How power relations affect the implementation of policy on equity in access to anti-retroviral therapy: The case of rural health centres in Malawi

Lloyd Kaulungu Simwaka
Malawi Interfaith AIDS Association

With the Regional Network for Equity in Health in East and Southern Africa (EQUINET)

In co-operation with the Centre for Health Policy, University of Witwatersrand and Health Economic Unit, University of Cape Town

DISCUSSION PAPER 69

September 2008

With support from IDRC (Canada)

Table of contents

Cite as: Simwaka LK (2008) 'How power relations affect the implementation of policy on equity in access to anti-retroviral therapy: The case of rural health centres in Malawi,' EQUINET Discussion Paper 69. EQUINET: Harare.

Executive summary

Malawi is one of the poorest nations in the world with an estimated 52.4% of the population living below a poverty line i.e. living on less than US $2 a day (MoH, 2004). Malawi and has one of the highest HIV prevalence rate in sub-Saharan Africa estimated at 14% among the economically active population of 15 to 49 year olds in 2005 and 12% in 2007 (MoH, 2005). With the rising HIV and AIDS cases coupled with high levels poverty in the country, the government of Malawi started providing free anti-retroviral therapy (ART) aiming to serve at least 50,000 people over a 5-year period, with financial support from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). However, even this goal left an enormous shortfall because in 2004, the Ministry of Health estimated that there were about 170,000 people in need of ART. This figure has been rising over the years due to new infections.

In order to meet increasing demand for the life-saving drugs, government embarked on an ART scale up initiative from 2004. The scaling-up of ART access has so far been very impressive. In 2003, only 2.3% of eligible HIV+ patients were on ART. At the end of September 2005, a cumulative total of 30,055 patients had been started on ART, and by December 2006, 82,001 patients had been prescribed ARVs, surpassing the set national target of 35,000. By June 2006, there were 129 facilities in Malawi providing ART to eligible people living with HIV. The number of facilities rose up to a little over 140 facilities in 2007.

The national ART scale-up plan contains several measures to promote equity, considering also that there are insufficient resources to cover everyone who is eligible. Any patient diagnosed HIV positive through voluntary counselling and testing or Diagnostic Testing and Counselling could be enrolled on the ART programmes based on the World Health Organisation staging procedures. Based on the National HIV and AIDS Policy and the findings and recommendations from various consultations carried out in the country, the government of Malawi through the National AIDS Commission developed in 2005 policy guidelines to be used by health facilities to promote equity in access to ART. This policy on ‘Equity in Access to Anti-retroviral Therapy’ outlines a set of eleven equity principles intended to be used to guide implementation and practice at facility level. Out of the total set of principles, this study specifically on the four most closely linked to equity and ART access:

- At the point of delivery in the public sector, ART enrolment will be on an open ‘first-come, first-served’ basis.
- Targeted gender-sensitive health promotion of ART will be made to groups of people considered to be in ‘strategic’ or in vulnerable situations.
- Implementers will be encouraged to overcome specific geographical barriers to access for remote populations.
- In the unexpected event that demand for ART outstrips supply priority should be given to people already on ART, pregnant women and young children.

The work was implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET) policy analysis theme work, in conjunction with the Centre for Health Policy, University of Witwatersrand. Focusing on the four principles outlined above, and using a case study approach and primarily qualitative methods, the study has analysed the power relations that influenced some of the policy outcomes highlighted in the report. The study therefore empirically considered implementation processes and has delineated the practice of power in policy implementation. This study therefore attempts to contribute to empirical investigation of the importance of power in health policy implementation.

The question that the study has addressed is: *how do power relations between health facility managers, providers and patients affect implementation of the policy on equity in access to ART?* To help answer the question, the following objectives were pursued:

- to understand how decisions are made by health workers relating to implementation of the ART programme within health facility;
- to identify the ways in which power relations and resistance among managers, health workers and patients at a health facility influence equity of access to ART; and
- to analyse the other factors influencing decision making at the health facility implementing ART activities.

While the study initially set out to look at implementation of the Policy Guidelines on Equity in Access to ART (MoH, 2005c), it subsequently changed its course and focused on the current practice and implications for future implementation of the Policy Guidelines. This was because at the time of the study the guidelines had not yet been rolled out to the health facilities for implementation, even though they were finalised in 2005. This study was carried out between November and December 2007 covering four purposively selected rural health facilities in two districts of the country. Two of the facilities were managed by the Christian Health Association of Malawi (CHAM) and the other two were government facilities. A comparative analysis of CHAM and government health facilities was done to establish the influence of facility ownership over the practice of health workers, and the implementation of the ART equity policy principles.

The study investigated practice against each of the policy principles under review. Of the four facilities under study, two were performing relatively worse than the others. In each district there was one poor and one good performer. Further, one of the poor performers was a CHAM managed facility and the other was a government facility. In the same vein, across the districts there is one good performer under CHAM and the other good performer is a government facility. These findings suggest that district management and facility type (CHAM vs. Government) do not clearly make a difference in performance across the sites.

Further examination of experience in the facilities clearly shows that health workers commonly exercise power in relation to patients, and that patient acquiesce with health worker behaviours. These practices of power seem particularly evident in the two worse performing facilities. In these facilities there was also clear evidence of poor managerial practice, that discouraged teamwork and de-motivated health workers, and of the negative impacts on facility staff of wider managerial action (such as failure to ensure adequate supply of drugs to treat opportunistic infections). In direct contrast, in the two better performing facilities, use of managerial power appeared to support positive health worker practices in terms of the Equity principles and despite wider managerial actions.

The study findings highlight the following key implications for implementation of the 'Policy on Equity in access to ART in Malawi':

- Introduction of the equity principles may not yield intended unless queue jumping, shouting, use of threats and abusive language etc. towards patients are not curbed.
- To ensure that there is a buy-in and effective implementation of the new policy, key staff need to be involved in the implementation of the policy at different levels and should be adequately informed about the policy before it is introduced.
- Lack of access to information and knowledge by most health workers will be a threat to the equitable ART scale-up agenda and policy implementation. Knowledge and information are key aspects of power in organisations and could be used by a few service providers to set and control the agenda thereby frustrating their colleagues who do not have the same knowledge and information.
- Availability of ART drugs in the health facilities is a very positive development, in part because drug shortages within facilities provide opportunities for the abuse of power by those working within the ART programme.

1. Introduction

Malawi is one of the poorest nations in the world. According to the 2004/05 Malawi Integrated Household Survey, 52.4% of the population live below the poverty line of US$2 per day, 25% of the population is chronically food insecure and child malnutrition has remained virtually unchanged since 1992, with almost half of children under five years of age in Malawi being stunted and 22% being severely stunted.

The Ministry of Health (MoH) is the leading provider of health services to the population, followed by the Christian Health Association of Malawi (CHAM), which owns 33% of the health facilities. The number of physicians per population has fallen by half, and life expectancy had fallen from 46 years in 1987 to 37 years in 2005, largely due to the HIV and AIDS pandemic. The 2005 Sentinel Surveillance Survey (MoH, 2005b) shows that HIV prevalence rates are estimated at 14% among the economically active population of 15 to 49 year-olds (MoH, 2005). The 2004 Malawi Demographic and Health Survey (MDHS) suggested that HIV prevalence was 12% among persons aged 15 to 49 years in 2004. Prevalence is somewhat higher in urban areas (17%) than in rural areas (11%). However, there is evidence that, while infection rates are slowing down in urban areas, HIV prevalence continues to increase in rural areas, where 85% of the population lives. The Southern region of Malawi is the most densely populated and has the highest prevalence rates, followed by the Northern and Central regions. The primary mode of HIV transmission remains through unprotected heterosexual contact (90%) (MoH, 2004).

An estimated 80,000 AIDS-related deaths occur every year in Malawi, resulting in a drastic increase in the number of orphans. In 2005, it was estimated that there were 501,963 orphans in Malawi as a direct result of AIDS deaths, with slightly over a million orphans and vulnerable children in total. A survey in 2003 found that one-third of all households hosted at least one orphan and that 30% of households cared for at least one chronically ill person (C-SAFE, 2003).

In the face of rising numbers of people infected by HIV and dying from AIDS-related diseases, Malawi, with financial support from the GFATM, started providing free anti-retroviral therapy (ART) with the aim of reaching at least 50,000 people in five years. But this is not enough. In 2004, the Ministry of Health estimated that about 170,000 people were still in need of ART, and the figure has been steadily rising due to new infections. Limited resources force decision-makers to choose who gets treatment and who doesn't.

The scaling-up of ART access has so far been very impressive. In 2003, only 2.3% of eligible HIV+ patients were on ART. At the end of September 2005, a cumulative total of 30,055 patients had been started on ART and, by December 2006, 82,001 patients had been prescribed ARVs, surpassing the set national target of 35,000 (MoH, 2006). According to the Ministry of Health, by June 2006, there were 129 facilities in Malawi (101 public and 28 private) providing ART to eligible people living with HIV. By end 2007 there were a little over 140 facilities offering ART services.

The plan to scale-up ART nationally already contains a number of measures to promote equity, taking into account the shortfall in resources to cover everyone who is eligible. For instance, to ensure geographical equity, ART scale up is supposed to be in place in all major government and CHAM hospitals in every district in the country. The equitable distribution of drugs to all districts should also be a priority, and has to be based on an estimate of HIV disease burden, using TB as a proxy. ART provision in Malawi is integrated into the health system and, at the chosen health facilities, there should be a minimum number of *clinical* staff (one clinical officer and one nurse) to minimise the diversion of human resources from essential health services.

In 2005, the Malawi government, through the National AIDS Commission, developed and introduced policy guidelines to be used by health facilities to promote equity in access to ART. These were based on the National HIV and AIDS Policy and the findings and recommendations from various consultations. This policy, the Policy on Equity in Access to Antiretroviral Therapy (ART) in Malawi, recognised that 'equity' is a judgment of fairness, which involves several different aspects that need to be balanced. It includes a set of eleven equity principles intended to be used to guide implementation and practice at facility level. Of the eleven principles, four are more directly relevant to equity and access issues and formed the main focus for this study:

- At the point of delivery in the public sector, ART enrolment will be on an open 'first-come, first-served' basis.
- Targeted gender-sensitive health promotion of ART will be made to groups of people considered to be in 'strategic' or in vulnerable situations.
- Implementers will be encouraged to overcome specific geographical barriers to access for remote populations.
- In the unexpected event that demand for ART outstrips supply priority should be given to people already on ART, pregnant women and young children.

Makwiza et al (2005) found shortfalls in health worker practice regarding these equity policy principles, for example they suggested that the principle of 'first-come-first-served' enrolment for ART was not being adhered to which then led to queue jumping to access ART. This finding is likely to have negative impacts on the second and third principles highlighted above in that the most vulnerable groups would continue to be marginalised. Regarding the fourth principle, there are usually long waiting lists in high-burden centres (serving 150 patients a month), mainly due to human resource constraints (ibid), and it can be assumed that the same problems are also likely to happen in medium- (50 patients a month) and low-burden units (25 patients a month). The main risks posed here are shortcuts in decision-making processes and further marginalisation of the poor and most vulnerable.

Although Makwiza et al (2005) explored equity and health systems in ART provision, they did not analyse the power relations that influenced some of the policy outcomes highlighted. Implementation processes always involve the exercise of power in some way (Barrett, 2004) but there is little empirical work from low- and middle-income settings to illuminate the practice of power in health policy implementation (Gilson and Raphaely, 2008). This study attempts to provide an empirical explanation of the importance of power in policy implementation in the health sector by asking how power relations between health facility managers, providers and patients affect implementation of the policy on equity in access to ART. To help answer the question, we aimed to:

- understand how decisions are made by health workers relating in implementing the ART programme within health facility;
- identify the ways in which power relations and resistance among managers, health workers and patients at a health facility influence equity of access to ART; and
- analyse any other factors influencing decision making at the health facility implementing ART activities.

The work was implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET) policy analysis theme work, in conjuction with the Centre for Health Policy, University of Witwatersrand. When the study began, the Policy Guidelines had not yet been fully rolled out to the health facilities for implementation, even though they were finalised in 2005. So, while this study initially set out to look at implementation of the Guidelines, it eventually changed its course and focused on the current practice and implications for future implementation of the Guidelines.

2. Methodology

The study was carried out between November and December 2007 in four purposively selected rural health facilities in two districts in the Central region of the country. The process of data collection was done over more than a month and nearly one week was spent at the each of the four facilities. All the facilities were providing ART services and are part of the scale-up process supported by the GFATM grant. They are located in market towns with similar characteristics, although one was a district headquarters. We selected two districts to allow us to compare the influences of district management over performance. According to the recent statistics, both facilities from one of the districts had a very high number of patients accessing ART services compared to the facilities in the second district, which is located quite close to the capital, Lilongwe (MoH, 2006). *Table 1* below provides the main characteristics of the health facilities visited during the study.

Table 1: Main characteristics of the four facilities sampled in this study

Characteristics	District 1		District 2	
	Facility 1	Facility 2	Facility 3	Facility 4
Ownership	CHAM	Government	CHAM	Government
Services – paying or free?	Paying	Free	Paying	Free
Manager of ART clinic	Administrator	Clinician	Administrator	Medical doctor
Are health workers trained in ART?	Yes	Yes	Yes	Yes
ART clinic separate from/integrated with other clinical services?	Separate	Integrated	Integrated	Separate

As the table shows, we selected two CHAM facilities (one per district) and two government facilities so that we could compare the influence of the two types of facility ownership on practice and implementation of the ART equity principles. It is commonly suggested that people prefer to access health services, including ART, from CHAM facilities because of better perceived quality of care. In particular, there is a common view that health workers in CHAM facilities display a more humane attitude towards patients largely due to religious beliefs, but also because staff benefit from some better conditions of service (such as better housing) than government staff. This is despite the fact that, as *Table 1* shows, government facilities offer free services while in CHAM facilities patients pay for services.

The CHAM facilities we visited were managed by administrators, whereas government facilities were managed by medical personnel. The ART programmes in all facilities were run by health workers who had been trained in how to run and manage them. With regard to location of the ART services in the facilities, two facilities (one CHAM and one government) s had integrated services; in the other two facilities, separate structures were devoted to ART services. A purposive sample of respondents was drawn from the health workers working in each selected health facility. Respondents were restricted to those working in the health facilities because they were better placed to provide the relevant insight and in-depth information needed to help answer the research question. For security reasons, their protection was paramount so we maintained confidentiality throughout the study. They were given a comprehensive introduction to the study, its objectives and methodology. Their consent, either written or verbal, was always sought. Approval to conduct the research was obtained from the National Health Sciences Research Committee (NHSRC) of the MoH.

We used qualitative research methods in the form of observation, fairly unstructured in-depth interviews using an open question guide and focus group discussions (FGDs). These techniques helped study participants to collaborate more actively with the researcher and his assistants, generating rich, detailed data through the expression of their own views and experiences. Relevant documents, reports and records were also reviewed prior to and during field data collection. A total of 32 health workers were interviewed individually in the four health facilities (eight at each facility), including the health facility manager and ART coordinators. Four (two male and two female) beneficiaries of the ART programme at each health facility were also interviewed. Four FGDs – one in each facility –were carried out with 67 mixed-gender ART beneficiaries who were people living with HIV and AIDS (PLWAs) who belonged to PLWA support groups and accessed ART at the four clinics.

The in-depth interviews with health workers sought to explore the ART decision-making processes with a view to establishing power relations among the health workers and with patients, and the influencing factors in the practice of power. Meanwhile, patient interviews and FGDs solicited views from the target beneficiaries which could be triangulated with information obtained from health workers. This mix of methodologies helped to validate the overall conclusions reached. All interviews and FGDs were tape recorded. Interviews with health workers were all in English with occasional expressions and statements in vernacular (Chichewa), while all FGDs and individual patient interviews were done in Chichewa. Every evening, the research team convened to discuss, analyse and crosscheck the information gathered during that day. These meetings were also used to plan for the following day.

Observations were made by the principal researcher and his research assistants about the physical structure and spatial organisation of facilities, physical objects and statements related to the policy principles at the facilities, verbal and physical behaviour, gestures and interactions between and among health workers, routine organisation of daily tasks and people who stood out at the facilities. The observations were then triangulated with the information collected through the interviews and FGDs. Although such observation may bias health worker behaviour positively, the research team were able to observe a range of salient issues that could not have been captured during interviews and discussions.

The principal investigator collected most of the data and recruited two research assistants from the Malawi Interfaith AIDS Association (MIAA) to help in the research process. The assistants were crucial in the administration and management of FGDs and also in carrying out observations. They were given one week of training prior to fieldwork in which they were:

- informed about the policy on equity in access to ART in Malawi and the policy analysis framework underlying the research (Walt and Gilson, 1994), which emphasises the way actors influence policy change processes, interacting with features of context and content;
- provided with information on power and how to investigate power; and
- given a review of the research protocol and techniques to be used in the study.

The data collection process consisted of three phases:

i. **Mapping the site:** We first identified potential sites and then got acquainted with them. Potential study participants were identified. Records, and other documentation, were also reviewed to get more familiar with the selected sites and ascertain their suitability for the study. Background information about the health facilities and their activities, especially those relevant to the research question, was obtained. Preliminary data was collected through observation, document reviews and informal conversational interviews. The data collected in this phase was analysed to inform and help determine the course of the second phase. The first visit is therefore referred to as 'mapping' process.
ii. **Collecting the main data:** Actor relationships and the role of power in the relationships were systematically explored using the above research techniques. Interviews were structured according to interview guides, with standardised open-ended questions. We used semi-structured interviews (SSI) to allow us to compare responses more easily.
iii. **'Mopping' phase:** A final visit to the study sites was done to clarify any ambiguities, investigate new leads and follow up on emerging issues.

Analysis then commenced. The performance of the four facilities was analysed according to the policy principles, and practices of power were deciphered through a detailed analysis of two key sets of relationships in the provision of ART – between providers and patients, and between providers, colleagues and managers. These power analyses drew on frameworks developed within the broader EQUINET policy analysis programme (Erasmus and Gilson, 2008) and also applied in other studies (Komba, 2008; Lehmann, 2008). Three dimensions of power were explored, based on Luke's (2005) concept of the three faces of power:

- efforts by one actor directly to control another's actions;
- efforts by an actor to resist the influence of another actor; and
- efforts by one actor to influence another's actions indirectly by shaping their understanding of themselves or what they should do and think.

3. Results

The MoH started implementing the scale up plan for ART in the country in 2004 by briefing 60 selected health facilities on the scale up plan. Selected clinicians and nurses from facilities that had met the requirements to be involved in the scale up plan underwent training sessions covering all aspects of ARV delivery. All staff involved in ARV delivery attended the training and had to pass the formal examination to participate in the ART programme. All the health workers involved in the ART programme that were interviewed had been trained and were using the 'Guidelines for the Use of ART in Malawi' as their reference material, although at one health facility it was observed that due to the high work load by the ART Coordinator and other staff in the programme, non-ART health workers are called upon to assist. At each health facility an ART Coordinator led the team of ART health workers.

The HIV and AIDS Unit in the MoH has overall responsibility for managing ARV therapy.ARV treatment guidelines for adults and children were made available in every facility which administers ARV therapy, and guidelines are updated at regular intervals based on national experience and new international knowledge. Every health facility participating in the ART delivery has a standardised registration, recording and reporting system.

A counselling and HIV testing service (CT) is linked to every unit providing ARV therapy, which is subject to regular quality assurance and quality control by the HIV and AIDS Unit. ARV treatment units are provided within the general health services, at hospital and health centre level, and regular supply of ARV drugs and HIV testing materials is ensured. The HIV and AIDS Unit developed and co-ordinates a plan of supervision, mentorship, monitoring and evaluation, while health facilities provide regular reports to the Unit. All ARV delivery sites provide standardised first line combination ARV therapy to HIV-positive persons who present themselves at health facilities and who fulfil the eligibility criteria.

On average, there were no major differences in performance between districts or between CHAM and government facilities because each district had one poor and one good performer, which tended to balance the statistics. *Table 2* measures performance of the facilities according to four policy principles.

According to the table, two facilities were performing relatively worse, of which one was a CHAM facility and the other was government owned; likewise with the good performers. This suggests that, in the four sampled facilities, neither district management nor facility ownership (CHAM versus government) make a difference in performance. However, health facilities with integrated services performed better than those where the ART clinics were separated from the facility's other activities.

Table 2: Performance of facilities measured against policy principles

Policy principles	**District 1**		**District 2**	
	Facility 1 (CHAM)	**Facility 2 (government)**	**Facility 3 (CHAM)**	**Facility 4 (government)**
Principle 1: Enrolling patients on a first-come, first-served basis	Poor	Very good	Very good	Poor
Principle 2: Eliminating discrimination and targeting vulnerable groups	Average	Good	Good	Average
Principle 3: Overcoming geographical barriers for remote populations	Poor	Average	Good	Poor
Principle 4: Prioritising patients with greater need when demand for ART outstrips supply	Average	Average	Average	Average
Overall performance	Poor	Good	Good	Poor

3.1 Principles 1 and 2: Enrolling patients, eliminating discrimination and targeting vulnerable groups

The policy Principles on Equity in Access to ART in Malawi highlight the open ‘first-come, first-served’ enrolment of patients for the ART services as one of the key principles in achieving equity in provision of ART to eligible patients. Any patient diagnosed HIV positive through voluntary counselling and testing (VCT) or diagnostic testing and counselling (DTC) could be enrolled on the ART programmes, based on the WHO staging procedures. In addition, facility staff should be encouraged to be non-discriminatory towards patients and others seeking help and ART services must target individuals from to vulnerable groups.

We found that equity in access to ART was compromised by:

- individuals who jump the queue, thereby violating the 'first-come, first-served' principle;
- delays in service delivery; and
- staff who intimidate patients by shouting at them.

The Policy on Equity in Access to ART emphasised the need to promote an open ‘first-come-first-served’ enrolment of patients in need for ART at the point of delivery. As *Table 2* depicted, this equity principle was well observed in two of the health facilities, but was not clearly observed in the other two facilities. Makwiza et al (2008) also observed this mixed result. There was no clear distinction between CHAM and government facilities as results e were mixed – one poor-performing facility belonged to government and the other to CHAM.

The experience of frequent queue jumping suggested the disempowerment of some patients. For example, the exercise of power over patients by health workers was observed at Facility 1, when one ART clinician wrote a note to one of the patients telling him to come out of the queue to be assisted first, in full view of everyone. When this was happening, another patient, who saw what was happening, pushed his way through to the clinician and knelt down, begging to be attended to immediately because he had been waiting too long. Seeing that the clinician was not taking notice of his request he grumbled in resignation: 'Even if I don’t get healed, it is too much waiting here.' In one of the more organised and better performing CHAM facilities (facility 3) where not even one report of queue jumping was made, patients said: 'We always follow the queue. There is no queue jumping by anyone whether known to the health worker or whatever the case may be.'

Delays by health workers in attending to patients at appointed times were noted in both government and one CHAM facility. Makwiza et al (2005) also found long waiting lists of

ART eligible patients, mainly due to human resource constraints. While there were genuine cases, in that health workers were sometimes delayed due to high workloads, several of the patients interviewed reported negligence and lack of consideration for patients.
It should, however, be noted that at Facility 3 (CHAM), ART services always commenced at designated times. This was mainly because the ART Coordinator was always on time and seemed more dedicated to duty. There were even reports that the Coordinator usually arrived at the clinic before patients, which showed a high level of commitment to his duty and helped make the facility one of the two better performers.

Cases of health workers shouting and using abusive language towards patients were reported in Facilities 1 and 4, mainly when patients complained about workers abusing their power by, for example, allowing acquaintances to jump queues. Some patients are deliberately humiliated by rude workers:

> *I missed one day to come and replenish my drugs (ARVs) and the health worker was angry with me and said: 'Am I the one who gave you HIV so that you should end up being so forgetful like this?' There was nothing I could do but just apologise.*

Patient from Facility 4.

In all the health facilities visited, it was clear that health workers did not give any preferential treatment to patients who were deemed to be key front-line service providers such as health workers, teachers and civil protection workers as required by the Policy on Equity in access to ART. Overall, this practice was based on the principle of non-discrimination. One teacher who was a member of a support group commented during a FGD:

> *Even though I'm a teacher, I am not given preferential treatment. But there are times when we can see that another patient is very sick and we would agree to allow them to be attended to first.*

With regard to reaching out to people living positively with HIV to encourage more people to speak openly about HIV and AIDS and access treatment, all health facilities managed to target and provide services to HIV and AIDS support groups that availed themselves.

3.2 Principles 3 and 4: Overcoming geographical barriers for remote populations and prioritising patients with greater need during ARV shortages

We further examined geographical coverage and drug availability at the health facilities. Government’s intention is to overcome all geographical barriers and make ART services available to remote rural dwellers. According to the Malawi Housing and Population Survey (1998), most Malawians (over 85%) live in rural areas and are poor.

3.2.1 Geographical coverage

Table 2, depicts poor performance in terms of geographical coverage for two of the facilities we visited. The other two facilities’ performance was average and good respectively. Performance in this regard was looked at in terms of the distances patients had to cover to access the services and time taken to receive treatment. Most patients have to cover long distances to access ART services. For instance, some patients who access ART services at Facility 2 indicated that they cover close to 50 kilometres to the facility which was the nearest. In this regard, some of them indicated that they had to start off as early as 4am or earlier to arrive at the health facility by 7am.

Travelling long distances to access ART services may act as a deterrent particularly for those that are very sick and weak and do not have money to use any public transport and/or hire local means of transport such as bicycles and ox-carts. Long distances patients have to cover to access ART services would also discourage some, making them abscond or miss ART clinic days, consequently reducing adherence to medication. Hence, despite the fact that government has gone a long way in increasing the number of ART sites, gaps still need to be closed to increase the number of people accessing ART. Having travelled long distances to a health facility, a patient may not have the energy to question health workers, especially if they fear being reprimanded. It seems likely, therefore, that patients may simply submit themselves to possible mistreatment at the hands of some health workers.

The other impediment in accessing ART services reported by most patients in both districts was the scarcity of CD4 counting machines. Patients had to travel long distances to have their immunity level tested. For instance, at the time of the study, Facility 4 did not have the CD4 count machine and patients had to go to Facility 3, more than 50 kilometres away. Patients at Facility 2 also had to either go to Facility 1 or another facility nearly 35km away, to access the CD4 counting machine.

3.2.2 Drug supply and availability

A rough assessment of the availability of ART drugs in the health facilities was carried out to further determine patients' access to the life-saving drugs and find out the possible practices of power related to the availability of drugs. Interviews with health workers indicated that there had never been cases of overall ART drug shortages in any of the facilities visited. However, it was noted that some health facilities were frequently experiencing shortages of Trimune 40 (T40) (a type of the ART drug).[1] T40 was reported to be running out faster than T30 in nearly all the facilities visited. In some cases when T40s run out, patients who were on this drug were being given T30.

Further discussion of this finding with an ART expert at the National AIDS Commission revealed that T40 was being phased out because of its negative side effects on patients. Hence the MoH decided that instead of using T40 and T30, all patients were to be on T30 as it did not cause the side effects experienced with T40. At facility level, this information was not provided to patients leading to confusion and fears among patients on the side effects of changing the drugs. Most health workers also seemed not to know about the change in policy. To substantiate this view, a health worker at one facility said 'there are more patients on T40 than T30 hence there is more demand for T40 leading to the shortage.'

This is a clear example of information gap between the head office and the facility level. If health workers do not know about some policy being introduced, it would be not be possible for them to implement it. In this case, health workers could not explain to patients the change in policy regarding the phasing out T40. This is an example of top-down policy change not communicated at all or well to health workers.

While ART drugs were reported to be readily available, bactrim (also known as cotrimoxazole) as an accompaniment to ART drugs and other drugs to treat opportunistic infections (OI) were reported to always be in short supply in all the facilities visited. Shortage of bactrim and other OI drugs is a recipe for favouritism and a fertile ground for wider corrupt practices, threatening equity in service provision. At one facility, patients in a focus group discussion expressed their reservations about the shortage of bactrim they usually experience. One patient said 'I am sure bactrim is there but they don't just want to give us'.

At one CHAM facility it was reported that free antibiotic drugs and other OI drugs could run out at the ART clinic but would be available for sale at the outpatient department. Thus, ART patients had to pay to access the antibiotic and other OI treatment drugs like anyone else. Most patients on ART indicated that they are poor and have problems buying the accompanying drugs. This contributed to the low performance rating of these facilities.

---

[1] T40 was being provided to PLHIV with weight of 60+ kgs while those with less were on T30. However, a scientific analysis of the two types of ART shows that performance of the two drugs is the same.

Government as been askd to include bactrim and others OI drugs on the list of specified free drugs covered in Local Service Agreement signed with CHAM.

3.2.3 Threats by health workers to deny patients drugs

In FGDs in two health facilities patients strongly indicated that as HIV sero-positive people, some health workers were discriminating against them in as far as medication was concerned. This is because the HIV+ people are considered to be 'already dead' and so not deserving of the free medicine that could otherwise be offered to HIV negative patients. One patient lamented the dehumanising attitude of the health workers at Facility 4: 'Health workers do not treat us as fellow human beings but as already dead people – corpses.' Another patient at the same facility commented on the abusive language used by a health worker in a consultation room after seeing a drop in the weight of the patient: 'You are useless people just wasting our time and drugs.'

The treatment of people living with HIV and AIDS (PLLWA) as 'useless', 'weak' and 'already dead' was also noted in a year-long study undertaken by the Leitner Centre (2007) to document the impact of stigma and discrimination on the lives of women living with HIV in Malawi. Patients not only have to endure abusive behaviour but also erratic drug availability.

3.3 Relationships between health workers and between workers and facility managers

On the whole, the relationship between health workers directly involved in the ART programme at facility level seemed good except in one facility where teamwork was not apparent. The two facilities that showed good performance also displayed a lot of teamwork among their health workers.

In Facilities 1 and 4, it was reported that the facility managers showed little interest in the ART programme. Although no clear reasons for this attitude were established, some pointers that could explain it. In one of the CHAM facilities, it was mentioned by patients that health workers concentrate more on the services for which they charge than those provided free of charge. As a facility that charges fees, it could be that health workers prioritise the paying services over the free services, including the ART clinic. Consequently, ART clinic users had to wait for health workers to finish their other duties before being seen.

While the above conclusion may have some grain of truth, it was interesting to note that the facility manager at Facility 4 (which is a government facility that provides free services) was also reported by some health workers to have had little to do with the ART clinic services. Therefore provision of health services at a fee may not be the only explanatory factor for lack of interest by health workers, particularly facility managers.

4. Discussion of results

4.1 Principles 1 and 2: Enrolling patients, eliminating discrimination and targeting vulnerable groups

The two main contributing factors for queue jumping were favouritism by health workers towards their friends, acquaintances and colleagues, as well as corrupt practices where they were receiving bribes to allow some people jump the queues. In this regard, health workers were using their profession and authority to exercise power over patients in the ART programme, and to practise favouritism:

> *Health workers would usually call their friends who came late and attend to them quickly while some of us who came earlier would have to wait. It was a struggle to*

> *get into the ART clinic building … No one here works on a 'first-come, first-served' basis mainly because the heath workers always come late and usually help the people they know first.*
>
> Patient at Facility 1.

Queue jumping like this contributes to greater health inequities because most patients have already travelled long distances to the health facilities and have to wait for hours before being attended to. Some patients are sometimes sent away and asked to come back on the following day, ignoring the distances they have to cover to and from the health facility. In Facility 1, queue jumping was also facilitated by the the ART premises being too small to accommodate all patients at once, so patients had to scramble to enter the building when services started. The makeshift ART facility - an old staff house - can only accommodate about 30 patients, yet the health facility handles over 400 patients in the ART clinic per day.

There were also reports of some health workers spending time chatting in their offices when they were supposed to be attending to patients. This was a clear display of power by the health workers towards patients, who were rendered powerless and at their mercy. To reinforce their power, some health workers shouted at patients who asked why they were not being attended to in time and even threatened to drop them from the programme. This form of intimidation contributed to a sense of powerlessness among patients. Health workers appeared to have created a climate in which patients were forced to concede health workers were always right and should never be questioned:

> *Despite the fact that most of us travel long distances to get to the facility and arrive very early in the morning, we are usually not attended to quickly. When we complain about delays, health workers do not attend to us and they have ignored our suggestion that two days every week should be specifically allocated to the ART clinic … We don't question what health workers do because they answer us in a rude manner and so we just leave them and accept whatever they say 'according to their profession'.*
>
> Participant from FGD at Facility 1.

Ignoring and rejecting patients' requests was a clear show of power by the health workers that they are the ones in control of the agenda and patients have no influence over their decisions. The health workers derived this power from their professional status, as well as from the authority bestowed on them to run the ART programme at the facilities. At Facility 4, the delay in attending to ART patients might also be a reaction by health workers to the fact that their facility manager was not keen to pay them their overtime allowances. The delay may be a form of resistance by the health workers, as one of them noted:

> *We always work overtime on the days we attend to patients on ART. However, our manager does not honour our overtime, even though it was approved by government that we should be paid for overtime.*

Patients at Facility reported that some health workers were treating the free ART programme as secondary to their core business of providing paying services to other patients:

> *Health workers tell us openly that they have a lot of work in the other departments and so would only attend to us later.*

Coupled with the high workload, health workers may have developed their own routines and ways of working as manifested in delayed attendance to ART patients, although there were also reports that even if workers arrive early, they sometimes sit chatting in one of the rooms for some time before opening the clinic, during which time, patients have to wait outside.

In response to health workers' abusive language and treatment of patients, some patients said they were just ignoring them to avoid reprimands while others indicated that they just wanted to maintain their respect and dignity. Patients are members of HIV and AIDS support groups and they encourage each other in group therapy not to give up and live positively. In this way, they manage to cultivate a sense of self-worth and dignity despite humiliating and degrading treatment due to their sero-status. Over time, the build up of abuse may trigger a revolt as support groups start to fight for their rights, ultimately creating an antagonistic provider-patient relationship and disrupting the ART programme.

4.2 Principles 3 and 4: Overcoming geographical barriers for remote populations and prioritising patients with greater need during ARV shortages

During the interviews with individuals and in FGDs, it was apparent that patients did not have any say or influence on shortages of the T40 or T30 ART drugs. They left everything to the health workers and could only wait to be advised by them what next steps would be in the event of shortages, i.e. whether those on T40 would go on T30. As indicated earlier, implications or side effects of these changes were not being explained to the patients. This was noted through interviews and FGDs, where all clients interviewed indicated that health workers were not explaining implications of the drug changes. And so, despite patients having questions about the changes, they did not question for fear of being shouted at and/or believing that health workers knew what they were doing as professionals and therefore could not be questioned.

The shortage of bactrim was reported by both health workers and patients as being because the antibiotic was also available to all patients and not only available for those on ART. The demand for bactrim was therefore high leading to shortages. At one of the CHAM facilities visited, bactrim was said to have been out of stock for nearly three months. Commenting on the scarcity of bactrim, one patient at Facility 4 expressed his scepticism about the drug shortage. In her view, the drug was there but the health workers at the facility chose not to give it to those on ART. They were treating PLWAs as ‘already dead’ people who should not finish drugs available for the supposedly HIV negative patients:

> *At this facility I always experience shortage of bactrim, unlike at Facility 3 where I used to go before where it was always available. I am sure the drug is there but they don’t just want to give us.*

This confirms what was reported in a FGD, as well as statements made by health workers at this facility, that this is a clear display of stigmatisation and discrimination being practised by health workers against HIV+ people at Facility 4, contributing to its poor performance.

Also at Facility 4, a patient recounted her experience, which she indicated was also happening to other patients, where a health worker shouted at her and threatened to remove her from the ART programme just because she failed to attend the ART clinic on the designated day but came a day after. While it is important for health workers to remind patients on the importance of attending ART clinics on designated days, the manner of their interactions with patients was sometimes clearly experienced as demeaning. Yet patients may have genuine reasons to miss the designated ART clinic days and shouting at them only degrades and add more pain to their already ailing lives.

In these various ways it seems that some health workers were behaving more as judges than servants of the people. Through their behaviour they sometimes not only violated the human rights of patients but also put to question the upholding of medical ethics by the health workers. It further engenders a sense of powerless and worthlessness among patients, in the face of the health workers and others who are assumed to be HIV negative.

4.3 Relationships between health workers and between workers and facility managers

The likely factors that seemed to foster cohesion among the ART health workers were the specialised training in ART and the authority and role bestowed on them by the HIV and AIDS Unit to run the ART programme at facility level. The observed teamwork among health workers provided a conducive environment for effective implementation of relevant policies in as far as the ART programme is concerned. At Facility 3, interaction among ART health workers was noted to be very high. This was mainly due to the strong support the ART Coordinator provided to his colleagues. The Coordinator also seemed to like his job and did not treat it as a secondary preoccupation, as was the case at the other CHAM facility.

It was, however, noted that despite teamwork among ART health workers there was little interaction between ART health workers and the rest of the health workers in the two poor performing facilities. For example, the non-ART health workers had barely any information on the ART programme in their facility when interviewed. This may have been a result of the centralisation of information by health workers in the ART programme or lack of interest by non-ART health workers to learn more about the programme from trained colleagues. In addition, centralisation of information may have been because the trained ART health workers wanted to look different from their colleagues, because of the training they received and their involvement in the ART programme, so creating some kind of professional divide that irritated their colleagues. This would then lead to increased workload for the ART health workers as they would not get help from their colleagues on the ART clinic days.

Centralisation of information is substantiated by the fact that nearly all the trained ART health workers kept copies of the 'Guidelines for the Use of ART in Malawi' at their homes and not at the health facility. This meant that only they could make reference to the documents and no one else, not even their colleagues. This practice further alienated other health workers and may have been the cause of low interest in the ART programme by the other workers. Since knowledge and information are key aspects of power in organisations (Clegg, 1989), ART health workers may have wanted to monopolise agenda setting and control of resources in the ART programme. These divisions are a show of power where the trained health workers want to show that they are different from their colleagues while the non-ART health workers try to resist by cultivating their own sense of self-worth despite the fact that they were not exposed to the ART training.

Interviews at Facility 1 revealed that the ART Coordinator attends all training or refresher courses on ART by himself. This made the other ART health workers leave all decisions to him as way of showing their unhappiness with the monopolisation of training opportunities. As a leader of the ART team of health workers, the Coordinator also, if subconsciously, seems to generate a spirit of ‘take-it-easy’ and foot dragging by the other ART health workers. This results in increased workloads and patient delays. As the Coordinator has a specialised clinical training he is very busy in other programmes, even when he is supposed to attend to the ART clinic.So, unless he delegates or asks another health worker to cover for him, everything in the ART clinic has to wait until he is through with his other duties. This leads to the delays in attending to ART patients that were frequently mentioned by patients at the facility.

There were also reports of direct communication from the HIV and AIDS Unit to the ART health workers in Facility 4, short-circuiting the facility manager. This is likely to cause friction between the facility manager and the ART health workers as it undermines the manager’s authority and may break the facility’s protocol or line of command. In response, the facility manager may use their organisational power to resist, by not showing interest in the programme and leaving everything to the concerned health workers unless called up to assist on specific areas, usually logistics and administrative.

As noted before, in this government facility health workers also expressed their lack of satisfaction with their manager because of not honouring payment of their locum allowances. It was reported that due to shortage of staff and therefore high workload as a result of the ART scale up, health workers have to work longer hours and are therefore entitled to an overtime allowance. Government introduced the locum allowance to motivate health workers as a mitigating factor for shortage of staff. However, the health workers were not being paid the allowances due to them and this is a likely spark for the health workers' frustration - leading to delays in attending patients and also fuelling their tendency to shout at patients, which has been reported above.

Apart from delays and shouting at patients, health workers may also resort to working more slowly than they can which is partly depicted in the delays to commence the ART clinic. The health workers in the ART programme have extensive knowledge on the programme which they may decide not share with the Facility Manager and can use it as an important weapon of resistance (Scott, 1986). For instance, they may disobey instructions from the manager knowing that they cannot be reprimanded because they have special skills that are important for the ART programme which could not be easily replaced. In such circumstances it would be very difficult for the manager to have the full cooperation of the health workers and effectively implement government policies. On the other hand, in the other government facility it was reported that the facility manager actively listened to the health workers and so was seen by the health workers as supportive and caring even if their concerns including payment of locum allowances were not fully addressed. Hence, the style or leadership is crucial for effective delivery of services.

5. Conclusion and recommendations

The findings from this study provide numerous examples of practices of power within the ART programme at health facility level. They also show how these behaviours have significant influence on, and implications for, implementation of ART policies, and thus performance of the ART programme, in Malawi. Based on the findings of this study, certain precautionary measures will need to be undertaken to ensure effective implementation of the Policy on Equity in Access to ART, when it is rolled out to the health facilities.

Table 3 below provides a summary of practices of power across relationships and facilities. It illuminates the particular ways in which health workers exercise power over patients with, in Facilities 1 and 4, overarching negative consequences for performance assessed against the Equity policy principles (see *Table 2*).

Various bodies of theory help to suggest deeper explanations for the observed health worker practices of power. According to Satyamurti (1981), for example, difficult work environments lead to the abandonment of ideals by workers, and to the adoption of techniques that enable clients to be 'managed'. Hence, health workers may try to cope with the pressure of work by spending time chatting among themselves, and sometimes even by shouting at patients who complain. The power relations described here may also provide support for the arguments of Hasenfeld and Steinmetz (1981), who suggest that bureaucrat-client relationships are exchanges in which, in social service agencies serving low-status clients, clients have little to offer except deference. Instead, the bureaucratic power advantage in such agencies enables them to exercise considerable control over the lives of the recipients of their services. Finally, the experiences reported here seem to reflect the behaviour of street level bureaucrats (Lipsky, 1980) who react to difficult and demanding working environments by processing clients in routine and stereotyped ways, including denigrating them.

Table 3 also suggests that health worker practices of power are in effect underpinned by the forms of resistance patients adopt in response both to their treatment by health workers and the indirect influences over their behaviour. In essence, patients seem to acquiesce with health worker control although, in Facilities 1 and 2, also seek to maintain a sense of self-worth and identity through their engagement in support groups.

The table finally suggests that health worker practices of power in facility 1 and 4 may be underpinned both by poor management practices within the facilities, and by the ways in which managerial actions by those working at higher levels of the system impact on staff in the facilities examined. Attempts to control the actions of street-level bureaucrats, as in Facility 4, may also only serve to encourage their resistance to managerial practices, and so act to increase their tendency to stereotype and disregard the needs of patients (Gilson et al, 2006). The fee charging practices in Facility 1 also help explain health worker behaviour towards patients. These experiences, however, contrast strongly with those of the two better-performing facilities (2 and 3) where managerial power was used to encourage team work and motivate staff, despite external influences (including fee charging in Facility 3).

5.1 Recommendations

Based on the findings presented above, the following are key implications for the future implementation of the 'Policy on Equity in access to ART in Malawi' as it is rolled out to all facilities.

First, the study showed cases of queue jumping, shouting at and using abusive language towards patients, which are indicators of corrupt practices and negative use of professional and institutional authority. Similarly, threats to deny patients drugs are a manipulation of clients by health workers. This would likely discourage most PLHIV to access services. The introduction of the equity principles may not, therefore, yield the intended results if these and other practices of power are not checked. Hence, for effective service delivery and ensuring equity in access to ART, threatening tactics and approaches displayed by health workers will need to be mitigated.

So, second, in order to ensure that there is buy-in and effective implementation of the new policy, all key staff to be involved in the implementation of the policy at all levels shall need to be adequately oriented on the policy. Particularly crucial for the realisation of policy goals and objectives are the health workers who, as street-level bureaucrats, have the direct responsibility of putting any health policy into practice and can easily formulate their own policy through practice. In seeking to ensure that health workers are more committed to policy implementation, managers at the facility level will need to use their managerial power in a positive and constructive way by, for instance, showing that they are actively listening to the health workers’ concerns.

Third, the study has also highlighted the issue of centralisation of information by ART health workers. This will be a threat to the ART scale-up agenda and policy implementation as knowledge and information are key aspects of power in organisations and could be used by a few service providers to set and control the agenda thereby frustrating their colleagues who do not have the same knowledge and information. This practice would affect policy implementation and there will be the need to promote a culture of information sharing and collective responsibility at the facility level.

Fourth, availability of ART drugs in the health facilities is a very positive development because any shortage of drugs is a source of abuse of power by those in charge of managing the ART programme. Indeed, some health workers may use their authority to manage the ART programme to practice favouritism and abandon the policy principles once introduced. Therefore, policy implementation will be most effective if steps are taken to create favourable conditions, such as ensuring that drugs are always made available in the facilities.

Table 3: Comparison of practices of power between sites

Practices of power in relationships between:	Categories	District 1		District 2	
		Facility 1: CHAM	Facility 2: Government	Facility 3: CHAM	Facility 4: Government
Health workers (HWs) and patients	HW control of patients	• HWs make patients wait for long hours before attending to them (consider free services of secondary importance) • HWs rude and abusive to ART patients • HWs allow their friends to queue jump • HWs ignore patient requests to introduce more days for ART clinic • ART HWs make final decisions to enrol a patient on ARVs or not	• HWs delay attending to patients • HWs allow some patients to queue jump (though not common). • HWs make final decision to enrol patient on ARVs or not	HWs make final decision to enrol patient on ARVs or not	• HWs make patients wait for long hours before attending to them • HWs ruse and abusive language towards ART patients • HWs allow their friends to queue jump • ART HWs make final decisions to enrol a patient on ARVs or not
	Patient resistance	• Patients discuss abusive HW treatment and just accept it as such • Patients keep their respect by not arguing against HWs’ abusive treatment. • Patients in a support group encourage and support each other through group therapy • Don’t bother about HW treatment as long as get ARVs.	Patients support each other through support groups		
	Patients influenced indirectly	Patients fail to question for fear of reprimand	Patients unable to question HWs because believe HWs are always right (shaping perceptions)		Patients unable to question HWs for fear of reprimand
HW-colleagues-	Control of and resistance to one	• ART coordinator always attending training alone	Overall positive managerial style	Positive managerial power encourages team	• Facility manager not paying overtime allowances

Practices of power in relationships between:	Categories	District 1		District 2	
		Facility 1: CHAM	Facility 2: Government	Facility 3: CHAM	Facility 4: Government
manager	another	• ART coordinator controlling the ART agenda and access to information & decision making • HWs outside ART programme not interested in it because they see it as an extra burden due to centralisation of power	encourages team work and good performance	work and good performance	• Facility manager not showing any interest in programme
Bureaucratic environment	Influence over health workers	• Direct communication from HIV and AIDS Unit to ART HWs undermines local manager • Shortage of supporting drugs (mainly bactrim) makes HW jobs more difficult • Fee-charging facility	Shortage of supporting drugs (mainly bactrim) makes HW jobs more difficult	• Shortage of supporting drugs (mainly bactrim) makes HW jobs more difficult • Fee-charging facility	• Direct communication from HIV and AIDS Unit to ART HWs undermines local manager) • Shortage of supporting drugs (mainly bactrim) makes HW jobs more difficult

References

1. Bauer M (1996) 'Narrative interview: Comments on a technique for qualitative data collection' Papers in Social Research Methods: London.
2. Bjuremlm H (2006) *Power Analysis: Experiences and Challenges*. SIDA: Stockholm.
3. Bongololo G (2005) *Using Research to Promote Gender and Equity in the Provision of ART in Malawi*. Open University Press: Lilongwe.
4. Buse K, Mays N and Walt G (2005) *Making Health Policy: Understanding Public Health*. Open University Press: New York, USA.
5. Buse K, Mays N and Walt G (2005) *Making Health Policy.* Open University Press: Maidenhead.
6. Erasmus E and Gilson L (2008) 'How to start thinking about investigating power in the organisational settings of policy implementation', *Health Policy and Planning* 23(5):361–368.
7. Gilson L, Erasmus E, Kamuzora P, Mathews V, Ngulube TJ and Scott V (2006) 'Applying policy analysis in tackling health equity-related implementation gaps'. *EQUINET Discussion Paper* 28. EQUINET: Harare.
8. Hyden G (2005) *Why Do Things Happen the Way They Do? A Power Analysis of Tanzania*. SIDA: Stockholm.
9. Hyden G (2006) *Beyond Governance: Bringing Power into Policy Analysis*. The Norwegian Association For Development Research: Oslo.
10. Jermier JM and Knights D (1994.. Resistance and Power in Organisations. Routledge: London and New York.
11. Johansson E, Longabd NH, Diwanac VK, Winkvistd A (2000). Gender and Tuberculosis Control Perspectives on Health Seeking Behaviour among Men and Women in Vietnam. *Health Policy* 52(1):33-51.
12. Komba A (2008) 'Evaluating the implementation of the Tanzanian National Voucher Scheme: A case study from the Ruvuma region, Tanzania.' *EQUINET Discussion Paper 67*. EQUINET: Harare.
13. Mgbako C, Fenrich J and Higgins TE (2007) *We Will Still Live: Confronting Stigma and Discrimination Against Women Living with HIV and AIDS in Malawi*. Leitner Centre for International Law and Justice, Fordham Law School: New York.
14. Lehmann U (2008) 'Exploring the concept of power in the implementation of South Africa's new community health worker policies: A case study from a rural sub-district.' *EQUINET Discussion Paper 63*. EQUINET: Harare.
15. Lukes S (2005) *Power: A Radical View*. Palgrave Macmillan: Basingstoke.
16. Mack N et al (2005) *Qualitative Research Methods: A Data Collector’s Field Guide*. Family Health International: North Carolina.
17. Makwiza I, Nyirenda L, Bongololo G, Loewenson R, Theobald S (2005). 'Monitoring equity and health systems in the provision of ART: Malawi country report.' *EQUINET Discussion Paper 24*. EQUINET: Harare.
18. Ministry of Health (2004) *Malawi Integrated Household Survey 2004/5*. Government of Malawi: Lilongwe.
19. Ministry of Health (2005) *Treatment of AIDS: A Five-year Plan for the Provision of ART and Good Management of HIV-related Diseases to HIV-Infected Patients in Malawi 2006–2010*. Government of Malawi: Lilongwe.
20. Ministry of Health (2005b) *Sentinel Surveillance Survey 2005*. Government of Malawi: Lilongwe.
21. Ministry of Health (2005c) *Policy Guidelines on Equity in Access to ART*. Government of Malawi: Lilongwe.
22. Ministry of Health (2006) *Treatment of AIDS: Guidelines for the Use of ART in Malawi*. Government of Malawi: Lilongwe.

23. National AIDS Commission (2005) *Policy on Equity in Access to Antiretroviral Therapy (ART) in Malawi*. Government of Malawi: Lilongwe.

24. Nkhata A (2007) 'The national scale-up of ARV therapy in Malawi: Update to September 2007', ART public lecture. Ministry of Health HIV Unit: Lilongwe.

25. National Statistical Office and ORC Macro (2005) *Malawi Demographic and Health Survey 2004*. USAID, DFID, UNICEF, UNFPA, Government of Malawi: Zomba, Malawi.

26. Thornson A and Johansson E (2003) *Equality or Equity in Health Care Access: A Qualitative Study of Doctors' Explanations to a Longer Doctor's Delay among Female TB Patients in Vietnam*. Division of International Health: Stockholm.

27. Ulin PR et al (2002) *Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health*. Family Health International: United States of America.

28. Walt G and Gilson L (1994) 'Reforming the health sector: The central role of policy analysis', Health Policy and Planning 9(4):353–370.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CHAM	Christian Health Association of Malawi
DTC	Diagnostic Testing and Counselling
FGD	Focus Group Discussion
Govt	Government
HIV	Human Immunodeficiency Virus
HW	Health Worker
MDHS	Malawi Demographic and Health Survey
MIAA	Malawi Interfaith AIDS Association
MoH	Ministry of Health
NHSRC	National Health Sciences Research Committee
OI	Opportunistic Infection
PLWA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
VCT	Voluntary Counselling and Testing

Acknowledgements

I would like to express my appreciation for the support provided by my facilitators and supervisors Lucy Gilson and Ermin Erasmus for their technical support, which helped me conduct this study. Lucy and Ermin were involved in training me in health policy analysis and provided significant input during preparation of the research protocol and during drafting of this report. They provided invaluable comments on the draft report. Thanks also to the anonymous reviewer of the draft report.

Special thanks go to IDRC Canada and EQUINET through the Centre for Health Policy of the University of the Witwatersrand for providing financial assistance and making the study possible and for all the logistical support.

My gratitude also goes to Mr Wycliffe Masoo and Mrs Edwina Hanjahanja for their diligence in helping me to collect data in the field. I would be remiss if I did not mention Mr. Gift Mkombozi who provided his assistance for driving the team around during field data collection.

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

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

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

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editor: Lucy Gilson, Pierre Norden, Rebecca Pointer