service barriers to access, particularly for children and vulnerable groups. Unless these health system issues are addressed, there is a risk of programmes not being sustained.. He proposed critical components for successful integration of the ART programme, including improved infrastructure; laboratory equipment, logistics and procurement procedures, staff and patient education and monitoring and evaluation.

### **Session 4: Equity in the public –private mix**

R Stewart, HST highlighted fears that in ART roll-out, fragile health systems could be overwhelmed and that resources could be inappropriately redirected. ART programmes should thus be developed in a manner that strengthens health systems and particularly the complementarity of private and public sectors. For this it is necessary to disaggregate the private sector into 'for profit' (e.g.: commercial, private GPs, medical insurance schemes and

traditional healers) and 'not for profit' (e.g. non government and community based organisations and religious organisations/mission hospitals). It was further noted that whether or not the workplace should be included in the private sector or regarded as a "third entity" sector needs to be resolved. There are various issues of concern related to private sector roles in ART programmes such as ensuring quality and standard of services like VCT, patient follow-up and counselling. It is important to make sure that the drug regimens used are the best available and are standardised across both the public and private sectors. In terms of monitoring, a single system would be a challenge given the different interests, needs and protectionism between the sectors and calls for overcoming antagonism and suspicion between government and private sector, and the current scarcity of readily available data in both the public and private sectors, including baselines from which impact may be measured.

### **Session 5: Human resource issues**

Ashnie Padrath Health Systems Trust South Africa noted there is an absolute shortage of skilled health care workers (HCW) in Southern Africa. The distribution of human resources for health (HRH) is characterised by various forms of inequity between public and private health sectors; urban and rural areas; tertiary and primary levels of the health system and exacerbated by migration out of the country. She noted that there is a triple burden of HIV/AIDS on health care workers as workers; carers and patients. This leads to sudden vacancies; long term indefinite leave; reduced availability for employment; short term absences from work; reduced capacity to train future workers; loss of institutional memory; increased workloads leading to stress and burnout; loss of job satisfaction; increased direct and indirect costs and increased risk of infection with HIV. Real or perceived increased risk of HIV can lead to great psychological stress. To address these problems, there is need to strengthen the health system as a whole; address broader endogenous and exogenous factors that contribute to internal maldistribution and migration; develop policies for production, retention and recruitment of health care workers and to monitor the effects of policies and equity impact of national ART programmes. Monitoring should encompass:

- Baseline information on distribution of health care workers.
- Effect of policies designed to retain, recruit and produce more health care workers
- Whether provision of ART is leading to inequitable outcomes
- Effect of ART policy on morale and job satisfaction of health care workers

Monitoring on HRH should have indicators on recruitment and retention; re-distribution; training and production and on the impact of ART on HRH and health services.

### **Session 6: Equity in access to ART**

Ayanda Bekwa ALP/ TAC proposed that the major barriers to equity in access to ART are distance to health sites providing ART, linked to issues of availability and costs of transportation. In South Africa for example, in poorer provinces treatment sites are located in central areas and people in the periphery of the province have difficulty in getting to these sites. She noted other issues, including the integration of prevention services in the ART programme, whether and how health workers access ART, overcoming the rural/urban divide, providing for access in children, such as through paediatric formulations for ART, ensuring that ART programmes do not compromise PMTCT uptake and avoiding competition between richer and poorer provinces in terms of drug procurement, human resources and implementation For monitoring equity in access, she suggested looking at:

- Adherence patterns between sexes
- Access among vulnerable groups e.g., prisoners, sex workers, IDUs, gay people

Management systems of ART sites was considered important as well as capacity of treatment sites to render services. The problem of waiting lists prevents those who are need to access and the solution could be to decentralise the ART programme to community health centres and local

clinics. In the discussion it was noted that cost is a major issue, particularly the cost of treatment and testing and the additional and sometimes 'hidden costs' such as transport, lost productivity and other opportunity costs of treatment. The group agreed that a priority was to disaggregate monitoring data by sex, ethnicity, geographic location and socioeconomic status, and concurred broadly with the indicators proposed in the background document.

All groups later assembled for plenary. Each group made presentations on the findings from their respective groups and this was discussed and reviewed in plenary. The table below summarises the areas of monitoring identified by the groups and discussed in the plenary synthesized into one framework. It shows the policy questions identified for monitoring, the possible broad indicators and level of disaggregation and analysis of the indicator.

### LIST OF EQUITY AND HEALTH SYSTEM INDICATORS FOR ART MONITORING

Priority policy questions to be answered	Monitoring will report on whether	Level of monitoring/ reporting
<b>Fair policy development</b>		
Was the treatment policy developed through a transparent and revisable process?	Documents describe how policy was developed, rationale for decisions made An appeals process is publicly available The monitoring framework and reports are publicly available	District, community National
Are the policies taken to local level and enforced?	The policy was discussed at local level, monitoring and evaluation framework and reports are available at local level	District Community
Do the stakeholders judge the policy choices to be legitimate and relevant?	It is publicly known who was involved in the decision making Stakeholders give feedback to the groups they represent Stakeholders implement the policy	District, community National Regional
<b>Equity in access to ART <sup>1</sup></b>		
Who is accessing ART?	ART Clients by: ◆ Age and Gender ◆ SES ◆ Social groups (eg race/ ethnic) ◆ Poor/non-poor ◆ Distance to Health centre ◆ Vulnerable population <sup>2</sup> Specific measures to enhance uptake in vulnerable groups (and ART client cover in those groups)	District, community National collation and analysis and reported to Regional level  District, community
What is the distribution of drug supply and procurement systems?	Distribution of dispensing sites Frequency of stock outs International price comparisons Proportion of facilities with stock of specified drugs expired	National District, national National/ Regional I District

<sup>1</sup> Many of the financing, health service, human resource and public-private mix indicators are relevant to this section and so are not duplicated

<sup>2</sup> Such as orphans and vulnerable children ; prisoners, commercial sex workers,

Priority policy questions	Monitoring will report on whether	Level of monitoring/ reporting
<b>Fair Financing</b>		
How sustainable is funding for ART?	Share of domestic vs external funding for ART and for HIV and AIDS programmes Share of external financing with funding time frames of <1yr, 1-3 yrs, +3 years Whether 15% share GDP to health is met	National Regional
How additional is ART financing?	Annual change in ART financing relative to total HIV and AIDS budget Annual change in ART financing relative to total funding of PRSP sectors	National Regional
How equitable and transparent is AIDS financing?	Proportional changes in allocation in response to demonstrated inequity Geographic (region/district) allocations in comparison to need for ART treatment	National District (or the relevant level to which national financing is disaggregated)
Has ART financing improved public sector financial management & absorptive capacity?	Timeliness and 'fullness' of actual disbursements and expenditure vs the agreed disbursement plan for HIV and AIDS and essential health programmes Share of external funding for ART disbursed through the public health sector.	National
Is there public accountability in budget development /oversight?	Whether there is public reporting of budgets and accounts	National, District
'Skewing' effect of ART financing on national priorities	Allocation by different services levels (referral/district/ periphery) Allocation to different HIV and AIDS activities/initiatives (VCT, behaviour change)	National, District Regional
<b>Integration into health services</b>		
How far is the ART programme government owned, vs donor driven?	Proportion of govt vs. regional vs international spending on ART Whether the ART programme is integrated in district and national health planning Share ART funds disbursed through mainstream budgets	National, regional  District, national  District, national
Does strengthening health systems as a whole improve ART delivery?	ART clients per trained staff/population ART clients vs fair financing indicators ART clients vs HR indicators	District, national, regional
How far are health services prepared for ART delivery?	% of districts who meet WHO standards <sup>3</sup> for delivery of ART	National, regional

<sup>3</sup> As set in the WHO consultation in Zambia see <http://www.who.int/3by5/publications/documents/zambia/en/>

Priority policy questions	Monitoring will report on whether	Level of monitoring/ Reporting
Is there synergy between ART programme and other health programs?	<p><b>Using PTMCT as an indicator</b>            % women referred from PTMCT for ART screening            % ART clients coming from PMTCT programmes            Share of staff in PMTCT provision points trained for ART management</p> <p><b>Using TB as an indicator</b>            % TB patients referred for ART screening            % ART clients coming from TB programmes            Share of staff in TB provision points trained for ART management</p> <p>Level of community referrals and support            Quality of management of opportunistic infection<sup>4</sup></p>	<p>District, national</p> <p>District, national</p> <p>District, national</p>
What benefit or harm do ART programmes bring to health systems? <sup>5</sup>	<p>See HR indicators of staff redeployment            See Financing indicators of public budget strengthening, skewing</p> <p><b>Proxy indicators:</b> comparing districts with and without Art services            Antenatal HIV in 15-24 yrs            Immunisation rates in districts</p>	<p>District, national, regional</p>
<b>Equity in the public-private mix</b>		
How are funds for ART strengthening public sector health funding?	ART resources (human, financial) shares between the public and the private sector	Subnational, national, regional
How co-ordinated and regulated is private sector ART provision? <sup>6</sup>	<p>Whether public-private partnerships are formalised            Whether private sector reports to the national health information system            Number of private providers accredited to provide ART            Level of regulation of private providers            Consistency of standards of care for same service /regimen across private for profit, private not for profit and public sector providers</p>	<p>Subnational, national, regional</p>

<sup>4</sup> Possibly using specific identified pppportunistic infections as indicators

<sup>5</sup> Needs research studies to assess costs and benefits of ART spending on Health Systems

<sup>6</sup> Noting the distinction between private for profit, private not for profit, and faith based organisations

<b>Priority policy questions</b>	<b>Monitoring will report on whether</b>	<b>Level of monitoring/ reporting</b>
How complementary is the private to the public sector? <sup>7</sup>	Share of private for profit, private not for profit and public providers providing ART by district % of people with advanced HIV accessing ART through the public, private for profit, private not for profit sector facilities as a share of people with advanced HIV	National Regional
<b>Human resources for health</b>		
Do health systems have adequate human resources for effective ART delivery and AIDS programmes?	Health worker distribution and ratios- health care worker /population; health care worker/ patient. % sites with waiting lists <1 month	District, national, regional  District, national
Where are additional health workers coming from?	Share of HRH brought into service <ul style="list-style-type: none"> <li>• Re-employed</li> <li>• From retirement</li> <li>• New production / training</li> <li>• Recruited from within the region</li> <li>• Recruited from outside the region</li> </ul>	District, national, regional
How are ART / AIDS programmes impacting on push and retention factors for health personnel?	Provision of salary and other incentives for health worker retention ART provision to health workers and their families. Share of staff trained / retrained for ART and generally Health worker level with authority to initiate treatment and do referrals Staff vacancy rates Staff turn over	District, national, regional
Are health systems able to absorb the new health workers needed?	Share of vacant public sector posts, Median time delays from recruitment to employment Whether METF frameworks allow for additional HR spending	National, regional

<sup>7</sup> Needs more detailed research to assess how the public-private mix is leading to movement of people to access service points across different service providers and districts

These policy questions and indicators were identified as a 'broad universe' of information that could be used to assess equity and health systems issues. It was noted that a further round of review was needed to ensure that the questions were addressed through indicators that were already collected, simple, clearly defined, and as few and least burdensome as possible to ensure compliance with the principle of one monitoring system and to ensure that the proposal was manageable.

## **6 Population and sectoral surveys and their link to monitoring**

The last presentation of the day was by Professor Karl Peltzer of SAHARA Human Sciences Research. The presentation outlined options for estimating HIV prevalence through antenatal surveillance and through population surveys. HIV surveillance methods need to provide information to plan national responses for prevention and care. Currently this is derived from antenatal sentinel clinic surveys and household-based surveys. The WHO and UNAIDS estimate of HIV-1 prevalence from antenatal clinics uses a curve-fitting approach with all available data over time, adjusting the median in non-urban sites down by 20% because of under-representation by remote rural clinics. This method assumes that HIV-1 prevalence in pregnant women is a good proxy for prevalence in all adults aged 15-49 years. It also assumes a female-to-male ratio of HIV-1 prevalence of 1.2 to 1. There are concerns about this method::

- Pregnant women only are not necessarily representative of the general population and may actually constitute a high-risk group for HIV infection as they have had unprotected sexual intercourse
- In most African countries the majority of pregnant women actually deliver their babies at home and do not use ante-natal clinic services
- In some countries in Africa no ANC-based surveillance has ever been done

An alternative approach also recommended by both WHO and UNAIDS is the use of household surveys. Many household surveys employ what is known as second-generation behavioural surveillance which combines HIV and behavioural surveillance within the same study. HIV/AIDS household surveys normally involve the use of representative samples of people of either reproductive age only (typically 15-49 among women and 15-54/59 among men) or all age groups that are drawn from the general population. Population-based surveys have not been widely used due to expense, ease of site surveys, and perspectives of leading scientists. Despite this several Sub-Saharan African countries have recently done such surveys, including Zanzibar, Zambia, Mali, Kenya and Zimbabwe's Youth AIDS Survey.

In countries without generalised epidemics such as Mali and Zanzibar there is much more agreement between antenatal survey estimates and those obtained from household-based surveys. Discrepancy arises between antenatal survey and household survey estimates in generalised epidemics eg in Kenya, South Africa, Zambia and Zimbabwe. As a result in 2004 UNAIDS and WHO adjusted figures of the number of people living with HIV/AIDS in several Sub-Saharan African countries and at global level in part as a result of the availability of estimates of HIV prevalence based on household surveys in countries with generalised epidemics as well as adjustments to country's populations.

The Human Sciences Research Council, commissioned by SADC is providing technical support to four Southern African countries, namely, Botswana, Lesotho, Mozambique and Swaziland, to undertake national population-based surveys of behaviour and HIV prevalence this year and next year.

Prof Peltzer suggested population indicators for equity and health systems aspects of ART programmes, including

- % of people with advanced HIV infection in need of ART by sex, age group, region
- (based on population survey)
- % people with accurate knowledge on the effect of ART (by age group, sex, SES, rural/urban)
- % people who know where to access ART (by age group, sex, SES, rural/urban)
- proportion of people who cannot pay to have access to ART
- % people with advanced HIV having physical access to ART clinic within one hour

Moving on to the use and methodology of Sector Surveys, he shared further results from a sectoral study in the health sector in South Africa. This study covered 721 medical professionals (specialists and doctors, nursing professionals and other nursing staff and other health professionals) in Mpumalanga, Gauteng, Kwazulu/Natal and Free State in the public and private health sector. Private health care was more likely to be chosen as a first option for those with more money, those belonging to a medical aid scheme and white people. Low income, black people are more likely to use primary health care services. The surveys indicate the potential benefits of ART to the health sector in reduced illness, absenteeism and mortality, reduced lengths of hospital stay and thus overcrowding, and improved quality of health management.

He suggested that sectoral surveys include equity and ART indicators, particularly those noted above for population surveys but disaggregated for the sector.

## **7. Reporting needs and institutional frameworks for equity and health systems monitoring**

The second day of the meeting was dedicated to further reviewing the monitoring indicators, the reporting of monitoring, the mechanisms and institutional frameworks and the way forward. The policy questions and indicators developed in the first day were reviewed and amendments made.

Andrew Banda, Director of Management and Information Systems at NAC, Zambia, made a presentation on **national reporting needs from monitoring of ART programmes**. He noted that implementation of ART in Zambia is based on the National HIV/AIDS Strategic Framework. This aims to reduce morbidity and mortality and eliminate the social economic impact of HIV and AIDS. It aims to encourage and support research in HIV and AIDS treatment and management. The scaling up of ART aims to provide universal access to quality care and treatment to all those who need it, within the overall HIV and AIDS response. National programme performance will be assessed for policy and planning using data from national indicators in the monitoring system integrated within the Health Information System. This includes areas of

- Coverage of services- number and characteristics of people receiving treatment and related services such as counseling and testing
- Quality of care – the extent to which national guidelines and standards of care are being adhered to in service provision
- Health outcomes - changes in morbidity, mortality, quality of life, absenteeism.

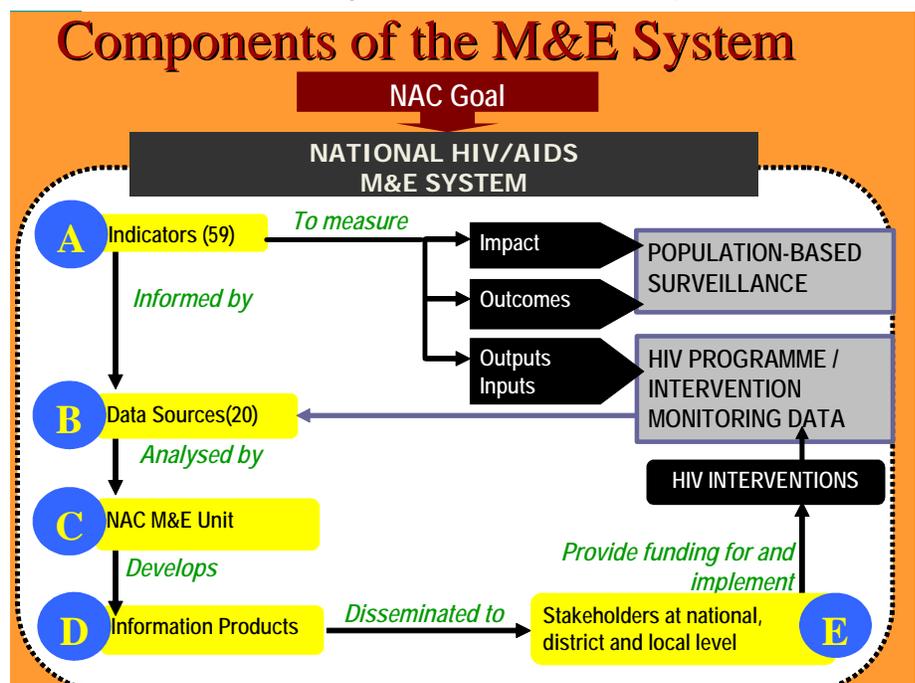
He gave examples of areas of reporting that would inform planning related to equity and health systems, such as:

- Degree of equity in reaching disadvantaged groups - ie: people on ART by rural/urban area, age, gender, poor / non poor, geographical region, and the share of districts with at least one center providing ART
- Sustainability of ART ie: share of annual government and private sector expenditure on ART, publication of disbursements and budgets

Dr. Francis Onyango of WHO (AFRO) made a presentation on **regional needs for reporting from monitoring of ART expansion**. He set his presentation in the context of the significant level of the epidemic, noting that AIDS is now the leading cause of death of adults in the region. Despite this, only 4% of Africans with AIDS are on ART compared to 54% in the AMRO region. The WHO 3 by 5 initiative promotes increasing access to treatment, with 2 million people targeted in the African region. This is an ambitious target but useful for mobilising action and resources. He outlined the steps that WHO has taken towards realizing the target, and the constraints identified in weak health systems, inadequate and untrained human resources and weak systems for national coordination. He stressed the importance of harmonized single authorities and systems as well as sustained quality medicines and diagnostics, including through bulk procurement of medicines and diagnostics and stimulation of local production.

Reporting from monitoring thus needs to address issues of access, adherence, and on the country profiles of delivery on ART. It needs to track drug procurement systems, financing systems, (insurance schemes, PRSPs etc.), the adequacy and training of the health workforce, logistics management, the quality of the public-private partnerships, the extent of community participation and whether there is improvement in quality of care.

Melachias Mwale of NAC, Malawi, outlined as a case example the **national institutional mechanisms** of the Malawi HIV and AIDS Monitoring and Evaluation System. He noted that the HIV and AIDS policy was developed, approved and launched without an explicit plan for monitoring and evaluation, that there is under reporting of HIV and AIDS data by implementers, that the data flow and structure from local to national has been set-up but is not yet fully implemented, that there is inadequate coordination and harmonization of data between funding agencies/development partners, government and NGOs and inadequate involvement of the private sector. He outlined the components of the monitoring and evaluation system shown in the adjacent figure, with indicators of inputs, outputs, outcomes and impacts.



The system uses a number of existing and new data sources, ie

New sources:

- ◆ Financial Management System Report
- ◆ Quarterly Service Coverage Report
- ◆ Workplace surveys
- ◆ Health facility surveys
- ◆ Behavioural Surveillance Surveys, and
- ◆ National HIV/AIDS Reports

Existing sources are the National HIV/AIDS research database; the NAC database and the NCPI questionnaire. Various sources are co-ordinated through the National AIDS Commission.

They produce a range of reports from this data, including:

- Quarterly Service Coverage Report
- Annual HIV/AIDS M&E Report
- Annual GFATM Progress Report
- Biennial UNGASS Report
- Regular Information System updates
- Ad hoc Information Needs

He noted challenges to the system, including the absence of a policy requiring reporting from all sectors for a unified system, weak involvement of the private sector and lack of adequate training for the system. On the way forward, he noted that NAC Malawi would engage an administration agency to collect all its required forms and collaborate with the Business Coalition to train partners on data collection.

It was noted in the discussion that multiple reporting imposed an undue burden on national authorities, and proposed that ways be found to reduce multiple reporting burdens of national authorities.

The **regional institutional framework for monitoring** was presented by Dr Erika Malekia of SADC. She informed delegates that the role of the SADC secretariat in this area is to co-ordinate, harmonize and develop programmes within the region, and that SADC seeks to achieve a sustainable system for monitoring the achievement of core priorities set out in its Business Plan for HIV and AIDS. The policy goals are set within several instruments, ie:

- The SADC HIV & AIDS MASERU Declaration approved by All Heads of States and Governments in July 2003
- Abuja targets and other Millennium Development Goals (MDG) approved by SADC member states.
- AU/NEPAD Health Strategy adopted in Tripoli and Maputo in July 2003.
- The SADC HIV & AIDS Business Plan and Institutional Framework to operationise the SADC Strategic Framework and Plan of Action 2003 – 2007
- The SADC Regional Indicative Strategic Development Plan (RISDP) approved by Heads of States in Arusha 2004 as SADC Plan of Action for 15 years.
- The SADC Protocol on Health – which entered into force August 2004
- The SADC Code of Conduct at the Workplace.

SADC priorities in the roll out of ART include

- Operationalisation of the regional and national HIV & AIDS strategic framework
- Combating poverty and promoting social justice and equity in health
- Facilitating development of policy guidelines for sustainable health systems for ART delivery in line with RISDP and Protocol on Health.
- Strengthening policies for human resource capacities;
- Establishing centres of excellence and exchange of best practices

- Mobilizing financial resources, including the SADC HIV and AIDS trust fund,
- Developing guidelines to monitor the global and national funds for combating HIV & AIDS, TB & Malaria.
- Collaborating with key stakeholders in implementing the Programmes indicated as a matter of urgency and seriousness to achieve the targets i.e. 3 by 5.

In relation to health systems, SADC has prioritised

- Developing guidelines to strengthen health systems for AIDS, TB & Malaria treatment
- Harmonising monitoring of health management and monitoring systems and sharing of best practices within and outside the region.
- Providing equitable and affordable access to generic drugs, research traditional medicine and nutritional supplements and ensuring joint procurement and harmonised medicine regulations.
- Developing standardised monitoring tools as indicators for meeting Abuja targets, MDGs regional and other national and regional targets within SADC.
- Ensuring members states increase resources to the entire health system for equitable scale up of treatment.
- Facilitating development of HIV and AIDS legislation, HIV & AIDS charter of Rights, codes of actions, and strengthening related legislation in the member states.
- Building the capacity of civil society to undertake implementation of programmes, resource tracking, and strengthening network and information exchange.

For SADC she noted the need for monitoring on core indicators for ART programmes, health systems and infrastructure, including access to services; coverage of centres established/facilities for ART programmes and impact data on AIDS related mortality. She also noted the need for regional monitoring of human resource development, joint procurement, local manufacturing, centres of excellence, medicine regulations, and guidelines, research in traditional medicines, nutrition, and food supplements, cross border interventions and of the Millenium Development Goals and spread of best practice.

She noted that after this meeting SADC would

- Obtain reports from on going programs on measures for strengthening health systems in ART programmes
- In collaboration with member states and key stakeholders, develop policy guidelines, and sharing information of best practices in ART implementation programme.
- Follow up the recommendations made during the meeting on monitoring equity and health systems issues in ART roll out within the wider monitoring framework.

Dr. T.J Ngulube of Chessore, Zambia concluded the session with an outline of the opportunities of **community level monitoring** to provide feedback, use and voice at community level. Monitoring at community level implies that communities participate in achieving desired goals, that partnerships be created, partners agree and accept to consider each others perceptions. It assumes that the outputs from the partnership will be greater / more effective than if either partner worked/ participated alone, without either losing their autonomy in the process. This is not always the case in partnerships with communities due to differences in access to knowledge, information, resources and authority. For the community and their organisations, there are concerns of

- Focus – ie that programmes work closely with individuals and groups that have the most significant effect on epidemic dynamics.
- Coverage and access – so that as many people and groups as possible are reached.
- Quality – that interventions are appropriate to the local context and target group and of a consistently high standard.

- Sustainability – ie that the organisation, its programme and its effects last over time.
- Impact - ensuring that adequate attention is paid to each of the issues of focus, coverage, quality and sustainability, so maximising the potential impact.

At community level, various impediments hinder community monitoring and evaluation. Most monitoring systems do not reflect community organization inputs and initiatives, do not monitor community roles and responsibilities and do not give adequate feedback to community level. As a way forward he proposed that community monitoring be implemented at local level, and that national monitoring incorporate indicators of concern to communities and use outcomes of community level monitoring.

## 8 Next Steps and Recommendations

The delegates then split into groups to finalise the recommendations from the meeting and propose follow up steps to be taken. This was done within three broad areas for follow up review:

- a. **The framework should be simple, clear and use existing data**
  - How can we further simplify the framework of issues and indicators (See table pages 9-12) ?
  - What indicators are not yet clear and need further work?
  - What indicators are not already collected by existing M&E (and HIS) systems? Do we need to include them? How should they be collected?
  
- b. **The framework should be owned by and useful to local, national and regional institutions and integrated within a unified M&E system**
  - What do we need to do to review and finalise the proposals at national, and regional level?
  - Who needs to do what to integrate these proposals into the unified monitoring system – local, national, regional, global?
  - What training, capacity and other support is needed to implement the monitoring?
  - What mechanisms / actions are needed to review and revise the proposals? Led by whom? Involving whom?
  
- c. **The framework should inform decision making and action**
  - What information 'products' are needed: produced BY whom, (with technical support from whom), FOR whom, how often and in what format?
  - What is the 'value added' of regional M&E for decision making and action to strengthen HS and equity in ART and AIDS
  - What priority information cannot be provided by M&E? Where should this come from?

### A simple, clear framework that uses existing data

Delegates reviewed the list of proposed indicators and identified a shortened and more precise list that could be used to assess equity and health systems issues. It was proposed that a 'bottom line' of **three core indicators of equity and health systems issues** be used at all levels, (global, regional, national, district, local) as shown overleaf:

### THREE CORE INDICATORS

1. The number ART clients disaggregated by gender and by age as a share of the total number of people eligible for ART<sup>8</sup>
2. The number of clients on ART disaggregated by level of care (primary, secondary (district), tertiary, quaternary/central) as a share of total clients on ART
3. The number ART clients disaggregated by rural/ urban tenure as a share of the total number of people eligible for ART<sup>9</sup>

Beyond these three indicators, from the larger list of indicators shown on pages 10-14, a shortlist of 13 indicators was identified.

### SHORTLIST OF 13 EQUITY AND HEALTH SYSTEM INDICATORS FOR ART MONITORING

Priority policy question	Monitoring indicator	Level of monitoring/ reporting
<b>Fair policy development</b>		
Was the treatment policy developed through a transparent and revisable process?	Publicly available documents describe a consultative process through which the policy was developed, and provide the rationale for decisions made	District, community National
<b>Equity in access to ART</b> <sup>10</sup>		
Who is accessing ART?	The number ART clients disaggregated by gender and by age as a share of the total number of people eligible for ART <sup>11</sup> The number ART clients disaggregated by urban/ rural status as a share of the total number of people eligible for ART	District, community National Regional level
<b>Fair Financing</b>		
How additional and sustainable is funding for ART?	Share of domestic vs external funding for ART and for HIV and AIDS programmes	National Regional
How additional is ART financing?	Annual change (increase) in ART financing relative to total HIV and AIDS budget Annual change in ART financing relative to total funding of PRSP sectors	National Regional

<sup>8</sup> It was noted that 'ART eligible' is assessed by using HIV prevalence data so that it may be more reliable to use HIV prevalence as the denominator for this indicator

<sup>9</sup> It was noted that 'ART eligible' is assessed by using HIV prevalence data so that it may be more reliable to use HIV prevalence as the denominator for this indicator

<sup>10</sup> Many of the financing, health service, human resource and public-private mix indicators are relevant to this section and so are not duplicated

<sup>11</sup> It was noted that 'ART eligible' is assessed by using HIV prevalence data so that it may be more reliable to use HIV prevalence as the denominator for this indicator

<b>Priority policy question</b>	<b>Monitoring indicator</b>	<b>Level of monitoring/ Reporting</b>
How equitable and transparent is AIDS financing?	Proportional allocation of ART financing relative to equity gap as measured by Number of people on ART in the target population as a share of the number of people eligible for ART <sup>12</sup>	National District
<b>Integration into health services</b>		
Is there synergy between ART programme and other health programs?	<b>Using TB as an indicator</b> % TB patients referred for ART screening % ART clients coming from TB programmes	District, national
Does strengthening health systems as a whole improve ART delivery?	Through analysis of ART clients vs fair financing indicators ART clients vs Human resource indicators	District, national, regional
How far are health services prepared for ART delivery?	The number of clients on ART disaggregated by level of care (primary, secondary (district), tertiary, quaternary/central) as a share of total clients on ART	National, regional
What benefit or harm do ART programmes bring to health systems? <sup>13</sup>	<b>Proxy indicator:</b> Number of ART carers who are specialist for ART as a share of the number of ART carers who are general health workers Immunisation rates in districts with and without ART services <sup>14</sup>	District, national
<b>Equity in the public-private mix</b>		
How are funds for ART strengthening public sector health funding?	Number of ART clients accessing treatment from public sector services as a share of total ART clients (disaggregated by age and gender)	District, national, regional
How complementary is the private to the public sector? <sup>15</sup>	% of people with advanced HIV accessing ART through the public, private for profit, private not for profit sector facilities as a share of people with advanced HIV - disaggregated by age and gender <sup>16</sup>	District National Regional

<sup>12</sup> ART eligibility can be proxied by HIV prevalence

<sup>13</sup> Needs research studies to assess costs and benefits of ART spending on Health Systems

<sup>14</sup> Selected as a proxy of the impact of Art provision on wider provision of primary health care services

<sup>15</sup> Needs more detailed research to assess how the public-private mix is leading to movement of people to access service points across different service providers and districts

<sup>16</sup> Advanced HIV is used as eligibility criteria may vary between countries e.g. South Africa requires laboratory confirmed diagnosis whereas Malawi does not.

Priority policy question	Monitoring indicator	Level of monitoring/ Reporting
<b>Human resources for health</b>		
Do health systems have adequate human resources for effective ART delivery and AIDS programmes?	Health care worker <sup>17</sup> / 100 000 population in the public, private for profit, private not for profit sector	District, national, regional

The proposals for the three core indicators, 14 shortlist indicators (and the wider list of possible indicators) need to be widely circulated for peer, national and stakeholder review and feedback, so that they can be included into national, regional and global monitoring and evaluation systems.

### **Steps towards local, national and regional ownership and integration within the unified monitoring system**

Delegates recommended that an audit be done to assess whether

- the three core indicators
- the thirteen shortlist indicators
- the larger list of indicators (p 10-14)

are already being collected within country monitoring and evaluation system in the region, to identify gaps and options for incorporating them into national and regional systems. It was agreed that the lead for integration of equity and health systems indicators into country level M&E systems be done by national authorities, while SADC lead in the integration at regional level and WHO/UNAIDS at the global level.

It was recommended that a regional audit be done to assess the extent to which the three levels of indicators are already captured by existing M&E systems. The countries at the meeting (Zambia, Zimbabwe, Mozambique, Tanzania, Malawi and South Africa) could be supported to pilot analysis of the equity and health systems indicators within their M&E systems. WHO further undertook to explore the feasibility of global application of these indicators (the top three and the shortlist of 14).

Once the indicators are agreed training on their collection should be integrated within wider training for monitoring tools for health workers from health facility level. Staff at higher levels would need training in relevant data analysis (supported by data analysis tools), while planners and other decision makers are given orientation on the use of monitoring for planning, evaluation and policy review.

### **Steps towards informing decision making and action**

Delegates proposed that using indicators within a unified monitoring system, it should be possible to present an annual situation report analyzing equity and health systems outcomes at local, national and regional level that would inform discussion

<sup>17</sup> Disaggregated by major category of personnel

- locally, to clarify roles of stakeholders, service providers and respond to community perceptions
- nationally, to assess national distributional and system issues for monitoring policy commitments and for planning and resource allocation
- regionally, to compare country progress, assess adherence to commitments and inform review of country models and approaches.

It was noted that reporting on these outcomes are made at regional, national, local level to

- political levels (regional: Integrated Council of Ministers, national: Executive, parliament)
- technical levels (regional: secretariat, officials, international co-operating partners national, local: officials and service providers)
- stakeholders (including people living with HIV and AIDS)

and that active review should be built around the reporting on the findings.

Delegates noted the 'added value' of a regional framework for monitoring equity as a basis for sharing good practices and lessons, tracking cross border issues (eg movements for ART procurement, harmonization of drug procurement and regulation, regional inequities leading to client movement) and assessing implementation of policy commitments. It was thus noted that SADC should with support from its technical partners publish the equity and health systems picture across countries.

Finally it was noted that there is a lot of priority information not captured through routine monitoring that calls for population or sectoral surveys, community qualitative assessments and in-depth studies. Areas for such deeper analysis were identified to include

- Assessment of 'best practices'
- Analysis of the way in which community perceptions, knowledge and involvement in influence equity and systems outreach, and of the impact of making ART available on social factors in HIV prevention and AIDS programmes (stigma, service uptake)
- Analysis of costs, benefits and trade offs to health systems in different approaches to ART expansion
- Analysis of systems trends in the different subgroups within the private sector in ART programmes, including informal private sector activities, and their impact on equity and on wider public health and health systems issues
- Analysis of ART resources and programmes on the 'push, pull and retention' factors on human resources for health

It was noted that studies will also need to be implemented from time to time to provide deeper understanding of issues arising from monitoring reports that may be more situation or country specific. It was proposed that research resources be made available, including from the SADC Regional Trust fund, to fund such operational research, with support from regional expertise for peer review of proposals and studies.

Delegates agreed in follow up that the report of the meeting be tabled with their relevant institutions, and that follow up will be made of the recommendations at global, regional and national level through the appropriate authorities present in the meeting operating at these levels. It was again noted that this is **not** about setting up any new or additional monitoring system, but ensuring that indicators of equity and health system performance/ impact are adequately analysed, reported on and profiled within existing systems.

## Closing

The meeting was closed at end of business of Friday, 8<sup>th</sup> October 2004. Rene Loewenson thanked the delegates for their participation in the meeting and for their significant contribution to an intensive work schedule. She noted EQUINETs commitment to working with SADC, WHO and national authorities and technical resources in the region to follow up on the recommendations made. She noted that EQUINET would endeavour to produce the report in a timely manner, circulate the report and proposals for wider peer review and work with SADC to take forward the steps proposed by the delegates. She drew attention to the EQUINET newsletter and website which aimed to share information on the significant volume of work being done in the region. She gave special thanks to the Malawi Ministry of Health and National AIDS Commission hosts, who had demonstrated 'the warm heart of Africa' and to the staff of Equi-TB Malawi and TARSC, who had carried out background work and provided significant logistic support to delegates. She hoped that the delegates had a safe journey home.

On behalf of Dr. Antonica Hembe, HIV/AIDS Manager of SADC, Dr. Francis Onyango of WHO AFRO officially closed the meeting. He also thanked the local hosts, the organizers and delegates. He asked delegates to make sure that the two days spent in Lilongwe should not be in vain but be a basis for building monitoring equity in access and health systems issues in ART programmes in the region and the world, while meeting the commitment to ensure that the many people in Africa who need treatment do access it.

APPENDIX 1



**EQUINET/ TARSC/EQUI-TB PROGRAMME**  
**Regional Meeting on Monitoring equity and health systems issues in**  
**ART programmes in Southern Africa**  
**Lilongwe, Malawi October 7-8 2004**



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## APPENDIX II



Southern African Regional Network on Equity in Health  
(EQUINET)  
in co-operation with  
EQUI-TB PROGRAMME Malawi



Regional Meeting on Monitoring equity and health  
systems issues in ART programmes in Southern Africa  
Lilongwe, Malawi October 7-8 2004

### October 6

7pm

Welcome Dinner  
Welcome and opening M Shaba, MoH, B Mwale NAC Malawi  
Introductions, Objectives Equi-TB/EQUINET

### October 7

8.30-10.00am

**Overview: Equity & health systems issues in ART expansion**  
R Loewenson, EQUINET  
Discussant: Dr E Schouten, MoH Malawi  
Discussion

10.00-10.30am

Tea/ coffee

10.30-11.00am

**Principles of unified systems for monitoring ART expansion**  
A Hembe SADC

11.00-12.00pm

**The Malawi case study of health systems monitoring**  
Equi-TB, B Kalanda, I Makwiza, J Kemp  
Discussion

12.00-1.00pm

### **AREAS FOR EQUITY AND HEALTH SYSTEM MONITORING**

1.00-2.00pm

**Parallel sessions** (6 sessions; See below)

2.00-3.15pm

Lunch

Parallel sessions continue

#### **Session 1: Fair policy development**

Comment on options raised N Daniels, Harvard  
Discussion: Goals, indicators, methods, sources

#### **Session 2: Fair financing**

Comment on options raised D Hamilton, DCI  
Discussion: Goals, indicators, methods, sources

#### **Session 3: Integration into health services**

Comment on options raised A Mpofu NAC Zimbabwe  
Discussion: Goals, indicators, methods, sources

#### **Session 4: Equity in the public –private mix**

Comment on options raised R Stewart, HST  
Discussion: Goals, indicators, methods, sources

#### **Session 5: Human resource issues**

Comment on options raised A Padrath HST  
Discussion: Goals, indicators, methods, sources

#### **Session 6: Equity in access to ART**

Comment on options raised A Bekwa ALP/ TAC

Discussion: Goals, indicators, methods, sources

3.15-3.30pm

Tea/coffee

3.30-4.45pm

**Plenary session feedback and discussion**

Discussion

4.45-5.30pm

**Population and sectoral surveys and their link to monitoring**

K Peltzer HSRC

Discussion

**October 8**

8.15-8.45am

**Recap of day one conclusions and summary of key areas for monitoring**

EQUI-TB/ EQUINET

Discussion

**MECHANISMS FOR EQUITY AND HEALTH SYSTEM MONITORING**

8.45-10.00am

**Reporting and analysis frameworks:**

*What is needed for policy review and programme planning, from whom, for whom, when, in what form?*

National needs

Mr. L Banda NAC Zambia

Regional needs

F Onyango WHO (AFRO)

Discussion:

10.00-10.30am

Tea/ coffee

10.30-11.45pm

**Institutional framework for monitoring**

National institutional mechanisms A Agabu NAC Malawi

Regional institutional mechanisms E Malekia SADC

Discussion:

11.45-12.30pm

**Community level monitoring:** how can monitoring provide for feedback, use and voice at community level?

TJ Ngulube CHESSORE Zambia

Discussion:

12.30-1.30pm Lunch

1.30-3.00PM

**Working groups on next steps:**

Gp 1: Developing and refining the indicators

Gp 2: Country level actions and inputs

Gp 3: Regional level actions, inputs & co-ordination mechanisms

Gp 4: Health systems issues that need deeper research

3.00-3.15pm

Tea/coffee

3.15-4.30pm

**Feedback of working group discussions**

**Resolutions of follow up work, actions and roles**

4.30-4.45pm

**Closing**



## Appendix III: OPENING SPEECH

### MONITORING EQUITY AND HEALTH SYSTEMS ISSUES IN ART PROGRAMMES IN SOUTHERN AFRICA

Lilongwe Hotel, Lilongwe  
7-8<sup>th</sup> October, 2004

**Dr. Mary Shawa**  
**Secretary for HIV, AIDS and Nutrition**  
**Ministry of Health, Malawi**

The meeting organisers, distinguished participants, ladies and gentlemen. It is my pleasure this evening to officially open this meeting on monitoring equity and health systems issues in antiretroviral (ART) programmes in southern Africa.

Malawi, like the rest of the southern African region is faced with an increasing HIV and AIDS epidemic. In this region, approximately 15 million adults and children are currently infected with HIV and an estimated 700,000 – 1 million currently have AIDS. It is common knowledge in public health that this region of the world has never before faced an epidemic of such a proportion before.

Over the last few years, the southern African region has added ART as part and parcel of a continuum of prevention, care, treatment and support in response to the epidemic. However, the region has had difficulties in supply ART to all eligible persons due resource constraints. As we gather for this meeting, only one eligible person in 25,000 is currently on treatment with ART.

It is a shame that this ART shortfall is widest for low-income communities using peripheral and rural health services. It is also a tragedy that certain groups of people; based on their gender and socio-economic status; are also marginalised when it comes to accessing ART. Ladies and gentlemen, let me also remind you that in the past decade or so, health systems in the region have been crumbling by the day, making them ineffective and inefficient providers of health services to the population of the region. You may agree with me that rolling out ART; amidst the disparities I have just pointed out and with almost non-existent health systems will be a very at order.

With the foregoing, as HIV and AIDS programme in the region roll out ART, it is imperative that they focus on among other things, two important aspects of it:

These are:

- 1. Ensuring equity in access to ART** and
- 2. Strengthening health systems**

One may ask how and why health systems are an important link in ART roll out?.

Firstly, ART roll out, be it through grant money from the Global Fund for AIDS, Tuberculosis and Malaria or the 3 by 5 initiative, implies an injection of large amounts of money into health systems. It is obvious that a weak health system would not be able to absorb large sums of money, let alone use the funds appropriately.

Secondly, a weak health system, unable to efficiently and effectively funds for ART, can potentially lead into a weak ART programme. The converse is also true; i.e. a strong

health system, able to utilise resources at its disposal, can lead into a strong ART programme.

Last but not least, ART roll out can also lead to weakening other parts of health service delivery while strengthening others. A good example is a situation where health staff move from areas which attract less funding to areas with substantial funding like ART.

Rolling out ART can therefore lead into a vicious circle of either weakening then health system and ART programmes; or strengthening health systems and ART programmes. It all depends on how the two are handled by those of us assembled here tonight and all our colleagues in the health field in this region of the world.

Ladies and gentlemen, there is hence an obvious need to ensure that there is equity in access to ART, and that ART programmes are used to strengthen health systems.

One way of ensuring that is to develop tools to monitor equity in access to ART and strengthening health systems through ART roll out. That is the overarching reason for this meeting.

You will agree with me that monitoring equity in access and health systems issues in ART programmes in the southern African region is a completely new concept. As we sit through various sessions in the next two days then, you will be pioneering a new aspect into the field of monitoring and evaluation of HIV and AIDS programmes; that is equity in access and health systems strengthening.

You will be adding knowledge to the field of monitoring and evaluation of HIV and AIDS programmes which has limited itself to surveillance, behavioural and epidemiological research.

Above and beyond that, I dare say that you will be bridging in a field which in essences uses a hard science of data management to complement and extend the field of human rights in health and gender; as you look into how to monitor equity in access amongst various disadvantaged groups.

It is my hope that this meeting will be just a start and not an end into itself. I would to see monitoring of equity in access and health systems issues incorporated into monitoring and evaluation systems of all National AIDS Commissions in the region. This meeting and group should be a springboard to achieve that goal.

Let us all note that if we do not address the issues of equity and health systems, our noble fight against the HIV and AIDS epidemic may be very lacking.

Mr Chairman, distinguished participants, ladies and gentlemen, I wish you good deliberations over the next two days and now I would like to officially open this meeting.

I thank you all