

Using research to promote gender and equity in the provision of anti-retroviral therapy in Malawi

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LIST OF ABBREVIATIONS AND ACRONYMS

ADB	African Development Bank
ART	Anti-retroviral therapy
ARV	Anti-retroviral
CDC	Centre for Disease Control
CHAM	Christian Health Association of Malawi
CIDA	Canadian Development Agency
DFID	Department For International Development
DHS	Demographic Household Survey
EQUINET	Southern Africa Network For Equity in Health
GFTAM	Global Fund For HIV/AIDS, Tuberculosis and Malaria
MoH	Ministry of Health
MSF	Medicins San Frontiers
NAC	National Aids Commission
NHL	Norwegian Heart and Lung Association
NORAD	Norwegian Development Aid
NSO	National Statistical Office
NTP	National Tuberculosis Programme
PMTCT	Prevention of Mother To Child Transmission
REACH	Research for Equity And Community Health
TB	Tuberculosis
UNAIDS	Joint United Nations Programme for HIV/AIDS
W H O	World Health Organisation
ZWRCN	Zimbabwe Women's Resource Centre and Network

1. INTRODUCTION

This paper explores the importance of using research to promote gender and equity in the provision of anti-retroviral therapy (ART) in Malawi. The purpose of the paper is to highlight the importance of operational research in advocating for programmes that are gender sensitive and can contribute to overall national economic growth and poverty reduction. The paper uses a synthesis of the findings of research in Malawi on how gender roles and relations affect access and adherence to anti-retroviral therapy and to illustrate how these can be used to advocate for more equitable policy and practice. The paper is structured as follows:

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SECTION 2: BACKGROUND TO MALAWI

Malawi is a land locked country situated in the sub-Saharan Africa. It has a population of about 10 million people (National Statistics Office, 2000). Studies show that 65% of the Malawian population is poor (National Economic Council, 2000). Malawi's poor are not a homogenous group but consists of a cross – section of the population including small holder farmers with less than one hectare of land, estate tenants, urban poor and female headed households. Research has shown that their chief coping mechanism is piece work which is normally sought on daily basis. About 40 % of the households are headed by women and most of these female headed households are poor (NSO and IFPRI 2002). Female headed households fare badly in terms of indicators of human capabilities like health, education, and employment (Ngwira and Mkandawire 2003). Research on national literacy shows that 21% more men than women can read. Women's literacy rates are estimated at 54% while those for men are 74% (NSO, 2002).

Malawi's mortality pattern is typical of a developing country with poor health indicators and a high proportion of deaths caused by infectious diseases such as tuberculosis, malaria and HIV/AIDS. HIV/AIDS constitutes a serious threat to the country as a whole as it has affected all sectors of the economy. In 2003, 87,000 deaths among children and adults in Malawi were reported to be due to AIDS (Ministry of Health, 2004).

In 2003, Malawi with financial assistance from Global Fund commenced a rapid scale up programme of ART delivery with the aim of reaching 80,000 people by

the end of 2005. Currently it is estimated that about 170,000 people are in need of ART at any given time (Ministry of Health 2004). The funds from GFTAM are enough to support only 80,000 people on ART for a period of five years (*ibid.*). There is need to focus not only on the impact the provision of ART will have on the health system as a whole, for example, provision of essential health services, but also on who is accessing ART. This is because ART programmes could serve to strengthen health systems through further investment and support of essential health services. Alternatively they could have a negative impact through diverting scarce resources from the wider health system and in the long term undermining long term access both to ART and to other public health interventions (Makwiza et al 2005).

There is a huge shortfall between the numbers of people in need of ART as compared to the available resources. In the light of limited health resources available, issues of promoting gender and equity become imperative. Failure to address gender relations and apply an equity perspective in the provision of services has proven to be detrimental to development. This is considered further in the following section.

SECTION 3 – THE NEED TO USE GENDER LENS ON THE HIV EPIDEMIC

Gender refers to men and women's characteristics, which are socially and culturally determined (WHO 1998). It is related to the perception of oneself in relation to others and how one is expected to think and act with respect to his or her biological sex (male or female) because of the way in which society is organized.

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 group, rural/urban residence and geographical region. Equity should therefore be achieved through redistribution of societal resources for health including the power to claim and the capabilities to use these resources' (EQUINET Steering Committee, 2004).

UNAIDS (2004) records show that out of 28 million people in Sub-Saharan Africa infected with HIV/AIDS, 58% are female and 42% are male. For different reasons and in different ways, young women and men in the 15-24 age category have been drawn into the large number of those living with HIV and now account for up to half of all new infections worldwide. The number of women and girls infected with HIV has now surpassed the number of men and the oppression and subjugation of women remains real. (For example, in Malawi the prevalence of HIV/AIDS among young women aged 15 -24 is four to six times higher than amongst young men of the same age (NAC Malawi 2004).

A number of factors make women more vulnerable to infection than men. From a biological perspective women are more likely to suffer lesions during sexual intercourse than men, creating a direct route of infection. The fact that seminal fluid is deposited in the female body also makes women more vulnerable to HIV (ZWRN, 2003). Women are also put at risk by a multitude of socio-cultural

factors that prevail in our patriarchal societies; these include the greater economic deprivation of women, customary norms that prevent women from negotiating for safe sex, use of condoms and faithful behavior (ZWRCN 2003).

Women, men, girls and boys have experienced the HIV/AIDS epidemic very differently, and this relates to their varied positions within diverse contexts. Gender inequalities persist in participation in or access to benefits of development all over the world (Tinker 1990). In Malawi women are disadvantaged in terms of access to health, education, and education services (Ngwira et al 2000; Semu et al 2003). This negatively impacts on their access to information and socio-economic services which further negatively affects their quality of life.

Women and girls continue to carry the disproportionate burden of nursing the sick through home based care work. The impact of HIV/AIDS on women has been referred to as 'triple jeopardy' (Bennet 1990) through recognition of the key gender roles that women are expected to fill: productive, reproductive and community. HIV/AIDS affects women as individuals, mothers and care givers in these socially defined roles. The socially defined roles of men and boys will also affect the ways in which HIV impacts on them (Tallis et al 2002).

Though HIV/AIDS is not exclusively a disease of the poor, deprivation associated with poverty increases the risks of infection and development of disease. People living in poverty are more likely to become sick and generally die more quickly due to malnutrition and lack of access to appropriate health care. Thus the HIV epidemic is bi-modal with peaks among the richer and better educated as well as amongst the poorest in society (Collins and Rau, 2000). The HIV epidemic among the rich is due to access to disposable income and position in society, including the ability to travel, which provides them with the opportunity to engage in sex which puts them at risk (Tallis et al 2002). According to Bayles (2000) it is mainly men that fall into this category and this is seen as an 'expression of their power.' This contrasts with the poor, especially poor women, whose poverty may lead to risky actions for survival as well as from taking protective action.

Our collective responses to ensure an equitable access to ART need to be guided by a robust, large scale, multi-sector strategy that incorporate the diverse needs and concerns of the most marginalized and deprived groups of men, women, girls and boys (ZWRCN 2003). The next section introduces the REACH Trust and outlines the research approaches we have deployed to explore how gender and equity shapes access and adherence to ART in Malawi.

SECTION 4 – INTRODUCTION TO REACH TRUST AND METHODOLOGICAL APPROACHES

The REACH Trust has grown out collaboration between the National TB Control Programme, the Sociology Department, University of Malawi and the Liverpool School of Tropical Medicine, UK. The Trust is based on principles of interdisciplinary research, research capacity building and ongoing dialogue with policy and decision makers. The Trust aims to promote strategies that enhance the delivery of health services for the poor, vulnerable and disadvantaged,

through the conduct of quality research in the major diseases of poverty which include malaria, TB and HIV/AIDS, and to promote equity in the provision of care and treatment for these diseases. We have been developing our HIV research portfolio with the technical and financial support from EQUINET which has worked to promote advocacy on the need to address equity concerns in ART provision and scale up in Southern Africa.

From a methodological perspective we have conducted research using multiple complementary methods. Both qualitative and quantitative methods are used to document context specific insights from respondents and to enable triangulation of findings. Qualitative methods employed include focus group discussions (FGDs) with patients and the community members, critical incidence narratives with key informants and participant observation. Quantitative methods include collation and analysis of existing data surveys (questionnaires) to quantify costs and delays in seeking care. Gender analysis has been carried out in all studies to allow in depth understanding of how gender influences choices and access to resources. Most of the studies were conducted to recommend potential interventions to policy makers and other key stakeholders for ensuring poverty and gender sensitivity in policy and practice. The next section introduces the studies we have conducted on ART provision.

SECTION 5 – SYNTHESIS OF KEY STUDIES

So far we have conducted 4 research projects on how gender and equity shape access and adherence to anti-retroviral therapy (ART). Three of these are qualitative and explore the particular barriers faced by women, men, girls and boys in accessing and adhering to ART in urban Lilongwe and rural Thyolo. The fourth study uses quantitative analysis of pre-existing national and district level data to assess how gender and axes of inequity shape ART provision and uptake. These studies are explored in turn:

5.1 Access and Adherence to ART amongst adults at the Lighthouse, Lilongwe.

The study aimed to explore HIV positive patients understanding of their illness and anti-retroviral therapy (ART) and to explore factors that influence treatment interruptions or drop-out from ART in Malawi. It was an explorative study which used a qualitative approach to investigate issues of understanding of barriers to adhering to ART. Focus group discussions (FGD) and in-depth interviews were conducted with patients on ART at Lighthouse, a comprehensive non-governmental service provider that implements the Government of Malawi provision of anti-retroviral therapy in Lilongwe. This facility started to provide ART at cost in 2002 and started to offer free ART in June 2004. It is important to stress that this research was conducted at the time when ART was provided at cost.

Most patients had a comprehensive understanding of their illness and the different ways HIV can be transmitted. The relatively high cost of accessing

therapy was commonly cited as the major factor that could cause patients to stop therapy, as illustrated in the following illustrative quotes:

Illustrative quotes from women and men on the barriers presented by cost include:

'Yes it true that most people are failing because of lack of money, they know that there are these drugs but they cannot come because of money' (Focus Group discussion (FGD) with women).

'It is expensive, it is the money which will cause most of us even though we have started we will die early because we will stop taking the treatment' (FGD with women).

The main thing that cause people not to start treatment is money because most people's income in Malawi is less that K3000, so if you think of getting K2, 500 just for yourself to buy medicine, how are you going to survive in the house? Most people still buy the medicine with an intention to protecting their lives but it is bringing a lot of financial problem (FGD with men)

'Only that most of the money is going to buy medicine so that to feed your family then there are also some children in school and it means they will need to have enough money for school even in your family you cannot even eat decently [eat three food groups] so that because of the medicine other things do not go well so this in future could make some one to say it is better I just stop taking the medicine and die' (CIN with a woman aged 34).

In a context of limited resources and costly drugs, individuals and families have to make very difficult decisions about who should access ART. There was some evidence that where men are the breadwinners they are likely to prioritise access to ART drugs for themselves. For example from one FGD men explained:

'So the problem that is there is that we men are selfish, selfish in the way that we are only buying medicines for ourselves and denying our partners to buy the medicine as well. May be if it were halved but K2500, how much money are do we get'.

'Like some of we are failing to have our partners at home to be getting the medicine as it is expensive and I cannot pay K5000, and then make sure we are eating and paying rent from the same amount. I can't manage, so it would help if the cost was lowered a little'.

Long waiting times at the clinic were also seen as a barrier to accessing care for many patients. Despite being on ART, many patients were reluctant to reveal their HIV status beyond their immediate family, because of stigma associated with HIV/AIDS in Malawi.

The findings clearly illustrate that cost constitutes a key barrier for patients to access and adhere to ART. This is the case for all patients, but particularly for poor women, who often have less access to cash than their male counterpart.

Through participation in a number of strategic working groups our research findings were influential in shaping the Malawian policy on equity in ART provision (free treatment on first come served basis with a particular emphasis on health promotion strategies for poor and vulnerable groups).

5.2: Access and adherence to ART amongst caregivers of children at the Lighthouse

This was a follow up exploratory study which was also conducted at the Lighthouse. The study's objectives included determining care givers related perceptions of barriers and enabling/motivating factors to adhering to ART for children and their understanding of HIV/AIDS. The findings were used to make recommendations to the Lighthouse for delivery of ART in pediatric patients. The study deployed focus group discussions, critical incidence narratives and participant observation.

Most patients reported a good understanding of HIV/AIDS and how ART works. However other respondents indicated that they did not know if there was a difference between HIV and AIDS. One respondent in the in-depth interview also reported that she had heard that children with HIV die when they reach the age of 15, whether they are on ART or not. It was noted that it is usually the mother who is expected to take the child for Voluntary Counseling and Testing. However there was common agreement that this should be discussed by both parents.

Below is a typical quote that illustrates this:

"It is the mother who takes the initiative to take a child for VCT because she is the one who stays with the child. As we have seen you find a woman coming here but she has left the husband at home. Then she will come to tell the husband that the child has been tested positive, can we go for a test?" (Male FGD)

The most reported problem was long waiting time at the lighthouse. Most people reported that when they come in the morning they finish in the afternoon. Respondents said that it is not good for children as they get tired easily. Respondents also hinted that the light house is understaffed as there are a lot of people coming but limited capacity.

This study was also conducted at the time when ART was provided at cost, and cost again emerged as a key barrier, as illustrated below:

'My child did not start treatment because of money as now I am alone, and my parents are not wealthy so from the money that I get I cannot afford to use MK 2500¹ for the drugs, as well as pay rent and even if you buy medicine you also need a good diet other wise what is the point sleeping hungry. It would be better if may be I could find a bit more money which I could use to start a business to help. But right now it is difficult.' (CIN with a woman whose child was not on ART)

'I told her father that our child had been found with the problem of HIV but because at the time we did not have money we did not start the child on treatment earlier on.' (CIN with a woman whose child was initiating ART)

¹ At the current exchange rate the equivalent of US\$22 per month

This second set of data also confirms the notion that making ART drugs free should increase access to all groups, poor women, men and children. The challenge in Malawi is to ensure that this is the case as ART roll out increases.

3. Equity Analysis of ART Provision in Thyolo

This was a follow up study to the first Lighthouse study outlined above. The study set out to explore barriers to accessing and adhering to ART in Thyolo district, a facility which has been offering ART for free since April 2003 with support from MSF-Luxembourg.

It is an exploratory study which used qualitative approach to investigate both enabling and inhibiting factors to accessing ART in Thyolo. Focus group discussions (FGD) were conducted with patients on ART, those initiating ART, community members and patients on TB treatment. Follow up of defaulters and eligible patients not taking up ART was also carried out. Key informant interviews were conducted with Home Based Care Volunteers and staff from different departments at Thyolo hospital. Observations were done to gain more insight on the process that patients follow to access ART and how they are sustained in the process. Critical incidence Narratives (CIN) with patients on ART, those initiating, and defaulters were conducted to complement data collection. Data analysis is still in progress, and preliminary findings are discussed below.

Most people displayed a good understanding of HIV/AIDS and how it is transmitted. However some people could not differentiate between HIV and AIDS. Although ART is provided free of charge there are still some barriers that prevent people from accessing and adhering to ART. Most people especially women mentioned lack of transport and food as the main barriers to accessing ART as illustrated in the case study below:

“Lack of transport money is always a problem because when it is your day of appointment and you don’t have the transport you cannot go. Even if you try to borrow from friends they cannot lend you because you are not employed you are just staying at home. Again when one is on ART one feels hungry quickly, but you do not have anything to eat so that you can take the drugs. If you don’t have adequate food the drugs are not effective - as a result you can die”. (FGD with community women).

However, most men did not express transport as a pertinent problem. This can partly be because men unlike women can cycle to the hospital on their own and in most cases men are the ones who have control over financial resources and they can save some money for transport. This is illustrated in the case study below:

We use the same public transport. We try our best to foot the transport bills. Should we say they should provide us with transport money as well? No. On the side of transport costs we will see what to do ourselves (FGD with community men).

In addition, it was found that HIV/AIDS patients often experience high levels of stigma and discrimination on the basis of their HIV status. As a result, many people were reluctant to reveal their HIV/AIDS status to people beyond their family. Many respondents hinted that those who do not disclose their status due

to whatever reason want to infect other people who are ignorant about their HIV/AIDS status. The most cited victims were young children as illustrated in the following case study:

“Usually Most people want to be spreading the virus to children. They tell the children things about fertilisation so that the children become eager to experience sex thus spreading the virus further” (FGD community men).

It was also found that stigma invokes powerful psychological feelings in people living with HIV/AIDS including how they view themselves in relation to other people. However, most women reported being deserted by their husbands upon showing signs of sickness. Below is a case study of stigma following a positive HIV test:

“I have already started to experience some stigma especially back biting. I had lost a lot of weight I even reached 30kgs. I was told to be receiving soy flour. People could say all sorts of things like all those who receive soy flour from MSF are HIV positive. MSF distributes this flour to HIV positive people. However I never took these remarks seriously because it was not by choice. I was married and I don't know who infected me it can be my husband. I could not do anything.” (CIN HIV positive woman on TB treatment)

Most patients hinted that the treatment they receive at the hospital when they come to receive ART gives them hope and a sense of worth. One woman in the CIN had this to say “when we come here to receive treatment the nurses receive us warmly. This in way encourages us to continue treatment.” Personal contact with the ART providers indicated that they try to establish relationships with the patients so that the patients feel free to express themselves. Respondents also complained of long waiting times on the queue. A man in an FGD had this to say “the problem is the numbers of those of us who receive these drugs have grown tremendously. As such it takes time for the hospital staff to trace your file”. The ART providers also hinted on the tremendous increase of patients on ART and they complained about shortage of staff in the ART clinic.

Monitoring equity and health systems in the provision of Anti-retroviral Therapy (ART): Malawi Country Report.

The report presents an equity and health analysis of the provision and expansion of ART in Malawi. It aims to provide a working example of a country level monitoring and evaluation. In line with the principles adopted in EQUINET regional consultation, it is produced within the context of ‘three ones,’ i.e. relying mainly on available routine monitoring data, and within existing national monitoring and evaluation systems.

The evidence for this report was collated and analysed within the major areas identified in regional consultations (EQUINET, 2005; Makwiza, 2005) on equity in ART scale up, as follows:

Two areas of equity, justice and accountability

1. Fair policy development, monitoring and accountability through fair processes
2. Equitable access to ART with realistic targets

Four areas of sustainability and efficiency

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 and accountable purchase, distribution and monitoring of drugs and commodities ART and essential health package.
7. Ensuring private sector ART provision complements and enhances public health system capacity.

The findings under each of these headings are summarized below:

In relation to **fair policy development**, it was shown that ART policy development was developed through a documented participatory process, including mass media, public consultation including people living with HIV and relevant institutions and commissioned studies in seven districts

Progress has been achieved in terms of **equitable access to ART with realistic targets** set. Scale up of ART started in 2004 and since then, ART has been provided free of charge in all public and Christian Health Association of Malawi (CHAM). The report found that 40% of the patients were male and 60% female; 95% were adults (13 years and above) while only 15 % were children. Most of the patients on ART (63%) were from the Southern with 10% and 27% from the Northern and Central region respectively. There were more women than men in every region. To access whether this reflects gender equity one would need sex disaggregated prevalence data. However such data is not yet available in Malawi, until the results of the Demographic Health Surveillance Survey are released (expected in September 2005).

In relation to **fair and sustainable financing and accountable financial management**, it was found that ART scale up mainly relies on support from Global Fund For HIV/AIDS, Tuberculosis and Malaria (US\$29mn). Other donors include UNDP, CDC, ADB and pooled partners which include World Bank DFID, NORAD, and Canadian CID Malawi, like many countries in Sub Sahara Africa, will in the near future need the support of the international world in scaling up its ART access initiatives. However the assessment of fair financing must take into account of the government contribution to the core health service and personnel through which ART scale up is taking place.

There has been some progress in integrating ART delivery within the **essential health package**. Integration with National TB Control Programme is relatively strong with joint training, cross referral and employment of TB/HIV officer with the responsibility of facilitating integration. It was found that 11% of all patients accessing ART come from the TB programme. However, integration with other programmes such as those aiming to prevent mother to child transmission (PMTCT) and sexually transmitted infections has been minimal.

In relation to **human resource development** to deliver the essential health package, it was found that there is a huge shortage in health due to high attrition rates. The major reasons behind attrition are death, resignation to work elsewhere, low salaries and poor working conditions. Currently clinical officers

and nurses provide ART, and there are significant vacancy rates amongst the two cadres (24.5% and 67.7% respectively amongst the MoH in 2003).

It was difficult to get information on the **sustainable and accountable purchase, distribution and monitoring of drugs and commodities for ART and the essential health package**, so the report does not include a specific section on this area.

The Malawi approach to ART provision is to try to ensure collaboration between the **public and private sectors**. It is envisioned that working positively with the private sector will take the burden off the public sector where human resources are limited and ideally enable more poor people to access public services for ART.

The report recommends that monitoring and evaluation of equity and health systems impacts be ongoing, well disseminated and complemented by qualitative data to ensure that challenges are understood and addressed early on in the programme.

SECTION 6 – SUMMARY OF KEY FINDINGS FROM THE STUDIES

The key findings from these studies from a gender equity perspective are summarized in the following box:

- Gender interacts with poverty to shape access to resources and decision making trajectories about accessing and adhering to ART.
- The way in which real and enacted stigma is experienced is influenced by gender and poverty and affects decisions around health seeking behaviour and ability to adhere to treatment.
- Providing ART free is an extremely important step in facilitating access by different groups. Since ART has been provided free more women than men are accessing ART in Malawi, which is in line with the presumed sex difference in prevalence rates (i.e. more women than men are living with HIV in Malawi)
- Even where the actual treatment is free opportunity costs (related to transport and displacement activities) and problems with accessing enough food are experienced, especially by women and rural communities.
- Staff shortages and long waiting times constitute additional barriers to ART access and adherence and are particularly challenging in the light of over-stretched and under resources Malawian health systems
- Looking at gender equity in ART provision means not only considering who is accessing ART, but also what are the implications of ART provision on the health system as a whole. Looking at ways to use ART to strengthen the health system requires integration and collaboration with other health service delivery packages within and beyond the public sector.

SECTION 7 – RESEARCH INTO PRACTICE: OPPORTUNITIES FOR ADVOCACY

At REACH Trust we are a firm believer of the need to translate research findings into policy and practice. However research findings are not a passport to policy (Davis and Chapman 1996). The relationship between policy and practice is not linear or straightforward (Groenwald, no date); we cannot assume that more research means more evidence based policy. We have identified a complex myriad of opportunities and challenges in translating gendered research into policy and practice. Key to this are four inter-related themes that are explored in turn (1) working in a participatory way with policy makers, practitioners and community members; (2) advocating research findings at strategic forums; (3) multi-method approaches and (4) 'strategic framing' - adopting different languages or discourses to discuss gendered research findings

(1) Working in a participatory way with policy makers, practitioners and community members

Davis and Chapman (1996) argue that research findings are more likely to be translated into policy and practice if 'researchers involve managers and policy makers in the development of the framework for and focus of research and if investigators assume a responsibility for seeing their research translated into policy' (1996: 865). We have tried to do this with all the projects above and have liaised closely with practitioners (at the Lighthouse and MSF-Luxembourg), policy makers and community members. We have advocated for the need for sex disaggregated data in order to interpret gender differences in access to ART and this has been responded to and changes are ongoing.

(2) Advocating research findings at strategic forums

Our work on barriers to access and adherence to ART was conducted at the time of policy discussions on how to scale up ART across Malawi. We presented our findings showing that cost constituted the key barrier to access to ART and that this was gendered, with women in particular struggling to meet the costs required, at a number of key policy discussions groups and strategic fora. Through participation at a number of strategic working groups our findings fed into discussion at the Ministry of Health and were arguably influential in shaping the Malawian policy (drugs provided free on a first come first served basis, with a particular emphasis on health promotion strategies that are geared towards poor and vulnerable groups).

(3) Multi-method approaches

Health research that contributes to change may require more methodological pluralism (Howden and Chapman, 1996). As documented above we have used multiple methods to try and ensure a holistic picture and to try and capture complexities.

(4) 'Strategic framing' - adopting different languages or discourses to discuss gendered research findings

We have found that it can be strategic to situate research findings within different languages or discourses depending on the audience. This has been referred to as 'strategic framing' and has been discussed in the gender literature (See

Theobald et al, 2005; Theobald, Squire and Tolhurst 2005; Pollack and Hafner-Burton, 2000). As individuals we may believe and work within a gender equity and rights discourse, i.e. poor women have a right to accessible and quality HIV services, but we may choose to situate our research findings within instrumental or technical arguments that prioritise efficiency or sustainability, as these may be more accessible to policy makers than a discussion of gender and rights. It could, for example, be argued that if HIV services are inaccessible or unacceptable to poor women, HIV programmes will be unable to meet their targets, which clearly threatens the *efficiency and sustainability* of the entire programme.

SECTION 8: SUMMARY

This paper has argued for the need to apply a gender equity lens to responses to the HIV epidemic, with a particular focus on ART provision (both access and adherence). Four studies that have been conducted by the REACH Trust on gender and equity considerations in access and adherence to ART are presented and the findings are synthesized. It was found that gender roles and relations intertwine with poverty to affect access and adherence to ART in a complex myriad of ways, even when ART is provided for free. There is a need for quality research to promote attention to gender equity concerns in ART provision and for ongoing responsive monitoring and evaluation to respond quickly to problem areas. If access to ART does not sound the bugle on the need to promote gender and equity then it is difficult to imagine what kind of epidemic it will be (ZWRCN 2003). In Malawi we are working with policy makers, practitioners and community members to get the bugle to play.

REFERENCES

- Collins, J. and Rau, B., (2000), **AIDS in the context of development**, paper No 4, UNRISD Programme of Social policy and development, Geneva: The United Nations Research Institute for Social Development (UNRISD) /UNAIDS
www.unirsd.org/published/sdp/collins/content.html
- Davis, P & Howden- Chapman, P. (1996) **Translating research findings into health policy** Social Science and medicine, 43(5):865-72.
- Makwiza I., et al (2005), **Monitoring equity and community health Systems in the provision of Anti-retroviral Therapy (ART): Malawi Country Report.**
- Ministry of Health (2004), **The programme of work, Sector Wide Approach.** Government of Malawi.
- National Economic Council, (2000), **Profile of poverty in Malawi1998: An analysis of the Malawi Integrated Household Survey, 1997-1998.** Poverty Monitoring System, National Statistics Office, Zomba, Malawi.
- Narayan D, Chambers R., Sha M.K., Petesh P, (2000), **Voices of the poor: can anyone hear us?** Washington DC, Oxford University, Inc. New York.
- Ngwira N, and Mkandawire E, (2003), **Cost of disparities in access to socio-economic services in Malawi**, Research # 0302, Institute for policy Research and Analysis for Dialogue (IPRAD).
- NSO and ORC Macro (2000), **Malawi Demographic and Health Survey 2000**, Zomba
- Simwaka B et al (20005), **Engendering communicable disease policy and practice: Experiences from Malawi**, (unpublished).
- Tallis V et al (2002), **Gender and HIV/AIDS**, www.ids.ac.uk/bridge/reports_gender CEP.html
- Tallis V., (2001), **'Treatment issues for women,'** Paper prepared for Treatment Action Campaign, South Africa.
- UNAIDS, (2004), **Report on the Global AIDS Epidemic**, Geneva.
- Zimbabwe Women's Resource Centre and Network, (2003), **Gender and HIV/AIDS: An analysis of Zimbabwe's national policies and programs on HIV/AIDS/STIS**, Harare, Zimbabwe.