Perspectives about policy implementation: A learning opportunity from the 2003-2013 Malawi HIV/AIDS Policy

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Abstract

Malawi published its first ever HIV and AIDS policy in 2003. The implementation of the policy provided a very necessary and critical step in Malawi’s organized response towards HIV and AIDS. Many achievements were registered in the period this policy was implemented. However, some components of the policy were not well-implemented. Our study explored barriers to implementation of provider initiated HIV testing and counseling (PITC) for sexually transmitted infections (STI) within general outpatient settings. Malawi also launched a revised HIV and AIDS Policy in December 2013. Although not part of this policy analysis, future years of implementation may face related issues observed during the implementation of the 2003-2013 policy.

Methods

This is a non-experimental, descriptive study using a case study design. We examined the implementation of provider initiated HIV testing and counseling component of the Malawi HIV and AIDS policy from 2003-2013 focusing on STI and outpatient clinic settings. We sought to understand perspectives of various stakeholders and users of the policy. We conducted in-depth interviews with policy makers, health care worker supervisors, health care workers and health rights activists.

Results

Major problems which affected the implementation of the 2003-2013 HIV policy were: selective prioritization of policies by government, lack of involvement of implementers in the policy making process, non-awareness of health workers about the existence of the policy, lack of healthcare worker training, unstructured supervision of policy implementation, poor harmonization of policies, lack of clarity about guidance to those directly implementing, unclear roles and reporting authority among the main national coordinating units.

Conclusion

Good leadership, effective coordination, involvement of key players in the policy making process, dissemination to primary users and decentralization or empowerment of local supervisors is key to successful policy implementation.

Introduction

Sub-Saharan Africa bears a disproportionately large share of the global HIV burden. An estimated 23.8 million people (66% of the global estimate) reside in Sub-Saharan Africa in 2013. Malawi is one of the top ten countries in southern Africa most affected by HIV. The country’s adult HIV prevalence is high at 8.8%. HIV and AIDS negatively affects the health and well-being of productive people.

In 2003, Malawi published its first ever HIV/AIDS policy—A Call to Renewed Action. The goal of the policy was to prevent further spread of HIV infection and to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation.1 This paper reviews the implementation of that policy by assessing provider initiated HIV testing and counseling (PITC) for sexually transmitted infections (STIs). We also look at how PITC in antenatal care, for prevention of mother to child transmission of HIV (PMTCT), was implemented. This approach was not clarified in the initial design of the Policy but Malawi adopted it soon after World Health Organization (WHO) recommended it in 2007. The 2012 Malawi Global AIDS Response Report indicated an uptake of only 28% in the general outpatient PITC, but 71% among antenatal women (for PMTCT purposes).3,4 The universal uptake goal was 75%. The follow up analysis in 2015 showed higher HIV testing uptake of 70% among pregnant women and 49% for STI patients.5,6 The study’s findings explain some of the factors that affected the HIV testing and counseling component of the policy. There are several known barriers that affect implementation of health-related policies. Fear of stigma and discrimination affects implementation of certain policies, low motivation and commitment, conflicting policies, and challenges in multilevel coordination affected implementation in three United States Agency for International Development (USAID) supported countries. Other barriers are lack of awareness policies, limited familiarity, and a lack of agreement among stakeholders and implementers. Limited time and financial resources, as well as work pressure have also been noted as contributing factors to poor policy implementation. Lack of political will was a barrier to implementation in South Africa, lack of government endorsement of these guidelines was another reason. In Uganda, lack of directives on exactly how HIV related policies were to be implemented negatively affected implementation. Top leadership’s low regard for HIV/AIDS, at odds with the recommendation of their own renowned technocrats and scientists, is also another barrier to implementation.7 Issues that enhanced good policy implementation include: health care workers’ training and involvement in HIV/AIDS services as well as their involvement in policy development.8

Studies that evaluate policies require drawing lessons or concepts from existing policy analysis frameworks. Issues of interest that must be considered include: problem identification, formulation, policy implementation, and evaluation.9 Our work focused on the implementation phase of the policy process and is modeled under the “top down” and “bottom up” perspectives of policy decision making.10 “Top-down” is defined as hierarchical execution of a centrally-defined or -formulated policy. Such a policy is handed down from the top leadership to those who are supposed to implement it. On the other hand, “bottom-up” is a process of policy formulation that is driven by grassroots stakeholders and their coalition partners. The latter includes substantial involvement of local users in the process and it is very relevant as it stimulates individual motivation, will, and internal commitment to influence good implementation.10 On the other hand, non-involvement of local users in the process brings resistance to acceptance.11

The adoption of HIV and AIDS services is well structured in a hierarchical system. The policy keeper and leader for HIV/AIDS in Malawi is the Department of Nutrition and HIV/AIDS (DNHA) in the Office of President and Cabinet (OPC). They work in close cooperation with the National AIDS Commission (NAC), whose role is to provide leadership on the coordination of the national HIV/AIDS response and resource mobilization. There is also the National HIV and AIDS (DHA) in the Ministry of Health whose role is to lead implementation of clinical response.12 We assessed the roles in policy implementation played by key coordinating entities and other system players such as health workers, their supervisors, and health rights groups to implement the policy. Health leaders exhibited bias by prioritizing PITC for PMTCT operations over the general PITC.

Methods

This is a descriptive case study of the HIV testing and counseling component of the Malawi HIV/AIDS policy from 2003 to 2013. We looked at PITC in STI outpatient settings and PITC in antenatal settings to ensure a balanced understanding of the HIV testing component. Experts, policymakers, health care workers and health workers, their supervisors, and key gatekeepers such as heads of institutions were interviewed to identify barriers and facilitators. We also involved national health rights groups to implement the policy. Health leaders exhibited bias by prioritizing PITC for PMTCT operations over the general PITC.

Results

A descriptive summary of barriers and facilitators to policy implementation across stakeholders (healthcare workers, policy makers, policy formulation and health rights activists) is provided below:

Barriers

• Policy design and selective prioritization by Government12
• Resource constraints
• Problems with policy awareness/dissemnation
• Lack of coordination among Government key units of the Department of Nutrition, and Cabinet (OPC). They work in close cooperation with the National AIDS Commission (NAC), whose role is to provide leadership on the coordination of the national HIV/AIDS response and resource mobilization. There is also the National HIV and AIDS (DHA) in the Ministry of Health whose role is to lead implementation of clinical response.12 We assessed the roles in policy implementation played by key coordinating entities and other system players such as health workers, their supervisors, and health rights groups to implement the policy. Health leaders exhibited bias by prioritizing PITC for PMTCT operations over the general PITC.

• Policy design and selective prioritization by the Government

The Government prioritized PITC for PMTCT over the general PITC. For PMTCT, all healthcare workers were trained in HIV testing. There was deliberate deployment of special HIV testing counselors by the government in antenatal clinics but there were none on PITC/STI. Placement of HIV testing counselors was erratic in PITC/STI. A health care worker stated: “Sometimes you could see that the government had put too much emphasis on one thing and diminished the other. For example, they put too much emphasis on PITC and PMTCT but they need to know that each service is very important.” (PITC/STI 307)

Resource Constraints

Apart from healthcare worker personnel, policy implementation requires some resources and supplies such as HIV test kits, gloves, and other related supplies. The implementation of the Malawi HIV/AIDS policy has sometimes been characterized by shortage of some of these supplies. In times of low supply, priority was given to PITC for PMTCT services at the expense of PITC/STI services.

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A senior healthcare worker observed:

“Sometimes it affected services negatively, certain districts would run out of test kits for about two or three months and we know that if a woman is denied PMTCT the baby’s health is at risk.”

(Senior healthcare worker 314)

**Process of Policy Making**

Healthcare workers’ perspectives on policy-making process

Most healthcare workers interviewed were not involved in the policy-making process. This led to poor understanding of the importance of policy dissemination and decision-making processes affecting policy implementation. Only one of the six participants in the STI/PITC category interviewed reported partial involvement in the policy-making process. On the other hand, two out of four PMTCT participants interviewed stated they had been involved in the policy formulation of the overall HIV/AIDS policy. One of the PMTCT healthcare workers who was involved in the process emphasized the importance of the involvement of healthcare workers in the policy-making process:

“There are a lot of things that even the policy makers are not aware of… My presence in those meetings or in the process of policy development was very important as I was giving them the information on what exactly is happening on the ground.” (PMTCT 300)

Health rights activists’ perspectives on policy-making process

Health rights activists who were interviewed expressed dissatisfaction with involvement in the policy-making process. They bemoaned their lack of adequate involvement and complained of poor involvement of the healthcare workers on the ground. One of the health rights activists hinted on this challenge:

“As an institution, we were involved but it was not meaningful… what I believe is that everyone should be involved on the ground. That could have been the very first page of the policy process” (Health rights activist 319)

**Policy Awareness/Dissemination**

Healthcare worker perspectives on policy dissemination

A lot of healthcare workers were not aware of the existence of the actual HIV/AIDS policy. Local healthcare leaders felt short of resources to pass on the policy to the implementing healthcare workers. In one instance, a healthcare worker team leader said he had the policy document in his office and library for providers to read but the providers from that facility had not been informed about where to access the policy. Healthcare workers did not easily find time to read the policy documents. Ironically, the same healthcare worker supervisor observed:

“Training health care workers will be encouraged rather than asking somebody to read because people may not necessarily read. You cannot point fingers at them but it may be because they were busy implementing and they don’t have the chance to go back and read…” (Healthcare worker supervisor 305)

It was interesting to note that the on-the-job training or sensitization about the policy did not go well. Some health care workers were unwilling to be briefed or trained by colleagues who attended formal trainings and they would have preferred to undergo formal training themselves.

Some health care workers, including a senior healthcare worker, indicated that health care workers who had attended briefings became jaded and frustrated that their colleagues benefited more in terms of incentives like certification, monetary allowances, and official recognition by various stakeholders. A healthcare worker said that one does not get recognition or promotion based on knowledge from peer debriefing no matter how well he or she performs on the job unlike those who go for formal training of a particular task.

A different healthcare worker echoed the need for formal training:

“I think formal trainings are very important. When you do formal trainings you just brief your friends only on important aspects but may miss other information.” (PITC/STI 307)

Another healthcare worker thought that the job orientation was generally acceptable but some did not accept the arrangement:

“Debriefing by colleagues who went for trainings is very acceptable to us and people implement what they learnt from others without problems. However, at a government facility where I am deployed, people resent such an arrangement because they think, someone has been paid and yet want others to do the work for free. I have such a situation where some workers, especially health surveillance assistants would refuse to support some other HIV testing related tasks until they are formally trained.” (PMTCT 301)

Health rights activists’ perspectives on policy dissemination

Health rights activists indicated that policy dissemination among staff and member organizations was through staff meetings, policy awareness, and distribution of copies of policy documents. However, they complained that policy dissemination generally lacked wide community consultation or participation. One health rights activist observed the need for a clear facility holder to face the community structures for effective dissemination of policies:

“…I recommend use of existing structures. The target audience should have a say and decide. This is critical because people will be able to identify what belongs to them.” (Health rights activist 319)

Another health rights activist bemoaned lack of clear leadership to enforce the policy process, a view that was supported by two health care workers (PMTCT 300, PITC/STI 303) and a healthcare worker supervisor (312):

“The policy awareness had gaps. Knowledge of what is contained in the policy was not adequate because after the government launched it, they depended on stakeholders to take (the policy) to the community. I did not see any other way of publicizing it from the Government perspective, the launch was the end.” (Health rights activist 318)

Healthcare worker supervisor perspectives on policy dissemination

Healthcare worker supervisors were the least satisfied about the policy-making process. Many felt sidelined by their top-ranking officials in the Ministry of Health in the execution of the HIV/AIDS policy. The major reason for dissatisfaction was lack of involvement in policy formulation and decision processes about its implementation. One healthcare worker supervisor sounded very concerned about lack of involvement:

“Largely it is because we are not involved or give our contribution to the policy making process. We do not even know what is in the policy. To be honest with you, I am supposed to know what changes were made, but I don’t.” (PITC/STI 304)

“I can say supervision is not that good, since I came here I have never been anyone coming to supervise services.” (PITC/STI 310)

**Coordination among Malawi Government units**

The HIV testing component of the 2003 HIV/AIDS policy faced coordination problems among the Malawi Government HIV/AIDS leadership units of DNHA, NAC and DHA. This challenge was shared by all groups of stakeholders. Sometimes healthcare workers received conflicting information from coordinating stakeholders, and therefore had no way to determine whose guidance should be followed during their implementation. One healthcare worker supervisor spoke strongly about the coordination problem among the stakeholders involved in the implementation of the HIV/AIDS policy:

“I think there should be harmony. Think about the big three; the DHA, NAC, and DNHA in the OPC. I think that they work in isolation. I remember at one point there was information that came from them (DNHA/NAC) but then the DHA contradicted it. This left healthcare workers confused on the right course of action to take …” (Healthcare worker supervisor 305)

The health rights activists interviewed and a policy maker also acknowledged poor relationships among these coordinating entities. A policy maker who was also rather hesitant to express the dissatisfaction, said:

“Honestly the coordination through that office (OPC) was sort of political. At the beginning, the rule of OPC was very difficult to understand, although there is some improvement now, the reporting, relationships of the role of face to face to the government is still unclear on some issues…” (Policy maker 316)

Although there has been generally poor coordination of policy implementation within the entire health coordination systems, some programs supported by external funders provided clear coordination frameworks. For example, a health rights activist said:

“The coordination or lack of it sometimes was so big that there was confusion to implementers. Sometimes it affected services negatively, certain districts would run out of test kits for almost two or three months and we know that if a woman is denied PMTCT the baby’s health is at risk.”

(Healthcare worker supervisor 304)

One of the health rights activists, two health care workers (PMTCT 300, PITC/STI 307) and a healthcare worker supervisor (312) echoed this view:

“Coordination was not that simple, I am supposed to know what changes were made and I was surprised that they are always saying something ‘different’, and when I ask them, ‘we are told by somebody from headquarters (Ministry of Health)’… I feel we were supposed to go together or I was supposed to be informed.” (Healthcare worker supervisor 305)

Senior healthcare worker/policy-makers’ perspectives about leadership

Senior healthcare workers and policy makers from the main coordinating units of Ministry of Health (MOH), NAC and OPC were responsible for coordinating operations with healthcare workers. There was blame shifting within this level of stakeholders. Those from MOH blamed counterparts from OPC, that their structure did not provide full responsibility and leadership in creating awareness and implementation. Healthcare workers, too, expressed concerns about the poor coordination. Apart from these coordinating units, local leadership of healthcare workers also fell short of their mandate by not acting as effective supervisors to ensure that the policy was known to healthcare workers and that its implementation was going well. A senior healthcare worker observed:

“When we do spot check supervision in the field, we get shocked to hear people have not seen the policy document but the good thing is that you will be able to tell them of that. This is really an issue of the manager on the site to be responsible and strengthen supervision to ensure that people have the policy document and are adhering to it.” (Senior healthcare worker 316)

Health rights activists’ perspectives about leadership

There was dissatisfaction among health rights activists about the government’s leadership and commitment toward policy implementation. They felt government did not do enough to make necessary mechanisms to ensure policy implementation. There were not enough debates or formulation of policy and distribution. One health rights activist observed:

“There has been little commitment of how to get the policy out and use it. The government did not do much apart from distributing as any other IEC materials.” (Health rights activist 319)

Another concern of health rights activists was about lack of harmonization of health policies. One activist observed that policies are supposed to be complimentary with each other for effective implementation but every related policy seemed to take its own vertical path. He called for the setting up of
Health care worker deployment issues

There was a concern about the need to formally establish a cadre of HIV testing counselors who will help the workers feel recognized and work better to implement services. One health care worker complained:

“This is a major issue, in our job we are not recognized... We have to be recognized... we have to be recognized... so that we are noticed in the workplace.” (Senior healthcare worker 316)

The problem is that many service providers are not trained for HIV testing and this puts implementation at a disadvantage... The best is to train all STI service providers on HIV testing and counseling as well.” (Senior healthcare worker 316)

Facilitators of Policy Implementation

Specific facilitators of policy implementation were highlighted and included in this study. Adoption of Option B+ Policy was another facilitator - a recommendation that all pregnant or breastfeeding women who test HIV-positive be immediately enrolled on ART and remain on treatment. This helped further improve the PMTCT component, availability of free HIV test kits. STI drugs availability were also a facilitator for implementation.

Another facilitator was that all HIV testing services were free and this appealed to many. "Another facilitator was that all HIV testing services were free and this appealed to many. This attraction is that the resources should be there so that the government fulfills its mandate of patient care during implementation (of the policy)." (Policy maker 317)

Many participants highlighted the importance of supervision of healthcare workers as a motivator to implement the policy. Supportive leadership should be demonstrated by ensuring that adequate supervision of health workers is done. The problem is that many service providers are not trained for HIV testing and this puts implementation at a disadvantage. Supportive leadership is very important in positively affecting implementation. Many participants highlighted the importance of supervision of health workers who receive formal training to share knowledge and disseminate the policy. Supportive leadership is very important in positively affecting implementation. Many participants highlighted the importance of supervision of health workers who receive formal training to share knowledge and disseminate the policy. This is an easier and important to implement the policy, would instill confidence in other stakeholders and properly direct healthcare workers.

In Malawi, HIV/AIDS or other health related policies are usually implemented in more than one ministry. This helps in coordination of moving policies forward at all levels of leadership need to be strongly advocated.

Lack of coordination among key units of the Malawi Government was another major problem. Stakeholders complained about poor coordination and lack of clear roles within the HIV/AIDS policy coordinating stakeholders in the HIV/AIDS Department, MOH and NAC. This may have negatively affected policy implementation. Clear coordination roles for all key stakeholders are critical to the successful implementation of the policy. It was acknowledged that some supervisors were trained but failed to orient staff under their jurisdiction.

One interviewee from a local government health facility noted that supervision is structured per zone and district. However, the decentralized supervisory practice is not strictly followed. Health care worker deployment was another important facilitator to the implementation of this policy, an adequate number of health care workers must be in place. Task shifting to a lay cadre of healthcare workers known as health surveillance assistants (HSAs) has already shown good success in support of ART scale up in Malawi[22]. However, this cadre had some challenges such as failure to meet some quality clinical competencies and being overwhelmed with several other public health tasks given to them. A specialized and dedicated cadre to be solely responsible for HTC is therefore needed in key health facilities. A cadre known as HIV Diagnostic Assistants has just been adopted in Malawi to support HIV testing services. It is currently supported through national governmental organizations. However, it is not established as a formal cadre within the government system like the HSAs. One of the healthcare workers proposed that the Malawi Government should formally adopt the special HIV testing cadre (PMTCT 301). In a bid to reach the UNAIDS 90-90-90 targets, there is a need to increase HIV testing strategies. A testing scheme like this could help. There were also problems with leadership support. This leads to varying applications for the part of health care leaders and health rights activists who are health care worker leader advocated keeping the policy

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